CASE MANAGEMENT & SOCIAL WORK: CASES WITH PEOPLE WITH MENTAL HEALTH PROBLEM

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ABSTRAK: *Pengurusan kes semakin mendapat perhatian dalam perkhidmatan sosial kerana dipercayai dapat meningkatkan kuasa klien, menambah pilihan klien terhadap perkhidmatan yang disediakan, serta mencapai penjagaan susulan yang berkesan. Walau bagaimanapun tidak ada kata sepakat mengenai apa yang dimaksudkan pengurusan kes serta penggunaannya. Terdapat banyak model pengurusan kes yang digunakan oleh berbagai pihak di beberapa buah negara. Kertas kerja ini ingin memperkenalkan konsep pengurusan kes dan perlaksanaannya berdasarkan ulasan serta contoh kes dari United Kingdom. Makna, objektif, fungsi dan model pengurusan kes akan dibincang berdasar kepada kes-kes berkenaan dengan kesihatan mental. Kelebihan dan kekurangan pengurusan kes turut dibincangkan. Akhir sekali penggunaan pengurusan kes secara global dibincangkan.*

ABSTRACT: *Case management has attained much belief from various social services to be a mean that can promote client empowerment, expand client choices of services, and to achieve a continuity of care in a timely and cost-effective manner. Nevertheless, there are no consensus on what case management really is and how it is being implemented. At present, there are no less than seven models of case management, for different group of service users, being used in different countries. Based on literature reviews and case examples from the United Kingdom, this paper wishes to introduce the concept of case management and its implementation. The meaning, objectives, functions and models of case management will be discussed based on the cases of mental health problems. Its strength and limitation will also be discussed. Finally the use of case management as a human services internationally is discussed.*

INTRODUCTION

Places for treating people with mental health problem used to be limited in mental hospital until chemically synthesised drugs were introduced in the 1950s. Since then, patients with mental illness can be treated outside the hospital, and long-stay patients can be discharged earlier. People who develop long-term mental health problem are now cared for in the community. The closing of mental hospital in the USA and in Britain is part of the reforms from institutional care to community care. However, the delivery of the necessary treatment and continuity of care is much complicated in the community than in mental hospital.

PROBLEM STATEMENT

Case management was devised in the USA to provide continuity of care for mental ill people. In the UK, case management was introduced in the Griffith Report (1988) along with the appointment of local authorities as the lead planning body for community care and the purchaser-provider split. The term 'care management' is preferred instead of 'case management' by related authorities (DoH, 1990). Case management is seen as a mechanism that can links users, carers and care providers together for continuity of quality services.

Although the legislative framework focuses on severely mentally ill people (DoH, 1994), the results of this policy is still unclear (Huxley, 1997). There have been

criticisms on the inappropriate of case management approach advocated by the British government. There are also concerns over the cutting in benefits and funding in health and social care that limit the potential of case management. The murder of innocent victims by severely disturbed schizophrenics suggest that the policy is failing many of those it is designed to help (Ritchie et al., 1994). With the estimation that in a population of 100,000, there will be 2,600 people who will require planned, prolonged health and social care (Goldberg and Gater, 1991), how case management sustain the pressure and provide the desirable results will be a major question.

OBJECTIVE AND LIMITATION

The objective of this essay is to discuss the application of case management with people with long term mental health problem. Firstly, the meaning and process of care management will be discussed. This is then follow with a brief discussion on people with long-term mental health problem and their needs. Based on two care management studies in Southwark (Thornicroft et al., 1993) and Newcastle (Svanberg et al., 1997), the next section will illustrate how care management is implemented. The strength and limitation of care management will then be discussed. Finally, discussion on prospect of care management internationally is attempted.

The focus of this paper is based on the implemetation of care management in the UK only. While the topic is related to mental health, in depth elaboration on the cause and remedy for mental health problem is beyond the scope of this study. The same applies to the operation of mental health services. Although there are some differentiation in the term 'care management' and 'case management' (Onyett, 1992), both of the term is interchangeable and carry the same meaning in this essay.

