

Integration of Research and Clinical Practice in the Evolution of Case Management

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During the eighties there was a discussion in the psychiatric service in central Stockholm on whether case management models could be a better way of assisting patients than traditional treatment. In the beginning of the nineties a two year project was undertaken. The results were very promising and showed the case management model to be superior in several aspects. There were however certain difficulties with the model used and some changes were necessary. This led to a new model that was studied more rigorously during 1993 - 1995. The results of this second study were encouraging and showed that the case management model could be developed further. A new project was outlined and launched in 1995, ending in 1998. The model we use now in 2000 is quite different to the one started in 1990 and represents the results of the three projects.

The First Project 1990 - 1992

In 1990 the first project was started. Through patient-completed questionnaires we ascertained that patients were very disappointed with their life situation, especially their living conditions. Patients felt that they had nothing to do during the day. The relatives of the patients were also highly dissatisfied with the latter's living conditions. To find out if a case management model could be of any help, 40 patients with long-term schizophrenic disabilities were randomly assigned to either an intensive treatment case management programme or standard psychiatric services. The case management model featured increased staff contact time with patients, rehabilitation plans based on patients' expressed needs and the presence of patients at team meetings where their rehabilitation plans were discussed. Patient use of emergency and inpatient services, quality of life, size of social networks and their relatives' burden of care were established at the start of the project and then two years later. The result showed that the intensive case management group had significantly fewer emergency visits than two years earlier and their relatives reported a significant reduction in burden of care. The size of patient social networks increased. Patients in the case management group also reported an increase in quality of life.

It was concluded that case management models function significantly better than standard treatment models even in a Swedish setting. There were however difficulties reported by the staff, where they experienced a conflict between their role within case management and their work as a team member in the outpatient unit. The case management model demanded great flexibility which was not always possible when staff members have outpatient unit obligations. Staff members also felt they lacked the knowledge to work effectively as case managers and requested more extensive training.

The Second Project 1993 - 1995

Building upon the success of the first project, a second project was started in 1993 and ended in 1995. It differed from the first project in several aspects. A small team of four staff members was formed within the outpatient unit. They worked only as case managers. In principle they used the same model as in the first project with the important difference that patients did not attend rehabilitation conferences. A support team was arranged and the case manager was obliged to report to the patient the results of support team discussion. Staff received lengthy and extensive training of one and a half years in this model of psychiatric rehabilitation. Their caseload was limited to no more than fifteen patients. As in the first project data was collected at the start of the project and then after two years. Sixty patients were given case management treatment.

The results from this second project were similar to those of the first. The patients in the case management group had significantly fewer emergency visits compared with results from two years previously. Their relatives reported significant reductions in the care burden. The patients reported that they experienced a better quality of life. However, patient networks were significantly reduced. The staff reported satisfaction with their training and considered it very useful. They also found it easier to confine their work to case management and carry out their role more effectively. However, there was a problem regarding roles in relation to the support team. In the first project both patient and case manager met with the support team. In the second project only the case manager met the support team. This meant that the case manager informed the patient of the decisions of the support team and what the team's discussions on the rehabilitation plan. This caused a conflict between the support team, the patient, relatives and case managers. In this situation it seemed as if relatives "handed over the work" to the case manager. This was reflected in the reduction of the patient's social network as the case managers came to replace the pre-existing family and social contacts.

The third project 1995 - 1998

After lengthy discussion a third project was started. The case management team was expanded with two more staff members. The caseload for each member was again limited to a maximum of fifteen patients. An important change was the modification of the rehabilitation planning process based upon a new dialogue between patients and case managers. For each patient a resource group was formed bringing together professional staff members, important relatives and other members of the patient's network. Selection was based on the potential role to be played by these individuals in relation to the rehabilitation plan. This resource group was invited to a rehabilitation conference where patient and case manager presented a preliminary rehabilitation plan. The conference objective became how to help patients reach their goals and be successful in their rehabilitation. In the conference the group discussed how to handle different problems and difficulties. The patient and case manager wrote down the results of the conference in the form of a rehabilitation plan and this plan was distributed among conference participants. Patient and relatives were encouraged to be active in the discussions on how to achieve the rehabilitation plan. The plan was followed up regularly at a minimum of six-month intervals.

This third study was one of ten different studies which were supported financially and followed up by the Swedish National Board of Health and Welfare. Two researchers were assigned to the project and data collected on patients, their relatives and staff. The results showed that hospitalisation days per patient were reduced by nearly 50%, and that patients were more satisfied with their life situation, social contacts and daily activities. Patient psychiatric symptoms were reduced and their relatives were very satisfied with the changes made. The patients were also very pleased with the work of their case managers and felt that the case managers had helped them with many of their needs. Significantly the involvement of patients and relatives in the planning of rehabilitation enabled patients to broaden their social networks rather than become more dependent on case workers.

Conclusion

The integration of research methods with clinical practice over the past decade has been very fruitful and the results of these studies has led to a decision by the government to introduce the case management model on a national basis for all psychiatric patients with long-term functional disorders. Such close coordination between research and clinical practice in Sweden is unusual and it is widely seen as an example of good practice.