CHALLENGING THE MYTHS AND ASSUMPTIONS:

INTENSIVE CASE MANAGERS' EXPERIENCES

by

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Abstract

Although there has been much research on intensive case management, little of it has focused on the intensive case managers themselves. Many assumptions exist about their experiences; however, these have not been adequately explored. A qualitative study was conducted to explore the experiences of intensive case managers. In-depth interviews were conducted with each intensive case manager and the interviews were analyzed. Four main findings emerged from the study; the participants have a specific set of beliefs that guide the way they interact with clients; the participants identify themselves as having a different set of goals than traditional mental health services; these differences can conflict with the goals of the larger mental health system; and the intensive case management team plays an important role in the day-to-day functioning of the team. The findings of this study provide insight into the experiences of the intensive case managers and have important implications for future planning of intensive case management teams and for intensive case managers themselves.

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Acknowledgments

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Introduction

Intensive case management is being recommended with increasing frequency as a model of mental health care for clients who are hard to serve or for whom traditional care services have been ineffective (Kirk, Koeske and Koeske, 1993). Numerous intensive case management programs have been started in the last decade and are achieving successful results. It has been suggested that the essential ingredients in the success of these programs are the intensive case managers themselves. Despite this little is known about intensive case managers experiences.

Personal Interest

My interest in the area of intensive case management started when I entered the mental health field in 1992. After working at Riverview Hospital, the Provincial Mental Health facility serving BC, for two and half years I was offered a position on an intensive case management team with a fairly new program designed to work with high risk clients leaving Riverview Hospital who had historically not connected well to services upon discharge. However the choice of this topic does not originate directly from my experience doing this type of work, instead it results from the responses I get when I speak to people about what I do. Experience has taught me that when people ask "What do you do?" I inevitably find myself trying to convince people that I do my job because I enjoy it and because I love it- **I love my job!** Despite my insistence that I enjoy what I do people are frequently dissatisfied with my answer. I have found that people feel the need to place conditions on my experience. For example, people

regularly say to me "but you must get really stressed out" or "but it must be really awful" or "but it must be really scary ". In fact none of the above are true yet people often insist that my job is 'unpleasant'. This experience extends beyond my friends and acquaintances to include many mental health staff (outside of intensive case management) with whom I interact.

My experience has been that I, and the people I work with like our jobs. However when I looked to the literature on mental health and job satisfaction I found that it echoed what many of my friends and acquaintances were suggesting - that mental health work is stressful, dissatisfying and difficult. In fact this belief was so ingrained in the literature it was generally taken for granted - it had become part of the folklore of mental health (Hromco, Lyons & Nikkel 1990).

As I looked deeper and deeper into the literature and asked more questions of my colleagues I found that not only did the literature not reflect my personal experience, it did not even address it. In the dozens of studies that I reviewed none asked intensive case managers what their experience was working in the mental health field. In fact, these studies simply assumed that intensive case managers were stressed out and dissatisfied and even predicted that they where at a higher risk for burnout and dissatisfaction because they worked 'closely and intensively' with clients (Kirk, Koeske & Koeske, 1993). It is these experiences that shaped my decision to explore intensive case managers' experiences.

Maxwell (1996) states that the conceptual context of your study - the systems of concepts, assumptions, expectations, beliefs and theories that supports and informs your research-is a key part of your design" (p.25). However he goes on to say :

> Becker (1986) warns that the existing literature and the assumptions embedded in it, can deform the way you frame your research, causing you to overlook important ways of conceptualizing your studies and key implications of your results. The literature has the advantage of what he calls ideological hegemony, so that it is difficult to see any phenomena in ways that are different from this that are prevalent in the literature. Trying to fit your insights into this established framework can deform your argument, weakening its logic and making it harder for you to see what this new way of framing the phenomena might contribute. (p.34).

Despite being aware of this and having experiences that were in opposition to the literature I got 'lost' in it. Many times I found myself echoing the assumptions found in the literature. This paper originated as a paper on intensive case managers' experience of job stress because the literature told me that intensive case management was stressful. Even when I thought I had a grasp on the assumptions I found myself taking statements for granted without challenging the underlying meaning.

The literature on mental health is extensive and diverse however very little of it is grounded in the staff's experiences. I chose a qualitative design in order to explore and understand the experiences of intensive managers. The literature has quantified intensive case managers experiences into discreet and objective measures. This study seeks to provide intensive case managers with a forum to have their voices heard rather than objectified.

This paper is divided into five chapters. Chapter one examines the current mental health system in order to better understand the context in which staff accept or reject new models of care. The research on staff's experiences working within this system is explored and assumptions and myths are highlighted. In addition models of case management are introduced.

Chapter two will explore three emerging areas in mental health: the consumer movement; psychosocial rehabilitation; and intensive case management. In addition, the process of intensive case management will be used as a framework to review further literature.

Chapter three introduces this research study which is aimed at exploring intensive case managers' experiences. This chapter describes the details of the study including the methodology used and provides a rational for the choice of a qualitative design. The results of this study are presented in chapter four and rely heavily on the use of verbatim quotes.

The final chapter discusses the findings of this study in relation to the existing literature and explores implications for future research. Suggestions for policy and practice are also addressed in this chapter including recommendations form the intensive case managers themselves.

Chapter One

The Mental Health Culture: Myths and Assumptions

Introduction

This chapter will provide a conceptual context or framework for the evaluation and critique of the literature relevant to intensive case managers' experiences. To fully understand the emergence of intensive case management and staff's experiences working within this model one needs to examine the influences that led to its development. This chapter will explore how staff's experiences have been shaped by the 'culture' of the mental health system. The concept of case management and intensive case management will be introduced and then the context in which it developed will be explored. A number of myths and assumptions embedded in the literature will be highlighted and challenged.

What is Case Management ?

Over the last three decades, there have been radical changes in the mental health, service delivery system (Harris & Bachrach, 1988). In response to deinstitutionalization, new programs, new models and new theories have been created, tested and discarded. Some approaches, however, have become part of the service delivery system; case management is one such approach (Harris & Bachrach, 1988).

Miller (1983) reminds us that "although it is tempting to view case management as a new approach in mental health services, today's case management is in fact a model with numerous antecedents and analogues" (p. 7). One of these antecedents is social work. Historically social work used a case

management approach in order to manage cases within a complicated human service network (Miller,1983). Some may argue as well, that case management's predecessor is the rural physicians who oversaw the multiple needs of the patients in his/her care. Still others identify the family as the first 'case managers' as they have traditionally been responsible for accessing and overseeing the care of their members (Bell & Vogel, 1968). Regardless of it's origin the definition of case management has grown to include a variety of services, interventions and policies (Harriss & Bachrach, 1988). Within mental health care, case management refers to overseeing a client's care by an individual (or team) to ensure that clients are linked to and receives the services they require.

There are many descriptions and definitions of case management. For the sake of simplicity two general categories of case management will be described. In one category are the less intensive, 'brokerage style', models of case management (Lamb, 1980). In these models, an individual is responsible for creating a service package fc. a client and for overseeing the accessing and provision of these services. Services may be provided directly but are more often than not accessed through multiple agencies. The case manager serves as a referral source and support person for the individual client. Clients who attend community mental health centers (CMHCs) are generally treated by a psychiatrist and 'case manager' who oversee their treatment. This case manager is usually office-based, and works a traditional work week. Clinical services are provided but social, recreational and life skills services are generally accessed through a referral to other service providers. In most CMHCs case managers have case

loads ranging from 30 - 100 and clients are seen at two week or one month intervals (Taube, Morlock, Burns & Santos, 1990; Intagliata, 1982). Given the caseload size, there is limited outreach and clients are not always pursued if they miss, refuse or cannot attend appointments. The large caseload size also limits the amount of time a case manager can spend with a client. This is the model used in most traditional community mental heath centers throughout Canada and the United States. It is also the model used by Greater Vancouver Mental Health Services (GVMHS).

The second category of case management programs are programs that provide intensive services to clients (for a comparison of these two models see Table I). In these programs, case managers have smaller caseloads, ideally ten clients to one staff (Stein & Test, 1980), and are responsible not only for creating a 'service package' for the client, but also for the direct provision of many of the services. Some are staffed 24 hours a day including weekends, while others rely on after-hours emergency staff. The emphasis on outreach and the intensity of the work done with the clients are the hallmarks of these models. The majority of services offered to clients in these programs are provided in the clients' home or home community (in vivo). Swayze (1992) states that intensive case management focuses on treating the individual and the individual's environment and is therefore different from traditional mental health services that focus almost exclusively on the treatment of the individual. This type of model is often reserved for use with clients for whom traditional mental health services have been ineffective and/or who need additional support to live successfully in the

Table 1
Comparison of case management models

Characteristic	Intensive case management model	Brokerage Model
Treatment base	Predominately in the community	Predominately in the clinic
Staffing	Clinical staff to client ratio around 10-1	Clinical staff to client ratio around 1-30 to 50
Frequency of contact	3-7X/ week	usually once every two weeks
Frequency of contact with family or support structure	Average once a week	Occasional
Medication	Can be administered by staff if needed	Responsibility of client or family
After-hours service	Monitored by program staff/team on call or after hours service	After hours service
Housing	Responsibility of staff	Varies but usually responsibility of client and family
Staff structure	Team structure usually multidiscipline	Individual staff model
Continuity of care	Team follows case through hospital, legal, health system or other contacts	Differs with each agency however client is generally followed through hospitalizations

Source Adapted from Taube, Morlock, Burns & Santos (1990)

community. It is generally used as an adjunct to traditional mental health services rather than as a substitute. For example, in Vancouver, the majority of persons with a chronic mental illness are seen at a mental health team by a case manager and a psychiatrist. For clients who need additional support, intensive case management programs have been created to supplement and work with the existing CMHCs. Out of the total number of clients served through GVMHS, approximately 5,000, intensive case management teams work with approximately 2% of the clients (GVMHS Employee Handbook, 1994).

As case management has increased in popularity and acceptance, multiple programs have sprung up. Some models focus on working with a single population: the homeless mentally ill person; the young chronic patient; the 'difficult patient'; the newly diagnosed; and/or the dually diagnosed. Others are more generic in their target population. Despite the differences in target population and intensity of service, all case management models share one thing in common - in each of these models one person or team is responsible for overseeing the care of an individual and ensuring that s/he access the necessary services.

The Training in Community Living Model

In recent years the intensive case management models have gained center stage in the mental health literature because of their success in decreasing hospital admissions. These models can be traced back to the work of Pasamanick & Hetrick but the most carefully defined and well established program of this type was developed in Madison, Wisconsin by Leonard Stein and

Mary Ann Test (1980). In 1972, these authors established an intensive program of community care for persons with a chronic mental illness that has become known as The Training in Community Living model or TCL. The overall goal of this program was to provide clients with all the necessary supports they would need to live successfully in the community (Stein & Test, 1980). The TCL model incorporated a team approach to client care and, to facilitate intensive and individualized service, client - staff ratios were as low as 10 - 1 (Stein & Test, 1980). The team utilized assertive outreach in an effort to engage clients and keep them in treatment and provided whatever services were needed. The team worked from a strengths perspective which shifted focus from the 'sick parts of the client to the healthy parts' looking for the 'nugget of strength' in each individual (Stein & Test, 1980). The model was open ended and staff continued to work with the client as long as necessary. Although the goals of the TCL model were shared by most CMHCs, the methods of intervention were quite different. The TCL program relied almost entirely on the use of in vivo treatment.

This model was based on the results of two pilot studies (see Ludwig, 1968; Marx, Test & Stein, 1973) which found that intensive and sustained aftercare was a crucial variable in producing success (as defined by decreased hospital time) after discharge. Research on this model confirmed the pilot results and the efficacy of the TCL model. The results showed that the experimental group (the TCL group) had a readmission rate of 6% while the control groups (traditional aftercare) rate was 58% (Stein & Test, 1980). In addition,

> their sustained community living was not gained at the expense of their quality of life, adjustment, self-esteem, or personal satisfaction. Instead relative to C (control) patients, the E (experimental) patients showed enhanced functioning in several significant areas and maintained less subjective distress and greater satisfaction with their lives in the 14 months of TCL treatment (Stein & Test, 1980. p. 396).

A particularly interesting result of this study was the disappearance of many of these differences once the TCL group was weaned to traditional aftercare services. In particular it showed a gradual increase in hospitalizations and in symptomology following the cessation of the TCL model (Stein & Test, 1980).

The findings from the TCL program have been replicated in many other communities and countries. Two randomized trials in Australia supported the findings of Stein & Test (see Hoult, Reynolds, Charbonneau-Powis, Weeks and Briggs, 1983). In addition they demonstrated the cost effectiveness of this model. Most research has continued to show that various derivatives of this model reduce hospitalizations, improves client's quality of life and improve psychosocial functioning (see Bush, Langford, Rosen & Gott, 1990; Bond, Miller, Krumweird & Ward, 1988; Modcrin, Rapp & Poertner, 1988).

Intensive case management teams, intensive outreach teams, assertive case management and continuous treatment teams all stem from Stein and Test's original model. It appears however, that in the process of these adaptations some of the essential pieces of the original model have been dropped. Rubin (1992) reviewed eight recent 'case management' studies and found mixed results. He emphasized that although many of these studies claim to be basing their programs on Stein & Test's TCL model, essential aspects of tne model may

be missing. This was certainly the case in two of Rubin's (1992) study groups, for example one group claimed to be using an 'assertive and intensive case management approach' saw clients on average only one time per week (see Bond, Pensec, Deitzen, McCafferty, Giemza & Sipple, 1991).

Rubin (1992) is not the only author to comment on the difficulties experienced when researching this topic. Schwartz, Goldman & Churgin (1982) have used the analogy of the Rorshard Inkblot to describe case management today: "[intensive] case management can be likened to a Rorshard Inkblot in which any range of diverse functions could be projected" (p. 1006). A standard definition of intensive case management remains elusive (Modcrin et al., 1988) and models differ conceptually and programmatically on a variety of dimensions. While many community mental health programs claim to be using an intensive case management model or utilizing the principles of the TCL model, closer inspection reveals many of the main principles and components to be missing.

Since Stein and Test first pioneered the TCL program in the late 70's many adaptations have been made to the original model (See Table 2). While the original model focused on avoiding hospitalization at all cost, the current model focuses on quality of life and acknowledges that hospitalization may be necessary at times. The changes to their model have been based on their twenty years of clinical experience and reflect the needs of the clients they serve.

Many programs have used the research findings of the TCL model as a foundation for program development. Although it is acknowledged that not all clients require the intensive support provided by the TCL model, Stein & Test

Table 2
Changes in the treatment principles of the training and community living model

Model phase	Target populations	Treatment principles
Improving the hospital	Inpatients	1) Improve psychosocial programming
Release to the community	Difficult- to-discharge patients	1) Abstain from hospitalization 2) "Constructively separate" pathological dependent patients and families 3) Expose patients to contingencies of the community 4) Work closely with community agencies 5) Assertively strive to keep patients in treatment 6) Teach coping skills in the community
Preventing hospitalization	Patients presenting for admission	1) Help patients obtain basic material resources such as housing 2) Provide a network of social supports 3) Capitalize on patients strengths 4) Hospitalize dangerous and medically complicated patients
Providing early, ongoing community based care	Young schizophrenic patients	1)Provide core services through the team 1) Develop long-term therapeutic relationships 2) Pace interventions according to patient's needs 3) Minimize the disabling effects of symptoms medically and environmentally
Maintenance in the community	Difficult, recidivist patients	1) Tailor programming to individual patients 2) Monitor patients closely 3) Titrate support according to the clinical situation 4) Support the right of the patient to live in the community 5) Assume overall responsibility for care but broker some services 6) Provide psychoeducation 7) Acknowledge family burden 8) "Constructively separate" patients and families when clinically necessary 9) View the hospital as the site of dramatic but limited interventions
A system of care	All patients in the public sector	1) Provide a variety of community treatment services of varying intensity 2) Provide psychosocial rehabilitation services 3) Provide mobile crisis services 4) Provide standard outpatient care 5) Provide a range of housing, vocational and inpatient services 6) Provide firm "gate keeping" to avoid unnecessary hospitalizations

Source: adapted from Thompson, Griffith & Leaf (1990)

(1980) have suggested that two philosophies inherent in the model and research findings have widespread application:

> First, the treatment of long-term mental illness requires a change in current strategies. The results of TCL research clearly indicate that preparation strategies are not appropriate for people who suffer from very long-term illnesses. The wiser strategy is one directed towards maintaining patients in community life. To accomplish this, treatment needs to be of indefinite duration and to focus attention not only on the patients' pathology but also on the patients' everyday needs and daily living skills and on providing the community with assistance in learning to live with long-term mentally ill patients. Second, the primary locus of treatment of such patients must be shifted from the hospital to the community. Although the hospital has a very important role to play in the total continuum of services, that role is limited, and the major therapeutic effort needs to be directed towards the community. Staff must be willing to move out of their offices and to do a significant share of their work where patients are living, recreating and working. (p.14).

The research in support of alternative models of care such as Stein and Test's TCL model, and the clinical recommendations they have made, have received wide spread attention. However a reluctance remains to utilize many of the components of this model (Gilman & Diamond, 1988). Many writers have commented on the systems reluctance to employ effective interventions and their reliance on ineffective ones (Bachrach, Talbott & Myerson, 1987; Minkoff & Stern, 1985). This in turn has been blamed on the staff (see White & Bennett, 1988; Minkoff & Stern, 1985). Despite the considerable attention the literature has given to discussing staff's reluctance to change, there has been limited research into the reasons behind this. What does appear clear however, is that theorists and researchers are recommending models of care that are not being fully implemented. This clearly deserves more attention given the negative

implications it has for both staff and clients. In order to explore this further I believe it is essential to examine the ideological framework in which new models of care such as intensive case management are created, supported and often rejected. This ideological framework I will refer to as the mental health culture.

