Final Report

What makes case management work for people experiencing homelessness?

Evidence for practice

authored by

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for the

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This project, a review of the evidence about case management practice, was initiated to address the following research questions:

1. How is case management undertaken in the homelessness sector and how does this compare with practice in allied service sectors?

2. Which approaches to case management are most likely to lead to the best outcomes for homeless clients?

3. Why do particular approaches to case management prove to be more effective than others?

4. What effect do case management practices have on the outcomes for people who experience homelessness?

5. What is the impact of case management on durations of support and the implications for improved client outcomes?

6. How does case management facilitate accommodation and support options for improved client outcomes?

7. What is the likely effect of the creation of 'front door' entry points to a range of homelessness services, at which need is assessed and then a referral to a service provider made, on case management practices?

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EXECUTIVE SUMMARY

BACKGROUND

Case management has been central to homelessness assistance practice in Australia since at least the early 1990s, when it was adopted as a key strategy to enhance the Supported Accommodation Assistance Program (SAAP). The approach was formally documented in 1997 with the release of the SAAP Case Management Resource Kit. This research synthesis project was initiated with the intention to provide a rigorous and independent evidence base for informing practice and policy, in particular the negotiation of the next SAAP program agreement.

AIM

The research synthesis aims to provide an evidence-based understanding of how case management works to contribute to the development of more effective responses to the needs of people experiencing homelessness. This report defines case management and synthesises the international scientific evidence on case management practice for the homelessness sector.

FINDINGS IN BRIEF

→ This research synthesis defines case management by its ability to increase a person's self-care capacity and make itself redundant. Case management is defined as an intervention which does not simply meet this or that need, but develops a person's capacity to self-manage their own access to any supports they need.

→ Synthesis of the evidence finds that case management achieves this outcome through a relationship between the client and the case manger or case management team which has the qualities of persistence, reliability, respect and intimacy, and which delivers comprehensive, practical support.

→ The direct provision of comprehensive, practical support is preferable to brokerage or referral to other services. Comparative studies have shown that case management is most effective when it provides direct assistance with practical and specialist support needs.

→ The evidence demonstrates that effective case management is a time- and resource-intensive intervention. However, controlled experiments show that it is cost-effective because it reduces other system expenditure such as hospitalisation.

→ Multidisciplinary teams providing a case management relationship with the required qualities has been proven to deliver reduced homelessness and more client satisfaction at no extra total system cost than office-based services, for clients requiring a complex service response.

→ The evidence identifies certain conditions which enable the case management relationship to deliver beneficial outcomes for people experiencing homelessness. These include:

  → access to housing resources and specialist supports;

  → individually determined support durations;

  → case management staff with advanced assessment, communication and relationship skills and regular practice supervision.

METHODOLOGY

The research methodology is primarily based on an evaluation method called 'realist synthesis' developed by Ray Pawson and others associated with the UK Centre for Evidence-Based Policy and Practice[1]. Realist synthesis defines a social policy intervention in terms of its mechanism and contextual conditions, and then evaluates and integrates quantitative and qualitative evidence to determine what we know about *why* it works, when and how (Pawson, 2006). This method produces evidence-based principles about how case management works and its limitations, in order to give policy makers and practitioners tools to improve practice, service design and implementation.

The project methodology also included several engagement processes with case management practitioners to ensure the practice-relevance of the findings. This included seven interviews with nine practitioners, and guidance from a project advisory group as noted in the Acknowledgements section of the report. Reference to interview material is identified in this report by a number in brackets (eg. (1)).

The research synthesis process collated over 200 sources of empirical evidence through comprehensive searching of the published literature. These studies were appraised for their quality, rigour and relevance to the research question, then systematically synthesised until extra evidence no longer produced significantly new insights. Fifty-three sources were consequently selected for this report. The scope was in the first instance limited to research published in the last five years; however earlier studies are included if they provide the most current evidence.

FINDINGS[2]

This synthesis of fifty-three credible sources of empirical evidence finds that case management works because of a relationship between the client and the case manager or case management team, with the qualities of persistence, reliability, intimacy and respect, that delivers comprehensive, practical support.

The synthesis finds that case management is a time- and resource-intensive intervention which nonetheless can prove to be cost-effective because it increases a person's self-care capacity and consequently reduces other service system expenditure.

To be effective, the case management relationship relies on highly skilled staff and access to resources, particularly housing and specialist supports (for example, expertise in psychiatric and substance use issues).

A persistent, reliable, intimate and respectful relationship

The synthesis finds that a case management relationship with these qualities produces the best outcomes for clients, and it also identifies evidence of the limitations which accompany the use of such a relationship.

Evidence from experimental comparisons of different case management models consistently finds that a persistent, reliable relationship directly delivering comprehensive, practical support produces better client outcomes than office-based monitoring and referral (Morse, 1999, Wolff et al., 1997, Coldwell and Bender, 2007,

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[1] For further information please refer to http://www.kcl.ac.uk/schools/sspp/interdisciplinary/evidence .

[2] Note that the evidence sources cited here are presented in detail in this report. For convenient access to further information on the individual study, please use the alphabetical listing of the studies on page 3.

Bedell et al., 2000). Two randomised controlled studies also showed this was at no extra cost due to reductions in total system expenditure (Wolff, 1997, Morse 2006).

Qualitative studies confirm that service users overwhelmingly value a persistent, reliable, intimate and respectful relationship. This finding was synthesised from thirteen qualitative studies from the United States, United Kingdom, Canada and Australia. The studies involved 665 research participants including adults and young people experiencing homelessness, palliative care clients or family members, community mental health case management clients, and people with substance use disorders.

Two studies found that highlighting the common ground between the case manager and the client helps to mitigate the inherent power difference and more broadly counteracts the isolating effect of stigma (Ware *et al.*, 2004, Kirsh and Tate, 2006). The significance of common ground is further indicated in the engagement advantage demonstrated by peer-case managers in an experimental comparison (Sells, 2006). By making a person 'feel like somebody' a respectful relationship is a practice of social inclusion.

The evidence showed that a persistent and reliable relationship of over six months in duration helps people to increase their self-care capacity, and that support intensity varies dynamically over time (Kirsh, 2006)(Muir-Cochrane, 2001). One study finds effective support occurring in the third year for people recovering from severe mental illness, and another finds behavioural changes occurring over many years for clients with personality disorders (Bradshaw et al., 2007, Nehls, 2001).

Evidence from studies of service users and service providers agree that respect is the key to a successful intervention (Kidd and Davidson, 2007, Nehls, 2001), and that a form of intimacy is a critical part of case management (Buck and Alexander, 2006, Angell and Mahoney, 2007). These findings are synthesised from fifteen qualitative and four quantitative studies. The studies had a total of 5080 research participants including people experiencing homelessness, service providers, and clients of mental health case management.

The evidence identifies two dimensions of intimacy: the genuine emotional connection that creates a relationship, and the intimate nature of case management activities, including for example, shopping, attending doctor's appointments, financial management, cleaning and providing rides. Intimacy is both an unavoidable part of the activities involved in the delivery of the outcome of comprehensive, practical support, and a key element of the emotional bond in a relationship.

The element of intimacy generates some of the most challenging practice concerns. These concerns include emotional ambiguity, power differences, professional boundaries and expectations, and the differing perspectives of clients and workers (Beresford et al., 2007, Dickson-Gomez et al., 2007, Angell and Mahoney, 2007). The evidence implies the need for significant support for case management staff, and further emphasises the importance of demonstrating respect in the relationship.

The empirical evidence does not conclude that either a single person or a team is best for case management. However, it is clear that the identified qualities of the relationship are necessary regardless of the case management model. For example, while there is evidence to suggest that very demanding clients with serious mental illness and co-occurring substance use disorders achieve better outcomes from a multidisciplinary team (Morse *et al.*, 2006), a qualitative study of this team case

management approach showed that a primary worker within the team was important for providing continuity and personal knowledge of the individual (Krupa *et al.*, 2005).

Limitations of the case management relationship

Three sources highlighted the significant variation in the outcomes *within* a group receiving case management, which in some cases exceeded any differential intervention effect (Vanderplasschen et al., 2007, Morse et al., 2006, Rayner et al., 2005). Poorer comparative outcomes were clearly associated with homeless persons and especially those with more severe medical and substance abuse problems.

The finding of a high-level of intra-group variation in these studies highlights the difficulty of the change that case management is deployed to achieve, and also the diversity within the group of people experiencing homelessness. It implies that the client's starting situation is a significant factor in the time it may take to achieve case management outcomes.

Similarly the largest study which has positively correlated the strength of the case management relationship with better housing outcomes after twelve months, also found that a number of the client's personal characteristics limited the formation of a relationship: a longer history of homelessness, a higher level of psychiatric symptoms or drug use, and less education (Chinman *et al.*, 2000, Chinman *et al.*, 1999).

Comprehensive, practical support

Comprehensive, practical support means direct assistance with daily living activities as indicated above. Two further elements are highlighted in the evidence base: assistance with housing, and access to specialist assistance like psychiatric and substance use treatments.

The evidence shows that access to housing is key for enabling the case management relationship to generate beneficial outcomes with people experiencing homelessness. An experimental comparison finds that access to affordable housing is the most significant factor in achieving housing stability for people also experiencing mental illness (Hurlburt *et al.*, 1996). A review of sixteen evaluations found that case management alone is not as effective as case management with housing (Nelson *et al.*, 2007). Furthermore, higher housing retention rates are achieved when the housing is not tied to substance use treatment, while still achieving equivalent substance use reductions (Gulcur *et al.*, 2003, Tsemberis, 1999).

There is evidence that people with higher levels of impairment due to mental illness or drug use do significantly better in combined housing and support programs, compared to case management alone (Clark and Rich, 2003). Specialist tenancy management is found to be particularly effective for improving men's outcomes because they experience less tolerance for challenging behaviours from private landlords (McHugo *et al.*, 2004).

To provide access to specialist assistance, multidisciplinary case management teams are found to be more cost-effective for people who require a complex service response, for example people with both mental illness and problematic substance use (Morse *et al.*, 2006). Furthermore, one study found that such teams also experience significantly higher job satisfaction and lower burnout rates, and provided some evidence that it was the access to relevant professional colleagues rather than the caseload size that had the positive effect on worker experience (Boyer and Bond, 1999).

An example of the multidisciplinary composition of such a team is one comprising social workers, psychiatrists, vocational trainers, substance abuse counsellors, nurse practitioners and housing specialists (Tsemberis *et al.*, 2004). This successful program provided case management services in conjunction with permanent housing.

Policy, program and practice implications

The critical practice implication from the synthesis is for case managers to develop relationships with their clients that are persistent, reliable, intimate and respectful. There are certain essential enabling service system conditions to allow for such practice, and these conditions are the basis for the implications for agency practice, program guidelines and funding body policies.

Two sets of program conditions are best avoided when implementing case management, since they undermine the operation of the case management mechanism and fail to demonstrate better client outcomes. Case management programs designed as short-term crisis responses, or as high caseload, office-based brokerage and referral services, do not allow case management to function effectively because a relationship cannot be developed or maintained.

The finding of persistence and reliability does not imply that everybody needs a *long* period of case management. Rather, it implies that case management durations must be individually negotiated with reference to the person receiving assistance and a realistic level of self-care as an outcome goal.

Implications for service system design and capacity

→ Case management requires an investment of time for relationship formation and maintenance, both in terms of the overall duration and frequency of contact within that duration. This implies a constraint on case load size, and recognition of a minimum duration threshold before outcomes can be achieved.

  → Available evidence indicates that six months may be the minimum required duration to establish a working relationship with people experiencing homelessness and mental illness, and more than six months will be required for the most disengaged clients.

→ Arbitrarily imposed case management durations may be inefficient if they end the relationship prematurely. Not only will this compromise the outcomes, but the initial investment in the relationship will be lost.

→ Direct service delivery by the case manager and/or the case management team is preferable to brokerage or referral to other services.

→ Case managers require access to housing resources and specialist supports.

  → Specialist tenancy management or housing and support integration is indicated, especially for men or for people with high levels of psychiatric symptoms or substance use issues.

  → Multidisciplinary case management teams are more cost-effective for working with people requiring complex service responses.

Implications for staff skills and support

→ Case managers need comprehensive assessment skills and the capacity to respond directly to a broad range of practical and emotional needs, for example, the capacity to assist with housing, nutrition, access to income support and transport, along with helping to manage the effects of social stigma, family breakdown or a history of trauma.

→ Case managers require high-level communication and relationship skills, including the capacity to sustain a genuine emotional connection with the client in the context of challenging behaviours and complex health needs.

→ Case managers need a high level of support, including professional supervision and multidisciplinary collaboration, to mobilise and manage the professional intimacy of the case management relationship.

→ Remuneration and professional recognition for case management in the Australian homelessness sector needs review as there is evidence it is not currently commensurate to the skills required.

Implications for the Supported Accommodation Assistance Program

The evidence demonstrates that current Supported Accommodation Assistance Program (SAAP) case management has a number of strengths that can be highlighted and supported. It also shows that a number of factors are likely to reduce its effectiveness.

SAAP strengths include expertise in comprehensive, practical support provided by an intimate and respectful relationship. The major weakness is the constrained average support durations which inhibit persistence and reliability in the case management relationship. Difficulties in accessing specialist support and appropriate accommodation also place limits on the capacity of SAAP case management to deliver stable housing and improved health for the client.

RESEARCH LIMITATIONS

The primary limitation of a research synthesis is that it cannot provide original empirical evidence. As a synthesis, it is necessarily limited to using the existing evidence base to answer the research questions.

This synthesis was constrained by the low number of experimental studies of case management in all fields, and in homelessness specifically. In Australia, the small number of studies available are either descriptive rather than analytical, program-specific evaluations which lack randomisation and a control group, or in-depth qualitative analysis.[3] The wide range of models and approaches delivered under the name of case management and the absence of program fidelity measures in Australian evaluations also limited their validity for this project.

Significantly, the evidence base is strongest in North American studies of community mental health case management for people experiencing homelessness. The findings synthesised from these studies were validated by engagement with local practitioners. Nonetheless, there are consequently significant gaps in the evidence about case management for specific groups experiencing homelessness in Australia, including Indigenous people, families, young people and women escaping domestic violence.

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[3] A significant exception is the Victorian randomised controlled trial of service delivery for young homeless unemployed young people. See http://www.yp4.org.au/. Results are due late in 2008.

PART ONE: KEY CONCEPTS

1 INTRODUCTION

This report comprehensively synthesises current empirical evidence about case management into an explanation of how and why the intervention can produce good results for people experiencing homelessness.

The report provides policy makers, practitioners and advocates with evidence-based principles to assess and refine existing case management programs, or design new models. It identifies the elements needed to get the best results for people receiving case management by explaining how and why the intervention works, and identifies some of the difficulties inherent in this intervention.

1.1 Australian and international context for homelessness case management research

This research is extremely timely in Australia as the Federal Government is in the process of revising the national response to homelessness. The first ever governmental Green Paper on homelessness, released in May 2008, presented a critical analysis of the current government response as well as highlighting existing innovation and good practice.

The Supported Accommodation Assistance Program (SAAP) has been Australia's primary national response to homelessness since its inception in 1985. Currently, Commonwealth, state and territory contributions to SAAP programs comprise approximately 58% of the total government spending on homelessness-specific programs (total estimated at $642 million for 2007–2008) (Government, 2008 27).

The Green Paper, *Which way home? A new approach to homelessness*, identified a number of characteristics about the current response to homelessness (Government, 2008 33-37):

→ Poor long-term housing, employment and education outcomes

→ Chronic cycling of homeless people through the service system

→ Failure of SAAP programs to move clients through to independence

→ One in four SAAP clients are repeat clients of whom about half access the program 3–4 times a year

→ Poor coordination between homeless-specific and mainstream services

→ Significant workforce challenges including low remuneration, lack of career path, and skills shortages.

Case management practice in homeless persons agencies is predominantly funded under the SAAP Act/funding agreement and is consequently impacted by these existing conditions.

In the Australian homelessness assistance sector, case management is a well-established support intervention, formally introduced into SAAP in 1997, but already established in practice well before. Practitioners recall coming across the term 'case management' between ten and twenty years ago, sometimes reflecting an interface with other areas of the human services, and in other cases a perceived continuity with the term 'casework'. Within Victorian homelessness assistance, there are also two recent service delivery initiatives that have furthered our understanding of the mechanisms and conditions for effective case management:

YP[4] : a three-year trial (2005–7) offering homeless young people a single point of contact to address employment, housing, educational and personal support

goals in a joined-up way over two years. The trial was due for completion in 2008. YP[4] was initiated by Hanover Welfare Services in partnership with Melbourne CityMission, the Brotherhood of St Laurence and Loddon Mallee Housing Services, and supported by five government departments across state and federal jurisdictions as well as by philanthropic organisations and peak bodies. See http://www.yp4.org.au/ (YP[4], 2007)

The **Homeless and Drug Dependency Trial**: a three-year trial (over 2001–2004) funded by the Department of Human Services (DHS) and operating across Melbourne's three Crisis Supported Accommodation Services: Hanover Southbank, the Salvation Army's Flagstaff and St Vincent de Paul Aged Care and Community Services' Ozanam House. The successful trial included a continuous case management and support model to engage drug-using clients and assist them to find pathways out of homelessness. See http://www.health.vic.gov.au/drugservices/pubs/hddt.htm (Drugs Policy and Services Branch Mental Health & Drugs Division).

Also important to note is that the SAAP case management resource kit is currently being revised for the first time since publication in 1997.

Findings of the research synthesis will be useful on two levels:

→ Service delivery: to aid practitioners in developing evidence-informed practice

→ Agency and system: to support evidence-informed advocacy where system change would improve outcomes.

The research synthesis will also help to put the SAAP program into a context of international evidence-based practices in homelessness support.

Case management is an international phenomenon. Some researchers have argued that case management today appears to be endemic to the human services (Gursansky *et al.*, 2003, Kennedy, 2000). It has become the mainstay of service delivery across welfare and health sectors in Australia, the European Union (EU) and the United States. One commentator goes so far as to declare:

Case management has become a ubiquitous representation of the post-industrial information age. In 25 years someone will surely look back and label today the 'Case Management Period.' (Keigher, 2000 227)

While becoming the dominant service-delivery model in the human service sector, case management continues to be described as a vague and even amorphous concept with much contention surrounding various models, approaches and styles. A 2005 report for Ireland's Homeless Agency advocating the implementation of a case management approach notes the 'considerable variation and some confusion' in the sector 'surrounding the interpretation of what care and case management is and how it might best operate in practice,' noting that 'there are a myriad of different possible interpretations and applications of case management' (Eustace and Clarke, 2005 5, 23). In an Australian context, Muir-Cochrane wrote that case management has been widely adopted by community mental health teams, despite a lack of clarity on 'what exactly case management is, and what case managers actually do' (Muir-Cochrane, 2001 210). Consequently, the success of case management in dominating human services practice has raised concerns, prompting Australian social work academics to raise a call for intellectual scrutiny of this phenomenon (Kennedy *et al.*, 2001).

In contemporary human services, case management is a way of delivering assistance often reserved for situations where the needs of the person are multiple or complicated (Rayner, 2006, Stephens *et al.*, 1991, Rothman, 1992, Vanderplasschen

et al., 2004, Ballew and Mink, 1996). This group of people is often described as 'challenging' or 'complex clients' though a less objectifying term would be a group requiring a complex service response.[4] Seen from another perspective, case management can also look like a form of cost reduction for governments, and indeed has carried this explicit policy direction in countries throughout the developed world (McDonald, 2006, Austin and McClelland, 2000). Case management for these reasons is a contentious term, and many different practice models are implemented in its name.

Our approach is to generate a functional definition of case management based on how and why it works, rather than entering the fray of comparing models and approaches. The research synthesis draws together a range of credible sources to build a coherent, evidence-informed understanding of the intervention.

This project was guided by a number of interviews with experienced case management practitioners (for more information see Section 2.5.2 and the Acknowledgements). Interview material is referred to in the text by a number in brackets (eg. (1)).

1.2 Chapter outline

PART ONE: KEY CONCEPTS, explains the ideas used by the study. The first chapter explains the research method, and provides a critical discussion of the issues relating to evidence-informed practice. It presents a short summary of the major methodology employed by the study, 'realist synthesis', and describes the processes used to engage with practitioners.

The second chapter sets out a theoretical framework for understanding how case management works. This framework is built from a critical analysis of policy documents, service-provider literature and practitioner input.

PART TWO: THE EVIDENCE, tests this framework against the evidence. It uses the research findings to assess if the theory matches the evidence, and subsequently amends and refines the explanation to produce the synthesis: an evidence-based understanding of case management.

Chapter 4 describes the overall scope and quality of the evidence base.

The subsequent thematic chapters present the evidence study-by-study to provide readers with the context and quality of the research findings. The findings from each section and chapter are synthesised at its conclusion.

The thematic chapters group the studies by their primary relevance to the mechanism, outcomes or contexts for case management. There is an inevitable thematic overlap as most studies provide evidence about more than one aspect.

Chapter 5 focuses on evidence that tests and refines the understanding of the mechanism of case management. Chapter 6 synthesises evidence primarily relating to the outcome of case management, while Chapters 7 and 8 integrate what is known about the contextual conditions in which case management is practiced.

The concluding chapter summarises the implications of the research synthesis for the Australian homelessness sector and draws on the findings to answer the research questions.

The Executive Summary presents an overview of the synthesis findings.

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[4] Thanks to Louise Coventry for this distinction, formerly manager of the Victorian YP[4] randomised controlled trial of 'joined up' practice for assisting homeless young people.

2 RESEARCH SYNTHESIS TO SUPPORT EVIDENCE-INFORMED PRACTICE

2.1 Evidence-informed practice

> If knowledge implies power, a central question concerning the generation of knowledge about 'what works' is: who or what is empowered as a result? (Robinson, 2001 235)

Using evidence to inform practice seems obvious: after all, why wouldn't we use what we know? Yet, as has been wryly noted, 'being sold on the idea is one thing; implementing it is quite another' (Moseley and Tierney, 2005 114). The difficulties are both political and practical.

First, evidence-based practice is contentious because there is disagreement about what sources of evidence should be counted, and for what purpose. Australian academics, Marston, Watts and McDonald have challenged the assumption that using evidence is a neutral way to make decisions (Marston and Watts, 2003, McDonald, 2006). They make clear the importance of asking not only *what* works, but how is this known, and *what counts* as evidence.

Second, evidence-based practice is practically difficult. Research evidence is a source of knowledge about 'what works' but is often inaccessible to practitioners (Lewig *et al.*, 2006, Nutley *et al.*, 2007). Obstacles typically include workload pressures, the priority of day-to-day client work, and a lack of access due to both physical and cultural factors (e.g. library membership or comprehension of academic style and jargon) (Kirk, 1999, Moseley and Tierney, 2005).

Moreover, suspicion and cynicism about previous policy reforms which have not been effective can lead to practitioner disengagement: as Pawson puts it, 'the process of continual policy renewal and endless evaluation can inoculate practitioners against listening to evidence' (Pawson, 2006 13). Resistance to research dissemination may also arise from the implication that current practice is defective. Effective communication of the evidence requires an acknowledgement of the existing knowledge, experience and commitment to quality service delivery among practitioners. Practitioners report that they want something that will help in their day-to-day decision-making, and they don't have time to waste listening to academic knowledge from people who do not understand what it is really like in the field (5,7). Studies of the factors that influence the use of research in policy starkly indicate that uptake of evidence has only partly to do with the quality of the information (Lewig *et al.*, 2006).

Practice guidelines based on a review of the available literature are advocated by some for promoting research use (Strehlow *et al.*, 2005). But even these can be far from useful as one author argues by imagining a hypothetical 'young social worker.' The social worker examines evidence-based practice guidelines for advice on an appropriate psychosocial treatment for schizophrenia (Kirk, 1999 305-6):

> She scans the guideline, asking: what about using individual psychotherapy?
>
> > The results of efficacy studies of psychotherapy are difficult to interpret. Earlier controlled outcome studies generally failed to demonstrate differential clinical/functional advantages of psychotherapy without medication over somatic therapies…Overall, the studies of the efficacy of

psychotherapy are of variable quality, making generalizations hard to draw. (p.27) [5]

What about family intervention?

It has not been demonstrated that any one of these approaches is superior to any of the others. The studies described all use somatic treatments in addition to the family interventions. While the use of different variants of family management and the different types of control treatments makes it difficult to compare the results of the more than 10 controlled studies, relapse rates typically have been halved. (p.27)

What about group therapy?

The evidence for the efficacy of group therapy is not strong, possibly because of the serious methodological flaws in many of the studies. Most studies of outpatient and inpatient group therapy were conducted in the 1970s; there have been few recent studies. (p.28)

Case management?

Results of controlled studies of the effects of case management have yielded inconsistent findings, probably because of methodological problems in design…(p.29).

Kirk offers sceptical support of the notion of practice guidelines while outlining in a humorous way the very significant practical constraints on both their development (rigour and relevance) and their useability. His point is not to disparage scientific evidence but to put it in a realistic practice context. Evidence is rarely comprehensive or categorical. Even evidence-based guidelines do not often provide definitive advice since, as he shows with the guidelines: 'the research literature itself is messy, methodologically flawed, often dated, inconsistent, and ambiguous' (Kirk, 1999 307). Different studies may contradict each other and it takes another level of analysis to determine why, or to draw a sensible conclusion. A further task is to extract the practice-relevant insights, and put them in a form that will be useful on the ground.

Kirk's view still resonates today with a widespread feeling among workers that experience is the best source of knowledge (2,5,7). Yet on the other hand, also common, is a frustration with practice disappointments and an appetite for new approaches that might yield better results for clients (1,3,5).

Current understandings of research use recognise the need to value the range of information sources necessary for the development of good practice. Research evidence is only one source of knowledge that can inform practice, but it is unique and valuable (Solesbury, 2001, Nutley *et al.*, 2007), so how can it best be mobilized?

The best evidence we have about using research to inform public services, is collected in the recent book *Using Evidence* (Nutley *et al.*, 2007). It carefully presents the factors influencing the uptake of research, and the evidence for the mechanisms to improve the use of research in policy and practice. The book makes two key recommendations: recognise and promote the value of conceptual as well as instrumental uses of research; and develop interactive, collective and iterative models/processes/products.

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[5] The guidelines cited are the American Psychiatric Association's "Practice Guideline for the Treatment of Patients With Schizophrenia" published as a supplement to the *American Journal of Psychiatry* in 1997.

Consensus on the use of research evidence says that research has at least three levels of influence: direct, indirect and environmental:

→ Direct instrumental use – literally 'do this not that' type of guidelines

→ Indirect cultural use – input for reflection in support of a workplace-learning culture

→ Environmental/foundational – background resources and a context from which unexpected creative solutions can emerge.

The first use describes a rational and linear process with intuitive appeal: 'if the findings are relevant and useful, practitioners will adopt them' (Nutley et al., 2007 112). Instrumental use of research has been most commonly associated with the idea of evidence-based practice or policy, and there are a range of strategies to promote it (NHS Centre for Reviews and Dissemination, 1999, Lewig *et al.*, 2006).

However Nutley *et al* describe a number of problems with the notion of instrumental use. First, there is a lack of practice-applicable research findings; second, it ignores organisational and other contextual factors that influence the actions of individual practitioners; and finally, it ignores the value of research use as a learning process. In particular they highlight the limitations of assuming that any particular research finding can be literally applied to improve an instance of practice either through a person's self-motivated learning or through top-down mandate in, for example, program guidelines. These strategies contain assumptions that research use is linear and a primarily individual process. In fact, they argue that learning is primarily a social and interactive process, and individual behaviour is heavily influenced by organisational and cultural forces.

The second two uses of knowledge, indirect and environmental, are more strongly supported by the available evidence on the use of research. This shows that research use is a complex, multifaceted and dynamic social process, and highlights the role and value of conceptual uses. Nutley *et al.* write that the conceptual use of research can

> bring about changes in knowledge and understanding, or shifts in perceptions, attitudes and beliefs: altering the ways in which policy makers and practitioners think about what they do, how they do it, and why. (Nutley et al., 2007 301)

The third, environmental or foundation impact is similarly characterised by interactivity and non-linear outcomes.

Of clear value are models which create and sustain interactions between researchers and research users in all stages of the research process from question-setting and research design to interpretation and dissemination of the findings (Lomas, 2000). The social aspect of research use is supported by the evidence: 'the one-on-one encounter consistently emerges as the most efficient way to transfer research' (Lomas, 2000 237). Engagement produces better instrumental use of research *and* activates the second two levels of research impact.

The second and third uses of research may seem frustratingly intangible in the present, yet they are actually a more realistic approach to social influence. Human history surely shows that social problems do not have linear solutions, and that social advances generally occur through creative and courageous leaps. Pawson comments:

> change actually takes place in a 'ontologically deep' social world in which the dormant capacities of individuals are awakened by new ideas, from which new ways of acting emerge. (Pawson, 2002a 19)

The indirect and environmental functions of research provide the conditions in which problems (current, emerging *and* unforeseeable) can be identified and solved – the right attitude, the right resources and the right interactions. While instrumental uses may address current problems, cultural and foundational uses set up the conditions for solving future concerns. Of course, community agencies have always had this interest in research use; research provides credible evidence for advocacy to government or other funding bodies, and forms the basis for raising public awareness.

This framework suggests that an effective format for 'evidence' includes not only the material aspects – written, verbal, short or long, visual, mode of dissemination etc. – but also the way in which the material is conceptually framed. For example, resistance to a message can be due to not acknowledging audience expertise, or blindness to factors that really matter to the audience (such as the lack of housing).

The following section explains how the approach taken in this study, known as 'realist synthesis,' responds to these dilemmas by foregrounding not only the defining elements of a particular practice intervention, but the conditions which are necessary for it to be effective. Realist synthesis is a particular kind of research synthesis.

2.2 Why do research synthesis?

This report synthesises recent scientific research about case management to determine what is known about it, and in particular, how to produce the best results for people experiencing homelessness.

In other words, the purpose of this research synthesis is to understand the evidence we have about case management and articulate the implications for practice, policy and program design. Unfortunately, not only is the evidence base a mess of different studies with varying targets, samples, questions and methodologies, but case management itself is a moving target. Case management comes with what seems like an unending series of qualifiers, referring to particular models, approaches, styles and/or funding streams. For example, case management may be

> Intensive, Enriched, Clinical, Advanced, Mobile, Brokered, Critical Time Intervention, Strengths-based, Community Care, Enhanced, Team, Assertive, Person-centred, Social Network, or Specialised.

And it has been adopted widely across the human services, for example:

> Homelessness, Problematic Substance Use, Cognitive/Physical Disability, Legal Aid, Child Protection, Special Needs Education, Mental Health Care, Psychiatric Rehab, Corrections, Aged Care, Primary Care, and Employment Services.

As a result, case management has been researched in terms of different types of activities and in relation to specific problems, for example, severe mental illness or a strengths-based rather than a brokerage approach. For the research synthesist, this diversity means there are very few opportunities to compare apples with apples.

The ubiquitous presence of case management in practically all fields of the human services is further complicated by the nature of homelessness itself. Very often case management in other sectors must deal with homelessness as an issue to be managed, and second, case management in homeless persons agencies may well need to call on the full range of human service specialties.

Research synthesis is useful in this context because it provides a way to manage the overwhelming body of research evidence on social policy and programs which has accumulated over time. While any good primary research will contextualise its findings

within what is already known, the sheer scale and complexity of available evidence today makes it particularly hard *to know what we know*.

> Ask any professional how they get to know what they need to know in their work and you get very diverse answers about the sources of their knowledge […] chances are that – even with the most sophisticated hardware and software – the availability of all relevant knowledge is a hit and miss affair. (Solesbury, 2001 8)

In response, the practice of systematically reviewing the literature as a form of research *in its own right* has grown in popularity. Various models have emerged: meta-analysis, systematic review, narrative review, best-evidence synthesis, and more recently 'realist synthesis' (Slavin, 1986, Pawson, 2002a, Gough and Elbourne, 2002, Jones, 2004). Within the medical field, best practice systematic review of randomised control trials is championed by the Cochrane Collaboration[6]. The Collaboration was established in 1993 as an international effort to provide the best source of evidence about health care by the electronic publication of regular high-quality reviews (Chalmers and Haynes, 1994, Clarke, 2004).

While the Cochrane model inspired establishment of the Campbell Collaboration[7] to provide a similar service for the social sciences, others have argued that systematic review in social policy and practice requires a different approach from that used in medical practice and research (Wallace *et al.*, 2003, Boaz *et al.*, 2001, Kirk, 1999). Not only is there a complex interactivity of factors operating in any individual case which cannot be tested by the gold standard large-scale randomised control trial[8] but also in the resource-constrained environments of social welfare programs, the best 'treatment' is often unavailable.

A further complication when assessing the 'effectiveness' of a human services intervention is that there are always multiple interested parties. For example, in case management there is the person seeking help, the case manager, the case management agency, the funding agency (usually a government department), and usually a range of other social service providers. The person's family and the general public may also have a stake in determining what is an effective intervention. Therefore, when assessing the effectiveness of social programs, a social work academic recommends the following question:

> Effective against what standard, effective for whom, at what personal and social cost? (Kirk, 1999 308)

The difficulties faced in evaluation of social programs are well documented (Moffitt, 2004, Pawson, 2006, Orwin et al., 1994, Salyers et al., 2003, McDonald, 2005 278-9). Reviewing a decade of UK policy in case management for people with learning disabilities, Cambridge details the complexity of models, program guidelines, and funding structures and notes dryly that it makes 'general lessons difficult to identify' (Cambridge, 2006). Cambridge ably describes the serial evolution of policies and programs – one approach layered after another, trials and pilots in different regions, and the proliferation of variations against a 'complex policy backcloth' and in 'an already confused micro-organisational landscape' (Cambridge, 2006 3). In another example, a comprehensive review of US welfare reform evaluations demonstrates that ideas about a program can be just as significant in producing social effects as the

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[6] See http://www.cochrane.org/

[7] See http://www.campbellcollaboration.org

[8] In fact this is increasingly recognised in medical research since even for apparently simple treatment events such as choosing the right drug for arthritis, effectiveness will be complicated by age, lifestyle, genetics, other medications, co-morbidities etc.

'actual intervention' (Moffitt, 2004). In response to these challenges, some researchers have begun calling for more *realistic* approaches to understanding and using the evidence. Realistic approaches in this context are defined as those which respond to the necessarily messy and complex world of cause and effect in social policy interventions.

2.3 Realist research synthesis

This report primarily uses a methodology called 'realist synthesis'. Realist synthesis was developed and championed by Ray Pawson and others from the UK's Centre for Evidence-Based Policy and Practice, funded by the Economic and Social Research Centre (Pawson, 2006, Pawson, 2002b, Pawson, 2002a). Realist synthesis proposes that research synthesis in the social policy area is best directed at refining the understanding of *why* an intervention works, when and how, rather than attempting a categorical answer to the question, 'what works?'.

In its broadest sense social policy intervenes in social and economic realities in order to generate politically desired outcomes. Evidence-based social policy and practice is intended to guarantee the desired outcome by using objective knowledge to determine *what works.* But to identify what works implies that we understand what *causes* particular social effects, and it is here that the realist perspective makes a striking contribution by proposing a new understanding of causality for social science evaluations. For Pawson at least, realists challenge the assumed links between policy design, program implementation and observed changes in people's lives (Pawson, 2006 17-37). For instance, he argues that:

> in order to be true to the nature of causal explanation and to be faithful to the character of social interventions, the evidence base must attempt to get to grips with social processes of extraordinary complexity. […] In the realist view, social interventions are always *complex systems thrust amidst complex systems.* (Pawson, 2006 35 original italics)

This implies a realistic embrace of the non-linear implementation chains which are involved in translating a policy document into practice on the ground. This is why realist synthesis focuses on building an explanation of how an intervention works, rather than producing a judgement about the merits of any particular program.

The new model of causality, the realist way of understanding how a social program causes its effects, is built on the analysis of three inter-related aspects of any social policy intervention: what it achieves, which element generates this effect, and under what conditions is it successful (Pawson, 2006 20-5). Or in simple terms, the outcome pattern (O) is produced by a mechanism (M) plus the contextual conditions (C):

$$O = M + C$$

The equation highlights the understanding that the mechanism and the context(s) are equally important for delivering successful results. The distinction between mechanism and context helps to explain why an intervention may work well in one randomised controlled trial and fail miserably in another. The mechanism is present in both trials; however, differences in the contextual conditions mean it cannot produce the outcome. Interventions, writes Pawson, are fragile creatures' (Pawson, 2006 30).

Analysing the structure of case management in this way allows the synthesis to get as much from the evidence about failure as that of success, and provides a concrete guide for the search process. Pawson comments,

> Knowing how social programmes work involves tracing the limits on when and where they work, and this in turn conditions how, when and where to look for evidence. (Pawson, 2006 25)

An explanatory model is built using the O = M + C equation and is deployed as an analytic and evaluative tool to manage the vast range of evidence. The evidence is analysed to find out what it says about the relationship between mechanism, context and outcome: how does the evidence support, contradict or refine the model? Does the intervention work as expected? The model is used to focus attention and enable a synthesis of the diverse pieces of evidence into a coherent evaluation of case management.

Counter-examples can help to clarify the causal mechanism in any particular intervention. For instance, it is generally agreed that case management does not primarily rely on a financial incentive, or on coercion through regulation and punitive compliance measures. Indeed, case management policy and program documentation typically defines an activity in which the case manager actively assists a client to navigate administrative and regulatory hurdles, or to deal with the impact of previous encounters with compliance mechanisms such as fines or debt-based exclusion. While a case manager may on occasion use incentives or coercion, such strategies would require skilful deployment to avoid alienating the client.

It is also important to recognise that within a social program there may be more than one mechanism in operation, so the realist synthesis may need to prioritise one mechanism upon which to focus. This prioritisation will reflect the needs of the commissioners of the research. In this case it is guided by the need to identify the elements of case management which are likely to lead to the best outcomes for homeless clients.[9]

In this research synthesis, initial analysis of policy documentation and input from experienced practitioners identified some competing theories about the mechanism of case management. It seemed that case management might work because of the coordination provided by an identified responsible role (the case manager as individual or team), or because of a structured assessment, planning, acting and monitoring process, or because of the relationship between case manager and client.

In the end, the theme of relationship was the strongest explanation that emerged from interviews with nine experienced practitioners and a review of policy and program literature. This conclusion was supported by the logical reduction of asking: what are the minimum conditions or elements that can be recognised as case management? What is unique to case management? What cannot be provided any other way? How is that unique service delivered?

The mechanism, outcome and contextual conditions are independent elements with distinct functions. The mechanism produces an effect in the social world. The outcome is the change produced by the mechanism given the conditions at the time. The outcome pattern has the function of indicating that there is a causal phenomenon that can be evaluated (i.e. a social service practice that has an effect). It is the interaction between the mechanism and the contextual conditions which produce the range of outcomes.

In the case management example, the relationship is a mechanism because it is the active ingredient without which the intervention can never work regardless of having the ideal conditions. For example, it is unlikely that a homeless person with severely

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[9] Research question two, three and four. See the research questions in the Acknowledgements section of this report.

impaired social functioning will increase their self-care capacity if only provided with a house to live in. Without the relationship to a case manager (the mechanism), the context will not produce the desired outcome.

The context(s) for any intervention can be analysed at multiple levels. For example, at a very broad level, housing and labour market conditions are a significant context which will shape the effectiveness of case management. Conversely, at a micro-level, the individual characteristics of the person seeking assistance will similarly determine what can be achieved. The complexity of possible contexts and their interactions is why it is very hard to produce transferable evidence-based generalisations. Pawson highlights the general importance of four contextual layers: individual (e.g. workforce skills, client capacities), interpersonal, institutional (agency culture) and infra-structural (political and/or public support, welfare resources) (Pawson, 2006 31).

Determination of the desired outcome can also be contentious because of the multiple levels at which outcomes are desired, and the multiple stakeholders inherent to any social policy intervention. There are outcomes for the client, for the case manager, and for the service system. Furthermore, for example, the service system can be further divided into individual provider agencies, industry peak bodies, state and federal government departments. Some desired outcomes like equitable and accountable distribution of public resources are common to most social policy, while others, like the reduction of substance abuse, are restricted to a family of interventions.

