Improving the Quality of Community Care for the Chronically Mentally Disabled: The Role of Case Management

by James Intagliata

Abstract

This article draws upon an extensive case management literature in order to integrate a number of key concepts and findings that must be considered by those responsible for the planning, administration, and provision of effective community care to the chronically mentally disabled. A discussion of the reasons for the current popularity of the case management concept within human services is followed by a detailed presentation of the objectives, ideology, functions, and structural elements that characterize case management systems. A series of practical problems and issues that must be addressed to effectively implement a case management system are then identified and analyzed. Finally, a set of recommendations for those developing case management systems is offered, and a number of important unanswered research questions about the delivery and impact of case management services are identified.

Although case management is not a new idea, it has gained increased popularity in the human services field in recent years, particularly as a mechanism for improving services delivery to chronically mentally disabled[1] persons. To appreciate the case management concept, it is useful to begin by examining some of the factors underlying its current popularity.

The pressing need for case management has emerged in response to two major forces that have radically changed the human services environment over the last two decades. The first of these is the rapid expansion of human service programs that took place throughout the 1960s and continued into the 1970s. As a result of this expansion, the overall availability of services increased significantly. Because public funding for these programs was provided primarily through narrow categorical channels, however, the network of services that has resulted is highly complex, fragmented, duplicative, and uncoordinated. Countless individual programs have been developed to provide extremely specialized services or to serve narrowly defined target groups. While these factors interfere with service accessibility for all potential users, the barriers are particularly burdensome for those persons whose complex problems require them to engage in multiple, disconnected programs in order to get the assistance they need.

This situation was recognized by many professionals, even during the early 1960s. For example, the President's Panel on Mental Retardation (1962) expressed concern about the ease with which consumers could secure needed services. According to this panel, the

[1]The term "mentally disabled" is used here to refer to both the chronically mentally ill and the mentally retarded.

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concept of a "continuum of care" was a critical consideration for service system planners and involved:

> The selection, blending and use in proper sequence and relationship, the medical, educational and social services required by a retarded person to minimize his disability at every point in his life span. . . . A continuum of care permits fluidity of movement of the individual from one type of service to another while maintaining a sharp focus on his unique requirements. The ongoing process of assuring that an individual receives the services he needs when he needs them and in the amount and variety he requires is the essence of planning and coordination.

Unfortunately, the networks of services in most areas have not developed with the planning or coordination necessary to ensure quality care for consumers. For example, Test (1979) notes that most professionals' familiarity with continuity of care consists of a variety of cliches that describe its absence. It has, in fact, become commonplace to use such terms as "the fragmented system," or to refer to the patients who "fall through the cracks" or "become lost in the system."

In response to these problems increasing attention has been given to the concept of services integration, especially by federal, state and local levels of government. In the early 1970s, the Department of Health, Education, and Welfare recognized the need for improved coordination of its own programs at state and local levels, and proposed a legislative initiative, the Allied Services Act, to facilitate integration of services. The Department also began a series of demonstration projects—the Services Integration Targets of Opportunity (SITO) grants—to test various services integration techniques at the state and local levels.

Under the SITO grants numerous service integration techniques were developed and demonstrated, including client-tracking systems, information and referral mechanisms, one-stop service centers, specialized management information systems, interagency planning and service delivery agreements, computerized resource inventories, and management reorganization projects (Mittenthal 1976; Morrill 1976). The one additional feature that was common to most of the SITO projects was creation of the role of "systems agent," operationally a case manager, who was expected to coordinate system resources for individual clients and to be accountable for successful client transit of the system. Thus, the widespread use of case managers as part of SITO efforts directed increased attention to the case management concept.

A second force that has radically changed the human services system, and that has also contributed to the current popularity of case management is deinstitutionalization. Before the movement toward deinstitutionalization, many thousands of mentally disabled persons were served in large public institutions. Though the institutions themselves were frequently characterized by overcrowding and dehumanizing conditions, the institutional model nevertheless offered the potential to meet all resident needs "under one roof" and thus provide reasonable continuity of and clear accountability for care (Kirk and Therrien 1975).

When mentally disabled persons were released from institutions, however, responsibility for their care and support generally became diffused among several agencies and levels of government. The roles and responsibilities of these agencies and specific actions that needed to be taken to meet the special needs of deinstitutionalized persons were not clearly defined, understood, or accepted (Government Accounting Office 1977, p. 24). As a result, deinstitutionalized persons were forced to depend for their support on a complex, uncoordinated network of community service agencies.

Although many people could manage such a situation reasonably successfully given sufficient persistence and patience, the mentally disabled, whose own abilities to cope are significantly impaired, were generally incapacitated by it. Thus, most did not receive the services they needed, either because the services did not exist or because they were unable to obtain them on their own (Test 1979). The negative consequences of failing to provide adequate and appropriate community care to deinstitutionalized persons have received widespread attention in recent years (Lamb and Goertzel 1977; General Accounting Office 1977; Bassuk and Gerson 1978; Segal and Aviram 1978; Willer, Scheerenberger, and Intagliata 1978). In response, a number of important initiatives have been developed to address the special needs of this population.

To meet the needs of the chronically mentally ill living in the community, the National Institute of Mental Health (NIMH) has developed the conceptual framework for a comprehensive network of required services—the "community

support system" (CSS)—and has provided funds to operationalize this concept through demonstration projects in 19 states and the District of Columbia (Turner 1977; Turner and TenHoor 1978; Turner and Shiffren 1979). The positive aspects of this comprehensive support approach for dealing with schizophrenic populations have been highlighted by Mosher and Keith (1980) in their review of psychosocial treatment strategies. At least 10 different potential elements of community support programs have been identified as part of the CSS concept. However, case management is considered to be the key element since it provides the mechanism for coordinating all system efforts.

There has also been considerable attention given to the need for better integration of the services provided to deinstitutionalized mentally retarded persons. In recognition of the need for better coordination of the community-based care of this population, specific services integration mechanisms were mandated by Congress in the Developmentally Disabled Assistance and Bill of Rights Acts of 1975 (DD Act, PL 94-103) and 1978 (DD Act, PL 95-602). In the 1975 version, there is a requirement that each client be assigned a "program coordinator" responsible for implementing the person's individual habilitation plan and attending to the "total spectrum of the person's needs." The 1978 version specifically mandates that coordination be achieved by the delivery of "case management services" to all eligible persons. These services are to involve an ongoing relationship between the clients and an agency or provider to ensure access to and coordination of all social, medical, educational, and other needed services.

In summary, the rapid expansion of human service programs created a sprawling, fragmented network of services. The subsequent attention given to the difficulties experienced by consumers in general, and the deinstitutionalized mentally disabled in particular, has led to the current widespread interest in services integration techniques, especially case management.