The Mental Health Culture

The current mental health culture and the emergence of intensive case management has been shaped by a number of social, economic and political circumstances and by two dominant factors - deinstitutionalization and the biomedical model. Although many authors blame the reluctance to adopt new models of care on the staff themselves, these factors shape the culture in which staff work and thus contribute to their acceptance or refusal of models of care. Therefore the following section will explore the ideologies which underlie deinstitutionalization and the biomedical model.

Deinstitutionalization and the Medical Model

Deinstitutionalization began in the 1960's with the systemic discharge of long-term patients from state/provincial mental health institution to the community. This was fueled by a number of factors: the discovery of psychotropic drugs in the late 50's; the civil libertarian movement that focused on the rights of the mentally ill person; evidence of the debilitating effects of long-term institutionalization; and the emerging ideology of community care (Marcos, 1990; Bachrach, 1989). This was an era filled with optimism, an era when people

believed the world could be made a better place through social action (Bachrach, 1989; Mechanic, 1987). Persons with a severe and persistent mental illness were viewed as victims of the inhumane conditions of the mental hospitals and there was a certainty that community-based care would offer them a more therapeutic and humane alternative and, possibly, a cure (Bachrach, 1983).

The 1960's were also the start of the antipsychiatry era. Books such as Kesey's (1962) One Flew Over the Cuckoos Nest, Szasz's (1961) The Myth of Mental Illness and Goffman's (1961) Asylum highlighted the atrocities committed in some institutions and challenged the notion of mental illness itself. Fiscal reformers had an interest in reducing the high costs of institutional care, and for a short time both fiscal and social reformers shared a similar agenda (Kuhlman, 1994; Bachrach, 1990). Together these aspects combined to support deinstitutionalization. By the mid 1960's, the foundations of institutional care had been undermined and the move to shift the care of mentally ill persons from institutions into the community began (Kuhlman, 1994).

It should be noted that although the deinstitutionalization movement was very similar across North America there were some differences. In Canada, the philosophy of deinstitutionalization applied to shifting the locus of care from large psychiatric institutions to general hospitals. The United States focused on moving care directly from state institutions to the CMHCs. Regardless of the authority initially responsible for community care, ultimately, the care for the chronically mentally ill person fell upon both the CMHCs and the acute care hospitals.

There were some CMHCs in existence prior to deinstitutionalization. These were known as aftercare clinics. These clinics provided medication and support for people with a mental illness living in the community. However, many of these centres were geared towards working with a higher functioning and less impaired population than many of the previously institutionalized persons. These clinics relied heavily on psychotherapy as the dominant form of treatment (Breakey, 1992). Although these clients required support, psychotherapy and medication, they did not have the multitude of needs and functional impairments that many of the previously institutionalized patients had. If these centres had previous experience working with people who had a chronic mental illness, it was certainly with someone whose symptoms were well controlled (Breakey, 1992).

Deinstitutionalization changed this and CMHC's and the general hospitals were now expected to manage a very different population. Unlike the higher functioning population, the previously institutionalized person often had symptoms that were not well controlled. In addition many were difficult to engage in treatment, had poor planning and coping skills, and had few social skills, due both to the long process of institutionalization and their illness (Bachrach, 1988). Psychotherapy alone was not going to replace the care provided by the institution - it was not going to help this group of people find food, access medical care or manage the daily stresses of living in the community.

By the mid 70's, there was a sense of failure and hopelessness as it became clear that meeting the needs of people with a chronic mental illness was going to be difficult (Mechanic, 1987; Bachrach, 1986). The seamless system of

total institutional care had been replaced by a fragmented system of services run by different providers, having different requirements. Life in the community was more complex and less easily controlled than life in an institution and bureaucratic obstacles and service coordination problems made getting help a confusing prospect (Kuhlman, 1994; Bachrach, 1990). Rather than rely on the fragmented community mental health system, many people would present in emergency centres or come to the attention of the police when they were in crisis, others were simply untreated (Kuhlman, 1994; Bachrach, 1988; Pepper, 1981). Some did not 'fit' into traditional community-based mental health services and others simply opted out (Marcos, 1990). Regrettably, this disillusionment meant that many chronically mentally ill were underserved by CMHC's and many CMHC staff became dissatisfied with their work (Kuhlman, 1994).

Although the ideology of deinstitutionalization shifted the locus of care from institutions to community the *focus* of care did not change and remained embedded within the biomedical approach. This approach encompasses both biological and psychological theories. It is determinist and isolates illness to the individual and thus "limits the consideration of social and environmental factors, because the primary focus is on the illness" (Golightly, 1997, p. 16). It neglects individual differences and in doing so creates categories of illness to be treated. Psychiatry is skilled at identifying treatment groups. Deinstitutionalization and the problems associated with it has led to the identification of many different diagnostic categories (Kuhlman, 1994). Each decade has had a different target

group; the 1970's was the 'deinstitutionalized patient'; the 1980's was the 'new chronic patient'; and the 1990's have identified the 'homeless mentally ill'.

The power and dominance of this model can be seen throughout the history of deinstitutionalization. Golightly (1997) states that "the biomedical paradigm has been highly successful in achieving unquestionable trust and acceptance as our society's basic approach to the definition, study and solution of multiple social problems" (p.16). This is particularly glaring in the history of mental health care. Despite the problems associated with deinstitutionalzation and the recognition by researchers that many of these problems are more than "psychiatric" in nature public officials and policy makers continue to turn to psychiatry and the medical profession for their input into handling this serious public policy issue (Breakey, 1992). By framing the problems in terms of the 'chronically mentally ill' the socioeconomic factors contributing to the problem become blurred because complex social problems such as poverty, homelessness and stigma are seen as secondary to the illness itself.

The medical model encourages the short term treatment of acute episodes of illness (Bachrach, 1990; Minkoff & Stern, 1985). The interest lies in treating the acute stages of the illness and the ongoing refractory symptoms and disabilities are inconsequential. In doing so the multiple, enduring service needs of the patients are often ignored (Bachrach, 1990). Illness is seen as a discreet experience that ends when the removal or stabilization of symptoms occurs (Minkoff & Stern, 1985).

The problems of deinstitutionalization have occupied much of mental health literature in the last twenty years. Bachrach (1990), perhaps the most noted author on deinstitutionalization, suggests that the problems of deinstitutionalization results from three flawed assumptions: the assumption that the 'chronically mentally ill' are a single homogenous population; the assumption that mental illness is episodic in nature; and the assumption that community treatment can replace institutional care. The source of these assumptions appears to be rooted in the dominance of the medical model.

The perceived failure of deinstitutionalization and the experience of it has had a dramatic impact on staff. The literature blames the failure of deinstitutionalization on staff's reluctance to work with this population(s) or on their inability to work effectively (Bachrach, 1990; Kuhlman, 1994; Lamb, 1979). The medicalization of the complex social problems caused by deinstitutionalization led in turn to a belief that mental health staff were ineffectual (Minkoff & Stern, 1985; White & Bennett, 1981). Quantitative studies on staff's experiences working within this system painted a grim picture. Staff were described as burned out, resistive and dissatisfied. These studies documented staff's experiences through objective measures such as the Maslach's Burnout Inventory and the Job Satisfaction Index. However, they did not explore the context in which these experiences occurred nor did they explore staff's experiences. The authors of these studies did not challenge these findings and eventually these findings became so entrenched within the literature even studies that refuted or challenged them were often ignored. These findings have

became part of the myths of mental health work. These myths and the assumptions embedded within them will be explored in the following section.

Confronting the Myths

Myths are defined as any fictitious story or account or unfounded belief (Webster, 1988). In examining the literature on mental health I found a number of myths. These myths are supported and reinforced by the culture in which they exists. They impact on staff by perpetuating a false belief about their experience and in doing so mask the truth. The following section will explore these myths and examine the assumptions underlying the development and the maintenance of them. These myths are as follows:

1. Job stress in mental health is related to client characteristics.
2. Mental health work with the chronic client is dissatisfying.
3. Interventions should be aimed at treating the symptoms of mental illness.

Job stress in mental health is related to client characteristics.

There has been volumes of literature devoted to supporting this myth. Hromco et al. (1995) states the mental health 'folklore' is that burnout and stress is high in case management. Researchers in the 70's such as Pines & Maslach and Cherniss & Egnatious focused their attention on stress, burnout and the relationship this had to mental health work. These researchers found that working with people who had a chronic mental illness was stressful to staff and that the closer and more intensely staff worked with these clients, the more stress

they experienced (Cherniss & Egnatious, 1978; Pines & Maslach, 1978). These findings are especially significant to intensive case managers as their job is to work closely and intensely with clients. This research quantified staff's experiences into measures such as the Maslach Burnout Inventory and the Professional Stress Scale. Much of this was researcher driven and set out to verify the psychometric properties of such measures. This focus on measuring stress and burnout prevented the emergence of other issues. The climate in which staff worked was not considered nor were other factors that may have contributed to their experiences working within the mental health system. Despite the serious implications of these findings, the research remained unchallenged for over a decade and continues to be cited in the literature including the literature on intensive case management.

Although client characteristics continue to be related to stress in a number of studies (Mirabi, Weinman, Magnetti & Keppler, 1985; Stern & Minkoff, 1985) this has been recently challenged in the literature (see Schulz, Greenley & Brown, 1995; Duquette, Kerouac, Sandhu & Beaudet, 1994; Kirk, Koeske and Koeske, 1993; Finch & Krantz, 1991; Penn, Romano & Foat, 1988). Of the five recent studies listed above none directly support the finding that client characteristics are related to stress.

Schulz et al. (1995) gives his suggestion as to why these findings may conflict with the more traditional research.

> The lack of relationship between client characteristics and staff burnout in this study is interesting in light of the considerable literature suggesting the plausibility of this link. A likely possibility is that staff mistakenly

attribute the source of their feelings of burnout to clients. This may be seen as another instance of blaming the victim (p. 342).

If Schulz's prediction is accurate the question still remains what is it that is stressful about working in mental health? Myth two may help to explain this.

Working with people who have a chronic mental illness is unrewarding.

Much of the early literature on stress also reported that mental health staff were dissatisfied with their jobs (Cherniss & Egnatious, 1978; Pines & Maslach, 1978). Again these early findings continue to be reported in the literature (Hromco et al., 1995; Ben-Dror, 1994; Minkoff and Stern, 1985). Early studies blamed this on the stress experienced when working with people who have a chronic mental illness. However newer research suggests that stress and burnout are highly related to a sense of accomplishment (Hromco, et al., 1995; Ben-Dror, 1994; Penn et al., 1988). Staff who feel a sense of failure and frustration with their work are often dissatisfied with their jobs. The staff in Pines & Maslach's study felt unsuccessful and this in turn was attributed to their clients. Perhaps one should ask what it is that they were trying to accomplish. The following quote from Pines & Maslach's (1978) study answers this. They described the staff in their study as:

> feeling stressed out and negative about their job and had entered the mental health profession with higher expectations of patients, but over time they began to view them as more apathetic, weak and powerless. They were more pessimistic about the possible effects of the work, seeing little chance of *curing* schizophrenia. (p. 235, emphasis added).

Although it has been long known that schizophrenia and other major psychiatric disorders can be chronic in nature there has been a reluctance to treat them as such (Minkoff & Stern, 1985; Mirabi et al. 1985; White & Bennett, 1981; Lamb, 1979). As a result of these unrealistic expectations staff experience burnout and stress and feel ineffectual. Minkoff & Stern (1985) describe this as the 'normative goal paradox' which they define as this:

> The tendency of trainees to bring to their work with chronic schizophrenic patients the attitudes and expectations of their work with acute, non-psychotic patients. Successful outcome for all psychiatric patients, including schizophrenic patients, has traditionally been measured according to normative standards, which include absence of symptoms, avoidance of relapse, full employment and full social interaction (p. 863).

Although Minkoff and Stern identified the problem they and a number of other authors have blamed the problem on the individual staff rather than challenging the origins of this definition of success (White & Bennett, 1981). Lamb (1979) states that there is a distinct bias in our society to apply normative goals of health and wellness to everyone and critiques the medcial model for failing to provide an appropriate framework for working with this population. He believes this population differs in their ability to meet the goals and standards set by the dominant model of care (Lamb, 1979). Staff trained in the medical model are taught that their role is to 'cure' illness (Minkoff & Stern, 1985). The use of this criteria to determine success creates a very narrow definition of wellness thereby promoting a sense of failure.

The reluctance to accept the chronicity of the illness has resulted in the belief that working with these clients is unrewarding and dull and that outcome is

hopeless (Bachrach, 1990; Mirabi et al, 1985; Minkoff & Stern, 1985). Although the above research was based on findings from physicians, Mirabi et al's (1985) study included social workers, nurses and psychologists. This study assessed professional's attitudes towards mental health work. Of the 436 people that responded 83% felt that burnout and frustration was common among those working with this population and a majority felt that staff were frustrated in their attempts to *effectively* treat chronic patients (Mirabi et al., 1985). One of their respondents put it this way:

> They do not reward our efforts by getting 'better' within an easily observable period of time or, if they improve, they backslide, and we can begin to feel much as they do about the hopelessness of their situation (p.405).

The reliance on cure as a goal of treatment is supported by the mental health culture and this places staff in an impossible position. If they rely on treatment aimed at cured they fail and become dissatisfied with their work. However cure and return to normative functioning is the only "success" that the medical model provides.

Interventions should be aimed at treating mental illness.

This is a hard myth to debunk. Part of the difficulty lies in the ideology in which mental health treatment is created. The majority of people working in mental health are trained within the medical model and those who come from other models are socialized by this dominant ideology. The medical model focuses on treating symptoms and the expectation is that models of treatment for

mental illness should also do this (Minkoff & Stern, 1985). Deinstitutionalization has shown us that treating the "illness" is not enough. It is the functional deficits resulting from the disability that create problems in living and these desperately need to be addressed . Multiple authors have commented on the need for "comprehensive care" (Bachrach,1990; Intagliata, 1982; Stein & Test, 1980). Psychiatrists themselves have identified the need to implement 'a comprehensive, non-reductionism, biopsychosocial evaluation and treatment model' (White & Bennett, 1981). Although psychiatry outwardly appears to accept the biopsychosocial model of illness and health some would argue that little has changed. Interventions remain focused on treating 'illness' and treating the 'social' appears to remain outside the legitimate responsibility of staff.

The acceptance of this narrow view of illness is not limited to physicians. Even social workers who traditionally have been responsible for the psychosocial needs of clients have shunned away from this responsibility. In fact studies have shown that social workers have an overwhelming preference for psychotherapy (Johnson & Rubin, 1983) a mode of therapy highly prized by the medical model. Glazer & Slater (cited in Baines, Evans & Neysmith,1992) state that in order to professionalize themselves social workers adopted the medical model and the concept of objective treatment. Numerous authors have suggested that the psychosocial interventions needed by many people with a chronic mental illness are not valued by staff because they are seen as poverty work - work that is seen as unprofessional and undignified by the dominant ideology (Deitchaman, 1980; Stein & Test, 1980).

Summary

The above myths and assumptions create a climate that rewards staff for working within the constraints of the biomedical model. Paradoxically the use of this model alone has proven unsuccessful in meeting the needs of the person with a chronic mental illness. Research exploring staff's experience has been built upon myths and assumptions generated and perpetuated both by this model and by the reliance on quantitative methods. Although some authors have identified the problems associated with the dominance of the biomedical model few have examined the implications this have for staff working within this system. In order to be valued and seen as professional staff must limit themselves to certain discreet roles and interventions supported by this model. These valued roles and resulting interventions are based on the dominant ideology rather than the needs of the clients. The need for a clear conceptual framework that addresses the unique needs and range of abilities of people with a chronic mental illness is lacking (Lamb, 1992; Minkoff & Stern, 1985; White & Bennett, 1981). This means that staff are working in the absence of a philosophy that gives meaning to their work (Lamb, 1992). The treatment of mental illness has been dominated by the ideology of cure and short term success. In recent years an ideology that emphasis rehabilitation and long-term outcome has begun to emerge. The following section will explore this new ideology.

Chapter Two
Revisiting the Myths: Moving Outside the Medical Model

A New Ideology

Recently a different ideology has been emerging within the mental health culture one that challenges many of the myths and assumptions of the current mental health system. The following chapter will examines the limited literature and research generated within this different setting and examine the implications of this new 'culture'. This literature emerges from three major sources; the consumer movement; psychosocial rehabilitation; and research on intensive case management.

The Consumer Movement

The consumer movement has gained power and momentum over the last thirty years (O'Hagen, 1993) and has added a humanness to the experience of clients within the mental health system. The limited studies that have examined the problems faced by these consumers define their problems in terms of economic and survival needs (O'Hagen, 1993; Wagenaar & Lewis, 1989). This definition includes a recognition that having a mental illness does not buffer one from the multiple stresses of a lifetime of poverty, inactivity, stigma, homelessness, isolation and exploitation (O'Hagen, 1993). Symptoms are seen as simply an added burden in their daily struggle for survival. In defining their experiences many consumer groups have been fiercely critical of the medical model. As this movement continues to gain political and economic power it's

influence on mental health planning and policy increases. This is perhaps most obvious in the United States were the National Alliance for the Mentally Ill (NAMI) has had a significant impact on the direction of mental health policy and funding including the increased acceptance of case management as service delivery model in the United States (Intagliata, 1982).

