

Exploring the Factors Influencing Care Management Arrangements in Adult Mental Health Services in England

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Abstract

This paper explores issues intrinsic to the development of integrated care for adults with mental health problems: multidisciplinary team working practices; arrangements for determining eligibility and assessment; integrating care management and the CPA; and joint commissioning. It comprises information from six case studies derived primarily from interviews with senior and first-line managers, consequent on a national study of care management arrangements. These findings are discussed in the light of current policy initiatives and demonstrate the complexities of developing assessment and care management arrangements within an integrated service framework.

Keywords: Care management, services for adults with mental health problems, integrated services, eligibility, assessment

Background

Community care for adults with mental health problems has been a primary policy concern since the hospital closure programme in the 1980s (Knapp *et al.*, 1992). Subsequently, through the development of care management, community care aimed to deliver planned and tailored packages of services to people with assessed needs, in accordance with individual need and preference (Cm 849, 1989). This is important because severely mentally ill people living in the community require a coordinated care package, provided through sources such as health, housing and welfare agencies. These agencies have historically often failed to adequately work together (Audit Commission, 1986; Holloway, 1991) resulting in increased hospital admissions, loss of contact with caring agencies and deterioration in mental health status (Marshall *et al.*, 2004), and sometimes with serious consequences (Ritchie *et al.*, 1994). In reviewing the development of community care for this group of people in the UK, three factors are important: integrated health and social care teams; assessment and care management; and joint commissioning in respect of service provision.

Integrating Health and Social Care Teams

Current thinking relating to multidisciplinary teams spanning health and social care can be traced to the interagency models of care management described in the guidance accompanying the community care reforms of the 1990s (SSI/SWSG, 1991a, b). It

was envisaged that for most adult groups the key partnership would be between health and social care although not to the exclusion of other agencies such as housing and education. Within this setting it was expected that care managers could be drawn from any agency or profession and the importance of a common training was recognised. Subsequently, the integration of health and social care teams has been emphasised as a means to coordinate service provision for adults with a mental health problem (Department of Health, 1998). The National Service Framework for Mental Health (NSFMH) (Department of Health, 1999a) suggested that Community Mental Health Teams (CMHTs) provide care according to one of two models: either providing all community-based care itself; or, as is most common in urban and inner city areas, complemented by additional teams providing specific functions, such as assertive outreach.

From the outset it was recognised that professional roles within such teams would overlap and that in some circumstances personal skills may be more important than professional background. It has been noted that in multidisciplinary teams it is appropriate for health professionals to be designated as care managers (SSI/SWSG, 1991a, b; Department of Health, 1995). For adults with mental health problems it is recommended that initial assessments should be jointly undertaken by health and social care staff (Department of Health, 1999a) and for improved clinical and social outcomes, specialist input from nurses, occupational therapists, psychologists, social workers and psychiatrists is required (Strathdee and Thornicroft, 1996).

Assessment and Care Management

With regard to services for adults with mental health problems the development of care management arrangements has been concurrent with that of the Care Programme Approach (CPA) introduced two years before. Responsibility for its implementation was vested in the local health service authorities, whereas responsibility for care management was vested in local authorities. With regard to both approaches, initial guidance offered considerable discretion in local arrangements (Department of Health 1990; SSI/SWSG, 1991a, b). Care management is intended for vulnerable adults who require an assessment of need and the implementation of a care plan in order to enable them to continue to live in the community. Within care management different approaches to assessment have been developed in response to differing levels of need. Initial guidance, which was generic to all adult user groups, allowed for the development of up to six levels of assessment (SSI/SWSG, 1991a, b). More recently, guidance has suggested three types or styles of care management as appropriate for different levels of response in order to provide an integrated and comprehensive approach to the provision of care: the administrative type, providing information and advice; the coordinating type, providing a range of fairly straightforward services; and the intensive type, providing support to a small number of users who have complex and frequently changing needs (SSI, 1997). Care management is considered to be essential in terms of delivering and coordinating the package of care as a coherent service that addresses the complex needs of those with severe mental illness (Strathdee and Thornicroft, 1996), an approach not dissimilar to that which is being employed in respect of chronic disease management for those with physical health problems (Cm 6268, 2004).

