

## **What is case management? a review of the literature**

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### **Abstract**

#### **Aim**

In the absence of a consensus on a definition or identification of a single model of case management this paper aims to identify common themes and core components of case management and explore a definition of case management utilising data from evidenced based research.

#### **Background**

Case management is now recognised as a valued process of care management. However, the definition and components of case management have been subjected to a variety of interpretations and there is much disagreement regarding its practice. As a result agencies have developed case management models that address a set of local issues.

#### **Method**

A literature review was undertaken and a critical discussion highlights the findings that should be considered when evaluating case management processes and efficacy.

#### **Conclusion**

Case management is a concept of dynamic processes that evolve to match patient needs with care and services within an organisational culture that spans a variety of care settings. Case management is defined as 'a healthcare strategy that ensures the efficient assessment, coordination, and allocation of individualised care and services, facilitating improved standards of care, health education, and inter-sectoral collaboration, which empowers service users and increases their quality of life by preventing disease exacerbation, providing continuity of care and maximising self-care.'

**Key Words: case management, care management, case management processes, literature review.**

## **Question: What is case management? a review of the literature**

### **Introduction**

The concept of case management, as a way to coordinate services in a given community, originated from public health nursing in the early 1900s (Sowell and Meadows, 1994). Once described as extended community services required to care for psychiatric patients, case management was in use in North America after World War II and was a term used in the 1960s to characterize programmes of care that overcame barriers of fragmented, duplicated and uncoordinated services (Giuliano & Poirier, 1991). Following the 1981 Omnibus Budget Reconciliation Act and Medicare's reimbursement payment system the focus of case management progressed from facilitating more accessible services to a greater social range to the critical financial monitoring of established services to managed populations (Giuliano and Poirier, 1991). In the UK throughout the 1980s and early 1990s, psychiatric hospitals underwent a period of closure and reduction in bed numbers. Described as "warehouses for human beings who have been discarded by society" (Stein, 1991, cited in Sandford and Gourney, 1996) these large institutions were seen to greatly disadvantage the individual suffering from mental illness and often compounded many of the negative symptoms of schizophrenia (Brennan et al, 2000). In the UK, the development of case management can be traced back to the Griffiths Report (1988), which was commissioned by the Government following the killing of a social worker by a former patient. In response the Government produced the White Paper: *Caring for People* (DOH, 1989). The paper gave prominence to the term 'case management' which, has become familiar to community nurses in all specialisms. Providing high quality care in a financially restricted environment is a world wide challenge to healthcare providers. Case management is now recognised as a valued process of care management. However, the definition and components of case management have been subjected to a variety of interpretations. It is universally appreciated that case management is "indistinct and amorphous" and there is much disagreement regarding its practice (Rothman 1992, p1). There are many definitions of case management but in general there is a professional inability to agree on one

widely accepted definition (Graham & Birchmore Timney, 1990; Piette et al, 1990; Rothman, 1992; Baldwin & Woods, 1994). As a result agencies have developed case management models that address a set of local issues. Rubin (1992) listed 13 distinct models. In the UK, health and social care communities are now being encouraged to adopt case management approaches with the introduction of National Service Frameworks (DOH 1999; DOH 2005a) which endorse the Care Programme Approach and the more recent Social Care Model (DOH 2005b).

### **Rationale**

The specific question answered in this review is 'What is case management?' Case management has been recognised as the prominent requisite for long-term care. However, it is not surprising that without a consensus on a definition of case management, a diverse development of case management models, that only address local issues will continue, (Orwin et al, 1994) and these are likely to be influenced by organizational culture (Piette et al., 1990). The rationale therefore was to identify core themes and identify the impact and efficacy on patient outcomes. In this review the inherent difficulties predisposing to the confusion surrounding the identification of case management are identified and discussed. The core themes that emerged from the research are synonymous throughout the diverse range of case management practice and are summarised in this review to universally define case management practice.