Psychosocial Rehabilitation

Psychosocial rehabilitation integrates the physical rehabilitation approach with various elements of psychotherapy. The main goals of physical rehabilitation are to "assist persons with long-term disabilities to increase their functioning so that they are successful and satisfied in the environments of their choice with the least amount of ongoing professional interventions" - success is defined by increased quality of life (Anthony, et al., 1983). The psychosocial rehabilitation approach borrows this ideology and uses it as a framework to work with people who have a chronic mental illness. There is a focus on: performance of everyday activities; the clients feelings of happiness; the provision of in vivo training; the development of self determined goals and; ongoing support (Anthony, Cohen, Farkus & Cohen, 1989). This model focuses on strengths rather than pathology. The clients potential for growth is emphasized and hope is an essential ingredient. It identifies the 'chronically mentally ill' as a heterogeneous group rather than a homogenous one and recognizes and honors the individuality of people regardless of their diagnostic similarities. Because of

this individualized service plans are emphasized and the notion that one can develop a uniform service to meet the needs of the 'mentally ill' is rejected.

Anthony et al. (1988) highlights the key differences between this model and the medical model. Specifically, while medical treatment focuses on the relief of distress, the alleviation of symptoms and the curing of disease, rehabilitation focuses on the restoration and maintenance of functioning. This model recognizes that it is generally the functional deficits resulting from the illness [disability] that create problems in living rather than the illness itself (Anthony et al., 1988).

The relationship between psychosocial rehabilitation and psychiatry has been tenuous (Bachrach, 1992). Even though there is nothing innately anti-psychiatry about it, psychosocial rehabilitation has often been pitted against psychiatry. It has been suggested that the polarization of psychiatric treatment from psychosocial rehabilitation may lie more in heightened 'turf' concerns than in ideological differences (Bachrach, 1992). Despite the significant differences between current treatment approaches and psychosocial rehabilitation there has been a recent recognition on behalf of psychiatry for the need to provide comprehensive care, individualized service plans and rehabilitation (Bachrach, 1992).

The research on staff's experiences using this model is optimistic. Finch and Krantz (1991) explored the experiences of staff who worked in a clubhouse that was based on the psychosocial rehabilitation model. The staff reported feeling satisfied with their work and in fact felt a high sense of accomplishment

despite working with closely and intensively with people who had a chronic mental illness (Finch & Krantz 1991). Finch and Krantz (1991) allude to the fact that research done in a traditional medical model with staff that have traditional beliefs may not be generalizable to newer models care. They go on to suggest that working from a psychosocial rehabilitation model may allow appropriate goals to be set with clients that ensure both the staff and the clients success (Finch & Krantz, 1991). It appears that these new models of care require staff to think about mental illness and it's treatment in a different way as their goal is not 'cure' but improved functioning. This models requires staff to work from a personal strengths perspective as opposed to one that focuses on psychopathology and to consider individual functioning in the creation of service plans. As was shown in the previous section the fact the medical model does not do this has been a central critique.

Intensive Case Management

Intagliata (1982) states that in order to understand the concept of case management one must also be aware of the ideology or belief system that accompanies it. He recognizes that intensive case management represents a philosophical shift away from more traditional medical models of treatment - a shift from cure to care. In describing the ideology, he states (and a number of other authors) that intensive case managers' explicit mission is to improve the quality of life of their clients through individualized service plans and the emphasis of clients strengths (Bromberg et. al., 1991; Witheridge, 1989;

Intagliata, 1982; Anthony, Cohen & Cohen 1983; Stein & Test, 1980). This ideology echoes many of the main principles of psychosocial rehabilitation. This model however, has also been shaped by the clinical needs of the clients whom receive these services. The changing of the goals of Stein & Test's model from a focus of decreasing hospitalizations to improving client's quality of life through the provision of concrete services highlights this (see Table 2).

The following section will explore the limited literature on intensive case management and the staff who work within this model. I will ground this research in a description of the intensive case management process as I feel this will best illustrate the ways in which it diverts from a medical model of treatment and moves towards a model of holistic care. It will also provide a clearer picture of staff's experience working within this model. Agreement exists among a number of authors as to the roles and phases of intensive case management. They have been described as including five phases: engagement; assessment; linking; monitoring; and advocacy (Hromco et al., 1995; Chamberlain & Rapp, 1991; Bachrach, 1989; Intagliata, 1982). The phases, roles and interventions are not used exclusively by intensive case managers however, intensive case management is described by the above authors as incomplete, if any of these roles or phases are missing.

The Intensive Case Management Process

The majority of clients in intensive case management programs have opted out of traditional mental health services; either traditional models are

ineffectual for them or they have been refused service by traditional agencies (Primm & Houck, 1990; Harriss & Bergman, 1988; Deitchman, 1980). Therefore intervention strategies and strategies for engagement must differ from those employed in traditional mental health services. Limited research exists as to ways to engage these clients.

A number of authors have commented on the importance of the engagement phase (Harriss & Bergman, 1988; Intagliata, 1982; Deitchman, 1980). The establishment of a trusting relationship provides the foundation through which all future services will be provided. Treatment occurs through the development of a therapeutic relationship and treatment of the environment occurs as the intensive case manager intervenes in the patients environment to create a responsive and supportive climate (Swayze, 1992). For many clients the engagement phase will last months even years, some clients never actually engage and others merely tolerate the intensive case manager's presence. Even the most resistive clients may however, benefit from simply the consistency of the intensive case managers presence in their environment (Breakey, 1992). These clients may not allow any intervention directed at their illness but may allow environmental interventions such as the provision of regular meals or housing. In order for intensive case managers to feel supported by the system these interventions must be seen as within the legitimate sphere of mental health care.

The reliance on home visits and in vivo service is one hallmark of intensive case management. For many clients the traditional outpatient clinic reinforces the stigma of mental illness and for clients who refuse to define themselves in

those terms engaging in the clinic setting is difficult if not impossible (Bachrach, 1990). Other clients are simply too disorganized to attend (Bachrach, 1980) and some are refused (Breakey, 1992).

While at home visiting has often been the cornerstone in the evaluation of at risk children and used widely in medical home visits the value of this with the chronically mentally ill person has not been widely recognized (Sullivan & Cohen, 1990). Part of the reason behind this lack of recognition may be psychiatry's historical connection to traditional psychotherapy. Staff trained in traditional psychotherapy are taught to work within the regulated structure of their own offices and to avoid outreach and home visits for fear of fostering dependency and tainting the client-therapist boundaries (White & Bennett, 1981).

Just as the move from institutions to CMHCs changed the work environment of staff so does the shift from CMHCs to the community. The use of home visits and in vivo service delivery requires staff to become acquainted with the client's environment and also to become intimately familiar with a variety of locations that are seldom (if ever) visited by the conventional practitioner: low rent hotels, boarding homes, slum apartment buildings, welfare offices, lockups, public shelters, unsavory street corners. In theory the visits take place where the consumer happens to be, wants to be or needs to be rather that where the worker would prefer to be (Witheridge, 1989). This is a marked shift from traditional health care services where the assumption is that clients will seek out treatment and treatment providers.

Little research looks at the impact of the clients community on the staff, however a few authors have commented on this. Primm & Houk, (1990) mention that it is extremely important that clinicians not be discouraged by the overwhelming problems presented by poverty. They go on to state "that working closely with severe mental illness in a setting of urban decay and social disorganization is a recipe for burnout" (Primm & Houk, 1990). Thompson, Miller & Leaf (1990) have also spoke to this issues,

> Society's marginal communities especially urban ones where many chronically mentally ill clients live face daunting problems, extreme poverty, stress, disrupted families, epidemic substance abuse, AIDS, crime, violence, underhanded and chaotic human service systems work and housing shortages and institutional racism providing comprehensive services admits such disintegration will be a severe challenge. (p. 632).

Despite these predication there has been a surprising lack of interest in this particular topic.

In addition to working in the client's environment it is essential that the intensive case manager work within the clients definition of his/her experience and allow the client to set the pace of treatment (Kuhlman, 1994). This represents a shift in power for mental health staff. Although 'client centered therapy' is generally accepted with the 'worried well' there appears to be a mixed belief among mental health professionals regarding the value of this when working with people who have a chronic mental illness. This may be related to staff's beliefs about the individual and the illness. If the illness is seen as the overriding the individual characteristics of the person staff may be more inclined to define a client's reluctance to engage or describe their illness in psychiatric

terms, as a lack of insight. If this is the case they may believe that 'going along with the client' will feed into their denial. Others may see it simply as a way for the clients to reframe their experience of mental illness and avoid the stigma associated with it (Breakey, 1992). The differences between the two groups and the impact on the clients they work with are poorly understood and have not been adequately explored. However, Goldfinger & Chafetz (1984) suggest "that even the most resistive clients might be willing to talk to mental health professionals even a psychiatrist as long as they are free to define the nature of the conversation" (p. 131). Minkoff & Stern (1985) suggests clinicians must learn how to adapt their therapeutic stance to fit the needs of the patient rather than take the same stance with all patients. This shows a recognition for the 'personhood' of each client and moves away from the idea that the 'client is the illness'.

Alternative strategies for engaging based upon the individual client may be required. For example often clients can be engaged through the provision of concrete services such as food, shelter or assistance in accessing benefits (Cohen & Sullivan, 1990; Lamb, 1980). Other times workers need to be more creative one example provided by Susser, Valencia & Goldfinger (1992) describes how a case management team connected with a man who lived in a park:

> A man who was living in a park was observed reading a bundle of newspapers while sitting on a bench. At first he was quite hostile to any approach by the outreach team. Regular weekly deliveries of newspapers were arranged, and he came to look forward to it. Later, the outreach team itself delivered the newspapers.(p. 130).

This illustrates the need for a creative approach to engaging people. Often observing the daily activities that are meaningful to an individual can open doors for the building of relationships by the case manager (Kuhlman, 1994). However a number of researchers have commented on staff's reluctance to incorporate these 'more creative' approaches (Rubin, 1992; Harris & Bergman, 1988; Intagliata, 1982). The use of these 'approaches' must be seen as being within the legitimate role of the intensive case manager and staff must feel supported in this role not devalued.

The engagement phase is critical not only because it lays the foundation for further work with the client but it also allows the case manager to begin to develop knowledge about the individual. This type of 'engagement' is very different than the engagement in insight oriented psychotherapy as the staff must take an active, supportive role rather than a passive, exploratory one (White & Bennett, 1981). For staff trained in traditional psychotherapy this may be a difficult shift to make (White & Bennett, 1981).

Assessment is the next phase. Even if the client is well engaged assessment can start as the intensive case manager begins to develop a sense of the persons overall functioning and mental status. Much can be learned during even a short visit with a new client and case managers need to be open to discovering this information in ways that differ from traditional office bound assessments. While traditional assessments often rely on an interview to gather information assessments that occurs outside an office setting may not. A client

may refuse to speak to the intensive case manager however a skilled worker will be able to learn a lot about a client simply by spending time with them.

Following the assessment phase are the planning and linking phases. The planning phase must reflect a clients wishes and needs (Kanter, 1989; Intagliata, 1982). Although much has been written about clients ability to identify their own needs (see Anthony, et al., 1983) the intensive case manager sometimes must plan for the client (Kanter, 1989). They must sometimes act from a knowledge of their clients best interests even when the plans diverge from the clients preferences for example when arranging an involuntary committal or negotiating for medication compliance (Kanter, 1989; Swayze, 1992). This is just one of the many ethical dilemmas faced by intensive case managers in their work[1]. In addition to acting against a client's wishes intensive case managers face ethical issues regarding 'assertive outreach' - At what point does assertive outreach become 'harassment? How many times do you try to reconnect with a client? If a client tells you to leave them alone when he/she is hospitalized and angry do you? These are just a few of the issues intensive case managers must deal with.

The linking of clients to identified services and supports is a crucial function of the intensive case management (Chamberlain & Rapp, 1991; Bachrach, 1989; Harris & Bachrach, 1988). Case managers must determine how much assistance clients need to access and link to services. For some clients the prospect of attending a group or drop-in centre may be overwhelming and the

[1] A description of the ethical dilemmas is beyond the scope of this paper. For an overview of these ethical problems see Diamond & Wilker (1987) *Ethical Problems in the Community Treatment of the Chronically Mentally Ill.* Jossey-Bass: San Francisco.

intensive case manager may need to accompany the client several times or stay with the client for the duration of the program until the client feels comfortable attending on his/her own. Collaborative relationships with mental health staff providing these services is essential. In order to engage the client in a new program the client must feel safe and comfortable in the new environment. This is a good example of the intensive case manager work with the client and the clients environment.

Much of an intensive case managers work during this phase of treatment involves not only making the client feel comfortable but also ensuring agencies feel comfortable. "By developing a genuine appreciation of the concerns of other agencies case managers can effectively prepare both the client and the staff for what they can expect from each other " (Kanter, 1989. p.364). White & Bennett (1981) suggest that this may be an uncomfortable role for medical residents trained in the medical model as they may be uncomfortable working in the "role of consultant, and listening to and respecting the opinion of other caregivers with less training" (p. 342). Other disciplines experiences fulfilling this role have not been thoroughly explored.

Once the linking is complete the intensive case manager is also responsible for monitoring the clients progress in various settings and can be called upon by agencies if concerns arise. Monitoring is essential because the client may require different services depending on his/her level of functioning at the time. During periods of relapse clients may need a low demand atmosphere where as at other times they may desire a more challenging setting. Again a

solid relationship with various agencies can be of assistance here and can provide the intensive case manager with valuable information on the status of clients. As was discussed earlier this long-term follow up with a client is in opposition to the quick and acute treatment of the medical model.

When working in the clients environment the intensive case manager may need to advocate on the clients behalf in order to access services. Successful advocacy is facilitated when the case managers can work on behalf of the client and still empathize with the concerns of the service provider (Kuhlman, 1994). Some providers may be reluctant to have certain clients involved in programs for a variety of reasons ranging from fear to concerns around hygiene. It is part of the advocacy role to alleviate these fears and concerns and to support the staff in the provision of these services (Kanter, 1989). In order to do this staff themselves must be comfortable around their clients. White & Bennett (1981) state that the biggest obstacle to the effective treatment of mental illness is the attitudes of the mental health profession, the medical community and the community at large. If staff themselves stigmatize people with a chronic mental illness and are reluctant to provide service to them they will not be able to successfully advocate on their client's behalf.

Throughout this whole process the intensive case manager must also be consulting with families and other care givers. Primm & Houck (1990) suggest that one way for case managers to engage and provide assistance to clients is through contact and support of those who are closest to them. Often families have a greater insight into the strengths and abilities of the client. The years of

support many families have devoted to the care of their member provides them with a keen sensitivity to signs of decompensation or stress. In addition families can be valuable sources of information about which services have worked in the past and which services have failed. The term caregiver does not apply to family alone for some clients it may be their financial assistance workers or others may have connected well to staff at shelters or drop-ins. The importance of these relationships should not be underestimated as many clients with a chronic mental illness find it difficult to forge relationships.

The provision of direct services is an essential activity of intensive case management. This may include assisting with the client's shelter, food, clothing, income, medical and dental care and rehabilitation (Kanter, 1989). In addition skill training in activities of daily living such as shopping, laundry or taking the bus are also provided by the intensive case manager. Again these activities must be seen as legitimate by the larger system.

As one can see the roles of the intensive case manager will vary greatly from client to client. Someone thrust into the role of intensive case management must function essentially as a trouble shooter, confronting and resolving a wide range of problems many of which are unpredictable (Intagliata, 1982). In doing so they must be ready to play whatever role the situation requires, outreach worker, broker, advocate, counselor, teacher, community organizer or administrator (Hamilton 1997; Intagliata, 1982). The multiplicity of roles demanded by intensive case managers is well documented in the literature.

Witheridge (1989) has suggested that the prospective intensive case manager should:

> have a solid familiarity with recent development in biological psychiatry, psychopharmacology, rehabilitation theory, psychodiagnostics, sociology and anthropology, including social systems, race, ethnicity, class and culture and familiarity with recent history of social welfare, mental health law and related topics. (p. 141).

Some authors have commented on the need for intensive case managers to 'go with the flow' and to be willing to shift from one role to the other quickly in order to respond to the needs of their clients (Witheridge, 1989; Stein & Test, 1980). Staff who have rigid role expectations or who have rigid role expectations applied to them will find the multiple roles and 'role blurring' of intensive case management especially difficult (Intagliata, 1982).

Finch & Krantz (1991) and Witheridge (1989) have suggested that the personalities of staff may play a role in the acceptance of such a diverse range of roles. Witheridge (1989) suggests because of their attitudes, interests and even temperaments certain individuals are unquestionably cut out for the job of intensive case manager. Despite this comment he does not elaborate on what those attitudes, temperament or interests are except to say that intensive case managers require a genuine concern for working with persons who have a disabling psychiatric problem. Witheridge (1989) has suggested that their are certain aspects of the intensive case managers job that cannot be taught and that it is easier to teach someone clinical skills than it is to change their attitude towards clients. The limited research that discusses intensive case management

hiring practices supports this and numerous programs place heavy emphasis on staff attitudes towards the chronically mentally ill person (see Bromberg, Starr, Donavan, Carney & Pernell-Arnold, 1991; Witheridge & Dincin, 1985).

