# Case Management – Unit 1

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| **1** | | (None) | (no script) |
| **2** | INTRODUCTION TO CASE MANAGEMENT—What Mental Health Clients/Consumers Want and Historical Context | | (no script) |
| **3** | Video: How to Use This Course | | |
| **4** | About This Course | [center this at top]<br>Best teachers of how to be a case manager are the clients!<br>• Review of what those being served say they want<br>• Historical foundation<br>• Case management definition | Welcome to Unit 1 of the Case Management series.<br>So you are going to be a case manager. Congratulations! The case manager has become one of the most important positions in the field of mental health treatment today. The purpose of this series is to provide you with some of the basic knowledge you will need in order to be effective with your clients.<br>Goals for this course include providing you with information that will contribute to the development of the competencies that will help mental health clients or consumers move toward well-being and recovery.<br>--Increasingly, it is recognized that *the best teachers of how to be a case manager with adults with a severe mental illness are those very same adults themselves.*<br>Starting with the perspective of the people being served, Unit 1 examines the significant role of case management in the mental health and substance abuse treatment fields. Topics include:<br>--a review of the expressed wants and needs of those being served.<br>--a brief historical review of the history of case management and mental health and substance abuse treatment, including examining the deinstitutionalization movement, the community support movement, the mental health consumer movement, and outcomes management.<br>--And finally we will define case management.<br>In future units of this course, we will explore the basic functions and various models of case management, identify competencies of case management practice, and define who the consumers of case management services really are. |
| **5** | Course Objectives | • ID what people say will help<br>• ID key events and historical trends in mental | At the conclusion of Unit 1, you will be able to identify what people being served by the behavioral health field, especially those with mental illness, say will help their lives improve and also what competencies they want their case managers to have.<br>--In addition, you will identify key events in the history of mental health treatment for adults with severe |

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| | | health treatment<br>• Define case management | mental illness.<br>--Finally you will define case management, a definition that will serve you as you complete the remaining units of this course. |
| **6** | Course Prerequisites | | To gain the most value out of this course, it is assumed that you have completed the following or the equivalent… |
| **7** | Course Agenda | • What clients are saying<br>• History of case management<br>o Early activities<br>o Mental health treatment<br>o Consumer movement<br>o Outcomes management<br>• Definition of case management | Our agenda begins with a review of what clients are saying.<br>--Then we will do a brief tour through history to see the evolution of case management in mental health and substance abuse treatment fields<br>--This will focus on initial case management activities.<br>--The trends of mental health treatment.<br>--The mental health consumer movement.<br>--And outcomes management.<br>--This unit will conclude with a good working definition of case management.<br>Resources for all the content you will encounter are listed in a reference document in the Attachments section. |
| **8** | What Clients Are Saying | "What would make your life better right now?" | Let's listen to what your clients are saying about what matters to them.<br>--In answer to the question, "What would make your life better right now?" Jean Campbell and Ron Schraiber found some interesting answers in their 1989 research. Before we summarize their research, try answering the following questions. |
| **9** | What Clients Are Saying | Question #1: You are a health care client. What would make your life better right now?<br>a. satisfying relationships<br>b. money, jobs, education<br>c. housing<br>d. increased mental and physical health<br>e. medications<br>f. structured living environment | Make note of your answer. Then answer the next question. |
| **10** | What Clients Are Saying | Question #2: You are a health care professional or a family member. What would make the life of your client/family member better right now? | When you've noted your answer to this question, learn what the researchers found out. |

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| | | a. satisfying relationships<br>b. money, jobs, education<br>c. housing<br>d. increased mental and physical health<br>e. medications<br>f. structured living environment | |
| **11** | What would make your life better right now? | What would make your life better right now?<br>[3 columns]<br>1. Money, jobs, education<br>2. Satisfying relationships<br>3. Decent housing<br>4. Mental & physical health improvement<br>Also…<br>• Creativity<br>• Respect for rights and human dignity | The answers may surprise you. In 1989, Schraiber and Campbell, researchers in the Mental Health Consumer Movement, published the following about their Well-Being Project.<br>In response to the question, "What would make your life better right now," there were different responses depending on the group that was asked.<br>--Clients saw more money, having jobs, education, and training as significant.<br>Not a single mental health professional mentioned money or jobs. Only 5% of professionals listed education and training as significant.<br>--Family members and professionals thought a "structured living environment" would be a key to improving lives, while not one mental health client thought so.<br>--The second most important factor for clients was the development of satisfying relationships.<br>• 69% wanted an intimate and sexual relationship.<br>• 44% wanted to be married.<br>Not a single mental health professional or family member suggested that clients' sexual needs were significant.<br>--The third most important factor to clients was decent housing. Not one family member or mental health professional saw housing as a priority.<br>--As the fourth most important factor, 19% of clients identified an improvement in mental and physical health as a primary goal.<br>--Professionals and families emphasized medication/chemotherapy as the way to achieve that, while only one client thought that. Medications were not high on the agenda for most clients.<br>Other factors important to clients included:<br>--Creativity – 23% of clients valued their creativity, no family or professionals saw creativity as important<br>--Respect for rights and human dignity – 93% of clients felt their human rights had been violated, especially basic freedoms and control over their treatment. Many professionals agreed that they often did lose control over their treatment.<br>--Value client input – 56% of clients feel mental health professionals consider what they have to say to be valid or important. |

