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Assessment and Case Management

Implications for the implementation of 'Caring for People'

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Virginia Beardshaw
David Towell
April 1990

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Foreword

This report was originally commissioned by the Department of Health's assessment and case management project group. Its purpose was to provide the group with a survey of some of the available literature on assessment and case management. The King's Fund and the report's authors most gratefully acknowledge the Department of Health's kindness in permitting its publication. The report in no way represents Departmental policy, and should not be interpreted as foreshadowing its forthcoming Circular of Guidance on case management and assessment.

Summary

Caring for People: Community care in the next decade and beyond outlines a new framework for delivering community care services to adults with disabilities. The white paper's emphasis on changes in assessment requirements and on the management of individual cases are two important elements of the proposals.

This briefing paper sets out to review the literature on models of assessment and case management in order to identify key issues which will need to be addressed as Social Services Departments implement the changes outlined in *Caring for People* and the National Health Service and Community Care Act 1990. A paper of this size cannot hope to be comprehensive. Instead it attempts to clarify available models for both processes; identify their key features; and analyse the implications of these for implementation of the white paper changes.

The introduction frames the detailed consideration of assessment and case management with a more general discussion about what service users and their carers need from services. It goes on to consider what *Caring for People* has to say about service delivery, and how assessment and case management should contribute to it. The first section discusses existing assessment methods, and includes a detailed case study of a recently introduced formal assessment system – Local Education Authorities' assessment of special educational needs under the 1981 Education Act – as well as a summary of the assessment requirements of the 1986 Disabled Persons (Services, Consultation and Representation) Act.

The second section examines UK and North American models of case management, and analyses the issues they were established to address as well as the extent to which they may have met them. Five UK case management projects are discussed in detail, with a special focus on critical issues raised by their evaluations. Possible models for the further development of case management are suggested, with a short discussion of their likely positive and negative effects. The final section raises key issues for service development, including service systems design and training.

Introduction

The community care diagnosis

People with disabilities need different things depending on who they are and how they live. They may need someone to shop, clean or cook for them, or do the washing. They may need aids or assistance to wash and dress themselves or to get to the toilet. The place they live may not suit them in some ways, and they may need help in adapting it or in moving elsewhere. They may require advice, training or support for finding and keeping a job and/or on obtaining income support and disability benefits. They may need daytime occupation, help with transport and/or someone to check that they are safe and well. They may need tablets or other medicines and help with taking them. They will need general health care and may also need medical and nursing attention for health problems related to their disability. They may need help with problem solving or with learning (or relearning) social skills. From time to time they may need refuge or care during a crisis, and/or advice to help them cope better with the strains and stresses of life.

Families, and others who care for disabled people, may need help too. This can mean assistance with domestic tasks and direct caring so that they can go out to work or cope better at home. It may mean 'cover' at a time of illness or absence, or a chance to take a break. Carers may themselves need advice on income support and benefits, aids and adaptations, or on housing. They may also need additional support and advice of various kinds. Sometimes their needs will be virtually the same as those of the person they care for, but sometimes they will be different. At times this can mean conflict.

The form that all these needs take will be shaped by the social, economic and cultural background of individual disabled people and their carers. People from minority ethnic communities may at times define their needs differently from people from the majority culture.

The amount and type of help that people with disabilities and their families need from statutory services depends on their circumstances and abilities as well as the scope of their personal networks. Very often, however, the needs of frail elderly people, people with physical or learning disabilities and people with long-term mental health problems are complex, and span the provision of different agencies and voluntary organisations – notably those concerned with social services, health, housing, education, employment, leisure and social security – as well as the private sector.

Currently, the services offered by these agencies and organisations are often unable to combine to meet the needs of individual people and their families effectively and efficiently. Agencies may adopt different eligibility criteria for providing certain types or levels of service. Provision is frequently inflexible and unresponsive to disabled people's needs and those of their families. Help may only be available at certain times or in set places, and the jobs that an agency's staff are able to do are often defined in a way that seriously limits their ability to offer the kind of assistance that would best suit disabled people and their families. At the same time, community-based health and social services staff often perform very similar tasks, which can lead to multiple interventions for some people and gaps for others. This problem is compounded by the difficulty of targeting resources appropriately on those most in need.

Investment in existing, inflexible, services have meant that agencies have found it very difficult to move to forms of help that relate more closely to individual disabled people's needs and preferences. In addition, people with disabilities and their families are rarely involved in planning or monitoring the services they use.

Problems of this kind have bedevilled the development of community-based services in Britain during the last twenty years. Perverse incentives in funding and planning which have favoured residential care and other established service strategies have compounded the problem. These difficulties have been amply documented by policy analysis at national level. By the end of the 1980s, this combined with academic and policy-oriented research to create a thorough critique of existing community care policies and practice. Over many areas, policy makers, representatives of service users and providers came to broad agreement about the defects of the present system (Audit Commission, 1986). This shared understanding and concern about the problems associated with the development of community-based services for people with disabilities forms a backdrop for the publication of *Caring for People: Community care in the next decade and beyond*, the government's proposals for the reform of the organisation and financing of social care services.

Caring for People: values and tensions

Caring for People states that:

> *Community care means providing the right level of intervention and support to enable people to achieve maximum independence and control over their own lives* (paragraph 2.2).

Promotion of individual choice and independence are central objectives of the white paper proposals. *Caring for People* maintains that the changes it outlines are intended to give people "a greater individual say in how they live their lives and the services they need to help them to do so", in order to help people achieve maximum possible autonomy and live as normal a life as possible in their own homes (paragraph 1.8).

At the same time, the white paper emphasises the importance of targeting resources on those most in need. It stresses that decisions on service provision "will have to take account of what is available and affordable", against a background of local authorities' own stated objectives and priorities (paragraph 3.2.12).

Tension between the objectives of self-determination, independence and the need to ration services underlie *Caring for People,* along with the difficulty of maximising choice for individuals and their carers at the same time as taking account of "the local availability and pattern of services" (paragraph 3.3.1). Individual local authorities' abilities to reconcile these different sets of requirements will have a critical influence on the way in which the changes proposed in the white paper affect people's lives. The challenge is to create a system that genuinely centres on disabled people's needs and preferences – and those of their carers – at the same time as ensuring that available resources are not exceeded; that they are targeted on those people most in need; and they are used as effectively as possible.

To do this, the agencies and organisations involved will need much more comprehensive information about their clients' needs as whole people. They will also need to take account of the special needs of particular ethnic minority communities. *Caring for People* states "Minority communities may have different concepts of community care and it is important that service providers are sensitive to these variations. Good community care will take account of the circumstances of minority communities and will be planned in consultation with them" (paragraph 2.9).

The role of assessment and case management

Assessment and case management are key components of the strategy for community care outlined in *Caring for People.* The white paper sketches a new framework for the organisation and funding of services for people who need residential care or help to live at home, and designates local authority social services departments (SSDs) as the lead agencies for social care provision.

It defines four key responsibilities for SSDs in their new role: assessment of an individual's need for social care; design of packages of services to meet assessed needs of individuals and their carers; securing service delivery from a variety of providers; and monitoring the quality and cost effectiveness of services (paragraph 3.1.3). It gives the government's view that case management may be useful for designing care packages, since it provides "an effective method of targeting resources and planning services to meet specific needs of individual clients", particularly where needs are complex or significant levels of resources are involved (paragraphs 3.3.2, 3.3.3).