THE DEVELOPMENT OF CARE MANAGEMENT

The earlier work in case management was mainly concerned with the fragmentation of the community services for people with long term mental illness (Thornicroft et al., 1993). Since then case management has been expanded to other fields of helping profession. Weil et al. (1985) have identified that case management are in use among children, elderly people and their family, people with learning difficulties and physical disabilities as well as mentally ill people.

Case management was introduced to the UK through the Kent Community Care Project (Davies and Challis, 1986) and Care in the Community Project (Challis et al., 1988; Challis et al., 1989; Challis et al., 1990) by the Personal Social Services Research Unit (PSSRU) at the University of Kent. From there the concept of case management was widely spread and experimented in conjunction with the government policy of de-institutionalisation and the shift to community care. The encouraging outcome from these works influenced the government. First, the Audit Commission (1986) described the deployment of case management in detail. Griffith Report (1988) further specify that 'no person should be discharged without a clear package of care devised and without being the

responsibility of a named care worker'.

Then, the white paper on community care, *Caring for People* (DoH, 1989), pointed 'where an individual's needs are complex or significant levels of resources are involved, the government see considerable merit in nominating a 'case manager' to take responsibilities for ensuring that the individual needs are regularly reviewed, resources are managed effectively and that each service user has a single point of contact'. Finally statutory requirement of case managers in the local authority were stated in the 1990 National Health Service and Community Care Act that 'they shall assess one's needs for services and shall then decide whether his needs call for the provision by them of any such services'. We can conclude that case management is the core of the community care reform in the UK in the 1990s.

DEFINITION

There has been a wide range of definition on case management. Weil and Karls (1985) define case management as 'a set of logical steps and a process of interaction within a service network which assure that a client receives needed services in a supportive, effective, efficient and cost-effective manner' (p.2). Moxley (1989) defines case management as 'a client-level strategy for promoting the co-ordination of human services, opportunities and benefits. The major outcomes of case management are...the integration of services...and achieving continuity of care' (p.11).

Onyett (1992) sees case management as a way of tailoring help to meet individual need through placing the responsibility for assessment and service coordination with one individual worker or team. The official definition by the Department of Health (1991) defines care management as 'the method of systematically linking the process of identifying and assessing need with the arrangement of monitoring and review of service provision'.

Rothman (1991) sees case management as incorporating two broad functions, which are: (1) providing individualised advice, counselling, and therapy to clients in the community, (2) and linking clients to needed services and supports in community agencies and informal helping networks.

O'Connor (1988) further distinguishes between case management practice and case management systems. Case management practice is referred as the direct practice activities of a case manager that contribute to the implementation of a client's care plan. It is primarily the responsibilities of the line workers. Case management systems is referred as the administrative structure, the interagency networks and the formal and informal community resources within which case management practice take place. It is principally the responsibility of agency supervisors and executives.

OBJECTIVES OF CASE MANAGEMENT

The government policy guidance (Department of Health, 1990) has described the objectives of case management as:

(1) Meet individual care needs through the most effective use of resources;
(2) Restore and maintain independence by enabling people to live in the community wherever possible;
(3) Prevent or minimise the negative effects of disability, illness or mental distress in people of all ages;
(4) Achieve equal opportunities for all;
(5) Promote individual choice and self-determination and build on existing strengths and care resources, and
(6) Promote partnerships between users, carers and services providers in all sectors.

These objectives of case management strongly reflect and correlate with the objectives community care policy after the 1990s: de-institutionalisation, needs-led services, provider-purchaser spiit for mixed economy of care, multiple choice and individualism.

CORE TASKS OF CASE MANAGEMENT

Understanding the core tasks (Davies, 1992) or the 'logical steps' (Weil et.al., 1985) of case management will tell us more of the process in case management. There is a general agreement on the core tasks of care management functions which comprises assessment; care planning; direct and indirect intervention; monitoring; review and evaluation.