The Concept of Case Management Services

Numerous definitions of case management have appeared in the human services literature in recent years. Though they vary somewhat, their common theme suggests that case management is a process or method for ensuring that consumers are provided with whatever services they need in a coordinated, effective, and efficient manner. The specific meaning of case management, however, depends upon the system that is developed to provide it. In turn, the particular characteristics of the system are shaped by the context in which it is expected to operate. The characteristics that more fully define case management systems include objectives, ideology, functions, and structural elements.

Objectives. A variety of objectives have been associated with case management efforts. Perhaps the most fundamental of these is to enhance the *continuity of care* provided to clients. Test (1979) suggests that continuity of care, in fact, has two dimensions. The first is cross-sectional such that, at any given time, the services provided to an individual are comprehensive and coordinated. The second dimension is longitudinal, and necessitates that the system continue to provide comprehensive, integrated services over time, as well as be responsive to ongoing changes in the person's needs. This longitudinal dimension is particularly critical when case management systems are intended to serve populations whose disabilities are not only significant but also lifelong. Thus, to ensure continuity of care, case management efforts must take both of these dimensions into account.

Other objectives frequently associated with case management are the enhancement of *accessibility* and *accountability* within the service system. As mentioned previously, the current human services system comprises multiple categorical programs, each with its own eligibility criteria, regulations, policies, and procedures. As a result, clients are likely to experience significant difficulties in gaining access to many of the services they need. Case management with its provision of a designated agency or service provider to assist clients in negotiating the system is thus intended to make services more accessible. Another consequence of the fragmented character of the service system is that it becomes exceedingly difficult to assure accountability when multiple agencies are involved in meeting a client's needs. Case management is intended to enhance accountability by designating a single person or agency as responsible for the overall effect of the system (Baker and Northman 1981).

One final objective of case management is to enhance the *efficien-*

cy of service delivery within the system. In the absence of case management it is frequently reported that clients either fail to receive the services that match their needs or, if they receive services, they are provided in an improper sequence or untimely fashion. Thus, the potential positive effects of available services are greatly diminished. By fixing responsibility for developing and implementing a coordinated service plan on a single person or agency, however, case management is intended to improve the efficiency of the service system.

This objective of enhanced efficiency is sometimes equated with that of reducing costs for service delivery. While, in theory, case management might reduce costs within the system, in practice, case management often results in the identification of more client needs and the delivery of more services (Mittenthal 1976; Morrill 1976). Thus, while the specific services delivered to clients may be more cost-effective, it does not necessarily follow that total service costs per client will be reduced by case management.

Ideology. To understand the case management concept, it is also important to be aware of the ideology or belief system that accompanies it. The following components typically characterize this ideology:

- The planning and implementation of service plans must be responsive to the fact that individual clients are unique, each with their own set of strengths and needs.
- The services and supports provided to clients must vary over time in their type and intensity if they are to continue to fit the changing configuration of each client's strengths and needs.
- The level of support provided to clients should match the degree of their individual deficit. Clients should be encouraged to function as independently as they can.
- The commitment of case management services to clients must be open-ended. It is a support that must be made available around-the-clock and throughout the lifespan according to clients' needs.

If those designing a case management system wish it to operate according to these principles, care must be taken to design and scrutinize all aspects of the system so that they are taken into account (Jessing and Dean 1976). The subsequent discussion of the functions and structures of case management systems will illustrate how these aspects of case management ideology are, in fact, operationalized.

Functions. Case management is frequently presented as a process comprised of multiple functions without specifying the persons or structures responsible for carrying them out. According to Agranoff (1977), the five basic functions of a case management system include:

- Assessment of client need;
- Development of a comprehensive service plan;
- Arranging for services to be delivered;
- Monitoring and assessing the services delivered;
- Evaluation and followup.

These five functions—assessment, planning, linking, monitoring, and evaluation—in fact appear in almost every description of a case management system, regardless of its context.

There are additional functions, however, that are considered to be important components of some case management systems. While some of these functions might be subsumed under Agranoff's five basic functions, a number of them clearly expand the role to be played by a case management system. The additional functions that appear most frequently in case management systems are outreach, direct service provision, and advocacy.

The appropriate range of functions for a case management system varies with the context. Acknowledging this, Ross (1980) offers three different models for case management programs designed to serve elderly persons in need. Table 1 presents the set of functional components associated with each of the three models. According to the author, the major difference among them is the increasing amount of control over provider agencies that is exercised in the coordination model and the comprehensive model. This multimodel conceptualization is offered not to suggest that the more comprehensive models are necessarily more effective, but rather to illustrate that there is a range of options to consider when designing or implementing a case management system.

Structural Elements. While it is useful to describe case management systems in terms of goals and functions, one must ultimately discuss the specific structural char-

Table 1. Three models for case management programs[1]

Minimal model	Coordination model	Comprehensive model
Outreach	Outreach	Outreach
Client assessment	Client assessment	Client assessment
Case planning	Case planning	Case planning
Referral to service providers	Referral to service providers	Referral to service providers
	Advocacy for client	Advocacy for client
	Direct casework	Direct casework
	Developing natural support systems	Developing natural support systems
	Reassessment	Reassessment
		Advocacy for resource development
		Monitoring quality
		Public education
		Crisis intervention

[1] Ross (1980).

acteristics that are required to enable such systems to function effectively. Though the functions that define case management do not necessarily require that one create a role for a person termed "case manager," this is by far the most common structural characteristic of case management systems.

Case manager. The need for a human services generalist worker whose function is to coordinate services for the individual client has been recognized since the early 1960s (Intagliata 1978). The concept of an expeditor (case manager) was adapted by Reiff and Reissman (1965). Since that time, various labels have been used for this role including: case manager (the term to be used here), integrator, expeditor, broker, ombudsman, advocate, primary therapist, patient representative, personal program coordinator, systems agent, and continuity agent, to name but a few.

Case managers are the most critical components in the case management system. They serve as the human link between the client and the system. In collaboration with other providers, case managers ensure continuity of care to clients by ultimately determining the services, environments, providers, and duration of service that will be of greatest advantage to the consumer. In addition, the case manager has the responsibility for ensuring the achievement of the highest possible level of social, economic, and physical integration of consumers.

Specifying the particular functions performed by case managers is not a simple task. Although great care is often taken to define the scope of activities that case managers engage in, the reality is that substantial differences typically exist between officially mandated patterns of case manager activity and actual patterns of service (Caragonne 1979). The reason for this is that someone thrust into the case manager role must function essentially as a trouble-shooter, confronting and resolving a wide range of problems, many of which are unpredictable. More specifically, case managers have the unenviable task of assuring that clients receive appropriate, coordinated, and continuous care from service systems whose design provides for none of these features. As a result, persons acting as case managers must be ready to play whatever role the situation may require—outreach worker, broker, advocate, counselor, teacher, community organizer, planner, or administrator (McPheeters 1974; Turner and Shiffren 1979).

Undoubtedly, the comprehensiveness and intensity of the role that case managers assume should be tailored to fit the particular needs of the client populations being served. The case manager functions that are judged to be essential when serving one type of client may be elective or even inappropriate for another. However, three functions must be viewed as essential for case managers regardless of their clientele.

