

Clinical Case Management: Definition, Principles, Components

Joel Kanter, M.S.W.

The burgeoning field of case management for long-term psychiatric patients has been handicapped by a lack of conceptual models that delineate the diverse activities of case managers. Based on the actual practice of case management, the author outlines a model of clinical case management that moves beyond the view of the case manager as a systems coordinator, service broker, or supportive companion. Using a contemporary biopsychosocial model of mental illness, the clinical case management model integrates the clinical acumen, personal involvement, and environmental interventions needed to address the overall maintenance of the patient's physical and social environment. Clinical case management involves 13 distinct activities, including engagement of the patient, assessment, planning, linkage with resources, consultation with families, collaboration with psychiatrists, patient psychoeducation, and crisis intervention.

Mr. Kanter is a team leader on the community care unit at the Mount Vernon Center for Community Mental Health in Alexandria, Virginia, and a faculty member of the Washington School of Psychiatry in Washington, D.C. Address correspondence to him at 305 Hamilton Avenue, Silver Spring, Maryland 20901. An earlier version of this paper was presented at the Hospital and Community Psychiatry Institute held October 25-29, 1987, in Boston.

As case management of mentally ill individuals becomes an important cornerstone of community treatment, the lack of clearly articulated models of case management practice has become increasingly apparent. While case management is an important function for many staff in community programs, there is no consensus about what case management is or how it should be practiced.

In this paper, I will outline a model of clinical case management that reflects the actual practice of case management with a diverse group of mentally ill persons. This approach contrasts with much of the case management literature that is written by policy planners or administrators and that emerges from a more abstract analysis of patient and system deficits (1-6). Moving beyond a limited view of the case manager as a systems coordinator, service broker, or supportive companion, this model recognizes that case managers, when not overwhelmed by massive caseloads, are concerned with all aspects of their patients' physical and social environments, including housing, psychiatric treatment, health care, entitlements, transportation, families, and social networks (7-9).

Definition

Clinical case management can be defined as a modality of mental health practice that, in coordination with the traditional psychiatric focus on biological and psychological functioning, addresses the overall maintenance of the mentally ill person's physical and social environment with the goals of facilitating his or her physical

survival, personal growth, community participation, and recovery from or adaptation to mental illness.

This definition has several distinctive components. First, it identifies case management as a modality of mental health practice, recognizing the necessity of special training and skills comparable to those required in psychotherapy, psychopharmacology, or psychosocial rehabilitation. Clinical case management is a specialized professional field practiced by case managers and other mental health clinicians; it is not merely an administrative system for coordinating services (10).

Second, while focusing on the patient's physical and social environment, this definition recognizes the importance of integrating case management into a comprehensive biopsychosocial treatment plan. In contrast with case management models that advocate segregating case managers from clinical staff (11-13), this approach requires close collaboration between case managers, psychiatrists, and other clinical staff.

Finally, this definition of case management focuses on all aspects of the physical and social environment. While many approaches use the Joint Commission on Accreditation of Hospitals' definition of case management (14), which emphasizes linkages to formal resources of the physical environment such as housing, entitlements, and medical care (12,15), clinical case management recognizes that informal resources of both the physical and the social environment are often essential to survival and growth. From this perspective, a

mere referral to a housing program is an inadequate response to a person who needs to develop a social network and fulfilling daily activities.

Principles of clinical case management

Before the components of clinical case management practice are outlined, five central principles will be discussed.

Continuity of care. Even though "continuity of care" has become a bureaucratic catchphrase with little clinical significance, it should reflect an appreciation of the patient's need for support and treatment over an extended period. Long-term patients, who have difficulty forming trusting relationships and maintaining historical perspective (16), are best served by ongoing personal relationships with case managers who are familiar with the past and present manifestations of their illnesses, their past and present personal functioning, and their social networks.

While many treatment approaches advocate simplistic, time-limited approaches to assessment, planning, and treatment (17), longitudinal studies of the mentally ill suggest that progress is made through extended experimentation between clinician and patient as they try out and evaluate a variety of treatment strategies (18,19). For example, should case managers schedule relapsing patients for a psychiatric consultation, or should they address stressors with supportive psychotherapy or environmental changes? If hospitalization is indicated, should they negotiate a voluntary admission or work with other caregivers to obtain a commitment order? With each situation, case managers develop an increasing capacity to make such clinical judgments.