The process of engagement, assessment, linking, monitoring and advocacy are seen as essential parts of any intensive case management program. However, it is more than the parts alone - it is the ideology behind the parts that makes this model different. By focusing on the individual and acknowledging each client's differences the ideology that fuels this model moves away from the reductionism of the biomedical model. In addition, by focusing on both the client and the environment this model begins to address some of the social and economic issues that people with a chronic mental illness face everyday. Research on staff's experience using this model or any model that differs from traditional services is very limited. At this point further research is needed to clarify staff experience using this model and the systems response to it.

Becoming an Intensive Case Manager

New intensive case management staff who like their jobs talk about their own deinstitutionalzation and their change from being an immobile therapist to a mobile one - a therapist who can provide a range of services to the client depending on what they require at they time (Thompson, Griffith and Leaf, 1990). Other intensive case managers prefer to return to their 'in office environment' as they like to have more control over their environment. Not all intensive case managers adapt well to their role and some persist on clinging to traditional office

problems he experienced in his move to expand their crisis services in Dane County. He is 'not surprised' when staff are reluctant to volunteer and describes the resistance of staff to move from office based treatment to working in the clients community:

> We asked for volunteers for this new mobile outreach team that was to be developed, but it was no surprise that there were none. Following accepted personal policy the most recently hired staff were chosen to be reassigned and to this program: they were faced with the decision of either accepting or leaving the Center. In fact, all the reassigned staff entered the program, but immediately began looking for other jobs. A few found they really liked it but most found other jobs and left. (p.28)

It appears that given the option some staff easily slip into the intensive case management role while other staff prefer the more rigidly and clearly defined role of a community mental health worker. Unfortunately the literature has not yet identified all the factors that influence this.

Many of the central tasks of case management are devalued and seen as less than professional (Intagliata, 1982) and some case managers are reluctant to perform such function. Broadening ones range of interventions to include meeting the social welfare needs of the clients is an essential aspects of intensive case management. As Witheridge & Dincin (1985) point out "after all its the seemingly trivial activities of daily living that produce some of the most stubborn and critical problems for people with psychiatric disabilities" (p. 73). As mentioned previously this area has been neglected in the research. Although we know that some staff are unwilling to broaden their roles we also know that there

are intensive case managers out there performing these multiple tasks. What remains unknown is the difference between the two.

Conclusion

Intensive case management teams are springing up all over North America and many are achieving exciting results. Despite this little is known about the intensive case managers or their experiences. Upon entering intensive case management the worker opens themselves up to a shift in ideology, in work setting, in client population and interventions used. Intensive case managers are required to have an enormous range of skills, perform a 'systems' worth of tasks and develop therapeutic relationships with clients that have not had their needs met by traditional mental health services. Ben-Dror (1994) states that the success of the community mental health system rests on the ability of the case manager to do his/her job yet little research has explored this. A number of authors have commented have commented on the need for more research in this area (Breakey, 1992; Cohen & Sullivan, 1990; Harriss & Bachrach, 1988). Given the gaps in the literature and the reliance on research generated within the medical model paradigm **the purpose of this study is to explore the experience of intensive case managers.** The ramifications of this shift in treatment is poorly understood and has not been well explored in the literature.

Chapter Three
Research Design

Introduction

This chapter presents the research design I used to begin to understand the experiences of individuals who work within an intensive case management model. The first section will explore and justify the choice of a qualitative design. The second section will examine my understanding of the theoretical principles that provided a foundation for this study. The final sections will document the research process and methodology followed in this study.

General Design

This study utilized a qualitative design. A number of factors influenced the choice of this method. First, none of the literature reviewed was grounded in intensive case managers' experiences. Instead, the literature on intensive case management has been quantitative and has reduced intensive case managers' experiences into measures such as the Maslach's Burnout Inventory (1978) and The Job Satisfaction Index (Cushway & Nolan, 1996). In addition, the reliance on quantitative research results in the use of predetermined categories and therefore limits and narrows the results rather than allowing them to emerge from the data. This study's first aim was to identify the experiences rather than simply 'assume' that certain experiences existed. A qualitative approach is the most appropriate for this. Miller and Crabtree (1992) point out that:

> The aim of identification is one of the most neglected aspects of scientific inquiry. All to often investigators create concepts based on some "gut" feeling, their own reasoning or previous literature. They then produce measurement instruments that reify the concept, giving it the appearance it really exists out there. The result may be research that is powerful (minimal type 2 error) and minimizes false positives (type 1 error) but also may be solving the wrong problem (type 3 error) or solving a problem not worth solving (type 4 error). Qualitative field research, the documentary-historical style, and philosophical inquiry are ideally suited for the essential task of identification. (P.6).

Second, the research on intensive case management has been 'tainted' by assumptions and 'folklore' (Hromoco, et al., 19945) such as the link between client severity and stress. These assumptions are found throughout various studies and have not been explored critically. As this study is interested in exploring intensive case managers' experiences, I needed a method that would allow me to explore the meaning behind the experiences rather than simply document that certain experiences or beliefs are present. A qualitative design will allow me to move with the data and to change direction if necessary. It is flexible and allows the incorporation of new and unexpected ideas. As there is little known about intensive case managers' experiences, it is essential that the research approach be flexible enough to incorporate new or unexpected phenomena.

Third, qualitative research is interested not only in physical events and behavior but also in how the participants make sense of this and how this in turn influences their behavior. This in-depth process will allow me to explore the 'lived experience' of the participants, including the meaning they attach to particular events, situations and behaviors.

Fourth, qualitative research incorporates context and allows events, actions and behaviours to be viewed and examined within the environment in which they occur. The circumstances in which these events, actions and meanings are shaped are not treated as confounding variables to be 'held constant' but as contributing to the creation of their experience. Given the myths and assumptions embedded within the research reviewed I felt this was essential. All of these reasons listed above shaped my decision to choose a qualitative design.

Perspectives

This section will describe my knowledge of the perspectives that provided the foundation for this study. The design of this study was influenced by two perspectives namely feminist research principles and hermeneutics. Both perspectives shaped the research process and will be discussed separately.

Feminist Research

Cancian (1992) states that the goals of feminist research are to 'challenge inequality and empower women and other marginal groups'. Although no one 'feminist method' exists there are some common methodological features of feminist research (Cancian, 1992). This study 'borrowed' some of these features to help guide it's design. It is not however, a feminist analysis of intensive case management as the traditional focus on gender is omitted. These features are as follows:

1. The belief that people and their subjective experience are a legitimate source of knowledge and furthermore that subjective experience is a credible

source of data (Cancian, 1992). This reflects the feminist critique that "the positivist emphasis on abstract theory and complex quantitative data...devalues the personal experiences and everyday knowledge produced by nonelite people" (Cancian, 1992. P. 625). This study seeks to explore the experiences of a group that have been, so far, ignored by traditional research. It is based on the belief that their stories regarding their experiences are a valid source of data and does not dismiss them as an invalid source of knowledge.

2. The belief that behaviour and experience are best understood within the social context in which they occur rather than separated out and viewed in isolation from each other (Riger, 1991). The majority of the research reviewed has ignored the impact the 'mental health culture' has had on staff's experience. I felt it was essential that this 'cultural context' be incorporated in order to fully understand the experiences of the participants involved.

In addition to the points above, feminist principles also influenced my choice of data collection method and the way in which this collection was carried out. Many aspects of feminist methodology are intended to reduce the power inequities between the researcher and the participant. Reinharz (1992) states that the best information is generated from interviews in which the relationship is non-hierarchical and thus attempts should be made to reduce the power between the researcher and the participants. This was done in a number of ways:

1. The use of an unstructured and later a semi-structured interview assisted in reducing the alienation and distance between myself and the participants

because I allowed the participant to control the process and the direction of the conversation (Reinharz, 1992). In addition to letting go of control of the interview itself, the scheduling of the interviews was decided upon by the participants.

2. I defined the interviewee as the expert and explained to each participant that s/he had been asked to participate because of his/her expertise in this area.

3. I did not distance myself from the participants but instead offered information about myself and my background and started each interview by asking participants if they had any questions for me. In addition I freely answered question directed at me that came up during the interview process.

4. At the end of the interview I encouraged the participants to make suggestions regarding the interview process and to add any additional information that they felt was central to this topic, again stressing that they knew better than I the important areas that needed to be covered.

Hermeneutics

In addition to the feminist principles outlined above I relied on principles employed by hermeneutic research. Hermeneutics is a branch of phenomenology that is interested in the interpretation and creation of meaning. (Kvale, 1996) notes the goal of hermeneutics is to go beyond a mere description of the data to uncover the meaning the participants attach to everyday lived experience. In doing this, the researcher must dialogue with the data; this is generally referred to as the hermeneutic circle (Kvale, 1996; Tesch, 1990). This involves establishing meaning of the parts in relation to the whole - the researcher must constantly be moving back and forth between discreet parts of

the text and the whole. Although this has been described as a circular process Kvale (1996) describes it as a spiral with each curve deepening the meaning and the interpretation.

Several hermeneutic strategies influenced the design of this study: First, there was a back and forth process between myself, the transcripts, the literature, my colleagues and my own beliefs. A 'dialogue' was carried out with the text in which I asked questions of it and of my responses to it. This 'dialogue' continued throughout the data collection, analysis and writing of the findings.

Second my point of view, experience and history are considered an integral part of the interpretation process. Rather than attempt to 'bracket' my experience and my interpretation, I acknowledged that my experiences and my background will shape the way the text is interpreted. Not only did I immerse myself in the text and listen openly to the participants experiences I also stepped away and examined it from *my* perspective using myself and my beliefs to examine and question the data. Therefore the results of this study reflect my interpretation of the interviews and I own them as my own.

Third, the interpretive process included context and this was continuously brought into the analysis as the individual parts were examined against the whole text. This allowed me to move outside the text and consider and question how it was related to larger social context in which the participants live and work.

These two perspectives, feminism and hermeneutics, together provided me with a framework from which to design my research. The choice of data

collection methods and the type of analysis were all shaped using the above principles.

Situating Myself

My professional training is in social work and I have been a full time member of an intensive case management team for over two years. Being the researcher and a member of an intensive case management team had both benefits and drawbacks. The benefits were numerous. As an intensive case manager myself I am intimately aware of the nature of the job and therefore had a pre-established background in the topic. I was familiar with much of the research and with many of the problems and concerns regarding intensive case management. In addition, I had a pre-established relationship with many of the participants and at least a familiarity with others. I shared a common language with the participants and understood their idiosyncrasies. I was also familiar with many of the experiences they described and this provided a common ground for the establishment of a relationship.

The above benefits of being a member of the 'group' were also paradoxically, drawbacks. Many times the participants would start to tell me a story and then stop and say 'oh you know what it's like'. I found myself constantly asking people to elaborate despite the fact they felt 'I knew what they meant.' Having a shared language with the participants also meant that at times I did not challenge or attempt to clarify what they mean or to whom they were referring. I attempted to be aware of this during the interview process and requested many

participants to clarify what they meant when they used terms specific to intensive case management. Despite this, I inevitably missed things and on occasions after reading a transcript I had to contact the participant again and request clarification.

I also ran the risk that participants would be unwilling to share information or beliefs that could be seen as violations of 'intensive case management'. However, I was pleasantly surprised by how candid the participants were with regards to many issues that could be seen as negatively reflecting on their ability to do 'good' intensive case management.

I was always aware of my need to be open to the participants' beliefs about intensive case management that differed from mine. However, this group of intensive case management are a powerful and assertive group of staff and it was hard *not* to hear them. In addition I highlighted any comments that challenged my own beliefs about intensive case management in order to further explore my responses to the participants comments.

The Research Process

Sample

Given the small number of intensive case managers in Vancouver, the sample description will be purposely vague in order to maintain the anonymity of the participants. Participants were recruited via a recruitment letter (see Appendix 1) that was sent to staff who met the following criteria:

1. They worked primarily on an outreach basis.
2. They were mandated to work with people who have a severe and persistent mental illness.
3. They provided direct services to the client.
4. They self identified as performing intensive case management.

Given my own involvement in the mental health field, I was aware of staff who met these criteria and purposely sampled from them. Because of the limited number of intensive case managers in Vancouver, many of the staff were aware of my research prior to my sending out recruitment letters (Appendix I). Out of the eleven staff that were identified as meeting this criteria, six volunteered prior to sending out recruitment letters and three contacted me after receiving the letters. Two staff did not contact me after receiving the recruitment letters and were therefore not included in the study. Nine people in total volunteered for the study. Participants were informed of the voluntary nature of the study and this was clearly outlined in the consent form (see Appendix 2).

All the participants worked in the Vancouver area and all were connected to the formal mental health system as paid employees. Two of the nine staff were male and the remaining seven were female. Five of the staff has a background in nursing, and the remaining four came from a variety of disciplines including social work, rehabilitation and psychology. All staff had worked in the traditional mental health system before joining an intensive case management team.

The Interview Process

Interviews were arranged at the time and location of the participants' choice. The interviews were unstructured and started with a global question "Tell me about a typical day." This type of unstructured interview allowed for a range of topics to arise and was flexible enough to incorporate a variety of themes. Following the first interview, a rough guide was created that included headings I wanted to cover. This guide changed and grew following each interview.

Participants were interviewed in a particular order. I chose to interview the first three participants in the beginning for three reasons. One, I had a pre-existing relationship with them and felt they would feel free to discuss their work with me. Secondly, they were well aware of my research topic and I had had many informal discussions with them prior to their interviews. Finally, they were articulate and comfortable speaking with me regarding their experience as intensive case managers and I was confident they would easily 'lead' the interview rather than having to rely on myself to question them. This allowed the initial interviews to be very open and exploratory. With each interview more and more questions were added to my interview however I found I rarely had to ask specific questions to have the information covered as most participants spontaneously addressed the topics covered in the interview guide.

Data Management

Permission was requested to audio-tape all interviews and each participant agreed. During the interviews I jotted down headings of topics that

appeared particularly important to the participant or ones that were described with much emotion. Immediately after the interview, notes were written that expanded my interview notes and included any peculiarities about the interview such as interruptions or difficulties getting the interview going. Most interviews lasted one to one and a half hours.

Following the interviews, I explained to participants that I would be giving them a copy of their transcripts to edit and add to if they wished. These were dropped off to participants along with a thank you note and a self-addressed stamped envelope in which they could provide anonymous feedback regarding the interview process or to provide additional information. Edited transcripts were picked up at the participants convenience and only one transcript was changed in any significant way. This particular transcript was full of gaps and holes as the tape was very difficult to follow. The participant sent me a revised version that addressed many of the questions in the original transcript.

All the tapes were transcribed verbatim including pauses, errors and repetitions. The first three transcripts were transcribed by myself and the remaining six were done by a professional typist. All transcripts were checked for accuracy and read while listening to the audio-tapes. During this time, I began noting ideas and questions that arose while reviewing the transcripts. In addition, because of my close involvement with intensive case management, I highlighted items that challenged my own beliefs or raised questions or doubts in my mind in order to remind myself of my own response to these statements so that they could be further examined.

Analysis

The analysis began with the first interview and continued until the final categories were created. All transcripts were read prior to the next interview and this re-reading allowed me to reflect on what had been said and to expand my interview guide if necessary. A few categories and sub-categories emerged from the interviews themselves and others were teased out of the transcripts.

I initially began with line-by-line coding but did not feel that this captured the essence of what was being said. I then switched to highlighting major 'chunks' of text that I felt spoke to intensive case managers experiences. These 'chunks were assigned tags or codes that reflected the general meaning of the statements. I kept 'theoretical memos' regarding the chunks that included why I labeled them as such and what I felt they were saying. Each transcript was highlighted and I grouped similarly tagged 'chunks' together to create categories. Initially this was done with each transcript in isolation of each other. In the beginning these categories were very concrete, for example two large preliminary categories included the 'role of the team' and 'the impact of the environment'. By the end of the analysis these categories had grown to be more abstract. After each transcript was highlighted in isolation, I then moved across transcripts to see if any categories could be grouped together.

During the categorizing process (across and within transcripts), I remained alert for differences, contradictions and variant themes. In addition, any statement that did not 'fit' with me was included in a category labeled 'my stuff' to be examined more critically.

Once the 'chunks' of text were tagged with the initial labels, I photocopied the transcripts onto different coloured paper and cut out each chunk of text. These were then placed in a category. Once all the text was sectioned and placed into categories I then created a 'story board' for each category. This 'story board' was a large piece of cardboard on which I could stick the cut up chunks of text and move them around in an attempt to create a story from the pieces of interview regarding a particular category. The cut up transcripts were attached to the boards with a spray glue that enabled me to peel them off and move them around as much as needed. Some of the finished 'story boards' were very close to the original and others changed dramatically as the analysis progressed.

During the creation of these story boards I continuously went back to the transcripts to ensure I was capturing the participants words and not simply trying to 'fit' pieces into my own categories. This story board method combined with the traditional coding and categorizing helped to verify the findings as the story boards essentially reflected the coding of the material.

Once the story boards were completed, they were compared to the transcripts to ensure that it reflected what the participants were telling me. In addition after each story board was developed, I went through the transcripts and summarized the main points and themes and then compared those summaries to the final stories that emerged form the story boards.