The first and perhaps most basic role that must be played by case managers in any system is *to remain aware of the comprehensive needs of their clients.* This means that case managers must be aware of, though not necessarily directly involved in, the initial intake and assessment of their clients. If these functions are assigned to other workers in the system, it is important that case managers be in close contact with them so that there is no slippage in the communication of crucial information. The assessment of client needs must be an ongoing process that does not stop after initial formal intake sessions. Thus, regardless of the role that case managers play during intake, they must stay in regular contact

with their clients, remaining sensitive to and observant of changes in their clients' needs. This activity is crucial because the case manager is the only provider in the system whose responsibility is being aware of the "whole" client.

A second basic function is *to link clients to services* that will meet their needs. To do this case managers must be aware of the resources that are available to their clients. These resources include both services and entitlements (e.g., food stamps, Medicaid). To be effective linkers, it is also important that case managers function as advocates for their clients. Though individual service plans may call for referral of clients to certain services, there may be barriers that inhibit clients from actually receiving them. Potential barriers include service agencies' restrictive regulations and policies or the reluctance of many generic providers to serve clients with particular disabilities (e.g., mental illness, mental retardation). In addition, it should be noted that it is sometimes the clients themselves who resist being served or "drop out" of service. While respecting clients' individual rights to refuse treatment, case managers should actively encourage clients to help maintain their motivation for treatment. This is especially true for adults with severe and chronic mental or emotional disorders (Turner and Shiffren 1979).

The responsibility to link clients to services does not require that case managers also be responsible for making the professional clinical decisions about which services are appropriate to meet their clients' needs. If, however, the development of an individual service plan is conducted by another professional or team of professionals, it is crucial that the case manager, as well as the client, be actively involved in the process. Involvement of the case manager has several important benefits: (1) it acquaints the case manager with the rationale and expectations for the treatment prescribed, (2) it allows the case manager an opportunity to inform clinical treatment staff about the local availability and adequacy of the services being considered, and (3) it provides the case manager with an opportunity to serve as the client's advocate, raising questions about specific decisions or making alternative suggestions.

The third essential function of case managers is *to monitor the services being provided to clients.* The most basic aspect of the monitoring process is to ensure that the agreed upon services are being received. This means that case managers must have ongoing contact with both clients and their service providers to ensure that appointments are being kept. In addition, the case manager must be responsible for assessing the appropriateness and effectiveness of the services provided. To do so, the case manager must not only keep in contact with the client and service provider but, if feasible, also visit with the client while the service or program is actually being provided. This kind of firsthand contact often provides valuable feedback otherwise missed. If case managers are not given the authority to change clients' treatment plans, then there must be effective mechanisms enabling them to communicate their observations to those persons who do make these decisions.

While the three activities of assessing, linking, and monitoring are the essential elements of the case manager's role, the "process" of carrying out these activities also requires consideration. *Perhaps the most influential aspect of the case management process is the quality of the personal commitment that case managers develop toward their clients.* The case manager is the human link between the client and the system, and the only service provider concerned with and responsible for the whole client. Individual case managers thus provide a mechanism for personalizing the service delivery system. The human relationships that develop between case managers and clients should be considered a fundamental strength of the case management model, and case management programs should be structured to facilitate and capitalize on this process.

While the essential aspects of the generic case manager role have been described, case managers who are expected to meet the needs of special populations, such as the mentally disabled, must assume more intensive and comprehensive client responsibilities. The special needs of mentally disabled persons necessitate that effective case management systems provide clients with such additional supportive services as:

- Assistance with managing problems of daily living;
- Crisis intervention;
- Individual level advocacy;
- Systems level advocacy.

However, while case managers ought to have some role in providing these types of special support, the extensiveness of each of these additional case-management func-

tions necessitates that certain aspects be delegated to other direct care staff, supervisory or administrative level staff of the agency providing case management, other specialized service agencies, and even consumer groups. A brief discussion of each of the additional supportive services will illustrate the considerations involved.

Case managers for the chronically mentally ill are commonly expected *to assist their clients with the management of simple life activities and practical daily problems.* In New York State, for example, case managers of CSS clients often provide their clients with the assistance or encouragement they need for the proper maintenance of their personal hygiene or individual households. Other supporting activities might include helping clients prepare a grocery list, accompanying them on a shopping trip, or transporting clients to a needed service if no other arrangements can be made.

Although case managers can be expected to provide some of the support that clients may need in managing daily activities, they clearly cannot meet all of their clients' direct service needs in this area. If system developers are not sensitive to this issue, there is the risk that case managers who are hired for the purpose of coordinating and monitoring the efforts of multiple direct service providers will themselves become another group of specialized direct care staff. Thus, systems planners might assign the responsibility of teaching clients community living skills to direct care staff who have special expertise in doing so. For clients who need continuous and intensive support in negotiating the community, other types of special service providers can be used.

Weinman and Kleiner (1978), for example, employed lay persons to act as enablers for chronic mental patients living in the community. These persons spent several hours each day with their individual clients teaching them basic community living skills, escorting and introducing them to services and resources in the community, and acting as a liaison to gain the understanding and support of neighbors and local merchants for their clients. This program was highly successful in facilitating clients' adjustment to the community and is an example of the way that case manager functions can be extended and provided more intensely through the use of specialized ancillary staff.

Another important case management function is *crisis intervention.* The need for this type of support is particularly critical for those clients whose abilities to cope with living stresses are impaired or deficient. For example, the adjustment to community living made by many formerly institutionalized psychiatric patients is quite tenuous. Significant crises may be precipitated by unexpected changes in the environment, even events that seem trivial to persons with a "normal" level of coping ability. If such crises are not managed in a timely fashion, they can easily lead to significant deterioration in clients' levels of functioning and perhaps to their rehospitalization.

Because of their frequent ongoing contact with clients, case managers are likely to encounter such crisis situations. At the minimum, they must be prepared to provide clients with personal support. However, case managers need not be expected to function as therapists or to assist their clients directly in resolving the crisis. Instead, it may be more appropriate for them to refer or accompany the client to a crisis intervention team or agency.

Individual client advocacy is yet another important case management function, since some agencies may be resistant to providing entitlements or services to chronically disabled persons. In many situations such barriers can be overcome by the case manager through informal interpersonal negotiation (Riffer and Freedman 1980). However, in more difficult cases it may be necessary for case managers to enlist the support of supervisory or administrative level staff within their own agency or even to make use of more formal channels to advocate for clients. This may involve seeking the assistance of legal aid services or of agencies that traditionally provide advocacy services for clients in need (e.g., Mental Health Associations, Associations for Retarded Citizens). In fact, because of administrative barriers and conflicts of interest, citizen groups and legal advocates rather than formal service providers are often in the best position to provide certain types of advocacy (Governor's Interagency Task Force 1979).