At the outset the CPA was applied to all mentally ill patients accepted by the specialist mental health services and it has subsequently been rationalised into two levels in order to promote consistency in approach. It has been suggested that an integrated system incorporating the CPA and care management should include the following features: a single operational policy; one point of access for health and social care assessments and the

provision of care; a single approach to risk assessment; a shared information system; and agreement on the allocation of resources including devolved budgets if possible (Department of Health, 1999b). A key difference between care management and the CPA is in respect of the buying and delivering of services and accompanying budget devolution (Hughes *et al.*, 2001), and it was noted that social services departments provide their own barriers to integration through an insistence on conducting their own assessments before releasing funds (Moore, 1996). In respect of assessment, a recent inspection of mental health services found variation in approaches to this both between and within councils, with no common assessment arrangements, although it was found that some core assessments were in the process of development (Department of Health, 2002a).

Joint Commissioning

Four elements of commissioning have been identified as pre-requisites for good practice: the analysis of need within the general population based on local evidence; strategic planning incorporating the views of users and carers; contract setting and market management, which both stimulates new services and provides reasonable security for established providers; and contract monitoring, which ensures acceptable standards of care within an agreed price range (Cm 4169, 1998). Whilst it was found that many aspects of care provision had improved since 1995 (Department of Health, 1999c), the NSFMMH noted that insufficient finance was resulting in many authorities failing to offer a comprehensive range of services for people with mental health problems, and also poor care coordination (Department of Health, 1999a). Development of a comprehensive range of services, systematically planned and delivered on the basis of identified health and social need, was required. This reiterated an early priority of the community care reforms relating to the concept of a seamless service (Cm 849, 1989). It would appear that whilst government initiatives have emphasised the coordination of care and integration of the service system across individual, agency and district levels (Smith *et al.*, 1996), cultural, professional and organisational factors have made this difficult to achieve in practice

(Kay, 1998). The circular, 'Better Services for Vulnerable People' (Department of Health, 1997), required health authorities (the then commissioners of health services) and local authorities to work together to agree joint investment plans for continuing and community care services. These plans were intended to focus on those services at the interface between health and social services. Subsequently, the Health Act 1999 placed a new Duty of Partnership on strategic planners in health and social care to achieve service specific national standards and demonstrate progress against local milestones.

Method

Care management arrangements were categorised into distinct groupings, using data from two postal questionnaire surveys of all English local authorities' social services departments in existence in 1997. The first of these provided an overview of care management arrangements for all adult user groups and the second was specific to mental health services (overall response rate 104/131 [79%]) (Challis *et al.*, 1999, 2003). Four indicators were selected to identify distinctly different patterns of care management arrangements on an *a priori* basis utilising both substantive and practical criteria, derived from the literature and current policy concerning care management for adults with mental health problems, and pragmatically reflecting the quality and distribution of the data. Fieldwork was undertaken in six areas of England, each reflecting a unique combination of the indicators described above. Following data collection and analysis (Challis *et al.*, 2004) two of the four indicators were selected as the most relevant for further investigation: whether or not NHS staff act as care managers and whether or not an approach to care management involved two or more tiers of assessment. The former has been recognised as an indicator of integrated service provision in older people's services (Challis *et al.*, 2001) and is therefore used in this study in relation to mental health services as a means of achieving the integrated approach to care coordination advocated in policy guidance (Department of Health, 1999b). The latter is an approach which distinguishes between simple and complex client needs (Challis *et al.*, 1998), and assessment is of course one of the

core tasks of care management. Table 1 shows how the six areas (A–F) selected for fieldwork were categorised using these two indicators.

Table 1 Categorisation of care management arrangements, indicating selection of local authorities

	NHS care managers	No NHS care managers
2+ tiers of assessment	D and E	B and C
1 tier of assessment	A	F

The findings reported in this paper relate to information which sought to explore the links between social services departments and other statutory agencies and the influence of local factors, such as traditions of joint working, on service delivery. Interviews were undertaken with a first-line manager and a senior manager in each authority. The former was designed to provide an insight into the context in which care management was undertaken, particularly multidisciplinary working. The latter was designed to elicit information about the strategic commissioning framework in which care management was practiced, and its relationship to other key components of the service delivery system. The interviews were recorded, transcribed and subject to a contents analysis. Box 1 shows the themes covered in the semi-structured interviews, with illustrative examples of key areas of enquiry for each. Relevant documentation relating to assessment and care management procedures was also examined and information corroborated with responses to the two postal questionnaires referred to above.