Use of the case management relationship. Personalized continuity of care involves more than just elegant discharge plans or attractive records. Case managers gradually develop collaborative relation-

ships with patients, families, and other caregivers. These relationships enable case managers to intervene more skillfully over time, preventing crises when clinical status or external resources change. For example, relapse may be averted if patients, concerned relatives, or other caregivers contact case managers when they first notice prodromal symptoms, allowing medications to be adjusted and stressors to be alleviated.

The case management relationship encompasses all of the interpersonal dynamics inherent in psychotherapy. Although most case managers attempt to interact with their patients on a conscious and concrete level, transference and countertransference reactions abound (7,20). These reactions crystallize around the reality nuclei of the parental functions at the core of the managerial relationship (21).

Although the analogy of case manager as "travel companion" instead of "travel agent" (22) has a humanitarian appeal, mentally ill persons require case management when they have substantial deficits in their social skills, judgment, and initiative that interfere with successful community functioning. Thus as case managers help patients negotiate with a complex social environment, their role can be conceptualized more accurately as one of "travel guide."

Case management interventions invariably reflect an ongoing assessment of patient capabilities and limitations analogous to assessments made by parents. Conflicts inevitably occur when patients, case managers, and other caregivers disagree in their evaluation of what patients are able or willing to do. Even though most case managers explicitly support the principle of client self-determination, these tensions occur and should be consciously acknowledged.

Titrating support and structure. While prior conceptualizations of case management have focused on providing or brokering services to patients viewed as in-

ept and resourceless, clinicians and researchers have recognized both the heterogeneity of persons with long-term mental illness and the variable course of these disorders (23). Like psychiatrists who adjust medication dosages to reflect the patient's fluctuating competence in coping with an ever-changing world, case managers collaborate with patients and social networks in titrating the levels of environmental support and structure needed to facilitate survival, personal development, and adaptation to mental illness (24).

In case management as in psychopharmacology, both inadequate and excessive dosages—here, dosages of environmental variables such as support, structure, and stimulation—have deleterious effects (25). In many communities, inadequate resources have had a more visible impact (as in the plight of the homeless mentally ill) than have excessive supports. However, empirical studies have demonstrated that lower levels of social support sometimes have more positive effects than higher levels (26–28).

Recognizing patients' changing needs, case managers commonly offer high levels of support, including assistance with housing, transportation, and entitlements, when patients re-enter community life after psychiatric hospitalization. As patients' mental status stabilizes, support is reduced, and patients are expected to manage more of their own affairs. Case managers confront many clinical decisions as they determine the appropriate pace for reducing their support. When should the case manager stop reminding a patient in advance of an appointment? When can a patient begin using public transportation? When can a patient be transferred from a group home to a supervised apartment? Although these questions may appear mundane, such clinical judgments may result in unfortunate outcomes.

Flexibility. Patients' changing internal and external worlds require case managers to flexibly

tailor their intervention strategies to accommodate diverse patient needs. The frequency, duration, and location of interventions should reflect an appreciation of each patient's individual needs and wishes. In various situations, case managers may meet their patients daily, weekly, monthly, or even quarterly for different lengths of time. Contacts may occur in the office, home, day program, or neighborhood. Because case management patients generally lack faith in human relationships, this technical flexibility is often an essential element in the engagement process.

This flexibility is a means to achieving case management goals, not an end in itself. With many patients, firmness is sometimes more essential than flexibility. For example, a patient with a long history of medication noncompliance may be asked to begin injectable medications before referral to a supervised apartment program.

Facilitating patient resourcefulness. In finding the proper balance between flexibility and firmness, clinical case managers attempt to facilitate their patients' personal resourcefulness, helping them manage their own lives. Most case managers overtly support this goal, although many attend more to patients' needs and deficits than to their strengths and assets. While professional training helps clinicians identify psychopathology, functional deficits, and inadequate environmental resources, many contemporary treatment models overlook the ways patients participate in their own recoveries (29,30).

Similarly, case managers often ignore the importance of informal social networks and "competent others" in the recovery process (31-33). When case managers begin relationships with newly discharged patients, they have difficulty determining whether the patients' current functional impairments and environmental deficits, often affected by residual symptomatology, reflect transitory or long-term status (34).

As Harding and associates (23) have suggested, our expectations are shaped by clinical experience with more dysfunctional patients. While patients who fall between the cracks and relapse after a premature discharge quickly come to our attention, we often are less aware of the many patients who improve dramatically in their first weeks in the community.