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| | | | --On the other hand over 90% of professional and caregivers surveyed said they listen to clients and they consider what they say to be valid "all" or "most of the time."<br>In addition, consider this: 57%--more than half—of clients surveyed have been told that they were resistant, rebellious, or "mentally ill" when they disagreed with the opinions or advice of mental health professionals.<br>--And finally being fully informed of the benefits and risks of treatment – Over 60% of professionals reported that they inform clients of the risks or benefits of their care plan "all" or "most of the time," but more than half of all clients surveyed said they are "seldom" or "never" fully informed of the benefits or risks of their care plan or therapy. |
| **12** | What Clients Are Saying | "What do you think is the most effective treatment for severe psychological and emotional problems?" | In answer to the question, "What do you think is the most effective treatment for severe psychological and emotional problems," professionals emphasized treatments of some sort... |
| **13** | What Clients Are Saying<br>What Clients Are Saying<br>What Clients Are Saying<br>What Clients Are Saying | Therapist list:<br>• Psychotherapy<br>• Medications<br>• Structured living<br><br>Client list:<br>• Relax, meditate, take walks, hot bath<br>• Have hope<br>• Note barriers of poverty, inadequate housing, discrimination, and unemployment | …psychotherapy, medications, structured living—depending on which profession was answering the question. Fewer thought that client empowerment in the therapeutic process was important.<br>Very few felt as the following therapist did. He said "Any treatment form which emphasizes reliance on self and support system, as opposed to the mental health system, which decreases dependence, which emphasizes building a strong sense of self—of one's capabilities; which encourages people to take risks, to grow, to figure out what makes them happy. This can be community mental health, or work, or church, or friends." This statement is much more in line with what the Mental Health Consumer Movement is calling for from the mental health service system.<br>Client responses and comments included:<br>--54% reported that they relax, meditate, take walks, or take a hot bath when they are having problems.<br>--Hope is considered critically important by mental health clients. 40% of the clients surveyed see their lives going forward right now; over 60% said that "all of the time" or "most of the time" they have aspirations for the future. As Campbell says, the loss of hope for mental health clients may not be a reflection or a symptom of psychological or emotional problems but rather reflects the despair of stigma and discrimination.<br>--Many consumers report that poverty, inadequate housing, discrimination, and unemployment are major barriers to community integration, while researchers and service providers tend to focus on the narrower context of symptoms and mental health treatment.<br>--Further research supports that clients express a strong desire for more social interactions with case managers and a desire to rejoin the social world. Findings show that clinician optimism about the client's potential for positive future functioning is related to client satisfaction with the client-case manager relationship. |
| **14** | What Clients Are Saying | *Social inclusion must come down to somewhere to live, something to do, someone to* | Anderson observes: Social inclusion must come down to somewhere to live, something to do, someone to love. It's as simple—and as complicated—as that. |

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| | | *love. It's as simple—and as complicated—as that.* | |
| **15** | What Clients Are Saying | "What competencies do you want in your mental health care providers?" | Finally, what competencies do people want in their mental health care providers?<br>In 1998, Campbell provided a list of core competencies of service providers as described by clients or consumers. In their own words, here are some of the attitudes, knowledge, and skills they want you to develop to become an effective case manager. They certainly make sense in light of the research that was described earlier. |
| **16** | Core Competencies | [Put these 8 lists on the next 8 slides] | Empowerment<br>• Treat the consumer like they believe (s)he can shape his/her own future—hope is what (s)he needs most.<br>• Give the consumer freedom to make his/her own mistakes.<br>• Understand and support the consumer's need to regain "critical consciousness" or self-awareness.<br>• Learn how to provide choice and avoid controlling behaviors. |
| **17** | | | Self-Management<br>• Learn how consumers live with and manage their disorders.<br>• Learn about and support consumer self-control of psychotic symptoms.<br>• Learn how to accept consumers' feelings of sorrow, despair, anger, frustration, joy, excitement, etc. without pathologizing. |
| **18** | | | Stigma/Language<br>• Learn to respect people's dignity by taking into account their status as survivors of the mental health system and of physical and sexual violence, as well as their cultural and ethnic diversity, including sexual orientation.<br>• Learn about how much psychiatric labels and language can stigmatize and diminish people.<br>• Learn not to treat consumers as children.<br>• Learn to avoid stigmatizing language.<br>• Learn methods to support community interaction with consumers.<br>• Learn that an inability to perform valued tasks and roles—and the resultant loss of self-esteem—are significant barriers to recovery. |
| **19** | | | Education<br>• Set up training programs to teach consumers how to work with the local mental health board and the mental health system.<br>• Learn and then provide training for consumers in how to work effectively with human service systems and how to access benefits. |
| **20** | | | Communication Skills |