Within the wider service system, assessment and case management are intended to mediate between the needs of individual disabled people and his or her carers and available community services. In essence, assessments – which are mandatory – will determine eligibility and establish needs. Case management is an option which local authorities can use to manage the inter-related tasks of needs assessment and the design, management and monitoring of individual care packages.

In practice, it may be unhelpful to think of assessment and case management as separate activities. In fact, the two processes are closely related. One of the main messages of the white paper is that all 'cases' assessed as being eligible for local authority provision will need to be actively managed.

Monitoring and reassessment will be important to this process. In the same way, assessment is an important element of case management, as are reassessment and monitoring. It may be useful to think of assessment and case management as part of a process for managing support for people with disabilities, rather than as a one-off event or a special role. As such, they should be considered as different steps which local authorities may need to take both to meet the formal requirements of the new legislation and to support people with disabilities effectively.

Assessment

1

The role of assessment in the white paper proposals

Caring for People states that social care assessment is intended for "people whose needs extend beyond health care to include social care and support for mobility, personal care, domestic tasks, financial affairs, accommodation, leisure and employment" (paragraph 3.2.2). Its objective is "to determine the best available way to help the individual", and the white paper makes it plain that this should not be approached solely in terms of his or her suitability for a particular existing service (paragraph 3.2.3). In particular, from April 1991 local authorities will be required to assess new applicants for public support for residential care (paragraph 3.7.2).

Following the implementation of the white paper, assessment will become a specific responsibility of social services authorities. The government's intention is to channel the assessment and allocation processes for everyone needing social care so that most referrals come through local authorities and the same assessment process applies, regardless of how people are referred or which services they are requesting. *Caring for People* makes it clear that this does not mean that other agencies should be excluded from assessments, or that social services authorities can make decisions about services managed by them. Instead, social services authorities will need to ensure that other agencies' involvement and contribution to assessments are managed effectively. Authorities are required to ensure that one individual takes managerial responsibility for dealing with each case effectively (paragraph 3.2.7).

Both assessment and allocation procedures will now have to be more explicit, in contrast to current arrangements, where some services are allocated in an unsystematic manner, and others - notably state-supported private residential care - are subject only to financial criteria. Local authorities will be required to establish their own cost effective assessment procedures, in accordance with a detailed code of guidance to be published by the Department of Health during 1990 (paragraphs 3.2.10 and 3.2.13). There will be a wide variety of entry points into assessment procedures. Social services authorities will be required to publicise them and to establish and make public criteria of eligibility for assessment and the way in which assessments will work (paragraph 3.2.9).

Different levels of complexity

In practice, while some assessments will be simple, others should appropriately involve a range of different professional disciplines from across health and social care agencies, other local authority departments and voluntary organisations. The white paper stresses the need for simplicity, and says that assessments should avoid duplication by building on established arrangements where possible – for example, when a patient has been assessed on discharge from hospital (paragraph 3.2.12). Clients' and carers' preferences should be taken into account, and where possible assessments "should include their active participation" (paragraph 3.2.6). Nevertheless, *Caring for People* states that assessments will need to be made with explicit objectives and priorities in mind, and decisions made as a result of them "will have to take account of what is available and affordable". Provision should be targeted on those most in need (paragraph 3.2.12).

In essence, the white paper requires local authorities to:

- Determine eligibility criteria for social care assessment.
- Develop explicit assessment processes for social care provision, including state-supported private residential care, which will take account of clients' and carers' needs and preferences and which will be managed by one individual.
- Create a differentiated assessment system which will gear the extent of the involvement of SSDs and the contribution of other agencies to the particular range of needs presented by client and carers appropriately and cost-effectively.
- Publicise these procedures.

Implementation of these arrangements will result in the introduction of an explicit eligibility system for state-supported social care, such as has traditionally operated in the housing field. Provision will depend on the extent to which the resources allocated to care provision can be matched with needs assessments. This is certain to vary between local authorities, as will eligibility criteria, unless the Department of Health's code of guidance for assessment procedures is designed to be interpreted prescriptively. The need to balance considerations of equity with the need to ensure flexible local-level policy development that takes account of local authorities' particular

1.1

TYPES OF SOCIAL CARE ASSESSMENT

	Eligibility for assessment determined by:	*Client/carer involvement*	*Worker/agency(ies) typically involved in assessment*	*Aim*	*Assessment criteria*
ASSESSMENT FOR SERVICE					
Example: SSD home help/home care	**Referral by Primary Health Care Team, SW, client or carer**	**Clients consulted, but service considerations may override client preferences on intensity, timing and tasks covered**	**Home Care Organiser (SSD)**	**To determine eligibility and need for home care services**	**Frequently ill-defined but may include:** • **'dependency' i.e. ability to perform domestic and self-care tasks** • **stress on carer** • **risk** • **financial eligibility for charges**
FORMAL ASSESSMENT FOR SERVICE					
Example: LA residential care	**Referral by Primary health care team, SW, client or carer**	**Clients and carers consulted but considerations of carer stress, risk and availability of alternatives may be more important for outcome than client preferences**	**Individual Social Workers Residential Care Panel (SSD)**	**To determine eligibility and need for LA residential care**	**As in above example**
MULTI DISCIPLINARY NEEDS ASSESSMENT					
Example: Individual Programme Planning for people with learning difficulties	**Assessed learning difficulties of individuals**	**Variable — clients and carers can be excluded**	**Community Mental Handicap Team Members (HA/SSD)**	**To determine the range of interventions and services appropriate for the individual person with learning difficulties**	• **competence of individual** • **development needs of individual** • **stress on carers** • **risk** • **client preferences**
MULTI-DISCIPLINARY NEEDS ASSESSMENT REQUIRED BY STATUTE					
Example: Statement of special educational needs (1981 Education Act)	**Assessed special educational needs of individual child**	**Parents can comment on and/or go on to appeal the statement**	**District Handicap/ Child Development Teams and others (HA; SSD; LEA)**	**To arrive at a statement of special educational needs which outlines appropriate educational provision for the individual child**	• **specialist assessments by relevant professionals/ organisations, i.e. speech therapy, OT, nursery/school** • **comments by parents**

Key: HA: Health Authority SW: Social Worker SSD: Social Services Department LA: Local Authority
LEA: Local Education Authority OT: Occupational Therapist

Sources: Challis and Davies, 1986; J Neill *et al*, 1988; B. Goacher *et al*, 1988; SSI, 1988b.

circumstances and conditions may prove taxing for policy makers within local authorities.

Social care assessment: the state of the art

Currently, people seek support for residential care and social services in a variety of ways. They may apply – or be referred – for local authority residential care, or for domiciliary services or day care. They may have rights to services under the 1986 Disabled Persons (Services, Consultation and Representation) Act. They may seek financial support for private residential care from the social security system. In other instances, they may not 'seek' services at all: instead, they may be required to accept health or social care under compulsory sections of the Mental Health Act 1983, or to move to residential care because they are felt to be unable to continue to live in their own home.

Assessments currently form an essential part of statutory agencies' and voluntary organisations' response to requests and referrals by or on behalf of disabled people and their carers. At present, they generally involve establishing needs and determining eligibility for a particular service or sets of services. At times, however, assessments can be more limited: as an example, current arrangements for state-supported private residential care determine eligibility solely through financial criteria, without any attempt to assess 'need'.