Thus, while individual client advocacy is an important case management function, it cannot be delegated solely to case managers. As with other functions, there may be a need to involve other levels of agency personnel or specialized providers of services in order to provide clients with the degree of support required.

A final case management function to be considered here is *sys-*

tems level advocacy. In the course of trying to assure that clients receive continuity of care, it is inevitable that case managers will identify gaps in the service system. In other words, the system to which they are attempting to link their clients is likely to be incomplete. Needed services will simply not be available. The role of case managers in such a situation is, at a minimum, to document the gap and make their supervisors aware of the situation. However, there is a need for more direct action if the situation is to be alleviated. This is another example of a case management function that must involve key actors in addition to case managers. The intervention that is required to develop new service resources must take place on a systems level.

In order to facilitate systems level change it may be appropriate for case managers to begin by banding together not only to document the unmet need as a group but to act as a catalyst stimulating others to act (Horejsi 1978). These others may be the group of clients who have a similar unmet need or the agencies that may be responsible for planning, funding, and implementing the needed services within the locale. If continuity of care is to be provided to clients, case management activities must take place at many levels within the system.

Thus far, this discussion of structures needed to provide effective case management has focused primarily on just one element, the case manager. The individual in this role has the responsibility for the coordination of services at the individual client level. While this level of coordination is essential, the effectiveness of the case manager's efforts is constrained by the degree of support provided for case management at higher levels within the system. Thus, in order for a case management system to operate effectively there must be other formal structures for assuring coordination and linkage of services on a systems level.

Core agencies. Although there are many possible approaches for assuring the systemic integration of services for given target populations, almost all of these involve the allocation of special coordinating power and authority to a specified agency at the local level. The President's Commission on Mental Health (1978, p. 65), for example, recommended that "state mental health authorities, in consultation with local authorities, designate an agency in each geographic area to assume responsibility for assisting the chronically mentally ill from that area." Consistent with this suggestion, NIMH, in its contracting for the development of community support systems, expects state mental health agencies to specify a "core CSS agency" in each planning area to act as a convenor and catalyst in assuring that the comprehensive needs of the CSS population are met. More specifically, this core agency is responsible for the assessment of the needs of the CSS population, the negotiation of the interagency linkages and agreements necessary to provide all needed support services including case management, and the development of new service components to remedy any gaps in the existing service network (Turner and Shiffren 1979).

The importance of establishing this type of structure as part of an effective case management system cannot be overemphasized. One of the major lessons learned from services integration efforts thus far has been that compliance with the coordination efforts of case managers depends on a formal set of contracts that bind providers to deliver specified services to case-managed clients (Mittenthal 1976; Ross 1980). The core agency for a given locale is the most appropriate negotiator of such contracts. However, it can negotiate and implement such agreements effectively only if it has real enforcement power. Such power can result from the control of funds to purchase services from other providers, legislation or guidelines that require providers to respond to case manager requests, or the core agency being designated to serve as the single entry point into the entire local provider system.

Another important role that can be played by a core agency is to take responsibility for the development of new service components. While a major function of case managers is to link clients to services, they cannot perform it effectively if needed services do not exist. Thus, one of the very real constraints that case managers face is the adequacy of the service system in which they operate. If the system needs to be moved, a core agency is likely to be a far more effective change-agent than is the case manager. Nevertheless, even a core agency is unlikely to function effectively in this role unless it is explicitly empowered with the authority or responsibility for local system development.

Summary. Case management is a complex function. If effective continuity of care is to be provided for clients, coordination must take place at many levels within the

system. Among the many possible structural elements that could be developed to implement case management, two have been specified as essential. The first is the case manager who provides coordination and integration of services at the client level. The second is the core agency which is responsible for coordination and linkage of programs at the local systems level. The specific details that must be considered when implementing the overall case management system are considered below.

Case Management Implementation

Systems Level Issues

Federal. In order for case management systems to function effectively, they need to be supported at all levels of governance within the service system. The federal level has already expressed clear support for the development of coordinated case management services for mentally disabled individuals. For the chronically mentally ill, federal support for the case management concept has taken the form of financial support of NIMH Community Support Program demonstration efforts, all of which have case management as a key service component. Further, as already discussed, federal support for the provision of case management services to the developmentally disabled has actually taken the form of a legislative mandate (PL 95-602). Ultimately, however, it is up to the states to respond by designing and actually operationalizing case management systems.

State. At the state level, the first step that needs to be taken in building a case management system is to fix responsibility for the program in a single agency of state government. Organizational structures for case management systems must be statewide in order to ensure uniformity and equity in the services delivered to those in need (Lippman 1976). However, the decision of which agency should assume responsibility and authority for providing case management services to the mentally disabled will vary from state to state.

In states that have separate departments to serve particular subgroups of mentally disabled persons, it is generally preferable for case management to be provided by the department most familiar with the given target population. However, since effective case management systems inevitably require the cooperation of all providers of human services, such a lead agency must coordinate its efforts with the activities of other specialized departments within state government. In New York State, for example, the Office of Mental Health has played the lead role in developing and managing the Community Support System (CSS) services that are being provided to chronic psychiatric patients living in the community. However, the Governor's Interagency Task Force has been formed to bring together the various human service departments that relate to CSS clients in order to enable them to serve these clients better.

One subcommittee of this task force deals specifically with case management services since they are such an essential component of the overall system. This subcommittee comprises representatives from the Office of Mental Health, Department of Social Services, Office of Vocational Rehabilitation, Office for Aging, and Office of Mental Retardation/Developmental Disabilities.

> Its purpose is to improve the practice of case management functions, finding out which agencies are currently fulfilling those functions and making recommendations which will reduce duplication and enhance efficient and effective delivery of case management services to CSS clients. [Governor's Interagency Task Force 1979, p. 1]

Such an interagency coordinating body is essential when case management services are delegated to an agency that serves just a particular population or provides only specific service functions. However, the need for such a mechanism may be somewhat less in those states in which the total responsibility for providing human services is assigned to a single, generic agency. Clearly, the nature of the existing human services organizational structure at the state level will be the primary determinant of how case management efforts are organized and administered. Nevertheless, it is also possible to alter organizational structures for case management purposes.

One example of such an alteration would be to create a totally new generic state level agency whose sole responsibility is the case management of human services clients. This model offers the advantage of avoiding a potential conflict of interest by separating case management from the provision of services. However, it may result in a style of case management that is not as individualized to clients as that which could be provided by agencies intimately familiar with the specific needs of

their specialized target groups. In addition, the fiscal expenditures required for the creation of an entirely new department are likely to be substantial. Given the current climate in which resources for human services are shrinking, it is thus probably more realistic to build case management systems into the structures that presently exist.

Local. Regardless of the option that is chosen, once a state level agency has assumed responsibility for case management of a particular client population (e.g., mentally ill, developmentally disabled), this agency must then develop a plan for fixing the responsibility of case management in selected agencies at the local level. The primary consideration in selecting these agencies is that there be a single agency defined as responsible for each geographic subarea of the state. Further, since these "core agencies" provide the primary responsible mechanism for service integration within their regions, they must be chosen on the basis of their demonstrated leadership capacity.