The data analysis procedure was a process of constant dialogue between the data, my theoretical memos and field notes, the preliminary analysis and

many of the participants themselves. Although I did not return the analyzed data to the participants for feedback I did have a number of occasions to clarify my 'hunches' and interpretations of the transcripts by discussing my findings with co-workers.

Chapter Four
Results: Intensive Case Managers Speak Out

This study's aim is to explore the experiences of people who work in intensive case management. In order to best do this I will present my findings using the words of the intensive case managers themselves. Their experiences have been organized into categories. The three categories that emerged from the interviews include; The Person is Not the Label; Doing Work Differently and; Us Versus Them. In the first category the values and the beliefs of the participants are explored. The second category discusses how having these values influence the work they do. The final category examines how the participants 'fit' into the traditional mental health system and their experiences using intensive case management in the existing 'mental health culture'. Each of the categories will be explored and explained through the use of quotes taken from the interviews. The section will present recommendations that the intensive case managers made during their interviews.

The Person is Not the Label

This category emerged out of the way intensive case managers spoke about their work, their roles and most importantly their clients. It examines the beliefs and values that shape the way the participants work with their clients. Although this category was the last to emerge from the data, it will be presented first as I feel it provides a backdrop to the other categories.

This category has two main sub categories; respecting the person and moving beyond the symptoms.

Respecting the Person

Intensive case managers describe themselves as having a set of shared beliefs that influence the work they do. Although each individual team member is unique, there is a commonality of beliefs and attitudes that provide a foundation for the work that they do.

> We haven't really discussed a philosophy as a team but I can see underlying notions are very, very similar (#2, 12).
>
> The philosophy of the team has to be a team philosophy. It can not be the personal philosophy of one person. (#9,8).
>
> It really helps if you are all grounded in why the program exists - like why are we funded and you have to talk about it so that everyone on the team can also sort of internally understand why they exists, you know, why is this team here, Why is this work different than working in an institution. Part of that internal understanding helps you to then understand what your work should be. (#3,6)
>
> Staff are all pretty much all on the same wave length. It's like you know what the right and the left arm are going to do. (#6, 13).
>
> We all believe the same things you know. (#6,6).
>
> Attitude is critical, it's important that staff are working on the same thing and the same philosophy (#7,5).

Not working "on the same thing" or within the "same philosophy" negatively impacts on the clients.

> If we're not working on the same philosophy, it's really difficult to help the client move along because one person is telling them one thing and another is telling them something completely different (#9,8).

This "philosophy" appears to be made up of a number of different beliefs and

values. **Respect** for the client was identified by participants as essential.

> I think there has to be commonality of respect for the clients or you wouldn't be able to work at the team. (#2,12)

> First of all they are human beings and they are entitled to a certain amount of respect (#1,3).

> I'm going to treat them with respect, I'm going to treat them with dignity. (#2,2).

Part of respecting the client is described as acknowledging their individuality.

The need to be flexible and responsive to the unique needs of each client is highlighted.

> You don't go in and sort of say well, this is what we tend to do or this is what our rule is. You've got to work exactly moment from moment depending on where the person is, what their needs are and what would work best for them at that moment. (#8, 15)

> You just have to change your style with each client that you are with. (#2,4).

> You need to sit down with the individual and listen and clearly identify what it is that makes them tick. What it is that is important to them and everyone is different and then you can find something that will give their life meaning. (#7,13).

Being **non-judgmental** is an aspect of respecting the individual. This includes accepting people for who they are and being tolerant of differences. A number of participants highlighted this.

> You have to be tolerant and be able to accept yourself and your differences in order to effectively work with other people and accept that they don't have to change. It's not my job to change them. (#2,10).

> You've got to be able to be in the client's world and not be to judgmental-not be judgmental at all about substance use and about their appearance-about what's important to them. (#8,4).

> You have to be flexible, open-minded, tolerant and have an ability to take people as they are to be part of this team.(#2,12).
>
> It's about connecting with the client on his own turf and accepting him. That is what it is really all about. (#1, 8).

Being non-judgmental is described as allowing clients to make choices even if they are choices that the intensive case managers wishes they wouldn't make.

> I believe, that people are allowed to make choices in their life even if I see their choice as the wrong choice, from my personal belief system. So, for example, it's not uncommon to see our clients using drugs, exchanging needles. You drop them off after they get their money and you know they're going to make a hit around the corner. (#9,15).
>
> I think you need a very positive and open attitude. The people we are working with are adults and we have absolutely no right to voice our own biases and opinions on them. I mean if a client is out there actively snorting coke and stuff, it's not my right to say I don't really agree with what you are doing. When they say they are ready to change, my role is to make them aware of the support available and if they ever want to get off it, I'm there for them and there are things here to help them. But it is not for me to judge what they are doing (#7,16).

Moving Beyond the Symptoms

Intensive case managers describe themselves as working with the **whole person** and moving beyond symptom reduction to focusing on working with all aspects of the clients life. Two participants identified the work as being rooted in 'Maslow's Hierarchy of Needs'.

> Well I think for me the number one thing is Maslow's hierarchy of needs. You need to have a decent living environment that is number one and that is our biggest problem is having people in that awful area. They need to have a close network of systems working together, they need to have affordable food, they need affordable leisure, it needs to be a range of service. (#7,11).

> It's like looking at Maslow's hierarchy of needs you know, which I guess I'm really grounded in. The reality is that people need to live and that people are people. (#8,3).

The traditional focus on symptom reduction and the reliance on the medical model is described as incomplete and unfinished because it does not focus on **quality of life**. It is seen as simply the foundation upon which the real work that makes the difference to the clients begins.

> It needs to be much more of a holistic approach instead of this medical model approach. What I think makes a difference is that we build trust with somebody. It's the non-medical approach that makes the difference with these clients and that's what is needed. You've got to look at what is a way more innovative way of helping these people have a better quality of life and I think quality of life should be instead of just "okay once we have their meds in place then it's solved" then once every two months or once a month for ten minutes that's, I'm sorry that's not good enough. (#7,12-13)

> When you have a philosophy that is holistic and sort of looks at all aspects of the person including mental health stuff but also all the other stuff, it allows you to see the person as whole person rather than just a group of symptoms. (#5,13).

> I think in doing this kind of work we get to see people in their whole life. We get to see how folks basically function on a day-to-day basis and get to meet their friends, and their neighbors and see their housing situation. Our assessment can be way, I think, more thorough and present the whole picture of a person's life.(#8,1)

Others describe seeing the person in a more holistic way. This focus on seeing the 'whole' person appears to be related to their belief about respecting the individuality of a client. If the intensive case managers were to focus only on the medical aspects of the individual, they would be violating their belief of respecting the uniqueness of the client.

> I think that we are able to see people in a more holistic way.(#9,4)

> It gives me a much better sense of who of the person is if you look at it from a holistic point of view. (#7,3)

This allows participants to see the "person beyond the label" and brings a sense of 'humanness' to the work.

> I hate the labels because most of the people I deal with are called difficult or non-compliant. The label does not define the person. (#2,8)

> I feel the humanness should take precedent over the clientness. (#4,4)

One of the nurses describes how she is doing her whole job now and sees the work she did in the past as incomplete. Her outlook has changed and if she returns to a more traditional setting she will go back with a broader outlook.

> I feel I am doing my job and I'm not just doing one little piece of it. I feel I'm contributing more to what I actually am. I am a psychiatric nurse and I should be not just looking at meds, meds are important, of course, but there is so much more and I feel that I should be looking at those other areas as well. In that way, I like it much better, even though it is more challenging (#5,2).

By including the social welfare needs of their clients in their assessments and treatment plans, intensive case managers move away from a more traditional medical model of practice. One intensive case manager speaks of her experience working in a CMHC.

> It's funny. When I left we did a sort of mini-evaluation and I had good results but one of the comments was that I needed to focus more on the medical concerns medical/mental health concerns of the individual and not the other issues. To me that's like that is the work we do. Life is not just the medical/mental health diagnosis at all. I almost kind of felt proud. I did look at the mental health of course but I looked at the other issues and I even discussed and brought up these concerns because it is a very holistic kind of work we do. Where as at that team, it's not what they do. (#8,15).

These beliefs and values coupled with their smaller caseloads, influence the way the intensive case managers work. This will be explored in the following section - doing work differently.

Doing Work Differently

As intensive case management moves staff from the office setting to the streets, roles, interventions, and the goals of therapy, all change. This category examines the implications of this change in their day-to-day work. As mentioned in the beginning of the chapter, all these pieces are related to and influenced by staff's beliefs and values. When intensive case managers describe their 'typical day' their beliefs are visible. This category is therefore not so much a separate entity as it is a different layer of their experience. It provides a deeper insight into their beliefs and values by showing them in action.

Working in the community impacts on all areas of the intensive case managers practice and their stories reflect their focus on developing strategies to work on the street and in the clients environment. Four sub categories emerged from this category: hitting the streets; new roles; redefining therapy ; and taking care of each other.

Hitting the Streets

As therapy moves from the office to the street many new factors come into play. The participants describe the impact of 'losing the office setting'. Staff are

no longer available in the office next door and one is required to work in the client's environment in which the staff have little control. Rules change and office protocol for both staff and client shift in favor of the client.

The pace of the day is described as hectic and staff must be "on" at all times. Intensive case managers describe having little control over the way their day goes as they move from one situation to another. Although appointments are often scheduled, they are apt to change as staff juggle their schedules in an effort to meet the needs of their clients.

> Well, the most important thing about a typical day is it's frequently chaotic; so if you think your day is going to work out one way, it often works out totally different. More often than not, the day that I set out to plan at 8:30 in the morning is very seldom the day that I talk about at the end of the day. So, chaos is probably the name of the game.(#2,2).

> I come to work, the phone rings and whatever crisis is going on at the time is the one I'm with. (#1,1).

> The work doesn't tend to be routine the way office work would be. We work with whatever the issues are on that given day. (#6,1).

When providing service on the street rather than in an office, staff lose control over many factors. **Staff safety** becomes an issue. Because staff no longer has immediate access to other staff or to clients charts or telephones the intensive case managers describe planning their visits carefully and identify the need to be keenly aware of their environments. As their work moves from the safety of an office to the 'unknown' of the streets, certain precautions must be taken. This participant talks about the importance of planning visits.

> When I go into a building I'm aware of where the exits are, I know the client's address and who their doctor is, I know that, if I'm knocking on a

> door, not to stand in front of the door in case someone comes at you with a knife. I mean you just have to stand to the side (#7,7).

This participant describes the loss of control. Not only does she have to be aware of the client but she also has to be aware of all the other people on the street and in the hotels that she visits.

> In outreach you have so many other variables you have to look at that add to your stress, like drug addicts on the street, hotel managers or just other people in the hotels that may be a little unstable and you have to take those things into account (#7,1).

The need to be aware of your environment is described as 'constant'. These two participants describe this as having to be 'on' at all times.

> In this kind of work our days are basically jam-packed. We're on every minute, as you know. (#8,15).

> You have to be with it all the time. You can't be off in some other world thinking about your personal problems or anything; you need to be always aware of where you are and who you are seeing (#7,6)

> Most work with the clients is done in their homes and home environment.

Participants identified a number of stressors associated with this. **Isolation from other staff** was often cited as a contributor to stress and intensive case managers described their experience of 'aloneness'. Not "having back up" and having to "rely on my own skills" was also prominent. This solitary nature of the work is seen as increasing the need for well-trained professional staff. Participants described this experience in relation to more traditional mental health settings like a hospital or a mental health team.

> If you have a crisis that you're having to deal with then you have to phone people to get the next person covered whereas at a team there is usually someone to back you up, someone to take over that appointment. We don't have that (#5,1)

> I think your assessment skills have to be really excellent and you have to be able to figure out and prioritize what you can do in a situation. I mean can you get the person there on their own, do you need back up, the police and ambulance ? (#7,3).
>
> We work on our own a lot. I mean we do have access to other staff but it's different than in the hospital because there you always have people within close proximity that you can draw on immediately. (#6,8).

The shift from working in a hospital or team setting to working on the streets in the poorest area of Vancouver was at times "overwhelming" and was emphasized by one participant in particular.

> When I see girls that look like they are 12 years old, walking down the street stoned, prostituting, that really gets to me (crying) (#5,3).
>
> Just two days ago a girl was murdered you know on Main St. not far from here [name of client] told me yesterday but I heard it on the news as well #5,3).

Staff know all too well the impact this environment can have on people and express a sadness when they see a 'new' person in the area.

> You know it breaks my heart when I see a young girl working down here working the streets. When I look at her and I see she's fourteen or fifteen and she's got a beautiful smile and she still had physical beauty and I know ten years from now the probability is pretty good, if she is still alive, I will probably be working with her (#2,19).

Sometimes the intensive case managers need to leave the environment and take a break.

> Sometimes you have to get out of the environment or you're going to go crazy you know, go some where nice for lunch or just sit somewhere quiet, the noise down here can be overwhelming (#5,13).

There is a recognition that clients also need to escape. This is described as pleasurable for both the staff and the clients. This reflects the intensive case managers' focus on seeing the individual and recognizing the person as more than just a cluster of symptoms but instead as a person who experiences the same stress from the environment as they do.

> You take a person out for coffee, you take them out for an ice-cream cone - I mean some of the clients I work with have never been to a Dairy Queen in their life - not that Dairy Queen is my idea of fun but - a lot of things people take for granted are somewhat far removed from what their idea of normal is - so you take them for a drive, take them to Stanley Park, take them to Kerrisdale, take them for whatever it happens to be - just get them out of this environment (#2,3).

Another participant describes this as doing things that "ordinary people do' and as lessening the distance between the 'client' and 'staff'.

> Things that ordinary people do, like go to movies or go for drives or go to the beach or whatever, it makes it much more pleasurable, much more real or much more life-like and not as stayed and sterile and mind-dulling as simply keeping your distance from the client (#4,7).

New Roles

The solitary nature of the work coupled with the focus on quality of life leads to a much broader role for staff. As the focus shifts to caring for the multiple needs of the client rather than symptom reduction, intensive case managers are required to perform an array of duties within a range of systems. Because much of the work is performed individually, staff must become more able to handle a variety of situations on their own. Nurses are required to do work that would traditionally fall within social work such as accessing benefits and social workers are required to perform tasks that are traditionally within nursing such as

medication checks and monitoring side effects. The participants discussed this **blurring of disciplines** and the impact it had on their roles. Learning to interact in all these new systems is described as difficult at times as each discipline has a set of rules that are followed and may be foreign to someone entering into it for the first time. One of the intensive case managers described it this way.

> I think it is critical that everybody understand the illness whether you are a nurse or social worker, that you understand the medication and the systems and how they effect people and also the diagnosis and how they effect everybody. But that is only a part of it is more: "how does that then impact on the individuals quality of life and their social contacts ?" (#7,21).

This nurse talks about her broader responsibility.

> I find it much, much broader. In the hospital it was much more medically oriented, of course, and a much narrower view. It was either symptom management, watching for side effects of meds, watching symptoms, this kind of thing. It was so much smaller and very little talk about discharge planning. (#5,1).

The multiplicity of roles could be overwhelming, however it is also described as a benefit to staff as they have opportunity to access other's expertise and expand their skills.

> I am a social worker, I'm a nurse, I'm a psychologist, I'm a doctor, I'm a friend, an advocate. I like that- sometimes it is overwhelming, yes, and there is a lot I don't know - but there is a lot I have learned (#5,2).

> The team atmosphere, I mean the uniqueness of it is that everybody brings something and we can utilize that so that it's diverse and it's dynamic and you use expertise in different ways and hopefully you get sort of maximum for the clients. But also that maximum for yourself so you want continuous growth (#9,8).

> I love the idea that we all come from different disciplines because I can talk to[social worker] about social work things, [rehab staff] about leisure skills and vocation and stuff like that. I mean, that is not my area of expertise and it is so nice that I can go and consult with one of the other members on the team and then [coordinator] has got coordinating and

> supervisory skills and she is well-versed in all that area. It is wonderful. I love that. I have learned so much from my co-workers (#5,9).

At times the multiplicity of roles and needed knowledge is overwhelming.

> It's not just mental health anymore. It's the multi-disabled individual who has drug and alcohol, mental illness, abuse history and all those combined. Sometimes I think: "my God where do you start ?" and I feel at a loss. I certainly don't have the expertise to deal with all those issues.

Learning to **interact in all the new systems** can be difficult as each discipline has their own set of rules that are followed and may be foreign to someone entering for the first time.

> Each discipline has their own set of rules and I am not always aware of what the rules are or agree with them, I remember you telling me that social services was a convoluted system and I didn't know what you were talking about but I sure do now. In the hospital, I never had to deal with social services or try to access housing for people (#5,3).

This nurse speaks to her expanding role and acceptance and enjoyment of it. Now she believes there is more to her role of psychiatric nursing than 'meds and side effects'. Her perspective has shifted and if she returns to a more traditional system she will be different.

> I'll tell you one thing: I'd be far more vocal about discharge planning when I went to ward rounds. I wouldn't just be sitting there spewing off signs and symptoms and side effects and medications and all this stuff and yes sir, no sir, thank-you very much sir to the doctor and the social worker and psychologist. I would be far more vocal. I would say no. No. I disagree and this is why and come on out and I will show you why (#5,3).

It appears from this quote that intensive case management allows staff more freedom to define their roles and responsibilities. This nurse describes how limited her role was role in the hospital if she returns to this setting she will be different.