Assessments are a basic part of any service system, and making them is an important component of many health and social care workers' jobs. Within any given agency, a number of different types and levels of assessment operate. These cover a range of different activities, including informal decisions to refer an individual to a particular agency or organisation; decisions by service organisers about client eligibility and need for 'their' particular service, for which precise criteria may not have been established; multi-disciplinary assessments intended to create and/or manage a range of interventions and services for a particular person; through to formal assessments of need which are a statutory responsibility of the agency(ies) concerned, such as assessments for Statements of Special Educational Need under the Education Act 1981 and assessments for compulsory detention under the Mental Health Act 1983. Examples of these types of assessment with an indication of the different actors involved in them and some of the criteria they use is given in Box 1.1.

The key thing to grasp, however, is that assessments of different kinds are a standard feature of existing social services provision. In considering how to adapt current arrangements to the requirements outlined in *Caring for People* the task will be to build on existing strengths and avoid known weaknesses. Some of these are discussed in the sections which follow, where a variety of different types of assessment are presented to give examples of current practice.

Assessments for particular services

Home help/home care

Assessments for local authority home help and home care services are the responsibility of home help organisers (HHOs). They tend to be unsystematic and based on informal rules and established routines rather than clear policy guidance about eligibility and the need to match resources to client need and preferences. This is partly a function of HHOs' large caseloads - which one recent study of eight local authorities established at an average of 210, with a range of between 150 and 480 cases (SSI, 1987). They also reflect a more general lack of clarity about service aims and objectives, as well as the large number of functions that HHOs are expected to fulfil (Davies and Challis, 1986).

As a result, the service offered tends to follow standard formulae ('two hours shopping; two hours cleaning; one hour laundry' is one such) and it has proved difficult to reorganise services to permit client and carers' needs to be more precisely met (Tomlinson, 1989). Shifting patterns of care away from housework towards a wider range of tasks geared at maintaining people at home has also presented a challenge for SSD managers.

In practice, it appears that relatively few people referred for home help services are refused them after an assessment by the HHO – with the result that service planning and targeting effectively becomes the responsibility of referral agents (Davies and Challis, 1986). It also means that the intensity of the service is commonly sacrificed to its 'cover'.

On the positive side, however, assessments by HHOs can have the advantage of simplicity since only one worker is involved. With the right organisational backup, training, and resources, this can mean a speedy response to client and carer need from someone with considerable experience of helping older people at home.

Local authority residential care

Assessment for local authority residential care (Part III accommodation) is generally the responsibility of social workers, and although local procedures vary, the results of their work is commonly presented to SSD panels who determine eligibility and allocate available places. This process has been criticised for its tendency to determine clients' eligibility and priority for long-term residential care rather than to analyse the situation of carers and clients and assess alternative strategies for support (Challis and Davies, 1986). In practice it appears that much assessment and allocation in this area remains service-led, and that this problem is a long-standing one which relates to the low priority traditionally attached to work with the elderly in social work training and practice. These considerations also mean that interventions tend to be triggered only by crises, where breakdown of informal care and/or perceptions of client risk dictate residential care as the preferred solution.

Recent research findings suggest that eligibility for Part III accommodation is determined largely by assessments of applicant's isolation; problems with self-care and domestic management; problems of caring and risk. However, these are often considered in general terms: detailed analysis of each of these aspects of need which would allow other forms of support to be considered are unusual (Neill et al, 1988).

Recent efforts to widen the scope of assessment for residential care to include consideration of alternative support strategies and the contributions of other professionals suggest that this is both desirable and difficult to achieve. Obstacles to progress include problems of negotiating professional contributions from other agencies, notably health; problems of sharing skills; and difficulties about making corporate decisions to use combinations of services because this entails resource commitments from a variety of agencies (Tomlinson, 1989).

Another direction that some authorities have explored is the application of standardised evaluation scales, such as the Royal Crichton Behaviour Rating or the Rutter Stress Evaluation Scale. Approaches of this kind have the advantage that they can be conducted by inexperienced or untrained staff, and that they encourage consistency between assessments. They can, however, engender a mechanistic, one-dimensional approach to evaluating need which is based around clients' deficits.

Multidisciplinary assessment

Multidisciplinary assessments involve a pooling of the approaches and skills of different kinds of social care and health worker within and across agencies. The intention is to provide a rounded, holistic view of the individual assessed, taking into account his or her capacities and strengths as well as his or her social and physical environment.

Over the past fifteen years, a number of influential reports, Acts of Parliament and national policy developments have favoured multidisciplinary assessment and teamworking. These include the Court Report (1976), which recommended the establishment of multidisciplinary District Handicap Teams (DHTs) with representation from health, social services and education; the development of Community Mental Handicap Teams (CMHTs), with representation from health and social services; the establishment of Primary Health Care Teams (PHCTs); joint assessments of elderly people; the 1981 Education Act, which established a system of multidisciplinary assessment and statementing for children with special educational needs (see Box 1.2); the 1983 Mental Health Act, which established individuals' rights for multidisciplinary assessment prior to possible detention under one of its compulsory sections; and the 1986 Disabled Persons (Services, Consultation and Representation) Act, with its emphasis on holistic assessments of people with disabilities in which their wishes and preferences are fully represented.

Many of the teams and groupings that have resulted from this emphasis on multidisciplinary working provide services as well as assessments, but assessing client need is, in every instance, an important part of their work.

While progress has undoubtedly been made, research and other evidence from this period makes it clear that further developments need to take place before multidisciplinary working – and the assessments that result from it – fulfils its potential. Problems with current approaches can be summarised as follows:

- It can be difficult to negotiate contributions from all the interests involved.
- Contributors with different training and experience can be reluctant to share skills.
- Multidisciplinary assessment processes are cumbersome. Obtaining contributions from a range of professionals can be administratively difficult, and expensive in terms of their time and that of administrative staff (see Box 1.2). This can mean that clients and carers find procedures slow and confusing.
- It is often difficult for professionals to agree the purpose of the assessment, with the result that contributors fail to focus on a common goal and set clear targets for its attainment.
- It can be difficult to avoid assessments which focus on clients' suitability for existing resources, rather than on clients' wishes and needs.
- Contributions may concentrate on clients' perceived weaknesses and deficits (see Box 1.3).
- Clients' preferences and needs, and those of their carers, can become marginalised (see Boxes 1.2 and 1.3).
- Monitoring and review arrangements frequently fail to be clarified during assessment, with the result that no one takes responsibility for them (SSI, 1985, 1987, 1989; Neill et al, 1988; Beardshaw, 1988).

1.2

ASSESSMENT OF SPECIAL EDUCATIONAL NEEDS UNDER THE 1981 EDUCATION ACT

The Education Act 1981 made important changes to the law on provision of education to children with special educational needs (SEN). Section 5(1) of the Act places a formal responsibility on local education authorities (LEAs) to assess children with special educational needs in their areas, with the aim of determining whether these needs require, or may require, the authority to make special provision to meet them. In doing so, LEAs must, as a minimum, seek educational, medical and psychological advice relevant to the child's needs. Voluntary organisations may also contribute.

One of the Act's most notable innovations is the way that its provisions involve parents in all stages of the assessment process, and give them formal rights to make representations and submit evidence to it. They may also appeal their child's Statement of Special Educational Needs to the Secretary of State for Education and Science. Sections 5, 7 and 8 lay down procedures under which parents may make representations and submit evidence to the LEA as part of the process of determining their child's special needs. Government circulars have emphasised the importance of LEA's providing parents with clear written guidance about the assessment process.