In addition, commissioning arrangements from the perspective of social services departments were examined to highlight degrees of integration of health and social care, utilising the previously identified descriptor of authorities: NHS staff acting as care managers, and a summary score was also created. We hypothesised that local authorities demonstrating close working relationships with commissioners and providers of health care would provide a more integrated service.

Box 1. Semi-structured interviews: key areas of enquiry

Senior manager interview

Organisational context – role of care management in service provision and scale and pace of changes in mental health services.

Strategic planning – principle partners and service commissioning.

Joint working with health – links between care management and the CPA and opportunities and obstacles to joint working.

Potential for change – impact of national policy on local practice and capacity for local service development.

First-line manager interview

Process of care management – targeting resources on the most vulnerable users, differentiation within the assessment process, ability of care managers to commit resources, continuity of worker, monitoring and review.

Multidisciplinary working – contributions to assessment and care management and information systems to support this.

Local initiatives – team-based initiatives including those to address quality in the care management process.

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Findings

Box 2 provides pen portraits of the six authorities. These describe the extent to which the senior manager within the social services department had responsibility for the management of nurses employed by the NHS together with whether or not they managed both fieldwork and residential and day care resources or solely the former. It can be seen that they are different in terms of the degree of integration as shown by staff undertaking care management and the span of control of senior managers.

Tables 2, 3 and 4 explore factors underpinning the two indicators selected for further enquiry: whether or not NHS staff act as care managers and whether or not an approach to care management involved two or more tiers of assessment. The first of these is examined in Table 2, which explores how this approach to care management manifests itself within a team setting. As illustrated earlier in Table 1, authorities A, D and E had NHS staff as care managers. Table 2 shows indicators taken from a range of sources, which facilitate this approach. Within the arrangement for single/joint managers, the interviews reveal the existence of

Box 2. Pen portraits of participating authorities

Authority A – a London borough in which a senior manager in the SSD was line manager for CMHTs comprising both NHS and SSD staff. There was a nurse manager and a social work manager within the team.

Authority B – a London borough with CMHTs, but social workers also members of a specialist team within the SSD, with a team manager. A senior officer in the SSD was responsible for both the specialist team and other social care provision.

Authority C – a metropolitan borough in which a senior manager in the SSD managed specialist teams comprising SSD staff only, including a team manager, and also specialist in-house mental health providers.

Authority D – a metropolitan borough, currently restructuring to provide a stand-alone mental health service with a social care budget. SSD senior manager responsible for all community-based services. The first line manager was responsible for both NHS and SSD employees.

Authority E – a county council, which in the area under review had CMHTs comprising CPNs and social workers and line managed by an SSD employee with a nurse colleague as a senior practitioner.

Authority F – a new unitary authority with CMHTs, but social workers also members of a specialist team within the SSD, with a team manager. A senior officer in the SSD was responsible for both the specialist team and other social care provision.

Table 2. Indicators of integrated provision within teams

	A	B	C	D	E	F
Single/joint managers ²	✓	X	X	✓	✓	X
Single case file ²	X	X	X	X	X	X
Separate case file/joint access ²	✓	✓	X	✓	✓	X
Single assessment document ²	✓	X	✓	✓	✓	X
Assessment for CPA accepted for care management ^{1,3}	✓	X	✓	✓	✓	X
Single care plan incorporating access to social care resources ¹	✓	✓	X	✓	X	X
If NHS staff act as care managers are care packages authorised in the same way ³	✓	-	-	✓	X	-
Total	6	2	2	6	4	0

Notes: 1. Senior manager interview; 2. First line manager interview; 3. Mental health postal questionnaire

two types of management arrangement: one line manager for two professional groups and separate line managers in one team for each of the two principal professional groups. The former was apparent in authority D and the latter in authorities A and E. Table 2 also explores the extent to which a single care plan is sufficient to access social care provision. This was the case in three authorities, only two of which had NHS staff as care managers (A and D). Also, it is noteworthy that in authority B there was no tradition of unit costs and budgetary devolution in respect of social care, other than for residential placements. This is a reflection of care management arrangements, and particularly budgetary devolution, within the relevant social

services department, exemplified particularly in authority D. Here, first line managers were responsible for allocating resources and were known as care managers and social workers and community psychiatric nurses (CPNs) were described as care coordinators and as such had no responsibility for the allocation of resources. This contrasts with authority A where CPNs and social workers could allocate resources for community-based packages of care with responsibility for residential placements vested in the manager to whom the team leader was accountable. Interestingly, none of the authorities had a single case file spanning health and social care. In total, seven indicators of integration between health and