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| | | | • Listen to the consumer and believe what (s)he says.<br>• Learn to compliment consumers respectfully on their ability.<br>• Learn to listen to consumers, and consider what they say to be valid and important. |
| **21** | | | Recovery<br>• Believe in the consumer's ability to recover.<br>• Learn to foster a sense of hope.<br>• Shift from a stance of demoralizing pessimism to rational optimism.<br>• Learn to break the cycle of disempowerment, despair, and learned dependency. |
| **22** | | | Medications<br>• Teach the consumer about the medications (s)he is taking.<br>• Learn to use the consumer as the expert on what medications work and do not work.<br>• Learn to recognize the subtle and severe side-effects of medications.<br>• Rather than support a program of medication compliance, support informed judgment of consumers by enabling them to learn what they are really like off medications. |
| **23** | | | Self-Help<br>• Support for self-help groups and enable consumers to access alternative supports.<br>• Support consumers helping other consumers recover.<br>• Learn about and then educate consumers on the history and organization of the consumer movement. |
| 24 | | | **Checkpoint** |
| 25 | History of Case Management | "Listening and learning from my clients…" [words coming out of book] | Over the course of history, beliefs about mental illnesses' causes and treatment approaches have changed a great deal. It is important to know something of this history to understand current values, philosophies, and services.<br><br>--The mental health field has not had a long history of "listening and learning from its clients." Current interest in doing so reflects significant changes going on in our society and with the mental health field and consumers over the last 20-30 years—changes reflecting a push for consumer rights and also accountability by those who sell products or provide services.<br><br>But what went on before our current time? |
| **26** | Volunteerism in the 1800s | • Poverty<br>• Alcohol | Case management historians often say that its precursor was the use of volunteers in the 1800s to help the poor deal with the conditions of poverty. Many blamed poverty for significantly contributing to the psychological, social, and moral ills of the poor.<br><br>--Also, alcoholism was seen as the result of not only poverty but of weak character. Volunteers exhorted the poor to stop drinking and to become more responsible. |

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| | | | Let's visit a few moments in the early story of social volunteerism. |
| 27 | Initial Case Management Activities | Thomas Chalmers<br>• 1819<br>• met individually and regularly with the poor for encouragement and training<br><br>Antoine Frederic Ozanum<br>• 1833<br>• provided emergency economic and spiritual assistance<br><br>Joseph Tuckerman<br>• 1835<br>• individualized work with poor; social action<br><br>Robert Hartley<br>• 1843<br>• urged to build character, abstain from alcohol, acquire the work ethic<br><br>Mary Richmond<br>• 1877<br>• concerned with rural-to-urban population shifts; activities called "social casework"<br><br>[fade out the images on last click] | In 1819, Thomas Chalmers, a Scottish preacher, organized a system of volunteers to meet individually and regularly with disadvantaged poor people to give them encouragement and training.<br><br>--1833 saw the establishment of the St. Vincent de Paul Society in Paris by Antoine Frederic Ozanum. This organization used lay volunteers to provide emergency economic and spiritual assistance to poor people.<br><br>--Two years later, Joseph Tuckerman, a Unitarian minister, influenced by Chalmers' work, organized the Boston Society for the Prevention of Pauperism, using many of Chalmers' principles of individualized work with poor families, volunteer visitors, and social action.<br><br>--Then in 1843, Robert Hartley, following Chalmers and Tuckerman, established the New York Association for Improving the Condition of the Poor. Middle-class volunteers attempted to build character as a way to end poverty by getting poor people to abstain from alcohol, become more self-disciplined, and acquire the work ethic.<br><br>--And in 1877, Mary Richmond helped import the Charity Organization Society—or COS—model into the United States from England. These organizations provided direct services and assisted private agencies in addressing the increasing social problems related to the rural-to-urban population shift. COSs, later renamed Family Service Agencies, used volunteers called "friendly visitors." Richmond applied the term "social casework" to the activities that affected the adjustment between the individual and the social environment.<br><br>--In time, however, the psychological ills of people came to be seen as intra-psychic—or internally induced—and efforts to improve external conditions languished. |

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| **28** | | | **Checkpoint** |
| **29** | Mentally Ill "Possessed" | [devil image?]<br><br>[devil image replaced by a building]<br>Asylums<br>• custodial<br>• overcrowded<br>• dehumanizing | Throughout time, the mentally ill were often treated as frightening, even possessed by the devil. They were routinely beaten or punished—sometimes hung as witches.<br><br>--Eventually, more humane approaches were implemented, but still the mentally ill were isolated in asylums. As those asylums absorbed more and more people, conditions deteriorated. Institutions became custodial in nature—overcrowded and dehumanizing. |
| **30** | Earliest Treatments | • 900s – hospitals in Cairo and Baghdad<br><br>• 1247 – Bedlam in England<br><br>• 1600s – Native American shamans summoning supernatural powers<br><br>• 1724 – Salem witchcraft trials<br><br>• 1773 – First mental asylum in Colonial America | --Looking back, we find the earliest known mental hospitals in the 900s in Cairo and Baghdad. The Sufi sect of Islam saw mental illness as a separation in the relationship of the individual to God.<br><br>--In 1247, the notorious British madhouse known as Bedlam was built, in which the mentally ill were routinely shackled and treated as a sort of sideshow for the general public.<br><br>--In the 1600s, Native American shamans, or medicine men, summoned supernatural powers to treat the mentally ill, incorporating rituals of atonement and purification.<br><br>--The Salem witchcraft trials sentenced 19 women to hanging in 1724. Sin, witchcraft, demonic possession—all were considered causes of mental illness. In addition to hanging, treatment of the mentally ill included beatings, chaining them to walls, purges, emetics, and other punishments.<br>It is not uncommon, even today, to find mental health clients who believe that God is punishing them or that the devil is in them.<br><br>--In early America, the insane were often auctioned off to be cared for by farmers, while others were sent to the poorhouse or driven out of town. But in 1773, the first mental asylum in Colonial America was established in Williamsburg, Virginia. |
| **31** | | | Checkpoint #2 |
| **32** | More Humane Treatments | Cotton Mather<br>• 1812<br>• advanced physical explanations for mental illness | Let's meet a few of the early pioneers in providing more humane treatment for the mentally ill and in defining mental illness as something other than demonic—as an illness with a physical or psychological basis.<br><br>--In 1812, Cotton Mather, a clergyman, broke with traditions and advanced physical explanations for mental illness.<br><br>--In that same year, Dr. Benjamin Rush, one of the original signers of the Declaration of Independence, wrote the first textbook for psychiatry and began advocating for humane treatment of the mentally ill. Dorothea Dix, in 1841, also advocated for kindness, retreat, security, and freedom from chains. The |