The 1981 Act marked a major shift in national policy on the education of children with special needs. As a result, many LEAs have had to rethink their policies and provision for SEN children. The philosophy which underlies the Act's assessment requirements stresses the need for a holistic view of the child that concentrates on his or her abilities and potential – this has involved considerable changes of approach and practice by many of the professionals involved in the assessment process. Unsurpisingly, the ways in which this new philosophy has been interpreted and the Act's provisions implemented has varied from LEA to LEA. Some LEAs had anticipated the Act's direction and provisions and had made changes in advance of its appearance on the statute books. Others found that they had considerable changes to make when the bill became law.

LEAs have also differed in the way in which they have developed assessment procedures in response to the Act. Although government circulars made detailed requirements about the form that these procedures should take, their precise form is open to interpretation. Research has highlighted four main problem areas with the assessment and "statementing" process which have arisen in certain LEAs:

- ***Lengthy and bureaucratic procedures:***

  Certain LEAs have introduced long-winded and cumbersome statementing procedures. Although central government guidance has stated that it should take no more than six months to assess for and make a Statement under the Act, the process can take as long as two years in some parts of the country.

- ***Problems with multidisciplinary assessment:***

  LEAs and other agencies – notably health – are unaccustomed to dealing with one another. In some places this has meant that involving other agencies in statementing has not gone smoothly, with the result that assessments are not as complete as they might be and/or take longer than is desirable. In addition, some professionals have found it difficult to adapt their practice to reflect the holistic, positive kind of assessment which the implementation of the Act requires.

- ***Parents can be marginalised:***

  When procedures are lengthy and complex parents can become confused, anxious and/or alienated. This can mean that their involvement and contribution is less central than the Act intended.

- ***Statements are framed with existing resources in mind:***

  In some places, assessments and statements appear to be framed around existing educational provision, instead of the child's needs.

Sources: Department of Education and Science and Department of Health, (1989); Goacher *et al, 1988*.

Mandated multidisciplinary assessment

Multidisciplinary assessment of children with special educational needs is mandated under the 1981 Education Act. This process, with a short summary of the research evidence on how well the assessment system works in practice, is discussed in detail in Box 1.2.

There are a number of parallels between the changes involved in the implementation of the 1981 Act and those that will result from the community care assessment requirements of the National Health Service and Community Care Act 1990. The 1981 Act marked a major shift in educational philosophy for children with disabilities and other special needs. As with *Caring for People*, the intention was to move from a service dominated assessment system to a holistic, multi-faceted one aimed at identifying children's individual needs in close collaboration with their parents. The ultimate goal was a 'package' of educational provision tailored around the particular child.

Inevitably, as with the implementation of any other major policy change, this process has taken place more smoothly in some places than in others. Recent research has identified the development of lengthy and bureaucratic assessment systems as a particular problem in some Local Education Authorities. Parents are reported to find systems of this kind alienating and confusing. Ensuring multidisciplinary working and contributions from

1.3

TWO ASSESSMENTS

The text in italics is two different assessments of the same person – Mr Edward Davis.

The first one was done by a multidisciplinary team of professionals as part of a regular case review cycle. It brings together information from psychological, social work, nursing, speech therapy and occupational therapy assessments along with a review of progress in a sheltered day care setting. The aim was to make proposals for the next year's therapy and programme objectives. Mr Davis did not attend the meeting at which this assessment was devised because his violent behaviour had resulted in exclusion from his day centre on the day that the assessment took place there. No one from his family was present either, although they had been invited to attend.

The second assessment took place at the suggestion of Mr Davis' day care organiser and was done by Mr Davis, members of his family, neighbors, members of his church and two of his social care workers with the help of an outside facilitator. The aim of this assessment was to share information and concerns about Mr Davis' present situation, and plan for the future.

I ***Mr Davis has a mental age of 3 years, 2 months. IQ = 18. Severe impairment of adaptive behaviour, severe range of mental retardation. Becomes agitated and out of control. Takes [medicines] for psychosis.***

Severely limited verbal ability; inability to comprehend abstract concepts. Learns through imitation. Has learned to unlock the Coke machine and restock it, and to crank a power mower and operate it.

His family is uncooperative. They break appointments and do not follow through on behaviour management plans.

II ***Ed lives with his mother and sister in [housing project]. Ten of his relatives live near by and they visit back and forth frequently. His father spends little time with him, but two of his sisters have been very helpful when there are crises. His family agree that he will live with one or another of them for the rest of his life.***

Ed is at home in his neighborhood. He visits extended family members and neighbors daily. He goes to local stores with his sisters and helps with shopping. He goes to church.

Ed dresses neatly, is usually friendly, and shakes hands with people when he meets them. He is a very big man, with limited ability to speak. When he gets frustrated and upset he cusses and "talks" to himself in a loud voice. These characteristics often frighten other people who do not know him well. He has been excluded from the work activity center because he acts "out of control" there. He has broken some furniture and punched holes in the walls there and scares some of the staff people very much.

Ed likes people and enjoys visiting in the neighborhood. He loves music, dancing, and sweeping. He likes loading vending machines and operating mechanical equipment. He likes to go shopping. He likes to cook for himself and for other people and can fix several meals on the stove at home. He likes to hang clothes and bring them in off the line. He likes to stack cord wood and help people move furniture. He prefers tasks that require strength and a lot of large muscle movement.

Source: J. O'Brien and B. Mount, 1988.

the full range of agencies has also proved difficult, and in some places assessments still appear to be framed around existing resources rather than individual need (Goacher *et al*, 1988).

Moving forward

The need to move towards a more genuinely holistic model of assessment where client and carer wishes are central and which has as its goal the identification of a range of appropriate supports for clients, rather than standard service packages - is widely recognised. It is reflected in provisions of the Disabled Persons Act 1986 (see Box 1.4) and in the white paper itself, which gives local authorities the responsibility for gearing assessments to client need in a cost-effective way.

Cost will undoubtedly be a key consideration: one estimate suggests that social services authorities will need to undertake around 100,000 assessments each year for state-supported private residential care in England and Wales (PSSRU, 1990). Since assessments for local authority residential care currently cost an average of £225 per case, with a range of between £50 and £300+, this new responsibility will itself have significant resource implications (Baldwin, 1990).

The literature makes it clear that in many local authorities assessments are organised in a piecemeal fashion, and that there is also a tendency for them to be service-dominated. At the same time, although the need to move to a different approach is widely acknowledged, significant difficulties with multidisciplinary teamwork have been identified. Changes in the assessment arrangements for children with disabilities give some idea of the problems which may be involved in this: efforts to move to more 'holistic' needs-based assessments for children with special needs have been patchy in the nine years since the 1981 Education Act was enacted. In some places bureaucratic procedures have undermined some of the effects that the legislation was intended to achieve.

Implementation of the 1990 National Health Service and Community Care Act will involve

1.4

ASSESSMENT UNDER THE DISABLED PERSONS (SERVICES, CONSULTATION AND REPRESENTATION) ACT 1986

The 1936 Disabled Persons (Services, Consultation and Representation) Act centres on giving people with substantial physical disabilities, learning difficulties and/or any form of mental illness new rights to assessment for services, with representation of their own choosing. Although Local Authorities are free to operate as if the whole Act is in force – and some have done so – the government has not yet issued commencement orders on certain parts of it. As a result, substantial portions of the Act remain to be implemented. These include Sections 2 and 3, which are concerned with representation and needs assessment and Section 7, which concerns the rights of people with a mental disorder discharged from hospital after six months or more.