The realist synthesis begins by defining the intervention and then documenting the theories used to justify it. Program theories are often implicit in policy documents as they contain the reasons why this intervention is used rather than any other. The first stage is a simple compilation of these theories, while the second stage is an iterative assessment and prioritisation to create a short list of the most powerful and persuasive theories, using preliminary reading of the research literature and dialogue with expert stakeholders. Pawson explains:

> The first part of the review […] consists of an exercise in 'conceptual mining', digging through the literature for key terms, abstract ideas, middle-range theories and hypotheses that might provide explanatory purchase on the multifarious differences. (Pawson, 2004 2)

Identification of middle-range theories and concepts is the way that realist synthesis manages the disparities in the evidence base – it is a way of turning pears into apples to allow the comparison of like with like.

Accordingly, the first phase of this research process collected a range of claims made in the name of case management. These claims, listed below, contain ideas about the purpose and/or main focus of the intervention. For example, it was variously stated that case management is useful because it delivers:

→ cost containment – efficiency, effectiveness, reduced duplication

→ accountability – single point for coordination and follow-through

→ therapeutic outcomes – personal development – assisting people toward higher levels of self-care, self-responsibility, independence and productivity

→ better project management – better planning, coordination, resource appropriation, and outcome achievement through a structured process

→ system improvement – compensating for fragmentation and gaps in the service system; and/or

→ improved bureaucratic control of resource allocation – a service that is documented, monitored and evaluated.

Along with this diverse set of claims, some policy documents describe case management as *a way of working* with people, *an approach*, rather than a service in its own right. For example, the 1997 *Case Management Resource Kit for SAAP Services* states that:

> Case management is an approach to service delivery. It is a way of delivering services. (Gevers, 1997 1.1)

Similarly a recent Irish government report describes homelessness case management as 'a new way of working with existing resources and staff' (Eustace and Clarke, 2005 4).

Through analysis of these theories the realist synthesis develops an explanatory model to explain the workings of the intervention by identifying the outcome pattern and defining the key mechanism and contexts which produce it. The explanatory model is necessarily a simplified account because its main function is to provide a 'workable device' for guiding a way through the complexities of the evidence base.

A previous analysis of the program theories underlying case management is provided in a 1998 review of the research and policy literature on case management for homeless persons, presented in the United States at a national symposium on homelessness research (Morse, 1999). Morse, himself a credible, published case management researcher, documents the conceptual assumptions behind case management programs, and describes the key models operating in the United States on which there was evaluation data.[10]

Morse notes that despite the widespread agreement about these assumptions, case management remains difficult to define and is implemented through a range of models and approaches. Morse documents eight distinct practice models in the field of mental health, and a range of less formalised adaptations of case management for dual diagnosis, substance abuse, homeless families and children, and primary health care (Morse, 1999 2).

Nonetheless Morse finds two common assumptions underlying case management for homeless services, and these confirm two of the claims listed above. First, the service system is fragmented and difficult to negotiate. Consequently, case management is assigned a role to facilitate access to needed resources and coordinate service provision on behalf of the client. Second, that there are particular characteristics of homeless people: they are often described as 'markedly mistrustful and suspicious of service providers, and to highly value their autonomy' (Morse, 1999 1). In response, case management should have a core focus on engagement and building a trusted working alliance with the client.

The conceptual analysis developed in the first phase then guides the purposive sampling of the literature and appraisal of the evidence pertaining to the mechanism, context(s) and outcomes. Data extraction and synthesis is an iterative and circular process of refinement. For example, the choice of concepts and propositions to test must be guided by the available evidence. Some theories are rejected simply because there is no empirical evidence on the topic. Or, a piece of evidence may generate a significant refinement to understanding, and consequently may trigger further search and data extraction. The goal of the synthesis is to integrate the evidence into a

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[10] The findings of his review of the empirical data is synthesised in Part Two.

coherent explanation. Contradictory findings need to either change and refine the model, or be dismissed by the model.

Thus the synthesis adjudicates between the program theories by finding that the evidence supports identification of the relationship as the primary and defining element which produces the outcomes of case management, given the right conditions. While the synthesis scope prohibited examination of the other theories, it is likely that they represent supportive mechanisms within the totality of the intervention. For example, the coordination provided by a case management approach and the structured processes employed by many case managers to plan and address specific goals are elements that produce a persistent and reliable case management relationship.

Realist research synthesis emphasises transparency in this process. Given that the social policy field is both complex and contentious, and that research has an inherent element of subjective judgement, the methodology seeks to make its selection choices as transparent and visible as possible. Rather than seek an unrealistic neutrality or universalism, the realist approach brings forward the workings of the review as fully as possible.

2.4 Search and appraisal of the research evidence

The bulk of the evidence synthesised for this review consists of published peer-reviewed journal articles. These are the standard for credible academic research, validated by the anonymous review of other experts in the field before publication. A second source of validated data was service delivery initiative research published on either government or agency websites. These reports lack the quality control of peer-reviewed publication but nonetheless provide a valuable source of evidence, when properly contextualised. The third source was policy documents, created by and usually published on service provider or government websites.

An important consequence of the realist synthesis method and the project's research questions was that the search was not limited to case management in the homelessness assistance sector. Accordingly, databases in social science and humanities were searched as well as those in the medical and community health fields. They were iteratively searched over the research period using multiple combinations of the terms 'case management', 'homeless', 'homelessness', and 'relationship'. The literature was searched using standard academic databases and the less systematic but proven method of 'snowballing' references from credible relevant studies.

Abstracts were then reviewed for relevance to the explanatory model being tested, and the selected studies (about 200) were collated for quality appraisal and potential inclusion in the synthesis. Criteria for including a study in the synthesis are relevance and uniqueness. A study must provide evidence that is relevant to the mechanism and its contexts, and it must offer new evidence (this may include providing a more rigorous confirmation of less certain findings).

The criterion for ending the data extraction phase was production of a coherent evidence-based explanation of the intervention. From a realist perspective, there is a certain threshold recognisable as 'theoretical saturation' once enough of the evidence is synthesised into a conceptually coherent explanation. This does not exclude the possibility of gaps, even gaping holes in the evidence base. There is an unavoidable element of judgement in this decision and it also must reflect the audience and purpose for the synthesis. Nonetheless, within the constraints of the project's scope,

the evidence search continues until new sources no longer add further refinements to the explanation.

Quality appraisal in the realist approach to quality has two elements – relevance: does the research address the framework we are testing in the synthesis, and rigour: does the evidence support the conclusions drawn by the researchers (Pawson, 2005).

2.5 Practitioner engagement

Interaction with the practitioner community, and especially with skilled practitioners from participating agencies, is a crucial feature of the project. The project builds on the diversity of good practice that already exists by adding evidence-informed practice to the current 'experience-informed' practices.

The AHURI model stresses the importance of engagement between the research and practice communities. Done properly, it is a mutually beneficial relationship. Time is invested by both parties because the outcomes are worth it. Researchers benefit from practice knowledge, from the view on the ground which contains raw truths usually only found in participant ethnography. Practitioners benefit from the big-picture view that can identify patterns and underlying reasons, and challenge the stereotypes of received wisdom. Research is rejuvenated by the chance to make a difference, while practice is nourished by the opportunity to be heard beyond its own world. Together, research and practice can find solutions to problems that matter, and go beyond beliefs presumed to be the truth.

The project used two main levels of practitioner engagement: an expert advisory group which met through the life of the project, and qualitative practitioner interviews.

In addition, new formats for research materials were tested at practitioner workshops, late in the project, and research findings were presented at two national practitioner conferences: The 5th National Homelessness Conference 21–23 May 2008, and The Case Management Society of Australia Conference, 12–13 June, 2008. The practitioner workshops were used to evaluate a range of prototype formats for research dissemination to practitioners.

2.5.1 Advisory group

A Project Advisory Group was convened to provide expert advice to:

→ Inform the design and implementation of the project

→ Guide the synthesis of the evidence

→ Assist in engaging with the homeless sector about the project.

The Advisory Group met at key milestones during the course of the project.

2.5.2 Practitioner interviews

In addition to the synthesis of the published research evidence, this project accessed an additional source of knowledge through qualitative interviews with experienced local practitioners. Interview nominations were sought from the Advisory Group members. Seven interviews, with nine practitioners, were completed between Nov-Dec 2007. When cited in this report, they are referred to by a number in brackets.

The practitioner interviews had a number of functions: as a sounding-board to assist in identifying and prioritising program theories, to contextualise the findings about the intervention by seeking local definitions, theories and perspectives about case management, to share and refine where possible emerging research synthesis

findings, and to gather data for the developmental second stage of the process to prepare the materials in a useful form for changing practice.

As the synthesis seeks to answer practice questions, the interviews were sought not only for theories about how the intervention works, but for common problems which could provide ways into the diversity of materials and findings. As noted above, to interest practitioners in research findings requires offering a practical return for their investment. Ideally, practice-relevant research findings will respond to questions or issues brought up by practitioners themselves.

A semi-structured interview schedule was compiled and tested. It functioned as a guide rather than a systematic data collection tool – as expected, the most useful information emerged when practitioners took the interview into their own areas of interest or concern in relation to the topic. Open-ended discursive questions were used to elicit dialogue which aided in identifying and prioritizing program theories. This approach allowed the researcher to use the interviews to test the emerging analysis of case management theories. Two questions that proved to be particularly useful were: what was the person's first experience/knowledge about case management and whether their ideas about it had changed over time?; and, what was the best thing the person ever learnt about case management and why? The interviews were taped to allow for review and further analysis of the themes.

The interview data provided the research with a current, inner-Melbourne practitioner perspective to supplement the evidence obtained from national and international policy and program documentation. The interviews provided an invaluable opportunity for dialogue, as did the Advisory Group, consequently engaging practitioners in the research process. The conceptual analysis was tested and refined by this dialogic interview method.

The risk of subjective bias in the interpretation of the interviews was managed by triangulating the results using Advisory Group input and two presentations of the research findings at national practitioner conferences.

Primary thematic analysis of the interviews used the measure of internal coherence. First, themes were validated between interviews using repetition and contrast analysis; and second, any unique themes were assessed for congruence with the conceptual analysis or emerging empirical synthesis. This exception analysis enabled the synthesis to refine the understanding of case management.

For example, one interviewee spoke against long-term case manager continuity due to the humiliating effect, for the client, of being seen to fail repeatedly (4). This point was in contrast with the rest of the interviews which promoted the value of long-term support and continuity of relationship. Assessment of this point against the synthesis analysis of mechanism and context shows that the apparent contradiction is in fact congruent with the analysis. The negative consequences of a persistent relationship reinforces the inference that the relationship is the active mechanism in case management, and also confirms the contextual factors of stigma and social marginalisation, and the long-term, profound nature of the problems faced by people experiencing chronic homelessness.

The interviews also pinpointed some key problems faced by case managers and therefore the areas in which research evidence could potentially provide useful resources.

3 CONCEPTUAL ANALYSIS OF CASE MANAGEMENT

3.1 Analytic method: mechanism, context, outcome

This chapter presents the key concepts used in the synthesis by analysing policy and program documents and practitioner input, and then defining case management in terms of the change it produces (the outcome pattern), the active element which is essential to create these outcomes (the mechanism) and the elements which are necessary to allow the mechanism to work effectively (the contextual conditions) (Pawson, 2006 20-25).[11]

A critical advantage of this analysis is that it generates a clear definition of the critical features of case management and how they relate to each other. Defining case management in terms of the mechanism and contexts clarifies which aspects of the intervention are essential and which are 'bolt-ons': elements that may meet other stakeholder needs but do not contribute to case management outcomes. This in turn provides a basis for choosing how to allocate scarce program resources, and for identifying which elements of case management practice to emphasise and support.

In addition, the analytic breakdown means that evidence on the significance of each element can be extracted from a wider range of sources than would otherwise be possible. The research synthesis can integrate evidence about the operation mechanism as it has been researched in other situations, and similarly find evidence about the impact of the contexts in studies of different social programs.

As explained in the previous chapter, the first stage of realist synthesis is to find, categorise and assess the theories which currently explain how case management works. Analysis of these theories generates a coherent, manageable explanation of case management that can guide the search and synthesis phase (Pawson, 2006 73-82). Relevant evidence is appraised and synthesised to confirm, deny or modify this framework and produce a refined, evidence-informed understanding of case management.

The final understanding arrived at through the synthesis presented in Part Two of this report is summarised in the following diagram, and description below.
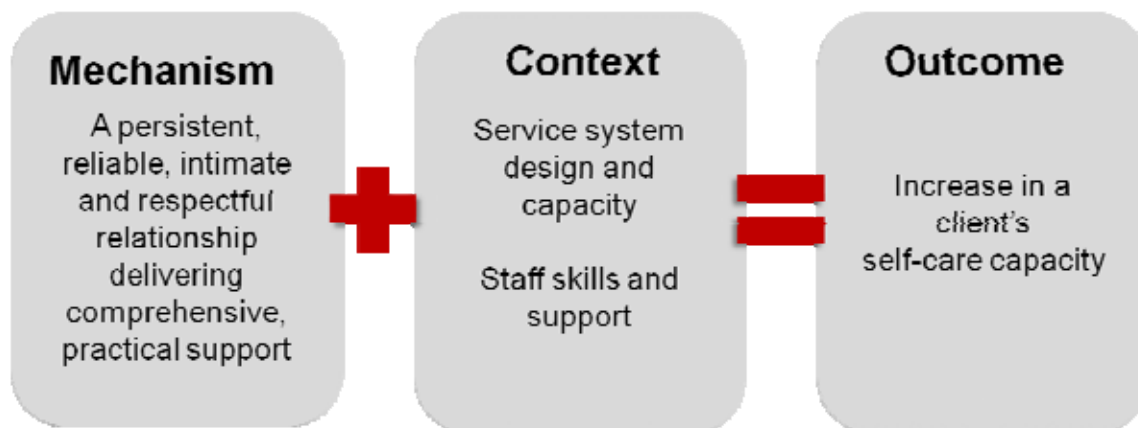
Case management provides comprehensive, practical support and results in an increase in a person's self-care capacity.

The mechanism is a relationship with these essential characteristics:

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[11] See chapter two for a more detailed explanation of the 'realist synthesis' methodology.

→ Persistence and reliability

→ Intimacy and respect.

The mechanism operates within the contexts of the capacity and design of the service system, and staffing issues. Each context has two significant enabling factors, and these form the basis for the policy, program and practice implications:

Service system design and capacity

→ timely access to appropriate resources, including housing, and specialist supports

→ determination of support duration and intensity on an individual basis

Staffing issues

→ high-level assessment, relationship and communication skills

→ adequate staff supervision, training and recognition.

3.2 Defining case management's outcome pattern, mechanism and necessary conditions

This section defines case management in terms of the realist categories of outcome pattern, mechanism and contextual conditions (Pawson, 2006 20-25).[12]

The first step of the analysis is to generate a coherent, grounded description of case management. Implicit within the description is a range of ideas about how and why case management works. The second step, therefore, is to analyse this description, along with other policy, program and practitioner material in order to define case management in terms of the mechanism and contexts which allow it to achieve an outcome for the client. The final step (presented in Part Two of this report) involves synthesising the scientific evidence to assess and refine the analytical definition. This process is iterative. The conceptual understanding and the evidence synthesis are essentially linked, and progress in one refines the other. To provide some transparency about the research synthesis process, this chapter conveys a sense of the stepped progress toward the understanding of case management developed in Part Two and summarised above.

The following description of case management was derived from local and international policy documents, service-provider material and local practitioner interviews. A list of the most significant published sources is provided in the box. The description is also indebted to informal conversations, and input from the project Advisory Group.

A description of case management

The case manager is a friendly professional who can assess and respond to the totality of a person's assistance needs including negotiation of the obstacles interfering with the person's ability to meet their own needs.

The case manager uses tools and professional expertise to plan and coordinate a response to these needs within available resources, and to help the person wherever possible develop their capacity for independence.

Case management is a professional care service characterised by:

    1. Stability, reliability, continuity, advocacy, and empathy

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[12] See chapter two for a more detailed explanation of the 'realist synthesis' methodology.

2. Professional expertise (advanced assessment, communication and relationship skills; knowledge of resource availability and personal or official links with providers)

3. Defined boundaries, honesty and client-directed goal orientation.

(Cooper and Yarmo Roberts, 2006, Case Management Society of Australia, 2004, Eustace and Clarke, 2005, Gevers, 1997, Ballew and Mink, 1996, Consumers helping others in a caring environment (CHOICE), Strehlow et al., 2005, Allen et al., 2007 , Upston, 1994, McDonald and Coventry, forthcoming 2008, Milne and Coventry, 2008, Case Management Working Group, 2006)

Analysis of the interviews with nine Melbourne-based case management practitioners provided the following set of ideas about the effectiveness of case management:

→ A good relationship is the essence of successful case management: rapport and engagement skills, emotional maturity and excellent support

→ Goals must be client-directed, as without client engagement any achievements are not beneficial for the client

→ Goals must be realistic since failing to achieve specified goals is damaging to the relationship

→ Frequency of contact and length of support relationship should be determined on a case by case basis

→ Lack of appropriate housing compromises the ability of case management to achieve positive change

→ Success relies on the client's participation and therefore cannot be forced.

The interviews overwhelmingly supported the claim that case management relied on a relationship and revealed a number of practice concerns which have been grouped together into the following three areas:

→ Boundaries and expectations – being someone's 'significant other'

→ Getting what is needed – service system capacity and accessibility

→ Challenging behaviours and social exclusion.

The analysis of these materials and the associated background documents found three major theories about how case management works:

8. Case management works because of the **relationships** developed by case managers between themselves and the clients, and between themselves and other agencies involved in the service system (and needed to assist clients).

9. Case management works because of a **structured, consistent, systematic process** that ensures all the client's needs are identified and the best possible plan is made and enacted to meet the needs and manage any risks using an efficient allocation of available resources.

10. Case management works because of the **coordination** provided by one responsible person or agency.

These three sets of ideas describe elements of case management practice that are sometimes described as working in an inter-related way, and at other times described as an implicit or explicit hierarchy. For example, some descriptions (e.g. program models) prioritise the element of a coordinating, responsible entity and do not allow the contact time necessary for the formation of a relationship.

Conceptually, and in practice, these theories sometimes compete because they rely on essentially different mechanisms and can be orientated toward achieving different outcomes. The importance of establishing an evidence-based and analytically sound hierarchy of these elements is to ensure that scarce human resources are allocated where they will do the most good. Therefore, the goal of the synthesis is to adjudicate between theories by defining the essential elements of case management.

The following analysis defines the pattern of outcomes produced by case management, the mechanism which is the active element capable of generating an effect, and the contexts which provide the conditions necessary for the mechanism to produce an outcome.

3.2.1 Outcome: increase in a person's self-care capacity

The pattern of outcomes produced by case management provides critical guidance for understanding how case management works. Pawson explains that the pattern of outcomes generated by a social program provides the first clue that there is a causal mechanism at work (Pawson, 2006 21-2).

Analysis of policy and program documents and practitioner interview data found that the primary successful outcome of case management is that a person no longer needs (or has a reduced need for) assistance to access the assistance they need. This definition is important to highlight that a successful outcome is not necessarily a reduction in the use of support services.

All people access services of one kind or another, either in the public, private or informal spheres. Whether a family accesses government-mandated foster care, a publically subsidised kindergarten, a private nanny, or a willing grandparent, has different economic and social implications. However, on another level, all these forms of assistance demonstrate a universal interdependency which characterises social life. It is partly the stigmatisation of the use of 'welfare' services as a form of unhealthy dependency[13] that drives the definition of reduced service use as a successful outcome. A successful case management outcome in contrast is defined as *an increase in a person's self-care capacity,* meaning an increase in their capacity to get the help they need, which does not necessarily result in reduced service use.

The primary outcome of case management is that people no longer need case management. In other words, case management develops the person's capacity for self-care.

Another way of describing this is that case management produces lasting change. The outcome is not simply the meeting of a person's needs in the moment, such as a crisis service might provide. Nor is it the outcome of this or that behavioural change, such as a substance treatment counselling service might generate.

In its very simplest form case management can be defined as an intervention designed to shift people from one point to another:

Pre-intervention	Person not able to look after themselves and not getting or not able to get the help they need.
Post-intervention	Person able to look after themselves, *or* getting the help they need and able to maintain access to this support on their own.

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[13] See for example, the arguments produced by the Centre for Independent Studies: Saunders, P., Humphreys, J., Dubossarsky, E. & Samild, S. (2008) *Declaring dependence, declaring independence: three essays on the future of the welfare state.* Sydney, Centre for Independent Studies.

Thus the outcome implies that a person is better able to self-manage their access to needed supports. Worth noting, the term 'interdependence' is quickly overtaking independence or even self-reliance as a policy and program goal, in recognition that a well-functioning person always relies on a range of social and material supports.[14] The outcome of case management may be, in other words, that the client develops the social skills required for effective self-management of their support needs.

The idea of a developmental outcome is expressed in this objective from the practice standards of the Australian Association of Social Workers.

The outcome of direct social work practice is that:

→ needs of clients are met;

→ their potential is developed; and

→ their control over their lives is fostered (2003 6).

The outcome of developing the person's potential and control over their own lives is clearly an ambitious and complex task, and must logically depend on the individual starting situation of the client. An outcome for a person beginning case management at a point in their lives where they are at risk of harm from their drug use and lack of shelter, will most likely be quite different from that of someone who is evicted for the first time in their middle adult years due to unforeseen circumstances.

The outcome pattern most commonly described by practitioners is a discontinuous and/or cyclical process. Practice-wisdom and program guidelines tend to agree that the developmental movement is neither linear nor unidirectional. This implies the likely importance of the case manager's dynamic and creative response, and their reliability and persistence.

The outcome of an increase in the person's self-care capacity can be reflected by improvements in a range of domains, including:

→ Access to stable housing

→ Reduced harm from alcohol or other drug use

→ Improved mental and physical health

→ Improved social functioning and life satisfaction.

Different empirical studies utilise one or more of these measures to evaluate the effectiveness of case management, and other programs, in creating a beneficial effect for their clients.

3.2.2 Mechanism: the relationship between client and case manager

This section describes the conceptual analysis which defines the mechanism of case management as the relationship between the client and the case manager. The mechanism, as noted, is the element of case management which has the causal potential to create the outcome. The mechanism has the potential to create positive effects on the client and their situation although it needs the right conditions to be effective. These conditions are defined in the following section on the contexts of case management.

What we know about the qualities of this relationship from the evidence base is presented in detail in *Chapter 5: The case management mechanism.* Synthesis of the

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[14] In Victoria at least, influenced by Shelley Mallet *et al.*'s youth homelessness research. See policy documentation for *Creating Connections:* Youth Homelessness Action Plan Phase 2, Victorian Office of Housing, 2007.

evidence base finds that persistence, reliability, intimacy and respect are the qualities required for the case management relationship. The conceptual analysis of case management provided here predicts the qualities of persistence and reliability, indirectly points to the importance of respect, and fails to identify the importance of intimacy, although with hindsight it is signalled by the practice concerns identified through the practitioner interviews.

The conceptual analysis overwhelmingly points to the relationship between the client and the case manager as the mechanism which has the potential to produce an increase in the client's capacity to care for themselves as defined above.

To check this analysis, it is helpful to compare case management to a form of human service delivery with a different kind of mechanism. For example, consider the bureaucratic distribution of assistance based on eligibility in a hypothetical drought relief payment to farmers. An application procedure is used to assess eligibility, following which financial assistance may or may not be provided. The mechanism in this case is the transfer of financial resources based on objective, transparent assessment criteria. The person receiving the assistance does not need a personal relationship with someone from the provider agency, the assistance is not tailored to their circumstances, and there is no intention that the person changes their behaviour in any specified way as a result.

Another relevant counter-example is the mechanism of a structured process. Many case management policy documents and texts define case management in terms of a set of core tasks. These show some variation reflecting different agency or practice philosophies but show a common structure. While there are some differences in naming and emphasis, we can, broadly speaking, identify four phases to the process:

1. Assessment (eligibility and needs)

2. Planning

3. Access, coordination and monitoring of services/resources needed – may include direct delivery and practical assistance

4. Review and evaluate: End (case closure) or return to phase one.

As a structured sequence of activities, the tasks are related to the mechanics of generic project management with its well-recognised benefits of ensuring systematic coverage of essential tasks including risk management, and the provision of boundaries and guidelines to assist in 'delivery' of 'outcomes' within time and resource-limited environments.

An apparent benefit of the structured task list is focus and boundaries. A structured process one practitioner explained is a useful support for managing the complex, out-of-control situations which are often encountered during case management. Planning and reviewing are processes which concentrate effort (of both worker and the person needing support), combat distractions, and promote continuity of actions. Another perceived benefit is as an assertion of boundaries and clear expectations to manage demanding clients and combat learned helplessness or welfare dependency. All of the practitioner interviewees emphasised the importance of telling people at the start what you can and can't do – especially when working within a time-limited support program.

Testing the idea of a structured process as the mechanism for case management with practitioners found that while structured tasks and case planning were extremely useful for a number of reasons, they could only be effective if there was a good relationship with the client.

A further reason to understand a structured process as a tool but not the mechanism of case management was that a technically defined intervention over-emphasises the importance of the case manager's skills at these activities or structured processes. For example, an imperative to move through the stages of case management can inadvertently endorse the assumption that the 'client' is a passive object that can be diagnosed and treated by an expert. These processes must be used through the relationship mechanism or they become merely bureaucratic, mechanical or contractual delivery systems.

Practitioners also commented that the activities of case management could vary infinitely in response to the needs of the client and the situation. Case management, they said, might only be the assessment part, or it might only be the engagement part. What made it case management, they reported, was the continuity of, and responsibility for the relationship with the client. The case manager takes responsibility to develop and maintain the helping relationship with the client. This may mean utilising a team approach. It may mean six months of simply saying a friendly hello and offering food or a blanket to gain the person's trust.

A consistent theme in the interviews was that case management is essentially a process of tailoring interventions. Case managers emphasised the importance of flexible and creative interventions in response to a dynamic and ongoing assessment of the person and their situation, commenting that 'what works' will depend on the person (1,2,3,4,6,7,5). The essential and necessary quality of the case management plan is that it is flexible and dynamic – constantly changing and adapted to fit with the current situation. It must respond to both the immediate crisis – for if it is of no use to the client, they will not stay engaged – *and* maintain a focus on longer-term goals, in order to model the continuity and follow-through the client is unable to achieve on their own (1,5). Structures and models are tools that can be extremely useful for the case manager, but they must also be prepared to let them go entirely.

The conceptual analysis concludes that without the relationship, you would no longer have case management. However, it was clear from policy documents, research literature and the practitioner informants that the case management mechanism was not just *any* relationship. Case management, explained a number of practitioners, is a relationship in which you feel like someone is *in your court* (3). Other significant qualities suggested by the analysis were persistence, reliability and client-directed goal orientation.

Persistence and reliability (a person in your court)

An implication of the development outcome is that case management should continue in a planned and structured way until the person has increased their self-care capacity to their satisfaction, usually measured by the achievement of agreed objectives such as stable housing. Case management does not need to continue until a person's problems are solved, but until they are able to manage their problems, including obtaining appropriate assistance when necessary.

Reliability and persistence is an acknowledgement that sustainable change is never made quickly, nor are the required resources ever completely and instantly available. This characteristic raises a key contextual factor, namely the policy restrictions on the duration of case management. In current SAAP case management funding agreements, average durations of support are used to set agency targets. This imposes an external pressure to 'close a client' that is unrelated to the person's situation. This duration constraint consequently impacts on the ability for case management to pursue client-directed goals (although practitioners develop skills in defining realistic goals within that timeframe, and in some cases this is a relief to

clients who may not be ready to address, for example, a major substance dependency (4)).

The reliable and persistent relationship is a mechanism that can model positive behavioural change such as the way consequences must be borne, and plans can be followed through. Persistence and reliability produces a reciprocal accountability.

Persistence implies that case management is supported and resourced to maintain contact with the client, including assertively following them and re-engaging when necessary. A well-recognised characteristic of the homeless client group is the tendency to 'disappear'. As a result, as practitioners repeatedly reflected, a client might have had any number of case managers in the past. Ireland's Homeless Agency model explicitly acknowledges and builds in an assertive outreach and high level of inter-agency communication to 'track people down' (Eustace and Clarke, 2005). In the evaluation of Supportive Housing initiatives in the United States it was noted that leaving the accommodation was not necessarily seen as a failure. Program design accepted such events as part of the process – perhaps similar to a relapse in the 'cycle of change.' Case managers therefore need the support and the resources to chase the client. Typically, under the SAAP program in Australia, homelessness case managers close a support period if the client leaves, although remaining open to the person re-engaging at a later time.

Client-directed goal orientation

Case management is a goal-oriented relationship – it is a helping relationship not a friendship. Practitioners interviewed for this project overwhelmingly emphasised that case management should assist a person to achieve the goals they set for themselves. One practitioner described it as a process of 'getting yourself out of the way' (2). Another emphasised 'it's not about rescuing or saving' (5). This case manager 'learnt the hard way' that if you try to achieve your own goals for the client rather than theirs you will simply waste your time. Another related and consistent comment from practitioners was that to achieve a whole lot of 'outcomes' for someone can leave them feeling even less capable than when you started (2,4,6,7). A person, practitioners explained, doesn't need their problems fixed, but they may need support to solve their problems themselves. Drawing on an example from personal care work, one case manager reflected that it is generally less efficient in the short-term to work in an empowering way. It takes more time, attention, patience, skill and commitment to support someone to do something themselves than to just do it for them (6).

Collaborative planning is partly to increase the client's engagement with the plan, but it is also a key tool in building trust by showing competence (Ballew and Mink, 1996 46-7).[15] Planning is a strategy to inspire confidence in the client and therefore it is in service to the key aspect of the case management mechanism: the relationship. Collaborative case planning is an opportunity to involve the client in decision-making, and to model and practise essential life-skills. A service that simply ensured medication compliance could not be called case management under this definition because it does not respond to the person and their goals. Focusing on a person's own goals has a key humanist commitment implicit, a commitment to the fundamental value of a human person and their potential.

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[15] There are a wide range of tools to assist in comprehensive assessment, planning and progress monitoring – for example St Luke's 'Five Columns'; St Mungo's Outcomes Star – visual scaling tool, see Burns, S. & Cupitt, S. (2003) *managing outcomes. a guide for homelessness organisations.* London, Charities Evaluation Services.; Ecological Mapping – Ann Hartman, 'Diagrammatic assessment of family relationships' *Social Casework*, 59, 1978: 465–76 – Ballew, J. R. & Mink, G. (1996) *Case management in social work : developing the professional skills needed for work with multiproblem clients,* Springfield, Ill., USA, Thomas.

3.2.3 Contexts: Service system design and capacity

The mechanism is what case management uses to get a result. But the same result is not achieved every time and this indicates that there are contextual conditions which impact on the effectiveness of the mechanism.

The analysis of policy and program documents and practitioner input shows that the broader human services system is a significant context for case management. The following diagram, generated from this analysis, describes the conceptual position of case management within the service system.

The diagram represents case management as an arrow at a median point along a continuum of care responsibility. On the left side is the bare minimum of state support – simple provision of information or material resources upon request, or by basic eligibility – and on the right side is the comprehensive support of a residential institution. The diagram depicts case management's developmental outcome pattern as an arrow that shows a change in the person's self-care capacity.

State responsibility for care

High   Low

| Institutional care or restraint | **Case management** Increasing a person's self-care capacity | Universal service provision |

Personal capacity for self-care

Low   High
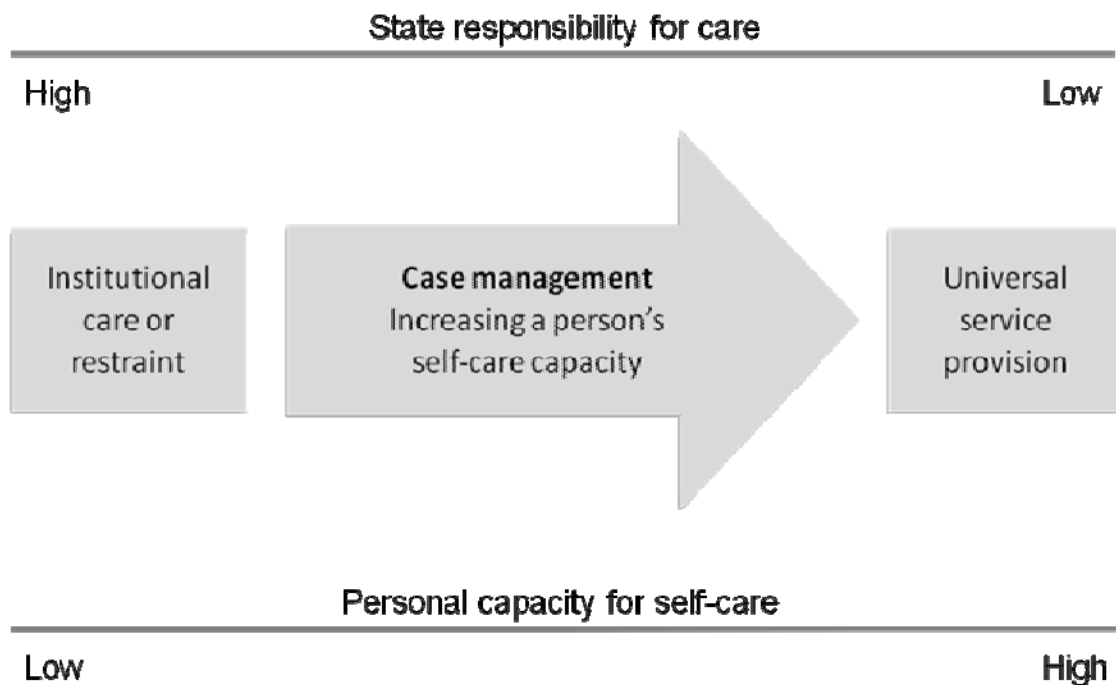
Placing case management on the care continuum indicates how the intervention is motivated both by a responsibility for care, and by the intention to shift this responsibility back to the person themselves. In its most altruistic aspect this intention is called empowerment. The management aspect of case management is a residue of the institutional pole of the continuum – an environmental model of care in which all aspects of the client's needs are taken care of, including the interaction between their needs. These two fundamental features of case management are sometimes in tension. Case management, the diagram implies, always involves a duty of care; however it is never total responsibility for the person as it seeks to maintain the person's 'dignity of risk' (2,5,6). The diagram further describes an inverse relationship between the responsibility to care for someone and their own capacity to care for themselves.

Reporting for the Victorian SAAP Unit, Department of Health and Community Service, in 1994, Bronwyn Upston claimed that case management 'refers to the management of service provision, *not* to the management of people' (Upston, 1994 7). Notwithstanding this intention, the demands of the care continuum, in other words the

'duty of care,' exerts pressure on the case manager to move toward person management. Negotiating this line between respectful empowerment and risk management in practice is the absolute core of case management (2,4,5,6). The second aspect of this challenge is the reality that sustainable behavioural change cannot be forced. Case managers report the feeling of responsibility coupled with helplessness while observing their clients making self-destructive choices (Milne and Coventry, 2008 9).

In this broad understanding of duty of care, it is important to note that contextual factors relating to the person being assisted also impact on the effectiveness of the case management mechanism. As a relationship, this mechanism is inherently dependent on both parties and therefore vulnerable to the disinterest of the service user. This is unlike, for example, income support, which provides a financial outcome for the person irrespective of their attitude toward the service.

There is contention in the policy and program literature about how to respond to this contextual condition. For example, case management, as recently defined in a report for Ireland's Homeless Agency, relies explicitly on a particular characteristic of the person receiving the service: the client 'must buy-in to the process and be a willing and collaborative partner' (Eustace and Clarke, 2005 26). This seems to contradict another principle in the same policy document, namely that it is only for those with *complex and multiple needs*, not an intervention aimed at every homeless person (citing the Dublin homelessness action plan 2004-2006 Eustace and Clarke, 2005 7). In contrast, social work researchers Ballew and Mink (Ballew and Mink, 1996) explicitly justify case management in terms of a person's difficulty in accessing assistance, and more congruently matches the mechanism to these characteristics. Ballew and Mink argue that case management is designed precisely to intervene effectively with people that have trouble accessing assistance effectively – case management is designed for people with poor help-seeking behaviour (Ballew and Mink, 1996 11, 12).

The point here is that the success of case management relies on a person's active involvement. However, no-one can be forced to engage or participate in a relationship, and this is a limitation inherent in the case management mechanism. Some of the empirical evidence synthesised in Part Two identifies the impact of personal characteristics such as severity of psychiatric symptoms, level of substance use and education.

However, the analytic focus of this report is on the case management intervention and what the evidence reveals about how to facilitate effective outcomes for clients. Consequently, while it is essential to recognise that client characteristics will constrain the ability of case management to move someone along this care continuum toward greater levels of self-care capacity, practice and policy can nonetheless operate in the most effective way on the basis of the available evidence.

Access to resources and specialist support

It is logical that the ability of case management to provide practical support for clients will at least partially depend on the resources of the service system. Timely access to necessary resources including material aid, housing assistance and specialist support is a requirement for delivering comprehensive and practical support.

Comprehensive support entails some kind of functional integration of different service systems or specialist assistance areas such as mental health, substance use and less prestigious but just as crucial, assistance with material aid – income, food, health and dental care, legal.

Practical support emphasises the importance of helping a person with these concrete matters, and in particular, it also highlights the role of housing. Case management for homeless persons agencies occurs with and without guaranteed access to accommodation or independent housing. Availability and the access criteria for such resources is a key context for case management.

The third diagram depicts the external inputs that case management may need to mobilise in order to achieve the purposeful direction toward greater self-care. These resources must be available and accessed in the right sequence and timing for a sustainable outcome. *Right* in this context means appropriate for the person, in other words accessed as part of an individualised package of support that is responsive to the person's situation. For example, provision of affordable housing without primary and mental health care or social and living skills may lead to further homelessness, anecdotally recognised as 'setting them up to fail.'

Person's increasing self-care capacity

employment, education, recreation

social and living skill development

long term affordable housing

primary and mental health care

crisis resources
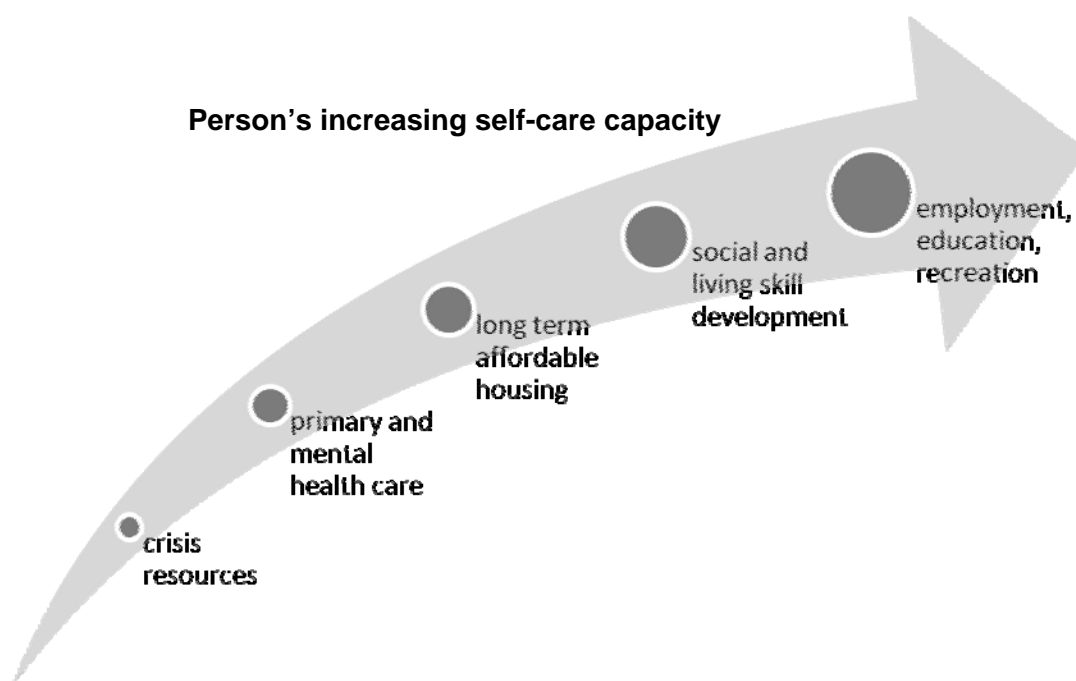
Staffing skills

A relationship mechanism and a developmental outcome implies that staffing issues will be an important context. Case management relies on a relationship and can only be as effective as the relationship skills of the practitioner, all else being equal. The following discussion shows some of the complex requirements of the case manager.