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| | | Benjamin Rush<br>• 1812<br>• first psychiatry textbook<br>Dorothea Dix<br>1841<br>• advocate for kindness, retreat, security, and freedom from chains<br><br>Asylums<br>• Social, political, economic forces came into play<br>• Became overcrowded<br>• Costs shifted to state-supported institutions | asylums she helped establish were small and personal and did cure some acute mental illness.<br><br>Other social, political, and economic forces, however, influenced the fate of the asylums.<br><br>--They were forced to absorb tremendous numbers of people, many who had chronic physical disorders, who were frail or elderly, or who were simply poor or unemployed, as costs shifted from county-supported almshouses to state-supported institutions. |
| **33** | New Definitions for Causes | Emil Kraeplin<br>1886-1926<br>• considered founder of psychiatry<br>• descriptions of:<br>o manic-depressive insanity<br>o dementia praecox (schizophrenia)<br>Sigmund Freud<br>1897<br>• focus on infantile sexuality and Oedipus complex as causes<br>• shift toward *intra-psychic* factors<br>• casework fell into disuse<br>• began movement toward more focus on prevention rather than treatment | --During the years 1886-1926, Emil Kraeplin, considered the founder of psychiatry, focused his work on the severe mental illnesses.<br><br>--His major contribution was a description of the illnesses, two of which he called manic-depressive insanity and dementia praecox (later renamed schizophrenia by Eugen Bleuler). Prior to Kraeplin's description, all mental illnesses were considered to be part of the same conglomeration of symptoms and behaviors.<br>Sigmund Freud, in 1897, abandoned the trauma theory of neurosis and began to focus on infantile sexuality and the Oedipus complex as causes of psychological and other difficulties.<br><br>--Thus, began the shift from seeing external factors as causes of difficulty in people's lives to intra-psychic factors—or causes internal to the individual.<br><br>--As a result, casework, the precursor to modern case management, fell into disuse—at least with social and behavioral problems.<br><br>--Some historians note that the broad acceptance of Freudian theory led the mental health field to focus on prevention rather than treatment of mental illness. |
| **34** | Birth of NIMH | National Institute of Mental Health (NIMH)<br>1946 | 1946 marks the formation of the National Institute of Mental Health. Its purpose was to conduct research, investigations, experiments, and demonstrations relating to the causes, diagnosis, and treatment of psychiatric disorders |

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| | | • to conduct research, demonstrations related to cause, diagnosis, and treatment<br>• to train personnel<br>• to assist states in best methods for prevention, diagnosis, and treatment | --to train personnel in matters relating to mental health<br>--and to develop and assist states in the use of the most effective methods of prevention, diagnosis, and treatment of psychiatric disorders. |
| **35** | Advances in Latter Half of 20th Century | Mid-1950s to 1970s<br>• Mentally ill released from state hospitals to community<br>o Discovery of psychotropic meds<br>o Concern about institutionalization<br>o Interest in rights of patients<br>o changes in payment for services<br>• Unfortunately…poor planning for after care | Starting in the mid-1950s through the early 1970s, various circumstances, including:<br><br>--the discovery of psychotropic medications<br>--concern about the negative effects of institutionalization<br>--an interest in the rights of patients<br>--and changes in payment for mental health services, led to the release of the mentally ill from the state hospitals to the community.<br>--However, poor planning and service design failed to successfully address the needs of this population.<br><br>Let's review this period in a bit more detail. |
| **36** | Scientific Research | 1950s<br>• Widespread experimentation<br>• Examples:<br>o insulin shock therapy<br>o frontal lobotomies<br>1954<br>• Chlorpromazine (Thorazine) introduced, widely administered | --In the 1950s, experimentation in the treatment of the mentally ill was widespread. Examples of now-discredited treatments used around that time include insulin shock therapy and frontal lobotomies.<br><br>--And in 1954, Chlorpromazine (Thorazine) hit the market. Within eight short months it was administered to over two million patients.<br>The discovery of the effects of neuroleptic medications on the symptoms of psychosis opened the door to the possibility of management of severe and persistent mental illnesses in the community. |
| **37** | Community-based Treatment Valued | 1953<br>• World Health Organization (WHO) concluded community-based treatment essential<br>• American Medical Association, American Psychiatric Association, | In 1953, the World Health Organization concluded that community-based treatment rather than institution-based treatment was *essential* for people with mental illness. The American Medical Association, the American Psychiatric Association, and the Council of State Government all reached the same conclusion. |