Assessment Requirements

The 1986 Act requires local authorities to undertake a variety of different types of assessment. These include:

☐ **Needs assessment**

(Section 3: not yet implemented)

When requested to do so by a disabled person or their representative, Local Authorities are required to provide a written statement specifying:

- **the needs accepted by the authority and the services they propose to meet them; or**
- **that in their opinion the disabled person has no needs;**

and

- **the reasons for their decision.**

If they do not propose to provide a service to meet an identified need they must state this and explain the reason why.

☐ **Assessment for services under section 2 of 1970 Act**

(Section 4: implemented April 1987)

Local Authorities must assess the needs of a disabled person for any of the services listed in section 2 of the 1970 Chronically Sick and Disabled Persons Act when requested by the disabled person, his or her authorised representative or carer.

☐ **Assessment of disabled persons leaving special education**

(Section 5: implemented February 1988)

Local Authority Social Services Departments must undertake an assessment of disabled persons leaving special education within five months of receiving notification from the Local Education Authority, unless the person involved requests them not to do so.

☐ **Assessment on discharge from hospital**

(Section 7: Not yet implemented)

When a person has received in-patient hospital treatment for a "mental disorder" (this term covers mental illness or mental handicap) for a continuous period of six months or more, the local authority has a responsibility to arrange a needs assessment before discharge, unless the person concerned asks them not to. This will be done in co-operation with the health authority, which will itself assess health needs.

In addition to these specific requirements for assessment, Section 8 of the 1986 Act requires local authorities to take carers' needs into account when making assessments. This Section was implemented in April 1987.

Implementation of the Act

Early evaluations of the way that local authorities have interpreted and acted upon the Act's assessment provisions suggests that implementation varies greatly between different local authorities. Central government's financial provision for implementation – some £49 million between 1988 and 1992 – has been largely directed at Sections 5 and 6. Overall, authorities have been concerned not to raise expectations in advance of resources being available to meet them. As a result, assessment requirements appear to be being interpreted narrowly.

Implementation of Section 4 appears to be largely service led, with little in the way of holistic, multidisciplinary approaches developing. The nature of the assessment tends to be determined by the type of services initially requested by the client, with the majority of assessments conducted by occupational therapists, although home care organisers, social workers and social work assistants are also involved. Information sharing between professionals following assessments is reported as being patchy. It is too early to say how authorities are responding to their responsibilities under Sections 5 and 6.

Source: Social Services Inspectorate, 1988.

considerable investments in new assessment approaches by Local Authorities. This will amount to a major culture change in many areas, and will demand concerted working from a range of groupings across professional disciplines and agencies. The challenge is a considerable one, especially since there are no established ways of gearing assessment types to need in a cost-effective way.

2 Case Management

Case management in *Caring for People*

Caring for People states that social services authorities will be responsible for designing care packages to meet individual needs, in consultation with clients, other professionals, "and within available resources". It gives the government's view that,

> *Where an individual's needs are complex or significant levels of resources are involved...[there is] considerable merit in nominating a case manager" to take responsibility for ensuring that individuals' needs are regularly reviewed, resources are managed effectively and that each service user has a single point of contact... Case management provides an effective method of targeting resources and planning services to meet specific needs of individual clients* (paragraphs 3.3.2 and 3.3.3).

The white paper states that case managers will often be employed by the social services authority, but that this 'need not always be so' (paragraph 3.3.2). It lists the elements of effective case management as including:

- identification of people in need, including systems for referral;
- assessment of care needs;
- planning and securing the delivery of care;
- monitoring the quality of care provided;
- review of client needs (paragraph 3.3.4).

Caring for People goes on to state that while it is not essential that the same manager undertake all these tasks for a particular client, a clearly identified individual should be designated for each function (paragraph 3.3.2). It suggests a range of backgrounds for case managers, with social workers, home care organisers or community nurses as possibly the most suitable (paragraph 3.3.4). It gives the government's view that there is advantage in linking case management with delegated responsibility for budgetary management as "an important way of enabling those closest to the identification of client needs to make the best possible use of the resources available" (paragraph 3.3.6). Authorities will be expected to indicate how they propose to use case management techniques and develop clear budgetary systems (paragraph 3.3.6).

Defining case management

There is no widely accepted definition of case management, and the term itself embraces a variety of meanings. Generically, case management refers to any method of linking, managing or co-ordinating services to meet individual need. The method evolved in North America during the 1970s and 1980s as a result of concerns about service fragmentation and cost containment in long term care (Zawadski and Eng, 1988). Capitman and others define case management as:

> *... an administrative service that directs client movement through a series of phased involvements with the long term care system. It is also an advocacy service that attempts to integrate the formal long term care system with the caregiving provided informally by family members, friends and community groups* (1986).

Challis (1989) has proposed the following set of core tasks for case management:

- case finding and screening;
- assessment;
- care planning and monitoring;
- review.

Case management can be distinguished from traditional casework and service management functions by its emphasis on tailoring services to the individual needs of particular clients, instead of "fitting them into" existing provision. Case managers are generally expected to make a holistic assessment of client need encompassing his or her physical and social environment and informal care networks, and then construct and manage a range of service or living options around them.

Monitoring, evaluation, reassessment and (if necessary) reprovision are an essential part of the case manager's brief. This contrasts with much current practice in both the social and health care fields where individuals are typically assessed for their eligibility for particular services, and little monitoring or reassessment takes place unless there are major changes in their circumstances (see Chapter 1).

Operating outside standard service systems is inherent in the way that case management principles have been applied in the UK. To take one example, the deployment of 'helpers' who performed a wide range of personal care and domestic tasks in order to support frail elderly people in their own homes was essential to the improved outcomes for frail elderly people achieved by the Thanet and Darlington case management projects discussed in Box 2.1 (Qureshi *et al*, 1989). As such, many British case management projects have been bound up with changes to service content and availability as well as improved co-ordination (Challis, 1986).

It is, however, important to recognise that a number of definitions, models and understandings of case management have developed in Britain over the past decade. As a result, the term remains an imprecise one, which is capable of multiple interpretations – especially when applied to existing service systems. Clear definitions and shared understandings of case management roles and functions will be important if it is to be applied productively to British social care. This will involve clarification of:

- the *level* and *position* from which case managers operate within the service system;
- the extent to which case managers themselves provide services;
- their accountability to social services authorities, other agencies, and to their clients and their carers;
- their control over resources in terms of access to services and individualised client-based budget allocations;
- clarification of how their responsibility for assessment and service allocation relates to that of managers of particular services and service providers within and across agencies;
- the extent to which agencies will be able to pool resources to provide individualised budget allocations for clients who need multi-agency support.

North American models

North American case management methods initially developed as a response to the related problems of service fragmentation; poor or non-existent resource targeting, coordination and control; and the difficulty of interweaving statutory and informal care productively. More recently, 'service brokerage' models, which centre on enhancing client advocacy and control of the service system, have developed in Canada. Individualised budget allocations from a range of health and welfare agencies have been essential to these developments (Marlett, 1989).

The US and Canadian literature makes it plain that case management models vary according to a number of criteria. These include the client group with which case managers are dealing, their position and level within the service system, whether or not they have authority to co-ordinate resources across agencies, definitions of their role, and whether or not they are responsible for individual client budgets. However, although the forms it takes may vary, the North American evidence makes it clear that high quality information systems about service choices and costs are a critical underpinning of effective case management, as are genuine options between services and support strategies for individual clients (Thomas and Towell, 1990).