The analysis showed that case management always involves a broader commitment to the coordination of resources or services to meet the person's range of needs, including monitoring and balancing the impact of different interventions. For example, addressing a long-standing need for drug rehabilitation may put someone's housing in jeopardy. A case manager in that situation would need to combine support to the person to catch the opportunity in the cycle of change, while negotiating a solution to concurrently meet the person's rental obligations and avoid homelessness.

The intensity and activities of case management reflect a modulation between these poles in response to a dynamic assessment of the person's support needs. For instance, the case manager may provide or organise a level of support close to the residential care and guardianship pole for a certain period due to an episode of mental illness – for example, arranging that rent and bills are paid on the client's behalf. Or on a particular day due to a dangerous level of drug intake calling an ambulance,

possibly against the person's will if required. Case management delivers this individualised, creative and flexible response using the mechanism of a relationship with the person.

Consequently, while other types or models of service delivery may use the term case management, they do not meet the criteria of this analysis. For example, in mental health community care, clients are assigned a clinical case manager; however this service is more properly defined as a form of specialist support. The restrictive adjective, 'clinical' indicates the delimited responsibility expected of this role, in contrast to the definition of case management. While the clinical case manager does provide a point of coordination and accountability in the limited field of their specialty, this cannot be called case management if it fails to assess and respond to the impact of other needs or factors in the person's life.

A discussion paper on *Case management and community care* released in May 2006 refers to these kinds of models as 'single need care coordination'. Case management, by comparison, 'focuses on the full range of health and social care needs of individuals with complex care needs' (Case Management Working Group, 2006 7) . Case management thus falls squarely within the social model of health. It explicitly recognises and responds to the inter-relationships between individual, social and environmental factors in maintaining a person's well-being.

Consequently, effective case management relies on maintaining a certain distance from any one particular problem in order to sustain the holistic coordinating function (Ballew and Mink, 1996 11-12). This distance is partly what defines a case management response as a distinct service compared to any particular form of assistance. It is the overview and planned, coordinated response to the whole picture of the person, in their context, that is achieved through the case management relationship. While some direct services will be provided, and indeed may be an essential part of building the relationship (conveying competence through the concrete demonstration of assistance, of how the case manager can be of use (Ballew and Mink, 1996 46-7)), these are provided in the context of a comprehensive assessment and response to the person.

This is also why practitioners explain that the case management relationship is more than a therapeutic relationship such as counselling (3). While the counsellor also develops, and relies on, a trusting emotional connection, in counselling this is solely used to more effectively address psychological and emotional difficulties. In contrast, case management primarily uses emotional connection and safety to enable better assessment of needs, and to promote the client's engagement with the planning and acting process that the case manager uses to move toward identified goals. For example, Rothman, in his research-based guidelines for case management differentiates it from other interventions by its 'broad attention to multiple needs in the client's life situation' (Rothman, 1992 3). Thus case management may at times involve an activity like counselling, particularly if the case manager has such a skill set, however the counselling need could equally be met through identification of the need, provision of a referral, and active, practical support to maintain access to that service (e.g. transport to the appointments).

Case management also deals with a particular complication: the fact that a person facing multiple, simultaneous problems, faces not only the task of managing each problem, and the inter-relationship of the problems, but also the inter-relationship of the assistance providers (Ballew and Mink, 1996 11-12). Practitioners anecdotally report that helpers with different specialities will not always work together in an efficient and supportive way. For example, until relatively recently, a person with drug and alcohol abuse issues and a mental illness has typically been caught between two

systems – with each specialist group insisting that the other problem must be solved before they can properly assist the person. While the need to work differently in the field now known as 'dual diagnosis' is widely recognised, this remains an example of the interactions and complexity which inevitably arise with co-existing problems and which case management is designed to address.

Case management relies on the ethical and emotional aspects of a particular type of relationship to assist and motivate a group of people who are by definition disengaged from the services and supports they need. And to achieve this takes what Noel Pearson calls in the context of Indigenous social policy the 'fine calibration' between rights and responsibilities, between support and empowerment. This calibration, he argues, can be as much a matter of implementation and the quality of interpersonal interactions as it is the substance of this or that intervention:

> The correct policy can easily turn sour because of incompetent implementation, because the calibration is lost: if a police force does not understand the aim of restoring social order to crime-ridden communities and that racism and sharp practice must not be tolerated, policy will degenerate into abuse and victimisation. (Pearson, 2007 47)

These considerations show how case management is defined by a tension Catherine McDonald claims is core to social work: the tension between the intrusive, controlling risk management or protective functions and the advocate's intention to 'stand on the side of' disadvantaged or socially marginalised people (McDonald, 2006 160).

This tension between control and empowerment is implicit in the care continuum diagram. The care continuum diagram positions case management between two poles of how a state provides services to its citizens. On one side is an equitable distribution of resources to citizens using a bureaucratic mechanism based on eligibility: universal service provision. On the other side is the total responsibility of institutionalised care. The first emphasises the service user's choice and personal responsibility while the second foregrounds the service provider's duty of care and protective risk management. The evidence shows that navigation of this territory between control and empowerment poses ethical challenges for case management practitioners and practical challenges for the service system.

Another implication of the sensitivity of the relationship mechanism to staff characteristics is that the relationship mechanism will be vulnerable to staff continuity. First, any turnover literally ends a particular relationship and produces an experience of loss. And second, *high* turnover will have a cumulative effect which undermines the key to the case management mechanism, namely the reliability and persistence of the relationship. Anecdotally, practitioners claim that anything that disrupts the relationship with the client can result in less successful outcomes, for instance staff turnover or even simply referral to another service provider.

Loss of experienced staff is also likely to impact on the capacity to provide comprehensive practical support. It means the loss of accumulated knowledge about the service system, and the loss of professional working relationships and shared histories which facilitate flexible and collaborative service coordination (McDonald and Coventry, forthcoming 2008). While organisations can establish protocols and other structures to support inter-agency collaboration beyond the personal level, these cannot fully substitute for the professional expertise of the case management staff.

PART TWO: THE EVIDENCE

4 SCOPE AND QUALITY OF THE EVIDENCE BASE ON CASE MANAGEMENT

4.1 Scope of published case management research

An indication of the scope of published case management research was obtained by searching the internet-wide academic search engine, *Google Scholar.* A search for the term 'case management' for the period 2003–7 returned 19,500 citations for the term 'case management' and 2,910 for 'case management' and 'homeless'.

An indicative analysis of the number of journal articles over time, shown below, finds a steep increase in the number of publications per year since around 1990.

Figure 4.1 'Case management' journal articles over time
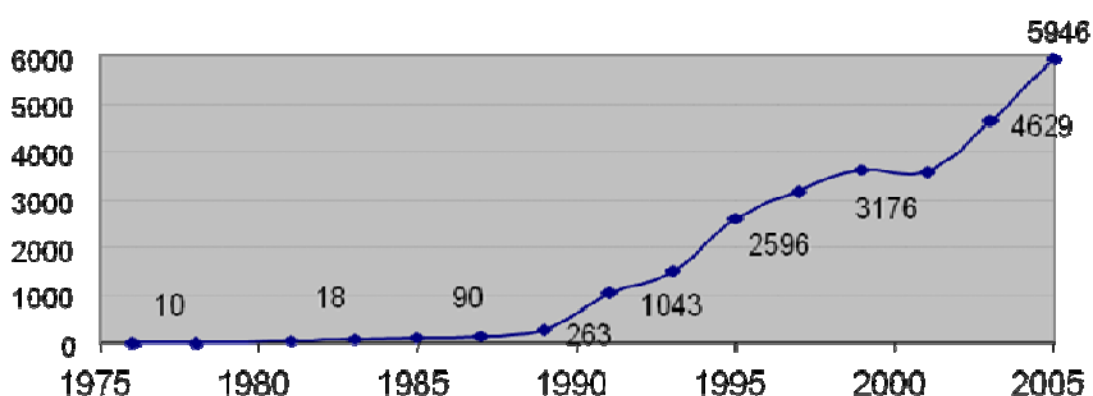
Source: EBSCOHost – Academic Search Premier, MasterFILE Premier, HealthSOURCE Nursing/Academic Edition, Alt Health Watch

Searching the *EBSCOHost* set of academic and health databases showed that the number of published articles per year had more than doubled between 1995 and 2005.

To focus the synthesis, the search targeted studies and review articles published since 2000. Published review articles covering pre-2000 literature were used to cross-check the breadth of the search and enabled important older studies to be followed up where necessary for the synthesis.

4.2 Publication date, geographic spread, methodology and research focus of the studies used in this synthesis

The following tables describe the fifty-three empirical sources synthesised in this report by year of publication, methodology, place of origin, and research focus.

Figure 4.2: Year of publication

Year	2007	2006	2005	2004	2003	2002	2001	2000	1999	1998	1997	1996
Number	14	9	4	8	3	2	3	4	4	0	1	1

The synthesis focused on the most current evidence by searching in the first instance for publications in the last five years: 2002–7. Earlier studies were included if they made a unique and significant contribution to the evidence base on case management for homeless persons agencies.

Figure 4.3: Methodology

	Primary studies	*Review articles*	*Total*
Quantitative	18	8	26
Qualitative	27	0	27

Eleven of the quantitative primary studies used a randomised controlled experimental design.

Flgure 4.4: Geographic scope

Australia	5
North America	41
Europe	7

The scarcity of peer-reviewed published Australian research on either case management or homelessness service delivery is a significant gap in the evidence base.

Figure 4.5 Research focus (not mutually exclusive)
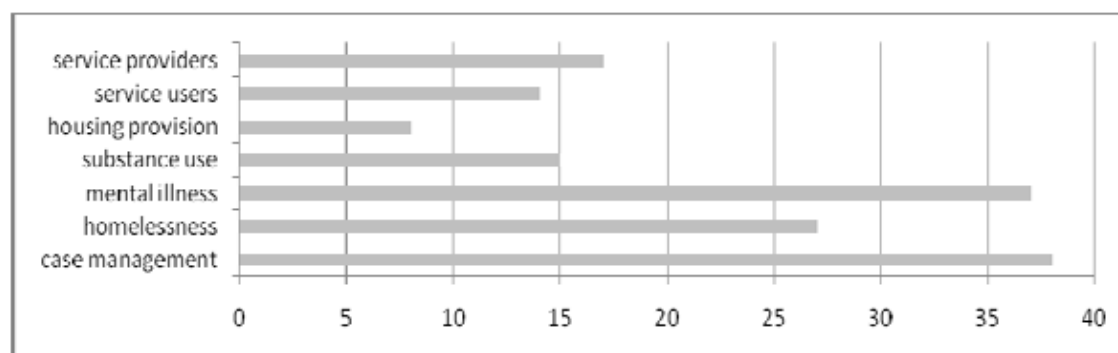
Many studies combined one or more of these research themes.

4.3 Strengths and weaknesses of the evidence base

Overall, the scarcity of Australian research in either case management or homelessness presents a serious weakness in the understanding of the contexts for case management and how they interact with the mechanism.

As can be seen above, a large proportion of the available research about case management for people experiencing homelessness is targeted at people with a severe mental illness. This reflects the funding and service priorities of the United States where the majority of research occurs. There, case management was adopted explicitly and overwhelmingly by the community mental health sector as the intervention to facilitate de-institutionalisation and/or to deal with its consequences (Rothman, 1992, Rapp, 1998).

A decade ago, a comprehensive review of homelessness case management research by Morse identified a number of weaknesses in the existing evidence base (Morse, 1999 6-7). Some of these weakness have subsequently been addressed to some extent, while others remain problematic. The number of randomised control experiments has slowly increased, and experimental design has improved over time,

especially the measures taken to maintain retention, and to control for program fidelity.[16] There is certainly enough evidence to identify the mechanism and contexts for effective case management.

There remains a distinct gap in studies that contrast case management with a 'no treatment' control, due no doubt to ethical considerations. Existing experimental studies typically contrast one model of case management with another form of service delivery, usually another form of case management. The predominance of mental health case management research continues, along with the dominance of North American studies.

As discussed in the second chapter, realist synthesis begins from an acknowledgement that social policy 'implementation chains' make the comparison of apples with apples extremely difficult. The problem of securing 'treatment fidelity' for example, continues to plague case management research, yet nonetheless many studies produce valuable findings that a realist review can extract and synthesise.

A significant gap is in longitudinal studies of case management for homeless people to identify what could be called the 'recovery milestones' and find out specifically how case management practice should change over time when working in this context. This research may find different milestones for different kinds of homelessness experience.

Research about case management practices in non-homelessness sectors is useful for two reasons. First, looking at the research evidence about case management and/or its mechanism and contexts as they are implemented in different service sectors can help identify what is specifically effective for the homelessness sector. Second, research into homelessness will invariably discuss specialist treatment areas, such as drug addictions, mental illness and primary health care issues, while research into those specialist fields will commonly deal with homelessness. In particular there is a high degree of overlap with substance abuse treatment and mental health care targets due to the well-documented prevalence of substance use and mental illness among homeless persons, particularly for the group who experience chronic or long-term homelessness (Holmes *et al.*, 2005, Rayner, 2006).

However, the use of this evidence base is not a judgement about the known or assumed links between mental illness and homelessness. While there is without doubt a coincidence of the two experiences, the overlap is partial. The overlap implies that successful strategies from the mental health sector may enrich the case manager's 'toolkit.' However, the primary reason for using this evidence is its relevance for testing and refining the synthesis understanding of the case management intervention.

Fortuitously, not only have the two sectors, and in particular community mental health, both implemented and researched case management, but both sectors also actively identify individuals experiencing homelessness within their treatment and research target groups. The area of dual diagnosis is particularly relevant to homelessness case management as a quintessentially boundary-crossing intervention; however, studies are only just emerging that focus on this area.

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[16] See Salyers, M. P., Bond, G. R., Teague, G. B., Cox, J. I., Smith, M. E., Hicks, M. L. & Koop, J. I. (2003) Is it ACT yet? Real-world examples of evaluating the degree of implementation for assertive community treatment. *Journal of Behavioral Health Services & Research,* 30.3**:** 304-320. for an example of a method for evaluating ACT implementation fidelity.

5 THE CASE MANAGEMENT MECHANISM: A PERSISTENT, RELIABLE, INTIMATE AND RESPECTFUL RELATIONSHIP

This chapter synthesises seventeen studies that provide evidence about the mechanism of case management. It finds that a genuine relationship between the client and the case manager is the active mechanism in achieving case management outcomes. Synthesis of the studies finds that four qualities of this relationship are consistently valued by clients and are required for an effective, working relationship. These qualities are persistence, reliability, intimacy and respect. The research particularly examines the implications of the quality of intimacy and finds that, while beneficial, it entails some risks for both case managers and clients.

5.1 Synthesis of the evidence: the case management mechanism

What we know

Section 5.2 The relationship makes a difference shows that the strength of the case management relationship is correlated with reductions in homelessness and greater life satisfaction for the client. The research identifies factors which impact on the effectiveness of this mechanism: service system variables such as the case manager's available time, and personal characteristics of the client such as their culture and personal history, the severity of psychiatric symptoms and their level of education and social support.

Section 5.3 A working relationship shows that the dimensions of emotional bonding and task consensus can be measured in the case management relationship and are correlated with better outcomes. It also indicates a relationship duration threshold for these benefits of six months.

Section 5.4 Persistent, reliable, intimate and respectful identifies the particular qualities which facilitate the development of an effective working relationship in the context of case management. The quality of intimacy is a consequence of the genuine emotional dimension and the everyday nature of the case management activities, which can include, for example, shopping, house-cleaning and visiting the doctor.

Section 5.5 Being more than a case manager finds that service users consistently indicate that they want a case management relationship to convey a sense of human solidarity and reciprocation. It also shows some of the risks inherent in the relationship mechanism and why respect is particularly important for case management.

The evidence in this chapter shows how the qualities of the mechanism work together but are individually irreducible. For example, persistence is necessary for developing a relationship, but without reliability, respect and intimacy it will not convey a genuine human solidarity. Intimacy without persistence, reliability and respect risks transgression of professional boundaries.

Persistence and respect builds the person's capacity to believe in and pursue their own goals, thus ultimately freeing them from the need for case management. Intimacy and reliability over time generate an experience of genuine social connection.

Implications

The evidence shows that the relationship is the 'active ingredient' in case management and consequently provides a significant implication about the duration of case management services. Time is required for the relationship to become effective. Consequently, case management services require time to establish the relationship before outcomes can be achieved. This also implies that the assessment of the outcomes of case management services will be more accurate when evaluated over the long-term.

A first, very significant implication of case management's relationship mechanism is its vulnerability to the tensions arising from an intimate, personal connection. These tensions cannot be avoided but can be managed with adequate staff skills and support, as the evidence presented in Chapter 8 demonstrates.

A further implication of the need for a high level of relationship and communication skill in the case manager arises from the finding that practical, comprehensive, persistent and reliable support is effective, but it must not threaten a person's experience of self-reliance and associated self-esteem.

Second, the relationship mechanism is inevitably dependent on personal characteristics of the client, including their aspirations and cognitive capacity. These factors cannot be controlled; however, program design can still facilitate the best possible functioning of the mechanism by attending to the skills and support of case managers, and the program resources required to create the right conditions. The evidence about elements is synthesised in Chapters 7 and 8 of this report.

5.2 The relationship makes a difference

This section synthesises the evidence from four sources which demonstrate that a measurable element of the relationship between case manager and client is correlated with beneficial outcomes.

5.2.1 Synthesis of the evidence: the relationship makes a difference

What do we know?

Chinman *et al* find that improvements to a homeless client's housing situation and general life satisfaction at 12 months were correlated with the presence and strength of the case management relationship at three months. They find that the relationship does not form immediately as there was no correlation with the baseline measures (Chinman et al., 2000 1146).

Chinman *et al* also find that nearly 50% of the participants at each time point *did not* experience a personal connection with their case manager and comment that 'the individuals who are better off are the ones who can best use treatment' (Chinman *et al.*, 1999). They find that being African American made you more likely to form a connection, as did having more education, social and public support. Being less psychotic, less intoxicated, and having spent less time on the streets was correlated with having a connection with your case manager.

Beddell *et al* find that mental health case management programs providing comparatively more direct assistance rather than brokering services from other agencies produced better results in client satisfaction, reduced hospitalisation, and increased treatment retention (Bedell et al., 2000 181-9).

Bourgois and Schonberg show that in a Los Angeles community of homeless heroin injectors, African Americans have quite different social networks and relationship practices than Anglo Americans (Bourgois and Schonberg, 2007 24-5).

Implications

Synthesis of this evidence finds that the relationship is a key to improving a client's situation through case management, and identifies three factors which can impact on the relationship.

First, the length and intensity of time invested in the relationship impacts on its development and effectiveness. There is a threshold for relationship development, and the level of direct service delivery provided by the case manager is an indirect measure of the time invested in the case management relationship.

Second, the severity of a person's psychotic symptoms, longer experience of homelessness and lower levels of education and social and public support will inhibit the formation of a case management relationship.

Third, an individual's capacity for relationship formation is differentiated by racial and socio-economic factors. Examination of the lived experience of homelessness is a promising direction for understanding the implications of racial or cultural differences for case management.

The second two factors limit the effectiveness of the intervention and are outside the control of the case manager or case management agency. As case management relies on a relationship mechanism, it is sensitive to the motivation and capacity of the client to engage in this relationship.

In addition, the findings highlight a significant variation within the group of people experiencing homelessness and mental illness, indicating the need for individualised responses.

5.2.2   The research: the relationship makes a difference

The ACCESS data set

Strong quantitative evidence of the correlation between a stronger case management relationship and better housing outcomes for people experiencing homelessness is the finding from an analysis of the Access to Community Care and Effective Services and Supports (ACCESS) data set. This data was collected over the first two years (1994–5) of a five-year national demonstration project in the United States.

The ACCESS program provided outreach and intensive case management in fifteen cities in an initiative to enhance service use and quality of life for homeless people with serious mental illnesses. During 1994, the program was implemented in eighteen communities, covering the major geographical areas of the US, and providing services to 100 homeless people at each site each year.

Chinman, Rosenheck and Lam analysed the data from the first two cohorts in the program. At baseline, 3,481 participants consented to participate, 2,943 completed the three-month interview and 2,798 (80.4%) completed the final interview, eighteen months after commencement. They found that a stronger relationship at three months predicted better housing outcomes at twelve months; in addition, those who reported the strongest case management relationship at three months experienced 50% fewer days homeless at twelve months than those reporting no relationship (Chinman et al., 2000 1146).

All the participants had at least one psychiatric diagnosis: in order of frequency, major depression (45%), schizophrenia, other psychoses, personality disorder, bipolar disorder and anxiety disorder. Sixty-six percent of participants were diagnosed with a psychotic disorder, and in addition, 44% of participants were diagnosed with alcohol abuse and 38% with drug abuse disorders.

This research was not randomised and had no control group; however, the large sample size and geographic spread make it a significant data set.

Chinman, M. J., Rosenheck, R. & Lam, J. A. (2000) The Case Management Relationship and Outcomes of Homeless Persons With Serious Mental Illness. *Psychiatric Services,* 51.9: 1142-1147.

This analysis of the ACCESS data set finds evidence of the positive correlation between case management relationship and outcomes for persons who are homeless and have a serious mental illness (Chinman *et al.*, 2000).

The method in this study allowed prospective investigation of concurrent and temporally predictive associations, thus overcoming the methodological limitations of retrospective analysis used in previous studies (Chinman et al., 2000 1142-3).

This study sought to increase understanding of the relationship between therapeutic alliance and outcomes among homeless persons with mental illness by statistically investigating correlations and dependencies between a range of demographic, social and illness variables. The independent variable was the case manager relationship which was categorised in three levels: no relationship, low therapeutic alliance, and high therapeutic alliance, as described above. The outcome variables were days homeless and life satisfaction.

A predictive correlation was found between presence and strength of the case management relationship at three months, and days of homelessness at twelve months. A significant association was found between relationship strength, days of homelessness and general life satisfaction. At twelve months, those in the high alliance group experienced 50% fewer days homeless than those with no relationship with their case manager. A similar but much weaker correlation was found between a high alliance and general life satisfaction (Chinman et al., 2000 1146).

As there was no program fidelity or consistency measures in place for this study, the finding does not rule out a common relationship factor that can be correlated with better outcomes.

No statistically valid associations were found between the baseline measure of the relationship and the final outcomes. This finding supports the idea that a human relationship is the mechanism since by its nature a relationship develops over time.

Chinman, M. J., Rosenheck, R. & Lam, J. A. (1999) The development of relationships between people who are homeless and have a mental disability and their case managers. *Psychiatric Rehabilitation Journal,* 23.1: 47.

This analysis of the ACCESS data set examined person-related characteristics which influence the development and strength of the relationship between case manager and a person experiencing homelessness and mental illness. This analysis is included in the synthesis because it provides evidence about the characteristics which promote or limit the effectiveness of case management.

It finds that predisposing factors for establishment of a case management relationship were being African-American, having more years of education, more social support and having spent fewer days homeless. Predictive illness factors were reporting more

psychological distress while having less observed psychotic behaviour and less substance abuse.

Structured baseline interviews with participants documented socio-demographic characteristics, which were matched with self-report and clinical assessment from the program screening phase. Repeat data was collected at three and twelve months post-baseline. At baseline two-thirds of the participants were men, and just over 45% were African-American. Due to the large sample size, all demographic groups were well represented at each time point. However, the authors note that retained participants were less likely to be men, and more likely to be African-American than those lost to the study.

Participants who reported having a personal connection with a case manager also completed a measure of therapeutic alliance. A modified published scale was used to assess the level of trust, conflict, agreement on treatment goals, confidence in the clinician's ability, and importance of the relationship (for more information on the therapeutic alliance concept see Section 5.2).

The study investigated which factors predicted development of a personal connection with a case manager and for those with a personal connection, which factors predicted the development of a therapeutic alliance.

Factors were categorised as predisposing or illness-related. Predisposing factors measured were race, gender, education level, level of social support (measured by number and types of people you could count on for a loan, ride to an appointment or get help with an emotional crisis), number of days without shelter in the last sixty days, and monthly total of public funds received in dollars. Illness factors were measured by observed psychotic behaviours and number of days intoxicated out of the last thirty days.

Participants were more likely to report a connection with a case manager if they had identified more psychiatric problems, but were less overtly psychotic, if they had greater public support, education and social support, were African-American or male, and had fewer days homeless and intoxicated. These conditions were repeated at three and twelve months, with a slight reduction of significance of some factors. A personal connection at baseline or three months was strongly correlated with having one at the final time point.

All participants were assigned a case manager but nearly half reported not having a personal connection at both time points: 48% at three months, and 44% at twelve months. Overall this group tended to be more symptomatic, less functional, have lower education, social and public support, and reported less subjective psychological distress (the authors note the latter can be interpreted as having less insight into their experience).

Another finding was that while more days homeless predicted less likelihood of forming a personal connection at baseline, among those who did report a connection, there was a significantly higher therapeutic alliance. The authors note that it is unclear if this is due to inter-group differences, or a possible effect of greater need producing greater loyalty if a personal connection can be forged.

Race proved to be a significant predictor in both forming a relationship and in strength of the therapeutic alliance but the researchers were unable to account for this finding. A possible explanation for this result is suggested by synthesising this evidence with an ethnographic study of homeless heroin users in San Francisco (Bourgois and Schonberg, 2007).

Bourgois, P. & Schonberg, J. (2007) Intimate apartheid: Ethnic dimensions of habitus among homeless heroin injectors *Ethnography,* **8.1: 7-31.**

This study is based on ten years of participant-observation fieldwork and photography among a multi-ethnic social network of approximately two dozen middle-aged homeless heroin injectors in California. It documents distinct racial dimensions to the capacity and strategies of individuals to take care of themselves. While there is much of interest about the experience of long-term homelessness in this study, the relevant finding for the synthesis is about a racialised difference in social networks (Bourgois and Schonberg, 2007 24-5). African American men tended to have active contact with their relatives, knowing their mothers' telephone numbers by heart and where their children lived. They were likely to maintain a network of extended family, friends and acquaintances. In contrast, the whites in the community were outcasts from their families and unlikely to know the whereabouts of their parents or their own children. This difference suggests that African American men are more likely to have the interpersonal skills needed to form the personal connection that case management relies upon, as found in study of the ACCESS demonstration project.

Bedell, J. R., Cohen, N. L. & Sullivan, A. (2000) Case Management: The Current Best Practices and the Next Generation of Innovation. *Community Mental Health Journal,* **36.2: 179-194.**

Case management models can be differentiated by the proportion of direct service delivery provided by the case managers themselves compared to obtaining services for their clients from other agencies using brokerage funds or referrals. This article reviewed the evidence from eight previous reviews of community mental health case management research to determine if this variable made a reliable difference to outcomes. Each program was classified full service, broker or hybrid and their performance was evaluated against eight outcome variables. The hybrid classification included, for example, versions of intensive case management and a 'Personal Strengths' approach

The review found that full service case management was consistently associated with increased treatment retention and compliance, reduced hospitalisation, modest cost savings, and good client satisfaction. Reduced symptom severity and increased functioning was also found in some studies, but not reliably. Full service programs were ineffective at reducing community service use (pp.181–7).

Brokered programs were not effective at treatment retention. They produced no change or increased hospitalisation, were associated with increased costs, and did not reduce community service use or symptom severity (pp.181–7). Hybrid programs achieved better outcomes with the more full-service characteristics they included (189). The authors conclude:

> It is probably time to abandon the other models of case management that rely heavily on brokering of services since they were associated with inferior outcomes. (Bedell et al., 2000 189)

One of the experimental studies reviewed by Beddell *et al.* concerns case management for homeless persons in particular and is examined in more detail below (Wolff *et al.*, 1997).

5.3 A working relationship

How and why does a case management relationship produce better results? There is some evidence available to answer this question although it is not extensive. Indeed, research by Hogard finds a distinct neglect of inter-personal processes in the program

evaluation literature (Hogard, 2007 305). Hogard reports that the current evidence on this topic comes primarily from research based or informed by psychotherapeutic knowledge (Hogard, 2007 305). This work stems from Freud's discovery of the specific therapeutic role of the relationship between client and therapist (Catty *et al.*, 2007, Sudbery, 2002). Freud found that the relationship was not just a communication medium, but also the site and source of problem-solving opportunities. The following section synthesises the findings from this evidence base.

5.3.1 Synthesis of the evidence: a working relationship

What do we know?

Mental health research has developed a body of evidence showing a modest positive correlation between a measurable relationship construct (variously called the 'therapeutic alliance,' 'working alliance' or 'helping relationship') and better treatment outcomes (McCabe and Priebe, 2004, Howgego et al., 2003).

In all measures, the relationship construct combines an element of emotional bonding and an element of task or goal consensus.

McCabe and Priebe also find a significant 'general factor' in the therapeutic relationship. They report the importance of respect and genuine connection, and also highlight areas of difficulty, namely that the service user's level of insight and the capacity to form the relationship may limit the effectiveness of the mechanism.

Coffey proves that distinct elements of connection and autonomy in the case management relationship can be measured and independently correlated with service user outcomes. Coffey provides indicative evidence that a friendly connection is critical to better outcomes, and can compensate for the impact of symptom severity; she also finds that service-user autonomy may be differentially related to outcome domains.

(Howgego *et al.*, 2003) and (Coffey, 2003) both find that six months is a minimum duration threshold for a relationship correlated with better client outcomes.

Implications

Synthesis of the evidence from these studies of the working alliance supports the inference that the relationship is the basic mechanism of case management. It shows that a relationship which includes elements of emotional bonding and task consensus has a beneficial impact on the person being assisted. However, the beneficial effect will be constrained by the person's capacity for relationship and level of insight. The ability for the case manager to establish a friendly connection is even more significant in this case because it can compensate for higher symptom severity.

The evidence confirms that time is required for the relationship to become effective, and that case management outcomes can only be assessed once this relationship has been established. The evidence here suggests six months as a threshold; however, there are too many contingent variables to consider this more than an indicative finding.

A final implication is that further evidence is needed to understand the complex operation of the relationship; there is a significant 'general factor' which remains unknown, and an indication that the balance between connection and autonomy in the case management relationship affects outcomes differently.

5.3.2   The research: a working relationship

McCabe, R. & Priebe, S. (2004) The Therapeutic Relationship in the Treatment of Severe Mental Illness: A Review of Methods and Findings. *International Journal of Social Psychiatry,* **50.2: 115-128.**

McCabe and Priebe comprehensively review studies that measured an operationalised concept of the therapeutic relationship in the treatment of people with severe mental illness in mainstream psychiatric care. They find and document twenty-two studies published over a period of twenty years (1981–2000). This review is included in the synthesis because it provides evidence about the relationship mechanism deployed in case management, and assesses the tools used to measure its effectiveness.

All twenty-two studies, using different measures, found positive correlations between client outcomes and a measurement of the therapeutic relationship. The finding held for a range of treatment groups, including depression, addictive disorder, psychosis, post-traumatic stress-disorder, and across both in- and outpatient treatment settings. They find that the therapeutic alliance is an independent predictor of treatment outcome, and also a mediating factor that influences the outcomes of other treatments such as pharmacological therapies (McCabe and Priebe, 2004 125).

All of the measurement scales assess both the bond between the client and therapist, and the quality of their collaboration using some combination of patient, therapist and external viewpoints. The authors report that all the measures show an acceptable level of reliability, and that the construct consistently shows resistance to further analysis as a 'general factor', accounting for two-thirds of the variation (McCabe and Priebe, 2004 123-4).

In addition, and unsurprisingly, the therapeutic alliance is conceptually and methodologically related to treatment satisfaction, with consistent empirical support for their positive inter-relation. Second, the alliance is related to 'insight' or the person's understanding of their own experience. Furthermore, they report some evidence that the therapist's interest in the person's experience is itself a relationship-building factor (McCabe and Priebe, 2004 124-5).

Howgego, I. M., Yellowlees, P., Owen, C., Meldrum, L. & Dark, F. (2003) The therapeutic alliance: the key to effective patient outcome? A descriptive review of the evidence in community mental health case management. *Australian and New Zealand Journal of Psychiatry,* **37.2: 169-183.**

This Australian review of the international literature (1986–2001) finds a robust, though modest, positive association between the therapeutic alliance of patients with mental illness and improved outcomes, similar to (McCabe and Priebe, 2004).

The review demonstrates the sizeable body of research into the therapeutic alliance. For example, it reports on two meta-analytic reviews which together covered 103 studies, spanning twenty years of research on the relation between the alliance and client outcomes. The review notes that there are a range of definitions and associated scales used to measure the alliance, and while they are not consistent, a high level of correlation has been demonstrated. Regardless of the theoretical background, the two key dimensions are the level of collaboration between client and clinician, and a measure of the personal attachment or bond between them.

The evidence clearly establishes a measure of alliance as a reliable predictor of client outcomes in mental health treatment. The positive association was found to hold across a range of moderator variables such as type of therapy, time, and type of outcome measure. Typical outcome measures include symptom severity, client

satisfaction, social functioning and medication compliance (Howgego et al., 2003 176-7).

The review highlights a methodologically strong study of 143 psychiatric patients over two years. This study found that clients with schizophrenia took longer to form an alliance, and overall that the first six months was critical for alliance development. Despite resolution of most active psychosis by three months, only at six months was there a significant increase in the proportion of people reporting a good alliance over the baseline (Howgego et al., 2003 176). A good alliance at six months was strongly correlated with greater medication compliance and better outcomes after two years, while over 70% of those reporting a poor alliance left treatment within three months.

The authors conclude that the alliance has potential as a predictor of outcome for patients engaged in case management services in community mental health. They describe an Australian research initiative to investigate the impact of the working alliance on client outcomes. Unfortunately, this project was abandoned due to high case management staff turnover (email communication, Howgego 2008), underlining the practical difficulties faced in researching this area.

Coffey, D. S. (2003) Connection and autonomy in the case management relationship. *Psychiatric Rehabilitation Journal* 26.4: 404 - 412.

The comprehensive reviews provided by (McCabe and Priebe, 2004) and (Howgego et al., 2003) find that a psychotherapeutically defined relationship construct, measured using the Working Alliance Inventory or related scales, consistently shows a modest correlation between a positive relationship and better client outcomes in the fields of psychiatry and community mental health case management.

This small quantitative study, like (Angell and Mahoney, 2007, Ware et al., 2004) and (Buck and Alexander, 2006) is selected for the synthesis because it develops the psychotherapeutic understanding of the relationship mechanism toward greater specificity and relevance for case management. It finds that the dimensions of connection and autonomy in the relationship can be independently measured and related to client outcomes.

The results show that a friendly connection rating at six months strongly predicted treatment satisfaction at nine months with an effect that compensated for the negative impact of symptom severity. They also showed that less case manager autonomy, in other words, more assertive case management, led to better outcomes in social life satisfaction.

It also finds that duration is a factor in relationship development. It found that the three-month relationship measure had minimal correlation with outcomes, while the six-month measure was predictive of outcomes in all three areas – treatment participation, client satisfaction, and satisfaction with social life.

The study explored the correlations between treatment satisfaction, social life satisfaction and the experience of connection and autonomy in the community mental health case management relationship over a period of nine months. The elements of connection and autonomy were measured along four dimensions, using both case manager and clients rating of their own and the other's behaviors. These dimensions were each tested for their correlations to the outcome variables: treatment participation, satisfaction with case management and with social life (twelve analyses at each time point).

The sample included forty-three case managers and fifty-five service users (thirty men and twenty-five women); data was collected at baseline, three, six and nine months using well-validated psychometric measurement tools including self-rating and

observational scales. This study was not targeted at people experiencing homelessness; however, only 14.5% of the sample lived independently, while nearly a third lived in a community residential rehabilitation program and 20% lived with parents or other relatives (Coffey, 2003 406).

Case management in this study was characterised by assertive outreach, a 10–15 client caseload, 24-hour responsiveness, and direct, practical assistance in daily living activities. The case manager also linked the clients to appropriate vocational, psychiatric and rehabilitation services and monitored the progress.

At the three-month time point, only two of the twelve analyses showed a correlation. Both were case manager ratings and are compromised by the subjectivity of the treatment participation measure (Coffey, 2003 408,410).

At six months, satisfaction with case management was linked to client's experience of friendly connection and greater autonomy from their case manager. In addition, while symptom severity impacted on this satisfaction, the influence of a friendly connection was stronger and able to compensate for this effect. Similarly, from the case manager's perspective, their rating of their own behavior showed a correlation between friendly connection and satisfaction that exceeded the impact of symptoms (Coffey, 2003 409).

Satisfaction with social life showed a different pattern. From the client's perspective, positive connection at six months led to greater satisfaction at nine months, while autonomy was not significant. From the case manager's perspective, the only predictive correlation was that a higher rating of autonomy in their own behavior was associated with less satisfaction with social life for the client at nine months. The author draws a tentative conclusion that a more assertive or directive approach from the case manager may be needed to achieve outcomes in social life (Coffey, 2003 409).

The value of this study is its indicative evidence about how specific components of the relationship may be related to the outcomes of case management. Generalisation of the absolute findings is limited by the small sample size for a quantitative methodology and the subjectivity of the outcome measures. However, its detailed analysis of both case manager and service user perspectives on their own and each other's behaviour is an important contribution to the synthesis.

5.4 Persistent, reliable, intimate and respectful

This section synthesises four sources of evidence which most directly identify the qualities required in the case management relationship. The significance of these qualities is indirectly confirmed by a range of other sources in the synthesis, as will be noted throughout the report.

5.4.1 Synthesis of the evidence: persistent, reliable, intimate and respectful

What we know

Beresford *et al.*'s findings from palliative social work provide evidence of the independent value of a genuine, respectful, personal relationship with the worker distinct from any particular services provided. The study also finds that it is the *combination* of practical and emotional support which is most appreciated (Beresford *et al.*, 2007).

(Beresford et al., 2007) identify difficulties that arise because the intervention relies on and mobilises an emotional relationship. These include the possible transgression of

professional boundaries – manifested as 'expecting too much', or alternatively, de-professionalisation – the worker is reduced to merely 'being a friend.' However, in relation to the fear of unrealistic expectations, they find that while service users valued a high level of accessibility, they did not consequently overwhelm the social workers with demands.

The findings of Nehl's study of case management with people with borderline personality disorder confirm those found in Beresford *et al.*'s research. Both studies also highlight the importance of contact time, and the qualitative experience that the worker *had enough time for them*. Nehl's study graphically illustrates the positive personal change in the client that case management can facilitate over time through persistence, reliability and respect and a genuine emotional connection.

Together Nehl and Beresford *et al.* demonstrate a robust congruence of these findings across quite different client groups.

Smith *et al.* identify that successful practice for people with borderline personality disorder involves the provision of structure, consistency, active engagement of the person in their own treatment plan, and the promotion of accountability for their own decisions. They also identify how the practice of respect in the relationship allows people to develop responsibility for their own behaviours (Smith et al., 2001).

Kidd and Davidson's ethnographic study of young people living on the streets in New York and Toronto finds a diversity of experience and aspirations, and particularly highlights the importance of respectful case management. Surviving on the streets, they find, is a source of self-respect and pride (Kidd and Davidson, 2007).

Implications

All the evidence in this section shows that respect is central to an effective relationship, and demands a refinement of our understanding of the developmental outcome of case management. The developmental goal was framed with an understanding of a relationship between the state's 'duty of care' and a person's ability to take care of themselves. The evidence from this section shows how the assumption of incapacity underlying case management may be damaging to the person being assisted. Case management must be provided with respect and recognition for the person's strengths and capacities in surviving the experience of homelessness.

The evidence also supports the conclusion that it is a persistent and reliable relationship that engages people in case management. This confirms that case management duration is important, and implies the need to monitor and limit case manager caseload size in order to ensure there is adequate investment in the relationship.