Table 3. Arrangements for determining eligibility and assessment for care management

Authority	Overall tiers of assessment ^{1,2}	Screening inside/outside team ²	Tiers of assessment excluding screening within team	Levels of CPA ²
A	1	Outside	1	2
B	2	Inside (workers)	1	2
C	2	Inside (team manager)	1	3
D	3	Inside	2	4
E	3 (CPA) 1 (SSD)	Outside	3 1	2
F	1	Outside or inside	1	3

Notes: 1. Care management and CPA documentation; 2. First line manager interview

social care provision in a team setting were identified. The three authorities with NHS staff as care managers had more of these indicators in place than those without and the respondent in authority D described the development of integrated service provision as creating a ‘one stop shop’ in a locality for adult mental health services.

Tables 3 and 4 explore factors underpinning tiers of assessment, indicating an approach that distinguishes between simple and complex needs. They summarise information relating to decisions about eligibility for service, tiers of assessment within care management and links with the CPA. Table 3 shows arrangements for determining eligibility for assessment within care management arrangements. As previously identified in Table 1, authorities A and F had only one tier of assessment. However, as Table 3 demonstrates, two other factors are of interest in this context: arrangements for determining eligibility and levels of CPA as determined locally. Interviews with first-line managers revealed at least three sets of arrangements for determining eligibility for assessment. In authorities A and E this function

was undertaken outside the team. In contrast, in authorities B, C and D this was undertaken within the team, either by front-line staff or by the team manager. Three authorities stated that they had one level of assessment in the local authority procedures and all these stated that responsibility for screening referrals was not undertaken within the team responsible for assessment, as occurred in the other three authorities. Authority E equated tiers of assessment for care management with the CPA, although in terms of the procedures of the social services department there was only one level of assessment. Indeed, in none of the authorities did tiers of assessment identified within the care management process correspond with levels of the CPA as they were locally interpreted. Moreover, in three of the authorities, the number of levels of CPA was in excess of that recommended in the guidance (Department of Health, 1999a).

Table 4 explores assessment in more detail and reveals four points of interest. First, whilst the majority of authorities had assessment documentation specific to the needs of adults with mental health problems, two authorities (B and F)

Table 4. Approaches to care management and the CPA

Authority	Generic or specific assessment documents ¹	Priority to care management or CPA ²	Assessment under CPA acceptable for care management ²	Care management or social work approach ³	3 types of care management (SSI) ³		
					Administrative	Coordinating	Intensive
A	Specific	No priority	Yes	Care management	X	✓	✓
B	Generic	Assessment and care management	No	Social work	-	-	-
C	Specific	CPA	Yes	Care management	✓	✓	✓
D	Specific	CPA	Yes	Care management	X	✓	✓
E	CPA specific SSD generic+addon	No priority	Yes	Care management	X	✓	✓
F	Generic	Assessment and care management	No	Social work	-	-	-

Notes: 1. Overview postal questionnaire; 2. Mental health postal questionnaire; 3. First line manager interview

were reliant on generic documentation applicable to all adult user groups. Second, in the same two authorities assessment as part of the CPA was regarded as a separate process to that within care management arrangements. This contrasts with the other four authorities where assessments of need made under the CPA were accepted as assessments for care management. Third, unsurprisingly, in the same two authorities priority was given to assessment and care management arrangements, rather than to the CPA. Of the remaining four authorities, two gave priority to the CPA and two did not accord a priority to one approach over the other. The fourth factor is the approach each social services department accorded to providing assistance to adults with severe mental health problems. In essence, this sought to explore the extent to which authorities had embraced the changed way of working consequent on the implementation of the community care legislation (a care management approach). This appeared to have occurred in four authorities, with authorities B and F representing a divergent view more typical of practice prior to 1993 (a social work approach).