Components of clinical case management

In many discussions of case management, five core components are enumerated: assessment, planning, linking, monitoring, and advocacy (1,6). Although most case managers perform these activities, this brief listing evokes a service-brokerage approach that does not reflect clinical case managers' comprehensive participation in their patients' lives.

As a result of examining the actual practice of case managers in a variety of agency settings, 13 components of case management practice have been identified (see Table 1). Beginning with the initial-phase components of engagement, assessment, and planning, these activities include interventions focused on the environment, inter-

ventions focused on the patient, and interventions encompassing patient and environment. While some authors and administrators have attempted to delineate various levels of case management activity (6), case managers, when not overburdened with massive caseloads, commonly move beyond restrictive program mandates to deliver the comprehensive range of services described here.

Initial interventions

Engagement. Engaging long-term patients in a case management relationship requires skill, sensitivity, and patience. Even though patients may have severe impairments, they often deny their difficulties and are reluctant to collaborate in any helping relationship. They worry that the recipient role will require them to relinquish their autonomy or become overly dependent.

The literature on psychotherapy with schizophrenic patients discusses many of the dynamics that arise in the process of engagement, and these observations can be adapted to the case management relationship (35-37). Although some case management literature implies that the engagement process can be resolved in weeks or months (11), building stable, collaborative relationships with mentally ill persons often takes several years.

Assessment. Case management assessment of long-term patients requires more than just evaluating their stated wishes, daily living skills, and environmental resources. It also involves an appreciation of their clinical status, conscious and unconscious motivations, latent capabilities, and social networks (34,38). Developing a comprehensive understanding often requires repeated personal contact and observation, reports from significant others, and a thorough review of prior functioning and treatment. Without accurate assessment, heroic case management interventions frequently are unsuccessful. A homeless schizophrenic patient may be unable to tolerate

Table 1
Components of clinical case management

Initial phase
Engagement
Assessment
Planning
Environmental interventions
Linkage with community resources
Consultation with families and other caregivers
Maintenance and expansion of social networks
Collaboration with physicians and hospitals
Advocacy
Patient interventions
Intermittent individual psychotherapy
Training in independent living skills
Patient psychoeducation
Patient-environment interventions
Crisis intervention
Monitoring

the excessive stimulation of an energetic halfway house, while a borderline patient may be unable to tolerate the isolation of an efficiency apartment.

After addressing presenting concerns, case managers can begin to formulate an assessment for long-term planning. For example, should the patient and family be encouraged to work toward competitive employment, or should they be helped to accept a lifetime of disability? Can the patient consider independent living, or will he or she always require a supervised setting? Recent findings from longitudinal studies can help case managers make more informed judgments (39).

Planning. Planning in case management must reflect an appreciation of each patient's conflicting wishes and needs (34). Although patients often present their desires in a simple and straightforward manner, their needs are usually more complicated. Like all of us, they want both freedom and security, independence and dependence. In many cases, they want both the autonomy of their own apartment and the parental care available in the family home.

In order to formulate useful plans, case managers must appreciate their patients' conflicting conscious and unconscious motives, especially the ongoing struggle between their yearnings for independence and dependence. Psychically unable to integrate these strivings, patients externalize this conflict, requesting assistance to achieve both ends with little awareness of the intrapsychic struggle. They may ask case managers to help them separate from parents and then—weeks after a placement has been painstakingly implemented, and perhaps after relapse and hospitalization—they may return home.

To avoid such outcomes, case managers must restrain their understandable impulses to stop the swinging pendulum of these conflicting strivings by preparing elaborate service plans or written contracts. Such countertransference re-

actions are a major cause of failed service plans. In many situations, case managers can do no more than helplessly witness their patients' internal struggles, assisting when possible during crises. Case managers must learn to tolerate the helplessness induced by patients' alternately submissive and rebellious behaviors and must patiently wait—often for many months—for this conflict to subside.

Finally, we must openly acknowledge that case managers sometimes plan *for* as well as *with* their patients (40): that they sometimes act from a knowledge of their patients' best interests even when that course diverges from patients' expressed wishes. However, like other mental health professionals (41,42), case managers are often uncomfortable with the explicit and implicit authority of their role.