### **Search Strategy**

Through the Royal College of Nursing Library services an Internet literature search of Ovid journals from 1995 – 2005 using the key words 'case management' produced 7052 results. All journals from all specialities were included. In order to save time and expense 349 full text on-line articles were accessed. A search of Pubmed and Blackwell Synergy databases found that the search largely replicated papers found in OVID.

- Inclusion criteria accepted English articles from both in-patient and community based patient groups. Patient groups included

generic long-term conditions, illnesses, diseases and mental health. Articles from different countries were included where a comparable healthcare structure, culture and environment existed.

- Exclusion criteria rejected studies from continents such as Africa and India due to the effects of specific cultural and environmental factors. Specific cost analysis studies and those written in foreign languages were excluded. Studies that failed to evaluate processes and patient outcomes were excluded.
- Appropriate frameworks (Oxman & Gyatt, 1988; Forchuk & Roberts, 1993; Bray & Rees, 1995) were utilised to critique the papers.

## **Methodology**

From 349 articles 12 papers were chosen for inclusion in this review and are illustrated in Appendix 1. 3 studies reported using random controlled trials, 2 utilised both qualitative and quantitative methodologies, and 4 were qualitative in design. There have been several reviews of the case management research literature and 3 reviews that looked at the efficacy of case management practice were included. A summary grid of the studies and their methodologies are illustrated in Appendix 1.

## **Reviews**

A review by Ferguson and Weinberger (1998) reported on the effects of case management programmes on patient centred outcomes, healthcare resource use and costs. The review only looked at randomised controlled trials and nine studies were included. Therefore, methodological rigour of this review is significant. The authors do not state how the papers were selected for the review or how the papers were assessed for validity. The studies were

combined narratively due to the heterogeneity of study design. The authors stated that the heterogeneity of the study design did not allow for formal quantitative methods to be applied. Although validity criteria was not reported, some validity issues relating to specific studies were mentioned. A significant review (Holloway et al;1995) in terms of methodological rigour, examined the effects of case management on psychiatric patients. The review focused on the organisation and coordination of services on behalf of the client and looked at various models of case management. Only randomised controlled trials , matched control, repeated measures and descriptive studies were included. The study designs were reported in a table. The strength of the evidence from the different studies was not quantified based on the study design and quality. The descriptions and definitions of the case management and control interventions are often not clearly defined in the literature. A review of research literature by Mueser et al; (1998) evaluates the effectiveness of different models of case management for persons with mental illness. There were no restrictions on the chosen 75 study designs. Just under half of the studies were controlled random assignment and included quasi-experimental and pre-post studies, therefore the methodological rigour is significant. The authors do not state how the papers were selected for validity but the methods for coding the results were described. Studies were combined in a qualitative narrative and tests for heterogeneity were not reported.

### **Qualitative Studies**

4 studies reported using qualitative methodologies. The aim of a descriptive survey by the Department of Nursing and Midwifery Services (1996) at the University of Glasgow was to identify the educational needs of mental health staff moving to community care from hospital services. The study aimed to identify current clinical strengths; ideal skills for mental health practice, existing educational levels and the level of the staffs' understanding of community care reforms therefore the methodology was appropriate. The method for testing validity was described but the authors did not report the characteristics of the respondents. 36% of the sample group (n=695) responded and it is unlikely that the results reflect the wider nursing