The British government formulation of care management (DoH, 1991) is divided into seven stages:

Stage	Tasks	Description
Stage 1	Publishing information	Making public the needs for which assistance is offered and the arrangements and resources of meeting those needs.
Stage 2	Determining the level of assessment	Making an initial identification of need and matching the appropriate level of assessment to that need
Stage 3	Assessing need	Understanding individual needs, relating them to agency policies and priorities, and agreeing the objectives for any intervention.
Stage 4	Care planning	Negotiating the most appropriate ways of achieving the objectives identified by the assessment of need and incorporating them into an individual care plan.
Stage 5	Implementing the care plan	Securing the necessary resources or services.

Stage	Tasks	Description
Stage 6	Monitoring	Supporting and controlling the delivery of the care plan on a continuing basis.
Stage 7	Reviewing	Reassessing needs and the service outcomes with a view to revising the care plan at specified intervals.

MODELS OF CARE MANAGEMENT

There are a vast variety of case management models. Levine and Fleming (1985), classified seven models of case management: (1) generalist, (2) specialist, (3) therapist case manager, (4) family, (5) psychosocial rehabilitation centre, (6) supportive care, and (7) volunteer case manager.

Lately, different terms are used to describe models of case management: assertive case management, intensive case management, rehabilitation case management, the strengths model, clinical case management, brokerage model and budgetary control model (Bachrach, 1989; Bond et al., 1989; Borland et al., 1989; Bush et al., 1990; Goering et al., 1988; Kanter, 1989; Rapp & Chamberlain, 1985; Rapp & Wintersteen, 1988; Huxley, 1993). Huxley (1993) argues that current care management model in the UK is perhaps concerned more with the organisation of centralised or decentralised budgetary control, and with eligibility criteria. It's not surprising that case management is as seen a concept ready for misinterpretation and projection (Rubin, 1992; Huxley, 1993).

According to Kanter (1989), the American case management is similar to the role of a travel guide escorting the user through a maze of service provider. The British approach is more identical to the role of a travel agent acting as a broker for other services and directing people to them according to their needs (Onyett, 1992). The British care manager is placed further up the management hierarchy and has the job of co-ordinating or managing direct-care staff.

PEOPLE WITH MENTAL HEALTH PROBLEM

Oliver et al. (1996) have divided people with psychiatric illness into 3 main groups in terms of the prevalence of the illness. They are:

(1) people with common illnesses - mixture of anxiety and depression related symptoms;
(2) people with less common illness - obsessional disorders, eating disorders and episodic forms of psychotic illness; and
(3) people with long-term psychiatric illness - which are either continuous or fluctuating in severity and which are usually associated with persistent forms of social disability such as chronic schizophrenia, chronic somatisation and chronic organic brain syndromes.

Social factors play a crucial role in the causation mental illness, in the course of the illnesses, and in the outcome of treatment and care (Huxley, 1997). People with long-term disabilities have complex needs. It is concerned with all aspects

of their patients' physical and social environment, including housing, psychiatric treatment, health care, entitlements, families and social networks (Kanter, 1989). Hence, they require a network of co-ordinated services based on a long-term model of care and a titration of various forms of intervention through an illness career (Bridges et al., 1994). The essential element of this model is the need to provide continuity of care, i.e. the process which enables a person to have an orderly and uninterrupted involvement with a network of services for as long as he or she needs them (Bridges et al., 1994; Shepherd, 1990, 1991).