Redefining Therapy

This sub-category emerged from the way intensive case managers do their work. It highlights the beliefs of intensive case managers in action. Intensive case managers describe the challenges they face trying to "engage" clients and the different strategies they must use in order to connect with clients. This 'therapy' or approach is different than what is used in a traditional CMHC as many of the clients referred to intensive case management programs have either not connected well to services or been refused by them. The focus is on **building the relationship** and sometimes just on **'being with'** the person.

> I think the neat thing about this work is that you don't start off presenting yourself and your work as being a medical office-based, therapeutic sort of presentation. Basically you're there to walk somebody through their daily life issues and I feel like in this kind of work you can honestly, honestly just be with the person and if you present that kind of rapport with someone -we're just here to be with you and there is no front and there's no judgment -it allows the relationship to develop. (#8,2)

Intensive case managers describe themselves as being grounded in the belief that being with someone is therapeutic. These intensive case managers emphasized the primacy of the relationship and were aware of the reluctance of some clients to engage. The relationship with client was described as both a part and a piece of therapy as many intensive case managers see just being with a client as therapeutic. This intensive case manager describes why he believes this is so.

> One of the few interesting things I have ever heard at a conference was this guy who worked for an organization and he studied why there a was better rate of improvement and longer stability in third world countries - this was like in India and Nepal and Malaysia and all that as compare to central Europe which had all these hospitals amount of pharmaceuticals

> and every modern sort of advantages and the key variable was that the people who had best success were with their family so the healing element is the human contact that was significant, you know. (#4,3)

This participant talks about the importance of getting to know the person. This highlights how respecting the individuality of a person is played out in practice. Again the human contact, or as this participant puts it, being with the person is emphasized.

> Find out what their interest are, their activities and just be with them. Just being with people is the most important way to form relationships. Some people are chatterboxes, some people can be just silent and you just have to change your style with each client that you are with and don't assume it is naturally going to happen because some clients will be with you because you're going to buy them a cup of coffee and if that's the way it is, that's the way it is. But I really believe even being with a person and buying a cup of coffee when you see them two months down the road and they're having they're psychotic or they're behaviorally disruptive, because you have that bond - that form of relationship, it's much easier to approach someone that you've spent time with and say, what can I do, can I help you, do you need a ride home, whatever it happens to be (#2,4).

The approach to the relationship is described as different than tradition mental health services. There is no assumption that clients are motivated to receive service and staff must move at the **client's pace** in order to engage clients. Often visits are very social in nature to start and eventually have more specific tasks. Again the focus is on 'being with the person.'

> I think that in an office or a team there is an expectation that the client is motivated and it has to be fairly clear that they are motivated and in this kind of work the motivation comes from the staff and I think that's really, really like the crux. (#8,2).

> We go at the person's pace, you know, we are not pushing, we are not demanding, we are not insisting. We're not having any expectations that they need to meet, we are just really able to be with the person. (#8,2).

> It's a matter of engaging them and finding a way that you can treat them in a fashion that is less arbitrary than the team. A team is you're welcome to come and you're welcome to stay home (#1,3).

> I mean initially when you get clients a lot of your visits are very social and you are just having coffee hanging out with the clients and trying to get them to engage. (#9,7)

In addition, because of the intensity of the work done with the individuals, the relationship is described as "deeper" or more "real".

> I think that it [intensive case management] allows you to develop a deeper relationship with the individual because you can be with them on a more casual basis. (#8,1)

> I think the client actually sees you as a person a person who cares because they see you come into their neighborhood without fear, without having a condescending manner, with more of a consciousness of who they are. We see them as an individual and then they will relate better and they will work better with you. I think it takes away from that professional barrier that is set up in an office setting so you will definitely get a lot more truth. (#9,4)

The issue of boundaries was raised as an important aspect of the therapeutic relationship. As intensive case managers move from the office to community to perform their work, new and different boundaries must be established. The natural boundaries set up in the traditional office setting are gone and need to be replaced by new different boundaries. The importance of this is heightened because of the intense relationship between the intensive case manager and the client. The process of establishing these boundaries was described by a number of intensive case managers. These boundaries must be continually reinforced as it is easy to slip from goal-directed visits to less therapeutic ones.

> One way of doing this and of establishing boundaries is referring to ourselves as staff. For one thing I repeat to clients quite often that I am a staff person. I call myself the community worker or whatever in any way sort of that their hear that, so that they don't think I am labeled as friend (#8,9).

> A lot of my clients say to me, you're my friend because they don't have friends so they think that automatically. You're working with them, you're going on outings with them and you're treating them like a friend so how I tend to deal with that, I say, it's like a friendship when we're out doing this but I am your nurse. Yes it is like a friendship. Yes we do get along really well. I wish that you could have more friends in your life and but it's really nice, I'm really glad that you were referred to us as a client and that we can work with you. So, sort of gently in that way but they still keep referring to me as their friend. (#3,1).

The importance of being conscious of goals and the necessity of 'mindful' practice was emphasized by many of the intensive case managers. This appears to be related to the loss of natural boundaries and the social nature of the visits.

> You have to be forever conscious of the fact that if you are working in the client's environment, you still have to maintain a therapeutic rapport and refocus and redirect so that it is not just a social outing although, I mean, that is important but sometimes dividing the visit by saying okay, fine, let's have coffee and talk about what you did for the last three or four days or since the last time I saw you and what's new in your life but all right what's the business at hand (#9,5).

It is described as easy to lose sight of the goals of the visit and when this happens the clients may begin to view the worker as simply a "free coffee".

> I think a lot of people who do outreach at first get caught up in and they forget that they are there for a reason and they lose sight of their goals are, they forget what the client's goals are and that milieu is totally lost and I think that's where you get clients that think of us as free coffee because that milieu has been destroyed (#9,4).

This is contrasted to a visits with a client where the milieu is healthy.

> Versus the client who say, okay now we are going to go to my FAW [financial aid worker] I've arranged that and I would really like to do this. It

depends on how much time you have or they start as soon as you arrive at their home saying -how much time do you have? These are some of the things that I would like to get done today so the milieu is already there (#9,4).

Taking Care of Each Other

Much of the participant's time is spent working alone but time together is seen as essential. Although much of this time is directed at passing along client information, a great deal of support, reinforcement and taking care of each other occurs. Sharing stories and experiences appears to have three functions: a clinical tool, a stress releaser, a way of receiving positive feedback and as a means of passing along information.

As a clinical tool sharing the days events with the group or with another person allows the intensive case managers to reflect on the day's work. This type of **debriefing** is described as allowing the participants to process their day. In addition it allows for clinical supervision and suggestions from other team members. Discussing **their reactions to clients** is described as essential.

This participant discussed the importance of creating an atmosphere where staff feel they can talk openly.

> But you see I believe that you have to create a milieu where staff have the opportunity to ventilate you know and that whatever their feeling that they are supported and that their feelings are recognized and that the message is never: "well you shouldn't feel that way about an individual". That the message is one of acceptance and that we can somehow go from people having an opportunity to ventilate to working some of that through and then coming up with a plan that will help them shift how they are reacting to the individual (#6,14).

> I think what becomes critical is that we then discuss sort of how we are feeling about the client and how we are dealing with them and then look at strategies. So we are all involved and on board with the same plan and that we don't get into sort of mothering or taking care of people and that we respect them as adults and that kind off thing. (#6,11)

The participants describe this as a way to deal with their own stuff and reconnect with the philosophy underlying their work.

> Debriefing is also a way to work through your own stuff and your own thoughts and feelings. (#8,11)

> I mean everyone has their own personal triggers and certain things are going to trigger me that wouldn't necessarily trigger you. A lot of it has to do with our own sort off personal issues so you have to be in an environment where you can talk about those things and they can be acknowledged. If it is too difficult to work with a client, then there is that support for you not to see that individual. (#6,13)

> I think it's important to meet everyday so that you talk a lot, to debrief a lot, so that you're hearing not only the facts of what happened in each day and situation but how a person felt and what they went through emotionally. It's almost like breathing together. (#8,5)

Time out to share experiences and to "vent" about one's day are expected. Each member is expected to provide support to others. There is an assumption that team members can be called on at any time to understand and listen to one another's experiences. This intensive case manager describes it as **ensuring the team's mental health**.

> Mental debriefing is probably the number one thing the team does in terms of ensuring its own on-going mental health process. The work is not easy. It's never easy and we have debriefing support around difficult issues and just emoting. (#2, 13).

The sharing of stories is described as **purging** the day's events.

> People are professional - they share things that need to be shared; a significant piece of information or anecdotes. But aside from that there is usually time for people to purge themselves of nauseating experiences. (#4,8)

Sometimes the intensive case managers are not aware of how absorbed in their work they become.

> You could be absorbed with some issue from work and not even aware of it ...you are not even self-conscious that you are thinking of it until someone points it out, you know, like dandruff on your shoulder. (#4,8)

Because of the shared sense of understanding the group is considered informed and is able to understand the intensive case managers' experiences.

> Ya, it feels good to be listened to about what you've done by informed listeners who can comment on it or joke about it or ask you or whatever and so it does you all have to do a bunch of crap all day and then to go home with this, it feels like having stuff in your pockets like mud or junk and not being able to work and not taking it out. It's a way of taking it out (#4, 9).

This support is seen as essential. The importance of sharing is highlighted by the one intensive case management who did not describe feeling supported.

> I don't get it (support) there, I get it at home and I shouldn't have to go home to get that. You need to have another worker that you can share the load with, that understands your case load and what you are trying to do and I understand what they are trying to do. We are working on the same wavelength. When we talk about something, we are talking about the same thing. When we are looking for successes we see the same sorts of things and you need that. That is so important. I think that is most important - not even for the work, just for having a person understand what you are doing and to be there (#1,12).

Sharing provides support and validation to the workers.

> It makes you feel good- if you had a difficult situation and you are able to solve it and it feels good because you've done that and it feels good to tell

> the story of how you did it and it is sort of a passive acknowledgment by your peers.

Being supported includes being able to **trust** your team.

> The role of the team should be that of support and there should be an incredible amount of trust among the members and there should not be a co-dependency but an interdependency so that each person's area of expertise can be utilized to the max (#9,7).

> Most of the time I feel supported by my team, yes. I know if I'm in a crisis situation, which often happens, that I could call for somebody and I know in the same way I know I would do my utmost to be there if a team member phoned and said, you know, I've got trouble with so-and-so at such a hotel could you come on down, I'd be there and I also know they'd be there as soon as they could. So I don't feel as if I'm alone. Because I'm in the team, I don't feel I'm alone in the Team. (#2, 12)

In addition, it is essential that there is a feeling of everyone working together and sharing the load.

> You know there are no sluggish people on the team and there is not that feeling that people aren't pulling their weight, so you're busy at least you know your co-workers are also (#6,6).

This intensive case managers describes what happens when this is not the case.

> If you feel like you're carrying the majority of the work load but not getting the support, then it just festers, it's like a pimple on your forehead you know, it just gets picked at, then festers (#9,8).

Us Versus Them

This last category emerged out of intensive case managers descriptions of themselves and the mental health system. The use of the term 'we and us' can be found throughout many of the quotes and is often used in contrast to 'they or them'. Intensive case managers appear to use these terms to differentiate themselves from other mental health staff or other people in general. 'We'

generally refers to the intensive case management team; however at times, it referred to intensive case management in general. 'They' or 'them' appears to be applied to any one person, group of people or program whose beliefs or values differ from those of the intensive case managers.

This category emerged from an examination of the language and descriptions intensive case managers used in regard to themselves and others and from the location that intensive case managers placed themselves within the overall mental health system. This category has five sub-categories: self-identity; beliefs about them; feeling misunderstood; when two worlds collide; and redefining success.

Self-identity

Intensive case managers describe the work they do as holistic and see themselves as actively trying to meet the needs of their clients. They identify themselves as doing **"client-centered work" that makes a "difference"**. They are critical of the medical model as they see it's focus on symptom reduction as incomplete.

> It needs to be much more of a holistic alternative approach instead of this medical model approach. What I think makes a difference is that we build trust with somebody. It's the non medical approach that makes the difference with these clients (#7,12-13)

> I am actively involved with solving and with dealing with these issues. I am not simply viewing these issues from my desk, commenting sympathetically about them and then sending the client back out into the environment while I sit comfortably at my desk. (#4B,3)

> We are all client-oriented and the client has to want the needs and see them as needs or wants whatever and that it is not us saying: "this is what

you need and that is essential". If we ended up with somebody being from the old school kind of thinking, I think we would have big problems (#5,9).

Even "difficult cases" can be reframed positively.

> Even though we get a referral that looks extremely difficult I think that there is a belief that, you know, let's take a fresh look at this person and see what they are able to do. I think that we show that by the fact that there has only been pretty much been one or two clients in the history of three and a half years that we have refused to see, unlike some of the mental health teams who have refused to see someone but we have continued on with them (#6,7)

Some participants felt that **other mental health staff recognized their work**.

> There is a mutual respect [between intensive case managers and case managers in CMHCs] of each other's area of expertise. (#9,11)

Some participants felt this recognition was due to the fact that they made the case managers' jobs easier because they provide support and assistance by working with the case managers clients.

> I think they generally appreciate the fact that we are around because we often make their jobs easier. (#2,11)

> I think we get a fair amount of recognition in the teams from the case managers who we have worked directly with. It's whenever you work directly with their clients that then people begin to understand what we do. (#6,10)

Although participants expressed the belief that others recognized their work, they sometimes felt that people outside of intensive case management **devalued and de-professionalized their work.**

> In some areas it's almost like we're looked at as a mental health volunteer position, like an MPA person or a CMHA volunteer worker or whatever and they don't realize that we are professionals. So I think it's always good to make sure that people are aware of our areas of expertise (#9,7).

> There is the odd one that I think they seem to think we're just like a bunch of chauffeurs or we just take them for coffee and that's all we do; that's all our role is. They don't see us as being far more proactive than that really genuinely trying to help the client reach his potential. I think there is some people and those people I think are often from the old school or they have a different philosophy than us. (#5,12)

> I feel that I am kind of - it may be the wrong interpretation but my interpretation is that I am sort of a free floater - you know, a guy that every team should have but no one knows what he does. He doesn't really do anything he sits around having coffee with these guys and makes a bunch of phone calls but doesn't really do anything. (#1,10)

Because of the nature of their work intensive case managers tend not to dress in typical 'office/professional' clothes and therefore lose the 'professional look' that is often associated with business suits or office dress. This intensive case managers goes on to explain the impact of this.

> Honestly, anthropologically speaking, even in the 19th Century, citizens were people who wore ties as a status and did not work with their hands so they were superior to the people who did grunt work....Somehow it made the jump that working in an office meant that you had more intelligence and more knowledge. (#4,10).

Another participant describes why she thinks people devalue intensive case management. The importance of having an office is highlighted and reflects the traditional definition of professional.

> Maybe they have fears. Maybe they feel the work is beneath them. Maybe it's because they're not in an office, they're not in total control. It's very threatening (#3,3).

During the interviews, intensive case managers located themselves in a number of different places in the mental health system. Some saw themselves as a piece of the overall system 'as a spoke in the wheel', others saw themselves as

a 'total outcast'. While the majority of the staff felt they were a piece of the system, they all saw themselves as somewhat different from traditional mental health services and many separated themselves from CMHC's.

> I do believe that we are all in this together and our team, our program, is part of a larger team which consists of the mental health teams, the hospitals, the whole all the services. So we are all in this together. (#8,10).

> I mean if we look at it as client-centered, the client is in the center and we are all just spokes that go around the client so we work together. (#9,11).

One participant placed himself totally outside the system.

> Oh, I am not aligned with the system at all, I am a total outcast and I actually have thought I'd like to maybe get out of the system all together and work with the clients themselves as sort of an advocate. I think that is where I would get most of my satisfaction - being a shit disturber (#1,).

Beliefs About 'Them'

During the analysis it became clear that someone can be placed in the category of 'others' for a number different reasons. These include: having beliefs that contradict intensive case managers' beliefs; not valuing outreach; and deprofessionalizing intensive case management or the intensive case managers themselves. When describing themselves and the way they work, intensive case managers often contrasted themselves to 'others'. 'Others' are identified in a variety of ways:

As having a **superficial relationship** with the client;

> An office worker has a verbal/conceptual interaction lasting around 20 minutes. That is by comparison an episodic and superficial contact. By comparison it is staid and officious contact. (#4,3)

As **burned out**;

> I mean we had one therapist saying 'oh come on that is ridiculous. He [client] is never going to do that' and yet he did very well. I think we have to say that we are willing to give the support and stuff I think. A lot of people have been in the system too long and that is not to say that people who are in the system for a long time are not effective I mean there are some people who have been in the system a long time that are very effective but there are some people who are just burned out. They just see the client as really ill and see them not as people but see them only as someone really sick. They are just kind of biding their time and that is unfortunate and if a person gets them as their therapist then what can you do (#7,10)

As **not seeing the real picture**;

> I mean, if you were in a Team in your lovely little office on the West Side or the West End or South Team or Kitsilano Team, you don't see the cockroaches and the rats and the used syringes and dirty condoms and the urine and feces in the bottles or on the floor of the hotel rooms that we sometimes visit. You don't see the reality of what the clients have to live with. The hallways of the hotels that we sometimes visit. They don't stumble over the bottles or whatever paraphernalia when clients come to their office. A lot of times, the clients will clean themselves up a little bit before they come to the office. They don't see all that shit when they're in an office. (#9,10)

As **not valuing outreach**;

> There are tons of them that don't believe in outreach! It is part of the problem. They don't see it as being part of the system. (#1,7).

and sometimes they are seen as **simply not caring**.