population because only the views of a small percentage of mental health nurses were studied. Armitage and Kavanagh (1996) used semi-focused interviewing of hospital and community nurses to identify and compare how hospital and community nurses perceived the provision of continuing care for patients and their experiences with discharge planning. Semi-focused interviews enabled probing and clarification of responses, which was appropriate for this study, and explored relevant topics and issues to construct a description, based on the understanding of the respondents. Both hospital based and community nurses were included and their variances in their skills and knowledge base were acknowledged. The study used an interview guide as a control measure to ensure continuity. However flexibility of the semi-focused interviews did allow the introduction of new subject matter. The authors report their methods for ensuring trustworthiness. The results of this study are likely to be trustworthy and show an accurate reflection of the views expressed by the nurses. A 2 year qualitative investigation by Weaver et al; (2003) aimed to identify the mechanisms of how the UK700 trial outcomes were generated and to investigate the nature and impact of forms of assertive casework. This qualitative study had two components. The first was a thematic interview survey and the second involved patient based case studies. Different levels of case management practice were analysed. The methods for ensuring rigour of this study were described in detail. Case characteristics were explicit and tables were used to illustrate results, which were weighted with evidence. Therefore the methodological rigour was significant. Types of case management were categorised into standard case management and intensive case management and the influencing variances were explored in detail. The findings of this study are likely to be trustworthy due to the study design. A study by Waterman, Waters and Awenat (1996) aimed to examine the feelings and concerns of new case managers, their conception of case management and their perceived educational needs following its introduction on a rehabilitation ward. Rigour was addressed in part through concurrent analysis of data, with data collection, which encouraged probing of issues important to the research participants. The definitions of case management reported in the literature are descriptive rather than evidenced based. The authors report which frameworks were

observed for data analysis. The sample however was too small to claim any trustworthy findings and this is acknowledged in the study by the authors.

### **Randomised Controlled Trials**

Of the three randomised controlled trials only the study by McBride et al; (2004) aimed to describe, classify and quantify nursing interventions using a standardized nursing classification system. Following the development of guidelines to identify interventions an independent review compared the interventions with nursing classifications and found a 90% agreement with correlations. This is a strength of this positivist study. Approvals from the Research Ethics Committees of the participating hospitals were acquired, informed consent was obtained from all participants and confidentiality was assured. The methodological rigour is significant and findings of this study are internally valid due to the randomisation of this study design. The retrospective study by Micheels, Wheeler and Hays (1995) aimed to identify whether case managed patients fared better than those under normal nursing care. The authors studied the records of 78 patients undergoing colon resection at an American hospital. Results were reported in dependency levels and the mean length of stay for patient groups. The authors do not report on methods for ensuring validity. The methodology of the study is appropriate. In a stratified randomised trial by Stuck et al; (2002) nurse practitioners were used to provide case management for homebound, chronic, or terminally ill patients to determine its effects on, patient outcomes, hospitalisation, medication and disease exacerbation. Participants were characterised into sub-groups within the intervention groups and compared with controls. The authors report the study controls and methods for ensuring validity. The methodological rigour is significant.

### **Mixed Methodology**

The aim of a study by Schmidt-Posner and Jerrell (1998) was to assess the cost-effectiveness of three case management models within the framework of one large, public mental health system for people with severe mental illness. The Clinical Team Model was regarded as the comparator and a justification was provided for its choice as the most likely model to be in use. The results

that measure effectiveness are likely to be internally valid due to the randomised nature of the study design, and the regression analysis carried out to assess the effects of confounding variables on the quantitative variables. The authors did not report on the sample size, comparability of patient groups, and randomisation procedure. The study reported that it was a prospective randomised controlled trial and the methodological rigour is significant. Quantitative data were collected from the patient group in terms of resource quantities, treatment programme variables and organisational factors and outcomes in terms of costs and effectiveness. Regression coefficients were reported as deviants around the grand mean of coefficients. Qualitative data was collected over 2 years from 64 staff interviews. The representativeness of the patient sample cannot be fully assessed due to a lack of information on the characteristics of the patient sample although inclusion criteria were specified therefore the methodological rigour is trustworthy. A study by Mackenzie et al; (1998) collected quantitative data using a descriptive correlation design that aimed to assess and evaluate outcome variables from patients and carers as a result of case management implementation. Outcomes were measured through the Sickness Impact Profile (Bergner et al; 1976); Cost of Care Index (Kosberg & Cairl, 1986); patient satisfaction scale; re-admission rates and accident and emergency attendance. Interviews, activity sheets and diaries to describe processes of nursing, roles and functions obtained qualitative data. Appropriately, as this study sought to examine processes and outcomes of case management both quantitative and qualitative research methods were employed and methodological rigour is significant. Although, the sample was reported to be a convenience sample, the limitations of non-random sampling are acknowledged.