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| | | and Council of State Government agreed | |
| **38** | Positive Mental Health Defined | 1955<br>NIMH definition of positive mental health<br>(box the following)<br>• the attitudes of the individual toward himself<br>• the degree to which the individual realizes his potentialities through action<br>• unification of function in the individual's personality<br>• the individual degree of independence of social influences<br>• how the individual sees the surrounding world<br>• and the individual's ability to take life as it comes and master it | In 1955, the NIMH defined positive mental health as:<br>• "the attitudes of the individual toward himself<br>• the degree to which the individual realizes his potentialities through action<br>• unification of function in the individual's personality<br>• the individual degree of independence of social influences<br>• how the individual sees the surrounding world<br>• and the individual's ability to take life as it comes and master it" |
| **39** | Rights Laws Enacted / Deinstitutionalization Begins | 1960s and 1970s<br>Rights of mental health patients asserted<br>• restrict involuntary commitment<br>• establish rights to refuse treatment<br>• set minimum standards for treatment<br>• consumer bill of rights<br>o right to safety<br>o right to be informed<br>o right to choose<br>o right to be heard<br><br>1961<br>NIMH recommendations:<br>• caps on admissions | The 1960s and 70s were a time when civil rights were asserted for everyone, including people with mental illness. Thus, various laws furthering the rights of mental health patients were enacted.<br><br>--Examples include those restricting involuntary commitment to state hospitals<br><br>--establishing rights to refuse treatment<br><br>--and setting minimum standards for treatment, especially minimum staff-patient ratios.<br><br>--In the 1960s, a consumer bill of rights was passed during the Kennedy administration. It included the rights of consumers to safety, to be informed, to choose, and to be heard.<br>Then in 1961, after a six-year study of mental health and its treatment, NIMH recommended significant improvements to mental hospitals, including caps on admissions once capacity was reached, and the establishment of community-based treatment centers. |

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| | | • community-based treatment centers | |
| **40** | Federal Government Involvement | 1962, 1965, 1974<br>Emergence of government programs<br>• Aid to the Permanently and Totally Disabled (APTD)<br>• Medicare<br>• Medicaid<br>• Supplemental Security Income (SSI) | 1962, 1965 (and later in 1974) The government funded Aid to the Permanently and Totally Disabled, (APTD) an early form of SSI, introduced Medicare and Medicaid funding only for patients <u>not</u> in state hospitals in 1965 and the Supplemental Security Income [SSI] program in 1974 provided incentives for policy makers to discharge patients to the community and transfer state mental health expenditures to the federal government. |
| **41** | CMHCCA Enacted | 1963<br>Community Mental Health Centers Construction Act (CMHCCA)<br>• Sources in community rather than institutions<br>• Lacked planning toward comprehensive services | In 1963, President Kennedy signed the Community Mental Health Centers Construction Act (CMHCCA), which provided for the construction and staffing of local mental health programs that were to provide services in the community rather than in isolated institutions. Although the enactment of this Act provided the impetus for community treatment, little planning went into developing comprehensive services to replace the limited care available for persons with a severe mental illness in institutional settings. No one thought to ask "*Where will all the people released from state hospitals live?"* |
| **42** | Deinstitutionalization | 1977<br>• Funding shifts from state to federal<br>• New standards of care<br>• Patients rights<br>• Psychotropic meds<br>\|<br>V<br>People leaving state hospitals | By 1977, the factors supporting deinstitutionalization included shifting funding from state to federal government, new standards of care (especially those valuing community-based treatment), protection of patient rights, and the increasing use of psychotropic medications. This seemed to be working in that people with mental illness were leaving the state hospitals. But the CMHCs were treating the "worried well" and not fully complying with the intent of the CMHCCA that established them—that is, the intent to fund a program to substitute for state hospitals in caring for the mentally ill. |
| **43** | Case Management More Prominent | Late 70s – early 80s<br>Case management<br>• Help clients find services<br>• Coordinate<br>• Monitor appropriateness<br>\|<br>V<br>"brokers" of service | It was then, in the late 70s and early 80s, that case management came into vogue. Case managers were to help mental health clients find and receive a wide range of needed services, to coordinate those services, and to monitor appropriateness. To a large extent, case managers were service "brokers" who remained available to clients whenever they were needed to "broker" more services and support appropriate use of those services. The assumption was that the severely mentally ill would need such services indefinitely. |
| **44** | Community Support | 1978<br>NIMH's Community | 1978 NIMH established the *Community Support Program (CSP) to address the failure of the original CMHC Act.* The following guidelines for the CSP were defined: "medical and mental health care; crisis |