Finally, the views of respondents in the four authorities who described their practice as embracing a care management approach (A, C, D and E) are detailed in terms of the balance of the team's workload between the three approaches to care management identified by the Social Services Inspectorate and described above: the administrative type, the coordinating type and the intensive type (SSI, 1997). Interestingly, in so doing they described arrangements for processing referrals of adults with mental health problems in their authority to a greater or lesser extent. Only one authority (C) undertook all three approaches within the specialist mental health team. Information relating to the administrative type was only available from two authorities (A and C). In authority A this role was undertaken by an information and access officer and in authority C by a team member operating what was described as an 'unofficial duty system'. All four authorities described themselves as undertaking both the intensive and the coordinating types. However, most of the teams' workload could be described as the intensive type, although in authority E there was also an assertive outreach team undertaking this work. In terms of the coordinating type of care

management, in authorities A and C the indications were that it was a small proportion of the work, undertaken in authority A only by the team manager. In authority D the pattern of work described most closely resembles the coordinating type identified in the guidance (SSI, 1997), where it represented the majority of new referrals and possibly also the division within teams between short and long term work, which was not apparent in other authorities to the same degree.

Box 3 explores the nature and extent of joint commissioning, as a means of identifying organisational arrangements associated with an integrated approach to the care of adults with mental illness. This is derived from a tool developed in 1994, applicable to arrangements at the time the fieldwork was undertaken (Mersey Regional Health Authority Office for Public Management, 1994). It identifies different levels of joint commissioning in three key task areas: management, contracting and budgeting. Senior managers in social services departments identified the position of local services on a continuum of five options, ranging from low to high integration on each task area. For ease of reference, these are scored one to five for each area within an authority. The interview data are used to provide illustrative examples.

In terms of management arrangements two of the authorities with NHS staff as care managers, A and D, had joint management arrangements. The informant in authority A described the current configuration of services within the authority as a 'virtual mental health service'. Authority E described itself as merging management for some mainstream tasks and was about to enter into a similar arrangement to authority A. In contrast authorities B and C reported that they identified lead project managers for some specific tasks within the joint commissioning of adult mental health services. Authority F stated it had established regular meetings of local health and social care managers.

Authorities A, B, C and D reported that they had established arrangements for some joint contracts with colleagues in the health sector. However, the responses of three of these authorities demonstrate a variety of arrangements: commissioning of

Box 3. Descriptions of joint commissioning arrangements by authority

Authority	Management	Contracting	Budgets
A	Single manager (SSD) for SSD and NHS budgets. (5)	Joint commissioning of services in the voluntary sector. (4)	SSD manager had responsibility for two separate budgets funding specialist placements in the health and social care sectors. (3)
B	Project board allocates lead responsibilities for development of integrated service provision. (3)	Two resource centres jointly funded and staffed. (4)	Plans for front-line staff to be seconded into the local NHS Trust within 6 months. (4)
C	CPA Review Group requested a manager to take responsibility for a quality audit. (3)	Joint contracting between SSD and Health Authority at a strategic level, rather than in respect of individual services. (4)	SSD carers grant allocated outside the usual planning process, following consultation with stakeholders. (2)
D	Single manager (SSD) responsible for managing and commissioning all community based services. (5)	No examples given of joint contracts to illustrate this. (4)	SSD manager had financial responsibility for CMHTs comprising social workers and nurses. (4)
E	Joint training and workforce strategy for all mental health workers for more than 40 organisations. Plans for integrated health and social care services. (4)	No examples given of contract alignment to illustrate this. (3)	Funding of resources shared between health and SSD on the basis of local idiosyncratic decisions. (3)
F	All agencies are members of the local implementation team, which meets regularly. (2)	Existing contracts and the contracting process clearly identified in SSD. Processes are less clear in the NHS locally. (1)	The process of identifying relevant spend was complete in SSD and still in process in NHS locally, spanning three Trusts. (1)

Note: The numbers in brackets relate to the summary scores, described in the text.

services within the voluntary sector; contracting at the level of an individual resource within the locality; and contracting for services at the strategic level. Interestingly, joint contracting in the context of individual services appears to be limited to specific initiatives. Authority E suggested there was alignment of contracts between health and social services, but provided no supporting evidence. The remaining authority, F, noted that existing contracts and the contracting process were more explicit within the social services department than the NHS locally.

Budgets within the joint commissioning process were variously described by participating authorities. Authorities B and D described arrangements whereby front-line staff from both health and social care were funded from a single budget. In one authority this arrangement was already in place (D), whereas it was imminent in the other (B). Joint inter-agency pump priming

budgets, which differed in both their nature and scope were reported by authorities A and E. In authority A a single manager was responsible for funding care in specialist long term care placements in both the health and social care sectors. In contrast, in authority E the arrangements for joint budgets were described as being for pump priming individual initiatives. Authority C demonstrated a lower level of joint commissioning in respect of budget setting describing, for example, a situation in which funds from the social services department had been used to provide a service spanning both health and social care. As a corollary to the previous information regarding contracting, authority F reported that whilst expenditure in respect of joint commissioning could be clearly identified by the social services department, this was not the case in the NHS, a situation made more complex because it involved three trusts.

