STRENGTHENING
At Risk and Homeless
Young Mothers and Children

Step by Step:
A Comprehensive Approach to Case Management

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An initiative of the Conrad N. Hilton Foundation, in partnership with The National Center on Family Homelessness, National Alliance to End Homelessness and ZERO TO THREE: National Center for Infants, Toddlers and Families.

Introduction

What is case management? How do you choose the right approach for your organization? What supports do case managers need to provide quality services?

Case management is one of the primary services offered to individuals and families who face multiple challenges, including severe mental illness, addiction, and homelessness. As the practice of case management has evolved, the term has become increasingly complex. Many organizations offer "case management" without clearly defining what this means, why they chose a particular approach, how it relates to existing case management models and outcomes, and how they prepare case managers to provide these services. This brief outlines steps organizations can take to design a comprehensive approach to case management, including:

- Researching and designing a model.
- Supporting staff in providing case management services.
- Evaluating impact.

Step One: Researching Models and Outcomes

Researching case management models and related outcomes is the first step towards articulating a comprehensive case management approach. Organizations with a working knowledge of case management models can make informed decisions about which model or models to incorporate in their work.

Case Management Models

The term "case management" encompasses a range of strategies and services that have evolved over decades. Case management was originally designed as a service for people with severe and persistent mental illness. Prior to the 1950s, mental health care was provided mainly in public mental hospitals and included mental health services and day-to-day supports. Significant changes in mental health service delivery, including new medications to manage mental illness and a movement towards community-based mental health centers, contributed to the deinstitutionalization movement of the 1950s and 60s (Smith, Schwebel, Dunn, & McIver, 1993). This led to a dramatic increase in discharges from psychiatric hospitals and an increased need for services in the community. It was difficult for people with significant challenges and needs to navigate community-based systems of care and to access psychiatric services. In 1977, the National Institute of Mental Health established the

Community Support Program (CSP) to improve coordination of community mental health services. This led to a new approach referred to as "case management" and new professionals referred to as "case managers" (Mueser, Bond, Drake, & Resnick, 1998).

A case manager was initially defined as an "entity (usually a person) that coordinates, integrates and allocates care within limited resources," with primary functions that include "assessment, planning, referral, and monitoring" (Rapp & Goscha, 2004). Working within this traditional approach to case management, known as the "Broker Model," case managers are responsible for assessing and referring people to community-based service providers as needed and monitoring these service connections (Mueser et al., 1998). This remains as a common model of case management; however, the paucity of community-based resources, long waitlists, and the intensive needs of many people who receive case management services has lead to the creation of new service models and shifting roles and responsibilities for case managers.

As various models of case management have emerged, case managers have moved from primarily coordinating services to providing services as well. The approach to service design and delivery varies by case management model.

- To address more significant mental health needs, the Clinical Case Management Model uses clinicians as case managers who provide direct, therapeutic support.
- Strengths and Rehabilitation Models focus on building strong relationships; emphasizing strengths; providing choice, autonomy and control; and assisting people in accessing and developing environmental and personal resources.
- Intensive models such as Assertive Community Treatment (ACT) and Intensive Case Management (ICM) are defined by "small caseloads, team structure, and increased provision of direct service rather than making referrals" (Mueser et al., 1998).
- Critical Time Intervention offers time-limited, intensive case management designed to support people in establishing community connections and supports (see Figure 1. for common case management models).

Figure 1. Case Management Models as categorized by Mueser et al. (1998). Information on Critical Time Intervention from Herman et al. (2007).

Standard Community Care Models	
Broker Case Management Model	This "traditional" approach to case management focuses on assessing needs, referring to services, and coordinating and monitoring on-going treatment. The case manager serves as coordinator of services, which are provided by a variety of agencies and professionals. Services are mainly office-based.
Clinical Case Management Model	This model uses clinicians as case managers to provide some direct services. Case management functions include engagement, assessment and planning, community linking, individual skills-building through interventions such as psychotherapy, psychoeducation, and crisis intervention. Much of the work is office-based.
Intensive Comprehensive Care Models	
Assertive Community Treatment (ACT)	Originally created by Stein and Test, the Program for Assertive Community Treatment (PACT), was designed as a community-based alternative to the hospital for those with severe mental illness. The ACT model is an intensive, comprehensive approach to case management, and is defined by small case loads (10:1); a multi-disciplinary team approach (usually at least two case managers, a nurse, and a psychiatrist); shared case loads; services delivered by the team in person's natural environment vs. making referrals outside of the team; unlimited timeframe; and 24 hour coverage. A range of services are provided (e.g., mental health, housing, daily living skills, socialization, employment, crisis intervention, substance abuse treatment).
Intensive Case Management (ICM)	Also developed to meet the needs of high service users, ICM focuses on low staff to client ratios, outreach, services brought to the client, and practical assistance in a variety of areas. The main distinction from ACT is that caseloads are not normally shared.
Critical Time Intervention (CTI)	CTI is a focused, time-limited intervention for the critical period as people transition from institutional to community care. Originally designed for individuals experiencing homelessness and mental illness, CTI has been adapted for families, veterans, youth, and other subgroups. This model is designed to bridge the gap between homeless specific services and community services. CTI is a phased approach to case management with a focus on building community support networks and facilitating a gradual transition to community-based service providers over a period of 9 months (Herman, Conover, Felix, Nakagawa, & Mills, 2007).
Rehabilitation-Oriented Community Care Models	
Strengths Model	Developed in response to concerns that services and systems focus mainly on limitations and impairments vs. strengths and capabilities, this model focuses on individual strengths, the helping relationship as essential, contact in the community, and a focus on growth, change and consumer choice. Case managers provide direct services.
Rehabilitation Model	This approach emphasizes the importance of consumer-driven goals and assessing and building concrete skills to attain these goals.