Most case management programs have encouraged flexibility in determining the types of agencies that should assume the leadership role at the local level. The core service agencies designated for the NIMH Community Support Program developed for the chronically mentally ill vary from public hospitals to community mental health centers, to county social service agencies (Turner and Shiffren 1979). Core service agencies designated to serve this same population in New York State include county departments of mental health, general county hospitals, family services agencies, and even state psychiatric centers. The regional centers that provide case management services to mentally retarded persons in California include existing service or advocacy organizations, hospitals, and some nonprofit corporations developed specifically to assume the coordination role played by a regional center (Lippman 1976). The use of different models for the core agency is an important feature of case management systems since the factors that contribute to an agency's effectiveness in the leadership role vary greatly from one locale to another.

While the agencies assigned the core agency role may have no problems in exercising leadership, it is a good idea to provide formal mechanisms to facilitate their coordinating efforts. The most essential of these is to provide them with "purchase of service" power so that they can more easily gain the cooperation of a variety of the local human service agencies in providing services to clients served by the case management system (Washington, Karmen, and Friedlob 1974; Ross 1980).

In addition, the use of a local level counterpart to the state level interagency task force described above might be considered. More specifically, local interagency cooperation could be facilitated if the core agencies were to form interagency committees comprised of those agencies within their area whose services would be required in order to meet the comprehensive needs of clients (New York State Office of Mental Health 1978). Such a local interagency committee could be a useful forum for negotiating which roles would be performed by whom and for identifying gaps in the services available to the target population of interest. Thus, the core agency can use this committee to strengthen its capacity for carrying out its charge to provide comprehensive coordinated services to clients and to ensure that the entire range of services needed by clients is available.

Another method for strengthening the capacity of local core service agencies to coordinate care for clients is to designate these agencies as the single entry point into the service system in their geographic areas. This, in fact, is a model that has been used for serving the mentally retarded in California (i.e., Regional Centers) and that was recommended for use in serving the developmentally disabled in New Jersey (Lippman 1976). The model has distinct advantages over that of a core agency which must rely on multiple outside agencies to refer the clients who are eligible for or in need of case management.

One final consideration is crucial in the development of a statewide case management system and requires coordination between planners at the state and local levels. This consideration regards the completeness of the various local service systems within which case managers must work. Since case management is primarily a service linking and coordination function, its impact ultimately depends on the availability of the needed services. If some clients need to live in a supervised residence in order to adjust successfully to the community, and no such residences are available, providing them a case manager will not solve their problem. Although case management can assist clients in getting the maximum continuity of care avail-

able from a given service system, case management cannot be expected to be a sufficient intervention in a system which is missing fundamental direct service components. Thus, the development of needed services must, in some cases, precede or at least be contemporaneous with the development of a case management system if it is to operate as intended.

Client Level Issues. Just as core agencies are responsible for service coordination at the system level, case managers are responsible for integration at the client level. In most cases, it is probably a good strategy for case managers to be a part of the core agency. Provided that the core agency has been given adequate authority and power, this close relationship enhances the ability of case managers to gain the cooperation of other service providers within the area. However, for a variety of reasons, some core agencies may choose to contract with another local service agency to provide case manager services. For example, this might be a good strategy for avoiding a potential conflict of interest when the core agency itself is a major provider of direct services to clients.

Regardless of where case managers are located, they are the key to the quality and the effectiveness of any case management system. While core agencies may provide the support and authority to facilitate interagency coordination, it is the individual case managers who must interact with a wide range of individual service providers in order to make the coordination actually take place for individual clients. Given the centrality of the role of the case manager in case management systems, it is important to consider how various aspects of the job design and context affect case manager effectiveness.

Case Manager Status. Perhaps the most essential aspect of the job design of the case manager role is the status that the case manager is given. One question frequently raised in this regard is whether the case manager should be a professional or a paraprofessional level worker. Since the demarcation between these two categories may vary from one human services discipline to another, however, it is probably more useful to discuss specific aspects of individuals' preparation for the role, including their educational background and previous job experience.

The important aspects of educational background are the type and level of academic degree obtained. In general, case managers have typically been individuals with education in a human services field. Some persons would suggest, however, that training in some human service disciplines may be more relevant to the case manager role than that of others. For example, individuals who have been trained to be aware of how to use various providers of human services in order to meet clients' needs (e.g., social workers, human service generalist workers) are likely to be better prepared to act as case managers than persons whose training has been focused primarily in a given discipline (e.g., psychology).

In addition to type of education, however, there is also the factor of level of education. The educational level reported for case managers in various programs described in the human services literature ranges from high school diploma (McPheeters 1974) to doctoral degree (Altshuler and Forward 1978). Depending on what is expected of the case manager, individuals anywhere within this range can function effectively.

The impact of level of education on job functioning will also interact to a great degree with the specific job experiences of the individuals involved. For example, case managers for chronic psychiatric patients in New York State include both persons who do not have college degrees but who have had extensive experience in working with these patients in state psychiatric facilities and persons who have masters level degrees in social work or counseling but who have had no prior contact with chronic psychiatric clients (Baker, Jodrey, and Morell 1979). Clearly, each type of worker brings different strengths to the case manager's role. Which strength is more important is not clear, since there is empirical evidence that level of education and number of years' experience in the specific problem field both seem to strengthen case manager effectiveness (Berkeley Planning Associates 1977).

In most systems, case managers are required to have no more than a B.A. level degree, which affords them a paraprofessional status. This fact has a number of consequences. First, it limits the range of activities that case managers can perform without supervision. In addition, due to their paraprofessional status case managers may have difficulty in establishing credibility with the professionals to whom they must relate in coordinating client care. While there is some evidence to suggest that the case managers can effectively re-

solve this problem over time (Baker, Intagliata, and Kirshstein 1980), they may occasionally require additional backing and support from their core agency.

Because of these problems, some program administrators might feel that it would be better to use professionals for the case manager role. However, while professionals may be capable of functioning more independently as case managers, they are likely to be unwilling to devote time to many of the important but "less professional" services which paraprofessional case managers frequently provide to clients (e.g., transportation to an appointment, assistance in filling out forms to secure entitlements, visiting a day program to observe client activity). For example, Caragonne (1981) found that many case managers in mental health settings spent extensive amounts of time providing direct services to clients (e.g., counseling, assessment) and neglected such key case management functions as linking, referral, followup, and evaluation. Further, since professionals are overqualified for many important case manager duties, they may "burn out " more quickly than paraprofessionals (Dormady 1980). Finally, an important economic consideration is that the use of professional level case managers would greatly increase the costs of any sizable case management effort.