In order to gain a picture of joint commissioning arrangements spanning management, contracting and budgets within a single authority a scoring system was used, with one point assigned for each factor. This revealed summary scores as follows: 13 points for authority D, 12 points for authority A, 11 points for authority B, 10 points for authority E, 9 points for authority C and 3 points for authority F. Of the four authorities that scored the highest, three (A, D and E) had NHS staff as care managers. The link between this and the hypothesis about integrated service provision is discussed in the next section.

Discussion

This paper presents information collected at a particular point in time from six local authorities selected as providing distinctly different approaches to care management in certain domains. It explores the arrangements for community based care for adults with mental health problems, using a descriptive case study approach. Care must be taken to view the findings in this context. In the ensuing discussion a number of issues are considered in the light of current policy guidance.

First, our hypothesis that close working relationships between commissioners and providers of health and social care would provide a more integrated service was explored. The principal finding relates to the difference in approach to commissioning between authorities A and F, with the former indicating a more integrated approach to service development and provision than the latter. Ostensibly, the principal difference between the two is that in authority A, NHS staff as well as social workers act as care managers. However, as the findings above illustrate there were also differences relating to indicators of integrated provision (Table 2) and their approach to care management (Table 4). Together, these factors suggest that integrated service provision and a more developed approach to joint commissioning are more likely to be found in a single authority. However, as Box 3 demonstrates, joint commissioning of service provision was not a common phenomenon in the six authorities included in the study. Moreover, when it does occur, it is comparatively small scale as authorities B and C indicated. This suggests that

responsibility for the commissioning and provision of these services remains largely within the NHS. Indeed it has been noted that social care commissioning will need to be further integrated with health care to ensure the most efficient use of available resources and deliver an improved service for users (Cm 6268, 2004). Furthermore, without clearly identified procedures for commissioning services it is difficult to routinely involve users in this process.

Second, as Table 2 reveals in terms of information systems, little progress had been made in bridging the health and social care divide in any of the six authorities. None of the authorities with NHS staff as care managers (A, D and E) had developed a single client case file. However, as Ovretveit (1997a) notes this takes time to create in the context of multidisciplinary teams. Fragmentation was also apparent in respect of documentation relating to care management and within this, access to resources. In an era where increasing emphasis is placed on consistency in the provision of health and social services and the quality agenda it is important that systems are developed which allow for effective monitoring and performance assessment of services (Department of Health, 1999a).

Third, these case studies provide information about different management arrangements as illustrated in Box 2. Authority D is particularly interesting, because within care management, budgetary responsibility is vested in the manager and not front-line workers, as is the case for example in authority A. However, in both contexts this person could either have a nursing or a social care background. In authority D no distinction is made between management, monitoring and clinical supervision (Ovretveit, 1997b), an approach typically adopted within multidisciplinary teams. Interestingly, current policy guidance, whilst advocating a lead officer for care coordination across health and social care to promote the integration of care management and CPA, does not specify the level of management at which this should take place (Department of Health, 1999b). In authorities A and D our senior manager informants exercised this role and were responsible for team managers.

Fourth, progress in implementing care management for adults with mental health problems, like other adult user groups, was variable reflecting the discretion inherent in the community care reforms, as regards the scale and pace of change. For example, as Table 4 demonstrates, two authorities (B and F) indicated that a social work approach to service provision was more apparent than the way of working embodied in care management. The NSFHM is more specific about standards for mental health services, arrangements for their delivery and mechanisms to measure their performance than the community care reforms (Department of Health, 1999a). It requires the integration of the CPA with care management to provide a single care coordination approach for adults with mental health problems. It will be interesting to review the extent to which this acts as a catalyst for change. Indeed, there were indications that it may have been a driver in respect of authority B, although as the senior manager respondent indicated, another significant factor was that it was enmeshed in the changes consequent on the establishment of a specialist mental health trust covering several boroughs.