The evidence suggests that knowing that someone is there if you need them paradoxically makes you less likely to need them. This is also a claim made explicitly in a discussion paper produced for Aged and Community Services Australia and the Case Management Society of Australia. The paper provides a composite case study showing that case management can provide a low level of monitoring support that gives older people the confidence to maintain their independence and is therefore cost-effective (Case Management Working Group, 2006 9). It also cites an evaluation that found reduced inpatient time for patients referred to post-acute care case management (p.11), suggesting that the care package gave people a level of confidence that facilitated an earlier discharge.

The underlying theory is that a genuine and reliable helping relationship enables people to cope better, not because of any particular service that is provided but due to the relationship itself.

The implications of the findings from work with borderline personality disorder are that the qualities of persistence, reliability and respect in the case management relationship can be therapeutic. In addition there are implications for the service system conditions. Professional support and collaboration between service providers operationalised as a high level of communication is needed to promote a consistent and reliable response to the person. Confirming this strategy, a number of practitioners interviewed explained that good inter-agency communication was useful for *case management* because it assists in *holding the person to the relationship* (1,5).

These findings suggest that the case management relationship provides two-way accountability. On the one hand, by having a single person responsible for the care of the client, and on the other by ensuring that the client must work through the consequences and the steps involved in achieving change. The coordination, accountability and single point of responsibility aspects of case management mean that a client cannot go to another service and claim that 'no-one is doing anything to help me.' Such a behaviour pattern, anecdotally well-recognised, of playing off services against each other, can be understood as part of a rational strategy to get what one needs from an unsatisfactory system. However, evidence from the treatment of personality disorders discussed here indicates that in some cases such 'splitting' behaviour can be counter-productive for the client.

Case management, through the qualities of reliability and persistence, ensures that there is a mutual accountability in the relationship and can mobilise the socially normative and developmentally supportive forces of reciprocity and accountability.[17]

The dimensions identified by these studies indicate some of the risks inherent in a relationship-based intervention, risks that were also consistently raised in the project's interviews with case managers. Further evidence about these risks is presented in *Section 5.5 Being more than a case manager*.

5.4.2 The research: persistent, reliable, intimate, respectful

Beresford, P., Croft, S. & Adshead, L. (2007) 'We Don't See Her as a Social Worker': A Service User Case Study of the Importance of the Social Worker's Relationship and Humanity. *British Journal of Social Work,* Advanced Access May 24, 2007.

This qualitative study of 111 service users finds a set of characteristics that define a positive support relationship (Beresford *et al.*, 2007). The UK study of palliative care social work finds that people overwhelmingly valued an experience of genuine, respectful, emotional connection with the social worker. The relationship was perceived as one that exceeded an administrative duty of care, and it was valued independently, although alongside, the worker's practical support and expertise.

This study was based on qualitative interviews with thirty-nine men and seventy-two women who were either bereaved or had a life-limiting condition. The participants included 9% who identified themselves as black and/or members of minority ethnic groups. They represented both rural and urban parts of the country. The study adopted a user-involvement research approach drawing on the researchers' extensive

experience, including the Shaping Our Lives National User Network and associated research projects. Data analysis used grounded theory approaches – interview transcripts were coded and themed; researcher-extracted ideas were tested in service user advisory groups. Care was taken in the recruitment process to eliminate sampling bias, and the interview schedule was designed to prompt critical and negative feedback.

The key finding was that people reported overwhelmingly positive experiences with specialist palliative care social workers. The authors rightly note that the context of dying and bereavement would be expected to generate intensity in the emotional bond. Notwithstanding the specificity of this context, the research has adequate analytic depth to enable the identification of general elements which make that bond a useful professional intervention.

The positive experience in palliative care was remarked upon in comparison to negative preconceptions and/or experiences of social work in other fields. Two contrasting service user comments highlight the difference:

> They may have that skill but they have to bond as well, there has to be that trust and that relationship (white, UK, male patient, aged fifty years). (Beresford et al., 2007 7)

As opposed to:

> Just fill that form—you should be all right—bye-bye—signed and finished, back in the file. (Beresford et al., 2007 7)

The difference that service users noticed in palliative social work was the quality of the relationship. What service users appreciated and what they felt assisted them in getting through a difficult experience was the 'bond' of a trusting and trustworthy relationship. It was the experience of someone who cared, who went out of their way, who was kind, and who made them feel valued:

> Well, esteem, pure esteem that's the feeling we had, that she cared about us you know (man aged sixty-six to seventy-five in a discussion group of bereaved people). (Beresford et al., 2007 10)

Time is a key factor in producing this positive experience of connection, as this comment indicates:

> I can't emphasize the time scale of things, there's no rush, you don't feel as though you are being a burden or that you know that you are wasting their time somehow. You know she's always got the time that you need (white, widowed mother of three young children, age group twenty-six to thirty-five years). (Beresford et al., 2007 11)

Service users also appreciated having a sense of control and feeling respected (Beresford *et al.*, 2007):

> She doesn't take a particular course of action or whatever, without first talking about it, and then she asks me if that is what I want to do […] (UK, Asian male patient, age group nineteen to twenty-five years). (p.9)

> She always asks you what do you hope to gain today in our meeting …so that you can have a chance to say. (white, UK, woman patient, age group forty-six to fifty-five years). (p.9)

> … she always said it's what you want, I'm only guiding you […] (white, UK, woman patient, aged eighty-four years). (p.10)

Other key skills and qualities valued by service users were professional knowledge and expertise – knowing what was available or being able to find out; reliability, continuity and accessibility. The authors conclude that what service users valued was 'someone who was prepared to stay alongside them in their journey,' while '[f]irmness and the ability to 'talk straight' were also important to people (p.14).

This study found the interlocked importance of the practical and the emotional elements of the relationship.

> What service users seemed to value from social work practice was that it was truly psycho-social; that is to say, it addressed both individual personal and psychological needs and the broader social circumstances and world people lived in and faced. These two were inextricable. The combination of practical help and support, with a relationship and 'friendship', were what so often were seen as valuable and unique. (Beresford et al., 2007 18)

The authors report that their findings confirm service user research in other fields including children, homeless adolescents (Netherlands), as well as two other government consultations with adult social care service users in the UK. They comment that this 'much broader and more equal' understanding of psycho-social takes social work practice beyond traditional casework approaches.

The finding of the importance of this reliable and accessible, genuine emotional connection provokes concerns about professional role boundaries. The authors comment:

> The knee-jerk reaction is to be fearful that the social worker is being exposed as somehow unprofessional or unboundaried or merely doing something anybody could do. (Beresford et al., 2007 16)

They consequently pursued further analysis to determine whether the relationship aspects valued by clients were signs of a transgression of the bounds of a professional role, and tested the hypothesis with their advisory group of service users. They also explored the possibility that the desired sense of accessibility might unleash unrealistic demands on the social worker, and concluded that this did not occur. It seemed that people felt supported and better able to cope, and consequently 'they did not necessarily call on it' (p.11). Beresford *et al.* conclude that service users had a clear understanding of the limits of the relationship.

Finally, Beresford *et al.* reflect on the service system context necessary to support the kind of relationship valued by service users in this study. They note:

> this aspect of practice has been undermined, with the increasing trend for social work within statutory services to be reduced to a time-limited, check-box exercise in which practical needs are scrutinized, but in which the relationship between social worker and service user is very much a secondary consideration. (Beresford et al., 2007 13)

They conclude that a policy emphasis on the role of 'referral agent' or 'navigator', and on splitting the assessment from the intervention parts of the role reduces the capacity of workers to engage in the relationship-building most valued by services users.

The evidence from the palliative care study is relevant to case management in homeless persons agencies because the emotional intensity of palliative care context has a number of similarities with the homelessness context. Not only is homelessness itself a crisis for most people (Johnson *et al.*, 2008), significant life events including bereavement, self-harm, loss of children are common among people experiencing chronic homelessness (Rayner *et al.*, 2005). As a result, the elements of relationship

identified by these service users will logically be applicable to the homelessness case management context.

Nehls, N. (2001) What is a Case Manager? The Perspective of Persons with Borderline Personality Disorder. *Journal of the American Psychiatric Nurses Association,* **7.1: 4-12.**

This study of the experience of community mental health nursing case management highlights the importance of an enduring personal relationship. The research explored the perspective of service-users using an interpretative phenomenological research approach (Nehls, 2001). The following three themes, described in the participants' own words, emerged from the interview data: 'My case manager treats me like a person', 'My case manager is more than a case manager', and 'My case manager has stuck with me for years' (Nehls, 2001 6).

The indepth qualitative study had a sample of eighteen adults; all but one were female. All had a borderline personality disorder diagnosis and at least six months experience of case management. The qualitative interviews lasted about an hour and were taped and transcribed. Participants were asked to describe a stand-out experience with their case manager, and then prompted to explore further what having a case manager meant to them. Multiple stage analysis, using three interpretative researchers and external validation, was used to extract common themes from the transcribed data.

Being treated like a person was fundamentally about being treated with respect:

> It doesn't seem like [the case manager] sits there and judges me. He listens to what I have to say and then… we'll talk about what we're going to do or what we're going to change. He doesn't tell me, "Well, you need to do this; you need to do that." Just "Why don't you try this?" That really makes a difference. (Nehls, 2001 6)

The case manager was seen as a partner rather than a directive authority, which consequently made it possible to choose to adopt the case manager's suggestions as compared to resisting the perceived coercion coming from other parts of the health care system.

Feeling like a person was generated by non-judgemental listening and experiencing a genuine interest from the case manager about their thoughts, feelings and values. An overly problem-solving focus could undermine the valued sense of human companionship:

> I feel very alone a lot of the time, so one of the big things for me to not be so alone is to have somebody else know what's going on, and that's the biggest thing I use my case manager for. I'll tell him, "Now you don't have to *do* anything; you don't have to *fix* anything; you don't have to send me anywhere; [but] just know what's going on."(Nehls, 2001 7)

It is important to note that this particular comment came from the context of long-term (over three years) case management. The kind of support that comes from human connection inherently requires a persistence and reliability to be experienced as genuine and trustworthy.

The second theme about being more than a case manager expressed appreciation of the comprehensive and practical scope of the support provided. Participants described receiving assistance in many areas of daily life, from getting medication and shopping to help with a car repairs. Assistance for things that appeared unrelated to the person's illness was particularly valued.

My case manager said that she'd help me with any kind of problem or concern I might have, and she really kept her word. She's like a lifeline. (Nehls, 2001 8)

This quote also underlines the significance of reliability in the case management relationship.

The intimacy of involvement in daily living activities seemed to make the case manager 'more than a case manager'. One person said 'my case manager is probably the most important person in my life' and described them as 'sort of like my big brother, almost like family.' Another person tacitly acknowledged the potential to misconstrue the relationship, while emphasising how important this bond was which persisted beyond illness management or problem-solving:

I see him like as a friend and as someone I can talk to. It sounds kind of weird because, I don't know, maybe some people think they're to help you through when you're having a real hard time but I don't…(Nehls, 2001 8)

This comment shows an implicit awareness of concerns about transgression of professional boundaries similar to those raised in Beresford's study. But for this person, that judgment is transcended by the real and significant value of this experience of a genuine emotional connection.

The final theme, 'my case manager has stuck with me for years', confirms the value of persistence and reliability in case management. The long-term commitment experienced by many of the participants (over two years for many, and in one case over ten years) gave people the opportunity to experience and resolve conflict in a positive way. One person recalled expressing their anger by a suicide attempt outside their case manager's house, which led to police involvement but was eventually able to reconcile with the case manager. They commented:

It was one of the first times that I can ever remember something devastating happening and actually working it through. In the past every time I did something terrible or somebody did something terrible to me, that was the end.…So, it's not like its been an easy relationship all the time. But there's something there that we have a real bond somehow. (Nehls, 2001 9)

Many participants ascribed their development of greater self-care to the persistence and reliability of their case manager. One person explained:

I was [a] real basket case…I was taking pills and trying to commit suicide, but now it's been a couple of years since I've had any trouble like that. It made all the difference in the world to have someone that you could depend on. (Nehls, 2001 9)

The study concludes that clients experienced their case managers as respectful, reliable and resourceful. Furthermore, a partnership with such a case manager provided a sense of personal satisfaction and over time led to a reduction in the level of services required.

Smith, G. W., Ruiz-Sancho, A. & Gunderson, J. G. (2001) An Intensive Outpatient Program for Patients With Borderline Personality Disorder. *Psychiatric Services,* **52.4: 532-533.**

This report from a case management program for people with borderline personality disorder (BPD) provides conceptual evidence of the value of a relationship with the qualities of reliability and persistence. Treatment for BPD explicitly draws on Donald Winnicott's developmental psychology and is focused on provision of 'an environment where the patient feels sufficiently safe and contained' (Smith et al., 2001 532).

Developmental psychology claims that mature adult independence is achieved not through the perfect meeting of needs but through a process of 'good enough mothering'. Winnicott developed the concept of 'good enough mothering' as the basis for the healthy psychotherapeutic relationship. This caring relationship provides a safe holding space to develop mature objective relations: to transition from subjective omnipotence to a realistic sense that the world is not under your control, nor designed to meet your needs, yet a world in which you can safely take actions to achieve satisfaction. Accordingly, Smith *et al.* describe four elements of effective treatment:

> reliance on structure, the expectation that each patient will be an active participant in the development and implementation of his or her treatment plan, ongoing identification of maladaptive interpersonal functioning, and a focus on adaptation to community life and a longitudinal perspective on the patient's life. (Smith et al., 2001 532).

The focus on structure, role clarity, planning and active participation in this treatment model is widely reflected in the case management literature. For people with BPD, these elements are effective because they support the development of a therapeutic relationship that provides *safety* and *containment*. Other important elements include frequent contact and the use of peer group work to mobilise peer accountability for behaviours.

The over-arching strategy for treatment of people with BPD is encouraging them to take responsibility for themselves, which involves a rigorous avoidance of over-protection or over-managing clients. Importantly, this implies a significant level of support for the practitioner to ensure they feel confident about allowing risk-taking and encouraging self-management behaviours (Smith et al., 2001 533).

Smith *et al.* also note the evidence about how to avoid the damaging effect of what they call 'splits,' in other words disagreement between service providers about what services the client should receive (Smith et al., 2001 533). A high level of inter-agency communication is recommended to reduce the likelihood of blaming the system, and developing the capacity of person with BPD to take responsibility for managing their own problems.

Smith *et al.* demonstrate that persistence, reliability and respect are the key qualities which encourage the person to take responsibility for their own actions. Supervision and support for the service provider is essential to practise in this way, as is coordination and communication with other service providers.

Kidd, S. A. & Davidson, L. (2007) 'You have to adapt because you have no other choice': The stories of strength and resilience of 208 homeless youth in New York City and Toronto. *Journal of Community Psychology,* 35.2: 219-238.

This qualitative study of young people experiencing homelessness in New York City and Toronto focused on stories of survival and strength. Like other research from a service user's perspective, it is valuable for the synthesis because it most notably tests the theory of a developmental outcome. The evidence from this study challenges the assumption that a person experiencing homelessness has any deficit in their self-care capacity. In fact, the data from over 200 young people living on the streets reveals a group of resilient survivors with a high level of self-care ability.

The study found that living on the street created profound transformations to a person's identity and their sources of self-regard and social support. The consequences ranged from empowering to destructive, and in some cases were both simultaneously (Kidd and Davidson, 2007 234-5).

A key implication for case management is that a high level of assessment, relationship and intervention skills are required. The findings confirm the need for respect, reliability and persistence, while adding the possible need for a level of emotional detachment. These stories demonstrate why case management must take care to avoid further damaging a person's self-esteem by disrespecting their capacities and strengths (Kidd and Davidson, 2007 236).

This study used indepth exploratory interviews with young people aged fourteen to twenty-four living on the streets in New York (100) in Toronto (108). Young people were recruited by agency worker referrals, by word of mouth, or by direct approach. The author spent time out on the streets and often approached young people directly. Interview style was informal, friendly and respectful. Contact was initiated by a comment such as 'Hi. I'm walking around and talking to folks living on the streets about how they get by.' Participants received $20 in McDonalds' vouchers at completion of the interview (Kidd and Davidson, 2007 220-2).

Conversations ranged from twenty minutes to three hours, typically lasting 30–45 minutes, and often extended beyond the formal interview. As some participants pointed out, the researcher was a novelty: 'a nonstreet adult who didn't get something and immediately go away—who seemed to want to hang out.' Interviews were taped, transcribed and thematically analysed. Themes and findings were verified through twenty-eight follow-up interviews with original participants, along with many informal conversations. Ethnographic field notes were taken throughout the process and also used to guide the analysis (pp.220–2).

The large sample size is unusual and not generally required for qualitative ethnography, since reliability of the themes based on saturation can usually be assessed at a smaller sample size. The large number of qualitative interviews primarily increased the quality of the nuance and expression of the themes.

The large sample design was chosen to allow for a concurrent structured survey quantitatively investigating factors involved in suicide. The author used standard ethical guidelines to assess and manage the risks of harm including provision of resource lists, and was able to connect individuals at high-risk of suicide to counsellors (p.222).

Overall the study confirmed the rich, conflicting diversity of experiences that get grouped together under the term 'homelessness.' Stereotypes are inadequate because they fail to capture the range of individuals and circumstances. The stories told of the complexity of individuals and their engagement with personal and social forces that both constrained and enabled. It was clear that some aspects of homeless life provided opportunities for self-development. One person commented:

> It is cool seeing other cultures and different cities. Once you figure out that you can still go and see the cities even though you are poor, it is f—king awesome.[..] You have something to be proud of. There are not very many people who are able to do that. (Kidd and Davidson, 2007 223)

On the other hand, there was a consistent lack of resources experienced by young people on the streets. This led to over-emphasis on any source of self-respect and support that could be gleaned: 'we hang on so tightly to every little shred of anything we get' (p.223).

A key theme was the radical shift in identity and perspective. In many instances this was negative and painful, though the distress could also be a motivating force driving people to seek a life that was more congruent with how they saw themselves. In some instances the shift was positive – freeing and a chance to experience independence

and self-reliance. In all cases, once a street mindset was developed, it was harder to leave.

> If something is familiar to you, it is comforting. You know people in it. You know the lifestyle of it. And there are not too many things that are unexpected. It's the same and it's habitual. People fear the unknown. Becoming sober and changing your life like, 'What am I going to do? How am I supposed to live? How am I supposed to get money?' I know this. I am good at this. (Kidd and Davidson, 2007 224)

Living on the streets often involved a change to the person's identity and a connection to a subculture or street community. The author describes being generally welcomed by people keen to reflect on their lives:

> People made space for me in their lives and stories, moving aside so I could sit with a group, finding me a piece of cardboard to sit on to provide relief from the frigid concrete, telling their friends that I was cool and they should talk to me. And the stories and communication of meaning were important. People pushed themselves. They struggled to communicate what their lives were like, told stories that were hurtful in the telling, sought to elaborate, and sought to make me understand. (Kidd and Davidson, 2007 221)

Positive aspects of the street community included helping friends out:

> Even if you are feeling like sh-t, and the other person needs something and you don't have much, giving will make you feel better. Even if it is a quarter or a cigarette or a smile. (Kidd and Davidson, 2007 230)

Yet ultimately, social connections on the street could be a barrier to regaining a normal life:

> Once you get yourself off the street, you are still involved in the street life because everybody knows you. It is like two worlds being combined into one, and I am trying to separate from that world, but I can't because of the friends that I was with out on the street, and we used to look out for each other and they are still there. And I am here. I can't ditch them. (Kidd and Davidson, 2007 229)

The social bonds were essential, and could also be treacherous:

> You really can't trust anybody too much, especially on the street, because a lot of people lie to get what they need. (p.228)

> A lot of times you don't know if these people are actually your friends until it comes down to it. Like if you go to jail and no one comes to visit you. (p.228)

Adapting to street life requires developing strength and the capacity to look after yourself without the help of family or the police. This was a source of pride and self-respect as the following comments indicate:

> The street, it helped me to be strong. Don't let nobody hurt you. I used to be really sensitive. I had to get strong because there are people who try to hurt you out there. (p.225)

> …someone can go to a university and know a lot of sh-t but they would come out here and wouldn't know what to do with themselves… people definitely take pride in that. (p.226)

Developing this strength and independence on the street can create a particular barrier to receiving help, one that must be sensitively negotiated by case management:

> I'm not proud that I'm homeless, but I'm proud that I can actually go through the day without constantly taking things from people. (p.230)

Access to needed resources and services must therefore be provided without compromising the person's hard-won sources of pride and self-regard.

Another difficult area that case management must often negotiate is problematic drug use. These young people describe the supportive and survival functions drugs have in their lives (Kidd and Davidson, 2007 231):

> The drugs were always there for me.

> When things get really bad, the only thing that keeps me from wanting to just roll over and die is heroin.

> It takes a long time to relate to people and get respected as a person, but if you want to get into a cool community of people, you just use drugs and it is an immediate in.

To let go of the risky resources and dependencies of drug use and street culture one must first acknowledge the benefits of the homeless reality, realistically confronting both the costs and the barriers to reintegration. The hurtful impact of social stigma, for example, of 'being profoundly rejected by my own society,' was described by many young people, though for some this was a lesson in questioning the superficiality of other people's judgements.

In fact, the assumption that a person must 'deal with their issues' to exit homelessness (and therefore that case management must assist them to do so) may be erroneous. Recent evidence (see Section 7.4 Acesss to housing resources) shows that people can move straight from the streets to permanent housing, without first conquering either mental illness or substance use issues, and achieve better housing stability than through conventional programs.

The following comments show how the choice 'to be homeless' is neither freely taken nor easily altered:

> It's how I live and it has to be. It is not the choice that I want. (p.224)

> There is nobody in the world that would want to sleep on the streets and not get help. (p.224)

> It is not a choice of 'I don't want to do dope today. I am not going to.' You have to. It's like a set of handcuffs. In other areas, I feel like I have more choices than the average person because I don't have quite as many responsibilities. So I am not tied down in that sense, but I am definitely tied down in the drug sense. (p.225)

Comparisons to the past and future revealed a complex weave of reasons for being homeless and motivations for change. For some people a difficult past made the streets attractive, while for others the contrast between the present reality of street life and their dreams for a mainstream future was a motivating factor. Children, for example, were often an inspiration to change. For some people, failed efforts became a further barrier:

> I've been happier living on the streets than doing anything else. I've tried a few times over the years to get my life together and it just gets worse and makes me feel worse. (p.227)

This comment highlights the persistence and reliability which is essential for an intervention intended to facilitate sustainable change. Relapses may be expected but people need support to cope with the damaging impact on their motivation and courage to change. Understanding and working with a person's experience of 'happiness' to facilitate hope requires advanced communication and relationship skills.

The researcher also found that emotional detachment was valuable for listening and connecting to young people. The author tracked his own reflections on the interview process through field notes. He noticed and was concerned by the sense of distance he experienced toward people's stories of suffering. Yet the interview results led him to infer that this detachment was, surprisingly, a tool for a closer interaction with the young person:

> They did not have to protect my feelings by omitting details, and I reduced the risk of those feelings being interpreted as pity, an instant rapport-killer for most kids. (p.232)

While this evidence on its own does not warrant a practice guideline, it is useful for adding to our understanding of the emotional complexity of the case management relationship.

The authors conclude that 'understanding what a "problem" is/means to a youth and how those meanings shift and have shifted will deepen our knowledge and ability to help and intervene' (Kidd and Davidson, 2007 236).

5.5 Being more than a case manager

This section synthesises evidence indicating that case managers need to be 'more than just a case manager.' The research highlights the dimensions of intimacy mobilised by the relationship mechanism, and indicates some of the consequent challenges.

5.5.1 Synthesis of the evidence: being more than a case manager

What we know

The study by Angell and Mahoney of case manager experiences finds there is a unique intimacy to both the tasks and setting of case management and a consequent emotional ambiguity to the relationship. It identifies that conflict and parental dynamics are central to case management because of the interaction between the relationship and the professional duty of care (Angell and Mahoney, 2007).

The study by Dickson-Gomez *et al.* demonstrates that social solidarity is important because very often being homeless, poor, or mentally ill is an experience of social stigma and exclusion. It also finds that the imposition of administrative compliance requirements or procedural hurdles can be a source of humiliation and disrespect in that context (Dickson-Gomez *et al.*, 2007).

The evidence from (Angell and Mahoney, 2007) and (Dickson-Gomez et al., 2007) reveals both the benefits of the relationship mechanism and some of the difficulties it involves.

The study by Ware *et al* expands our understanding of how the relationship mechanism generates outcomes by broadening the impact of personal, emotional support to include the benefit of positive, reliable social interactions over time. They

infer an inherent value in the experience of 'social solidarity' in the client–provider relationship for addressing the impact of stigma and social exclusion. The themes are congruent with the findings from the UK study of palliative care social work clients and the US study of personality disorder case management discussed in Section 5.4 Persistent, reliable, intimate and respectful (Nehls, 2001, Beresford *et al.*, 2007).

The study by (Sells et al., 2006) of peer-assisted case management confirms that a genuine relationship is extremely important for maintaining engagement in case management and specifically in the early part of treatment. Second, it suggests that the common experience and shared identity of a peer provider is very beneficial for developing engagement and this may be the most effective way to provide services for those most chronically disengaged. This finding adds weight to the inference drawn by Ware *et al.* on the importance of social solidarity.

The evidence from Buck and Alexander provides further refinement and concretisation of what is known about the important elements of the case management relationship. It confirms the significance of comprehensive, practical support, intimacy and reliability, and suggests a new emphasis on social connectedness both with the case manager themselves, but also through case management activities to the broader social world (Buck and Alexander, 2006).

Kirsh and Tate similarly confirm the qualities of the relationship already identified, and provide evidence about the importance of slow pacing, particularly in the engagement phase. They find that persistence in the relationship can be experienced as respectful rather than invasive if it is taken slowly (Kirsh and Tate, 2006).

Synthesis of the evidence in this section shows that 'being more than a case manager' is not a case of transgressing professional boundaries but is generated by comprehensive, reliable, intimate support that is not confined to instrumental concerns. The value of 'getting rides' highlighted in (Buck and Alexander, 2006) illustrates how it is little extras that provide the experience of a relationship which goes behind mere formality. (Ware et al., 2004) found that the experience of some flexibility in making appointments generated this quality.

Synthesis of the evidence also finds that the concept of client-directed goals can be generalised to the quality of respect because in some cases, saying no is part of case management, and in others a case manager is charged with providing mandated treatment, as (Angell and Mahoney, 2007) found.

Implications

An implication from this evidence for agency practice is that homeless persons agencies must ensure case managers receive adequate support and supervision so they can leverage the dimension of intimacy in the case management mechanism for the benefit of clients, without losing their professional integrity.

The implication of the inherent risks in the intimacy of the case management relationship emphasises the singular importance of respect. Humiliation and emotional manipulation are very real dangers, particularly because of the broader social context within which case management operates. Service system pressures to get people through and obtain outcomes can jeopardise the operation of the case management relationship. The scarcity of the welfare economy can indirectly result in practices and procedures that generate disrespectful experiences for already disadvantaged people.

5.5.2   The research: being more than a case manager

Angell, B. & Mahoney, C. (2007) Reconceptualizing the Case Management Relationship in Intensive Treatment: A Study of Staff Perceptions and

This study begins to develop an empirically grounded conceptualisation of the relationship in community mental health case management using qualitative research into the experiences of case managers themselves. It finds there is a unique intimacy to both the tasks and setting of case management and a consequent emotional ambiguity to the relationship. It identifies that conflict interactions and parental dynamics are central to case management.

Purposive sampling was used to recruit the fifteen workers who participated in this qualitative study. Case managers were recruited from two explicitly identified ACT teams, one from a rural and one from an urban area. The research used naturalistic observation and semi-structured interviews; the findings reported here rely primarily on the interview data.

The study found that case managers consistently valued the relationships with their clients, with comments like the following a common caveat to recognition of the job's difficulty:

> The most rewarding or the easiest [part of the job] is just being with the clients. [..] The most fulfilling thing is the level of relationship you gain with your client […] going through crisis with clients, and gaining that relationship… how it evolves over time, is absolutely invaluable. (Angell and Mahoney, 2007 178)

Client expressions of appreciation, trust and desire for contact were valued as indications that case management mattered to the client. Positive feedback from the client provided a sense of reward and satisfaction to the case manager, and its absence could feel like a rejection. Client non-compliance in particular led to the case manager feeling ineffective and powerless.

The intimacy of the activities involved in case management produced concerns about professional boundaries:

> ..you're doing the laundry an' you're cleanin' house with them… all these intimate things. If you're disclosing stuff about yourself… you could cross that line... And you are doing all these things with them that you would do with a, your friend. (Angell and Mahoney, 2007 180)

Staff reported that case management was easier when they liked the client, and when this did not occur naturally, they employ specific engagement strategies to increase their affinity with difficult clients by getting to know the client better.

Negative aspects of the relationship included issues about power and control over medication and financial management. These conflicts were generated by the case manager's felt sense of, or mandated responsibility for, the client's well-being. A common dilemma was raised by the tension between empowerment and protectiveness, sometimes described through a discomfort with parental-like elements of the relationship. This was judged to be an effect of external forces (such as mandated care) and as having the negative effect of putting the client in the role of a child. On the other hand some conflicts were also considered an important aspect of the role:

> You know, I've talked a lot about being a supporter, but there are times that case managers need to be the stop sign… being firm sometimes says, "You know, this is not part of your treatment plan. You know I don't believe in these behaviours and I don't want to engage in that behaviour with you"… I see

myself as advocate, as support, and supporting sometimes, again, means saying "no." (Angell and Mahoney, 2007 183)

This research finds that the case management relationship goes beyond the combination of emotional bond and goal and task consensus previously measured in research using psychometric tools derived from psychotherapy research (see Section 5.2). This is at least partly because of the complex contextual factors impacting on the relationship. Issues such as poverty, homelessness, substance addiction, criminal involvement and/or other mandated treatment factors both complicate the possibility of a working alliance, and generate uniquely important phenomena that structure the case management relationship. For example, the emotional bond is challenged by the potential for goal conflict, including the possibility of mandated treatment obligations.

Dickson-Gomez, J., Convey, M., Hilario, H., Corbett, A. M. & Weeks, M. (2007) Unofficial policy: access to housing, housing information and social services among homeless drug users in Hartford, Connecticut. *Substance Abuse Treatment, Prevention, and Policy* 2.8. http://www.substanceabusepolicy.com/content/2/1/8.

This study provides evidence about the case management mechanism and its context from a service user perspective. It finds that the combination of resource scarcity and need in which people experiencing homelessness find themselves creates a vulnerability to adverse impacts from administrative requirements and relationships with service system staff.

This qualitative ethnographic study used three rounds of indepth interviews (zero, three and six months) with sixty-five heroin and cocaine users in different housing situations, combined with key informant interviews and focus groups with fifteen housing case workers. Sampling, data collection and analysis are well described in some detail, and judicious use of direct quotes allows the subjects to speak for themselves. There is always a strong relationship between the quotes and the analysis.

This study provides evidence to explain the difference between broker-referral models and case management. Broker-referral model support was more likely to demonstrate a process that has been called 'creaming', commonly known in Australia as 'cherry picking', which means selecting clients based on their likelihood to manage well in a particular opportunity. The author notes that this practice develops under resource constraints: 'If resources are limited, then creaming is a rational strategy to ensure that resources are not wasted.' (Dickson-Gomez et al., 2007 7). This study found that the practice is more common when the role is focused on referring to programs rather than follow-up or follow through: 'Those who viewed their role as mainly referral often described a process by which they referred clients whom they thought had the best chance at success'(Dickson-Gomez et al., 2007 7).

In contrast, other workers saw their jobs as focusing on advocacy and this produced another mode of unofficial policy, in which resources are directed at the most challenging clients. This was jokingly referred to by a staff member as 'silting', the opposite of creaming:

> Our goal has been "Let's look at the people who have the worst histories that nobody else will ever house," and that's really the approach we take, and we have created policies around that. You know we don't rule people out. (Dickson-Gomez et al., 2007 7)

'Silting' was seen as a way to provide evidence of the effectiveness of supportive housing programs, by demonstrating success for people with the most challenging

problems. It also expresses a philosophical position about the provision of housing as a right and a foundation:

> We also feel strongly, and this is again the Housing First model, that you don't fix people first. They don't need to be fixed. They don't need to be ready. They just need to be housed and then you work from there and you work with intensive support. (Dickson-Gomez et al., 2007 7)

It is important to note that both 'creaming' and 'silting' are techniques used to manage high levels of demand. When there are not enough resources to go around, workers and policy makers attempt to rationalise rationing, but someone always misses out. For example, 'silting' produces a reverse exclusion expressed by one resident in the complaint that only 'trouble makers' get access to sought-after programs.

The study also provides examples of how service users make active choices about what services to pursue. For example, one service user used a shelter as respite when things got rocky with his girlfriend; the person often had difficulty with housing affordability but judged it too difficult to pursue subsidised housing:

> I didn't never get into that because I wasn't going to be following through on it because I was going home. I was just, you know, cooling off. (Dickson-Gomez et al., 2007 8)

While this service user described making a choice not to pursue a long-term solution, it was a choice shaped by procedural hurdles.

Administrative obstacles included the length of time it takes to get an application through, then waiting times, administrative requirements like correspondence in writing, and then shortness of time allowed to accept an offer. The study finds a real conflict between the administrative requirements of the assistance system and participants' inevitable lack of secure contact details. For many, these hurdles are prohibitive and at times humiliating. The required engagement with workers could also be a source of humiliation:

> She...act like....she giving it to me out of her pockets, which she is, which you all are, but she make you feel like you beneath. (Dickson-Gomez et al., 2007 6)

Similarly, others described the feeling of shame at providing personal documents like a police record. Furthermore, once accepted into a program, there can be arduous requirements that would be difficult for a housed person to comply with:

> I guess people just don't understand when you put, when you get this certificate, this, you know, Shelter Plus Care, you have so much to do. I don't know how anybody could have a job and go to all these meetings and meet with all these people that you have to meet with every day and do everything they requiring you to do. It's just, it's a lot. (Dickson-Gomez et al., 2007 9)

However, service user preferences and choices are always constrained and at risk of being swept away by desperation:

> I was so tired of calling and don't hear nothing and I know she gets tired of me calling and not getting any information. I mean... if something come through I told her to grab it, I don't care where it's at right now. You know, I'm in between a rock and a hard place at this moment. I can't be picky. (Dickson-Gomez et al., 2007 9)

Furthermore, compliance with program guidelines leads to rewards. This comment from a service provider is indicative of the relationship between compliance and reward:

> Upon an individual's entry into a shelter, initially they have approximately 97 days to be in the shelter. Within those 97 days hopefully they're working with a case manager and they are compliant with the service plan, agreed upon service plan between the client and the case manager. [If] they are just about ready to receive certain entitlements or assistance with employment, whatever the case may be, there is a possibility for an extension to be given to an individual as long as they are compliant with the service plan that was agreed upon. (Dickson-Gomez et al., 2007 10)

Another example is provided in the following comment from a service user. The person is being assisted with her own goal of seeking work yet nonetheless feels emotionally manipulated:

> Maribel: […] And my case manager is pushing me like, I feel that... what I'm doing is not enough for her.

> Ethnographer: Does Maria offer you any suggestions on where to go or is she just...

> Maribel: Yeah. She offered me, she went with me too. She's pretty good, you know, in helping me out and helping me do my paperwork and something. Go here, go there, but what I mean is that, it's not enough for her... I feel like she thinks I'm out there doing whatever I want to do and not doing what I'm supposed to be doing, you know? (Dickson-Gomez et al., 2007 11)

This research provides evidence about a tension in the case management mechanism between the necessity of setting firm boundaries with reliable consequences and the desire to maintain the relationship. The contrasting perspectives of workers and service users on the issue of worker discretion reveal the dilemma here. Service users interpret worker discretion as favouritism – people are rewarded for getting along well with staff, prior contact, a good relationship, a certain history or being judged as deserving. While workers perceive themselves as demonstrating flexibility in relation to client needs (Dickson-Gomez et al., 2007 10-11).

Finally, this study found that outcomes were linked to support from shelter workers that was comprehensive, practical and persistent. Experience with homelessness workers was in contrast to that with social security case workers who tended to only focus on application, eligibility etc. for that particular service, and did not help with other issues and especially not housing.

> Ethnographer: So, what does he [your social security caseworker] do, what's your relationship like with him?

> Carol: I'm a number... That's it. I'm just a number... Let me see, my nine digit number on my card, my insurance card, that's what I am to him.

> E: What do you talk to him about?

> P: Nothing at all. (Dickson-Gomez et al., 2007 6)

People in shelters had higher access to housing assistance because shelter case workers were informed about services and opportunities – shelter residents were therefore 'the first to know'; case workers or the agency often had formal or informal links with other housing programs or agencies. Residents received preferential treatment since generally, due to workload, shelter case workers only focused on the

residents of the shelter at any given time. An exception that proved the rule was evidence of case managers going out to look for 'their clients' and provide information about upcoming opportunities because the shelter was closed for that period (Dickson-Gomez et al., 2007 6).

Ware, N. C., Tugenberg, T. & Dickey, B. (2004) Practitioner relationships and quality of care of low-income persons with serious mental illness. *Psychiatric Services*, 55.5: 555-559.

This qualitative study of people with psychiatric disabilities finds that service users value a genuine and respectful connection with their care manager. It identifies a social aspect of intimacy.

The study conducted fifty-one in-person, semi-structured interviews with low income clients of a managed care program for people with psychiatric disabilities. Participants were randomly selected from a group who were concurrently part of a broader program evaluation. Interviews were not recorded due to participant reservations, but conducted by two-person teams to increase reliability and comprehension. They lasted between forty-five minutes and two hours, and participants were compensated by a small sum ($20) for their time. Interviews elicited information about participants' current relationships with two different practitioners and were analysed using the method of 'grounded theory' to determine client priorities for good care.

Participants in the study specifically valued a way of interacting that did not reduce them to a particular illness or condition. People did not appreciate being 'treated like a baby' or otherwise diminished:

> …don't assume I'm not educated because I'm black and mentally ill. People don't have to simplify their language when they talk to me. I may be mentally ill, but I'm not stupid! (Ware et al., 2004 557)

One participant commented approvingly that their provider 'treats me as the best person to know how I'm feeling' (p.557). And another said with appreciation: 'He makes me feel like I am somebody' (p.557).

The study found that a strong theme for service users was 'looking for common ground.' This involved focusing on the similarities between themselves and service providers, referring to themselves as peers or friends or as part of one team, and de-emphasising differences of power and status (pp.556–7).

Unsurprisingly, people appreciated many ways of being shown esteem and respect. These included feeling known as a person and being listened to with genuine interest. Many valued the sense that a worker had 'gone out of their way' even through a simple friendly gesture, or by concrete demonstrations of flexibility, responsiveness and accessibility: for example, responding to drop-in visits, returning phone calls, and respecting a person's other commitments when scheduling appointments (p.557).

The study identified eight categories in participants' priorities for care: getting 'extra things'; looking for common ground; feeling known; the importance of talk; feeling like 'somebody'; practitioner availability; practitioner flexibility; and opportunities for input into treatment. As always with grounded theory analysis, there is a subjective element to the descriptive categorisation. In this study, the quotes do not always sit self-evidently in the thematic categories, suggesting that further analysis could yield more rigorous conceptual inferences. Nonetheless, the cited quotations and thematic discussion speak eloquently of the importance of being treated well and being treated like a regular person, and these themes are congruent with other evidence in the synthesis.

The authors note that the qualities most prized by service users challenge many traditional treatment emphases, including firm professional boundaries and an exclusively clinical focus. They also present a slight variation on the literature investigating the value of the therapeutic alliance.

Ware *et al.* interpret the client priorities in their research as responses to the social exclusion experienced by people with mental illness. There is inherent value, they infer, in the experience of social solidarity in the client–provider relationship:

> Claiming and then winning recognition of connections based on commonality reduces social distance and increases integration for persons who are marginalized by psychiatric disabilities. (Ware et al., 2004 558)

This inference provides a resonant explanation for the relationship mechanism of case management. It implies that the case management relationship can provide a concrete instance of reintegration and social inclusion.