These various considerations would suggest that the most cost-effective alternative may be to hire paraprofessionals to perform the essential case manager functions of linking and monitoring. The other important case management functions of assessing and planning could be performed by these individuals to the extent to which they are capable but should ultimately be the responsibility of professional level clinician supervisors. Before making any final decisions regarding the degree of discretion and authority that paraprofessional case managers should be given in their activities, however, it should be noted that case managers attach great importance to autonomy in their jobs (Caragonne 1980). Further, their job satisfaction reportedly increases as they are given greater freedom and discretion in carrying out their role responsibilities (Graham 1980). There is no evidence that one particular level of autonomy is ideal, but it is advised that the degree of autonomy given to case managers must be matched to the expectations that were established when they were recruited for the role and that it be adjusted over time to reflect their increasing competence.

Training/Preparation. The development and implementation of a case manager training program should be viewed as an essential component in the building of any effective case management system. Regardless of the professional level of the individuals being hired as case managers, it is important that they approach their role with a clear understanding of their functions and responsibilities. Further, in order to provide a consistent and equitable statewide case management program, it is important that all case managers be given similar orientation and preparation for the job.

In considering the development of a statewide training package for case managers, it is essential to build in a great deal of flexibility in its implementation. The people who will be assuming the case manager positions will undoubtedly vary widely in the knowledge, skills, and competencies that they bring to the job. A useful strategy is to design a training program as a series of self-contained learning modules (Baker, Jodrey, and Morell 1979). In this way, those trainees who can demonstrate their preparation in a given area need not complete that specific module.

The statewide training package should focus on the basic aspects of the case manager role. It should include modules that present the rationale for the case management process and make explicit the values that are intended to guide the activities of case managers. These are modules that should be required for all trainees regardless of their prior job experience. Additional modules should provide basic information in such key content areas as the nature of mental illness or mental retardation (e.g., causes, definitions, associated consequences, limitations), common medications and their side effects, the local availability of specific services and the entire range of available client entitlements (e.g., SSI, food stamps), clients' legal rights, and the recordkeeping responsibilities of case managers. Training should also include modules that deal with the process of case management. These should focus on teaching case managers skills for relating to clients, setting goals, solving practical problems, knowing how and when to intervene in crisis situations, and advocating effectively for clients.

In training case managers for working with chronically mentally disabled clients, it is also impor-

tant to help trainees appreciate that the nature of the disabilities of many of their clients will severely limit their ability to progress behaviorally. Lamb (1979) has noted that unless staff who work with this client population have a realistic conception of what they can expect to accomplish, staff frustration and burnout are inevitable. Case managers must accept that enhancing the quality of clients' lives rather than increasing their level of independent functioning is a reasonable and appropriate treatment goal for this population.

In addition to considering the training content, it is also important to consider how the training can be implemented most effectively. One suggestion made by several authors who have evaluated case manager training programs is that care should be taken to avoid assigning complete caseloads to case managers until they have completed their training (Amadio 1976; Baker, Jodrey, and Morell 1979). While it is useful to have some actual client responsibilities during training so that trainees can apply what they are learning, there are indications that too much client responsibility interferes with learning. To avoid this problem, it may be desirable to conduct training intensively over a short period rather than to extend it in small segments over a longer period.

A final consideration is that while a basic statewide training program should be developed to prepare case managers for their role, plans should also be made to provide continuing education to case managers. An initial time-limited, intensive training program simply cannot be expected to meet all case managers' training needs. As with most positions, case managers will not really know what they need to know until they have been on the job for a while. Thus, either at the state or local level, continuing education sessions should be planned. Further, case managers themselves should be assessed periodically in order to determine the most important areas of training need so that continuing education sessions remain relevant and useful.

Supervision. The type and extent of supervision that is appropriate for case managers depends upon the range of functions that they are assigned and on the level of individual selected for the role. If experienced professional level case managers are hired, they certainly will not require the extent of supervision appropriate for a paraprofessional or less experienced individual in the same role. However, since most programs are likely to use paraprofessional level persons to fill this challenging role, it is extremely important to plan to provide them with adequate support and supervision.

Those assigned as case manager supervisors should perform several important functions. First, they must monitor the performance of case managers in a thorough, ongoing fashion. In addition to meeting regularly with individual case managers to discuss their caseload activities, it may be useful for supervisors to observe or even assist their case managers in working with certain clients. While one might assume that case management supervisors in all settings would routinely conduct such activities, the findings of Caragonne (1981) suggest otherwise. Specifically, she reported that many of the supervisors and program administrators at the 22 case management sites studied did not have accurate perceptions of the scope, extent, and pattern of their own case managers' activities. Further, it was exactly in those sites where supervisors were most out of touch with their case managers' activities that the case managers departed most drastically from their defined roles.

A second important aspect of the supervisory role is the staff development function. Supervision should include an ongoing commitment to the continuing education of case managers. Part of this education might be informal and consist of something as simple as encouraging case managers to develop a habit of generating multiple alternative strategies for dealing with clients' problems before taking action. However, it is also appropriate for supervisors to consider providing some more formal continuing education sessions to case managers. These sessions can be designed to be either didactic or experiential and should focus on specific content areas in which the case managers themselves feel a need for more background.

A third, and perhaps the most important, function of the supervisory role is to provide case managers with needed individual support. Graham (1980) found that the provision of consistent supervisory feedback and support to case managers of chronic psychiatric patients was associated with greater case manager work motivation. Apparently, case managers need such support in order to maintain an ongoing sense of the value of their work and the extent to which it is appreciated. Further evidence of the importance of providing

supportive supervision to case managers has been provided elsewhere. Specifically, Baker, Intagliata, and Kirshstein (1980) reported that case managers identified regular supervision as an essential activity for preventing "burnout." They described good supervision as providing them with an opportunity to "vent their frustrations with their clients and the system" and to receive support for their efforts. Further, Caragonne (1979) found that case management sites where supervision consisted more of supportive, enabling activities rather than of monitoring and control were also the sites where case managers exhibited less antagonism toward management, lower levels of absenteeism and stereotyping of clients, and, in general, fewer overall symptoms associated with case manager burnout.

Clearly, the role of the case manager supervisor is a very significant one. Establishing such an upper level case management related position not only provides case managers with an opportunity to receive needed support and back-up, but also offers case managers the possibility of upward job mobility. While such a position would provide just part of a case management career ladder, any efforts along these lines enhance the likelihood of case managers remaining with the system after they have significantly increased their expertise.

Individual vs. Team Case Management. Those implementing the case manager concept for chronic psychiatric patients living in the community have indicated that comprehensive responsibility for clients might be more appropriately assigned to a case management team than to individual case managers (Gittelman 1974; Kirk and Therrien 1975; May 1975; Altshuler and Forward 1978; Turner and TenHoor 1978; Test 1979). This team comprise a group of individuals who, together, are responsible for the case management functions of assessing, linking, and monitoring to assure continuity of appropriate care to clients. The individuals on this team may all be case managers or might include a case manager along with a variety of professionals from different disciplines (e.g., psychiatrist, nurse, psychologist, social worker).