Case Management Outcomes

Case management models should be evaluated for effectiveness and adapted as needed. All models discussed in the previous section have evolved based on clinical experience and outcome-based research. Challenges persist, however, in comparing case management models. These include outcome measures that are not equivalent across studies, and poorly defined control and comparison groups (e.g., "no services" or "services as usual") (Rapp & Goscha, 2004). Outcomes may also be impacted by variables other than the particular case management model, including caseload, severity of cases, case manager characteristics, and levels of training, supervision and support, many of which are not described in the studies (Rubin, 1992). Despite these issues, there is an ongoing effort to study a variety of case management models to identify practices that are most impactful.

To date, most research has examined the efficacy of case management services for people with severe mental illness. The Clinical Case Management Model is associated with improved social functioning and mental health and higher client satisfaction (Ziguras & Stuart, 2000). In contrast, Rapp and Goscha (2004) found that most studies of the Broker Model do not yield positive outcomes. In fact, findings include increased use of psychiatric hospitalization, little difference in quality of life, and lower consumer satisfaction with services. Research into the Rehabilitation-Oriented Care Models has found that the Strengths Model is associated with a positive impact on housing and improvement of symptoms for people receiving these services (Rapp & Goscha, 2004).

Intensive care models, including Assertive Community Treatment (ACT) and Intensive Case Management (ICM) for individuals with severe mental illness are the most widely researched models and have yielded the most consistently positive outcomes. In a review of 75 studies, Mueser et al. (1998) found the following preliminary outcomes:

- Reduced time in hospitals and improved housing stability.
- Modest support for decrease in symptom severity.
- A moderate effect on improving quality of life.
- Higher rates of consumer satisfaction.
- Lower levels of staff burnout and higher job satisfaction.

Two additional studies also demonstrate the success of ACT, reinforcing the positive outcomes of this approach. Ziguras and Stuart (2000) found that consumers who received ACT services showed greater improvements in social functioning and number of days hospitalized than consumers receiving clinical case management. Rapp and Goscha (2004) point to findings that the ACT model yields the best results for reducing psychiatric hospitalizations and shows some success in keeping people engaged in treatment.

Intensive case management models are used with a variety of individuals and families experiencing homelessness. Nelson, Aubry and Lafrance (2007) reviewed the literature on case management interventions for those with mental illness who have experienced homelessness, and found that ACT and ICM are particularly effective with this sub-population – especially in reducing psychiatric hospitalizations. Consumers accessed more assistance with housing, finance and supports than those receiving brokered case management, and people were more satisfied with services. Compared to other services, ACT and ICM are associated with greater improvements in functioning and adapting to living in the community and to more positive self-reports of health and well-

being. Critical Time Intervention (CTI), a model designed for the transition from institutional to community care for people experiencing homelessness, has demonstrated several positive outcomes for this population. CTI is associated with reduced episodes of homelessness once in the community and a decrease in negative psychiatric symptoms among homeless adult men (Herman et al., 2007).

Key Components of Case Management

Rapp and Goscha (2004) reviewed the research findings across common case management models and identified the following practices that are associated with statistically significant, positive outcomes:

1. Case managers participate in delivering services.
2. Whenever possible, case management services are provided in the community and in a person's natural environment.
3. Providers use a team approach to support consumers and each other.
4. There is a focus on building natural community connections (e.g., landlords, employers, ministers, neighbors, teachers, community centers, and coaches).
5. Case managers have access to quality supervision.
6. Caseload size is small enough to allow for higher frequency and quality of contact.
7. When possible, case management services are not time-limited for those with intensive needs.
8. Consumers always have access to crisis response services.
9. Self-determination and consumer choice are essential to success.