For example, case managers commonly initiate involuntary hospitalizations when patients endanger themselves or others. In other situations, they insist that patients take medications, or they counsel other caregivers on compliance issues. Although each of these actions may elicit patients' resentment, case managers can establish respectful relationships by acknowledging the authoritative elements of their professional role.

Environment-centered interventions

Linking with community resources. When linking patients with needed community resources, case managers must determine how much assistance patients need to complete a referral. Some patients are skilled at making their own connections, needing only the phone number of an appropriate agency. Others can manage if the case manager prepares the agency for the referral. Still others require a case manager or "competent other" (33) to personally accompany them to the new agency.

When case managers have established personalized working relationships with staff from other agencies, they can help their pa-

tients assume greater responsibility for negotiating service linkages. By developing a genuine appreciation of the concerns of other agencies, case managers can effectively prepare both patients and staff for what they can expect from each other.

Harris and Bergman (9) have eloquently outlined the therapeutic impact of patients' internalizing the integrative, rational, and proactive capacities implicit in case managers' environmental interventions. These negotiations provide patients with "a model for operating in the world as a capable individual, secure in the ability to influence external events." However, to help patients develop these capacities, case managers must empathically support a trial-and-error process that enables them to experiment with increasing autonomy as assistance is decreased.

Consulting with families and other caregivers. The relationships of case managers with important caregivers do not end with a completed referral. Nor should they be limited to formal agencies. When patients are dependent on either formal or informal caregivers, case managers should initiate consultations on an ongoing or intermittent basis. These caregivers may include family, friends, clergy, prison personnel, or staff from shelters, residential programs, day programs, or sheltered workshops.

In many cases, the quality of the patient's survival in the community is dependent on the concern, competence, and commitment of these caregivers. Besides offering information about mental illness and behavior management, case managers should be available to address questions or crises as they arise. Common issues include medication, changes in mood or behavior, and availability of community resources. Prompt response to such concerns, often with a brief phone call, frequently averts serious crises.

Family caregivers have special needs beyond those of professional and paraprofessional service pro-

viders. Unlike foster care providers or group home counselors, they have a long-term ethical obligation to their mentally ill relative. Because families do not voluntarily assume these obligations, they may also be more resentful about the burdens they shoulder, especially when they are not compensated with monetary rewards or the patient's love, gratitude, and reciprocal assistance. When burdens are excessive, case managers can help families locate suitable residential placements.

Finally, families are more concerned than other caregivers about their relative's future prospects for recovery and community adaptation. While some questions can be addressed in psychoeducation groups (43,44), most families can benefit from an ongoing consultative relationship with the patient's case manager (45-47).

Maintaining and expanding social networks. Case managers also strive to help patients maintain and expand social networks apart from families and formal caregivers (48). When such networks are functional, they address many social and physical needs, allowing families and case managers to focus their energies on specific concerns. An interested friend or neighbor can transport a patient to the clinic or invite him to a Christmas party. A fellow church member may know of a vacant room or suitable job. Because these relationships are initially difficult to assess, case managers should maintain an ongoing interest in such contacts, sometimes visiting patients in their home, neighborhood, or day program.

Collaboration with physicians and hospitals. Collaboration with psychiatrists, other physicians, and hospitals is an important component of clinical case management, in contrast with other case management models (11-13). Most notably, the impact of such collaboration can be observed in the maintenance of an effective medication regimen. As medication response is often more apparent to caregivers than to patients, psy-

chiatrists often must depend on case managers to monitor patient functioning between interviews. Also, because case managers are familiar with the home environment, they can help psychiatrists establish dosage schedules that facilitate compliance. Finally, they can help patients and caregivers cope with medication side effects, facilitating prompt psychiatric review when appropriate.

The relationship between case managers and hospitals is equally important. To promote effective treatment when patients are rehospitalized, case managers can provide hospitals with information about premorbid functioning, precipitants of relapse, and treatment history.

Familiar with both patients and community resources, case managers also play a pivotal role in the discharge planning process. Besides attending interagency planning meetings (49), case managers can collaborate with hospital staff in confronting patients about behaviors that impair community functioning. Finally, case managers can also use the hospital to establish or repair relationships with difficult patients. A visit to a hospitalized patient may demonstrate the case manager's interest more vividly than hours of community intervention.