US case management: multiple models

In the United States, establishment of Medicaid reimbursement for 'case managed' systems of long term care in 1981 was critical to the emergence of case management as a defined and separate service for frail elderly people. For this group, using case management techniques to control unnecessary nursing home admissions was an important stimulus to service development.

Zawadski and Eng have identified three models of case management for frail elderly people:

- The **Prior Authorisation Screening Model** in which a professional assesses the person considering institutional placement, determines whether alternative community services could be provided and, where appropriate, arranges those services.
- The **Brokerage Model**, where a professional assesses a frail elderly person, arranges services through other providers and monitors and reassesses the individual regularly.
- The **Consolidated Model**, in which a multidisciplinary team assesses needs and then provides the required services.

In essence, these three types of case management are graded in terms of the complexity and cost of meeting client need. The 'prior authorisation screening model' is analogous to the keyworker roles that have developed within many British services, while the 'brokerage model' conforms to the service brokerage model of case management developed in the UK, and discussed below (see, for example, Pilling, 1988). The 'consolidated model' bears a clear relationship to the workings of some British multidisciplinary teams.

Zawadski and Eng point out that the choice of model relates critically to client need:

> *The question is not: "Which model is better?" There are advantages and disadvantages to each. The more appropriate question is: "for what type of client and in what type of situation is each model most appropriate ?"*

They go on to suggest that while the brokerage model may be sufficient for a moderately impaired person with little or no informal support, a seriously impaired individual with a number of inter-related needs and limited informal support needs the consolidated model because of their multiple requirements and the need for close monitoring (1988).

Problems with continuity

In relation to services for people with long-term mental health problems, Mechanic has pointed out the danger of regarding case management as a panacea for the difficulties inherent in providing a range of services to support people disabled by mental health problems for long periods. Rapid turnover and 'burnout' among case managers and - at times - the limitations imposed by the fact that case management tasks are undertaken by relatively young and inexperienced individuals have proved obstacles to the development of managed services for this group in the United States (Mechanic, 1987).

These points are useful ones to bear in mind as case management is introduced into the UK for groups with long-term needs. Continuity of case management is likely to become an issue for people with physical disabilities, learning difficulties and long-term mental health problems, as well as for many frail elderly people and their families.

Canadian brokerage models

In Canada, the independent living movement has begun to develop different forms of agency or 'service brokerage' models for people with physical disabilities (Marlett, 1989). Similar systems are being developed for people with learning difficulties.

Service brokerage takes a variety of forms, but at its heart is a not-for-profit agency independent of both funding and provider interests. This helps the client identify appropriate supports and then works with them and their carers to obtain the individualised funding required to deploy them. Agencies employ case managers ('brokers') to help people with disabilities and their families identify their needs and make appropriate choices. Brokers are accountable to the client and to the agency, which is managed by a Board of Directors.

The ability to identify and negotiate individualised funding for people with disabilities is critical to the development of this model, which also depends on high quality information services, peer support for people with disabilities and the close involvement of clients and their personal networks in the brokerage process (Brandon and Towe, 1989). The Calgary Association for Independent Living (CAIL), which has pioneered the brokerage approach for people with severe physical disabilities, is itself controlled by disabled people.

The Canadian literature makes it clear that service brokerage has developed as part of the independent living movement's efforts to support severely disabled people in their attempts to lead autonomous lives in the community. As applied to people with learning difficulties, service brokerage is linked with efforts to move away from 'sheltered' work and living settings towards more genuine integration into mainstream training, work, and housing opportunities. These developments have taken place within the context of a wider discussion in both the United States and Canada about the extent to which people with disabilities and/or their families can undertake case management tasks for themselves. In some North American settings parents already act as case managers for their disabled children and receive payment for this work (Mount, 1989).

Case management in the UK

A number of case management pilot projects took place in this country during the late 1970s and 1980s, and these display different emphases on service brokerage and 'social care entrepreneurship' in which formal and informal care is interwoven using a variety of service inputs tailored to individual need.

In an important sense this means that the UK experience of case management has been different from that in the United States and Canada: North American case management has the integration of a diffuse and fragmented service system as its primary focus, and although this is important in the UK, case management here has also emphasised the need to move from service dominated provision to one where services are tailored to individual requirements.

An analysis of five UK case management projects is given in Box 2.1. This attempts to highlight important elements of each approach and to give a condensed summary of key points to emerge from project evaluations. It is important to recognise the extent to which the approaches summarised here vary. In particular, there appear to be differences which relate to the client group being served and the access which case managers have - or are able to construct - to alternative forms of provision.

At the same time, project evaluations have identified common themes. One is the case managers' small case loads. These are set at around 20-30 cases for most projects, although the Winchester project - which centres on developing individualised, client centred services for people with learning difficulties - has established case loads at 9, because of the intensive nature of the 'getting to know you' assessment method which is central to its operation. This project – which has not yet had its final evaluation – has also identified the lack of appropriate service choices as a major obstacle to service development, and there are, in addition, significant difficulties associated with identifying individualised client budgets made up of contributions from both health and social services (R. Archer and G. Robertson, 1989).

Interprofessional rivalries and problems associated with securing contributions from outside agencies were identified as significant difficulties in a number of the projects analysed in Box 2.1. The Gloucester project – where case managers from diverse backgrounds were placed in multidisciplinary Primary Health Care Teams – also found that their 'free floating' status, and lack of a peer-reference group with attendant career development and training opportunities was stressful for the individuals undertaking the case management role. The evaluation report comments that leaving case managers' status undefined would be "untenable in the longer term" (Johnson et al, 1989).

'Social entrepreneurship' models

In the Thanet case management project – which was designed and evaluated by the Personal Social Services Research Unit (PSSRU) at the University of Kent in the late 1970s and early 1980s – case managers were social workers who had a shadow budget for purchasing and support from community 'helpers'. This was set at two-thirds of the cost of a residential care place. Case managers were responsible for knitting together services and help from a variety of sources, including informal carers, in response to individual needs. They could choose to use conventional personal social services like home helps or day care, or could tailor make support services for individual elderly people by employing helpers to perform a range of personal and domestic care tasks. In order to promote the ingenious use of resources and close monitoring, case loads were deliberately kept to around 30 clients per worker. Case managers concentrated on the very frail elderly – people assessed as being the most likely to need residential care.

Evidence from this study suggests that social workers responded positively to the opportunity to construct flexible support systems around client need. Their assessments moved beyond narrow considerations of service eligibility to become more holistic and problem focused. This approach reduced the need for institutionalisation and significantly improved clients' quality of life, despite the fact that accessing resources across agencies – notably from GPs and specialist health services – proved problematic (Challis and Davies, 1986). The approach has been replicated and shown to be effective in different geographical and social settings, with some variations (Challis, 1989).

Service brokerage

In contrast to this approach, other case management projects have concentrated solely on a British version of service brokerage, in order to reduce service duplication, fill gaps and achieve a set of goals agreed with the client (Glendinning, 1986; Pilling, 1988). One example located case managers in a free-standing voluntary organisation. The case management task was defined as working with clients – all of whom had severe physical disabilities – to arrange a set of supports that best met their particular needs. 'Contracts', with goals and objectives agreed between the client and the case manager formed the basis for interventions with other agencies. Case managers, who were drawn from social work backgrounds, developed special expertise in local services available for their client group and regarded their role as 'client advocate' in negotiations with providers as their chief responsibility (Pilling, 1988).