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| | Programs Established | Support Program (CSP)<br>• Address failure of CMHCCA<br>• Guidelines:<br>o medical and mental health care<br>o crisis stabilization in least restrictive setting<br>o psychosocial rehab services<br>o support to family, friends<br>o involvement of community<br>o indefinite duration<br><br>Case management at the core | stabilization in the least restrictive setting possible, with hospitalization available when other options are insufficient; psychosocial rehabilitation services; backup support to families, friends, and community members; involvement of concerned community members in planning and offering housing or work opportunities; supportive services of indefinite duration, including supportive living and working arrangements and other such services, for as long as they are needed." (Torrey, 1988) For CSPs, Case Management was seen as the core of the CSP. Its function was to integrate various interventions and assure that necessary services and supports were continuously available to persons formerly serviced in state hospitals. |
| **45** | Mental Health Users Empowered | 1970s – today<br>Consumers worked toward change<br>\|<br>V<br>Possibility of recovery | From 1970s to today, former mental health patients and mental health consumers began work to change the mental health system so that it was less stigmatizing, recognized the humanity of mental health clients, and recognized the possibility of recovery, more hope-engendering—and thus, more empowering—of the users of its services. One definition of recovery provided by LeDoux (1995) in the newsletter of a Rhode Island "clubhouse" follows: "In general, recovery can be defined as the maximization of a consumer's life and the minimization of their illness with appropriate, relevant, and continuous flexible service and supports collaboratively developed and chosen." There will be more information in the upcoming section on History of the Mental Health Consumer Movement. |
| **46** | Self-help Movement | Self-help \|\| medical<br>Movement \|\| consumerism<br>\|\|<br>V<br>Choice, autonomy<br><br>15 million Americans in ½ million groups | As Campbell (1998a) states, "The self-help movement has grown alongside medical consumerism and provides people with a greater sense of choice and autonomy in dealing with their health problems. Up to fifteen million Americans, in as many as one-half million self-help groups, are addressing a range of illnesses, addictions, disabilities, and conditions (Wuthnow, 1994; Lieberman & Snowden, 1994; Madera & White, 1992). A recent national survey on the epidemiology of psychiatric disorders found that the largest single sector in the American mental and addictive disorders treatment system is the self-help sector (Kessler et al., 1997). Self-help and mutual aid support groups have been formed on virtually every topic of health concern in society. Self-help is based on the principle that people with a shared condition can come together to help themselves and each other cope with medical conditions, addictive disorders, physical disabilities, or psychiatric disabilities. … The proliferation of Offices of Consumer Affairs in state mental health agencies, state-wide consumer conferences, consumer-directed social centers across the nation, model consumer case management programs, and support for consumer research and policy professionals are indicators of a vibrant mental health consumer movement (Bevilacqua, 1993; Buckley, 1993; Campbell, 1998a; The Consumer/Survivor Mental Health Research and Policy Work Group, 1992; Scott, 1993)." |

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| **47** | Recovery Concept | 2004<br>Substance Abuse and Mental Health Services Administration (SAMHSA)<br>• Support notion of recovery | 2004 SAMHSA, the Substance Abuse and Mental Health Services Administration of the US Department of Health and Human Services, convened a panel to put together a National Consensus Statement on Mental Health Recovery and has, in doing so, supported the changed notion that mental health clients/consumers/survivors can recover. It identifies Illness Management and Recovery as one of the evidence-based approaches to be used in helping mental health consumers recover.<br><br>Today Recovery as a concept has received recognition both in the Surgeon General's Report on Mental Health (1999) and in the more recent President's New Freedom Commission on Mental Health Report (2003). SAMHSA recognizes the approach termed, Illness Management and recovery, as one of its evidence-based practices. |
| **48** | | | **Checkpoint** |
| **49** | Consumer Movement | Liberationist Reformist<br><br>Recovery model | Let's look further at the consumer movement in the field of mental health care. In the 70s and 80s, various ex-patient liberation and consumer self-help and advocacy groups began to develop.<br><br>--Some were liberationist, seeing the mental health system as destructive to people with mental illness.<br><br>--Some were reformist, wanting to work with the mental health system to change it so that mental health clients had more "voice" and control over their own treatment.<br><br>These consumer activist groups have made significant inroads into the mental health system. Mental health consumers are often included on mental health policy committees.<br><br>--The Recovery Model, which operates from the premise that mental health clients can recover and lead meaningful lives, is being widely implemented in community mental health centers and publicly-funded programs nationwide. |
| **50** | Journey of Healing | *Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.* | The Substance Abuse and Mental Health Services Administration (SAMHSA)'s Center for Mental Health Services (CMHS) publicly supports the meaningful participation of mental health consumers/survivors in all aspects of the mental health system. Its National Consensus Statement on Mental Health Recovery is as follows:<br>*Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential* (SAMHSA, 2004). |
| **51** | | | **Checkpoint** |
| **52** | **Consumer Movement History** | Elizabeth Packard, 1868<br>• founded Anti-Insane Asylum Society<br><br>Clifford Beers, 1909<br>• Former patient | 1868 Elizabeth Packard, founder of the Anti-Insane Asylum Society, published a series of books and pamphlets describing her experiences in the Illinois insane asylum to which her husband had had her committed. Due to ignorance and fear, many still believed that mental illness was the result of demonic possession—such early attempts at activism were largely ignored. However, these efforts were the precursors to the modern Mental Health Consumer Movement. |

