A Review of Case Management for People Who Are Homeless: Implications for Practice, Policy, and Research

by
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Abstract

Case management programs for homeless people have proliferated since the 1980s but some have questioned the meaning and clarity of the term case management while others have questioned its effectiveness for serving clients. This paper first attends to conceptual issues, identifying primary functions and process variables for understanding and describing case management services. The paper next describes models and approaches to case management for various client subgroups and specialty areas.

The paper also reviews the empirical literature on homelessness and case management, especially as it relates to treatment effectiveness and critical factors. Several conclusions are postulated, including that some case management approaches, especially assertive community treatment (ACT), are effective for helping people who are homeless with severe mental illness; frequent service contact is a critical ingredient leading to positive treatment retention and housing outcomes; case management is more effective with some clients than others. A number of gaps in our knowledge of case management are also identified.

The final section of the paper presents recommendations on exemplary practices. These include recommendations related to critical staff skills and abilities, service principles, case management models, and organizational practices.

Lessons for Practitioners, Policy Makers, and Researchers

Recommendations for homeless case management practitioners include focusing service delivery efforts upon:

- Conducting assertive, community-based outreach;
- Nurturing trusting, caring relationships with clients;
- Respecting client autonomy;
- Prioritizing client self-determined needs;
- Providing clients with active assistance to obtain needed resources;
- Maintaining small case loads; and
- Implementing ACT approaches.

The federal government is also encouraged to promote exemplary practices through knowledge dissemination, advocacy, and financing actions and to promote new research and knowledge on case management services for people who are homeless.
**Introduction**

Within the past two decades, case management has functioned as a cornerstone of efforts to serve people who are homeless. During that period, providers and researchers have recommended case management services for homeless people, policy makers have facilitated the development of case management programs through grant announcements, and Congress has encouraged States to provide case management through legislative initiatives (McKinney Act, PATH, mental health block grants). Program developers have adapted case management services for a variety of subgroups of homeless people, including those with severe mental illness, substance abuse disorders, people with dual diagnoses, pregnant women, and homeless families. Case management services need to be considered within a broad perspective that recognizes the multiple and serious needs of people who are homeless, the varying subgroups, the need for multiple interventions at various levels of society, and the crucial importance of adequate housing resources (Dennis et al., 1991; Federal Task Force on Homelessness and Severe Mental Illness, 1992; Morse, 1992). Undoubtedly, however, case management has become in practice one of the most common services to people who are homeless.

Why have case management services been recommended and implemented so frequently in the area of homelessness? In part, there is a general zeitgeist of case management within human services. More specifically, however, the initial development of case management services has resulted in part from several interrelated, key assumptions about the problems, causes, and solutions of homelessness:

1. People who are homeless have serious and multiple problems and unmet service needs and problems (Ball & Havassy, 1984; Morse & Calsyn, 1986).
2. The services and resources necessary to meet these human needs are contained within a fragmented system of disparate service organizations (Rog, 1988).
3. Additionally, the service system is often structured and operated in such a manner that it poses a number of obstacles and barriers for clients in need; clients, therefore, often have difficulty accessing needed services and resources (Goldfinger & Chavatz, 1984; Rog et al., 1987).
4. Case managers are thought to be necessary to “facilitate access,” “coordinate,” “negotiate,” and ensure services for client needs (e.g., Francis & Goldfinger 1984; Levine & Fleming; 1986; Oakley & Dennis, 1996; Rog et al., 1987).

Note the service system function inherent in these assumptions. As Hopper, Mauch, and Morse (1989), framed it, case managers perform “microsurgery on the service system.” Not surprisingly, some have considered case management to be one intervention strategy for changing and improving the entire service system as well as improving individual client outcomes (Mechanic, 1991; Raif & Shore, 1993; Surles, Blanch, Shern, & Donahue, 1992).

An additional set of beliefs about people who are homeless also facilitated the development of case management programs. Specifically, homeless people have often been described as markedly mistrustful and suspicious of service providers, and to highly
value their autonomy (e.g., Francis & Goldfinger, 1986). Case managers have been conceptualized as workers whose first task is to engage people who are homeless, developing and nurturing trust and a working alliance (Francis & Goldfinger, 1986).

While compelling arguments have been for case management services, significant questions and concerns have also arisen. Confusion about exactly what constitutes case management has been common. Others have questioned the effectiveness of case management.

The remainder of this paper will attend to these and related issues. Specifically, the following sections will:

- Discuss definitional and conceptual issues related to case management.
- Identify and briefly discuss different case management models or approaches used with homeless clients.
- Review the research literature related to the empirical study of case management approaches for people who are homeless, with a special emphasis upon the effectiveness of case management services. Conclusions will also be discussed and knowledge gaps identified.
- Draw from the literature to identify exemplary case management practices with people who are homeless. This section will also provide recommendations about how agencies can promote exemplary services.
- Conclude by providing additional recommendations on ways the federal government can promote exemplary practices.

