Social Work and Social Services

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J. Capitman, B. Haskins and J. Bernstein, 'Case-management approaches in coordinated community-oriented long-term care demonstrations'. *The Gerontologist*, *26* (1986), 398–404.

This paper describes variations in case-management approaches in twelve demonstration projects of long-term community care of the elderly in the USA. The authors describe case management as a service that directs client movement through a series of phased involvements with the long-term care system and which attempts to integrate the formal long-term care system with the care giving provided informally by family, friends and community groups. There are five readily identifiable components to the case management process: (1) Intake and screening – the initial process of identifying potential clients through referrals and procedures to determine eligibility. (2) Assessment and reassessment – acquiring relevant information about medical, functional, social and emotional status and service needs. (3) Care planning – the development of a care plan based upon the assessment which specifies the services to be delivered, their frequency, duration and objectives. This will involve meetings with the client, informal carers and formal caregivers. (4) Service arrangement – the process of contacting service providers, the client and family to arrange for the implementation of the care plan. This will include negotiation, ensuring service availability and developing substitute services. (5) Monitoring and counselling – this involves ongoing contact with the client and informal carers to check on well-being and satisfaction and to identify emerging service needs. Counselling or advice are likely to be provided during monitoring or in response to a crisis.

Two areas were considered where case management approaches appeared to differ in a noteworthy fashion. These were (1) the staffing and task allocations and (2) the procedures for controlling service use and costs. Two dimensions of staffing and task allocation were examined: (*a*) the degree of professionalisation referring to the proportion of staff who were professionally qualified and (*b*) the degree of specialisation referring to the extent to which individual staff performed all the case-management tasks for a given client or only undertook certain tasks. Two aspects of control of service use were also examined: (i) the scope of case-management control over a range of services and (ii) whether there were expenditure ceilings.

It was observed that there were considerable variations in the approaches to case management with regard to the professional levels

of staff, the allocation of case-management tasks to staff and in the scope of control of case management over the allocation of services. On the whole, lower levels of professionalisation and responsibility for a wider range of tasks were associated with lower costs, although even in projects where the level of professionalisation was relatively 'low' it would be deemed high in most British services. Of equal importance was whether case management was integrated into the service programme since one of the lower cost services was found to be highly professionalised and staff were undertaking the whole range of case-management tasks.

The authors conclude that case management and long-term care in the community are most effective where case managers are given the widest scope of control, integrated into the service agency and where clearly defined methods of cost containment are instituted, in particular ensuring that services were clearly targetted upon those for whom they were designed.

COMMENT

Whilst it is difficult to generalise from the very different system of services in the USA to the British context there are important lessons for the design of long-term community care services in this paper. British Social Services have tended to concentrate upon the development of a range of domiciliary services for elderly people and relatively little attention has been paid to the issue of coordination of those services at the client level. Projects which provide case management have tended to develop more in the field of mental handicap than the elderly although some examples are available.[1]

However, there is a clear advantage in Britain for the development of case management in the care of the elderly since, unlike the profusion of agencies in the USA, services are already organisationally integrated in Social Services Departments. Indeed, the case-management process could well be seen as a more helpful description of the roles and tasks of social workers in long-term care than the Barclay Report.[2] There does, however, remain the problematic separation of health and social care, and within those agencies the need to tackle the issue of targetting services upon those for whom they are most appropriate and of how to extend the span of control of case managers.

NOTES

1 Challis, D. and Davies, B. *Case-management in Community Care*. Gower, Aldershot, 1987; Davies, B. and Challis, D. *Matching Resources to Needs in Community Care*.

Gower, Aldershot, 1987; Stone, M. Home is where the help is, *Nursing Times*, 2 April 1986, 31–32.

2 Barclay Report. *Social Workers: Their Roles and Tasks*. Bedford Square Press, National Institute for Social Work, London, 1982.

C. L. McEvoy, C. L. and R. L. Patterson, 'Behavioural treatment of deficit skills in dementia patients'. *The Gerontologist*, **26** (1986), 475–478.

This pilot study compares the progress of a group of demented elderly patients with a matched group of non-demented elderly patients in a social skills training programme in a residential facility, a Mental Health Institute. All were over 55, able to walk and continent. The non-demented group included those with diagnoses of depression, schizophrenia and anxiety states. Five types of training were given. These were: personal information – basic personal details such as address and telephone number. Training is given for any such information not recalled. Spatial orientation – ability to find the dining room, bedroom and toilet. Communications – appropriate response patterns using role play. Activities of daily living – two levels of ADL were used, the first concerned personal hygiene skills including bathing; the second consisted of more advanced ADL such as laundry, money management and meal selection.

Training was given to correct identified deficits and patients were assessed on three occasions: before training, after one month and at discharge, on average 20 weeks after beginning treatment. Unsurprisingly, it was found that for personal information and spatial orientation, the non-demented were already functioning at an adequate level. However, in all the areas the demented made evident gains as a result of training. Improvement appeared most likely when physical practice was a large part of the training, when feedback was received from several sensory systems and when less cognitive involvement was required. The authors suggest that important physical behaviours may be remediable for the demented elderly, although since the study had no follow-up, it is not known for how long such improvements may be maintained without reinforcement. They also indicate that the approach is suitable for use in a community setting, in peoples own homes, and is relatively inexpensive since much of the training was undertaken by paraprofessionals with professional supervision.

COMMENT

This study reinforces the evidence elsewhere that some lost skills may be recovered in demented patients and that care must be taken to consider how retained skills can be used as a foundation for intervention to support these people living in their own homes. This is an area where such pieces of 'therapeutic optimism' are sorely needed.

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Medicine in Society

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P. J. Elton and J. M. Packer, 'A prospective randomised trial of the value of rehousing on the grounds of mental ill-health'. *Journal of Chronic Diseases*, 39 (1986), 3, 221–227.

Although 'social' interventions quite properly form part of the therapeutic armamentarium of the contemporary physician, few of these interventions have been subjected to the same degree or type of evaluation that a doctor would demand of drugs or surgery. There are many reasons for this including lack of confidence in the measurement of 'social' outcomes on the part of the doctor, and lack of faith in the relevance of evaluation and a certain vested interest in not evaluating their power base on the part of the professional purveyors of housing and social services. This paper from Salford represents a signal achievement in assessing the effects of rehousing on mental health by means of a randomised controlled trial, the gold standard of health and social services research.

The study presents some interesting ethical points. The generality of applicants for rehousing on grounds of mental health in Salford can expect less than 50% success. By entering the trial and agreeing to the randomisation process participants increased their chances to exactly 50%. However, it was considered that it would not be possible to carry out the study if the participants had to give fully informed consent so it was necessary to gain approval from 'their elected representatives'. In practice this seems to have been the Chairman of the City Housing Committee. It seems an alarming extension of the principles of local democracy for Councillors to consider it proper thus to act *in loco parentis* for individual adult citizens some of whom might well have voted against them at the last elections. On the other hand, to disburse public