## **Findings**

The results of the reviews (Ferguson & Weinberger 1998; Holloway et al; 1995; Mueser et al; 1998) show a small decrease in hospital admission time; small improvements in compliance with medication, functional status and

effective control of symptomology. However the evidence to support reduced costs is based on hospital admissions and only one study reported on the transfer of costs to the residential setting (Holloway et al; 1995) which is an important factor to consider. Therefore the assumption that case management reduces care costs across all settings is inconclusive in this regard. In general most of the qualitative studies reveal that the case managers specialist role involves the comprehensive assessment and matching of services to patient needs (Armitage & Kavanagh 1996; Dept Nursing & Midwifery 1996; Weaver et al, 2003). The study by Dept of Nursing & Midwifery (1996) describes 5 key skills appropriate to case managers whereas the study by Weaver et al; (2003) categorises the processes of case managers into models and identifies which, how and when a type of case management is practiced. One key theme that emerged from all the studies is concerns over boundaries and accountability of the case managers professional role; education, professional skills and accountability were poorly correlated with the boundaries of the role, policy and managerial support were inadequate. The study by McBride et al; (2003) classifies the processes and activities of case management using a standardised classification system. This is useful for the measurement and evaluation of certain case management activities. This form of standardisation may also be useful in determining if one particular type of case management is more effective than another, however, the study doesn't make a comparisons to any one recognised model or component of a model. Other studies would need to follow the same study criteria to effectively compare findings balanced against patient outcomes. The other studies (Micheels et al; 1995; Stuck et al; 2000) conclude that case management reduces costs through better control of clinical conditions, reducing hospital and nursing home admissions, which reduces the cost of care. In conclusion the evidence is weighted in favour that effective case management does reduce care costs. The study by Mackenzie et al; (1998) demonstrates that case management improves therapeutic nurse-client relationships and quality of care, whilst decreasing costs. Patient satisfaction was high and functional outcomes improved. The study reported a significant decrease in hospital admissions and A & E attendance. Case management interventions are reported to have changed behaviours by

patients and carers towards promoting self care. Activities of case management are identified as; clinician; health educator and self-care promoter; referrer to other professionals/services; and care coordinator. It was identified that specialist skills are required and operational problems were encountered due to poor protocols, budget constraints, lack of autonomy and limited time. The study by Schmidt-Posner & Jerrell (1998), found that the PACT Adaptation model performed significantly higher than the Clinical Team Model regarding observed-rated psychological adjustment and total psychiatric symptoms, and significantly lower on self-reported life satisfaction. Whereas the Intensive Broker Model was found to be significantly higher than the Clinical Team Model on psychiatric symptoms. The results therefore, favour the PACT Adaptation Model on functioning and the Clinical Team Model on life satisfaction and symptomology dimensions. The authors' qualitative analysis therefore, reports that there are differences in the way care programmes are organised and function. This provides some insight into the impact of case management on clients. The quantitative analysis reported that the PACT Adaptation model significantly reduced intensive mental health costs. The Broker Model had higher costs than the Clinical Team model.