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| | | • Founded National Committee for Mental Hygiene (now National Association for Mental Health)<br>• Focus on hospital reform<br><br>We Are Not Alone (WANA), 1948<br>• Former patients<br>• Fountain House – support of people leaving state mental hospitals | --In 1909, Clifford Beers, a former mental hospital patient, established the National Committee for Mental Hygiene. His initial focus was on hospital reform subsequent to his personal experiences there. He did stimulate public interest in the care and treatment of people with mental illness. However, he did not try to organize people like himself, knowing that the climate was not right for them to be heard. This committee later became the National Association for Mental Health in 1950.<br><br>To help mental health clients leaving the hospital, a group of former psychiatric patients founded WANA (We Are Not Alone) in 1948. Their efforts led to the establishment of Fountain House, a psychosocial rehabilitation service for people leaving state mental institutions. Members of Fountain House supported one another by creating a community among people struggling with serious mental illness. Fountain House served as the model for the "clubhouse" initiatives, which promote the importance of meaningful work in people's lives and which would serve as a model for psychiatric rehabilitation programs developed in the 1960s and 1970s. |
| **53** | **Consumer Movement History** | 1970s<br>• Patients' Liberation Movement<br>• Organizers called "psychiatric survivors" (survivors of the mental health system)<br>• Number of groups formed<br>• Felt mental health system destructive and disempowering<br><br>1972-1986<br>• Newspaper: Madness Network News<br>• Run by ex-patients | In the 1970s, many former mental health clients began to organize groups to fight for patients' rights, against forced treatment, to end stigma and economic and social discrimination, and to organize peer-run alternatives to the traditional medical treatment models. Organizers of these groups often called themselves "psychiatric survivors," that is, survivors of the mental health system, of having been psychiatrically labeled. Names of their groups were Insane Liberation Group, the Mental Patients' Liberation Project in New York, and Network Against Psychiatric Assault. They saw the mental health system as destructive and disempowering. These groups were part of a Patients' Liberation Movement, believing in the importance of consciousness-raising (as in the women's movement) and the need to limit group membership to only those who shared the common experience of being a mental patient.<br><br>In 1972, Madness Network News, a newspaper covering the ex-patients' movement in North America, began publication. It ceased publication in 1986. For most of its existence, it was run by an all ex-patient staff. |
| **54** | **Consumer Movement History** | 1973<br>Conference on Human Rights and Psychiatric Oppression<br>Co-sponsored by Mental Patients' Liberation Project of New York<br><br>1980s<br>• Reformists began to organize self- | The first Conference on Human Rights and Psychiatric Oppression was held in 1973 jointly sponsored by a sympathetic psychology professor and the Mental Patients' Liberation Project of New York.<br><br>In the 1980s, reformist consumers of mental health services began to organize self-help/advocacy groups and peer-run services. However, this group wanted to reform the mental health system, which they saw as necessary. Recipients of mental health services began to demand control over their own treatment. They demanded access to mental health policy-making groups. Peer-run services received government funding, and studies found they were effective and cost-effective. Examples of such groups might include Recovery, Inc. and Schizophrenics Anonymous. |

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| | | help/advocacy and peer-run services<br>• Saw mental health system as necessary<br>• Just wanted reforms, involvement<br>• Examples: Recovery, Inc; Schizophrenics Anonymous | |
| **55** | | [Some kind of summary] | Today there is a variety of organizations that claim to speak for patients or to be their advocates. Those that are composed of former and current mental health clients fall into a variety of groups. Some accept the mental illness label such as the National Depressive and Manic-Depressive Association. Some promote self-help in conjunction with treatment such as Recovery, Inc. Some see themselves as consumers such as the National Mental Health Consumers' Association, and some see themselves as liberationists, such as the National Association of Psychiatric Survivors. However, most mental health clients know little of any of these organizations.<br><br>With the support of a wide variety of reformist consumer organizations and mixed professional-consumer advocacy groups, state and federal recognition of recovery as a viable goal has been achieved. The liberationist ex-patients are teaming up with disability rights groups and the impoverished and fighting for a range of rights, including affordable housing, support for independent living, and much more. |
| **56** | Substance Abuse Treatment | 1972<br>• Treatment Alternatives for Safe Communities (TASC)<br>• Link offenders to drug treatment<br>• Monitor<br>1987<br>• NIMH projects involving young adults with both substance use and mental health problems<br>• Most projects used case management as a primary service to help improve treatment outcomes | --In the field of substance abuse treatment, we saw in 1972 Treatment Alternatives for Safe Communities (TASC) case managers who helped link individuals in the criminal justice system to drug treatment resources and monitored those individuals and services as part of an on-going effort to increase receipt of treatment and to improve retention in treatment.<br><br>--In 1987, the NIMH funded 13 demonstration projects targeted at young adults with coexisting substance use and mental health problems. Of these, 10 identified some form of case management as a primary service. NIDA and NIAAA also began including case management in their funded projects to keep people in treatment and to improve treatment outcomes, especially with those substance abusing individuals with complex needs. |
| **57** | | | **Checkpoint** |
| **58** | Outcomes Management | Outcome measures<br>• Symptom reduction<br>• Improvements in: | Outcome measures are being identified and publicized that include measures of symptom reduction and improvements in functionality (often emphasized by professionals as the goals of treatment), as well as measures of improvement in quality of life and commitment to recovery (more often emphasized by |