While Ware *et al.*'s research did not target people experiencing homelessness, their findings about the value of social solidarity can only be more significant for case management with that group. Even leaving aside the significant prevalence of mental illness among that group, homelessness itself is a stigmatising experience. Homelessness research has consistently shown that social exclusion and stigma is a powerful force structuring homeless people's experience (Snow and Anderson, 1993, O'Connor, 2003, Johnson et al., 2008).

Another perspective on the social dimension of intimacy in case management comes from research into peer-provided case management services.

Sells, D., Davidson, L., Jewell, C., Falzer, P. & Rowe, M. (2006) The Treatment Relationship in Peer-Based and Regular Case Management for Clients With Severe Mental Illness. *Psychiatric Services,* 57.8: 1179-1184.

This randomised controlled study compared the quality of treatment relationships and engagement in peer-based and regular case management (Sells *et al.*, 2006). It finds that early in treatment, peer providers seem to be more effective at communicating positive regard, understanding, and acceptance to clients, particularly those most disengaged, and this leads to better treatment retention and reported motivation levels.

Potential participants were selected on the basis of a diagnosis of severe mental illness (psychotic disorder and/or major mood disorder) and treatment disengagement. They were identified with the aid of the local mental health authorities and invited to an interview to find out more about the research project. One hundred and thirty-seven adults participated; about 70% had a co-occurring substance use disorder. The sample included 38% women and 28% African Americans. No information is provided about their housing situation.

Participants were randomly assigned to either peer-based or regular case management provider partnered with assertive community treatment teams: sixty-eight peer condition and sixty-nine control. Peer providers carried caseloads of 10–12, half the size of regular providers.

Information was gathered from two participant interviews at six and twelve months using credible self-report questionnaires to assess treatment relationships, motivation and service use (Barrett-Lennard Relationship Inventory and the Addiction Severity Index). Information about levels of engagement and service use was also gathered from service providers. The study experienced an attrition rate of 25% which is high,

but common for studies of people in this target group. Missing data analysis found no correlation with condition at six or twelve months.

The alliance was measured in three subscales: positive regard, empathy and unconditionality. At six months there was a statistically significant difference between treatment groups, with the peer provider group showing a better working alliance measures across all three subscales. There were no between-group differences at twelve months, suggesting that regular case management relationships can 'catch up' over twelve months (Sells et al., 2006 1182).

Regression analysis revealed that positive regard and empathy scores at six months were predictors of twelve-month self-reported substance use motivation and attendance at Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) meetings. Additionally, for a subsample rated by providers as the least engaged at the beginning of the study, the peer provider group showed improved engagement results. Contact rate with the peer case managers increased over the first six months while decreasing for the regular case management condition (Sells et al., 2006 1181-2).

A limitation discussed by the authors and familiar to the realist perspective, is the problem of isolating and standardising the experimental and control conditions. Peer providers are known to have different working styles (Solomon and Draine, 1996), and in addition there was a smaller case load and the possibility of deferring limit-setting and treatment contracts. In this case there was a clear pathway for treatment contamination since the peer and the regular providers worked together with the same assertive community treatment teams.

Buck, P. W. & Alexander, L. B. (2006) Neglected voices: Consumers with serious mental illness speak about intensive case management. *Administration and Policy in Mental Health,* 33.4: 470-481.

This is a qualitative study of service users' perceptions of the case management relationship during the first nine months of the service. It confirms previous findings about the importance of a genuine and intimate relationship with the case manager, and further finds a desire for connection to the broader social world.

The study also confirms the importance of concrete service provision around very practical needs such as housing, budgeting and transportation, at least within the early stage of the relationship. Reliability is key and the authors conclude that 'the seemingly little things matter' (Buck and Alexander, 2006 478).

The study was nested within a larger, quantitative study and used a prospective, repeated measures cohort design. Fifty-five consumer–case manager pairs completed the nine-month study, although in total data was collected from sixty-seven adults with schizophrenia or schizo-affective disorder and their case managers, from nineteen suburban and semi-rural agencies in eastern Pennsylvania. The participant group was equal men and women, predominantly white (80%), with generally low psychosocial function scores. While homelessness was not the focus of the study, responses indicated that housing issues were common.

None of the consumers had ever received case management services prior to the study. Participants were recruited by approaching new clients within the first six weeks, and inviting them to participate. Data was collected at baseline, then at three, six and nine months.

The Working Alliance Inventory and another validated scale were adapted for the setting and administered along with a set of open-ended questions (typically taking 10–15 minutes) designed to capture the core conceptual dimensions of the instruments (bonding and collaboration). Consumers were asked both to reflect on the

previous time period, and to comment on how they *would like* their case manager to help them in the future. The questions covered four elements of the relationship: helpfulness, likeability, expectations and communication. The interview data was recorded verbatim at the time and coded using grounded theory thematic techniques, rather than a question-by-question analysis.

Buck and Alexander find three primary themes: 'getting services,' 'being social' and 'being there for me' (Buck and Alexander, 2006 474). The research demonstrates that service users value the intimate and practical nature of the case management relationship.

The comprehensive and practical dimension of case management support is demonstrated in the following quotes (Buck and Alexander, 2006 475):

> She helped me get a social security card…[…] She helped me get into a group home.

> … he got me into the shelter…

> He took me to the eye doctor for an eye exam […] he is helping me get a pair through the Blind Association because I can't afford it.

> She helped me when she thought I could get a job. She had confidence that I could do it.

> He helped me by packing up my clothes and going to look for places to live with me. He drove me all over the place and we finally found a room.

> He helps me out with money—he's in my corner. He pushes for me.

Getting services included: assistance with housing, employment, benefits and medical care; help with money and budgeting; and getting rides. The service of getting rides is worth highlighting. It confirms other evidence about the value of this assistance for a generally disadvantaged group with little access to private transport, but it also carries the sense of support that goes beyond 'just a job' identified in both (Beresford *et al.*, 2007) and (Ware *et al.*, 2004). Getting rides was ranked by some consumers as what they liked most about their case managers, and by others as the most helpful element over the nine months of the study.

As the following quotes demonstrate, 'getting a ride' is experienced as being a friendly exchange rather than a professional taxi service (Buck and Alexander, 2006 476):

> He sometimes helps me out with a ride when I need it.

> If I don't have money for the bus, he'll give me a ride.

> He took me to the doctor and gives me rides when I need them.

> He takes me to the mall, he gives me rides. He is generous. He's a nice person.

Unlike transport to specific treatment or practical services, 'getting a ride' seems to cross a boundary into less directly instrumental support and results in a perception that the case manager is being *more than a case manager.*

The theme, 'being social,' emerged predominantly from the questions asking what consumers would like or would have liked from their case managers. People wanted more social activities in general, recreational outings like sport, movies, shopping and meals. Their significance is suggested in this comment:

> She takes me out for breakfast. That's something I never had before. (p.476)

The person ranked this as the most helpful element in the nine-month relationship, indicating the value of compensating for financial deprivation and social isolation.

Finally, the theme, 'being there for me,' captured the importance of generally being available and reliable. Consumers overwhelmingly valued both the emotional and practical aspects of a reliable relationship (Buck and Alexander, 2006 476-7):

> She was there for me when I went in for an operation—to support me and to be there for my family.

> When I broke down she was there for me.

> She's really been there for me when I have needed her.

> He's there for me when I need him.

> The way she's there to talk with me, to help me, to be with me. She's there for me and I like that.

As in the case of 'getting a ride,' the following comment suggests that consumers value a sense that the relationship somehow exceeds the strict bounds of a professional exchange:

> She was there for me, not for her job or the system, but because she wanted to be. (p.476)

One consumer expressed a desire for what Ware called 'social solidarity' in this disappointed comment:

> I expected us to get closer as friends and that he would help me achieve my goals; be there for me, support. (p.477)

Other negative experiences similarly indicate the importance of availability and reliability, and also reinforce the variety and intimate scope of case management. Consumers value responsive and practical assistance to a wide range of problems, and feel dissatisfied when it is not forthcoming (Buck and Alexander, 2006 477):

> I wish she would carry through with what she says. She told me she'd help with Christmas presents and never did.

> I need to get my driver's licence. It expired. I've asked her a few times to help me […] She hasn't got back to me or acted on it.

> She hasn't picked up my clothes from the lodge even though I have asked a million times. …she's never there for me. I get frustrated.

Kirsh, B. & Tate, E. (2006) Developing a Comprehensive Understanding of the Working Alliance in Community Mental Health. *Qualitative Health Research,* 16.8: 1054-1074.

This qualitative Canadian study of the case management relationship in community mental health services combined primary research with consumers, family members and service providers with analysis of the research literature to produce grounded theory. The study identifies that 'building and negotiating trust' and a feeling from the case manager of 'I'm on your side' are critical for developing an effective working alliance (Kirsh and Tate, 2006 1059).

This analysis was part of a larger research project on community mental health support. The full study included forty-two semi-structured interviews equally divided between consumers, family members and service providers, and a review of 177 selected journal articles (1988–1999). The study of the working alliance was

developed from a subset of this data comprising data from thirty-three interviews and forty-eight journal articles.

Similar to (Ware et al., 2004), (Coffey, 2003) and (Angell and Mahoney, 2007), Kirsh and Tate identify the need to operationalise the concept of the working alliance using the perspectives of the people who use community mental health case management services.

Along with findings that confirm the evidence already synthesised, this study highlighted the importance of slow pacing especially in the engagement phase:

> One consumer reflected:
>
> > *Even though I didn't want to be seen, they've seen me. . . . They approach you slowly, on the level that makes you comfortable, they don't force you. . . . Even if they say hello to you when you don't respond, they will leave you. . . . They just leave it be, go on their way, come back later. . . . I think that means a lot to people.*
>
> As a result of a gradual process, stated one service provider, "we get used to them, they get used to us, everybody feels comfortable."(Kirsh and Tate, 2006 1061)

Kirsh and Tate also found evidence in support of the social solidarity inference. Investigating the practice of reciprocal sharing that is promoted by strengths-based and recovery practice; they write:

> The interviews provided detail on valued ingredients in the sharing process. Specifically, they highlight the importance of service providers revealing themselves and their personal worlds (for example, recounting family life, past troubles, or happy moments) or participating alongside consumers in life tasks (e.g., preparing or eating meals). One consumer was amazed and grateful that her service provider had invited her to her wedding, noting that she had never been to one before. (Kirsh and Tate, 2006 1065)

This evidence confirms that the case management mechanism, the relationship, may be most effective when it directly addresses social exclusion – by involvement in a reciprocal and personal social connection. However, it also raises the issue of professional boundaries.

Kirsh and Tate found that service users appreciated knowing that their service provider had also been through adverse experiences in life, because this gave them an example of resilience and a sense that recovery was possible. Incidentally, this provides a further explanation of why peer models can be effective.

> Service providers were seen as "real people" if they shared aspects of their lives or their sense of humor.(Kirsh and Tate, 2006 1065)

This study confirms the value and need to seek concrete evidence about effective practice from the perspective of service users and providers.

Understanding the importance of the genuine social connection also reveals an area of difficulty for case management: the negotiation of professional and personal boundaries. Practitioners interviewed for this synthesis similarly expressed concern about being a person's only significant, trusted other and question whether it is healthy to have a paid professional in this role (1,4,5,6). Yet the evidence shows that a genuine social connection is an essential part of the case management mechanism.

This practice dilemma raises a larger policy implication about public education to build community support for social re-integration. The stigma and marginalisation of race, mental illness, homelessness, the range of disabilities and disadvantages, cannot be solved on an individual level since they are inherently social phenomena.

6 THE OUTCOME OF CASE MANAGEMENT: INCREASING A PERSON'S SELF-CARE CAPACITY

This chapter synthesises six studies that provide the most direct evidence about the outcome of case management. Other chapters also include studies which use concrete outcome measures such as a decrease in the numbers of days homeless, a reduction in hospitalisation days, or an increase in client life satisfaction. These measures provide concrete indicators about the outcome sought by case management, namely a significant and sustainable increase in a person's capacity to take care of themselves.

The evidence in this chapter demonstrates the importance of the persistent, reliable, respectful relationship, and indicates the investment of time required to achieve the outcome. It also assesses some competing outcome claims, in particular for service system integration and cost-containment. The studies show that while case management may indirectly contribute to these outcomes, and will certainly be facilitated by a well-integrated service system, its primary impact is on the client's ability to maintain their own health and well-being.

6.1 Synthesis of the evidence: case management outcomes

What we know

Section 6.2 Increasing a person's self-care capacity synthesises the evidence relevant to long-term outcomes, and to an increase in a person's self-care, specifically. It finds some evidence that, over time, the relationship mechanism can deliver a developmental outcome, assisting some people to regain independence. However, this is neither a guaranteed nor a straightforward process. A respectful relationship is highlighted as a key mechanism in supporting this process.

Section 6.3 Service system integration and cost-containment tests and rejects the idea that case management is primarily an intervention for delivering the service system outcomes of integration and reduced costs. The evidence shows that integration of the service system requires other mechanisms, while a goal of reduced costs per se may damage the case management relationship.

Implications

Case management is not an intervention with a mechanism that directly generates cost reduction or system integration outcomes. While the evidence in *Section 7.2 Enough, time, varying intensity and comprehensive, practical support* does show how case management can produce better outcomes at the same overall cost as cheaper service delivery models, it also confirms that better outcomes take time and considerable investment in the relationship, including practical resources. Reduced overall costs are delivered by reductions in cost-shifting to more expensive emergency services, not by expending less on the case management service, or by reducing community service use.

To generate an increase to a person's self-care capacity requires a skilful, persistent and respectful relationship delivering support over a length of time that may exceed three years. This implies a requirement for certain enabling conditions in the service system to allow case management to operate in this way.

Evidence about the service system conditions necessary to provide this case management service is the subject of *Chapter 7 Program resources needed for case management* and *Chapter 8 Skills and support needed for case managers*.

6.2 Increasing a person's self-care capacity

This section synthesises evidence from three sources which most directly address the way that the case management relationship can facilitate a change to a person's self-care capacity.

6.2.1 Synthesis of the evidence: increasing a person's self-care capacity

What we know

Mead and Copeland document the meaning and significance of recovery from a mental illness and the service delivery practice principles which can promote this recovery process. They find that the relationship is the key to effective practice and it should above all foster hope in the person being assisted.

Confirming the evidence presented in *Chapter 5 The case management mechanism*, Mead and Copeland emphasise the importance of respect, and a genuine social connection which foregrounds the commonalities between case manager and client rather than the differences. They find that an attitude which supports learning from the client, from their experience and from their recovery strategies, transforms the case manager from an expert into a collaborator and is a concrete demonstration of respect (Mead and Copeland, 2000).

Bradshaw *et al.*'s study of mental health case management makes a unique contribution by mapping a process of change over time. The longitudinal method finds evidence of a slow and not always smooth increase to the person's capacity to take care of themselves. They find that the first and second phases involve a disabling loss of self-control and social functioning, followed by a struggle to regain self-mastery. In this third phase, the person has comparatively low support needs but is nonetheless extremely vulnerable. It is a critical time because just as the person is re-establishing mastery over their own self, they confront an external social world over which they have little control (Bradshaw *et al.*, 2007).

Marvasti finds that the concepts of independence and self-reliance can have punitive consequences when mobilised in a service-delivery context. He shows how they can be used to justify the rationing of scarce resources among those seeking homelessness assistance, with potentially negative consequences for those deemed non-deserving (Marvasti, 2002).

Implications

Longitudinal evidence of the process of increasing a person's self-care capacity implies that the duration of case management be sensitively and individually negotiated. Reintegration processes take time and patience. They include significant obstacles and are extremely dependent on the social context. While people in this phase have significantly increased their self-care capacity, it is not a time to withdraw support formulaically or precipitously.

The goal of case management to develop a person's capacity for self-care is generally understood as an empowering and client-centred aspect of the intervention. However, there is a risk that 'empowerment and support to become independent' simply reinvents the oldest welfare distinction – 'the deserving poor' – by using it as another set of criteria for rationing scarce resources.

The evidence here confirms the findings of Chapter 5 about the importance of respect and further challenges the assumption that case management clients are 'unable to help themselves.' It implies that the outcome of increasing a person's self-care

capacity actually relies on foregrounding the person's existing strengths, while sensitively providing respectful assistance.

This implication suggests the need for highly skilled and well-supported practitioners, an inference supported by the evidence discussed in *Chapter 8 The skills and support needed for case managers.*

6.2.2   The research: increasing a person's self-care capacity

Mead, S. & Copeland, M. E. (2000) What Recovery Means to Us: Consumers' Perspectives. *Community Mental Health Journal,* 36.3: 315-328.

From the Recovery literature, this early article by two consumer leaders explains the meaning and significance of recovery (Mead and Copeland, 2000). Copeland and Mead document some of the known successful strategies for promoting recovery which include an attitude and concrete, practical supports.[18] This article is included in the synthesis because it presents further evidence from a service user perspective and links value principles to concrete strategies for building a respectful and collaborative working relationship.

Above all, the Recovery paradigm is a developmental paradigm. It is based on the belief that people can change, that they can return to functional and fulfilling lives by learning self-management techniques and having the right kind of support and safety net. Consequently, professional support should 'creatively help a person reconstruct a life narrative that is defined by hope, challenge, accountability, mutual relationship and an evolving self-concept' (Mead and Copeland, 2000 320). Giving people hope that they can recover is fundamental to the success of this intervention paradigm.

The developmental outcome is supported by (not just any) relationship: 'The desire to change is nurtured through the relationship, not dictated by one person's plan for another' (Mead and Copeland, 2000 321).

Echoing the theme of social solidarity, these consumer advocates warn that professionals should 'not perpetuate the myth that there is a big difference between themselves and people they work with' (Mead and Copeland, 2000 320). This call to de-stigmatise and normalise a socially marginalised individual through affirmation of common humanity is both an old idea and an ever-renewed challenge. It takes on a sharper significance in relation to homelessness because the most striking difference usually between a homeless person and the case manager is an apparent security of access to financial and material opportunities.

Mead and Copeland operationalise this recognition of common humanity through the concept of a mutual learning relationship:

> The implications of a recovery vision for services to adults with "severe mental illness" will be that providers of services will learn from us as we work together to define what wellness is for each of us on an individual basis and explore how to address and relieve the symptoms that prevent us from leading full and rich lives. (Mead and Copeland, 2000 325)

They also highlight the potential challenge this makes to conventional clinical relationships: 'Those of us who experience symptoms are demanding treatment as adult partners.' They sensitively describe the tensions in this challenge to traditional hierarchies because of a protective duty of care that is both ethical and professional. They write:

Health care professionals become fearful that, if they do not continue to take care of and protect people as they have in the past, people will become discouraged, disappointed, and may even harm themselves. (Mead and Copeland, 2000 325)

This dilemma is predicted by the model of the care continuum, and is discussed further in the chapter on service provider perspectives. The solution, they claim, is an assertion of the dignity of risk:

It must be recognized that risk is inherent in the experience of life. It is up to us to make choices about how we will live our lives; it is not up to health care professionals to protect us from the real world. We need our health care professionals to believe that we are capable of taking risks and to support us as we take them. (Mead and Copeland, 2000 325)

Copeland and Mead do not shy away from the reality that people with mental illness do not always present as willing or able to take responsibility for themselves and their own recovery. Resistance and apathy are reasonable consequences of the struggle with both mental illness, its associated stigma, and the preconceptions of the health system. They provide concrete and realistic suggestions for professionals to demonstrate how the Recovery paradigm is even more necessary in situations of 'learned helplessness.' Challenge and mutual accountability in a supportive environment conveys the underlying commitment to the person's capacity to change and grow:

We need to be asked if our idea of whom we'd like to become is based on what we know about our 'illnesses.' We need to be asked what supports we would need to take new risks and change our assumptions about our fragility and our limitations. (Mead and Copeland, 2000 321)

They emphasise the importance of hope, personal responsibility, education, advocacy, and peer support. They also address controversial issues, such as the nature of the therapeutic relationship, the place of medications in symptom control, and the need for attitudinal changes in mental health professionals:

Support, in a recovery-based environment, is never a crutch or a situation in which one person defines or dictates the outcome (Mead and Copeland, 2000 319).

Bradshaw, W., Armour, M. P. & Roseborough, D. (2007) Finding A Place in the World: The Experience of Recovery from Severe Mental Illness. *Qualitative Social Work,* 6.1: 27-47.

This study provides detailed evidence about the changing role of case management as a person becomes more and more able to look after him or herself. It is a longitudinal study of forty-five adults over three years, and tracks the process of recovery from severe mental illness. This article reports on what we could call the end phase of case management. By the third year, people were developing a sustainable level of self-care (including the ability to get help when it is needed) and beginning the process of reintegrating with their community and recreating a normal life.

The findings show that this period, occurring approximately during the third year of case management support, presents significant challenges for the person. The case management relationship is a trusted and valuable source of continuity during the re-engagement with mainstream society. Case management during this phase can usefully focus on developing the person's interdependence through family, friends, employment, education and mainstream health supports.

The study also found that people's recovery, and by implication the effectiveness of case management, is fundamentally constrained by the social context, including limited income, housing and education opportunities and stigmatising social attitudes.

Participants in the study were recruited from community mental health agencies in a north-central part of the United States. People were excluded if their primary diagnosis was substance abuse. Two-thirds of the participant group were female, and three quarters were Caucasian. Half the group had a diagnosis of schizophrenia. Case management was provided by professional social workers and tasks overall included crisis intervention, connecting people to resources, supportive therapy, goal development and medication monitoring.

Data was collected in semi-structured interviews of 1–2 hours, tape-recorded and transcribed. The material was coded and analysed using a carefully documented method to create descriptions of the invariant structures present across all the participants' lived experiences.

The full research project identified three broad phases of recovery, of roughly a year each. The first phase they call 'demoralisation.' It involves struggling with the overwhelming experience of mental illness and the associated consequences including dependency and loss of social functioning. In this first phase, the case manager is an ally and support: 'someone on my side'.

The second phase involves 'developing and establishing independence'. The person begins taking back control of their life by gaining mastery over their illness, and dealing with life disruptions and losses, including the impact of stigma. For many, it involved conflict with their case manager as they began to regain independence.

The third phase focuses on 'community reintegration' (Bradshaw et al., 2007 33). It includes acceptance of oneself and finding meaning in the illness experience, along with reconnecting with family, friends and the broader community. It involves coping with stigma and the reduction of opportunities. Reconciliation with the case manager occurs and this phase is a very positive collaborative relationship. In some cases, people began planning for the end of case management, although always with ambivalence.

The third phase was focused on managing the experience of mental illness and finding a place back in the broader community. Reintegration included a resumption of roles in the community through work and education, and within family and friendship groups. Normalcy was an important goal. People wanted to do 'normal things' and distance themselves from groups associated with mental health treatment. The person and the case manager sought to shift the sources of practical support toward family and friends and away from professional services.

This process, while invaluable, was not easy. Often there was a painful struggle to reconcile differences between the present and pre-illness social status and opportunities. Practical difficulties included dealing with gaps in employment record, or with people's fears and prejudice. Returning to parental duties was particularly challenging. Trying to make new friends after long periods of hospitalisation, and/or the disruption of previous bonds could mean confronting hurtful prejudice. Many people expressed some helplessness about how to reconnect:

> I have one friend [and] she's in detox. So that's it. I don't know anybody. That's kinda hard, too. (p.39)

This kind of isolation leads to more reliance on the case management relationship. Development of social skills and support to re-establish social connections is an important part of case management in this phase. In addition the case manager can

provide specific therapeutic counselling to assist the person to grieve losses, deal with shame and make sense of the illness experience.

Getting help from social connections, rather than a professional case management relationship with some elements of friendship, raised a number of complications. For example, the attitude of family members could oscillate between frustration with the person's progress and a disempowering over-protectiveness. Other people reported that when family members increased their level of support they could be simultaneously resentful about giving the help, and reluctant to give it up (Bradshaw et al., 2007 35).

Barriers to social integration were also very practical, and once again the theme of transport was prominent. Many participants equated financial resources and private transportation with independence, agency and social inclusion.

> Your destiny is controlled by a bus. You know, with a car, you can just start it
> up. (p.39)

The majority felt trapped by the low income and the dependency associated with financial assistance. Many efforts to regain independence and normal integration were blocked by low income, and/or limited education and employment opportunities.

The relationship with the case manager in this phase was strong and positive. The conflict in phase two was resolved and strong attachment was most common. The researchers comment:

> Respondents often indicated that although they were better and more capable
> of being on their own, they also were reluctant to give up case management.
> (p.37)

Twenty percent of the participants did not anticipate ending the case management relationship. This was not seen as a failure, but instead the ongoing presence of the case manager was a comfort.

Marvasti, A. B. (2002) Constructing the Service-worthy Homeless Through Narrative Editing. *Journal of Contemporary Ethnography,* 31.5: 615-651.

In this qualitative study of work practices in an inner city homeless shelter, Marvasti shows how workers judged service users on a range of personal criteria in order to justify the distribution of scarce resources. The study drew on three years of field work at an inner city homeless shelter.

Marvasti finds that the concepts of independence and self-help were used in a pathologising context that blamed the individual's situation on having a lack of these qualities. Accordingly:

> the idea of self-reliance [was] the basis for discriminating between 'legitimate
> needs' and 'abuse of services'. (Marvasti, 2002 621)

Close analysis of client intake interview transcripts showed three styles in the way the client's story was constructed: directive, confrontational, and dismissive. The worker used the intake interview to generate a narrative of the client's situation that functioned to demonstrate (or refute) the client's service worthiness according to the values and policies of the agency.

Marvasti finds that sometimes the worker and the client would collaborate to produce a narrative that fitted with the mission of the emergency shelter. The worker might ask prompting questions to elicit the information that would facilitate access to the shelter, and the client would reframe their situation in order to align it with the agency requirements (Marvasti, 2002 633-40). In this case, stories were adapted to fit the

agency's philosophical emphasis on independence and self-help which cast clients' troubles in the language of individual responsibility. Alignment with this narrative was used by workers to determine which clients were service-worthy in order to administer their limited resources. Fortunately, perhaps, the self-reflective sensitivity and reciprocity of a relationship has the possibility of a fine calibration to avoid slipping from motivational pressure into coercive abuse.

6.3 Does case management affect service system integration or costs?

The following section considers evidence which concerns the relationship between case management practice and the policy intentions of cost containment and service system integration.

6.3.1 Synthesis of the evidence: service system integration and costs

What we know

The evidence presented in this section demonstrates that there are significant tensions between the policy goals of cost-containment and efficiency, service system integration, and the delivery of personalised, respectful care.

Austin and McClelland find that the case manager's focus is on direct service delivery rather than system change (Austin and McClelland, 2000). McDonald and Zetlin find that service system integration is affected by a range of forces and factors that are beyond the scope of case management, and that system integration issues should be dealt with through a separate mechanism (McDonald and Zetlin, 2004).

Implications

Synthesis of the evidence about these tensions in policy documents and social work research with the evidence on the mechanism allows adjudication between competing theories on the outcome of case management. It leads to the conclusion that an efficient, integrated service system is a context rather than an outcome.

Case management can produce an experience of a more seamless flow of assistance to the person but this is opportunistic in response to the individual needs of the person being assisted. Better integration, communication and respect between specialist areas is an important context that can provide support for better case management outcomes. However, while efficient and effective distribution of services may in some cases result from case management, it cannot be seen as the primary goal without losing the essence of the intervention.

Specifically in relation to cost-containment, case management is a labour-intensive and highly skilled intervention and there are certainly more efficient ways to distribute services, if that were the primary desired outcome. In addition, the causes of service system fragmentation are beyond the scope of an individual case manager's sphere of influence and focus on these diminishes the time available for relationship work with the client.

6.3.2 The research: system integration

One of the most commonly cited reasons for case management (after de-institutionalisation) is that the service system is complex and fragmented (Upston, 1994 5-6). Due to the complexity of the service system, professional expertise is required to efficiently access available resources, and furthermore there is a need to

build collaborative relationships with other service providers to improve services to the client. McDonald and Coventry describe this as the second order of relationship work within case management (McDonald and Coventry, forthcoming 2008). Accordingly, case management is conceived as the solution to the complexity and fragmentation of the service landscape (Rothman, 1992, Case Management Society of Australia, 2004, Upston, 1994, Eustace and Clarke, 2005).

Case management is therefore assigned two levels of task. First, case management must create de facto integration by navigating the system for the client, and second it must identify 'gaps' in service delivery and work toward system change.

Is this a realistic goal? Austin and McClelland found that at least on an individual practitioner level it simply does not occur in practice (Austin and McClelland, 2000).

Austin, C. D. & McClelland, R. W. (2000) Case Management in Contemporary Human Services. *Australian Journal of Case Management,* **2.1: 4-8.**

This article presents a conceptual overview of the policy landscape in which case management occurs. Of particular relevance to the synthesis, the authors present findings from one of the author's mid-1980s study of the priorities of case managers in the aged care sector in four US states. Case managers were asked to rate the importance of client-oriented and system-oriented goals related to their work:

> Respondents overwhelming reported that their major responsibility was the provision of services to clients. System change was not a significant focus of their practice (Austin and McClelland, 2000 6).

Austin and McClelland argue that system integration is both unrealistic in theory and not carried out in practice, and ask:

> Should case managers be expected to function as system change agents, when the reality of their jobs minimizes their capacity to create system change? (Austin and McClelland, 2000 7)

This research suggests that system fragmentation is a context that makes case management more difficult, but is not solvable by the mechanism itself. This conclusion is supported by the evidence from the following study of the disability service system in Queensland.

McDonald, C. & Zetlin, D. (2004) The promotion and disruption of community service delivery systems. *Australian Journal of Social Issues,* **39.3: 267-282.**

This study of the community disability service system in six Queensland communities finds that service delivery systems were largely fragmented, relationships between agencies were often strained, and relationships with governments were not based on trust or reciprocity (McDonald and Zetlin, 2004 279-80). The research finds that the most effective process to support integrated community services was a formally constituted and funded service development function (McDonald and Zetlin, 2004 278).

McDonald and Zetlin report that there is a significant gap in the evidence base concerning community service delivery systems as such, and how to govern or manage service networks (McDonald and Zetlin, 2004 268-9). The study begins to address this gap by investigating the operations of the disability service delivery system in six Queensland communities. McDonald and Zetlin define the service delivery system as:

> all the formal services and informal support systems in a community locality which, ideally, function as a supportive network for dependent people enabling

them to live their lives to their fullest capacity (McDonald and Zetlin, 2004 269).

Data was collected from nine focus groups and fifty-six interviews with service providers across the six communities in 2001 and 2002 (p.271). The sample replicates Queensland demographic patterns and provides a spread of socio-economic circumstances (three communities above Queensland average and three below) and geographic locations including inner and outer urban, rural and remote communities (p.270).

The research found three categories of factors which disrupted the integrated functioning of the service delivery system in all of the sampled communities (p.271).

The first category was political factors. Political tensions within local councils reduced local government support, the involvement of local political party members in the community sector destabilised governance, and the impact of race issues led to an essentially isolated Indigenous service sector whose internal collaboration was moreover compromised by inter-agency politics (p.272). Inter-agency politics more generally affected all four of the urban communities and included distrust between large and small organisations, and distrust of peak bodies (pp.272–3).

The second category included two common factors within all the sampled community service delivery systems: a high turnover of staff resulting in a constant rebuilding of informal and formal relationships, and a tendency for agencies to be 'inward looking' and focused on their own service delivery primarily as a result of workload pressures. The research found that service system integration was improved in communities that had a funded service development function (McDonald and Zetlin, 2004 274-5).

The research found a third set of factors that disrupt system integration, associated with the funding departments (pp.275–7). These included: demarcation issues and the lack of inter-departmental collaboration; inflexibility in the control of resources that reduced agencies' capacities for innovation and creativity; and poor relationships with departmental officers. Poor relationships were evidenced in the experience of a disrespectful attitude such as 'perceptions that governments do not relate to them as partners, but as agents' (p,276) and on the other hand, an experience that the capacity for support had reduced over time. A further disruptive factor was the structural impact of competitive funding models on inter-agency trust (p,277).

6.3.3 The research: cost containment

While case management has its origins in social work's 'case-work,' dating from the early twentieth century (Ballew and Mink, 1996), its contemporary manifestations have a range of characteristics that are arguably in direct conflict with social work principles (McDonald, 2006 102 -113). Incarnated as 'managed care' in the US and 'care management' in Britain, case management has developed a significant cost-containment function. It has risen to prominence, argues McDonald, for 'the purposes of promoting the twinned goals of efficiency and effectiveness' (McDonald, 2006 102). In the US, case management's incarnation as *managed care* explicitly foregrounds the need to justify interventions based on effectiveness and cost-effectiveness. The cost-containment imperative effectively shapes both practice and research interests, and the explanatory models provided in policy documentation. This pressure is evidenced in an anxious comment from a US homelessness case management researcher:

Developing cost-effective approaches to assist these needy individuals in the current environment of scarce resources and pressures for efficiency from managed care programs is especially critical. (Wolff *et al.*, 1997 341).

McDonald argues that this use of case management is primarily the result of introducing market principles to the human services. She states firmly:

It is *not* about developing effective responses to need.' (McDonald, 2006 106)

In Australia, British-style care management has been implemented in the field of unemployment (McDonald and Marston, 2005, McDonald *et al.*, 2003). Without accepting McDonald's argument at face value, it is nonetheless clear that the goal of cost-containment may be in tension with the development of the evidence-informed case management mechanism synthesised in Chapter 5.

Cambridge, P. (2006) The Case for a New 'Case' Management in Services for People with Learning Disabilities. *British Journal of Social Work* Advanced Access October 31, 2006.

This study is selected for the synthesis because it demonstrates these tensions in the context of the United Kingdom. Cambridge tracks the policy documents through which UK social service provision has moved to brokerage and devolved budget implementation in successful efforts to de-institutionalise services. He describes the tangled implementation landscape within which case management finds its place.

Cambridge reports that while the documented intention of the move toward brokerage was to individualise service provision, in practice it resulted in budget-dominated allocations: 'In practice, cost-led purchasing predominates over needs-led purchasing' (Cambridge, 2006 11). In the UK, he finds, the principles of 'person-centred planning' have been deployed to champion the value of relationship mechanisms (case management) against cost-containment coordination mechanisms (care management).

Cambridge argues that the evidence is in favour of 'getting to know the person' rather than 'the constructed dependency of the client–professional relationship' which he finds typical of the trend in care management (Cambridge, 2006 19). He proposes a 'new model' for case management for people with learning disabilities in recognition and resistance to the fact that care management has become 'a welfare bureaucrat model, in which large caseloads make it impossible for care managers to develop person-centred approaches' (Cambridge, 2006 17).

7 CONTEXT ONE: PROGRAM RESOURCES NEEDED FOR CASE MANAGEMENT

This chapter synthesises twenty sources of evidence about the program resource contexts which impact on the ability of the case management relationship to achieve results for the client. It finds three enabling conditions: ability to establish a relationship and provide comprehensive, practical support, access to specialist supports, and access to housing resources.

7.1 Synthesis of the evidence: program resources

What we know

Section 7.2 Enough time, varying intensity and comprehensive, practical support establishes that case management which is ongoing, responsive to crisis and practical difficulties and uses frequent outreach modes of contact, produces better client outcomes and increases client engagement and satisfaction compared to office-based, high caseload, broker-referral case management.

Section 7.3 Access to specialist supports provides evidence from case management with homeless people with mental health and substance use issues. These studies show that case management facilitates engagement in specialist treatment for people also experiencing homelessness by addressing their other needs, particularly for material assistance, in a comprehensive, practical, reliable and persistent way.

Synthesis of the evidence in this section demonstrates that multidisciplinary case management practice can be a cost-effective way of providing access to specialist support services, and is more satisfying to clients than brokerage and referrals.

Section 7.4 Access to Housing Resources shows two dimensions of housing provision that create a context in which the relationship mechanism can work to produce an effective case management intervention. The two dimensions of the provision of housing are affordability and specialist, non-treatment contingent tenancy management.

First, assistance to address housing affordability is required. Housing subsidies (and support to secure an apartment) significantly increase the number of people with severe mental illness who are able to live independently in the community showing that for some people, affordability is the key.

Second, a complex, persistent and reliable service response is required for people experiencing complex difficulties including homelessness combined with mental illness and/or substance use issues, especially for men. Specialist supportive tenancy management is effective; however housing should be permanent and not linked to treatment compliance or abstinence requirements.

Implications

The implication of the evidence in this section is that the resources to provide comprehensive, practical support are essential for allowing the case management relationship to develop and generate an increase in the person's level of self-care in the long term.

This implies that the case management mechanism depends on key contextual conditions in the service system. The capacity to determine the duration and intensity of the support on an individual basis and the accessibility of housing resources and specialist supports are critical contexts that allow case management to work.

The evidence implies that housing is a key resource which makes a profound difference to the client outcomes achieved by case management, independent of the model deployed.

Additional housing provision is required to overcome affordability and access difficulties. Better outcomes can be achieved if it includes flexible, specialised tenancy management integrated with case management support, including:

→ persistent, reliable support before, during and after hospitalisation or other crises

→ coercive financial management if required to ensure rent is paid

→ provision of structured social interactions and/or other social integration components.

The implications of the persistence and reliability qualities identified in Chapter 5 are refined by the evidence here about contextual conditions. It shows that not everybody needs a long period of case management. The key element is a negotiated duration which supports establishment of a reliable case management relationship for the time required to produce the developmental change. Differentiated responses are important because people experiencing homelessness are not a homogenous group, and careful assessment and tailored interventions can therefore produce more cost-effective services.

7.2 Enough time, varying intensity and comprehensive, practical support

This section primarily synthesises the relevant evidence from a large body of quantitative evaluations of a case management approach which has been highly influential in community mental health practice, Assertive Community Treatment (ACT). The evidence relevant for this synthesis from studies of ACT concerns both the mechanism and the context of case management, as it demonstrates the inter-relationship between comprehensive and practical support and the development of a persistent, reliable case management relationship.

Assertive Community Treatment was pioneered and tested in the 1980s as a means to successfully deliver community-based care of persons with severe mental illness (Stein and Test, 1985). The resulting ACT principles have been widely adopted in Australia and Europe. For example, in Victoria, ACT was implemented in the mid-1990s through the mobile support and treatment services (email communication, Robyn Barnes, DHS 2008).[19]

Assertive Community Treatment is now a well-documented, and extensively evaluated case management model originally designed for community mental health and adapted for people experiencing both homelessness and serious mental illness (Wolff et al., 1997 342, Salyers and Tsemberis, 2007 619-21). Coldwell and Bender describe ACT as case management by a multidisciplinary team, low client/staff caseloads that enable frequent service contacts, community-based services that are directly provided rather than brokered through other agencies, and 24-hour availability to the client (Coldwell and Bender, 2007 393). Another key feature is ACT's time-unlimited and

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[19] For evidence of ACT in Europe, see for example, Killaspy, H., Bebbington, P., Blizard, R., Johnson, S., Nolan, F., Pilling, S. & King, M. (2006) The REACT study: randomised evaluation of assertive community treatment in north London. *British Medical Journal,* 332**:** 815-820. and Tyrer, P., Balod, A., Germanavicius, A., McDonald, A., Varadan, M. & Thomas, J. (2007) Perceptions of Assertive Community Treatment in the UK and Lithuania. *International Journal of Social Psychiatry,* 53.6**:** 498-506. These studies were not included as the synthesis had reached saturation.

assertively continuous service delivery sometimes referred to as the 'no drop out policy' (Salyers and Tsemberis, 2007 633, 635).

7.2.1 Synthesis of the evidence: enough time, varying intensity and comprehensive, practical support

What we know

Assertive Community Treatment (ACT) is an extensively evaluated assertive community mental health case management model using a multidisciplinary team, low client/staff caseloads that enable frequent service contacts, a high proportion of directly provided practical assistance, and unlimited support duration.

Coldwell and Bender found that on average, ACT subjects experienced a 37% greater reduction in homelessness compared to the control group (Coldwell and Bender, 2007 396).

Wolff *et al.* found that ACT produced better client outcomes at no greater total cost over a period of eighteen months (Wolff et al., 1997 347).

(Kenny et al., 2004) analysed the same data as Wolff *et al.* and confirm the better outcomes, but are unable to find any significant mediation by objective service utilisation variables, including contact frequency. This supports the conclusion that the case management mechanism is not any particular service but the quality of the relationship.