## **Discussion**

### **Defining case management: why is it a problem?**

'**Case**' as described by Yin (1994, p.22) '*can be some event or entity that is less well defined than a single individual*'. '**Management**', is described as '*the control and organisation of something*' (Cambridge University Press 2003). Another lexicon definition, within the context of case management, of '**management**' described by Sledge et al (1995), suggests that implicit in the term '**management**' is the '*authority over the conduct of work and control of resources*'. Furthermore they refer to service fragmentation and absence of linkage between community care and hospitalisation. Many have been unable to agree on one widely accepted definition (Piette et al, 1990; Graham and Birchmore Timney, 1990; Baldwin and Woods, 1994). It has been highlighted from many sources that case management is not a cohesive philosophy nor a disciplined set of ideas (Chan et al, 2000). The evidence from this review has demonstrated that case management practices vary according to the

organisational culture in which they are practiced. Gournay (2000) identified that terms such as assertive community treatment, home treatment and case management are used interchangeably. On the whole the positivistic perspectives of case management practice, patient outcomes and cost effectiveness appear to provide reliable evidence on which to guide nursing practice. However, the quality of the qualitative evidence varies significantly. The range of evidence from different clinical settings Armitage & Kavanagh (1996); Department of Nursing & Midwifery Studies (1996); Ferguson & Weinberger (1998); Holloway et al; (1995); McBride et al (2003); Micheels, Wheeler & Hays (1995); Mueser et al; (1998); Stuck et al (2000); Waterman, Waters & Awenat, (1996); Weaver et al; (2003), demonstrates that case management is practiced in hospital settings as well as the community, for acute or chronic illness management. This supports the theories by Hale (1995) and Bergen & While (2000) who describe managed care and case management as synonymous strategies for co-ordinating services. Case management therefore can be described as a health-care strategy. In summary drawing on the themes that emerged from the research in this review, case management could be defined as *'a healthcare strategy that ensures the efficient assessment, coordination, and allocation of individualised care and services, facilitating improved standards of care, health education, and inter-sectoral collaboration, which empowers service users and increases their quality of life by preventing disease exacerbation, providing continuity of care and maximising self-care.'*

### **Cost v Care**

King et al (2000) describe uncertainties about organisational services and processes of delivery as problems inherent in attempting to define case management. Difficulties in establishing a clarity could be attributed to the two potential divergent social goals of case management: (1) the service advocate function: accessing and coordinating resources for service users, and (2) gatekeeper function: containing costs of extended care (Brennan and Kaplan, 1993). Many case management programmes in the US that focus on access to resources have relegated cost control to a secondary source (Cruise and Liou, 1993). The positivistic evidence was strong in identifying the

cost benefits of case management. Certainly the evidence (Ferguson & Weinberger 1998; Holloway et al; 1995; Mackenzie et al; 1998; Micheels et al; 1995; Mueser et al; 1998; Schmidt-Posner & Jerrell, 1998; Stuck et al; 2000) in this review identified the overall cost benefits of case management whilst the qualitative study by Mackenzie et al; (1998) found that budget constraints were significant problems for case managers. Case management is therefore an efficient system of coordinating and accessing resources to match care with need.

### **Quantifying case management**

Case management is 'indistinct and amorphous' and many disagree about the practice of it (Rothman, 1992, p.1). The evidence from the review clearly shows that case management practice is diverse. Interestingly only McBride et al; (2004) aimed to describe, classify and quantify nursing interventions using a standardized nursing classification system. This standardised process would be useful in classifying the nursing processes of different case management models and would certainly give evidence to guide nursing practice. However, the study by Schmidt-Posner & Jerrell (1998), demonstrated that case managers switch between models according to the patient's needs. Is it possible therefore to classify case management practice into set models of care without first standardising nursing processes or components of case management practice as demonstrated by McBride et al; (2004)? Because case managers switch between models this would certainly provide an explanation for the confusion surrounding its practice and difficulty in evaluating its effectiveness. However, case management is a dynamic process that evolves to meet the needs of patient care delivery. No one model operates across all boundaries within all clinical settings therefore the surrounding confusion and the problem of quantifying and evaluating case management will always be inherent.