> A [community mental health team] team is: "you're welcome to come or you're welcome to stay home; you're welcome to be well or you're welcome to be sick so you choose", and I don't believe in that approach at all. (#1,3)

> You know how they [hospitals] are so quick to discharge people and they just don't give a shit where they end up. (#5,11)

Intensive case managers refer to 'other' by a variety of titles including; elitist assholes, white elephants, office boys, old school and insiders. These terms do

not only separate 'others' from 'them' but also describe the reasons they have been differentiated. This participant refers to 'others' as elitist assholes because they see intensive case management as a step below mental health work in a community mental health centre.

> They're elitist assholes and if that's their opinion I don't have the time of day for them because as far as I'm concerned, we're helping the person fit in and adjust to society so I just have to laugh at somebody like that. Like, you know, I think you and I've both had an experience where we had one guy in our group say, only people who need experience would apply for ***** or ***** (intensive case management teams). Well, as far as I'm concerned, it shows where he's coming from and what level he's coming from and he's not worth the time of day. (#3,3)

White elephants and insiders refer to people who do not do outreach.

> If you are sitting in an office, I like to refer to them as white elephants, you are very much in tune with what the client is telling you but I don't know that your eyes are actually open to outside that room. (#9,4)

> Office boys, by comparison sit in their offices - they see the clients for three minutes a month and we see the client an hour every second day. (#4,9)

"Old school" was a term used on a couple of occasions by participants and appears to identify people who rely on a traditional medical model approach. This term is perhaps the most derogatory as people from the old school are described as paternalistic, controlling and having narrow views of health and illness. They are associated with terms such as rigid and negative and seen as being pessimistic about the abilities for clients to grow and change.

> I think there are some people [who don't appreciate intensive case management] and those people I think are often from the old school or they have a different philosophy than us. (#5,12)

> It would be horrible if we wound up with staff who were super controlling or negative, you know, someone from the old school. (#7,5)

Feeling Misunderstood

Many participants believed that people outside of intensive case management cannot, and do not understand the experience of the intensive case managers.

> No one really has any idea what I am doing I don't think they really can, they expect you to send people to the hospital (#1,10).

There is a belief that intensive case management has to be done to be fully understood.

> I think to fully understand it (intensive case management) is to have people come out and work along with us, it's not something you can explain to someone, people just don't understand what our day is like (#6,3).

She goes on to say.

> I think, as we have talked about before, by presenting cases that really demonstrate the work that we do with people because then people can visualize it, they can think of an actual client (#6,4).

Not only do people not understand what intensive case managers do they don't recognize all that these workers have to deal with.

> Some people at the top don't recognize what you're having to deal with in a day, they minimize it (#6,3).

Many of the intensive case managers described feeling that others could understand their work better if they "just came out" and saw what they did. There was a belief that if 'they' just came out and did intensive case management 'they'

would change the way they worked with the clients. This was especially true of 'others' outside the community mental health system.

> To get these guys to understand, I think they should come out they should rotate. They should give me a worker. You need to spend a lot of time with them, and show them what really happens and get them used to being in the area and walking around down here you can survive - and then maybe rotating someone else. I think that even goes for the hospitals. The PAU and those places should send a nurse down for about two months or a month to orient them to this area and to what we do so that when we do send somebody to the hospital, they aren't immediately, if they can walk and talk, turned around and sent back out again. They can see where they live and the conditions and what they have to put up with and they might be somewhat more easier to deal with (#1,8).

This intensive case manager feels that if there was more community training, staff could see the whole picture.

> I mean, they just don't have a clue and I really think that, I think of my training and I'm sure it's probably the same with other disciplines, there is not enough training and practicums. We have a community practicum but it is not enough. You need more community training and once you are in the job, whether it is in a hospital or whatever, I think people need to get out in the community on a regular basis. Even starting with going out I think that in every job they should get out there in the community and have a look because we should all be working together and we are not. We are working as separate entities. If people saw, if they looked at the whole picture, we could improve the planning immensely but they have to get out and look (#5,11).

<u>When the Two Worlds Collide</u>

Differences in opinion between the intensive case managers and other staff do not happen often, but when they do they are described as stressful. The disagreements between intensive case managers and case managers in the CMHCs are described as the most problematic because of intensive case manager's dual role of working with the client and with the case managers. Even though intensive case managers work both for the client and the case manager they emphasize their responsibility to the clients.

> We are accountable to the client's primary therapist [case manager], but first and foremost to the client and to try and negotiate on the client's behalf and say to their therapist: "hey maybe you're not hearing what this individual is saying" (#7,14).
>
> We have a responsibility to the case manager but also to the clients. We need to support them and to try to negotiate with the case manager and say: "maybe you're not really hearing this individual" (#5,11).

This worker refers to it as tunnel vision.

> Well, just trying to get your point across about what a client needs and they're not seeing it or they're not seeing the need or they're misinterpreting what the need is. Not that I'm always right about everything, I know I'm not, but when you see that a client needs something done and you are trying to explain that to a worker and they are not seeing it or else they have this tunnel vision and, they believe the clients are just manipulating you or whatever. You know: "lighten up a little bit, relax a bit, don't be so rigid" (#5,13).

Not recognizing the client's experience was cited as a cause of clashes.

> I think that differences in opinion can be a big issue. We have run into cases where they [the case manager] are viewing them [the client] as a lost cause. They might not recognize that the client has been through the system so many times that they are burned out and distrustful (#6,13).
>
> What I see in the system from the mental health centres is people getting really burned out and nixing the person off before getting to know them and just seeing them as behavioural or attitude problem or something instead of looking at the individual and saying: "this is a person in severe crisis that has a multitude of problems and so how can we effectively help that individual ?" (#7,10)
>
> I think that differences in opinion can be a big factor when working with case managers. We have talked about people who have an attitude that 'oh don't bother with this person they have been doing this for years, they are just going to end up in the hospital again, so what is the point'. They don't give us the support to try new things with the individual (#6,17).

In response to the question: "do you find working with clients stressful ?", one intensive case manager had this to say.

> I wouldn't be surprised if you, after doing this survey, find that staff find other staff more stressful than clients (#4,7).

Other participants described staff conflict and the state of the system as a source of frustration and stress.

> I think it's when you work with unwell staff. I've always been a true believer that it's never the client and the degree to which how ill they are, it's the staff you work with (#6,12).

> I find it more stressful having to deal with some of the workers out there. (#5,13)

> I find the staff stressful and the system; the system is stressful not the clients. (#7,9)

> I feel stress when I see that it's not the clients agenda we are working on, it's someone else's personal agenda and my understanding of the program philosophy is that we are client-oriented. I get frustrated when some person thinks that the clients aren't behaving in the way they want them to. It's that very paternalistic, maternalistic or whatever fucking attitude (#9,10).

This stress is not just experienced on an interpersonal level but at a systems level as well. There is an understanding that many of problems are due to high caseloads and to decreased funding and there is as sense of frustration expressed at the overall mental health system which is described as having a different set of beliefs and values from the intensive case managers. Again the **system** is described as **incomplete**.

> We work in a system that sees the person as a group of symptoms and treats that and then treatment stops. And it's treatment not rehabilitation. And treatment tends to stop once the symptoms are managed and then it is a matter of maintaining somebody in the community (#7,13).

> Some woman lives in Riverview for three years and all of a sudden she ends up down here-well the drugs, the alcohol. They come out stable but probably fragile as any- can you imagine being looked after for how ever long, all your needs met everyday, secure ? - it's like sending a six- year

> old child out into the community and saying: "now ***** you have to make it on your own-there's a nice little hotel down there and you can live in that room and everything will be fine, don't worry, just go to the mental health centre "...It's like a sentence -I feel like saying: " why don't you just kill them ? While you have them in the hospital, give them a big shot of morphine and get it over with because that is what you are doing by sending them down here" (#1,9).

These participants suggest the system is not looking at the big picture or perhaps not looking at the client holistically.

> The review panels often don't look at the big picture, they just look at the client for the 15 minutes they talk to him or whatever - OK, discharge him. Then the client comes out, still very sick, has no knowledge or insight or anything into his illness or his situation, what he is going back to and then bang, they are out into some seedy little hotel, maybe an appointment to a mental health team, maybe not, nobody to take them. They don't know and they don't care (#5,11).

The system is seen as not caring for the clients unless they are disruptive or cost too much money.

> The chronically mentally ill in the downtown east side are ignored by everyone. There is no advocate for them-absolutely none. They come down here and they are discharged here and it is like we don't want to see or hear you and a lot of the ones I am talking about don't want to be seen or heard either (#1,3).

The clients are seen as attended to only if they are hurting someone.

> Nobody right now is terribly interested that we work with these folks to improve their quality of life because they are not hurting anyone (#8,13).

Economics and powerlessness are described as coming into play.

> It's much cheaper to discharge somebody and let them float through the community than it is to try to stabilize them and then bring them out into the community in adequate housing. It requires intensive labor and no one is prepared to pay the cost. You can talk to people about it and everybody in the business knows about it but no one is willing to do anything about it because they have no political clout whatsoever, they are ignored. Until they get some clout, they will continue to be ignored (#1,3).

In an effort to decrease these tensions, intensive case managers describe trying to market their programs. Having **pride** in their work and educating other staff on their roles and expertise is seen as an important part of **selling the program**.

> If we're selling the program, we're proud of it and we're holding it up and we're doing good work, then it comes back tenfold. So that's the key is always having that sense of pride in the work I'm doing. (#3,4)

> How we present ourselves and the other is by educating other team players as to what our role is and what our credentials are. I started to tell you about this client who has bipolar disorder as well as advanced hemophilia and she is going on to dialysis. We were at the mental health team at the same place and time as her therapist and they started to ask the client questions that she couldn't quite articulate with regard to her shunt and I started to explain it to them and to what was happening and the psychiatrist looked at me and said: "where did you get all this knowledge ?" and I said: "well, 20 years ago I was in dialysis" and he went: "Oh" and I said: "well, maybe you would be interested in knowing what my qualifications are and what my role is." Since then, he has been absolutely incredible to work with but I don't think there's enough education as to what our role is so we have to do that continuously and it's a pain in the ass (#9,7).

> Like, when I'm with other professionals, I love to talk about what we're doing, especially at the interest group. I'm always speaking up saying: "wow, you know, we've worked with this person, we've worked with that person" and the other part of it is because I do speak up so much, I've presented at a number of conferences about what we're doing with our clients, you know, how good it is, so I think that whole pride in the program, that whole selling of the program and working with other hospitals and other professionals. When I go to [name of hospital], the staff can't say enough nice things about our program, about what we're doing. When I go to [name of hospital], I walk in, they're all say hi ******they're all positive, they're all just, you know, thrilled about our program. So, I think it comes from us. (#3,3)

Despite trying to educate people about the teams it appears that word does not spread quickly.

> We have a good reputation but I don't think we are well enough known yet. Since I've started, which will be [date], I think we have got a higher profile but not enough yet. Just for an example, yesterday when I met a new client

> at the [name of CMHC], they had never heard of us before. I mean they had just heard about [coordinator] but they didn't know anything about our program so I sat down with the case manager and the doctor and explained our program in a condensed version of what we do and you know they're saying: "oh gee, that sounds like a good idea". They were really surprised, they had never heard of it so, as an example and that happens a lot. So I guess over time we will get more of a higher profile (#5,6).

Another workers suggests a group approach.

> I think that if we use all our small teams, like if you look at [all intensive case management teams] and, you know, the [another intensive case management team], that as a group, we could actually have somebody educating the other staff and our partners in the organization almost on a continuous basis. Like I think that somebody should be attending all the orientations to represent the outreach teams and, of course, have it very clearly defined among our own teams as to what we do so that people are made more aware of us (#9,7).

Success

Influenced by the goals of their work and their beliefs about clients, intensive case managers develop a definition of success that is based on their clients individual characteristics. Because the goals of intensive case managers focus on assisting clients to improve their quality of life, success can be achieved by finding someone housing or simply having someone go for coffee with you. This is described as creating more realistic goals for both the clients and the staff. Intensive case managers appear satisfied with the smallest of changes and see even the most "infinitesimal" changes as successes. Their focus is described not in terms of 'fixing people' but on engagement and the building of the relationship

This is how one person described his notion of success.

> I think you have to change your view of success. The old success, the sort of institutional success that you have a guy who is acutely ill and you bring him into the hospital and keep him there for however many months

> and the person walks out of the door like he was when he was well....when you're trained like that it is difficult to change your view to see the small change, really small, infinitesimal changes (#1,4).

Normative goals are understood to be unrealistic for many of their clients. There is an understanding of the depth and complexity of their impairments

> I really do believe that some people find it really difficult to do the tiniest things in life and I can understand that, that is okay. So I guess when I think about it the motivation comes from the fact that I feel it's okay that people don't have to perform and they don't have to meet my expectations (#8,3).

In addition, intensive case managers were very realistic about their ability to "save" people or "change their lives".

> If someone is thinking: "we are all going to be saving this population", they shouldn't be working here because we're not. (#8,7).

> So if you are rigid, expecting people to do what you tell them to do and think that by coming down here you are going to change peoples' lives, well that's a laugh.(#2,12).

This intensive case manager defines success in terms of improving quality of life.

> This kind of work is grounded in a strong belief that people have the right to a quality of life, and so, if you're from or, I try to come from, the fact that people have a right to quality of life and so what we are trying to do with everybody is improve their quality of life and we focus on that (#8,8).

Some successes are very obvious others are more subtle.

> When you see clients who go from almost a stuperous state, who couldn't communicate with anybody, now able to sit and articulate what they're feeling when they haven't been able to express their feelings before, and you played some little role in that, it's great. When the client can say to you: "you know, I'm not as sick as I used to be and I think there are people out there who need you more than I do. But I know that if I really need you, I can call but I don't need to be seen three times a week or two times a week or even once a week. A call every month or every two months is sufficient". That's a hell of an accomplishment, especially if they're out of the[name of intensive case management program] program. I like that (#9,9).

> When I see someone who was totally disorganized, could not make a decision and their life was in shambles and after you have worked with them for a period of time to see them functioning in even small little steps be it, you know, the fact that they've gone back to school or they've got a volunteer work position or they're just keeping themselves clean in the sense of hygiene or whatever, it makes you feel good because you had some part to do in that (#9,9)

Many times success is simply having the client talk to you.

> Getting to talk to somebody who hasn't talked to anybody - that is a success (#1,5).

Some clients never move beyond the engagement phase yet intensive case managers still describe a sense of success and satisfaction in connecting to a client.

> But they will see me. They like that. They will talk about what we do-I will say: "what do you do during the week" and they say: "Well Monday I go for my blood-test; then on Tuesday I come and see you; and [name of doctor] and then on Friday you and I go for lunch; and on Thursday there is a hockey game on TV". That is his life and he won't accept anything more than that (#1,2).

The participants described feeling that their successes were not always seen within the system because they are looking for the big change. Developing a relationship may not be a valued goal to the system. By changing the definition of success to engaging a client or forming a relationship many of the successes of these intensive case managers become invisible to the larger system that still defines success in normative terms.

> [Name of case manager in CMHC] is looking at it from a different perspective. He is coming from the perspective of: "does this person come into to the team all the time? Does this person look better than he did when he was first compliant?" You can't look at it that way (#1,5)

> I think you have to be able to be quite invisible in this kind of work. You've got to search your soul as to why you're doing this. If you're doing it because you want to stand out, because you think this is like something really important, that people are going to give you a lot of credit for or because you think it is a special program (#8,5).

As intensive case managers struggle to meet the overall goals of their clients they find that this is not the goals of the system. It is obvious to the intensive case manager that the big system does not support their notion of success.

> The public wants to hear that good money is spent usefully and I know that, I think that we just have to accept that and understand that. People from afar don't really understand the situation unless they're in it. So, people from afar don't understand our kind of work or they don't understand the needs of the client who isn't making his or her needs real obvious. I think it will always be like that - it comes to the survival of the fittest in business. We will take care of those who, through being taken care of, will take away from the pressure on the system. I think that we, in these kind of programs, can get away with helping some of those who aren't as obvious by sneaking them in (#8,14).

Voices From the Streets

Throughout the interviews many of the participants made recommendations regarding the training, hiring and supporting of intensive case managers, this following section is a compilation of what they had to say.

1. Intensive case management is a distinct and unique piece of the mental health system. Continuing education needs to be offered that addresses the unique experiences and challenges faced by this group of staff. Little education to date has been directed at this type of service. Suggested topics include: dealing with the hard to engage client; transference and

countertransference issues; the ethics of outreach; conflict negotiation; and advocacy skills.

2. Eight out of the nine staff interviewed emphasized the need to have experienced staff in this line of work. Because of the isolation and the nature of the clientele (difficult to engage) seasoned staff were seen as essential. Concern was expressed regarding the many inexperienced staff working with this population particularly in the downtown east side. The concern was not just for the staff's safety but also for the safety of the clients and a number of participants highlighted situations where the clients were at risk because of medication errors or staff oversights. The participants did however emphasize that 'experienced' staff did not always mean professionally trained staff it meant staff that somehow learned the multiple skills needed to work effectively.

3. The need for support was highlighted by staff as was the belief that that support was not always available outside of their own team. As was mentioned earlier many of the participants did not feel that 'others' could understand their work. One recommendation was to have new staff spend a day or longer 'on the streets' in order to see the type of work intensive case managers do. It was felt that this would not only benefit the intensive case managers themselves but also the clients because new staff would then develop a greater understanding of the clients experiences.