Krupa *et al.*'s qualitative study of ACT clients finds that they valued a reliable relationship with 'a genuine, caring attitude' that 'filled a social void,' had enough time to develop, and an intensity and quality determined on an individual and responsive basis (p.20). These qualities were supported by elements of the ACT model including 'continuity, individualization, the flexibility of round the clock services and assertive follow-along activities' (Krupa et al., 2005 23). They also find that a key worker was important within the ACT team context to provide continuity and a personal knowledge of the individual (p.20).

The review by Morse finds that people who are more able to engage in a relationship, i.e. less unwell, less substance-dependent or with better relationship skills (evidence that this includes women) achieve better results from case management (Morse, 1999), independently confirming (Chinman et al., 2000, Chinman et al., 1999).

Rayner *et al.* find that persistent and reliable case management was successful in engaging and retaining a homeless drug-using population. Median drug-use treatment duration by the end of the Trial's third year was thirteen months, well above previous reported results that found two-thirds of homeless clients stayed less than thirty-five days (Rayner et al., 2005 16).

Muir-Cochrane finds that case management practice was dynamically moderated in response to case load and the intensity of need of individual clients within a case load. Nurses modified their case management practice by changing the level of attention and emotional involvement directed at the client and their needs, using dynamic and ongoing assessment and prioritisation.

Implications

The evidence base on Assertive Community Treatment case management shows the inter-dependence of the relationship mechanism with the contextual conditions that allow provision of persistence, reliability and comprehensive, practical support.

The experimental comparison between a relationship-based intervention that provides direct, practical assistance and the broker-referral model of service provision confirms that a reliable, persistent relationship providing comprehensive and practical support is the key to effective case management.

Social work researchers, Ballew and Mink, like many practitioners, argue for the importance of concrete practical demonstrations of assistance to the development of a relationship (Ballew and Mink, 1996 47). Practitioners interviewed for this project consistently commented that 'getting a few wins' was essential for developing credibility and building trust in the case management relationship (1,3,4).

The interdependence of the relationship mechanism with the provision of comprehensive, practical support confirms the evidence in *Section 5.4 Being more than a case manager* about the intimacy of case management.

The finding that contact frequency did not mediate housing outcomes, while housing and financial assistance partially did, indicates both that the relationship is not dependent on contact frequency, and the significance of timely access to resources for reducing homelessness. It demonstrates that without the context of housing and financial assistance when required, the intervention will not be as effective for reducing homelessness.

A final point worth making from the ACT studies is the possibility that certain models of case management can exacerbate the tension within the case management mechanism between the qualities of persistence and respect. Evidence of this tension is presented in Section 5.4. The possibility of this issue is raised in a recent conceptual assessment of the principles of ACT against the principles of a mental health 'recovery orientation' which prioritises consumer choice and empowerment (Salyers and Tsemberis, 2007). Salyers and Tsemberis note for example that a mandated contact frequency may reduce consumer choice about the level of support desired (p.633).

The sensitivity of case management outcome to personal characteristics of the service user supports the hypothesis that the relationship is the key mechanism for the case management intervention.

Finally, the study of the service users' experiences of ACT provides qualitative confirmation that the comprehensive and practical support provided in an ongoing, persistent way over time allowed the establishment of a relationship that fundamentally supported the person's development and capacity to re-integrate into community life following serious mental illness.

7.2.2 The research: enough time, varying intensity, and comprehensive practical support

Morse, G. (1999) A Review of Case Management for People Who Are Homeless: Implications for Practice, Policy, and Research. IN FOSBURG, L. B. & DENNIS, D. L. (Eds.) *Practical Lessons: The 1998 National Symposium on Homelessness Research.* U.S. Department of Housing and Urban Development and the U.S. Department of Health and Human Services.

This review of empirical studies of case management with people experiencing homelessness found ten randomised experimental studies focused on case management methods for people experiencing homelessness. All of them also targeted people with a serious mental illness. In addition, nine non- or quasi-experimental designs were reviewed including studies with non-randomised

comparison groups, pre- and post-analysis and retrospective reviews; however these have produced equivocal results partly due to methodological limitations.

Eight of the ten experimental studies showed more positive outcomes compared to the control group (Morse, 1999 5). Five out of six studies researching the ACT approach reported beneficial outcomes, and two of three studies of a more intensive case management compared to standard care also reported better outcomes. Intensive case management is not formally defined like ACT but it is commonly associated with assertive and persistent outreach, reduced case loads and active assistance in accessing needed resources. In seven studies, the outcomes included fewer days homeless/more days stably housed; the remaining study measured outcomes in terms of treatment engagement and retention. Across three of five studies correlating service factors with outcomes, frequency of contact was associated with better client outcomes (Morse, 1999 6).

Morse also reports some evidence about client characteristics that were linked to better outcomes. Each of the following findings were reported in two or more studies: better outcomes for clients with less homelessness experience fewer psychotic symptoms, fewer substance abuse issues, or who were female (p.6).

In summary, the majority of experimental studies showed that the ACT model of case management and 'more intensive' case management proved more effective than standard care control groups in delivering outcomes for clients experiencing homelessness. Drawing also on programmatic recommendations in the literature, Morse concludes that the relationship between the case manager and their client was highly significant and that engagement skills are the key for homelessness case management (Morse, 1999 7).

Coldwell, C. M. & Bender, W. S. (2007) The effectiveness of assertive community treatment for homeless populations with severe mental illness: A meta-analysis. *American Journal of Psychiatry,* **164.3: 393-399.**

A more recent meta-analysis, published in 2007, brings Morse's review up-to-data. Coldwell and Bender appraise the evidence on the effectiveness of the ACT model for case management in homeless populations with severe mental illness. This review is included in the synthesis to demonstrate the weight of evidence in favour of the assertive community treatment (ACT) model of case management specifically for people experiencing homelessness.

The study draws a credible conclusion that the ACT case management model for people with severe mental illness is effective in producing positive outcomes for people who are also experiencing homelessness.

Coldwell and Bender searched the major databases including MEDLINE, PsychINFO and the Cochrane Database of Systematic Reviews for abstracts published up to and including 2003. Fifty-two abstracts were found, and ten of these were selected under their quality criteria: six randomised control trials and four observational studies. This meta-analysis adds one further randomised control trial, and two new observational studies to the group of studies reviewed by (Morse, 1999).

This small number of studies was further divided based on outcome measures: housing stability and hospitalisation. Symptom severity measures were judged to be too disparate across the studies to allow for a meaningful meta-analysis, nor were diagnostic indicators able to be compared.

The most significant result was found using the housing outcome measure. Eight of the ten studies reported a reduction in days homeless for the ACT model, (including four of the six randomised control trials). On average, ACT subjects experienced a

37% greater reduction in homelessness compared to the control group (Coldwell and Bender, 2007 396). The meta-analysis also found some positive but overall ambiguous effects in relation to hospitalisation outcomes requiring further empirical research for resolution.

Selected studies were not assessed for program fidelity; however, the meta-analytic approach offers the advantage of mitigating selection and program fidelity effects, and the authors did not detect any consistent bias across the sample. They also conducted a test to identify possible bias due to non-publication of unfavourable studies, with negative results. The small sample size does necessarily limit the credibility of this meta-analysis, but taken together with the rest of the evidence base, it validates a growing consensus about the effectiveness of the ACT approach.

Comparison of Assertive Community Treatment and Broker-referral case management

The following two studies analyse a data set collected in a randomised control trial of ACT conducted by a team of researchers including Morse, who conducted the 1998 comprehensive review presented above. The first study focuses on cost-effectiveness, while the second focuses on the factors which made a difference in the outcomes.

The experiment compared three approaches to case management: ACT with an additional semi-volunteer community worker, and Brokered Case Management (BCM). Participants were followed over 18 months, and those in the ACT programs were found to achieve better housing stability outcomes (Morse *et al.*, 1997).

Brokered Case Management typically involved case loads of around eighty-five and infrequent, office-based contacts with the client. The case manager assessed needs, developed a service plan, purchased the services, and monitored progress. In contrast, the ACT case managers had case-loads of 10–15, offered a non-time-limited range of supportive and practical assistance, including material aid, transportation, daily living skills, and typically used outreach to make contact with their clients. One of the ACT programs also included a semi-volunteer 'community worker' whose role was to promote social integration through, for example, leisure activities (Wolff et al., 1997 341).

At study commencement, 165 participants were randomly assigned to one of the three original conditions; 105 received one of the two ACT treatments and sixty received BCM. Of the sample, 58% were male, 55% were African American, and the mean age in years was 34.76. More than 66% of the sample had a diagnosis of schizophrenia, 25% had an AXIS II personality disorder, and 24% had a substance-use disorder. The average participant had not had a permanent place to stay for over thirty months.

Potential participants were recruited from the emergency room and inpatient units of the local, state-funded psychiatric facility. Participants had to be currently homeless or at risk for homelessness based on a prior homelessness experience, and have had psychiatric diagnosis (AXIS I disorders). People with a violent crime conviction in the last year were excluded for safety reasons.

Client outcomes were measured in four domains: service contact, client satisfaction, stable housing and psychiatric symptom severity. Days in stable housing and psychiatric symptom severity were measured at baseline and eighteen months. The housing measure focused on the previous thirty days and excluding any form of rough sleeping or crisis accommodation. Interviewers assessed symptom severity using a validated Brief Psychiatric Rating Scale 24-item scale.

Service contact and client satisfaction were measured using monthly interviews. The service contact intensity variable was collected from participants' self-report about the number of days they had contact with the program and/or other agencies. They were asked to specifically report the number days the program assisted them with the following activities: (a) finding permanent housing, (b) activities of daily living (e.g., emergency food assistance, help budgeting, help cooking, or housecleaning), and (c) emotional or psychiatric problems (counseling).

Wolff, N., Helminiak, T. W., Morse, G. A., Calsyn, R. J., Klinkenberg, W. D. & Trusty, M. L. (1997) Cost-Effectiveness Evaluation of Three Approaches to Case Management for Homeless Mentally Ill Clients. *American Journal of Psychiatry,* **154: 341-348.**

This cost-effectiveness study confirms the value of a persistent and reliable relationship mechanism and its provision of comprehensive, practical support. This study compared the outcomes and costs of the three approaches for clients with a serious mental illness and experience of homelessness over a period of 18 months. It found better client outcomes at no greater cost for the ACT approaches to case management (p.347).

Clients assigned to the two assertive community treatment conditions had more contact with their treatment programs, experienced greater reductions in psychiatric symptoms, and were more satisfied with their treatment than clients in the brokered condition. The study found that ACT produced better hospitalisation and health cost outcomes, with no difference in medication compliance or quality of life (Wolff et al., 1997 346).

The cost-effectiveness analysis was able to access longitudinal data on eighty-five clients, from the initial intake of 165 randomly assigned to three treatment regimens. This was only partly due to study attrition; fifty participants were ineligible for the cost-effectiveness analysis because they either entered too late in the grant period or did not provide consent to release data from service system records. Data was available for twenty-eight people in assertive community treatment alone, thirty-five in assertive community treatment with community workers, and twenty-two receiving brokered case management (Wolff et al., 1997 342).

Detailed service utilisation and cost information were collected for each participant for eighteen months after the initiation of treatment and for the six-month period immediately preceding random assignment. Services were valued at their average costs, which were based on a full cost accounting of the resources used to produce these services.

There was a significant difference in the attrition rates between the three programs, with brokered case management having the highest attrition, while no other demographic variable had significance. The proportion of clients missing was significantly greater for the brokered condition (63%) than for assertive community treatment only (44%) or assertive community treatment with community workers (33%). The authors conclude that 'home visits, supportive services and skill training, transportation, and advocacy in obtaining entitlements and other needed resources […] appear to be the critical ingredients that produce positive client outcomes' (Wolff et al., 1997 348).

Another important finding was a difference in the expenditure patterns for clients between the programs. Although differences in the total costs over eighteen months was not statistically significant between the programs, ACT case management cost more than brokered case management, and the ACT program spent more on vocational assistance and direct material aid to the client. In contrast, BCM was

characterised by cost-shifting to other parts of the service system, particularly inpatient mental health care (Wolff et al., 1997 345-6).

Kenny, D. A., Calsyn, R. J., Morse, G. A., Klinkenberg, W. D., Winter, J. P. & Trusty, M. L. (2004) Evaluation of Treatment Programs for Persons with Severe Mental Illness: Moderator and Mediator Effects. *Evaluation Review,* 28.4: 294-324.

This study investigates the client and service characteristics from a randomised control trial comparing of ACT case management and brokered case management in an attempt to determine what makes a difference.[20]

Using more sophisticated mathematical modelling, this analysis shows that while all participants improved over time, there was a clear and increasing separation between the two groups. The ACT group improved at a rate 40% greater than the BCM group, which is considered to be a moderate effect size (Kenny et al., 2004 310).

The psychiatric symptom outcome analysis also found a moderate differential effect size, with the BCM group showing a small increase in psychiatric symptoms while the ACT group showed a decline.

The study then analysed the outcome data of the two programs for correlations to factors relating to the person being assisted (moderator effects) and factors relating to the treatment itself (mediator effects). The client characteristics tested for their moderating relationship to outcomes were: race, gender, age, homeless history, schizophrenia diagnosis, substance abuse diagnosis, and personality disorder diagnosis. The analysis of stable housing outcomes (days housed per month) found and controlled for two covariates – housing history (homeless at baseline) and criminal arrest history.

Mediation was tested primarily against service utilisation variables. Data was also obtained on frequency of service contact and on specific service use, including assistance with housing, counselling, daily living, substance use services, and medication adherence.

No mediating correlation was found between contact frequency and housing outcomes; however, specific services were found to partially mediate housing outcome and these were: more housing assistance from their program and other agencies, and more financial assistance (Kenny *et al.*, 2004 312). No reliable mediators were found for psychiatric symptoms, and no reliable moderators were found for either housing or psychiatric symptoms (312, pp.314–15). There was a clear correlation between medication adherence and reduced symptoms; however, adherence was not affected by the program group, therefore it was not a mediator.

The authors speculate that the absence of any significant moderator for either outcome measure could be explained by the tailoring characteristic of both case management programs. The evidence for this inference is not conclusive since other studies show an outcome difference based on a person's impairment and a stronger impact in these cases of the housing context (Clark and Rich, 2003), while another shows the impact of personal and illness characteristics on the quality of the case management relationship (Chinman *et al.*, 1999).

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[20] Details on this experiment are provided above (link). Findings that replicate those already reported by Wolff, N., Helminiak, T. W., Morse, G. A., Calsyn, R. J., Klinkenberg, W. D. & Trusty, M. L. (1997) Cost-Effectiveness Evaluation of Three Approaches to Case Management for Homeless Mentally Ill Clients. *American Journal of Psychiatry,* 154**:** 341-348. are omitted.

A question left unexplored is the potential causality between housing outcomes and psychiatric symptom outcomes. The longitudinal analysis showed a greater effect on housing outcomes in the early part of the study while the effect on psychiatric symptoms was more gradual. Some evidence about the interaction of these two outcomes is found in studies of the impact of housing on case management; this evidence is included at Section 7.4 Access to housing resources.

This study finds three things relevant to the synthesis. First, that duration matters because the effectiveness of the relationship-based treatment increases over time; second, that practical assistance with housing and finances makes a difference; and third, that another factor not captured in the study's data collection must account for the difference in outcome.

The authors conclude by stating that the concept of a therapeutic alliance shows promise in the search for mediators. They report that a pilot of the original study collected therapeutic alliance data on about half of the sample and found it to be significantly higher in the ACT group.

Krupa, T., Eastabrook, S., Hern, L., Lee, D., North, R., Percy, K., Briesen, B. V. & Wing, G. (2005) How do people who receive assertive community treatment experience this service? *Psychiatric Rehabilitation Journal,* **29.1: 18-24.**

This was a Canadian study which analysed qualitative data from six focus groups of people receiving ACT services from four different teams, with a total of fifty-two participants (Krupa et al., 2005 19). It found that the case management relationship was the foundation of ACT's effectiveness at assisting a person with serious mental illness to live in the community (p.20).

The relationship characteristics found by this study confirms those identified by the synthesis in Chapter 5. It was a reliable relationship with 'a genuine, caring attitude' that 'filled a social void,' had enough time to develop, and an intensity and quality determined on an individual and responsive basis (p.20). Medication compliance and the control of finance were sources of conflict in the relationship, as were case managers who maintained very strict professional boundaries and refrained from friendly, social communication (Krupa et al., 2005 23).

Two additional points of relevance for the synthesis were: first, the finding that a key worker or 'prime' was important within the ACT team context to provide continuity and a personal knowledge of the individual (p.20); and second, that the ACT qualities of persistence, reliability and comprehensive, practical support facilitated the relationship:

> specifically continuity, individualization, the flexibility of round the clock services and assertive follow-along activities (p.23).

The study finds therefore important contextual elements required to support the effective operation of the case management mechanism.

Rayner, K., Batterham, D. & Wiltshire, R. (2005) *Rebuilding Lives: Final-year Findings on the Homeless and Drug Dependency Trial's Continuous Primary Case Management and Pathways Response (Part B),* **Report 9. Melbourne, Hanover Welfare Services, The Salvation Army, St Vincent de Paul Aged Care and Community Services and the Victorian Department of Human Services.**

This study was the final report of The Homeless and Drug Dependency Trial (HDDT) and is selected for some unique qualitative data representing a service user's perspective on long-term case management. The evaluation's reported outcome findings are limited in value because the trial did not use randomisation or a control

group, so outcome measures were pre- and post-comparisons, nor was the evaluation report peer-reviewed.

The relevant and unique information to extract for the synthesis is qualitative data from the service user perspective as represented in a series of case studies in the final evaluation report. These case studies were compiled for nine participants who agreed to be interviewed three months after exiting the trial, based on the interview and other sources of data collected during their participation in the trial such as administrative data, case notes and case plans (Rayner et al., 2005 161-3).

The case studies cannot be considered representative of the trial sample, but the findings make a unique contribution to the synthesis by providing qualitative data on dynamics identified from other evidence sources.

The HDDT targeted homeless people with drug dependency. A significant component of the trial, and the reason it is of key interest to this synthesis, was the provision of 'Continuous Primary Case Management.' The case management was supported by additional housing resources to create pathways out of crisis accommodation, and a day recreation program. The trial also included considerable capacity-building among staff at the crisis accommodation services; however, this is less relevant for our purposes.

The HDDT model of case management was explicitly 'client-centred' and 'relationship-based' with a comprehensive and practical focus acknowledging the interconnection of issues such as drug use, housing, health, family and unemployment (Rayner, 2006). This is consistent with research showing that most people develop drug use issues as a result of being homeless, and that this complicates their efforts to get out of homelessness, often leading to chronic experiences (Chamberlain *et al.*, 2007). The HDDT found that:

> homeless clients with complex problems do want to address their problems and on the whole can remain engaged in treatment when they are specifically targeted and supported appropriately. Access to supportive and low-cost housing, however, is essential to achieving long term outcomes (Rayner, 2006 40).

In other words, people are willing and able to move toward greater self-care responsibility if they feel their individual circumstances are taken seriously, and if external resources (like emergency accommodation and long-term housing) are available in the right sequence and timing.

The program was successful in engaging and retaining participants, and exceeded previously reported durations of drug treatment for homeless people (Rayner, 2006). Median treatment duration by the end of the Trial's third year was thirteen months, compared to an earlier study which found that two-thirds of homeless clients stayed less than thirty-five days (Rayner et al., 2005 16).

This study also highlights the challenges faced by people experiencing homelessness and drug dependency. It found that 84% of the 157 participants experienced a significant life event during the course of the case management (Rayner et al., 2005 119). Significant life events were defined to include significant family/relationship issues; suicidal ideation or suicide attempt; self-harm; significant mental health issues; significant physical health issues; non-fatal overdose; arrest; involvement in a violent episode; and eviction.

The final HDDT report includes nine case studies with clients who participated in an interview three months after they left the program. Four things stand out from these case studies: first, the complexity of the life situation faced by people – extended

homelessness, mental illness, experience of violence, troubled or absent relationships, social isolation, sexual abuse and trauma histories, low income, poor employment and education, legal, criminal and police involvement, antisocial behaviour, crime and illegal substance use; second, the importance of housing; and third, the importance of managing on one's own.

This third point is also remarked upon in the report's conclusion, noting that there were concerns prior to the Trial that long-term support would lead to dependency. In fact, clients were generally eager to disengage once their goals had been met, often, as shown in the case studies before system goals such as abstinence, or social integration were achieved. For example, for 'Melissa', fortnightly heroin use and precarious finances was a life under control:

> Melissa stated she had exited the Trial after some time as she had achieved what she had wanted to, stating that she was 'set up, off the streets, not on drugs full-on, and in a settled relationship' with her parents.(Rayner et al., 2005 176)

The fourth point relates to the importance of the relationship with the case manager. Two case studies refer to the impact of a negative relationship – for one a good relationship was never established as they felt the case manager did not get along with them and was inexperienced. For another, loss of their first trusting relationship with a worker because of staff turnover was never recovered.

The relationship mechanism is also demonstrated negatively in the difficulty of 'making links' with other service providers. A number of case studies describe the difficulty of making a link that sticks, and our interviews revealed similar anecdotes (2,5). This evidence helps explain why the brokerage/referral model tends to be less effective. It is not simply a lack of information about services that prevents the person getting what they need. The relationship mechanism, based on an understanding of the person, and a commitment to staying with them, and supporting them to access the particular service is what allows the person to successfully get the help they need.

Muir-Cochrane, E. (2001) The case management practices of community mental health nurses: 'Doing the best we can'. *Australian and New Zealand Journal of Mental Health Nursing* **10: 210–220.**

This Australian study investigating the case management practice of community mental health nurses provides evidence demonstrating the importance of non-linear changes in case management intensity (Muir-Cochrane, 2001). Muir-Cochrane's detailed ethnographic study reveals the way nurses prioritise clients within their caseload as having needs that are 'intensive', 'maintenance,' 'low maintenance,' and 'sleeper.' Prioritisation of these client 'groups' enables the nurses to manage higher than recommended caseloads by tailoring their practice accordingly.

The study involved eight months of participant observation in a South Australian community mental health centre. The researcher recorded her observations in field notes and a personal journal. She also conducted formal and informal interviews. The five study participants were all qualified general and mental health nurses, with a minimum of ten years and a maximum of twenty years mental health nursing experience.

Optimal caseloads in this community mental health care context were designated at 25–30 clients, while in practice caseloads could range between forty-five and sixty, with no upper limit (Muir-Cochrane, 2001 211, 214). Nurses felt that clients in the 'intensive' category were more likely to receive 'a proper service' defined as 'comprehensive case management' (Muir-Cochrane, 2001 214). Case management relationships varied in duration between six months and many years depending on the level of the person's impairment.

Muir-Cochrane found that nurses modified their case management practice by changing the level of attention and emotional involvement directed at the client and their needs. Variables included the frequency of contacts (from more than daily to three-monthly, or on request), relationship with family or carers, initiator of the contacts, activity spheres and the type of assistance provided – from medication monitoring to practical daily living assistance, mental state assessment and crisis intervention, quality of life improvements, and goal-setting. The intensity of a crisis intervention response was seen to reduce the capacity to engage in long-term planning and goal achievement with others. While nurses in this study expressed frustration at being unable to *properly*[21] case-manage all their clients, their dynamic categorisation allowed for a long-term monitoring of 'sleeper clients' ensuring an enduring relationship that could be re-accessed in case of crisis.

Evidence from aged care similarly suggest the importance of this low-intensity enduring case management relationship for providing the security and confidence that can enable independent living (Case Management Working Group, 2006 9).

7.3 Access to specialist supports

This section synthesises five sources of evidence about the role of access to specialist supports, such as substance abuse treatment, in relation to the practice of case management.

7.3.1 Synthesis of the evidence: access to specialist supports

What we know

The two reviews by Vanderplasschen *et al.* on case management with substance-using populations find that there is little evidence on the effectiveness of case management at directly improving treatment outcomes for substance use disorders (Vanderplasschen *et al.*, 2004, Vanderplasschen *et al.*, 2007). They show that case management operates as a comprehensive and practical *facilitator* to increase the effectiveness of particular, specialist interventions such as substance use treatments by increasing engagement and treatment retention. This finding is significant for the synthesis because the negative findings assist in identifying the limits as well as the strengths of case management.

(Vanderplasschen et al., 2004) find that the prerequisites for successful implementation include: integration within the broader service system; accessibility and availability; provision of direct services; a team approach; a strengths-based perspective; and for workers, appropriate training and supervision.

(Vanderplasschen et al., 2007) find there is more significant variation in the outcomes *within* a group than between the different interventions studied. Poorer comparative outcomes were clearly associated with homeless persons and especially those with more severe medical and substance abuse problems. (Morse et al., 2006) similarly found very high intra-group variation in treatment costs, with a large standard deviation in most cost categories.

(Morse et al., 2006) found that integrated substance treatment plus ACT was more cost-effective than either conventional ACT or standard care as it produced better outcomes at no extra cost than standard care. Clients were more satisfied with their

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[21] 'Proper' case management was defined by a particular theoretical model adopted by the policy/program guidelines.

treatment program and reported more days in stable housing. There were no significant differences between treatment groups on psychiatric symptoms and substance use.

Implications

The finding of a high level of intra-group variation highlights the difficulty of the change that case management is deployed to achieve. It implies that the client's starting situation is a significant factor in the achievement of case management outcomes.

Nonetheless case management is able to deliver better outcomes than those achieved without it, because the persistent relationship increases engagement in specialist treatment.

Poorer outcomes for homeless substance users implies that addressing practical needs for shelter and nutrition, for example, improves the effectiveness of the specialist resource. The most consistent outcome of case management for substance-using populations is increased engagement and retention in substance use treatment programs. This is partly due to the relationship, and partly due to the capacity to assist the person with the range of other factors (for example, housing, income and other health needs) that may impede their engagement with substance use treatment.

The evidence in this section demonstrates that multidisciplinary teams are effective and more cost-effective for working with homeless clients that have mental illness and substance use issues. This method is more cost-effective because the in-house expertise requires less service intensity to achieve outcomes, and also reduces cost-shifting onto other services.

7.3.2   The research: access to specialist supports

Vanderplasschen, W., Rapp, R. C., Wolf, J. R. & Broekaert, E. (2004) The Development and Implementation of Case Management for Substance Use Disorders in North America and Europe. *Psychiatric Services,* **55.8: 913-922.**

This implementation-focused review compared case management programs in the United States, the Netherlands and Belgium. The research questions were jointly developed through a workshop at the Third International Symposium on Substance Abuse Treatment and Special Target Groups, Belgium, 2001 and were applied to eighty-nine peer-reviewed publications (1997–2003) about studies with over 100 drug-using participants (Vanderplasschen *et al.*, 2004).

The review finds a number of prerequisites for successful implementation. These include: integration within the broader service system, accessibility and availability, provision of direct services, a team approach, a strengths-based perspective, and for workers, appropriate training and supervision. They find that the following broad principles are almost always used in successfully implemented programs – 'community based, client driven, pragmatic, flexible, anticipatory, culturally sensitive, and offering a single point of contact'.

The findings confirm case management's comprehensive and practical characteristics. They cite five articles agreeing that the impetus for implementing case management was the recognition that many persons needing substance abuse treatment also had additional significant problems. The need for case management was attributed to 'growing complexity of individuals' problems and systems of care'. There was a related change in the understanding of substance use disorders which were 'increasingly becoming recognised as multifaceted, chronic, and relapsing disorders that required a comprehensive and continuous approach' (Vanderplasschen

et al., 2004 913). Some support is provided here for the hierarchy of interventions. Unsurprisingly enough, it seems that people show a greater commitment to treatment if they are receiving practical assistance. This is similarly supported in the evaluations of ACT.

The authors define case management as 'a client-centred strategy to improve coordination and continuity of care, especially for persons who have multiple needs' but they note with dismay:

> Despite its widespread application and popularity, case management is not unanimously defined, and its practice varies from place to place because of diverging objectives, distinct target populations, program and system variables, and other immediate local concerns. (p.913)

They consider studies based broadly on four models for case management of substance use disorders – 'brokerage-generalist model, assertive community treatment-intensive case management, the strengths-based model, and clinical case management' but they note with some frustration that 'most practical examples only vaguely resemble the pure version of a case management model' (Vanderplasschen et al., 2004 915). It is therefore unsurprising that no conclusive findings can be drawn about the comparative effectiveness of one model over another.

To be expected, as in the more recent review, the authors conclude that there is very little categorical evidence on its effectiveness for the substance-using population, citing in particular a dearth of randomised and controlled trials with sufficiently large samples. One study of ACT with a comprehensive approach, assertive outreach and direct counselling showed little impact on drug use, but did show improvements in relation to other risky or anti-social behaviours. Another, much larger study (1,400 compared to 135 in the first) found that intensive case management showed a comparative decline in drug use, criminal involvement and an increase in treatment participation compared to two (unidentified) other interventions (Vanderplasschen et al., 2004 915).

The review discusses some ambiguity in the findings about the role of respect and coercion in case management practice. Coercion has been shown to create an adverse effect in the management of mental illness, yet in the case of substance use a number of studies find coercion is both cost-effective and produces positive client outcomes. Negative consequences of coercion are also cited in the literature including increased risk of burnout among staff and clients becoming completely dependent on the case manager. There is also a contrasting piece of evidence from two studies that used strengths-based case management. Both studies delivered positive outcomes in treatment retention and consequently drug use and criminal involvement. The review reports:

> According to clients, retention was promoted by the client-driven nature of goal setting and was facilitated by case managers' assistance in teaching clients how to set goals. (Vanderplasschen et al., 2004 919)

The importance of respect emerges from these two studies. There is not enough evidence in this review to adjudicate or reconcile what appear to be contradictory implications about the role of respect and coercion in case management.

The impact of the capacity and design of the service system emerge from two specific findings. The review identifies a need for either 'sensitivity' or brokerage funds to deal with capacity-related system barriers, and a need for formal agreements and protocols to ensure recognition of the case manager's authority across disciplinary boundaries.

Without one or both of these strategies, there is a danger that rather than achieving service integration, the practice functions as yet another fragment:

> Case management risks being just one more fragmented piece of the system of services if it is not exquisitely sensitive to potential system-related barriers, such as waiting lists, inconsistent diagnoses, opposing views, and lack of housing and transportation. (p.915)

The case manager's professional expertise, communication skills and patience can help to 'smooth the way,' and give the client an experience of an integrated service system. The case manager can use their sensitivity to system barriers, along with flexibility and creativity, to come up with alternatives when the needed resources are not available. On the other hand, as one study found, access to brokerage funds significantly increased the effectiveness of case management, a finding that has also emerged from the YP[4] case management trial.

The review thus finds that successful case management depends significantly on 'integration within a comprehensive network of services'. It also indicates that case management is dependent on service system capacity since clearly, if needed treatments are not available, then achieving 'treatment retention' will be impossible. Five studies are cited which raise the need for formal protocols and agreements to support the case manager, by establishing their authority and role, consequently facilitating their access to other specialist treatments or resources. This evidence suggests that the service system design and capacity is an influential context which impacts on the effectiveness of case management.

Vanderplasschen, W., Wolf, J., Rapp, R. C. & Broekaert, E. (2007) Effectiveness of different models of case management for substance-abusing populations. *Journal of Psychoactive Drugs,* 39.1: 81-95.

This review analysed forty-six articles with outcome data published in peer-reviewed journals between 1993–2003, after applying selection and anti-bias procedures. Rejecting a strict adherence to randomised controlled trials typical of meta-analytic reviews, these authors also considered pre- and post-evaluations, in other words outcome analysis based on participants' situations before and after the intervention. This choice was at least partly due to the low numbers of randomised controlled trials presently available.[22]

They also sought to establish if any particular *model* of case management was more effective than another. Once again the results were less than compelling.

> Although some studies have shown that this intervention works, it is still unclear what exactly makes this intervention work. (Vanderplasschen et al., 2007 93)

Despite these disappointing conclusions, we can extract a number of useful pieces of evidence for the explanatory model sought by this synthesis.

While many studies showed evidence of positive effects against baseline, in other words, participants' situations improved during the course of the study, these outcomes could not be reliably ascribed to the intervention because there was no control group. The authors found that while some research designs have found benefits including increased treatment retention, stabilisation of problematic life

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[22] Three of the authors are currently involved in a Campbell Collaboration to review the literature and evaluate the effectiveness of case management for people with substance use disorders. Hesse, M., Vanderplasschen, W., Broekaert, E., Fridell, M. & Rapp, R. C. (2007) *Case management for persons with substance use disorders (Protocol)*, Campbell Collaboration. http://www.campbellcollaboration.org/doc-pdf/MortenHesseFinalProtocolCampbell.pdf

situations, improved quality of life and high client satisfaction, subsequent randomised and controlled trials have often failed to provide categorical evidence of comparative effectiveness.

Of methodological interest, the inconclusive findings suggest a poor match between review method and review target. As discussed earlier, the realist's explanatory goal recognises the difficulties of definitive evaluation, the impossibility of 'pure' implementation, including the inevitability of program 'drift', and hence the futility of seeking 'program fidelity.' In a pragmatic, and realistic response, the realist reviewer mines the evidence to build a better understanding of the mechanism. Randomised controlled trials (RCTs) are a valued source of evidence, part of the rich array of knowledge needed to understand how social policy can assist people. But expecting the RCT to provide definitive cause and effect evidence ignores the reality that the object of study – 'the intervention' – is a moving target. For this reason the realist reviewer seeks the anatomy of the mechanism, the bare bones – the mechanism and contexts which make a difference.

Case management did not reliably produce better drug use outcomes – but it consistently produced better treatment retention. This evidence affirms the role of the trust and hope-building relationship which can support the person's capacity to make productive use of assistance resources. Furthermore, evidence from evaluations of strengths-based case management, an approach which puts considerable emphasis on the personal relationship, similarly showed promising results particularly for 'persons with little motivation for change' (Vanderplasschen et al., 2007 91). Three studies showed that a focus on strengths and a good relationship between client and case manager is associated with positive outcomes.

The authors suggest that expecting too much of the intervention might explain the inconclusive or inconsistent results. It was designed, they note, 'to provide ongoing and supportive care to clients and to link them with community resources and existing agencies' (Vanderplasschen et al., 2007 92). Case management in this field, they explain, was always intended as a supplement to drug treatment and the evidence does show beneficial outcomes in stabilising or improving life situations, and increased treatment retention.

Morse, G. A., Calsyn, R. J., Klinkenberg, W. D., Helminiak, T. W., Wolff, N., Drake, R. E., Yonker, R. D., Lama, G., Lemming, M. R. & McCudden, S. (2006) Treating homeless clients with severe mental illness and substance use disorders: Costs and outcomes. *Community Mental Health Journal,* 42.4: 377-404.

This study is selected for the synthesis because it provides further confirmation of the operation of a persistent, reliable relationship (in this case delivered by a multidisciplinary team) to deliver a practical and comprehensive response to the full range of the person's needs. The target of this study (people experiencing homelessness, mental illness and problematic substance use) focused squarely on the hardest to help, people often trapped in chronic homelessness.

This was a longitudinal experimental study of two case management models and standard care control group over two years. The target group was people experiencing homelessness with both severe mental illness and substance use disorder, the so called 'dual diagnosis' clients. The intention was to compare costs and outcomes of three models of service delivery. Participants were randomly assigned to three treatment groups: integrated treatment plus assertive community treatment (IACT), assertive community treatment only (ACTO) and a standard care control group.

The study found that integrated substance treatment plus ACT was the most cost-effective treatment as it produced better outcomes at no extra cost than standard care. Clients in the IACT and ACTO programs were more satisfied with their treatment program and reported more days in stable housing than clients in the control condition. The average total costs associated with the IACT and control conditions were significantly less than the average total costs for the ACTO condition. There were no significant differences between treatment groups on psychiatric symptoms and substance use.

This study was conducted by researchers experienced in the field, and the study is very strong on treatment fidelity. It monitored service delivery and provided training support throughout the study period.

The authors outline the key elements of integrated treatment:

(a) assertive outreach, which is needed to engage many dual disorder individuals into treatment; (b) motivational interventions, which are needed to gradually help individuals who are not committed to abstinence to develop personal goals for substance abuse recovery; (c) a stages-of-treatment approach, which includes the following phases: engagement, persuasion, active treatment, relapse prevention; (d) cognitive behavioural counselling, which helps people develop skills for an abstinent life style; and (e) interventions to strengthen social networks supportive of recovery.

In addition, note the authors, interventions should take a long-term perspective and be culturally competent and comprehensive.

Participants had to be literally homeless, either without shelter or staying in emergency accommodation, have a severe mental illness (defined for the study as schizophrenia, atypical psychosis, bipolar disorder, recurrent major depression, schizo-affective or delusional disorder), have a diagnosable substance use disorder and not be currently engaged in an intensive case management program.

The final sample size was 149, out of 196 eligible people who were randomly assigned to treatment groups. Attrition was due to 19% who refused consent for release of service use data from other agencies, and 12% who were lost to follow-up. Analysis of the attrition group showed significantly more days of alcohol use and fewer days of stable housing than the final sample.

Eighty percent of the final sample were men, and 73% were African American. Participants were recruited by the researchers from a variety of street and service locations, and after preliminary screening were invited (and paid) to attend an eligibility interview. Two-hundred and fifty-eight people were ruled out at this point (and referred to other services) primarily due to not meeting the severe mental illness criterion.

Participants completed a baseline interview, and were then supported to link up to the assigned treatment program. They were subsequently interviewed every month for twenty-four months and received a small financial compensation. They were asked to report on the number of days of seeing staff from their program, days staff talked to them about their substance use, and days living in stable housing. Symptom severity, treatment satisfaction and substance use were assessed using standard self-report scales. The data were aggregated for analysis into five time points (baseline and every six months).

Treatment condition significantly affected program contacts with ACTO exceeding those of IACT, which similarly exceeded those of the control condition. This was an unexpected result and the authors speculate that the lack of substance use expertise

on the case management team led to a higher frequency of contact. Both IACT and ACTO produced more substance abuse treatment contacts than the control, but there was no significant difference between them. And overall the frequency was low, leading the authors to consider that treatment fidelity in the IACT condition was not high enough to produce effects.

Client satisfaction was significantly higher for both IACT and ACTO groups compared to the control, as was number of days in stable housing. There was also an effect of time on housing which was significant in the first year, as all clients generally increased their number of days housed.

Psychiatric symptoms did not vary by treatment, but improved over time as found in other studies. Improvement was most marked in the first six months. Similarly substance use severity decreased over time, mostly in the first six months, while no significant correlation was found with the treatment group.

The study also investigated and compared treatment costs of each group using a comprehensive accounting method consistent with other published studies. It found a large standard deviation in most cost categories. This reflects a high intra-group variation with some clients having low costs and others very high costs.

The IACT condition had the lowest substance abuse treatment costs, indicating the cost-effectiveness of having specialist support incorporated into the case management team.

Overall they found that ACTO was the most expensive treatment, and that IACT and the control group had no significant cost difference. In effect, it was not less expensive to rely on the less expensive 'standard' treatment because people's needs still had to be met, consequently incurring other costs from other providers.

Calsyn, R. J., Klinkenberg, W. D., Morse, G. A. & Lemming, M. R. (2006) Predictors of the working alliance in assertive community treatment. *Community Mental Health Journal,* 42.2: 161-175.

Cunningham, J., Calsyn, R. J., Burger, G. K., Morse, G. A. & Klinkenberg, W. D. (2007) Client Outcomes and the Working Alliance in the Client-Case Manager Relationship: A Causal Analysis. *Care Management Journals,* 8.3: 106.

These two articles report on the same data set as the previous study. Both focus on an analysis of the case management relationship and investigate possible correlations with client outcomes, client characteristics and treatment variables. Both analyses were only able to find modest correlations.

The quality of the relationship was rated by both the client and the case manager at both three months and fifteen months, using a twelve-item version of the Working Alliance Inventory (WAI), originally developed for research into the psychotherapeutic relationship. The instrument measures two dimensions of the relationship: emotional bond and goal collaboration.