An earlier project, which designated social workers to act as specialist 'key workers' for families with severely disabled children, also involved a service brokerage approach in that case managers attempted to improve service coordination by negotiating with key agencies on their clients' behalf. However, comparison with controls found that project clients did not fair significantly better in terms of services received or their co-ordination, although they valued the specialist knowledge and interest of their key workers (Glendinning, 1986). Later commentators have attributed this to key workers' lack of leverage on the service system through budget-holding or other means (Challis and Davies, 1986).

Building on 'keyworkers'

In addition to the case management projects discussed in Box 2.1, there have been a number of recent attempts to build on 'key worker' and 'care coordinator' approaches to improve care management for members of different priority groups (see, for example, the head-injuries and disability team projects discussed in Hunter, 1988). These tend to involve giving members of multidisciplinary teams responsibility for arranging and monitoring 'care packages' for clients assessed as having long-term needs.

However, the literature makes it clear that grafting case management into multidisciplinary

2.1

FIVE UK CASE MANAGEMENT PROJECTS

Sponsor Agency	*Client Group*	*Referrals*	*CM's back-ground*	*CM's case load*	*Access to Resources*	*Budget Holding*	*Additional training for CM*
THANET							
Project based in an experimental social work team in SSD	**Frail Elderly People**	**SWs Area Team; GPs; City Nurses**	**SW**	**25 - 30**	• **Direct access to community care 'helpers' through budget holding** • **Ability to purchase small aids to daily living adaptations**	**'Shadow' budgets for each client of two thirds of cost of residential care place. Expenditure above this required line management sanction.**	
Key points from Evaluation	• **Change to service content involved since helpers provided more flexible services than traditional home helps;** • **Service judged cost effective and also increased life expectancy when compared with control group;** • **Problems experienced with accessing community nursing and specialist health care;** • **Duplication of assessments with existing service organisers, especially Home Care Organisers and Community Nurses;** • **CMs ability to deploy community care helpers flexibly and imaginatively to meet individual need and support informal care critical to scheme's success**						
DARLINGTON							
Joint HA/ SSD-based in multi-disciplinary geriatric teams	**Severely Disabled Elderly People discharged from hospital**	**Multi-disciplinary geriatric team**	**SW**	**20**	• **CMs managed HCAs who combined traditional home help and nursing assistant roles**	**Two thirds cost of hospital placement**	
Key points from Evaluation	• **Substantial change in service content as well as changes to delivery involved. This was through creation of HCA role. In practice, HCAs undertook a wider range of tasks and activities than either home helps or nurses, and received additional training;** • **Project resulted in reduced burden on carers when compared with control group;** • **Substantial cost savings identified for group receiving project services;** • **Improved quality of life and quality of care outcomes were achieved when compared to control group;** • **Probable decrease in numbers of people requiring long stay hospital care ('bed blocking') reported.**						
CAMDEN							
Free standing voluntary organis-ations	**People with severe physical disabilities**	**SSDs; NHS; Self-referrals**	**SW**	**50 people over 2 year period**	**CM acted as broker/advocate for client with other agencies and voluntary organisations**	**None**	**CMs familiarised selves with local services and welfare benefits system**
Key points from Evaluation	• **Services evaluated as successful in improving individual needs-based care 'packages' for clients;** • **Reduced service duplication in some instances;** • **Depth of knowledge of local resources and welfare benefits highly valued.**						

Sponsor Agency	*Client Group*	*Referrals*	*CM's back-ground*	*CM's case load*	*Access to Resources*	*Budget Holding*	
GLOUCESTER							
CM based in Primary Health Care Teams (PHCT)	Frail Elderly People	From PHCT members	Diverse	32 (with additional research tasks)	• Limited budget for small aids normally unavailable from OTs etc (e.g. vacuum flasks, hot water bottles) • CM a broker/ advocate for client with other agencies and voluntary organisations	Limited: only small aids budgets	• Thorough grounding in information about the range of facilities/ services for elderly in the area • Special training in welfare benefits
Key points from Evaluation	• CM's 'free floating' undefined status without access to further training and a peer reference group identified as being untenable in the long term; • Turf battles and boundary problems with other members of PHCT a problem; • CMs welfare and elderly services expertise highly valued by PHCT members.						
WINCHESTER							
Joint HA/ SSD special project	People with learning difficulties		Diverse	9		Identification of individualised client budgets is proving difficult because of differences between HA and SSD accounting and information systems	
Key points from Evaluation	*NB Project in progress, evaluation not complete* • Small caseloads dictated by intensive 'getting to know you' holistic assessment; • Problem of absence of appropriate services / help to meet assessed individual need a major obstacle to designing appropriate individual 'packages'; • Problems of freeing resources 'locked up' in conventional Adult Training Centre type day care for alternative uses a major concern.						

KEY: CM: Case Manager SW: Social Worker HCA: Home Care Assistant HA: Health Authority
SSD: Social Services Department

Sources: Archer and Robertson, 1989; Challis and Davies, 1986; Challis et al, 1989; Dant et al, 1989; Pilling, 1988; Quereshi et al, 1989.

teamwork can be problematic. In particular:

- Inter-professional rivalries can compromise effective working.
- Interpretations of the 'keyworker/case manager' role may be coloured by particular professional backgrounds, with the result that clients receive a markedly different service depending on the key worker they have been assigned.
- The case manager role is frequently defined very widely and a multiplicity of tasks is ascribed to it. As a result, the individuals who undertake it are obliged to develop their own – necessarily limited – interpretations of what being a keyworker involves.
- Accessing resources within and across agencies may depend on negotiation with, and further assessment by, service managers.
- It can be difficult for keyworkers or case-managers to monitor long-term clients effectively if they are at the same time providing a short-term service to other clients of the multi-disciplinary team (Challis, 1989; Beardshaw and Morgan, forthcoming).

Emerging UK case management models

To summarise, there are currently a number of different approaches to case management in Britain, and this has undoubtedly contributed to the multiple meanings that the term has acquired (see above). In the broadest terms, it is possible to contrast an emerging 'service brokerage' model, which centres on service co-ordination and (at times) an emphasis on client advocacy with a 'social entrepreneurship' one, which relies on achieving improved outcomes for clients through the use of individualised budget allocations.

In many ways, these models are not distinct: advocates of social entrepreneurship are quick to point out the importance of budget holding – and the access to alternative means of provision that it represents – to case managers' ability to act on clients' behalf by providing genuine alternatives to standard services. Advocates of 'service brokerage' see independence from resource considerations as an important part of client advocacy, yet early evaluations of this approach cast some doubt on its ability to improve outcomes for individual clients and their families.

It may be significant that the agency version of service brokerage – a conspicuous feature of the Canadian model discussed above – remains a rarity in Britain, although it has been piloted in Camden (see Box 2.1) and a user-controlled version has been proposed by the Derbyshire Centre for Integrated Living. Instead, there appears to be a growing tendency to develop 'key worker'/'case manager' roles from within single or cross-agency multi-disciplinary teams – something that can be problematic for the reasons discussed above.

There are a number of options for developing the case management role within the service systems which develop as a result of *Caring for People*, and these will need to be carefully tailored to the needs of the people these arrangements are intended to serve. Some of these are summarised in Box 2.2, with an assessment of their positive and negative features. A number of them are further discussed in work by Renshaw and Challis (1987; 1989).