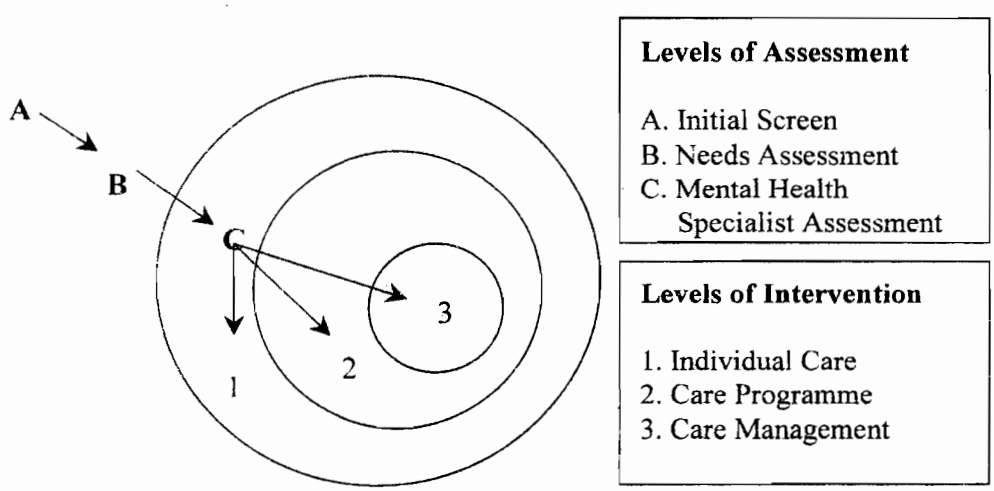
CASE MANAGEMENT IN MENTAL HEALTH

In order for us to have a clear understanding of case management for people with long-term mental health problem, two cases will be discussed. The Southwark model provides a clear theoretical framework of how the care management process operates while the Newcastle model provides a detail description on what happened in each stage of care management.

Care Management in Southwark, London

The processes of assessment and care management in Southwark were planned through an inter-agency group comprising the local authority officers, and representatives from all the health providers and purchasers and the voluntary sector. Within the care management system, they have come to an agreement on the levels of assessment and levels of intervention (see fig. 1).

Fig. 1 – Level of mental health assessment and treatment in care management system (Thornicroft et al., 1993:768)



a. Screening Stage

Since access to mental health services often bypass social services department, the bulk of the initial screening will probably undertake by staff not working for the local authority.

Hence it can take place in many community settings – social services offices, general practitioners' surgeries, and centres of voluntary organisations, or in hospital before discharge. Information is recorded in a standard forms and then is sent to the appropriate care management and assessment team in social service department or hospital, whose responsible for the complete cycle of the seven stages in care management.

b. Assessment Stage

The team member making the main assessment of needs for community care uses a structured form with headings covering all areas of potential need. In the process, clients and carers should be consulted. Clients are also offered advocacy services. Although the model of care management planned for Southwark is mainly one of brokerage, social workers will still be able to offer personal help to their clients when this seems useful within the agreed care plan.