Fifth, eligibility criteria and arrangements for the management of referrals are highlighted in these case studies. Government guidance recognises a single point of access for health and social care and generic eligibility criteria for all adult user groups (Department of Health, 1999b; Department of Health, 2002b). These requirements provide several challenges and conundrums as the case studies revealed a number of ways of screening eligibility for service both within and outside specialist mental health teams. It appears inevitable that referrals will continue to come both directly and indirectly to these teams and it is not unreasonable to expect a difference in the amount and quality of information between these two sources. The successful implementation of Fair Access to Care (FACS) guidance requires a consistent approach to screening referrals both in the context of integrating the CPA with care management and determining eligibility for the latter. Moreover, as the case studies illustrate that with one notable exception (authority C) our informants were unable to describe arrangements for administrative care management in respect of adults with mental health problems. The specialist

mental health teams did not view the administrative type of care management as being within their remit and it was not clear where this role was undertaken within the authorities, suggesting perhaps a lack of clarity over arrangements for screening community based referrals in respect of adults with mental health problems.

Finally, it is relevant to note that whilst five authorities stated that most of their work related to intensive care management, as described by the SSI (1997), the case studies revealed little information about its components. Moreover, it is a notable feature of adult mental health services that little is known about the components of intensive care management in contrast, for example, to old age services (Challis, 1999) and systematic reviews have only limited relevance in this context because they include an international component (Marshall *et al.*, 2004). It is also important that account is taken of the particular nature of mental illness and that consequent needs will fluctuate over time and require different levels of response. This suggests that investigation into the components of intensive care management and its relationship to assertive outreach and mental state is required before judgements are made about the nature and value of this approach. The priority accorded to this in the NSFHM highlights its importance.

On reflection, this has been a useful exercise in attempting to classify the plethora of arrangements which influence care management practice in adult mental health services. It began with four indicators relating to care management which was then reduced to two: the presence or absence of NHS staff as care managers and whether the approach to care management is predicated by at least two tiers of assessment. The subsequent exploration of the data suggests that the first indicator is a more reliable distinguishing characteristic than the second and it would appear that this is associated with a stronger commitment to the joint commissioning of services than is typically associated with authorities that do not have NHS staff as care managers. The number of tiers of assessment had less utility, possibly accounted for by the influence of other factors relating to care management arrangements, such as the operation of eligibility criteria and the extent to which this approach is reflected in practice. This

suggests that organisational rather than practice based issues may provide a more coherent framework for classifying care management arrangements.

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References

Audit Commission (1986) *Making a Reality of Community Care*, London: HMSO.

Challis, D. (1999) Assessment and care management: development since the community care reforms, in the Royal Commission on Long Term Care, *With Respect to Old Age: Long Term Care – Rights and Responsibilities, Community Care and Informal Care*, Research Volume 3, Part 1, Evaluating the Impact of Caring for People, M. Henwood and G. Wistow (eds) Cm 4192-II/3, London: The Stationery Office.

Challis, D., Darton, R., Hughes, J., Huxley, P. and Stewart, K. (1998) 'Emerging Models of Care Management for Older People and those with Mental Health Problems in the UK', *Journal of Case Management*, 7(4): 153-60.

Challis, D., Darton, R., Hughes, J., Stewart, K. and Weiner, K. (1999) *Mapping and Evaluation of Care Management Arrangements for Older People and Those with Mental Health Problems. An Overview of Care Management Arrangements*, Discussion Paper 1519/M009, Manchester: PSSRU, University of Manchester.

Challis, D., Weiner, K., Darton, R., Hughes, J. and Stewart, K. (2001) Emerging Patterns of Care Management: Arrangements for Older People in England, *Social Policy and Administration*, 35(6): 672-87.

Challis, D., Hughes, J., Stewart, K., Venables, D., Weiner, K. and Darton R. (2004) *Mapping and Evaluation of Care Management Arrangements for Older People and those with Mental Health Problems: Mental Health Services*, Filed as Discussion Paper M066, Personal Social Services Research Unit, University of Manchester.

Cm 849 (1989) *Caring for People: Community Care in the Next Decade and Beyond*, London: HMSO.

Cm 4169 (1998) *Modernising Social Services. Promoting Independence, Improving Protection, Raising Standards*, London: The Stationery Office.

Cm 6268 (2004) *The NHS Improvement Plan, Putting People at the Heart of Public Services*, London: The Stationery Office.