4. The need for time together as a team to debrief and re-hash the days events was highlighted by each participant. Despite this many commented on how difficult it was to take time away from the clients and do this. One participant recommended having team time as a requirement when developing intensive case management teams.

Conclusion

The goals of this study was to provide a forum for intensive case managers to tell their stories. These stories provide much insight into their day-today experiences. Their values and beliefs became clear as I read the interviews and the stories they told. Each intensive case manager appeared firmly grounded in their belief system and although each participant was unique many commonalties emerged. These beliefs and values shape the way the participants work with their clients and their goals of this work. The focus on increasing quality of life was another overriding theme. Many times these goals are seen as different than the larger mental health system and this reduces the visibility of their work. While the intensive case managers focused on improving functioning and quality of life the larger system is seen as focusing on symptom reduction and the 'quick fix'. At times this creates strain and frustration much of which is directed to towards the system. Although strain occurs on an interpersonal level as well the systemic problems appeared to overshadow this. Despite the stress generated by the system they work in all nine participants interviewed participants liked their jobs. In fact many stated they 'loved them' (6/9).

Chapter Five
Discussion

This chapter will discuss the findings of my study with respect to the literature that already exists. In addition, recommendations for future research will be discussed as will implications for practice.

Return to the Existing Literature

The goal of this study was to provide a forum for intensive case managers to be heard and I believe, in that regard it was successful. However this study also adds to the existing literature on mental health services and thus needs to be incorporated into it. The literature review suggests that one of the main problems facing the current mental health system is the lack of a clear conceptual framework that supports and guides staff who work with people who have a chronic mental illness. This framework would focus services on maintenance of functioning and improved quality of life. Although this 'paradigm shift' is being included in many organizational mandates, it is currently not supported by the larger socioeconomic system. The current 'mental health culture' is bounded by the stasis found in large bureaucracies and compounded by fiscal restraints that impinge on staff's ability to work from a 'care' model. Despite the talk of 'shifting priorities' in mental health care and the move to a more 'care oriented' system, health care financing promotes the use of a 'biomedical' approach. The systems resistance to change is fueled by the dominant ideology in society which

continues to view 'success' in normative terms. I believe, the absence of such of a model impacts on all the findings of this study. With this in mind I have identified three major findings. These are: intensive case mangers did not identify clients as a source of stress; intensive case managers define success in very broad terms; and time together as a team fulfills a number of essential functions.

"It's not the clients who are stressful"

Intensive case managers did not identify clients as a source of stress and this is in contrast to much of the previously cited literature. The source of stress was identified as conflict with staff and with the system. While some participants labeled staff as stressful these comments were generalized and may likely reflect their feelings towards the system rather than staff in general. This can be seen in the results section as most of the negative comments and labels are attached to 'they' rather than a specific person.

These findings challenge the myth that mental health work is stressful because of the clients and adds to the limited research that disputes this. In addition it adds support to the literature that identifies organization factors rather than client characteristics as generating stress (Schulz, Greenley & Brown, 1995; Duquette, Kerouac, Sandhu & Beaudet, 1994; Finch & Krantz, 1991; Penn, Romano & Foat, 1988). The participants identified a number of factors within the system that added to their experience of stress and none were related to the clients themselves.

It is likely that more than one factor influences staff's experience of stress and job satisfaction. Finch and Krantz (1991) suggested that it was also the beliefs of the staff in their setting that influenced their ability to reframe 'stressful' events. They suggested that the focus on doing things with the clients rather than doing things for the clients lessons the impact of failure. I would like to expand on this to suggest that it is not simply whether or not one sees oneself as doing with or doing for but it is in fact related to staff's beliefs about client autonomy and control. The participants I interviewed clearly placed the clients in control of their lives. Their role was simply to assist clients in the areas with which they wanted assistance. The interventions were generally client driven and client guided. Because clients were believed to be autonomous agents successes and failures were not viewed as a result of the intensive case manager but as a collaborative effort between client and staff. If staff have a paternalistic attitude towards clients and refuse to allow clients to set the goals and boundaries of 'treatment' then success and failures will fall within the responsibility of the staff This creates a significant amount of pressure for staff as clients are less likely to follow through on plans that have been developed without their involvement (Anthony et al., 1983). Clearly further study is needed to clarify the relationship between attitudes and beliefs towards clients, and staff's experience of stress and job satisfaction.

"Success is getting someone to talk who hasn't talked to anyone before"

The literature points to the need for staff to redefine success and it appears that the intensive case managers in this study were able to do this. A number of participants commented on the need to set individualized goals rather than rely on normative definitions of success. This appeared to have positive benefits for the staff as they were not trying to 'cure' the incurable. One participant suggested that working in an intensive case management team may be easier than working in a CMHC because of this redefinition. She explains it this way.

> There is no expectation that we are going to perform miracles or get people to drastically change their lives...we take people at the bottom of the line and any improvement that happens, well, that's a plus but it doesn't have to be an expectation. So in some ways working in intensive case management is less stressful than if you were working in a CMHC because the expectations to change people or shift them might be less (#2,14)

It appears from the results that the participants ability to redefine success was built upon their focus on the individuality of the client and the emphasis on individualized service plans.

Intensive case manager's ability to redefine success seems to be rooted in three factors: their clinical knowledge of the client; their focus on meeting the unique needs of each client throughout the use of individualized service plans; and their focus on rehabilitation over cure. Although many authors have recommended redefining success few studies have examined the values and beliefs that lead that to this definition. Minkoff & Stern (1985) state that clinicians

must learn to develop individualized outcome criteria and attainable treatment goals that are based on the person's own history and baseline. These findings suggest that intensive case managers were able to do this.

Some authors have suggested that the philosophical shift away from a medical model of care which focuses on pathology, to a psychosocial model of care that focused on strength somehow mitigates the stress response (Bromberg, Starr, Donavean, Carney & Pernall-Arnold, 1991; Finch & Krantz, 1991; Witheridge, 1991). Many of the participants in this study ascribed to the psychosocial rehabilitation approach. In addition, unlike the group studied by Pines & Maslach (1978) or Cherniss & Egnatious (1978) this group of staff did not have 'curing' clients as their goal. Perhaps having a more realistic goals for the clients create more realistic goals for the staff as well.

Even if participants don't define success in terms of 'change' or improvement they identified this as a goal of the overall system. Many participants stated that funding was connected to programs that could demonstrate their effectiveness. This 'effectiveness' is not defined by an increase in quality of life but generally as a decrease in service use. Although many authors have commented on the need for the system to redefine it's priorities it has yet to do so (Lamb, 1992; Bachrach, 1990; Intagliata, 1982; Stein & Test, 1980). As long as the overall system sets treatment goals that differ from those of the staff (intensive case management staff or other mental health staff) staff run the risk of feeling ineffectual. These differing goals lead to an 'invisibility' of the work of the intensive case managers.

"You have to take care of each other"

This study clearly supports the use of a team based intensive case management model over an individual one. The team was described by participants as being central to the well being and functioning of the intensive case managers. I suggested in the analysis that the team served a number of functions including a forum for debriefing, clinical supervision and support.

I found only two sources that discussed the debriefing function of the team. Intagliata (1982) in his lengthy article on case management, states that a good supervisor provides staff with an opportunity to "vent their frustrations with their clients and with the system" (p. 688). He goes on to suggest that those agencies using an individual (intensive) case management model must pay close attention to the need to provide adequate support to staff. Although he does not expand on this recommendation it was clearly echoed by the participants interviewed. The one participant who did not feel supported was working from an individual case management model and stressed the need to have someone with whom he could talk regarding his experiences.

Bond et al. (1988) studied three new intensive case management programs that were created from existing CMHCs. One of the three intensive case management teams chose to use an individual case management model (one where the clients are not shared but allocated to specific intensive case managers within the team) and then moved to team intensive case management model. The participants noted "feeling better about ourselves with a team approach". In addition at the end of the study period all three teams emphasized

the value of a team approach stating that a shared caseload was necessary "to keeping our sanity" (p. 416). Despite the significance of these comments they were not elaborated on. This was also discussed by the participants in this study who define the roles of the team as support, clinical supervision and a forum for debriefing. Participants discussed "feeling good" when they were listened to and validated by their team. This becomes all the more important when the larger system is not validating the successes of the intensive case managers.

The use of time together to discuss clients and to debrief appears to be an essential. A number of authors have commented on the need to examine one's personal attitudes towards mental illness (Minkoff & Stern, 1985; White & Bennett, 1981). In addition debriefing appears to allow staff time to deal with countertransference issues that arise when working closely and intensively with these clients. The implications of this are poorly understood and clearly need more research.

Implications for Future Research

This study has led me to ask many more questions regarding intensive case managers experiences than it has answered. This section will therefore highlight some of the questions generated by this study and suggest areas for future research.

As stated in the research design the interpretations of the result of this study are mine, and I recognize that my experiences and beliefs have shaped the way the interviews were interpreted. Future research in this area could provide a

forum for these results to be explored and discussed with the participants. Although 'member' checks were conducted throughout the study a focus group would provide an ideal forum for the further exploration of these findings. In addition these findings could provide a starting point for additional studies with other intensive case managers.

The participants in this study felt devalued at times by the larger mental health system. In order to further examine this mental health staff outside of intensive case management could be interviewed. Considering there is much research to suggest that intensive case management would be devalued and deprofessionalized by the system this would be a valuable study.

The differences between staff who feel valued by the mental health system and those who do not deserves further attention. A more in-depth qualitative study could do this. Although this study identified this issue, it did not explore all the factors that may contribute to participants sense of being valued. The location participants place themselves within the mental health system may also tie in with this issue. Participants who felt undervalued and isolated tended to locate themselves on the outskirts of the system or remove themselves from it all together.

Given the central role of the team future research could further explore the many roles of the team and attempt to develop a more thorough understanding of this. The role of support appears to play an essential function in the well being of the intensive case managers however the means by which it occurs are unclear.

This research could then be used to help develop intensive case management teams and to increase the support in existing teams.

As debate continues on the merit of individual case management versus team case management researchers could start to explore the effects these two approaches have on staff. Given the importance this group of intensive case management placed on the team itself, issues such as the role of the team, group identity and team building are worthy of future research.

Two noticeable commonality among the participants in my study were their self confidence and the belief in the work that they do. I would describe this group intensive case managers as self confident, firmly grounded in their views of the clients and the role of intensive case management and as being comfortable with their own personal styles of work. Each participant was unique in many ways and there were considerable differences in how they explained themselves and their roles. However underlying all the differences was a self assurance and self confidence. Although the role of personality is poorly understood perhaps researchers should look beyond beliefs about intensive case management to include intensive case managers beliefs about themselves.

Implications for Practice and Policy

This section will explore my own recommendations for policy and practice based on the findings in this study. In addition I will highlight concerns I have regarding the changing mental health system and it's impact on intensive case management .

1. Intensive case management teams should be required to meet daily. Each participant in this study emphasized the importance of spending time together as a group. However, many participants also emphasized how easy it was for this to be missed. Given the many positive functions this plays I feel this needs to be emphasized in the creation of new teams and supported by the system as a legitimate way to spend time.

2. Intensive case management teams need to be kept small. This recommendation is based on a number of factors. First, the team approach to intensive case management is supported by the literature and requires the creation of small teams in order for information to be shared. Second, the participants in this study emphasized the need to be able to trust and rely on their team members. These types of relationship take time to develop and require a small, close knit unit.

3. Intensive case management teams need to remain flexible both in the range of services offered and in the way they operate. The roles of intensive case managers must remain open and flexible, the institution of rigid boundaries, mandates and roles will interfere with the intensive case managers ability to meet the needs of each individual client.

4. The findings of this study point to the need for strong and focused leadership in intensive case management teams. The coordinators must be firmly grounded in the values and goals of intensive case management. Additional support should be available for the coordinators of these programs.

5. Based on the findings of this study I would recommend that staff unfamiliar with intensive case management or outreach spend a day with one of the intensive case management programs in order to familiarize themselves with the program and the goals of these programs.

6. The separation of rehabilitation services from clinical services not only fragments service delivery but fragments the clients as well. It also serves to perpetuate the belief that rehabilitation is separate from standard mental health care.

Before concluding this section I need to mention two issues that have continued to emerge throughout the writing of this paper. First I need to comment on the impact of caseload size has had on the existing community mental health system. GVMHS was built on the belief that staff were to take an 'aggressive approach' in their outreach to clients - it was built on an intensive case management model (see Sladen-Dew, Bigelow, Buckley & Bornemann, 1993). In their 1993 article Sladen-Dew et al. describe the approach as this:

> Office-based psychotherapeutic strategies are de-emphasized in favour of practical assistance and support to the patients and their families where it is needed - their homes, out on the streets, in hotels, schools and longterm care facilities. An overly "professionalized" approach is de-emphasized and case managers are encouraged to be creative in finding practical solutions. (p.309).

I believe if GVMHS wants to maintain it's status as a 'leader' in innovative mental health care caseload size must be addressed. The development of intensive case management teams within GVMHS is evidence of the increasing demands placed on staff. In the past staff were expected to do their own

outreach and their own intensive case management. However as caseloads size continues to increase staff's ability to do this is compromised. This I believe, contributes to the division between 'us and them' - it contributes to the division between those who work in an office and those who work on the street. This in turn may contribute to intensive case managers feeling 'devalued and deproffesionalized' by the existing system.

It concerns me that while the mission statement of the organization emphasizes enhanced functioning and quality of life, caseloads are increasing to the point where this is no longer possible and staff are forced to work with clients on an emergency basis only. I stress this point not only because of the negative implications it has for staff in CMHCs but also for intensive case management teams. As caseloads increase and staff are limited to crisis intervention the role of intensive case managers and case managers in the teams become further and further apart and the potential for increased conflict occurs. In addition to the limits caseload size place on taff there is also a belief expressed by some of the participants that not all staff are in favour of 'outreach'. Although some participants offered their ideas as to why this was the case this urgently needs to be addressed.

I will close this section with my final concern, a concern about the future of intensive case management. In doing this paper I have realized that the beauty of intensive case management lies in its flexibility, its ability to be responsive to the needs of each client. While one client may need vocational training another may need a walk in the park and still another may just need to 'be with' someone.

At this point intensive case management has the flexibility to do this. However the system's need to 'professionalize and specialize' eventually destroys this flexibility. I guess what I am really trying to say is that I am worried, I am worried that my job will be eaten up by the system and become a job with institutional standards and bureaucratic obstacles. A job where meeting the goals of the 'system' become more important than meeting the goals of the clients.

Where is Social Work

When I began to look at the literature on intensive case management I was struck by it's similarity to social work. The focus on autonomy, respect and dignity of clients is the foundation upon which social work is based. In addition, many of the roles and tasks of intensive case management echo those of social work. In general both approaches work from a 'person-environment fit' model and rely on an ecological or systems framework to shape their assessments (Johnson & Rubin, 1983). Perhaps the most striking similarity is the optimism each model is based on - they both believe in people's ability for growth.

Despite the similarities between these two models research suggests that social workers are not interested in intensive case management. Johnson & Rubin (1983) state:

> Despite the strong conceptual similarities between social work and case management, the strongest deterrent to the prominence of social work in this area may be, paradoxically, the preference of many social workers themselves. A large number of social workers in settings were case management is appropriate appear to be indifferent to such work (p.52).

In fact, research has shown that social worker's prefer psychotherapy over many

of the roles intensive case managers must perform (Rubin, 1992). This in turn has been related to social works desire to professionalize. Unfortunately research has found that social work has moved away from their traditional focus on environmental interventions as it has incorporated a more 'biomedical model' or objective model of care. This is discussed in the following quote:

> Interviews with faculty and students found that, at the time, many MSW mental health practicums denigrated work with the chronically mentally ill ands discouraged environmental interventions. In most practicums, brokerage and advocacy were deemed superficial; instead students were encouraged to deal with deeper underlying aspects of pathology. Moreover, most MSW students seeking placement in the mental health field did so based not on their commitment to that field of practice, but on their aspirations to become psychotherapists (Johnson & Rubin, p.52).

I believe no other discipline has an underlying philosophy that so closely mirrors intensive case management. It appears that the lack of a conceptual framework which supports working with long-term chronic mental illness has also influenced social workers' choices.

Conclusion

This study's goal was to explore the experiences of intensive case managers. Through nine interviews the experiences of these participants began to emerge. Many of the stories told were positive and reflected the enjoyment they received from their work. Some of the stories were not and these reflected the conflicts and stresses the participants faced in their day-to-day work. Each participant offered valuable insight into the goals of intensive case management and the beliefs and values that provide the foundation for these goals.

Although each intensive case manager was unique many commonalties were found. The focus on respecting the client and working to improve their quality of life was emphasized. Sometimes this focused clashed with the larger mental health system and this created strain at a number of different levels; interpersonal, systems and societal. Despite this, the participants remained firmly grounded in their goal to assist clients in improving their quality of life.

This paper allowed me to step outside of my role as an intensive case manager and explore the system in which I work. Guided by the words of the participants I have thought about issues in mental health and intensive case management that have never occurred to me before. This paper has allowed me to look critically at the system I work within and to examine many of the 'taken for granted' myths and assumptions present. In addition it has highlighted for me, the need for a new framework that will support staff in the efforts to meet the needs of their clients and focus on increasing quality of life. I would like to close

this paper with a quote: "We all need to be in this together, you know, not just for the clients sake but for the staff too." (#7,7).

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