Advocacy. The case management literature has largely neglected the clinical dimension of effective advocacy. While some authors recommend investing case managers with "clout" (13), successful advocacy is facilitated when case managers articulate patient assets and deficits, empathize with the concerns of providers, and offer them ongoing support and consultation. While "clout" may help patients initially obtain services, it may also elicit providers' resentment and anxiety, which often destabilize the referral.

Although case managers prefer to advocate for their patients' stated wishes, they must sometimes advocate for their best interests instead. In particular, case

managers must take this position when initiating commitment proceedings. In such instances, they should acknowledge that their action may damage the case management relationship.

Patient-centered interventions

Intermittent individual psychotherapy. Since Lamb's presentation (50) of the therapist-case manager model, the relationship between case management and psychotherapy has been a major source of controversy. Many authors have criticized this model, arguing that most therapists neglect the management needs of long-term patients (11,51). While this neglect has occurred in some programs, most case managers, trained or not in psychotherapy, frequently counsel patients on a variety of concerns, including social relationships, impulse control, affect modulation, or self-esteem. These concerns often require prompt attention, preempting referrals for psychotherapy to other agencies or departments. In everyday practice, case managers address many of their patients' psychotherapeutic needs, especially as so few continue in a more traditional long-term psychotherapy (28).

Thus in most cases the issue is not whether the patient has both a case manager and a psychotherapist, but whether the case manager is effectively providing psychotherapeutic interventions. Although case managers may not label conversations about roommate conflicts as "psychotherapy," the skills involved are largely identical to those required in psychotherapy. The case manager must build a relationship, respect defenses, explore relevant issues, and consider what sort of reflective, clarifying, or interpretive comments are most appropriate. Everyday stressors, such as roommate conflicts, can often be alleviated by ego-supportive conversations (52-54), and possible relapse or homelessness averted.

Although such interventions are most often made on an intermit-

tent basis, a sense of continuity eventually develops. As issues resurface over time, case managers become increasingly knowledgeable and empathic. As in traditional psychotherapy, case managers gradually establish a therapeutic alliance and struggle with transference and countertransference reactions.

Teaching independent living skills. Case managers directly tutor their patients in a range of independent living skills, including money management, nutrition, household maintenance, and transportation. This teaching sometimes occurs in planned, didactic interventions, but more often takes place informally as patients cope with the exigencies of daily life. Case managers can support patients in trying new experiences that offer naturalistic reinforcements of daily living skills (55).

Patient psychoeducation. While family psychoeducation has received more attention, patient psychoeducation is an important component of case management (56). Helping patients begin to acknowledge and accept their disability is one of the major clinical challenges of community treatment (57).

Compared with other disabled groups, mentally ill persons find it especially difficult to establish a sense of identity unimpaired by feelings of grandiosity or insignificance. Some are helped by a straightforward discussion of their diagnosis, which enables them to appreciate their impairment (58). Others become more defensive, denying their difficulties when confronted by didactic interventions. Within the context of a long-term relationship, case managers can explore ways of helping patients accept their impairments and develop a perspective that combines hope with realism.

Patient-environment interventions

Crisis intervention. Over time, case managers spend as much time intervening in crises as they do in any other activity. Familiar with their patients and their social net-

works, they can intervene more skillfully and efficiently than specialized crisis services. Optimally, patients and caregivers will contact a trusted case manager before crises have escalated. A simple phone call can clarify a letter from Social Security, arrange for a medication refill, or address similar concerns that may precipitate relapse.

Case managers' knowledge of the patient and his or her social network enables them to rapidly assess the significance of changes in clinical status. In some instances, seemingly minor changes may pre-empt relapse. In other cases, severe symptoms may be weathered by a determined patient receiving adequate support.

Monitoring ongoing progress. While monitoring patient progress, case managers must balance demonstrations of concern with respect for patient autonomy. Fearing both approval and disapproval, patients often experiment with new activities and behaviors without consulting with case managers or other caregivers. Like adolescents, they want both the sustained interest of their caregivers and the privacy to learn by trial and error. Case managers must learn to tolerate these conflicting wishes, remaining aware that a friendly phone call sometimes may be greeted with suspicion.

Case manager training

The above activities outline a model of clinical case management that requires a professional level of skill and competence (7-9). This model can be differentiated from both the traditional professional interventions of psychotherapy and chemotherapy and the paraprofessional interventions of the service-brokerage (4,6) and supportive care (2,11) models of case management.