Whichever models are adopted, however, it is already clear that the introduction of this new approach will involve a considerable change in service management within social services departments, as well as a major shift in work methods for the professionals who assume case management roles. It is unclear how social workers and other professional groups who may be asked to undertake case management will react to this new brief. In an analysis of the major changes involved, Challis (1989) has identified the following problem areas:

- identification of suitable personnel;
- the availability and suitability of training to equip case managers to develop long-term care strategies which cross agency boundaries;
- possible conflict with existing service managers and line managers;
- cost.

In practice, the changes required to introduce effective case management systems will be very complex, not least because they will need to take place at four levels at once. In addition to the introduction of case management itself, this will involve improved collaboration and planning between agencies; improved inter-professional working within and across agencies; and much greater flexibility from front-line care staff.

2.2

DEVELOPING CASE MANAGEMENT: POSSIBLE MODELS

'Single Worker/Single Agency' Model

Since this model is based on a one-to-one relationship between client and case manager it has the advantage of simplicity and continuity for the client, always assuming that case managers remain in post for protracted periods. For clients with complex needs that stretch across agencies, using case managers as a 'single door' to services would represent a considerable simplification of existing arrangements.

However, case management tasks would need to be tightly defined in order to avoid the problems arising from idiosyncratic or professionally influenced interpretations of the role. It is also possible that defining the role in this way would inhibit the appropriate delegation of tasks to other staff.

Case managers' influence over the allocation of other agency's resources would have to be carefully defined through community care planning and other arrangements.

'Shared Core Tasks' Model

Here, case management tasks would be shared out between different staff, with professional staff undertaking complex tasks like assessment, care planning and counselling and administrative staff taking responsibility for co-ordination, monitoring and review. This could represent an efficient use of scarce staff resources for the agency responsible for case management, but it might also result in confusion, 'buck passing' and loss of continuity with individual clients. In addition, separation of care planning from monitoring and review could reduce learning and the cross-fertilisation of ideas and experience between and within cases.

'Joint Agency' Model

The effective management of clients with complex, long term needs will almost inevitably involve integrating contributions of various kinds from different agencies and voluntary or private sector organisations. Dovetailing health and social care inputs is perhaps particularly important for frail elderly people and people with long term mental health problems. For these groups, the development of case management which is supported by joint agency working – perhaps by basing it in a multidisciplinary, cross-agency team – may be especially appropriate.

However, experience suggests that such developments can be problematic in practice. To succeed, they must actively circumvent the difficulties listed in the 'keyworkers' section of the main paper, and delineate clear lines of accountability to their 'parent' agencies. In addition, the development of shared information and budgetary systems are likely to prove difficult and involve a certain amount of organisational upheaval.

'Independent Agency' Model

Independent organisations organised along Canadian 'service brokerage' or other lines could undertake case management for particular clients or client groups on an agency basis. Indeed, the development of agencies of this type has been advocated by the British Council of Organisations of Disabled People and the UK Independent Living Movement for some years. Separating out the case management function has the possible advantage of enhancing client advocacy by distancing case managers from resource considerations and other organisational constraints. It may, however, weaken case managers' leverage within service systems.

Sources: R. Wood, 1988; J. Renshaw, 1989; D. Challis, 1989.

3 Key issues for service development

Caring for People presents major challenges to the field agencies responsible for its implementation. Social Services Departments, in particular, will be responsible for initiating very considerable organisational and managerial changes to the way that vulnerable people are supported in the community. These include the development of pluralistic forms of social care provision, and a more focussed approach to its deployment through improved assessment and case management systems.

This report has sketched out some of the key features of existing UK approaches to assessment and case management, and raised some current and potential problems about their development and application within social services authorities and the other agencies and organisations responsible for providing social care. Its final chapter poses some key questions for service development, in order to suggest some issues which individual social services departments need to address as they develop their own assessment and case management systems.

Overall objectives

The changes proposed in *Caring for People* are intended to enable people to live as normal a life as possible at home or in home-like surroundings in the community; to provide the right amount of care and support to allow people to achieve maximum independence; and to give service users a greater say in how they live their lives and the services they need to do so (paragraph 1.8). Is this an adequate statement of the objectives to be achieved through assessment and case management or does it need to be further elaborated within social services departments? There will certainly be trade offs between these goals. These include the extent to which the white paper's requirement that arrangements enhance clients' self-determination, and independence can be reconciled with the need to ration resources and target them on those most in need. Similarly, consideration will need to be given to how fairness between individual cases should be balanced against the need for flexibility to meet individual needs and preferences.

Assessment

Objectives

- What is the purpose of assessment? Is it to determine need or is it to determine statutory agencies' responsibilities with respect to particular individuals ?
- How can we ensure that clients' needs and preferences are fully taken into account in the assessment process?
- How can we ensure that carers' needs and preferences are central to the assessment process?
- What mechanisms are needed to support clients' contributions as full partners in assessment? What mechanisms are needed to support carers?
- Will clients and carers' from ethnic minorities need different kinds of help when making their contributions to assessment? What might these be? How should they be organised?
- How can we best ensure that the new assessment arrangements are aligned with peoples' rights under existing legislation (for example, the Disabled Persons Act 1986 and the Mental Health Act 1983)?

Organising assessments

- How can we build on existing best practice to develop client-centred assessment methods?
- How can we work from current practice to develop an assessment system in which assessment expertise and procedures are geared appropriately to client need? What will determine the level of assessment applied to particular individuals?
- What should the role of other agencies be in this? In particular, how can their skills be most efficiently and effectively deployed?
- To what extent (if any) will procedures need to be different for people with different types of disability?

Supporting the assessment process

- What are the skills needed for undertaking various types of assessment?
- What are the methods used in assessments of various kinds?
- What training implications might these and other aspects of the assessment process have?

Case management

Objectives

- Effective case management requires the existence of genuine service choices and other options for clients. How will these be achieved?
- How should case managers be held accountable to their agency and to their clients?
- Will the white paper's emphasis on self-determination and choice for clients and their carers permit them to choose to 'opt out' of case management organised by social services authorities and provide their own?

Organising case management

- When will it be appropriate to divide up the key components of case management (defined in the white paper as identification of people in need; assessment; care planning; monitoring quality; and review) among different people, and when will it be appropriate for one person to undertake all of them?
- When will it be appropriate for case managers to hold budgets (however defined)?
- When will it be appropriate for case managers to be located within a single agency? When should they operate from a multidisciplinary, cross-agency team? When should they be based in a contractor agency?
- Should we make any links between particular models of case management and the needs of particular priority groups?
- What influence might case managers have over the deployment of other agencies' resources or provision?
- If case management is to be introduced effectively, it will be important to define case managers' role tightly. How can this best be done?
- How should case management relate to resource allocation for individual clients?
- How should case management relate to resource planning?

Supporting case management

- How can the assessment and allocation functions of case managers and service managers (and others, for example GPs) be reconciled?
- How can inter-professional tension be minimised as case management is introduced?
- What training will case managers require? How can this best be organised and provided?
- Which (if any) professional backgrounds should case managers be drawn from?

This list suggests a number of the key issues and questions which need to be addressed as assessment and case management systems are designed. There are no obvious 'right' or 'wrong' answers to many of them, and different approaches will, in any case, suit different localities and circumstances.

Caring for People suggests that 'simplicity is the key'. Certainly, its prime objective is simple: 'to determine the best available way to help the individual'. However, establishing the objectives, organisation and support mechanisms for assessment and case management will be complex and challenging. As managers within Social Services Departments set about this task it may be helpful for them to bear in mind the white paper's ultimate aim: to improve the quality of life for vulnerable people living in the community.

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