Step Two: Selecting a Case Management Approach

There are many factors to consider when selecting a case management model, including staffing, resources, population being served, feasibility, and possible funding streams for this work. An organization may choose one model to adopt with fidelity or they may modify an approach to meet the needs of their population (see case example, page 6). It is important to include staff in a variety of roles in the process of selecting or adapting a case management model. One way that a program can do this is by creating a multi-disciplinary workgroup consisting of a core group of staff representing all roles in the agency. This group makes a commitment to:

- Review existing models and outcomes.
- Identify challenges/successes of current approach (if an organization is already using a specific model).
- Address feasibility issues and "best fit" for the population being served.

If a program is small enough (e.g., a staff of 12-15), the workgroup may include all staff. In this case, discussions may take place during regular staff meetings or at a separate time. In larger programs, it may be unrealistic to get all staff together on a regular basis. Creating a smaller multi-disciplinary group of staff may make things more manageable. This workgroup reports back to all staff and gathers feedback about particular models and/or aspects of models that staff members are interested in using as part of their approach to case management.

Hope & Home

San Gabriel Valley, CA

Hope & Home is a program designed to serve young mothers and children who are homeless or at risk of homelessness. Part of the Conrad N. Hilton Foundation's *Strengthening At-Risk and Homeless Young Mothers and Children Initiative*, Hope & Home is a partnership between PROTOTYPES: Centers for Innovation in Health, Mental Health and Social Services, and Foothill Family Services, both located in the San Gabriel Valley, CA.

Case management is one of the primary services offered to families in the Hope & Home program. When the program began, the service team was not working from a particular model of case management. The role of the case manager was mainly to link and refer families to community-based services. The program found that the families being served had intensive needs that required support beyond what was being provided. Case managers felt isolated and overwhelmed by the number of family needs that were going unaddressed. Challenges with mainstream services, including long waitlists and a lack of communication between the case manager and community-based referral agencies, resulted in what they described as "fragmented" care.

To better serve families and support their case managers, the Hope & Home leadership decided to redesign its program. Building upon the principles of Assertive Community Treatment (ACT) -- a model that PROTOTYPES had used successfully in other programs at its agency-- the team developed an intensive case management model that incorporated a team-based, multi-disciplinary approach. This allowed a wide range of services to be provided to families, including housing and child-specific services. The program placed an emphasis on addressing the mental health needs of both parents and children, with mental health assessments and follow-up services offered by licensed clinicians to each family. The new program enables Hope & Home to provide comprehensive and holistic services that incorporate a strengths-based and recovery-oriented approach emphasizing flexibility, choice and family-driven goals. As a result, families and staff are better supported and better able to achieve their goals.

Once an organization finalizes its approach to case management, all staff should receive a summary of the key components of the model. A brief summary may address the following components (listed with sample descriptions):

Case Management Model: Intensive Case Management

Population served: Homeless Families

Staffing: Team approach that includes case manager, clinician, housing specialist, and employment counselor.

Role of Case Manager: Coordinates services and provides some direct services as needed.

Services Provided: Life skills, parenting education, mental health, housing, and employment services.

Method of Service Delivery: Home-based when possible or in the community (e.g., shelter settings). Services are brought to the family.

Schedule of Service Delivery: Weekly visits by each team member. Options for additional support or crisis intervention if needed.

Reason for Choosing This Approach: Based on a review of the literature and the intensive needs of our population, this approach led to the most successful outcomes with families similar to those we serve. This approach is the best fit for our staffing and preferred method of delivering services and working with families.

Step Three: Supporting Staff

A knowledgeable and competent work force is critical to the success of any case management strategy. As the concept of case management has evolved, provider roles and responsibilities have become more complex. Case managers are often required to coordinate and deliver services, yet there are few professional guidelines for how to provide quality care. This lack of clarity can lead to inconsistent service provision that impacts the efficacy of services. A comprehensive approach to case management includes developing clear expectations about the core skills and competencies necessary to provide quality case management services. Performance evaluation and professional development opportunities should be aligned with these skill areas.

Community Support Skill Standards

The Community Support Skill Standards were developed in 1996 by the Human Services Research Institute in Cambridge, Massachusetts, and represent a national set of competencies for direct support professionals, including advocates, case managers, counselors, family support workers, housing specialists, outreach workers, shelter workers, and vocational counselors. The Community Support Skill Standards are organized around 12 broad competency areas that include Communication, Assessment, Participant Empowerment, and Crisis Intervention. A national validation study of core competencies for direct support professionals in 2007 called for the inclusion of three additional competency areas for a total of 15. Within each competency area, skill standards are identified, and under each skill standard, specific activities and performance indicators measure mastery (see Figure 2, page 8). These Skill Standards represent the “gold standard” of direct support work and reflect the skills, knowledge and attitudes that an experienced worker develops over time. The Community Support Skill Standards have been approved by the National Alliance for Direct Support

Professionals, and they inform the College of Direct Support, an internet-based curriculum for direct support professionals (see resource list for additional information on the Community Support Skill Standards).