The first analysis focused on predictors of the working alliance. They were unable to explain most of the variance in both the client and case manager ratings of the alliance. Increased motivation to change substance use and reduced conflict in relationships did predict the client's rating of the strength of the relationship. However, overall less than 10% of the variation in alliance ratings at fifteen months could be explained by the outcome analysis. Transportation assistance was the only treatment variable correlation with the client's rating of the alliance at fifteen months.

The second analysis investigated causality in the relationship between client outcomes and the working alliance. Previous evidence has been ambiguous about

whether symptom reduction leads to a better working alliance or the other way around. This analysis found a small relationship which was largely reciprocal.

The authors conclude that the WAI may not be an appropriate tool for investigating the case management relationship for people experiencing homelessness, problematic substance use and material disadvantage. Either, they suggest, the relationship is not as significant with this client group, compared to a more affluent group from which the WAI was developed, or the nature of the alliance in case management is not being effectively captured by the instrument. Case management involves a very different set of tasks than psychotherapy, for example advocacy, assistance with daily living and social recreation. The role, they note, can have friend-like characteristics and may be better captured using items from social support inventories. Chapter 6 synthesises a significant body of evidence which confirms these speculations.

7.4 Access to housing resources

This section synthesises eight sources of evidence about the role of housing in facilitating beneficial case management results for people experiencing homelessness.

7.4.1 Synthesis of the evidence: access to housing resources

What we know

The studies in this section provide evidence about the role access to housing plays in generating outcomes for people experiencing homelessness, and how this contextual factor interacts with case management.

(Tsemberis et al., 2004) and (Padgett et al., 2006) contrast a continuum model of supervised accommodation contingent on treatment and sobriety, moving toward independent living, with the approach of providing immediate permanent housing without treatment prerequisites. They find that housing provision that is provided on treatment compliance or abstinence has a lower housing retention rate and does no better at reducing substance use or improving psychiatric symptoms.

(McHugo et al., 2004) find that housing stability outcomes improve if the housing provider shares the goal of maintaining housing for the group of people for whom challenging behaviours and substance use often leads to homelessness, incarceration, poor health and early death. This is particularly important for men because they experience less public tolerance for their behaviours and are consequently at higher risk of severe sanctions such as eviction and arrest (McHugo et al., 2004 979).

Rich and Clark also find a significance of gender in the effectiveness of case management and its sensitivity to contexts. Men did much better in programs that combined housing and support. Men in a combined program increased their time in stable housing by nearly forty days on average more than men in case management alone (Rich and Clark, 2005 77).

Structured social interactions (Rich and Clark, 2005 78) and specialist tenancy management (McHugo et al., 2004 979) were of particular benefit to men.

(Clark and Rich, 2003) find that individuals with a high level of impairment due to psychiatric conditions and/or substance use did more than twice as well in an integrated housing and support program than in case management alone. Housing

outcomes for low-impairment individuals were equally as good with case management only (Clark and Rich, 2003 82).

The findings about the impact of gender and social functioning on case management outcomes correlate with the findings of the impact of symptom severity and substance use on the capacity to form, and benefit from, a case management relationship (Chinman *et al.*, 1999). The gender difference impact recalls the racial differences found in the social interactions and networks of black and white homeless heroin injectors (Bourgois and Schonberg, 2007). Together these studies provide evidence on the importance of social and personal factors.

Nelson *et al.* (2007) show that the provision of housing allows the case management mechanism to generate more housing stability for people experiencing homelessness.

Hurlburt *et al.* (1996) showed that affordability was a significant context that affected case management's ability to generate a housing outcome. For a significant proportion of people, a subsidy along with case management support was enough to secure independent living. For other individuals, particularly men with both mental illness and substance use histories, specialist housing management has distinct advantages.

Implications

The findings imply that the impact of the housing context depends on the characteristics of the person being assisted. Specialist housing provision is particularly effective for people with high levels of impairment. Case management alone will have low success levels. Gender should be considered when designing programs to support social interactions.

The evidence here confirms earlier implications that relationship development is not easy. Hindering factors include the severity of psychiatric symptoms and substance use, lack of education and social supports, and longer experiences of homelessness. People's interpersonal capacities and strengths have gender, racial and ethnic dimensions and the development of a case management relationship is affected by these differences.

The key policy implication is that case management and housing interventions will be more effective when combined if the person has a severity of disability due to psychiatric symptoms or substance use.

McHugo *et al.*'s (2004) study is useful for the synthesis particularly because it appears at first to contradict the Housing First study findings. In fact, the evidence from this study underlines that housing provision for people with challenging behaviours is itself a specialist service. Integration of this evidence builds a more complex picture of what is going on. The integrated model represents a housing provider with a commitment to housing people who have experienced homelessness and may need a complex service response to maintain their health and housing. This conclusion is supported by the approach taken by Housing First and is most likely a factor in their demonstrated higher housing stability outcomes.

The comparison of integrated and parallel housing and support provision confirms the principle of relationship that became apparent in the studies of ACT and dual diagnosis case management approaches (Section 7.2 Enough time, varying intensity and comprehensive, practical support). That evidence showed that specialist assistance, for example for mental health, problematic substance use and vocational support is more effective and more cost-effective when there is a specialist worker integrated within the case management team. Treatment participation and engagement is higher.

In this case, the integration of tenancy management with the case management support component of the response produces a better outcome.

The comparison of two models of housing provision demonstrates the way the housing context can conflict with the case management mechanism dimension of *respect and social solidarity.* Case management cannot provide a relationship of respect that supports client-directed goals if a key aspect of the context, namely provision of resources and specialist support at the right time, is contingent on restrictions in consumer choices such as abstinence, curfew and social isolation.

The Housing First evidence also affirms the importance of a relationship demonstrating respect as high levels of consumer choice favorably affect housing stability outcomes. It is the approach to the integration of housing and case management that makes the difference.

Studies of the service user perspective show that the ability to help someone work on their level of self-care depends on a relationship of respect (Sections 5.3 and 5.4). The Housing First studies show that when this respect is also demonstrated in the approach to housing provision, client outcomes are improved.

7.4.2   The research: access to housing resources

Nelson, G., Aubry, T. & Lafrance, A. (2007) A review of the literature on the effectiveness of housing and support, assertive community treatment, and intensive case management interventions for persons with mental illness who have been homeless. *American Journal of Orthopsychiatry,* 77.3: 350-361.

This article reviewed sixteen outcome evaluations of housing and support interventions for people who experience homelessness and a severe mental illness. It found that housing outcome effects were highest in programs that included housing and support. Case management alone was not as effective as case management (or other forms of support) combined with some kind of permanent housing.

Studies were selected on the basis of publication in a peer-reviewed journal, empirical quantitative study design with a comparison or control group, focusing on documented housing and support, ACT and/or ICM programs, and people with mental illness and a history of homelessness. All of the selected studies were conducted in the United States.

All the studies included a measure of housing outcome, typically either a proportion of the sample housed at follow-up, or days housed during a given period. Housing outcome measures were used to calculate the effect size for the experimental condition, which was corrected to avoid any upward bias from small samples. Other psychosocial or mental health outcomes could not be meaningfully compared across the studies due to the wide variety of measures and domains.

Ten controlled evaluations of housing and support were reviewed, with decent longitudinal domains. Only one study had a follow-up period of less than a year, and five covered a period of two or more years. The overall effect size for the housing intervention conditions was 0.67 (0.8 and above is considered a large effect size) (Nelson et al., 2007 358).

Two of these studies which directly compare case management alone with housing and case management are considered in more depth below. Of the other results, it is worth noting that short-term residential programs reported no positive effect on housing outcome (pp.353–4), and only one of nine studies that examined psychiatric symptom outcomes found any effect from the housing intervention (p.354).

The review also considered research into the effects of ACT and ICM without associated housing provision. Details relevant to this synthesis from these case management evaluations have been extracted directly from the important studies in the section on allied sectors.

A number of familiar caveats limit the usefulness of this kind of review, chiefly the wide variety of models and definitions of case management, especially in practice, which obstructs clear attribution of cause and inhibits cross-study comparison of effects.

Nonetheless, it was possible to find that all the studies of ACT showed better housing outcomes compared to the control condition, although with a lower overall effect size than the combined housing and support programs (0.47 compared to 0.67). Two of the four studies of ICM found the intervention produced better housing outcomes than the control, although once again producing a lower effect size (0.28).

While the review findings are clearly in favour of combined housing and support programs, the authors caution that no study has directly compared ACT alone (proven to increase housing stability) with permanent housing and support, implying that the latter may not be as strikingly more effective in such a comparison. From a realist perspective, such concern is not particularly useful and reflects a futile search for the 'best' intervention. Of more interest is to refine our understanding of why each program works in order to facilitate appropriate tailoring of interventions to local circumstances and priorities.

In addition it must be acknowledged that the ACT model has thoroughly influenced community mental health case management practice. Thus, while a pure model comparison may not have occurred, the Hurlburt *et al.* study, for example, reviewed by Nelson *et al.* and examined below, tested a case management program with the key elements of assertive community treatment.

This review article confirms that housing provision is a crucial element in achieving improvements for people with severe mental illness and a history of homelessness. Next we take a closer look at two of the reviewed studies which directly compared permanent housing and case management with case management alone, along with other research to get more detail about why, for whom, and what type of housing makes case management work.

Hurlburt, M. S., Wood, P. A. & Hough, R. L. (1996) Providing independent housing for the homeless mentally ill: a novel approach to evaluating long-term longitudinal housing patterns. *Journal of Community Psychology,* 24.3: 291-310.

This study used a randomised longitudinal experimental design to test a response to people experiencing severe mental illness and homelessness based on primary assistance to access independent housing alongside non-compulsory community mental health case management.

This study found that access to housing was the most significant factor in producing housing outcomes. The success of people with severe mental illness at managing to quickly secure and then maintain independent housing challenged the assumption that mental illness prevents people from living independently. This evidence vindicated the approach of providing independent housing which is not linked to mental health treatment compliance, and allowing clients to control their level of contact with case management services.

A more recent variation of this approach called Housing First has subsequently been applied and evaluated for homeless people with both mental illness and substance use issues, as we review below.

The study ran over two years and 362 people (of 466 referred from a range of community sources) were eligible and agreed to participate at baseline. The design varied two conditions: the type of assistance to access housing and the intensity of case management (standard and intensive). Half of the group received subsidised housing access through a federal government subsidy program that issues certificates to low-income people so they can chose independent private accommodation (Section 8). The group was evenly divided and randomly assigned to each of the four possible experimental conditions, thus each group had ninety or ninety-one participants.

Participants had to be diagnosed with a severe and persistent mental illness and be either currently homeless or at risk. In the two months before the baseline interview, 64% had spent more than one week on the streets or in shelters, and the remaining participants either had no stable home of their own or had spent extensive recent time in a psychiatric facility. Participants were excluded on the basis of risk of harm to themselves or others, some types of criminal history, and some for substance use. Housing authorities required that participants with a history of illegal drug use were actively committed to sobriety. The researchers note that the selection criteria did exclude some of the most difficult and dangerous individuals from the study.

The Section 8 certificate application process is considerably bureaucratic and for this study some of the processes were streamlined and tailored toward people with severe mental illness. For example, a single specialist housing worker processed the application and explained the requirements. Participants received close support from their case manager. Despite these precautions, not all of the participants assigned to this condition were able to secure the certificate.

The intensive case management condition in this study resembles the principles of assertive community treatment. In comparison to the standard county service, the intensive case managers had smaller case loads (twenty-two versus forty), were better paid, used a formal team approach, and provided 24/7 support focused on practical matters including entitlements, housing and employment.

Case managers collected information about their clients' housing situations every thirty days, and this was collated to create bi-monthly data points. The researchers also conducted four independent interviews following the baseline, one every six months during the study. The study used three measures to investigate the effect on housing outcomes: type of housing secured; stability of housing (maintenance of living arrangements over time); and the amount of time taken to secure stable independent housing.

The value of this study is the attention to the details of living arrangements which provides a valuable level of detail to the picture since most studies measure housing outcomes with a simple numerical measure such as 'days stably housed.'

The data was analysed using statistical processes to investigate correlations between and within the groups. At first, a survival analysis was used to investigate what influenced the length of time it took to achieve housing consistency (defined as the first two-month interval at which a person was then consistently housed in some type of housing for more than 95% of the rest of the study period). Gender was the only significant factor, with women achieving consistent housing almost six months earlier than men, while neither of the experimental variables affected the results. Finding no significant result, the researchers realised that the consistency definition concealed much of the possible variation in living arrangements. This interim finding highlights a

risk for program and policy evaluations. Adopting the wrong outcome measure can conceal important distinctions within outcome patterns that would otherwise explain sustainability and effectiveness.

Subsequently the researchers identified a set of six housing outcomes based on distinct patterns in people's living arrangements. The second round of analysis based on this set of housing patterns found that access to Section 8 was significantly associated with housing outcomes and found no strong correlation with either type of case management.

Overall 57% of Section 8 participants achieved independent housing, about double the rate of those without (30%). The Section 8 also strongly influenced the time it took to achieve independent housing. This group was more than eight times more likely to achieve independent housing in the first six months.

While the Section 8 condition did not strongly affect the proportion of clients finding any sort of stable living arrangements, it made a significant difference to securing independent rather than community housing. Within the group who achieved stable living arrangements, those with Section 8 certificates were more than seven times more likely to achieve this in independent rather than community housing.

Alongside this striking increase in the proportion of people with severe mental illness who could quickly secure and maintain independent housing, there remained over 40% of the group with Section 8 subsidised access who did not. Nineteen percent were known not to have achieved stable housing of any sort, and a small group disengaged from the study.

Tsemberis, S. (1999) From streets to homes: an innovative approach to supported housing for homeless adults with psychiatric disabilities. *Journal of Community Psychology,* **27.2: 225-241.**

This article compares retention rates in two different housing programs designed to meet the needs of people experiencing homelessness and mental illness. It finds that immediate access to permanent housing with non-compulsory support achieved more than 80% retention over three years, while the standard treatment-contingent program achieved less than 60% retention over two years (Tsemberis, 1999 231-2).

Features of the immediate permanent housing program include scattered apartments (no more than 10% of any building) which are assigned on a first come, first served basis. Participants were involved in choosing their own apartments, and enjoy standard tenancy rights. Support and treatment agencies have no relationship with the landlords. Assertive community treatment teams provide services in the community, including practical outreach support and monitoring with a harm minimisation approach, including money management if necessary (for more detail, see the other ACT studies). Another key feature of the program is to ensure that tenants do not lose their accommodation in the case of hospitalisation and/or psychiatric or substance use relapse.

The standard approach comes from a mental health treatment paradigm and views accommodation as part of a therapeutic response. Clients are monitored and moved through a continuum of supported living situations stretching from hospitalisation to independent housing, as they are judged to be ready. Treatment compliance, abstinence from substance use, and therapeutic outcomes govern the progression which is accompanied by increasing personal freedom and reduced staff supervision. Implicit in this model is an assumption that people with mental illness must be 'housing ready' before they are placed in permanent independent accommodation, and 'housing readiness' is best determined clinically.

The immediate housing program sample consisted of 139 adult tenants; nearly three-quarters were male, and 42% were referred directly from the streets. Nearly half were diagnosed with schizophrenia and over 60% had a co-occurring substance abuse disorder. After a period of thirty months, 84.2% of the original sample remained housed.

The standard treatment sample included 3,811 people who were placed between 1992 and 1996 in a variety of residential treatment settings in New York. All had been homeless at one time; 40% were referred from psychiatric hospitals but none from the streets. To calculate the housing stabilisation rate, residents who had moved between different settings within the program were counted as continuously housed. At the beginning of 1995, 2,864 individuals were housed in various settings while 1,707 remained housed at the end of 1996. This generated a retention rate of 59.6% over the two-year period.

The study design means that the two groups were not matched, nor was there any control for pre-program differences. The sample groups were broadly similar; however, they differed in two respects: the immediate housing group had a higher proportion of dual diagnosis and a majority of participants who were not engaged in any treatment at the time of intake. These characteristics could imply more difficulty adapting to independent living, and therefore strengthen the significance of the comparatively higher retention rate.

Tsemberis raises a number of features of the standard approach that may have caused the differences in housing retention rates. First, it radically reduces consumer choice and self-determination. For example, when asked, consumers prefer to live independently. The contrast between street independence and the restrictive structures of a group residential program may cause a person to return to homelessness. Similarly, there is a coercive element and a potential abuse of power when accommodation security is predicated on treatment participation. Second, psychiatric rehabilitation research shows that skills learnt in one setting are not necessarily transferable. Learning to live with fifteen other patients may be of little help for living in a mainstream neighbourhood. Finally, the gradual reduction of support inadvertently leaves the person with the least support at arguably the most stressful time, i.e. moving to independent living.

Tsemberis, S., Gulcur, L. & Nakae, M. (2004) Housing First, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health,* 94.4: 651-656.

Padgett, D. K., Gulcur, L. & Tsemberis, S. (2006) Housing First services for people who are homeless with co-occurring serious mental illness and substance abuse. *Research on Social Work Practice,* 16.1: 74-83.

These two articles report on the same randomised longitudinal study which followed 225 adults over four years. The first article reports on the outcomes at twenty-four months, and the second at forty-eight months.

The New York Housing Study was part of a federally funded national demonstration project over eight sites. The study began in 1996 and was the first randomised experiment comparing housing-first and treatment-first approaches. Both articles found that neither severe mental illness nor substance use precludes formerly homeless people from maintaining housing. They provide a rigorous evidence base to support the claim that access to housing should be provided without requirements for either mental health treatment compliance or abstinence.

Participants in the study had spent fifteen of the last thirty days on the street or in other public places, had a history of homelessness over the last six months and an Axis I diagnosis of severe mental illness. In addition, though not a criterion for inclusion in the study, 90% of participants had a history or diagnosis of alcohol or other drug disorders. The Housing First program did not exclude people for criminal history or violent behaviours.

Participants were randomly assigned to two different housing programs. After some administrative difficulties, the final sample was eighty-seven people in the Housing First group and 119 in the control (intentionally oversampled to allow for expected higher attrition rates).

Housing First tenants were provided with services from interdisciplinary ACT teams (assessed for fidelity and found to be satisfactory in a separately published report). The team included social workers, psychiatrists, vocational trainers, substance abuse counsellors, with the added modification of a nurse practitioner and a housing specialist. Housing and support are closely linked but distinct. Two additional conditions are strongly encouraged – participation in a money management program including payment of 30% of income in rent, and meeting with a staff member at least twice a month.

There were no significant demographic differences between the two groups at baseline. The total sample was nearly 80% men. Half the group were diagnosed with a psychotic disorder, and half were staying on the streets or public spaces at intake. The randomly assigned groups were demographically equivalent, as were the attrition group, and none of the demographic variables were correlated with outcomes.

Participants were interviewed every six months and were paid for their participation. A short phone call was made between interviews to maintain contact. After the first twenty-four months, the study retention rate was at 78% which provided more than adequate sample size for statistical power. Data was collected on residential stability, drug and alcohol use, substance abuse treatment use and psychiatric symptoms using standard or modified, validated measures.

At twenty-four months there was a clear finding that the Housing First group reduced their homelessness significantly faster. They spent less time homeless and more time stably housed than the control group at each of the time points. Additionally, after two years, 80% of the original participants were still housed.

The groups did not differ significantly in substance use or psychiatric symptoms. However, the control group reported significantly higher use of substance abuse treatment services, increasing over time, while the Housing First group reported a decrease in service use.

The Housing First group also consistently perceived their level of choice to be higher than those in the control group. It is notable that both groups reported the same level of choice when asked what level *they would like to have,* at baseline.

Treatment-first clients reported comparable levels of alcohol and substance use while using higher levels of substance use and psychiatric treatment services. Under-reporting of substance use is extremely likely, but more likely in the case of treatment-first participants because of the potential for adverse consequences. The potential under-reporting bias therefore simply underscores the finding that coercive treatment programs are not more effective at reducing substance use despite more treatment service provision.

It is worth noting that the analysis compared only clients who could be considered housed at any given time point, hence the sample size varied dramatically as people

were excluded if they were institutionalised, incarcerated, in shelters or on the streets. A conservative significance threshold was used to correct for the multiple group comparisons.

The authors also speculate that the mismatch between use of treatment programs and level of substance use may imply that people in the control group were using drug treatment as short-term housing.

The findings at four years extend and confirm the findings from twenty-four months (Padgett et al., 2006 79-80). A retention rate of 87% was achieved over the four years. No significant differences were found between the groups in either alcohol or other drug use, though there appeared to be a small trend for Housing First participants to use less alcohol. Housing First participants had significantly higher housing stability rates. While this article focused on comparing the level of substance use and treatment utilisation, it also reports briefly on comparative housing stability at the end of the four-year study: in the previous six months, Housing First clients were stably housed 75% of the time compared to 50% of the treatment-first clients.

Coercion is a feature in the provision of housing through treatment-first approaches which require some form of treatment compliance or abstinence to secure or maintain independent housing. This approach is contrasted and challenged by the consumer-led movement toward housing-first models for people experiencing homelessness, mental illness and serious substance use. In the Housing First model, respect is built into the program assumptions:

> …if individuals with psychiatric symptoms can survive on the streets then they can manage their own apartments.(Tsemberis et al., 2004 652)

McHugo, G. J., Bebout, R. R., Harris, M., Cleghorn, S., Herring, G., Xie, H. Y., Becker, D. & Drake, R. E. (2004) A Randomized controlled trial of integrated versus parallel housing services for homeless adults with severe mental illness. *Schizophrenia Bulletin,* **30.4: 969-982.**

This randomised controlled trial contrasted two models of housing and support and tracked the outcomes for 121 people over eighteen months. It reveals important nuances about the influence of the housing context in generating the effectiveness of case management. It is not only the provision of housing which is important, but also the interaction between the support and the housing management.

The study compared a program of parallel housing and support with an integrated program in which support providers had some control over housing stock. They found that participants in the integrated housing services group experienced less time homeless and reduced psychiatric symptom severity. Parallel housing services did not generate any compensatory benefits through greater consumer satisfaction.

This study also found evidence of how social stigmatisation creates and constrains the outcomes case management seeks to achieve. It found that men did significantly worse in the parallel housing program than women primarily because they tended to exhibit challenging behaviours that were less tolerated by private landlords.

This study contrasts two approaches that they define as *parallel* and *integrated* housing services provided in Washington, DC. The parallel model consisted of ACT case management which included practical assistance to find independent housing but whose workers had no control over housing stock. The integrated model provided a model of clinical case management and housing services though a team who also controlled a variety of housing options. Case management in both programs was classified as intensive, with caseloads of about fifteen; the primary difference was the

ACT team approach. A process evaluation assessed program fidelity on both housing and case management dimensions during the study period.

The two approaches are related to the polarity described by Tsemberis (1999) as the Housing First versus the linear residential treatment model. These authors note that in practice, hybrid models have become common now with a range of variation in philosophy and operation. Their study design is based on differences in the relationship between the housing and the mental health services, and defines the two approaches using the following dimensions:

→ Housing control – whether a mental health provider owns or leases the property

→ Housing integration – whether the housing is segregated from the mainstream community (for example, an apartment block rented predominantly to mental health clients)

→ Landlord's decisions – whether the tenancy is contingent on treatment participation

→ Live-in support staff – if there were any.

Three other aspects were measured: the level of consumer involvement in decision-making about services provided; community-based service provision (outreach rather than clinical settings); and the level of twenty-four-hour service availability.

Housing program fidelity was assessed at six-monthly intervals and confirmed that the models maintained their distinctions in the first three defined dimensions. Both programs provided similar levels of live-in staff and community-based services, and were comparable on consumer preference for services and twenty-four-hour availability.

Case management services were relatively similar; both programs scored equally on average using a validated tool for measuring ACT fidelity, although they differed in some details.[23] While the ACT program model is explicitly designed to provide the comprehensive support needed to maintain independent housing, it was found to be less effective in this comparison with the integrated program. The authors note a number of possible explanations including the relative inexperience in the parallel program team; however, they lacked the process data to evaluate these influences. Again, the complexity of social service provision confounds the straightforward evaluation of cause and effect, even with a sophisticated approach to program fidelity and study design. This ambiguity is expected by the realist approach, and justifies the synthesis method of theory-driven review to increase our understanding of why case management works.

A total of 121 participants were randomly assigned to one of the two programs (sixty parallel / sixty-one integrated). Just over half the participants were women, and over 80% were African-American. At the study's commencement, 85% were homeless. Substance use was assessed during screening and controlled for in the randomisation so that both groups had an equal proportion of participants with a substance use disorder. Participants were followed up at six, twelve and eighteen months to determine their housing situation and how satisfied they were with it. Levels of psychiatric symptoms, substance abuse, victimisation and quality of life were also measured using validated psychometric scales.

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[23] The integrated program scored higher on individualised substance abuse treatment and dual disorder treatment groups, while the parallel team rated higher on team approach, and having a psychiatrist, nurse and vocational specialist on staff.

Criteria for the study included enrolment in the local mental health service system, diagnosis and history of a severe mental illness (roughly two-thirds had schizophrenia spectrum disorder, and just under a third with a mood disorder), risk of homelessness due to previous episodes or residing in precarious housing, and ability to participate in the research interview and to give informed consent.

The study retained nearly 85% of participants. The nineteen people who dropped out had significantly different housing histories from the remaining participants. They had spent more time homeless during their lifetime and less time in stable housing during the previous six months. More people dropped out of the parallel housing program (20% compared to 11.5%). The post-attrition groups remained comparable.

Overall the study found that the integrated housing services model delivered better outcomes, and the parallel housing services model had no additional benefits to compensate.

While participants in both groups reduced the amount of time spent homeless and increased the number of days in stable housing, the integrated housing services showed a consistently higher proportion in stable housing at each time point. In the table presenting the mean proportion of time in different housing categories, the integrated housing services group also shows a comparatively higher rate of change from six to eighteen months.

The second key finding was that outcomes were significantly influenced by the interaction of gender and program type. Men in the parallel housing program spent significantly less time in stable housing and reported lower general life satisfaction than the women in that program. The women had equivalent outcomes to the integrated housing services group where there was no gender difference.

McHugo *et al.* draw the conclusion that the most important principle is shared goals between housing and support providers.

> Private landlords or independent housing programs have no strong incentive to find a solution that is in the consumer's best interest when less problematic tenants are available, whereas an integrated team bears a long-term responsibility for the consumer, before and after disruptive episodes.(McHugo et al., 2004 979)

This conclusion lends further weight to the importance of reliability and persistence in case management. It is increasingly recognised that homelessness for the majority of people is a cyclical experience (Robinson, 2003, Johnson *et al.*, 2008 , Chamberlain *et al.*, 2007). We know that both mental illness and problematic substance use have a cyclical intensity, and also that people tend to develop such issues the longer they experience homelessness, leading to greater risk of chronic or long-term homelessness. In addition, just the ongoing financial vulnerability caused by low or unstable income opportunities, similarly tends toward the possibility of multiple experiences of homelessness.

Service use data was collected for the previous two weeks at each assessment point and aggregated into medical and dental care, alcohol and drug use, psychiatric services and other services. There were no significant differences between the two programs in service use. Participants in both programs increased the proportion of days in their own apartment and a reduction in institutional stays, with no significant difference. There were also no significant differences for exposure to violence, or reported days of drug or alcohol use. Satisfaction with housing and the neighbourhood was similar across both groups for those in stable housing, as it was across the smaller proportion of both groups in their own apartments.

Further analysis of the type of housing situation for those in stable housing did not reveal anything useful. It showed that the proportion of people placed in independent apartments was similar, but the integrated program had placed more people in group homes and the parallel program had a higher proportion in single-room occupancy accommodation. Without information about the comparative availability of housing stock, it is not clear if this is a program effect, a housing stock availability effect or a within-group variation effect (matching the right accommodation to the person's needs).

Once again there is no one-size-fits-all, and a high within-group variation indicates the importance of the relationship mechanism. Case management works because it can deliver a personalised service response through a collaborative engagement with the person's own goals, and this above all, generates the outcome of the person requiring less assistance.

Clark, C. & Rich, A. R. (2003) Outcomes of homeless adults with mental illness in a housing program and in case management only. *Psychiatric Services,* 54.1: 78-83.

Rich, A. R. & Clark, C. (2005) Gender differences in response to homelessness services. *Evaluation and Program Planning,* 28.1: 69-81.

These two articles report on the same study which compared the effectiveness of two types of homeless service programs over twelve months. One program included guaranteed access to housing along with support, while the other provided only specialised outreach and case management.

The first article reported that highly impaired individuals did substantially better in the comprehensive housing program than those assigned to the specialised case management program. Persons with low and medium symptom severity did equally well in either program (Clark and Rich, 2003 82). The second article found that men, in particular, experienced better stable housing outcomes within the comprehensive housing program (Rich and Clark, 2005 75).

The study used a quasi-experimental (non-random) design to compare outcomes for people participating in each program. Clients entering the programs over the period December 1997 to April 1999 were asked if they wished to participate in the study. Data was collected at the time of recruitment and then followed up six and eight months later.

The groups were not equivalent and consequently the analysis allocated participants to high-, medium- and low-impairment subgroups, based on psychiatric symptoms and degree of alcohol and illegal drug use.

In total 152 people completed the baseline interview, eighty-three from the comprehensive housing programs and sixty-nine from the case management-only program. Ninety-one per cent had a previous history of homelessness, and the participant group was predominantly white (77%). This racial composition is not characteristic of people experiencing homelessness in the United States and reflects instead the particular demographics of the west coast of Florida. About half of all participants had a primary diagnosis of a psychotic disorder, and mood disorders accounted for another 45%. About half also had a secondary diagnosis of a substance use disorder. The comparison groups differed demographically in only one significant respect: more people in the case management-only group had been homeless more than once (78% compared to 62%).

Housing situation data was obtained using a follow-back calendar method to collect information about a person's movements in and out of different living situations and

reasons why. Validated retrospective, self-report tools were used to collect information about substance use, psychiatric symptoms, unmet service need, quality of life and health. Participants also completed the Working Alliance Inventory to give a measure of the quality of the case management relationship.

The comprehensive housing program (delivered by two agencies but considered as one condition for the purpose of this study) included guaranteed access to housing, housing support services and case management, while the specialised case management included active outreach, medication management, assistance with obtaining housing, and linkages to other services.

The typical duration of case management support was a key difference between the two programs, noted by the researchers but not factored into their analysis. The case management-only program was designed to be used for six months, and had an average duration of ninety days. The comprehensive housing program, in contrast, offered case management for as long as the consumer had a need, and most participants received this support for the duration of the study.

Program fidelity was established and monitored during the study. The comprehensive housing program model was documented at the outset and used to rate the provider agencies during the data collection period. The model included the following components: guaranteed access to housing, housing-related support services, active linkages to other services and resources, a supportive organisational climate, and strong staff–consumer relationships. Each component was operationalised through objective criteria and rated using multiple data sources in order to check program fidelity across the three providers.

At the midpoint of the study both comprehensive housing programs showed a high degree of fidelity to the model. The case management-only program was found to share a similar organisational culture, adding credibility to the claim that any outcome differences related to the housing component. This claim is weakened by the difference in support duration between the two case management models, since the evidence shows the critical impact of support duration on the functioning of the case management mechanism (the relationship). However, this point does not compromise the finding of a within-program difference between men's and women's outcomes.

The research deployed a random regression model to track changes over time for individuals, and for the population as a whole. Due to the number of participants who lacked data for one of the time points, the follow-up assessments were combined to increase the statistical power of the analysis. Those who completed two interviews had their scores averaged. In this combined analysis, 108 people completed at least one follow-up interview, giving a retention rate of 83% for the comprehensive program, and 56% for the case management-only group.

The study design was not randomised; however, the research used statistical tools to compensate for any recruitment bias. Analysis of the two groups showed that the group who received case management only was significantly more impaired at baseline on both psychiatric symptoms and substance use measures. Consequently, regression analysis was used to assign each participant a score that represented their level of impairment based on a combination of these factors. Impairment was categorised as high, medium and low, so that the analysis could identify any differential effect of the experimental conditions on these subgroups of participants.

The attrition rate was strikingly different between the groups. The case management-only group, which was a time-limited program, had sixty-nine, thirty-three and twenty-five participants respectively at the three time points, while the comprehensive housing program had eighty-three, sixty-six and sixty-three participants over time.

Attrition analysis showed that people who dropped out did not differ significantly from those who stayed on any demographic variable, or on impairment, suggesting that the program group was a factor.

While study engagement and treatment engagement are quite distinct, it is reasonable to infer that that the shorter support duration contributed to reduced stable housing outcomes, also making research follow-up a more difficult task. And conversely, it is likely greater satisfaction with housing outcomes would support continued research participation.

The subsequent outcome analysis showed a very strong effect of program type on housing outcomes, stratified by the impairment subgroups. Both groups also showed improvements in symptom severity and substance use over time, but these outcomes were not linked to either program type or impairment.

Housing outcomes were moderated by the level of psychiatric symptoms and substance use interacting differentially with the program type. Low-impairment individuals in the case management-only program increased their days of stable housing by an average of 109 days over a 180-day period, while high-impairment participants in the same program showed only fifty-two days increase on average. In sharp contrast, high-impairment individuals in the comprehensive housing program had an average increase of 106 days, more than double their case management-only counterparts.

The second article reports on a gender analysis of the same data set and provides new information for the synthesis about the differential importance of social interaction support.

Men in the comprehensive housing program increased their time in stable housing by an average of around seventy-six days compared to thirty-seven days for those in the case management-only program (Rich and Clark, 2005 77). This is considered a moderate effect size. Women on the other hand, experienced comparable reductions in homelessness across both programs, although the specialised case management group showed significantly greater improvements in stable housing.

Further analysis of the women's data revealed that the difference in stable housing between the groups was generated by more time spent in psychiatric hospitals. Despite no difference in the symptom severity measure, twelve women in the comprehensive housing program compared to one in the case management-only program experienced a psychiatric hospital stay. The authors suggest that the closer case management contact characteristic of the housing program, coupled with assumptions of women's vulnerability, may have contributed to the higher hospitalisation rate.

Hospitalisation time was not counted as stable housing even if the person came and returned from stable housing. In contrast, if the person entered and exited from homelessness, the entire period of time was counted as functional homelessness. Thus the increased stable housing result is partly an artefact of the data interpretation.

To clarify the between-gender result, the researchers investigated a number of other possible influences but found no significant correlations. The impairment scores reported in the previous article showed no association with the gender differences. Using the Working Alliance Inventory measure and the unmet needs measure, they ruled out differential staff practices. Changes in income over time, and absolute income levels were also investigated, since these are known to vary with gender, but no interaction was found.

Consequently, the authors suggest that differences in male and female social functioning may be a cause of this result. In this study, the comprehensive housing program participants had regular, close contact with their case manager, and informal social contact with other residents in the program. Case history interviews anecdotally demonstrate that men valued the semi-structured social support, for example a weekly 'potluck' dinner. Men in the case management only program did not have these opportunities (Rich and Clark, 2005 78). Inversely, the authors cite some evidence that this kind of support might be less relevant for women, since homeless women tend to generate and/or maintain social connections more than men.

The research by Rich and Clark is of particular interest for Australian homeless persons agencies because the model of case management tested in this study is close to the existing SAAP program guidelines. Where this model of case management is provided without linked access to housing, particularly for men or persons with high impairment due to mental illness or substance use, we can expect that it will be significantly less effective at increasing stable housing.

8 CONTEXT TWO: THE SKILLS AND SUPPORT NEEDED FOR CASE MANAGERS

This chapter synthesises ten sources of evidence that directly establish the skills and support needed for case managers. The evidence here is supported by the research synthesis presented in Chapter 5 which establishes that the relationship between the case manager and the client is the mechanism of case management.

8.1 Synthesis of the evidence: case manager skills and support

What we know

Section 8.2 Advanced communication and relationship skills identifies a high level of skill required for case managers, confirms the evidence that the relationship is the case management mechanism, and implies the need for commensurate recognition and remuneration of staff.

Section 8.3 Staff supervision and support shows that the emotional complexity of the case management mechanism entails supervision and support for staff. This enables staff to mobilise the potentially therapeutic aspects of the relationship while protecting them from professional burnout.

The evidence presented in this chapter confirms the findings about the processes leading to an increase in a person's self-care capacity in *Section 6.2 Increasing a person's self-care capacity.* This implies a strong link between the staffing context and the capacity of case management to facilitate developmental change for the client.

Implications

Synthesis of the evidence in this chapter shows that high levels of skills and support are needed for the case management relationship to function effectively.

Staff supervision and support can be provided to reduce negative consequences including client humiliation and worker burnout. These implications are also inferred by the practice risks identified in Chapter 5.

A significant implication is that staff need to be recognised and remunerated for these skills.

8.2 Advanced communication and relationship skills

This section synthesises seven sources of evidence relating to the interpersonal skills required of case managers so they can effectively mobilise the relationship mechanism.

8.2.1 Synthesis of the evidence: advanced communication and relationship skills

What we know

Essock *et al.* find that the quality of staff skills was more important than the model of case management in a randomised controlled longitudinal comparative study (Essock *et al.*, 2006).

Allen *et al.*'s qualitative study of service providers in an Australian trial of 'joined up' service delivery for homeless young people documented an extensive range of relationship and communication skills required for the case managers (Allen, 2003).

(Greene et al., 2006) provide evidence from the perspective of the mental health 'recovery paradigm' about the importance of skilled communication and relationship management (also see (Mead and Copeland, 2000)). The evidence documents the subtlety required to develop and support the aspirations of case management clients, particularly their sense of hope. It demonstrates the skills required to operationalise respect in case management practice.

(Arnold et al., 2007) provide a qualitative study of strengths-based case management demonstrating the way it provides a responsive tailoring of interventions using the assessment and relationship skills of the case manager. This study highlights the profound impact of poverty on the ability to develop hope and motivation, indicating the external challenges to case management's potential to generate an increase in the person's self-care capacity.

(Juhila, 2007)'s study of service provision in a homeless women's shelter finds that staff used a sophisticated and dynamic range of relationship styles to gain the trust of the women and consequently to provide directive or therapeutic interventions.

Rigby and Longford document the complex and sophisticated emotional work involved in assisting people with personality disorders. For example, they find that training must address 'the biggest problem in clinical practice, which is how to 'be' with patients; how to manage one's own anxieties, and how to help patients safely to be in contact with their anxieties' (Rigby and Longford, 2004 337).

O'Connor finds that people experiencing chronic homelessness can benefit from a persistent and reliable psychotherapeutic relationship. The communication and relationship skills required by psychotherapy are indicative of the advanced skill level demanded of the case manager working with the chronically homeless. O'Connor finds that the combination of practical and emotional needs typical in this client group presents a significant challenge, and requires strong support for staff (O'Connor, 2005).

Implications

The combination of a respectful relationship and the skills identified in this section implies that case management *creates the conditions* in which a person can develop their self-care capacity, rather than generating or forcing change. An anecdote from the field of personal care related during a practitioner interview describes this subtle and skilled intervention which is not a rescue mission: it takes considerable restraint to allow a person to struggle to put on their own socks over a period of many minutes, when you could do it for them in no time at all.

The high level of skill required for case managers, documented in this evidence base, and implied by the evidence of the relationship mechanism, implies the need for commensurate recognition and remuneration.

8.2.2   The research: advanced communication and relationship skills

Essock, S. M., Mueser, K. T., Drake, R. E., Covell, N. H., McHugo, G. J., Frisman, L. K., Kontos, N. J., Jackson, C. T., Townsend, F. & Swain, K. (2006) Comparison of ACT and Standard Case Management for Delivering Integrated Treatment for Co-occurring Disorders. *Psychiatric Services,* **57.2: 185-196.**

This randomised controlled longitudinal study compared two models of case management for delivering integrated treatment to people with mental illness and a co-occurring substance use disorder. The key finding was that the quality of skills in the treatment staff was more important than the model of case management.

People eligible for the study had a major psychotic disorder, an active substance use disorder, a high level of service use in the last two years, and were homeless or unstably housed with poor independent living skills.

Study participants were enrolled between 1993 and 1998, and were followed over three years. In total, 198 participants were randomly assigned to the two treatment conditions. The group was largely male (72%) and either African American (55%) or Hispanic (14%). Ninety per cent of the group were retained for the three-year study and participated in research assessments every six months.