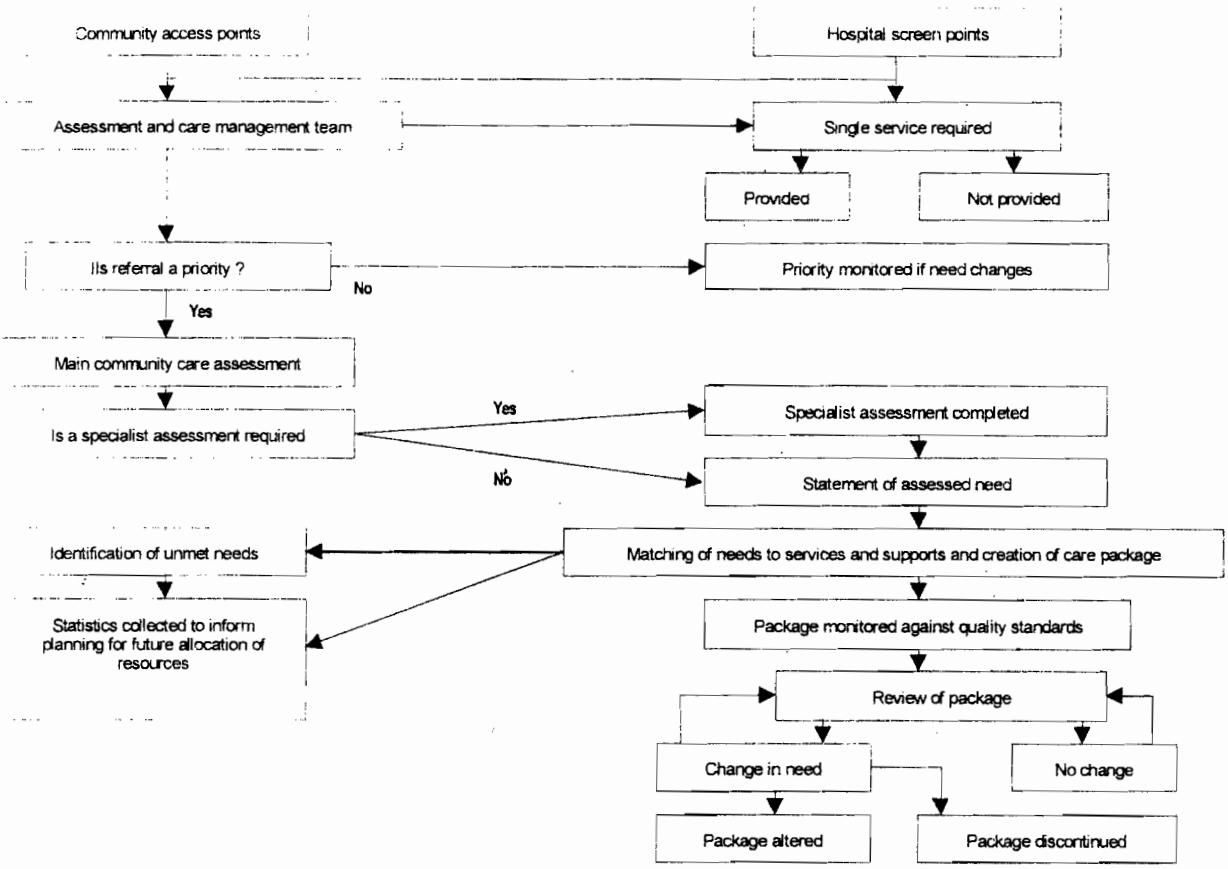
c. Specialist assessments

A high percentage of clients and patients will need complex interdisciplinary assessment. This may be performed by a variety of mental health professionals including social workers, psychiatrists, community psychiatric nurses, and psychologists. The professionals will use standardised methods covering a range of possible problems in order to make the assessment as uniform as possible. Southwark's model attempts to combine the entire legislative requirement (Mental Health Act 1983 and NHSCCA 1990) in one structure. It comes up with three level broad levels of services support or intervention: low, medium and high. Access to these levels of intervention is determined by the result of the specialist needs assessment. As shown in fig.1, clients with low level of support needs will be allocated for individual care (1) while care management (3) is only available for clients with high level of needs. The whole process of assessment and care management in Southwark is illustrated in fig.2.

Care Management with People with Dementia, Newcastle

This two-year project was set up in July 1992, It was aiming to enable people with dementia to live in their own familiar home environment and to provide practical and emotional support to their carers. 18 out of 30 referral clients were qualified for care management input. The project implementation was strongly person-centred which focused on the clients and their individual constellation of needs and strengths and on tailoring care to individual needs. The relationship of the care manager with the person with dementia and their carers was regarded as being of primary importance. Listening to the expressed needs of users and carers was emphasised and active participation from carers was emphasised and encouraged.

Fig. 2 - Assessment and care management process in Southwark (Svanberg, et. al., 1997)



In order to move away from the service-led tradition of social services department's practice, the care manager in this project was not the budget holder. The care management budget was held centrally by a member of the project development group. The care manager accessed funding through a code with authorisation from the budget holder. No financial ceiling was imposed for individual care packages in order to ensure that needs-led approach could be fully explored and also to identify realistically the range and scale of costs. The same practitioner for any one individual carried out the tasks of assessment and care planning.

a. Assessment

Similar to the Southwark case, the project started with publication of information to the public. Multidisciplinary assessment was used to assess users and carers needs. However it was done separately to avoid over-emphasise the views of the carers over the views of the users. Immediate needs were identified and agreed between user, carer and care manager, and a temporary measure were deployed until detailed care plan could be developed. All existing

supports for immediate needs were recorded in the first Individual Care Planning Chart (ICPC 1).

b. Care Planning

Care planning was conducted in two stages. Firstly, an Individual Care Planning Team (ICPT) was convened for each person using the service, consisting of major provider of dementia care, the care manager, the clinical psychologist from the project (who chaired), the budget holder and two advocates (on behalf of the user and carer respectively). Users were not invited but will be fully represented by the care manager who has earlier face to face work with the users. The ICPT would familiarise themselves with the needs, and then looked at the least intrusive ways of meeting the assessed needs and preferences, and only looked at services available. The agreed plan will then recorded in Individual Care Planning Chart 2 (ICPC 2). Secondly, after the implementation of the care plan, the ICPT continued to review their impacts and to find improved ways of meeting the needs, of modifying the care arrangements and of improving the acceptability of the forms of care to the users.