Department of Health (1990) *The Care Programme Approach for People with a Mental Illness Referred to the Specialist Psychiatric Services*, HC (90)23/LASSL(90)11, London: Department of Health.

Department of Health (1995) *Building Bridges. A Guide to Arrangements for Inter-Agency Working for the Care and Protection of Severely Mentally Ill People*, London: Department of Health.

Department of Health (1997) *Better Services for Vulnerable People*, EL(97)62, CI(97)21, London: Department of Health.

Department of Health (1998) *Modernising Mental Health Services. Safe, Sound and Supportive*, London: Department of Health.

Department of Health (1999a) *Modern Standards and Service Models: Mental Health - National Service Framework*, London: The Stationery Office.

Department of Health (1999b) *Effective Care Co-ordination in Mental Health Services: Modernising the Care Programme Approach, A Policy Booklet*, London: Department of Health.

Department of Health (1999c) *Still Building Bridges: The Report of a National Inspection of Arrangements for the Integration of Care Programme Approach with Care Management*, London: The Stationery Office.

Department of Health (2002a) *Modernising Mental Health Services: Inspection of Mental Health Services*, London: Department of Health.

Department of Health (2002b) *Fair Access to Care Services, Guidance on Eligibility Criteria for Adult Social Care, LAC(2002)13*, London: Department of Health.

Holloway, F. (1991) 'Case Management for the Mentally Ill: Looking at the Evidence', *International Journal of Social Psychiatry*, 37: 2-13.

Hughes, J., Stewart, K., Challis, D., Darton, R. and Weiner, K. (2001) 'Care Management and the Care Programme Approach: Towards Integration in Old Age Mental Health Services', *International Journal of Geriatric Psychiatry*, 16: 266-272.

Kay, A. (1998) 'Community Care Reforms - Challenges which Remain after five years of Implementation', *Integrate News*, 69: 7-10 (April).

Knapp, M., Cambridge, P., Thomason, C., Beecham, J., Allen, C. and Darton, R. (1992) *Care in the Community: Challenge and Demonstration*, Aldershot: Arena.

Marshall, M., Gray, A., Lockwood, A. and Green, R. (2004), Case management for people with severe mental disorders (Cochrane Review), in *The Cochrane Library*, Issue 3, Chichester: John Wiley & Sons.

Mersey Regional Health Authority Office for Public Management (1994) 'Developing Joint Commissioning for Community Care, A Workbook for Managers', Liverpool: Mersey Regional Health Authority Office for Public Management.

Moore, R. (1996) 'Lessons from the Mental Health Task Force London Project', in G. Thornicroft and G. Strathdee (eds) *Commissioning Mental Health Services*, London: HMSO.

Ovretveit, J. (1997a) 'Evaluating Interprofessional Working - A Case Example of a Community Mental Health Team', in J. Ovretveit, P. Mathias, and T. Thompson (eds) *Interprofessional Working for Health and Social Care*, Basingstoke: Palgrave Macmillan.

Ovretveit, J. (1997b) 'How to Describe Interprofessional Working', in J. Ovretveit, P. Mathias, and T. Thompson (eds) *Interprofessional Working for Health and Social Care*, Palgrave Macmillan, Basingstoke.

Ritchie, J.H., Dick, D. and Lingham, R. (1994) *The Report of the Enquiry into the Care and Treatment of Christopher Clunis*, London: HMSO.

Smith, P., Sheldon, T.A. and Martin, S. (1996) 'An Index of Need for Psychiatric Services Based on Inpatient Utilisation', *British Journal of Psychiatry*, 69: 308-16.

Social Services Inspectorate (SSI) (1997) *Better Management, Better Care*, The Sixth Annual Report of the Chief Inspector, Social Services Inspectorate 1996/7, London: The Stationery Office.

Social Services Inspectorate and Social Work Services Group (SSI/SWSG) (1991a) *Care Management and Assessment: Manager's Guide*, Social Services Inspectorate and Social Work Services Group, London: HMSO.

Social Services Inspectorate and Social Work Services Group (SSI/SWSG) (1991b) *Care Management and Assessment: Practitioner's Guide*, Social Services Inspectorate and Social Work Services Group, London: HMSO.

Strathdee, G. and Thornicroft, G. (1996) 'Core Components of a Comprehensive Mental Health Service', in Thornicroft, G. and Strathdee, G. (eds) *Commissioning Mental Health Services*, London: HMSO.