**Definitional and Conceptual Considerations: What is Case Management?**

Across all health and human services, case management remains a loosely defined service which is less well understood than one might expect, given its widespread application and popularity” (Willenbring, Ridgely, Stinchfield, & Rose, 1991, p. 14). This statement applies equally to the field of homelessness, where case management has been characterized as “a much discussed but poorly defined concept” (National Resource Center on Homelessness and Mental Illness, 1990, p. 1). The conceptual confusion has resulted in part from a lack of definitional specificity. In the past decade, some theorists and researchers have focused increased attention on conceptualizing and defining case management (e.g., Raif & Shore, 1993; Willenbring et al., 1991). Particularly useful is the review and conceptualization of Willenbring and colleagues. They suggest that case management services can be defined in terms of their specific service functions. They identify six primary functions that characterize case management (see also Joint Commission on Accreditation of Hospitals, 1979):

- Client identification and outreach: to attempt to enroll clients not using normal services
- Assessment: to determine a person’s current and potential strengths, weaknesses and needs
• Planning: to develop a specific, comprehensive, individualized treatment and service plan
• Linkage: to refer or transfer clients to necessary services and treatments and informal support systems
• Monitoring: to conduct ongoing evaluation of client progress and needs
• Client advocacy: to intercede on behalf of a specific client or a class of clients to ensure equity and appropriate services

They also note four additional functions which are common but variable across case management services:

• Direct service: provision of clinical services directly to the client
• Crisis intervention: assisting clients in crisis to stabilize through direct interventions and mobilizing needed supports and services
• System advocacy: intervening with organizations or larger systems of care in order to promote more effective, equitable, and accountable services to a target client group
• Resource development: attempting to create additional services or resources to address the needs of clients

Another common additional function of case management is *discharge planning*. Discharge planning often incorporates many of the above functions as case managers help clients plan to transition from one type of setting or service program to another.

The description of functions helps to provide more specificity to the definition of case management. However, as Bachrach (1992) noted in the broader area of mental health services, there is still a lack of consensus “about the precise meaning of case management” (p. 209; see also Rog et al., 1996). In part, this results from the practice of a number of different models or approaches to providing case management. Different case management models generally (but not always) perform the primary functions identified above; however, they vary not only in the presence or absence of the additional functions listed above, but also in other important ways. Especially important are the *operational or process* characteristics of case management programs, which Willenbring and colleagues distinguish from the functions of case management. The process characteristics measure more *how* case management services operate, rather than *what* they do. The following list of seven process variables, selected and modified from Willenbring and colleagues, are relevant for understanding similarities and differences between specific case management services.

• Duration of services (varying from brief, time limited to ongoing and open-ended)
• Intensity of services (involving frequency of client contact, and client-staff ratios)
• Focus of services (from narrow and targeted to comprehensive)
• Resource responsibility (from system gatekeeper responsible for limiting utilization to client advocate for accessing or utilizing multiple and frequent services)
• Availability (from scheduled office hours to 24-hour availability)
- Location of services (from all services delivered in office to all delivered in vivo)
- Staffing pattern (from individual case loads to interdisciplinary teams with shared caseloads).

In addition to these seven variables related to how case management programs operate, it is useful to consider who is involved in case management:

- Who is the client target population?
- Who are the staff, and especially what are their disciplines?

**Case Management Approaches and Models**

Table 1 provides a listing of case management models and approaches which have been described in the published scientific or practice literature (or included in widely circulated government monographs or reports). The phrase models and approaches are used to include both (a) programs that are well-established in theory or research as well as (b) programs that represent emerging methods that are commonly used in clinical practice, even in the absence of an extensive, preexisting theoretical or research basis. Table 1 includes data, where available, considering several of the key operational or process variables described above. These case management approaches are briefly described below under five client subgroups: people with severe mental illness, people with severe mental illness and co-occurring substance abuse disorders (dual diagnoses), people with substance abuse disorders, people with primary health disorders, and homeless children and families. The majority of the published literature concerns case management approaches for people with severe mental illness; thus, the following discussion is more developed in this area, and, unfortunately, underdeveloped in other areas.

**Severe Mental Illness**

As shown in Table 1, intensive case management (ICM) approaches (see Rog et al., 1987) have been widely used with a variety of homeless subpopulations, including people with substance abuse disorders, homeless families, and especially with people with severe mental illnesses. ICM is illustrative of an approach that has emerged from the field in the absence of an extensive, preexisting theoretical or research basis. Its popularity for homeless clients has in part probably arisen from clinical principles–assertive and persistent outreach, reduced case loads, active assistance in accessing needed resources–that are compelling given the nature of clients’ needs and system characteristics. Not surprisingly, however, ICM approaches are sometimes mentioned without extensive description of their programmatic functions or process characteristics. Further, the comparability of ICM across programs or homeless subgroups is unclear and questionable; there appears to be significant operational differences across ICM programs but these are often not systematically described or assessed.