c. Implementing Care Plan

When coming to implementing the care plan, there were three tasks: (1) administrative, (2) service negotiations and introductions to support workers, and (3) co-ordination and monitoring. The care manager calculated care hour and costs. Apart using funding from the project budget, care manager also identified and accessed resources from other sources in maximising the user's purchasing power. Care manager was also responsible for introducing suitable support workers to the users and carers gradually. Lastly, the care manager would monitor the responses and arranged appropriate intervention if necessary.

d. Reviewing

Reviews by local specialist mental health team at their clinic base on users mental health and reviews by care manager, carers, support workers and providers on care plan were carried out in a regular basis. Users and carers needs and satisfaction will be re-assessed if there were any shortcomings.

e. Evaluation

Various measures were used to evaluate users and carers experience. The care manager interviewed the users while an independent researcher evaluated carers. Interviews were also carried out with key professionals. All the data were recorded for preparing a separate report.

DISCUSSION

The care management experience in Southwark and Newcastle has given us, at least, some idea of care management with people with mental health problem in the U.K.. The Southwark example illustrates the process of care management in the social services department setting. The Newcastle project is an experiment

that illustrates a more ideal way in care management in a different organisational setting. Both cases, along with other studies, provide invaluable insights into the potential strength and limitations of care management for people with long term mental health problem.

STRENGTH OF CASE MANAGEMENT

Accessibility

One of the outcomes from the purchaser-provider split is the publication of information of resources and guides by the local authority. This will tell the public where to go, what is available, who to contact etc. The appointment of a particular care manager for a user has made the contact easier for users, carers and providers. Case management can be given the job of assertively taking help to those who find it difficult to become involved in mental health services or are reluctant to do so because of negative expectations (Onyett, 1992).

Continuity

One of the objectives and advantages of care management to ensure continuity of care. As long-term mental health problems are typically episodic in nature, a patient needs for support will change drastically from time to time. Continuous, accessible contact with a named worker allows early intervention to prevent problems worsen. Care manager will review care plan with users, carers, providers and other professionals to ensure that the well being of the user and carer, is maintain from time to time.

Co-ordination

The care manager is responsible for ensuring that comprehensive assessment, monitoring and review of need is achieved, and that efforts are made to activate the services and other forms of help required (Onyett, 1992). The job of the care manager is to co-ordinate the input of other workers or agencies to achieve high-quality service for clients. They are not meeting clients' needs personally, but to see they are met.

Flexibility

When come to the provision for people with mental health problem, the needs of service providers and society are usually placed ahead of the needs of the users. Although the application of user-centred approaches to the planning of care are still very far from universally practised within mental health, care management provides on-going assessment and review in concern with continuos modification of services input to produce the best outcome for users (Onyett, 1992). The Newcastle project has shown the initiative for user and carer empowerment.

Efficiency

Studies show that care management with people with mental health problem has significantly reduced the length of hospital stays and increased users and carers satisfaction compared to traditional services (Onyett, 1992). Also there are indicators showing that quality services can be achieved at no extra cost (Davies, 1992). However, efficiency is not just about saving money. Intagliata (1982) argues that as a result of efficiency in identification, more people who need services provided are found and thus increasing the overall cost.

LIMITATIONS

Eligibility

As one of the motives behind the current community care legislation is to find a way of limiting expenditure on residential and nursing home care, many local authorities face limited resources. Although information needs to be published in the initial care management process, the limited resources available bind it. In another words, criteria will be imposed to provide services to qualified users only. This may not be the weakness of care management but as most people with mental health need special care such as day care, community respite facilities and flexible home support services, insufficient and inadequate of these resources will limit the potential of care management.