Clinical case managers should have the personal commitment and compassion implicit in supportive care models and the bureaucratic skills implicit in service-brokerage models. They should also be trained in an array of clinical skills,

including assessment, treatment and service planning, consultation, supportive psychotherapy, and crisis intervention. To help formulate creative responses to unpredictable situations, case managers can benefit from a formal grounding in the behavioral sciences.

Although none of the traditional mental health disciplines (psychiatry, social work, nursing, and psychology) systematically educate its trainees in this array of interventions, many effective case managers are professionals with graduate training. Other skilled case managers lack formal professional training, yet, like battlefield medics, have developed formidable skills through intensive clinical experience and comprehensive inservice training.

Case managers who autonomously deliver an array of interventions can be differentiated from "case aides" who provide limited services under careful supervision. Certainly paraprofessional and volunteer staff can assist case managers by accompanying patients to a new agency, teaching daily living skills, or monitoring ongoing progress.

However, if the competencies necessary for clinical case management are to be developed, generic training in the mental health disciplines must be augmented by years of continuing education and clinical supervision. A realistic approach to developing case management manpower requires a combination of changes in graduate training programs (particularly in social work and psychiatric nursing), intensive inservice training and supervision, and salary incentives that promote the pursuit of continuing professional development.

Caseload size

As case management programs are rapidly being established, administrators often express concerns about optimal caseload size. As in analogous discussions of classroom size, this determination cannot be made without evaluating patient characteristics, community

resources, and program goals. Factors affecting optimal caseload size include patients' current and pre-morbid functioning; the mixture of newly referred unstable patients and long-term stabilized patients; the risk level of the target population (59-61); the availability and accessibility of other community resources; and the program's success in attracting and retaining skilled case managers.

Depending on these factors, optimal caseload size may range from five to 50 patients. Caseloads must be small if they consist of high-risk populations of acutely psychotic individuals (60) or deinstitutionalized inner-city patients with few personal or social resources (59,62). With more heterogeneous patient populations and established networks of community resources, larger caseloads are feasible (63).

Discussion

The clustering of 13 different components in the clinical case management model raises several important questions. First, is there any unifying conceptual principle that links these disparate interventions, or are they merely a random listing of staff activities? The identification of these components has emerged from a simple examination of actual case management practice, not from program ideologies or job descriptions. These components reflect essential activities not included in either the service-brokerage or supportive care models, activities requiring both clinical skill and environmental interventions.

As outlined in the definition, the participation in the patient's environment—in all aspects of the patient's life in the community—is the unifying principle that underlies clinical case management. This participation involves directly interacting with formal and informal community resources as well as helping patients manage their own interactions with the environment. These interventions do more than maintain the patient in a secure community setting; they also fos-

ter the patient's development and capacity for autonomous functioning (9).

Assuming the importance of these case management components, is it viable for a single individual or small team to personally conduct most of these interventions? Might not patients be better served by a network of helping persons with relevant specializations? In some communities, a given patient has a case manager (service broker), a psychotherapist, a "family clinician" (43), a hospital liaison worker, a mobile crisis team, a skills trainer, and, of course, a psychiatrist.

Although this array of specialists functions collaboratively in some hospitals, the likelihood of such cooperation in community settings is minimal. Stationed in different agencies and programs, these specialists are unlikely to submit to the sort of clinical leadership that is exercised by hospital psychiatrists. Yet without such leadership, patients are often pulled in different directions.

To promote continuity of care, clinical leadership in community settings is best provided by small professional teams of case managers and psychiatrists (60,61,64). Although some might argue that community psychiatrists should be directly involved in most components of case management, a division of labor between psychiatrists expert in biological interventions and case managers expert in environmental interventions efficiently uses available mental health personnel. While both kinds of professionals have their unique realms of expertise, they must base their collaboration on an integrated biopsychosocial understanding of mental illness and human behavior.

Finally, are the clinical skills implicit in the clinical case management model (8-10) compatible with the personal qualities of enthusiasm, commitment, warmth, and respect emphasized in other approaches to case management (11,12)? Will clinical case managers be tempted to retreat behind their desks, preferring to distance

themselves from their patients and communities? Because career opportunities for case managers are still limited by low status and remuneration, these questions await further study. Yet patients are ill served by having to train succeeding generations of case managers who leave as they become competent. In coming years, we need to develop professional value systems that recognize both the clinical skills and the personal qualities demonstrated in our best examples of community treatment (65).

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