### **A system of health care delivery**

Baldwin and Woods (1994) describe case management as a refined intervention that addresses difficulties posed by fragmentation and partial funding of services for persons who require long-term support. Traditionally case management has been provided to people who need life-long care such as people with a mental illness, chronic medical conditions, the elderly, and developmentally disabled people (Rothman, 1992). However, the evidence from the research in this review demonstrates that case management is a system of healthcare delivery that can be delivered both in the short term (Micheels, Wheeler and Hays, 1995) or over a longer period of time (Stuck et al; 2002). Case management is a strategy of managed care that can be adapted across all health care settings both hospital based and community, for both acute and chronic illness.

### **Contextual Variables**

Once seen as a role with social services orientation the nursing perspective was not a feature of reviews nor of individual projects (Challis et al; 1990; Phillips and Penhale 1996). However more recently the UK Government has been more prescriptive about the professional qualifications most appropriate for the case manager's role; proposing key domains for new community matrons (DOH 2005b) who will manage the long term care of individuals living in the community. These contextual variables, such as national policy, local organisational agendas and professional approaches and intersectoral collaboration are important to the phenomenon of case management. Themes that emerged from the qualitative research that support this theory (Armitage & Kavanagh 1996; Dept Nursing & Midwifery 1996; Weaver et al, 2003) were concerns over boundaries and the autonomy of the case managers professional role; education, professional skills and accountability were poorly correlated within the boundaries of the role; policy and managerial support were also found to be inadequate causing problems. The standards and reliability of these qualitative studies varied. What is apparent is the need for further research to determine the impact of these contextual variables upon the success and effectiveness of case management practice.

## **Implications for Practice**

The study by McBride et al; (2004) found that utilising the nursing intervention classification system was useful in capturing case management interventions using a standardised terminology. Within the context for practice development this could lead to an improved understanding of post discharge needs and interventions resulting in an increase in nursing knowledge and evidenced-based practice. Mackenzie et al, (1998) identified areas of improvement to clinical practice through processes of case management such as the identification of patient and carer problems, enhanced communication, coordination of services through direct referral, improved interventions and the promotion of self care, trust and cooperation, and improved relationships and patient outcomes amongst others. Case management certainly appears to be beneficial to both patient and health care provider. What is clear is the need to evaluate the fidelity of case management model implementation to explore determinants of positive and negative case management outcomes. This means further research is required that looks at and compares different models which employ case management activity. This would certainly help to identify components of the predictive patient and case manager relationship and outcomes. However, to achieve this it would be necessary to focus on comparing outcomes against model components rather than one model against another to predict which patient groups respond better to certain components.

## **Conclusion**

In the absence of a clear protocol and definition agencies have developed models that address a set of local issues. Furthermore it is clear that case management practice is not confined to one set model and processes range across different models adapting to patient needs. Because case management is a flexible and attractive intervention for addressing a wide variety of patient groups it has become inherently impossible to impose a universally accepted model. Because of this definitional ambiguity case management guidelines and interventions are more difficult to construct, (Graham and Birchmore Timney, 1990). Therefore the development of a wide variety of case management models is not surprising (Orwin et al; 1994).

There are many different features that distinguish how case management is practiced, (Loomis, 1988; Korr and Cloninger, 1991; Rothman, 1992; Brennan and Kaplan, 1993; Holloway et al, 1995). However, research has not advanced to the extent in which one model is said to be better than another (Rothman, 1992) and most researchers agree that no one model is appropriate with all patient groups. Further research is needed to evaluate case management processes against patient outcomes if case management is to be effectively evaluated. An inherent tension exists between the gatekeeper function and the advocate function regardless of the overall system's needs (Piette et al, 1992). These potentially competing goals affect both service delivery and the evaluation of outcomes. Case management is a concept of dynamic processes that evolve to match patient needs with care and services within an organisational culture that spans a variety of care settings.

The differing research paradigms provided a diverse range of perspectives; an evaluation of case management processes; patient outcomes; and identified both positive and negative determinants. Therefore a review of the research from different paradigms was necessary to answer the review question. Case management is a dynamic process, operating in a diverse range of clinical settings. Including research from different paradigms was useful in determining the problems associated with contextual variables and the influences on case management practice.

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