Funding

The Southwark experience reports that the formula dictating how social security budgets transferred to local authorities discriminates against those with few existing private and voluntary providers within their boundaries. At the same time, guidelines from the DoH say that 90% of the social security element of funding transfer should be spent on residential care and day care for elderly people. This left limited money for other user groups. In the Southwark case, the authorities altered the percentage for elderly people to 80% but yet people with mental health problems will receive approximately 6%. When we have 53 to 66 % of people with mental illness in social work cases (Huxley et al., 1988; 1989), the funding is clearly inadequate.

Model of Care Management

The separation in the functions of assessment and provision, as evidence in many cases in the UK care management model, can be categorised as the administrative model where the care manager relies heavily on linkage and brokerage. The DoH (1990) advocates the practice of independent non-provider where care manager is mainly concerned with co-ordinating and purchasing care. The rationale for the purchaser-provider split is the need for care manager to avoid conflicts of interest. However care managers as employees of purchasing agencies, there is no guarantee that they will be concerned with maintaining high service quality or a vociferous advocacy role. People with mental illness may also find the administrative model unacceptable and less effective (Huxley and Warner, 1992). There are evidences showing the increase in bureaucracy. The formalisation of

procedures threatens to change the nature of social work practice (Lewis et al., 1997).

This approach may have advantages in terms of case finding and gatekeeping, but services that simply assess and refer on cannot be said to be practising case management as the core tasks are separated. Care manager who also perform direct-care role can obtain good relationship with user and thus be able to assess user's need adequately, to make informed decisions and to guide user through complicated and bureaucratic service systems (Lamb, 1980). Assessment of people with long-term mental health needs is an ongoing process involving continuous monitoring of outcomes. It is not a one-shot screening and allocation process.

Co-ordinating Professional Inputs

Care manager may encounter difficulties in liasing with providers in the mental health system particularly if the care managers prescribe certain forms of provision, on the basis of their assessment, that conflict with the perceived professional autonomy and decision-making powers of the providers. The Newcastle experiment has suggested that empowering people with dementia and their carers in the community relate to empowering care providers (Svanberg et al., 1997). Care providers will only respond adaptively so long as they are engaged in a process which is defined, by themselves and by others, as being meaningful and successful.

The question here is whether care management is a specialist job designation or a set of task that can be integrated into normal working practice. There are pros and cons in each side of continuum. The partition of health and social care can leave professionals in both agencies into unfamiliar ground if they take up care management as part of their jobs. Psychologist may be an expert dealing with user's mental health, but may be ignorant of user's social needs and the bureaucratic system in various agencies. Social workers or non-professional care managers from social services agencies may face the opposite if they are not trained in mental health field.

Following-up & Co-ordinating in a Team

One of the major problems in continuity is on following-up cases regularly. Newton and Walsh (1995) have shown that uncoordinated or failure to link the care programmes by different providers will get the user no where. Unless a named care manager in a care management team is in-charge of one user from the beginning till the end, communication breakdown during referral will deteriorate the condition of the user. The Newcastle example has shown the importance of the co-ordinating role lies on the care manager. It is the responsibility of the care management team to name a particular worker for a user.

SUGGESTIONS

The purpose of care management systems needs to be clear by the authorities involved. Care management has demonstrated its effectiveness in reducing

numbers of hospital long-stay, but its purpose is not reducing the use of hospital facilities. The potential of care management will be limited if there are inadequate resources and facilities available locally.

Responsibility for care management cannot be shared around. Care management offered to a defined population must rest with a single agency at local level. This is to reduce communication breakdown and improve continuity.

Co-operation between different agencies should be enhanced. Care managers and professionals need to understand and accept each other's strength and limitation. The core tasks of care management should not be split up. The care manager is responsible for the well being of the user at all times regardless of their engagement with other agencies (Onyett, 1992). Care managers need to ensure that users are able to access advocates outside of service-providing system if they cannot provide such facilities as they are confined by agency legislation.

Suitable model of care management should be implemented. There are evidences suggesting that assertive care management or clinical care management (Kanter, 1989; Onyett, 1992; Huxley, 1993) is more suitable for people with long-term mental health problem. Counselling, a 'providing' task, had to be remain part of the care manager's work with clients (Lewis et al., 1997). Nevertheless, present evidences do not show any differences between administrative model and clinical model in term of effectiveness (Teoh, 1998).