According to Test (1979), the advantages of a team structure are that it provides (1) more continuous coverage and coordination since the unavailability of a single case manager does not incapacitate the client; (2) better planning based on the availability of more points of view for managing difficult problems, a factor especially important for maintaining energy and creativity in working with chronic clients; and (3) a way to avoid the isolation that may lead to burnout of the individual case manager who must face tedious, seemingly endless, and emotionally draining problems alone.

A recent report on the case management efforts at one of the NIMH Community Support System demonstration sites in New York State provides some support for Test's (1979) position. Specifically, Reagles and Sheets (1979) reported that after a year of using the individual case management model to serve caseloads of chronic psychiatric patients, two significant problems had surfaced. These were the overwhelming burden of responsibility leading to staff burnout and the dysfunctional phenomenon of clients becoming overly dependent on case managers. In response to these problems the program has switched to a group case management model in which the ultimate responsibility for individual clients' care rests with an interdisciplinary team rather than one case manager.

While the team model of case management may not be appropriate or feasible in all programs, those using an individual case manager model must pay serious attention to the need to provide case managers with adequate support. If case managers are not included as part of an interdisciplinary treatment team, then it is essential that the case managers themselves be organized either formally or informally for the purpose of mutual support. One possibility is to designate them as a distinct formal organizational entity, the "case management unit." Whether or not such a unit is formed, there is a need to provide mechanisms that facilitate the regular interaction of case managers as a group. Examples would include daily morning meetings, weekly supervision sessions and periodic training sessions.

Caseload Characteristics. A major factor influencing the style and effectiveness of services offered by case managers is the number of clients for whom they are responsible. It is a simple fact that as the number of clients assigned to a given case manager increases, the amount of time the case manager can potentially devote to each individual client decreases. Graham (1980) confirmed this relationship in his study of case managers who were serving varying sized case-

loads of chronic psychiatric patients in New York State. He reported that as caseload size increased, case managers *did not* increase the number of clients seen each week. Thus, the frequency with which individual clients were seen by case managers decreased with increasing caseload size. This relationship is extremely important to consider because there is evidence that the quality of case management services is strongly related to the intensity of contact between client and case manager (Berkeley Planning Associates 1977).

Increasing caseload size can affect not only the amount or frequency of case managers' contact with clients but also the nature and quality of client contact. In a study of case management being provided to chronic psychiatric patients, also in New York State, Baker, Intagliata, and Kirshstein (1980) indicated that the increase from caseload sizes of approximately 15 clients to as many as 30-50 clients had a significant impact on case managers' working styles. In addition to the inevitable consequence of having less time for each client, case managers reported that:

- Their efforts with clients had become primarily reactive rather than proactive such that the majority of their time was consumed responding to crises rather than anticipating problems and helping clients to plan ahead for them;
- They were always "on the run" and no longer had the chance really to get to know their clients and their needs;
- In order to save time, they had begun increasingly to do things for clients instead of helping clients become more independent;
- Their frequency of contact with clients was increasingly being determined by clients taking the initiative to contact them rather than vice versa (i.e. "the squeaky wheel gets the oil");
- The amount of time they were required to spend simply documenting their efforts with clients was consuming an increasingly alarming portion of their time that otherwise might be spent with clients.

Clearly, these are troublesome developments that potentially, if not immediately, threaten the quality and effectiveness of their case managers' efforts.

Undoubtedly, caseload size is an extremely important factor shaping case management. However, determining ideal caseload size is a difficult task. The number of clients that a case manager can serve effectively will vary depending on the mix of clients' levels of functioning (acute/chronic needs), the degree to which clients live close together or in scattered locations, and the competencies of individual case managers. Lannon (1979) reported that case managers serving chronic psychiatric patients tended to give more attention and service to those individuals who had poor community living skills or who exhibited behavior management problems. Graham (1980) indicated that case managers who serve specialized groups of clients tend to have different work patterns than those serving mixed caseloads. Specifically, he reported that case managers serving only psychiatric clients living in family (foster) care homes spent significantly less time in direct client contact than did case managers assigned a mix of clients living in varied community residential settings.

Clearly, a variety of client characteristics affect case management activities, independent of caseload size. However, it is useful to discuss at least estimates of reasonable caseload levels based on actual program experience. For chronic psychiatric patients being served in community support system programs in New York State, suggested estimates for an individual case manager's load have ranged from a low of 15 clients (Reagles and Sheets 1979) to a high of 30 (Baker, Intagliata, and Kirshstein 1980). On the other hand, those reporting the use of the case management team model for a similar client population describe team member/client ratios ranging from 1/4 (Test 1979) to 1/10 (Reagles and Sheets 1979).

Regardless of the client population being served, determining ideal caseload size ultimately depends on the type of case management that program planners intend to offer. If, for example, case managers are expected to provide clients with support only when they are in crisis, they may be able to handle caseloads of 40-50 clients. However, if case managers are expected to assess clients' needs, develop treatment plans, link clients to services, monitor clients' progress, attend to needs of clients' families, and update treatment plans in an ongoing fashion, caseloads of 20-30 clients are likely to be more appropriate.

The actual caseload size that is ideal for serving any client group should be determined on a program by program basis. Thus, as part of the planning for devel-

oping a case management program, it may be wise to set caseload sizes conservatively low at first and then, if all goes well, gradually increase them while monitoring the consequences. In this fashion, the decision to set fixed caseload sizes can be made more empirically and rationally.

Other Contextual Factors. There are two additional contextual factors that can have a significant impact on how case managers perform their functions. The first of these is the degree to which the existing range of services available to clients meet their comprehensive needs. A number of studies of case managers' activities (Caragonne 1979; Baker, Intagliata, and Kirshstein 1980; Graham 1980) have indicated that case managers' activities are significantly shaped by the service system in which they operate. If, for example, there are relatively few services available, case managers spend relatively little time linking clients to services. Further, when certain important support services are unavailable, case managers are likely to devote their own time either to providing or creating the needed services. These results are important for program planners to consider. They indicate that case managers' actual activities are shaped ultimately by the constraints of the environments within which they work, not by their formal job descriptions.

The other contextual factor that deserves consideration is that the local agencies that assume responsibility for providing case management in their respective regions are each likely to develop somewhat unique case management programs. Though efforts may be made at a state level to give programs essential structural and ideological uniformity, the implementation of these guidelines at the local level is ultimately shaped by the unique local contexts.

Factors that result in interprogram variation include the differences between regions in population make-up, geography, availability of support services, history of interagency cooperation and competition, and case management ideologies of the individual core agencies. Thus, a statewide case management effort typically comprises the activities of a variety of somewhat unique case management programs. While monitoring mechanisms to ensure a certain amount of program uniformity and equitable quality care for clients are desirable, local flexibility in program implementation should be not only tolerated but encouraged. This flexibility enables programs to be tailored to meet both local and individual needs.