In this study, assertive community treatment was contrasted with standard clinical case management. The standard clinical case management had roughly double the case load of the ACT team, but they delivered at least some services in the community, worked with the client's support systems, and directly treated substance use disorders.

Staff in both case management services were trained and supported throughout the study to provide integrated treatment. This included comprehensive assessment, individual motivational interviewing, group treatments and stage-wise interventions based on the best evidence for integrated treatment practice.

The study found that over three years, both groups showed equivalent improvements. Outcomes were measured for psychiatric symptoms, substance use, global functioning and life satisfaction, and housing stability. At one site, the ACT group showed more rapid improvement at first, but steady improvement by the standard group resulted in no significant differences over time.

Allen, J., Hawkins, L., McDonald, C., Quinn, M. & Williams, J. (2007) *YP[4] Case Management: Report on the evaluation of workforce implications*. **Melbourne, School of Global Studies, Social Science and Planning, RMIT University.**

This qualitative study of the workforce requirements for case management provides evidence of the communication and relationship skills required for case management. The study involved thirteen interviews with case managers and senior managers associated with a randomised trial of 'joined up' case management for homeless unemployed young people known as 'YP[4].'[24]

The study found a set of skills and dispositions that were required (Allen et al., 2007 9-10). These are divided in the table below into those which are logically related to the relationship mechanism, and those which are required to provide the comprehensive and practical support outcome given the service system capacity and design conditions.

	Skills	*Dispositions*
Relationship	An ability to empathise, understand and establish relations with young people	Acceptance and tolerance
		Patience
	Assessment skills	Emotional maturity
	Highly developed interpersonal and counselling skills	Common sense
		Flexibility

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[24] **YP[4]** is an Australian three-year trial (2005–7) offering homeless young people a single point of contact to address employment, housing, educational and personal support goals in a joined-up way over two years. YP[4] was initiated by Hanover Welfare Services in partnership with Melbourne CityMission, the Brotherhood of St Laurence and Loddon Mallee Housing Services, and supported by five government departments across state and federal jurisdictions as well as by philanthropic organisations and peak bodies. For more information, see www.yp4.org.au

	Referral skills	Responsiveness
	Problem-solving skills	Willingness to adopt a participatory and inclusive approach (i.e. in regards to clients)
	Capacity to think holistically	
	Capacity to promote and manage service system integration in respect of clients	
		High degrees of motivation
	Capacity to translate knowledge developed via intervention to inform policy	A task-oriented and solution-focused orientation
		Commitment to social justice and human rights
	Time management skills	
	Organisational skills	Creativity
		Intelligence
Comprehensive and practical support	Advocacy skills	Capacity to be innovative and creative
	Highly developed communication skills at levels other than the interpersonal and other than client-focused.	
	Highly developed networking, negotiating and brokerage skills	
	Capacity to match clients with appropriate jobs	
	Capacity to work within and across the service delivery system	

The study concluded that the skills, disposition and experience required for case managers in the trial are 'extremely high and unlikely to be fulfilled' given the remuneration offered for these positions (Allen et al., 2007 16-17).

Greene, G. J., Kondrat, D. C., Lee, M. Y., Clement, J., Siebert, H., Mentzer, R. A. & Pinnell, S. R. (2006) A solution-focused approach to case management and recovery with consumers who have a severe mental disability. *Families in Society-the Journal of Contemporary Social Services,* **87.3: 339-350.**

Client-directed goal focus has been linked to the development of hope, known to be a key factor in facilitating recovery from serious mental illness (Greene et al., 2006 341-2). A person develops or sustains hope when 'a person has a clearly defined goal, perceives one or more clear routes to the goal (pathways), and perceives himself or herself as having the ability to reach that goal (agency)' (Greene et al., 2006 341).

> Integral to the success of the case management process is the case manager developing and maintaining a positive collaborative working relationship with the mental health consumer (Greene et al., 2006 340).

Perhaps most influentially, the 'Boston Recovery Model' approach to psychiatric rehabilitation has built an evidence base showing that the development of hope has a specific and measurable impact on client outcomes in the case of recovery from mental illness. The Recovery Model was explicitly defined in opposition to the medical diagnostic model. It is widely accepted that case management was put in place in response to widespread de-institutionalisation (Rothman, 1992). Initially, explains Greene *et al.*, community mental health case management was about stabilisation and maintenance. The main goals were reduced hospital admissions through medication and symptom management, as it was believed that serious mental illness was incurable. Citing a significant body of emerging research, Greene *et al.* explain the current evidence shows that most people can experience what is called 'recovery'

which is restored functioning and independence, even if some symptoms remain. The emerging recovery paradigm places the emphasis on reintegration and normal functioning, in a word, recovery.

While recovery from mental illness is a non-linear and individual process, research has shown that it is facilitated by the experience of four factors: hope, coping skills, empowerment, and supportive social networks (Greene et al., 2006 341). Another author confirms: 'a collaborative, trusting, and supportive relationship is central to facilitating hope and helping one move towards recovery' (Salyers and Macy, 2005 102). Person-Centred Planning is a similar approach with an emphasis on client involvement and goal-setting: 'The client is facilitated to voice their hopes, dreams, fears and vision of their own future within an informal but structured process that concludes with positive statements [about] the client's future' (Eustace and Clarke, 2005 17).

Greene *et al.* argue that case management practice will have to change in order to support the principles of consumer recovery (Greene et al., 2006 339). They present a way to operationalise strengths-based case management through the micro-techniques of solution-focused therapy for case management in community mental health (Greene *et al.*, 2006). The interviewing techniques presented in the article can be used for 'patiently, consistently, coherently, and respectfully working with consumers'. If they are applied 'in an inauthentic, formulaic manner' it could damage the working relationship. The interviewing tools 'are simple, but not simple to use effectively' (Greene et al., 2006 347). It is essential that the person 'experiences the case manager as being truly interested in and curious about them as a person and not just as handling another case' (Greene et al., 2006 344).

Discovering and mobilising a person's strengths takes skill and sensitivity, since by definition they are experiencing themselves as in need of assistance, unable to help themselves. An example of operationalising a strengths approach is to focus on a person's coping skills when things are not getting better. People are often unaware of the skills they are using to manage and survive the presently difficult situation – strengths practice is to help them notice these skills, to notice what is working, and support them to do it more (Greene et al., 2006 346). Another technique is to focus on exploring what the person has achieved in their desired goal areas in the past (Greene et al., 2006 343).

An example of the philosophy and approach of the 'recovery' paradigm is provided by the website of a US consumer-based service provider called *CHOICE* (Consumers Helping Others In a Caring Environment). The following quote provides an indication of the importance of respectful case management:

> "I'm not a case and I don't need to be managed!" reads a lapel pin popular with some mental health activists, and admittedly "case management" is a term with both unfortunate connotations and an unfortunate history. But at CHOICE the purpose of case management is to assist consumers in identifying, securing, and sustaining the range of resources necessary to a satisfying life in the community. Our case management is not about treatment; it's not about imposing a structure, or making sure someone takes medication. We don't focus on what's wrong with someone; our principle focus is on what's right.

> Our clients know what they want out of life; the problem is, often they have been told by clinicians, family members, or other authority figures that they don't. The fact of being diagnosed with mental illness has robbed them of the right to have dreams and aspirations, even of the right to make their own

mistakes. A case manager can function as a support, a sounding board, a resource specialist and an advocate for clients looking to create positive and lasting change in their lives. (Consumers helping others in a caring environment (CHOICE))

Founded by a consumer in 1994, the organisation has grown into a fully fledged community mental health service. The way CHOICE defines case management confirms a finding that emerges consistently from the perspective of service users and service providers: respect is the bottom line.

Arnold, E. M., Walsh, A. K., Oldham, M. S. & Rapp, C. A. (2007) Strengths-based case management: Implementation with high-risk youth. *Families in Society-the Journal of Contemporary Social Services,* 88.1: 86-94.

This was a small qualitative study to explore the implementation of strengths-based case management with runaway adolescents. It concluded that the model can be successful with this target group and identified some distinct areas for case management focus due to the particular developmental challenges faced by young people.

The findings highlight the skills required to deliver the qualities of reliability and persistence, and reinforce the value of respect as a technique for developing a person's capacity to take care of themselves by increasing their self-esteem through goal achievement.

Arnold *et al.*'s pilot study was of eleven runaway young people using strengths-based case management and exploring the implementation factors for applying the model to adolescents.

Perhaps the main challenge is to persevere with these youths, even when they may doubt their own abilities to accomplish the goals they have set for themselves. (Arnold *et al.*, 2007)

Key case manager skills are familiarity with youth needs, strong assessment and interpersonal skills, and must follow through with commitments made to the young person.

This study highlighted the profound impact of poverty on the ability to develop hope and motivation. For example the issue of transportation was a barrier on many levels. This study confirmed previous research showing that young people from socio-economically disadvantaged backgrounds are less likely to attend their mental health appointments.

The study identified a range of adolescent-specific barriers and developmental challenges that must be tackled by case management; these included the impact of peer pressure and conformity, and the precariousness of family dependence, particularly in cases of family abuse. This evidence demonstrates the way that the case management relationship allows for a sophisticated tailoring of interventions to the individual being assisted.

Juhila, K. (2007) From Care to Fellowship and Back: Interpretative Repertoires Used by the Social Welfare Workers when Describing their Relationship with Homeless Women. *British Journal of Social Work,* Advanced Access August 4, 2007.

A Scandinavian study provides some detailed practice evidence showing that an underlying attitude supports a diverse range of other supportive interventions. The study is an examination of the practice of workers at a homeless women's drop-in centre and accommodation site (Juhila, 2007). It finds that staff used a sophisticated

and dynamic range of relationship styles to gain the trust of the women and consequently to provide directive or therapeutic interventions.

Ethnographic analysis of a group diary kept by the workers identified six practice 'repertoires', or sets of activities along with a particular style and an implied relationship between worker and client. This analysis focuses on a period of thirteen months in which there were diary entries on 258 days, or almost every weekday. The average length of the entries is half a page of handwriting. The diary was not an official document but kept by the workers for their own professional interests, consequently the quantitative analysis of the text cannot be assumed to correlate identically with the delivery of services.

The most common repertoire, categorised as 'Care', meant that workers were assisting the homeless women in coping with daily life and meeting their health or survival needs, acting as an advocate or mediator with other services, and expressing unconditional concern and emotional attachment. Care appeared in 29% of recorded interactions. Assessment involved observation sometimes followed by expert assessments and intervention plans and occurred 22% of the time. Control, defined as monitoring whereabouts and activities, normalising interventions (for example to maintain hygiene or improve treatment retention), and setting disciplinary limits, was represented in 15% of interactions. Therapy involved in-depth and personal conversations with the women, encouraging women to 'open up' and develop more self-insight through sympathetic, active listening and occurred in 7% of the record. Service provision was defined as responding to the women's requests and also accepting feedback about the service. It was identified in 13% of interactions. Moments of fellowship, identified in 14% of the notes, referred to times when it seemed 'the barrier between worker and client was crossed', there was a shared identification or a 'we' often due to grief, sympathy or celebration.

Juhila shows how the six repertoires are intertwined in a flexible and dynamic way – they do not 'belong' to either particular workers or particular clients, and can in fact co-exist in any one particular episode of service delivery, and draws two conclusions. First, she challenges a common claim that some styles of activity are incompatible, for example fellowship and control, by meticulously demonstrating how a number of repertoires can be evident in even a short description of a service encounter. And subsequently she infers that it is the repertoire of caring, the most frequently appearing in the diary, which 'carries' any potential conflicts between the different repertoires:

> In a climate of security and trust, the other repertoires are made possible. In this climate, assessment and control are not used to exclude the women from the services, and even critical feedback from the women concerning the activity of the organization does not bring unfortunate consequences to those who give it. In a caring climate, it is also easy to open up and venture into therapeutic conversations, as well as into fellowship, which do away with the barriers of expertise. (Juhila, 2007 13-14)

Juhila finds that the attitude of 'care,' expressed as advocacy and empathy, are qualities that create the conditions for an effective relationship. These qualities provide a foundation for more directive or potentially alienating interventions such as limit-setting.

Rigby, M. & Longford, J. (2004) Development of a multi-agency experiential training course on personality disorder. *Psychiatric Bulletin,* **28.9: 337-341.**

Providing assistance to people with personality disorders is recognised as one of the most difficult activities within the human services (Rigby and Longford, 2004). Rigby

and Longford note 'the capacity of people with personality disorder to 'suck in' the services of many professionals in a reactive and unproductive way' (Rigby and Longford, 2004 341). The practice evidence accumulated and expressed by these training providers indicates the high level of assessment, communication and relationship skills required for case management in homeless persons agencies.

Practice guidelines published in the United Kingdom suggest that working with personality disorders requires workers with 'personal resilience and particular personal qualities that allow them to maintain good boundaries, survive hostility and manage conflict'. They need the 'ability to withstand the particular emotional impact that working with personality disordered patients can have on relationships within a team and service' (National Institute for Mental Health in England, 2003, p.44: cited by (Rigby and Longford, 2004 337). Rigby and Longford claim that training must address 'the biggest problem in clinical practice, which is how to 'be' with patients; how to manage one's own anxieties, and how to help patients safely to be in contact with their anxieties' (Rigby and Longford, 2004 337).

The significant overlap between personality disorder and homelessness is anecdotally recognised. In the UK, it is known that people suffering from personality disorder are usually ineligible for mental health services, and as a result their care falls to the other social services including homelessness and corrections (Snowden and Kane, 2003).

O'Connor, J. (2005) Between the street and the consulting room: The role of therapeutic frame in working with homeless clients. *European Journal of Psychotherapy & Counselling,* 7.4: 217 - 233.

Evidence of the need for a high level of staff communication and relationship skills, comes from research into psychotherapy for chronically homeless individuals (O'Connor, 2005). This study also finds evidence to support the qualities of reliability and persistence in the relationship. The study's methodology is the analysis of two clinical case studies, positioned within a well-argued assessment of current understandings of homelessness. O'Connor focuses attention on the possible psychology of the group of people who experience chronic homelessness, while carefully acknowledging the dimensions of poverty, market failure and socio-economic disadvantage, and recognising that many people are able to recover from homelessness once they secure adequate affordable housing. O'Connor describes the group in terms very familiar to homelessness practice:

> …they have deep difficulties sustaining a home; they move repeatedly into homelessness, even when a home is available. From the vantage point of observers, this often has the appearance of self-sabotage, and is perhaps too neatly described in terms of the broad construct of personality disorder. (O'Connor, 2005 219)

O'Connor focuses on one element of a therapeutic relationship – the provision of 'containment' (for further information, see Smith, 2001 p.32, Sudbery, 2002 p.307). The two case studies contrast a successful and a failed intervention, but it is not the specific psychodynamic theory advanced here that is of interest to our synthesis (although it represents a potential training area a case manager may wish to pursue for their 'toolkit'). Evidence from psychodynamic practice contributes to the understanding of the developmental potential of a relationship, and the characteristics of that relationship which have been proven to have beneficial effects. Psychodynamic research and theory confirms and explains why the qualities of reliability and persistence are important in working with homelessness, and also highlights the level of skill required in a case manager and the need for regular supervisory support.

O'Connor's psychotherapeutic approach involves extensive knowledge of personal and family history, and confirms a point raised by a number of practitioner interviews:

that 'getting to know a person's full story' is an essential part of successful case management for the most challenging clients (5,2,6). This was explained as increasing their capacity to deal with the very challenging behaviours of some of their clients. Understanding the person as someone with a history was essential for being 'a person in their court.' From O'Connor's perspective, tolerant knowing of the person conveys to them that they are acceptable, providing the psychological foundation of a healthy personality that children generally get from the reliable and persistent love of their parents.

The therapeutic aspects of the relationship cannot function if the psychotherapist is invested with sole responsibility for the client. O'Connor shows that therapeutic work should only be attempted in the context of wider supports, and must be seen as one of a range of interventions to help. The practitioner must beware of taking on too much responsibility for the person:

> In the absence of other supporting frames, we may easily adopt a role for ourselves that is overly ambitious and, in this way overstep our own areas of competence.(O'Connor, 2005 225)

Similarly, practitioners commented that sometimes a team approach is essential to maintain persistence simply due to the extremely challenging nature of the behaviours of the client (1,3,5).

Practical constraints will also limit the effectiveness of the relationship in providing safety and security just as powerfully as the person's own history. Accordingly, therapeutic environments are needed which focus on developing security and safety and help the person develop a sense of connection with others. However, in these environments there is a risk of creating:

> a place where people are simply given things to do, where they are educated and prepared for something towards which they have no aspirations – where there is an attempt to assemble their lives on a culturally acceptable model. (O'Connor, 2005 225)

In other words, without a client-directed goal focus, the developmental motivation of *case management* will lean unhelpfully toward the side of normative regulation.

> Homeless people meet rejection and suspicion at every corner and can often find in the response of services something that is pushy or demanding; services are understandably keen to find solutions and to achieve these quickly.(O'Connor, 2005 225)

O'Connor's point is affirmed by a client comment in the Dickson-Gomez study discussed in Chapter 5.

8.3 Staff supervision and support

This section synthesises three sources of evidence directly relating to the impact of staff supervision and support on case management.

8.3.1 Synthesis of the evidence: staff supervision and support

What we know

(Sudbery, 2002) finds that skilled supervision is essential for enabling the worker to make sense of their emotional experience and, when appropriate, use it for the benefit of the client.

(Boyer and Bond, 1999)'s quantitative study of case manager burnout rates found that lower case loads and the support of a multidisciplinary team reduces burnout despite working with the most challenging client groups.

(Stein and Craft, 2007) found that a reliable measure of a case manager's personal growth correlated positively with personal accomplishment and higher job satisfaction while it was not associated with emotional exhaustion which is a known indicator of professional burnout. This study provides evidence of the reciprocal impact of the case management relationship.

Implications

Professional support and development activities that encourage a case manager's personal growth have the potential to increase staff retention and improve client care.

Formal supervision can allow the case manager to manage their emotional reactions to the case management relationship.

Collegial support, for example in a team context, can also be considered for improving staff retention and satisfaction.

While there are few studies directly addressing the role of staff support there is a significant body of indirect evidence synthesised in other areas of this report. Primarily there are logical implications from the evidence about the relationship mechanism. As discussed in the syntheses in Chapter 5, the nature and qualities of the relationship imply both a high level of skill and a significant level of support for the case manager.

8.3.2 The research: staff supervision and support

Sudbery, J. (2002) Key features of therapeutic social work: the use of relationship. *Journal of Social Work Practice,* 16.2: 149 - 162.

This article provides a theoretical framework to understand the need for regular supervision of case management staff; it also identifies the emotional maturity of the relationship and communication skills required by staff, and some practical conditions that facilitate use of the relationship mechanism.

Sudberry outlines two important conditions that enable effective use of the relationship. First, there needs to be skilled and emotionally mature workers, able to be 'emotionally "quiet" and receptive,' who are supported by supervision to deal with the responses that inevitably arise in the intimacy of the case management relationship. Second, on a practical level, the provider agency should be committed to providing 'regular, supportive comfortable "interviews,"' oriented toward reliable and predictable support rather than reactive crisis response. The author describes the organisational support which may be required to achieve this stability, including managing expectations, service demands and resources.

Sudberry summarises the psychodynamic understanding of social work accumulated over four decades of research. From this perspective, the goal of social work is to produce therapeutic, empowering and developmental outcomes for clients. This is achieved through a relationship which delivers three key features: attention to basic needs, response to aggressive impulses and the lessening of punitive self-criticism. Use of this relationship requires managerial and supervisory functions including staff support and particular work arrangements and expectations.

Psychodynamic theory assists in understanding the mechanism of case management, namely, the relationship with its emotional intimacy and resulting difficulties. These difficulties include experiences, for both or either client and case manager, of dependency, humiliation, loss or confusion about professional boundaries, and frustration with a sense of intractable obstacles or a sustained inability to get what one wants or to take care of oneself.

The essence of psychodynamic social work is the skilful use of the helping relationship in the present moment to address and transform barriers from the past. Sudberry explains that this work is essentially an intervention into the nature of a person's relationship with themselves and others, including people and institutions, alongside and through practical assistance. The problems experienced by people will always be a combination of external and internal difficulties. The internal or subjective difficulties will be replicated in the relationship with the person helping them.

The internal difficulties are understood as complex consequences of the person's personal history. For example, both disempowerment and inappropriate aggression are often associated with an experience of child abuse. The present moment of relationship offers an opportunity to either re-enact these dynamics, or, and here lies the developmental potential, to overcome the historical residues by creating new choices in behaviour.

The final source of internal difficulties described in this article is the need for a person to have a positive relationship to themselves. This aspect of the work addresses some of the subjective causes of low self-esteem, lack of confidence, self-attack and self-destruction. A severe and punitive self-critic has been variously associated with depression, aggressive outbursts, and general lack of agency.

The worker will experience in turn emotional reactions triggered by the relationship, which may be part of the re-enactment of the client's history, or related to their own past reaction patterns. Suppressing these reactions will be neither effective nor therapeutic. In fact, the subjective experiences of the case manager may hold valuable information for the client, if communicated appropriately. Skilled supervision is essential for enabling the worker to make sense of their emotional experience and when appropriate, use it for the benefit of the client.

Boyer, S. L. & Bond, G. R. (1999) Does Assertive Community Treatment Reduce Burnout? A Comparison with Traditional Case Management. *Mental Health Services Research,* 1.1: 31-45.

This study investigated organisational or program factors which could lead to worker burnout by comparing two approaches to case management in common use in the United States – the assertive community treatment (ACT) model[25] and a traditional model (TCM) which involved predominantly broker-referral services with caseloads of thirty or more.

It found that ACT case management program staff had significantly higher job satisfaction and lower burnout rates, despite working with a very challenging client group over long durations.

Written surveys were distributed with decent follow-up procedures to case management agencies in Indiana and Michigan during 1990–1. Sampling criteria included full-time work, six months or more in the position, caseloads including clients with severe mental illness and at least 50% of time spent in direct service delivery.

Two hundred and sixteen eligible surveys were returned – between 109–119 for the ACT sample and 94–97 in the TCM (varying sample size for the different survey instruments). The two groups were generally comparable except that the ACT case managers were older.

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[25]ACT is case management by a multidisciplinary team, low client/staff caseloads that enable frequent service contacts, community-based services that are directly provided rather than brokered through other agencies, and twenty-four-hour availability to the client. See Section 7.1 for more detail.

The surveys used published, reliable self-report scales to measure burnout, job satisfaction and the work environment. They also included an instrument specifically designed for this study to measure case management work attitudes, including: shared responsibility, workstyle compromise, competency, growth and respect (from the organisation).

In the comparison between groups, on all measures the ACT case managers had a significantly more positive view of their job. They reported greater job satisfaction and personal accomplishment, and lower burnout and emotional exhaustion than the TCM group. They reported more favourable perceptions of their work environment and lower perceived workload.

Another analysis searched the individual groups for correlations to burnout. Of case manager characteristics, they found that age was negatively associated with burnout for the ACT group, while years in the current position was significant for the TCM group. Among TCM case managers, the percentage of clients with schizophrenia, and the proportion of time spent on paperwork were correlated with increased burnout.

Across both groups the four strongest predictors of burnout (in order of significance) were age, time spent on paperwork, caseload size and case manager type. Case manager type was the strongest predictor of job satisfaction.

While the study design could not resolve which elements of ACT produced the better outcomes, there was some evidence to suggest that a low caseload in itself was not the cause. A subgroup working within the TCM model had a smaller caseload ratio (15:1) yet they reported similar burnout levels and significantly lower job satisfaction.

These results, while not without limitations, are strengthened by the fact that ACT case managers tend to have a higher proportion of clients with schizophrenia and/or substance abuse. Their lower burnout rate is therefore more notable since they are dealing with a group of clients known to challenge human services workers.

Stein, C. & Craft, S. (2007) Case Managers' Experiences of Personal Growth: Learning from Consumers. *Community Mental Health Journal,* 43.2: 183-195.

This study designed and assessed a new self-report instrument to measure case managers' feelings of personal growth. Personal growth is defined as 'positive changes related to the ways that people view themselves, their life philosophy, and the value that they place on relationships with other people' (Joseph & Linley, 2005 cited in Stein and Craft, 2007).

The study was designed to investigate one of the foundations of the recovery movement: the collaborative and mutually educative relationship between consumer and service provider. The authors cite Mead and Copeland's article, discussed above. While negative impacts such as professional burnout and job dissatisfaction have been studied, little research has explored either positive impacts of case management on the case manager, or the case manager's experience of learning or growth. Consequently, Stein and Craft set out to design and test a psychometric instrument for exploring one possible area of positive impact of case management work on the case manager, namely their experience of personal growth.

Case managers were recruited from mental health agencies in two states and a national case management conference. They were contacted by mail, and the questionnaire return rate was 51%, giving a total of ninety-eight participants. Participants were seventy-four women and twenty-four men, but there were no significant variations found on gender or the other demographic variables collected (ethnicity, age, marital status, and educational level) or between recruitment methods.

The study concludes that 'personal growth' is a concept that is meaningfully understood by case managers, can be credibly measured, and is congruently associated with known properties such as professional burnout and job satisfaction.

The personal growth scale correlated positively with personal accomplishment, and insignificantly with emotional exhaustion. Greater feelings of depersonalisation were associated with lower personal growth scores. Personal growth scores were positively related to reports of higher job satisfaction, and unrelated to social desirability scores. Older participants and more experienced case managers reported higher perceptions of personal growth.

The key instrument designed for the study was the *Case Manager Professional Growth Scale*. This used sixteen statements drawn from the literature on stress-related personal growth, rated with a five-point Liekert agreement scale. To investigate its properties and validity, the scale was tested and correlated with other published psychometric measures. This included a twenty-two-item self-report instrument which produces three subscales measuring emotional exhaustion, depersonalisation and personal accomplishment, (the Maslach Burnout Inventory) and a scale to measure the impact of social desirability in participant's responses (Maslach *et al.*, 1996 and Fischer and Fick, 1993 respectively, cited by (Stein and Craft, 2007 186-7)). Correlation with job satisfaction was assessed using a *Case Manager Job Satisfaction* scale designed for the study based on six items to assess perceptions of job satisfaction in the areas of salary/pay, caseload, supervision/support and paperwork. The study found good construct validity for the instrument.

The quantitative instrument was supplemented with a qualitative survey asking about a professional experience that had significantly impacted the case manager's life. These qualitative data revealed the importance of making a difference to consumer's lives, which was not captured by the personal growth scale. This theme was reflected in 40% of responses, while the next most common theme, the experience of personal reflection arising as a result of working with case management, appeared in 26%.

The authors note that it is not clear if the reported personal growth was related to collaborative relationships with consumers or to the social role as a helper. There is more evidence supporting the later deduction since the qualitative data highlighted the importance of 'making a difference' and the second most common theme reflected the impact of a comparison between the case manager and their less fortunate clients:

> I find that on a daily basis I am blessed to have the life I have. It makes me realize that 'your mental health' is very precious and one should be thankful and not take it for granted.

And similarly from another case manager:

> Working with severely mentally ill people has made me more thankful for the health I am blessed to have.

While the study found that nearly 60% of participants felt that 'the longer they worked with consumers, the more they realized that their own lives were not that different', interpretation of this finding must be balanced against the prominence of helping experiences and importance of comparisons between the case manager and their client.

The study identifies the potential for targeting professional support and development activities toward personal growth for increased staff retention and improved client care.

The finding of a benefit to the case manager in the form of 'personal growth' must be treated cautiously because of the small sample size and exploratory design. However, this work by Stein and Craft provides solid evidence that the relationship between client and case manager can have an impact on the case manager which is experienced positively, though the nature and implications of this impact remains unclear. The findings do not provide any conclusive support for the concept of a mutually beneficial learning exchange, and furthermore raise a question about the source of the positive effect. Naturally, for an exploratory study of this nature, the conclusion of benefit needs further investigation, as does the instrument itself. Nonetheless the evidence relevant for the synthesis is that the case management relationship has a reciprocal impact.

9 CONCLUSION

This research synthesis finds robust support for the use of case management practice with people experiencing homelessness, documents some key conditions required for it to be effective, and identifies some of case management's inherent limitations.

The first phase of the research process found that case management is an intervention that is very commonly implemented, yet poorly defined. Case management practice occurs in name, at least, within a wide range of operational contexts, and across service delivery contexts as different as psychiatric services and aged care.

In this study, careful analysis of program and policy documentation and practitioner input was used to create a working definition of case management which guided a comprehensive search and appraisal of the current scientific evidence. Case management was initially defined as an individualised, supportive intervention with the ability to increase a client's capacity to access the support they need, therefore ultimately removing the need for case management.

Synthesis of the evidence produced a tighter, evidence-based definition and a coherent and rigorous set of case management defining elements. The final synthesis of fifty-three empirical sources finds that for case management to be effective it requires the establishment and maintenance of a persistent, reliable, respectful and intimate relationship between the case manager and the client, and the delivery of comprehensive, practical support.

One of the most significant goals of this research project was to resource practitioners by providing access to a critical synthesis of the evidence base. Dissemination of the research findings to practitioners will include a number of strategies. In addition to the publication of the final report, materials may include an online, interactive format, a condensed summary report, and workshops.

9.1 Practice and policy implications

The practice and policy implications of this research are closely linked because current funding provisions and the accommodation scarcity currently experienced in the Australian homelessness sector will constrain most practitioners' abilities to implement some of the most critical practice change implications.

This research has six major implications for the Australian homelessness sector:

→ The need for formal arrangements to provide case managers with access to specialist expertise in allied service sectors (including mental and primary health) potentially through multidisciplinary case management teams

→ The need to extend the available duration of SAAP case management support (currently thirteen weeks average) to ensure sufficient establishment time, followed by time to achieve an increase in a person's self-care capacity

→ The need to maintain the existing practical, comprehensive support focus and to maintain or reduce SAAP caseloads (currently average at 10–12)

→ The need to allow for case management continuity once a person has been housed (currently homelessness case management ceases at that time) in recognition of the investment required for a relationship-based intervention

→ The need to minimise the provision of case management without access to housing for people with a history of homelessness and/or requiring a complex service response

→ The need to assess current practice and program settings against the evidence-based principles identified here. (Case management practice can vary widely on the ground. See below for some general implications for case management under the existing SAAP program guidelines).

Possibly the most important conclusion to draw from this synthesis is that effective case management is a time- and resource-intensive intervention. The investment required to establish and maintain the relationship may be wasted in short-term, crisis-orientated programs of 3–6 months duration.

Short-term relationship-based interventions are anecdotally a source of frustration for workers and for clients. The consequent failure to achieve significant client outcomes is suggested by the evidence published in the Homelessness Green Paper that one in four SAAP clients are repeat clients of whom about half access the program 3–4 times a year (Government, 2008 33-37). Note that the synthesis does not find evidence that case management must be ongoing or extremely long-term for *all* people, but that the duration must be negotiated on an individual basis.

In addition, case management effectiveness will necessarily be limited by personal characteristics of the client, beyond the control of the case manager. Nonetheless, the evidence shows that, for any given client, case management practice which provides a persistent, reliable, intimate and respectful relationship, supported by access to resources, will deliver the best possible outcomes.

The following points present more detailed practice and policy implications for the service system, the staffing context and specifically for the Supported Accommodation Assistance Program.

Implications for service system design and capacity

→ Case management requires an investment of time for relationship formation and maintenance; both in terms of the overall duration and frequency of contact within that duration. This implies a constraint on case load size, and recognition of a minimum duration threshold before outcomes can be achieved.

   → Available evidence indicates that six months may be the minimum required duration to establish a working relationship with people experiencing homelessness and mental illness, and more than six months will be required for the most disengaged clients.

→ Arbitrarily imposed case management durations may be inefficient if they end the relationship prematurely. Not only will this compromise the outcomes, but the initial investment in the relationship will be lost.

→ Direct service delivery by the case manager and/or the case management team is preferable to brokerage or referral to other services.

→ Case managers require access to housing resources and specialist supports.

   → Specialist tenancy management or housing and support integration is indicated especially for men or for people with a high level of psychiatric symptoms or substance use issues.

   → Multidisciplinary case management teams are more cost-effective for working with people requiring a complex service response.

Implications for staff skills and support

→ Case managers need comprehensive assessment skills and the capacity to respond directly to a broad range of practical and emotional needs, for example, the capacity to assist with housing, nutrition, access to income support and

transport, along with helping to manage the effects of social stigma, family breakdown or a history of trauma.

→ Case managers require high-level communication and relationship skills including the capacity to sustain a genuine emotional connection with the client in the context of challenging behaviours and complex health needs.

→ Case managers need a high level of support, including professional supervision and multidisciplinary collaboration, to mobilise and manage the professional intimacy of the case management relationship.

→ Remuneration and professional recognition for case management in the Australian homelessness sector needs review as there is evidence it is not currently commensurate to the skills required.

Implications for the Supported Accommodation Assistance Program

The evidence demonstrates that current Supported Accommodation Assistance Program (SAAP) case management has a number of strengths that can be highlighted and supported. It also shows that a number of factors are likely to reduce its effectiveness.

SAAP strengths include expertise in comprehensive, practical support provided by an intimate and respectful relationship. The major weakness is the constrained average support durations which inhibit persistence and reliability in the case management relationship. Difficulties in accessing specialist support and appropriate accommodation also place limits on the capacity of SAAP case management to deliver stable housing and improved health for the client.

Areas that could be improved to promote more effective case management:

→ Flexibility in relation to support duration, and in general an increase in average expected support durations for people with histories of homelessness and/or mental illness, and/or substance use issues

→ Access to specialist professional support – most effective when integrated via a multidisciplinary treatment team

→ Recognition of advanced practitioner skills and provision of advanced training programs

→ Increase in supportive housing options or residential dual diagnosis programs for those people with complex needs

→ Increased emphasis on social integration programs to support case management

→ Increased remuneration levels to accord with the level of skill required.

9.2 Answers to the research questions

The following section summarises the findings of the synthesis to briefly answer the research questions.

1.   How is case management undertaken in the homelessness sector and how does this compare with practice in allied service sectors?

The research process found that the comparative question could not be usefully answered because of the multitude of practices implemented in the name of case management, both in homelessness and other human services. It soon became apparent that a descriptive answer to this question would either lead to the conclusion, 'it depends,' or require an exhaustive empirical study of homelessness practice which was beyond the project brief. Instead, the research synthesis produced

an evidence-informed definition of case management built on understanding how the intervention works to improve the client's situation.

While the scope of the research project did not include an empirical survey of case management practice, a number of conclusions can be drawn from the analysis of policy and program documentation and from interviews with nine practitioners.

Case management practice in the Australian homelessness sector is primarily shaped by the SAAP funding guidelines. Case management was identified in 1993 as a strategic direction for SAAP, intended to improve the program's ability to meet support needs, demonstrate outcomes and more effectively match resources to needs (Upston, 1994 p.30). The approach is documented in the SAAP Case Management Resource Kit (Gevers, 1997 p.47) and the National Practice Principles for SAAP Case Management (National Case Management Working Group, 1997 p.371).

Consequently, case management in the Australian homelessness sector is predominantly undertaken within the SAAP funding guidelines with an average support duration of thirteen weeks and a caseload of 10–12. Some program variations exist with smaller caseloads, shorter or longer support durations and access to more or less brokerage funds. In common across these variations, homelessness case management consists of practical support provided by generalist case managers. Specialist support, for example psychiatric or drug and alcohol expertise, is usually provided by an external referral to other services.

In addition, some case management is associated with short-term (congregate care crisis accommodation) or medium-term housing. The case management is only provided while the person is in the temporary accommodation, and typically oriented toward the person's compliance with an activity plan designed to secure other housing.

2. Which approaches to case management are most likely to lead to the best outcomes for homeless clients?

The research synthesis found that case management approaches that provide a persistent, reliable relationship characterised by intimacy and respect and deliver comprehensive and practical support are most likely to lead to the best outcomes for homeless clients. Access to affordable housing, and in some cases, specialised tenancy management, are shown to increase the effectiveness of case management for reducing homelessness particularly for single men with substance use and mental health issues.

The synthesis did not find adequate evidence to discern if case management with particular groups experiencing homelessness in Australia such as asylum seekers, Indigenous people, families or women escaping domestic violence, is known to benefit from different qualities. However, the synthesis did find evidence that the relationship mechanism is sensitive to cultural differences and personal history. Further synthesis of the research on working with specific cultural groups would refine the understanding presented in this report.

3. Why do particular approaches to case management prove to be more effective than others?

Comprehensive and practical support is effective because it addresses the material deprivation faced by people experiencing homelessness. The intimacy of case management is effective because it facilitates the provision of this practical support, for example, by assisting people with daily living tasks. A persistent, reliable, respectful relationship is effective because the experience of homelessness involves a complex set of causes for each individual which can take time and courage to

address. The relationship is particularly effective because it functions as a concrete instance of social inclusion and helps to address the impact of stigma and marginalisation.

4.   What effect do case management practices have on the outcomes of people who experience homelessness?

For people experiencing homelessness, the most consistent finding is that case management practices can increase stable housing outcomes (reduce number of days homeless) and increase client satisfaction with the service. For clients also experiencing mental illness or substance use issues, case management can increase their engagement with specialist supports and reduce rates and/or duration of hospitalisation.

Case management practices that include the development of a persistent and reliable relationship, are able to manage the tensions associated with the intimacy of the relationship, and can access the resources to deliver comprehensive, practical support are found to have the most beneficial impact on people's situations compared to other types of support.

5.   What is the impact of case management on durations of support and the implications for improved client outcomes?

The synthesis found no direct evidence regarding the comparative impact of case management on the duration of support relative to other kinds of interventions. Rather, it identified duration as a factor that affects the development of a persistent and reliable case management relationship, which in turn is critical for achieving better outcomes.

The implications from the research synthesis are that duration of support should be individually determined because arbitrary or fixed durations compromise the qualities of reliability and persistence in the relationship.

The synthesis also found evidence of a minimum duration threshold for relationship development, therefore implying that case management of less than six months duration is specifically not recommended. Short-term case management does not allow relationship formation and compromises the quality of persistence.

An effective duration is one which allows the establishment of a case management relationship, and its maintenance, for the time required to produce a self-care capacity change. Individually determined durations are important because people experiencing homelessness are not a homogenous group.

6.   How does case management facilitate accommodation and support options for improved client outcomes?

Case management is able to facilitate accommodation and support options by providing comprehensive and practical support through a high level of direct service delivery, including assistance with housing, material aid, transport and daily living activities.

However, improved client outcomes are constrained by the availability of accommodation and support options. These resources are critical contextual conditions for effective case management.

7.   What is the likely effect of the creation of 'front door' entry points to a range of homelessness services, at which need is assessed and then a referral to a service provider made, on case management practices?

The synthesis found no evidence about the possible impact of different referral or initial assessment practice on subsequent case management outcomes. Knowledge of case management would benefit from further research in this area given the importance of the establishment phase of the relationship.

9.3   Research limitations

The primary limitation of research synthesis is that it does not provide original empirical evidence to answer the research questions. As a synthesis, it is necessarily limited by the characteristics of the existing evidence base.

Consequently a key limitation for this project is that the existing evidence base is predominantly comprised of research conducted in the United States, and furthermore research focused on case management for people with a serious mental illness. The North American bias in the literature limits the project's ability to synthesise rigorous evidence about specifically Australian contextual factors. However, the methodology employed by the study ('realist synthesis') is particularly well-suited to managing this difficulty as is explained in Chapter 2.

There are consequently significant gaps in the evidence about case management for specific groups experiencing homelessness in Australia, including Indigenous people, families, young people and women escaping domestic violence.

The research synthesis is limited by the low number of experimental studies of case management in all fields, and in homelessness specifically. In Australia, from the small number of studies available, the majority are either descriptive rather than analytical, or program-specific evaluations which lack randomisation and a control group, or indepth qualitative analysis.[26] The wide range of models and approaches delivered under the name of case management and the absence of program fidelity measures in Australian evaluations also limited their validity for this project.

Another limitation is that the practitioner input was restricted in scope to inner Melbourne service providers and will necessarily contain the bias of that perspective. The research method reduces the effect of this bias by the cross-validation with the international and national literature, and the input of the Advisory Group.

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[26] A significant exception is the Victorian randomised controlled trial of service delivery for young homeless unemployed young people. See http://www.yp4.org.au/ Results are due later in 2008.

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