Whatever their role, care managers must receive adequate training, back-up and support from their organisation in order to ensure continuous high quality services and avoid staff burn-out. Indicators such as Quality of Life (Oliver et al., 1995) can be used to evaluate care management effectiveness.

PROSPECT OF CASE MANAGEMENT INTERNATIONALLY

Care management can be a useful tool for workers in the public services to provide quality services to users. It has been experimented and implemented in several industrialised countries (Davies, 1992). Where there is a trend aiming for accountability in public sector services, care management can offer a vehicle for monitoring the delivery and quality of services inputs (Onyett, 1992). In Britain, care management will continue to play a vital role in the community care reform. With the continue of previous Conservative government reforms by the Labour government, the challenges ahead for care managers may be to be more creative and assertive in searching for resources as benefits were reduced. Care management will itself be a resource and a vital link between user and service providers within the unfamiliar mixed economy of care.

The introduction of care management internationally, however, needs to be cautious. The implementation of care management so far basically took place within an industrialised welfare-state context where various benefits are available. Contrary to the experience in Britain, developing countries like Malaysia never has a welfare state system. The obstacles in these countries will be the underdeveloped mixed economy of care, underdeveloped social work education and limitation of benefit entitlement. It is possible that care

management may end up placing its priority on the continuum of managerial role than direct-care role in the social welfare department. However, as majority of people traditionally relies on self-reliance and informal assistance, care management can still be used to facilitate users and carers in the promotion of normalisation of people with long term mental health.

Taiwan, for instance, relies on community health nurses to monitor the progress of people with long-term mental health problem. However they are also undertaking the caseload of child care, people with chronic illness and women's health problem cases (Yang, 1999). The implementation of case management in Taiwan needs to identify who should be the case manager.

Nam Soon Huh, a professor of social work at the Department of Social Welfare at Hallym University in South Korea recently completed a study on the adaptation of the geriatric task-centered case management model in a Korean community service setting. Dr. Huh used a task-centered case management approach to assist elderly client in accessing and coordinating needed services. (http://www.task-centered.com/tcnews.htm). Likewise, in Japan the focus of case management is on elderly people (Ozaki, 1999). Case management will be implemented in Japan begining April 2000.

Judging on the development of case management internationally, it is possible for Malaysia to implement case management. Indeed, there are indicatiors that case management may be of benefitial to people with mental health problems and their carers in Penang (Wintersteen et al., 1997). There are several questions that need to be addressed:

(a) Who are the clients who needs case management?
(b) Who should be the case manager? Social worker in the Department of Social Welfare? Medical Social Worker? Community Mental Health Nurses? Occupational Therapists? or Paraprofessionals? This relates to the training of case managers.
(c) Who will provide funding for services needed? Who are the service providers?
(d) Which model of case management to be used?
(e) What are the legitimate judiciary power of case managers or social workers?

The case example of case management in Southwark and Newcastle can be used as a model for implementing case management in Malaysia. Before case management is used nationwide, it is recommended to start with pilot project on various group of clients.

Care management logic is a useful universal lingua franca and body of general theorems (Davies, 1992). Its potential as a multitasking role may fit the bureaucracy of the public agencies in different countries. Nevertheless, the training of therapeutic and counselling skills will be a key success for effective care management and that is the challenge for everyone.

CONCLUSION

This essay has tried to discuss the use of care management with people with long term mental health problem. The definition, objectives and core tasks of care management have shown the potential benefits for co-ordination and continuity of care in the community. The need of people with mental health, particularly those with long-term needs, has demonstrated the complexities for care. The Southwark and Newcastle care management experience were used to reveal the process of care management in Britain. Several advantages and limitation of care management for people with long-term mental health problem were also discussed followed by some suggestion for improvement. Finally the prospect of care management in Britain and developing countries were discussed. In conclusion, care management can achieve worthy outcomes if certain problems can be anticipated. Training, support and co-operation among authorities involved will be the key for success.

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