Organizations providing direct support services can integrate the Community Support Skill Standards into performance evaluations to assess employee strengths and professional development needs. Using common performance standards allows for consistent expectations across an organization. At a broader level, agencies may align all-staff trainings and professional development opportunities with the Community Support Skill Standards. If organizations choose to develop their own set of skills and competencies for case managers, they may consider using the Community Support Skill Standards as a guide.

Figure 2. Competency Area 1: Participant Empowerment

(This format is repeated for every skill standard within each of the 15 competency areas.)

Skill Standard A

The competent community support human service practitioner (CSHSP) assists and supports the participant to develop strategies, make informed choices, follow through on responsibilities, and take risks.

Activity Statement

The competent CSHSP assists the participant to identify alternatives when faced with the need to make a decision.

Performance Indicator

The participant reports that the CSHSP has helped him or her identify alternatives when making decisions.

Activity Statement

The competent CSHSP assists the participant to understand the potential outcomes of all alternatives and helps identify potential barriers.

Performance Indicator

- The participant reports that the CSHSP assisted him or her to see the consequences of specific courses of action.
- Given a scenario, the CSHSP cites barriers that limit choices for participants and describes ways to overcome those barriers.

Step 4: Evaluating the Impact of Your Services

Organizations should evaluate the effectiveness of their case management approach and make adjustments as needed. A good way to start is by considering the following strategies:

1. Be clear what you want to know.

What outcomes are you expecting for staff and consumers (e.g., decreased hospitalizations, increased staff retention, maintained housing)? What do funders want to know? Are there specific aspects of your model that you would like to focus on?

2. Gather information.

Develop concrete strategies for collecting information about the questions you are trying to answer. Specific methods of data collection should be formally integrated into your service design. Quantitative data may be collected through methods such as surveys, record reviews, and analysis of existing program data. Qualitative information can be collected through focus groups and interviews with consumers and staff, observations, and case studies.

3. Analyze the data.

Create a plan for collecting, consolidating, and reviewing information about service activities. Look for themes and patterns and refer back to original questions and anticipated outcomes.

4. Put the data to work.

Develop systems for providing feedback or reports based on what you find. Adjust service design and delivery where appropriate based on outcomes.

Conclusion

Providing quality case management requires organizations to prioritize effective service design and delivery. It is important to be proactive and strategic when choosing a case management model, make professional development a priority, and identify methods for documenting and evaluating your case management services. The steps outlined in this brief are designed to provide case managers and their agencies with guidelines to design a comprehensive approach to case management. With a clearly articulated and well-evaluated case management model, organizations can better serve individuals and families and set the stage for future growth and development.

References

Herman, D., Conover, S., Felix, A., Nakagawa, A., & Mills, D. (2007). Critical time intervention: An empirically supported model for preventing homelessness in high risk groups. *Journal of Primary Prevention*, *28*, 295-312.

Mueser, K.T., Bond, G.R., Drake, R.E., & Resnick, S.G. (1998). Models of community care for severe mental illness: A review of research on case management. *Schizophrenia Bulletin, 24*(1), 37-74.

National Alliance for Direct Support Professionals. (2008). The *15 NADSP Competency Areas*. Minneapolis, MN: Author.

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.

Rapp, C.A., & Goscha, R.J. (2004). The principles of effective case management of mental health services. In Davidson, L., Harding, C. & Spaniol, L. (Eds.), *Recovery from Severe Mental Ilnesses: Research Evidence and Implications for Practice* (pp. 24-51). Boston, MA: Center for Psychiatric Rehabilitation.

Rubin, A. (1992). Is case management effective for people with serious mental illness? A research review. *Health & Social Work, 17*(2), 138 – 150.

Smith, G.B., Schwebel, A.I., Dunn, R.L., & McIver, S.D. (1993). The role of psychologists in the treatment, management, and prevention of chronic mental illness. *American Psychologist, 48*(9), 966-971.

Taylor, M., Bradley, V., & Warren, R. Jr. (1996). The Community Support Skill Standards: Tools for Managing Change and Achieving Outcomes. *Skill Standards for Direct Service Workers in the Human Services*. Human Services Research Institute. Cambridge, MA.

Ziguras, S.J., & Stuart, G.W. (2000). A meta-analysis of the effectiveness of mental health case management over 20 years. *Psychiatric Services, 51*(11), 1410-1421.

Strengthening At Risk and Homeless Young Mothers and Children is generating knowledge on improving the housing, health and development of young homeless and at-risk young mothers and their children.

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