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| | | • Functionality<br>• Quality of life<br>• Commitment to recovery | clients/consumers as the goals of treatment). Interestingly, even back in 1989, studies (Gowdy & Rapp) showed that an outcome orientation of mental health managers led to increased service effectiveness. It has been said that effectiveness, meaning client outcomes, should be the "philosophical linchpin" of human services organizations (Patti, 1985). |
| **59** | Outcomes Management | Outcomes Management<br>"a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity"<br>- World Health Organization, 1948 | In 1948, the World Health Organization defined health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (World Health Organization, 1993) |
| **60** | Outcomes Management | Mental Health Statistics Improvement Program, 1976<br>• Need to identify data standards, measures<br><br>Paul Ellwood, 1988<br>• "Father" of outcomes management<br>• Stated need for national database<br>• Measurement of outcomes | In 1976, NIMH established the Mental Health Statistics Improvement Program to identify data standards or common measures to be used in the mental health field.<br><br>And in 1988, Paul Ellwood, sometimes considered the father of outcomes management, stated that there was a need for a "common patient-understood language of outcomes;…a national database…that estimates as best [it] can the relation between medical interventions and health outcomes…." |
| **61** | What to Measure? | Difficult to define desirable outcomes<br>[2 boxes]<br>Professionals may focus on:<br>• Functionality<br>• Symptom reduction<br>• Recidivism<br>• Treatment used<br><br>Patients may focus on:<br>• Quality of life improvements<br><br>3 columns<br><u>Past</u>: Measures of output & volume<br>• admits, discharges, readmits | The breadth of the definition of health, as just described, creates difficulty in defining desirable outcomes. Personal and social well-being is seen by many scientific researchers as "soft" or subjective data. Differences in perspective between health care professionals and patients and their families on what is important as an outcome raises questions about what to measure. As noted in The Well-Being Project results (Campbell and Schraiber, 1989), professionals may focus on functionality, symptom reduction, recidivism, and the treatment used, while patients may emphasize improvements in the quality of their lives as the most desired outcomes. This struggle between perspectives has influenced the focus of outcome measures in the behavioral health field over time.<br>▪ In the past, behavioral health services used measures of output and volume (e.g., numbers admitted and discharged, numbers readmitted, numbers completing service, number of treatment beds/sessions used, and so on) to make judgments about the value of services.<br>▪ With the advent of outcomes management, it became desirable to use measures of symptom change (e.g., improvements in CAFAS scores or Beck Depression scores) or improvements in functionality (e.g., improvements in GAF scores or ADLs or GAIN scores) in outcome measurement activities.<br>▪ And, now, more recently, with the recognition of the importance of including the consumer and addressing consumer values, outcome measures are being defined that are important to those who receive services—measures that explore quality of life improvements as a result of treatment or |

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| | | • completions of service<br>• treatment beds<br>• sessions<br>• etc.<br><br><u>Advent of outcomes management</u>: Measures of symptom change (scores), improvements in functionality<br><br><u>Consumer input</u>: improvements in quality of life | service delivery. |
| **62** | Improvements in Measurements | Mental Health Statistics Improvement Program (MHSIP), 1989<br>• Published by NIMH<br>• Reference for much of public mental health data system development<br><br>NHSIP Quality Report (MQR), 2005<br>• ID new measures<br>• Includes consumer values and perspectives | In 1989, the Mental Health Statistics Improvement Program (MHSIP) identified what measures needed to be in a mental health data system. FN-10, published by NIMH, containing those measures, has been the reference document for much of the public mental health data system development that has gone on since.<br><br>And in 2005, MHSIP published the MHSIP Quality Report (MQR) which identified new measures to use in measuring performance in mental health which included consumer values, perspectives, and a way to look at the extent to which organizations incorporated the Recovery Model in its operations and values. |
| **63** | More Than a Broker | Case manager role to teach clients to:<br>• Find and use resources themselves<br>• Advocate for themselves<br>• Define their goals<br>• Achieve their goals | Case managers have a key role in helping mental health consumers along this journey and in helping organizations achieve and maintain a commitment to Recovery. More than simply "brokering" resources for clients, they are teaching clients how to find and use resources themselves, how to advocate for themselves, how to define their goals and go after achieving them, and much more. |
| **64** | | | **Checkpoint** |
| **65** | Defining Case Management | Definition should include:<br>• Core functions<br>• Recovery focus<br>• Emphasis on achieving outcomes of case | With our brief tour of some of the history of mental illness and of case management, we now need to begin defining Case Management and your new job.<br><br>--There is good agreement about the core functions of case management for adults with mental illness—and we will explore these in detail in future modules. However, for our commonly-accepted definition we |

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| | | management | want to include these core functions, plus a recovery focus and an emphasis on achieving outcomes of case management.<br><br>Take a moment and write down the components you think should be in a definition. The compare with the one from the National Association of Case Management. |
| **66** | | | **Checkpoint** |
| **67** | Arriving at a Definition | "…professional practices in which the service recipient is a *partner*, to the *greatest extent possible*, in:<br>• assessing needs<br>• defining desired outcomes<br>• obtaining services, treatments, and supports<br>• and preventing and managing crisis<br><br>The focus of the partnership is a *process* that assists the person to achieve the *greatest possible degree of self-management* of disability and/or life challenges."<br>- National Association of Case Management | Now let's compare what you noted with the definition from the NACM:<br><br>*"Case Management and service coordination are professional practices in which the service recipient is a partner, to the greatest extent possible, in assessing needs, defining desired outcomes, obtaining services, treatments, and supports, and in preventing and managing crisis. The focus of the partnership is a process that assists the person to achieve the greatest possible degree of self-management of disability and/or life challenges.*<br><br>Looking over this definition, take another moment and try to list some key coordination activities that will go along with this definition. |
| **68** | | | **Checkpoint** |
| **69** | Key Coordination Activities | Key coordination activities:<br>• Hopeful relationship<br>• Assessment of strengths and needs<br>• Developing service plan in partnership with person/family<br>• Locating, linking, following up with needed services<br>• Monitoring, coordinating, adjusting outcomes<br>• Crisis prevention, intervention<br>• Advocacy | Continuing with the NACM definition, it suggests that key activities include:<br>--Engaging in a hopeful relationship with the person and family served<br>--Assessment of strengths and needs<br>--Developing in partnership with the person and the family a service plan to achieve desired outcomes<br>--Locating, linking, and following up with needed services and supports<br>--Monitoring, coordinating, and adjusting services and supports to achieve desired outcomes<br>--Crisis prevention and intervention<br>--And advocacy for the person and the family"<br><br>So how did you do? |

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| **70** | | | **Checkpoint** |
| **71** | References | | References for this unit are listed for you in a separate attachment. Click on the attachments button. |
| **72** | Final exam | | |