Summary and Recommendations

The design, development, and implementation of a statewide case management program for the chronically mentally disabled is a complex task that requires the coordinated efforts of human services providers at all levels of the system. Consequently, the level of difficulty facing those charged with this task depends upon the degree to which the structures and actors within the system facilitate cooperation and collaboration. However, since the need for case management has resulted, at least in part, from the lack of coordination and cooperation within the system, the development of case management services will inevitably be hindered by significant barriers.

Perhaps the easiest solution would be to start over by designing, building, and installing a completely new human services system into which case management services could be neatly incorporated from the very beginning. Unfortunately, this is not a realistic option. Instead, planners must develop case management programs that can be "fit into" existing service systems. They must build upon the system components that provide potential for enhancing service coordination and continuity while working around those elements that create service fragmentation. In addition, some new mechanisms and structures for ensuring coordinated continuous care will need to be designed and implemented. In each case, the end result must be a case management program that reflects the unique strengths and needs of the system of which it is a part.

A number of suggestions and recommendations for the effective implementation of case management systems have been discussed here. The major considerations can be summarized as follows:

- The development of a case management system should begin with a thorough assessment of client needs and the service resources that currently exist to meet them. Plans must be made to begin to fill identified service gaps. Case management alone cannot be expected to solve the problems created by incomplete, inadequate service systems.
- The responsibility for providing case management services to a

given population of mentally disabled persons should be delegated to a single agency at the state level. If this agency specializes in serving this particular client group, steps must be taken to involve representatives from all other relevant human service agencies at the state level in the process of planning and implementing case management services.

- The agency responsible for case management services at the state level must delegate case management authority and responsibility to "core agencies" at the local level. These core agencies must be responsible for establishing interagency cooperation in their locales and for providing case management services. To create reliable human services networks in their regions, core agencies must be supported with formal mechanisms for enhancing cooperation (e.g., purchase of service authority, legislation).
- Case managers are the most important service providers in a case management system. While they do not perform all case management functions, they are the human link between the client and the system. They assure that clients are receiving all the services they need, in the amount and at the time they are needed. To function effectively, case managers must be provided with adequate training, supervision, and ongoing support.

Evaluation and Research Needed. To enhance the quality of case management services, there is also a clear need to give far greater attention to conducting systematic ongoing evaluation of and research on case management systems. Two types of evaluation efforts should be considered. In the early phases of program development, it is important that evaluation be conducted and focus on measuring program implementation. Information that is produced from this phase of evaluation can provide system planners with formative feedback that can be used to keep program development "on track" or to modify or reshape program design if deemed necessary. These process evaluation efforts should help to pinpoint how case management services are provided and the factors that seem to affect their delivery. This information is important if administrators or providers are to understand or replicate the results of any case management program.

Once case management programs are functioning as intended, it is appropriate for evaluators and researchers to shift their focus to measuring program outcomes or benefits. Examples of outcomes that should be studied include the extent to which the various objectives of case management services, described earlier in this article, have actually been met. These include enhancing the continuity and comprehensiveness of care, improving the accessibility of services to clients, and increasing the efficiency (i.e., cost effectiveness) with which needed services are provided.

In addition to assessing the extent to which case management enhances the effective functioning of an extant service system, it would also be useful to evaluate the impact of those direct services which case managers provide to their own clients, often as a means of filling in gaps in the service system. Further, since as described previously, the case manager is the important *human* connection between the client and the system, it would be useful to assess how having such a personal advocate affects clients' feelings about themselves and their responsiveness to the services to which their case managers link them.

In addition to evaluating a number of aspects of the process and outcome of case management, there is also a need for research to determine how a large number of important contextual variables exert their influence on both case management processes and outcomes. In general, these factors can be grouped into four major categories. The first category includes the individual characteristics that case managers bring with them to their jobs. These characteristics include age, level of education, relevant work experience, and their expectations about the job. A particular research question that should be addressed regards the relative influence of case managers' education, experience, and personal qualities on their work activity patterns and overall effectiveness.

The second category of variables includes the characteristics of the clients who are served. These characteristics include age, functional skill level, level of maladaptive behavior, institutionalization history (degree of chronicity), and current diagnosis and symptomatology. Important research questions in this category relate to how client characteristics affect the frequency of case manager contact, the total amount of case managers' time expended, and the specific nature of the assistance which case

managers provide to their clients.

A third category of variables comprises the characteristics of the case managers' job design and work environment. These characteristics include the breadth of role responsibilities, degree of job autonomy, size of client caseload, the individual vs. team model of case management, and the type and quality of supervision provided. One important researchable issue in this area is the optimum number and types of disabled persons in a caseload. Other important research questions relate to identifying the factors that enhance work motivation, reduce burnout, and increase overall job tenure and effectiveness among case managers.

A fourth and final category comprises characteristics of the broader services network within which case managers must function. These characteristics include the degree of service availability, the extent of interagency cooperation, and the type, if any, of core agency functioning within the locale. Important research questions in this area involve the assessment of how the extent of cooperation and connectedness between key agencies influences the case management process and what types of core-agency models work best to enhance case management effectiveness.

A number of exploratory studies (Lannon 1979; Baker, Intagliata, and Kirshstein 1980; Graham 1980; Ross 1980; Caragonne 1981) of factors that affect case managers' activities and effectiveness have already been conducted, and their results have been discussed elsewhere in this article. However, much important research remains to be done. Each of the categories of variables described deserves more extensive attention and a variety of research methods can prove useful. These include case study approaches as well as experimental and quasi-experimental designs. Further, to gain a better overall sense of the relative importance of and interactions between the major categories of variables outlined, complex multivariate research designs will eventually be required. Nevertheless, ongoing work in this area is essential. Without solid empirical information on case management, program development can only continue to take place in a haphazard fashion.

The importance of research on case management should not be minimized. Given the present economic and political climate in which available funding for human services programs is shrinking significantly, case management programs will be particularly vulnerable since they provide indirect services to clients. If a choice has to be made between using funds for case managers or for work skills training programs for clients, it is likely that the more direct client services will be funded. Thus, if case management programs are to remain viable in the 1980s, it is crucial that program administrators have the information that is needed to demonstrate their value and effectiveness.

The development of case management systems is an ambitious undertaking. However, there is good reason to believe that the outcome will be worth the effort. Evaluations of service integration projects have reported that the use of case teams and case manager linkages leads to increases in the accessibility, comprehensiveness, and volume of services provided to clients (Baker and Northman 1981). Caragonne (1979) came to similar conclusions and, in addition, reported that the use of case managers led to more effective packaging of client service plans, documented gaps and duplications in service networks, and generally promoted organizational responsiveness to consumer needs. Although this evidence is encouraging, it is important to acknowledge that many questions about the most effective methods for providing case management services remain unanswered. At present, like many aspects of the human service field, case management is more art than science. Thus, as we proceed to implement case management systems for the chronically mentally disabled, we must remain open to learning and change.

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