*Assertive community treatment (ACT)* programs represent another common approach for homeless people with serious mental illness. (For this review, the ACT approach is meant
to encompass programs identified in the literature as Continuous Treatment Teams or CTTs. The terms ACT and CTT are sometimes may represent subtle programmatic differences but often in practice and research they are synonymous terms, or indistinguishable from one another.) The ACT model has been highly researched and well-established as an effective community-based intervention for non-homeless people with severe mental illness (see Stein & Test, 1985; Burns & Santos, 1995). It has also been widely disseminated throughout a number of states as a model program for some people with severe mental illness (Deci et al, 1995). ACT proponents eschew the term case management (e.g., Stein, 1992); despite the validity of these objections, ACT is often included within reviews of case management and will be considered within this rubric in this paper as well. The model does indeed differ significantly from many case management approaches, especially in its emphasis on direct treatment and services, shared caseloads, and use of an interdisciplinary team that includes specialists such as psychiatrists and nurses.

The ACT model has been adapted in various ways to improve its relevance to a homeless population. These adaptations parallel many of the principles followed by homeless outreach and ICM programs; they include assertive outreach, engagement strategies, and an increased emphasis on clients’ resource and housing needs (Dixon et al., 1995; Morse et al., 1992). Investigators have also added new innovations to the basic ACT model by adding both adjunct lay citizen community workers (Morse et al., 1997) and mental health consumers (Dixon et al., 1994) to the treatment team. Despite these modifications, one advantage to the ACT approach is its clarity and specificity in program principles, functions, and operations. The model is well described, and researchers have developed an instrument to measure the degree of fidelity of any one program to the ideal ACT program (McGrew & Bond, 1995; Teague et al., 1998). ACT teams for homeless clients with severe mental illness have recently been widely promoted and replicated through the CMHS ACCESS program (Johnsen, Samberg, Calsyn, Blasinsky, Landow, & Goldman, 1998).

A review of the literature (see also Table 1) suggests that a number of other case management approaches have also been developed for homeless people with serious mental illness. In addition to ICM and ACT approaches, two additional models are Clinical Case Management and Social Network Case Management. Both provide sound theoretical justifications for their clinical and social network components, respectively, while also incorporating basic ICM principles and characteristics. At present, however, neither model appears to be widely practiced.

The Strengths Model is often advocated and implemented for the broad (non-homeless) population of people with severe mental illness (Rapp, 1993). Features of this model include a focus on the environment as well as the individual client, use of paraprofessional staff, emphasis on client strengths rather than deficits, and a priority placed on following client directed interventions. The Strengths Model has recently been implemented in a large demonstration for homeless clients in Kansas under the ACCESS grant (Johnsen et al., 1988).
The **Critical Time Intervention** (CTI) is a new approach developed and tested for people who are homeless with severe mental illness (Susser, Valencia, Conover, Felix, Tsai, and Wyatt, 1997). The CTI approach focuses upon strengthening a person’s long-term ties to other services and supports while providing emotional and practical support during the critical period of a transition from shelter to housing.

Also appearing within the literature are approaches which are noteworthy for their use of consumers as case management staff. The use of consumers and peers has been incorporated within various models of case management, including homeless ACT teams that include a consumer advocate (Dixon et al, 1994) and ACT teams which are almost exclusively comprised of consumer staff (see Herinckx, Kinney, Clarke, & Paulson, 1997). *Consumer Case Management* approaches have advocacy support, offer important work roles for former patients, and may be helpful for engaging clients suspicious of traditional mental health providers.

Finally, *Broker Case Management* approaches, meanwhile, are also commonly provided. Broker models emphasize assessment, planning, referral, and monitoring functions without extensive outreach, linkage or direct service contacts. While common, they are not recommended for homeless clients (Morse, Calsyn, Klinkenberg, Trusty, Gerber, Smith, Templehoff, & Ahmad, 1997).

**Dual Diagnosis**

Many case management programs for homeless people with severe mental illness have also served large number of persons who also have a co-occurring substance abuse disorder. Often, this has been a de facto rather than planned intervention, given the high prevalence of co-occurring substance abuse disorders among homeless people with severe mental illness (Federal Task Force on Homelessness and Severe Mental Illness, 1992). More recently, there have been increased efforts to address the specialized needs and problems of people with these dual diagnoses, especially among the non-homeless dually diagnosed population (e.g., Durell, Lechtenberg, Corse, & Frances, 1993; Jansen, Masterton, Norwood, & Viventi, 1992; Jerrell & Ridgely, 1995; Osher & Kofoed, 1989; Young & Grella, 1998). These services often follow the principles of *Integrated Treatment* (e.g., Mercer, Mueser, & Drake, 1998; Minkoff & Drake, 1991), which focuses upon an interdisciplinary, concurrent treatment approach to substance abuse, mental health, and other related client needs. A recent review of the treatment outcome research for all dually diagnosed clients recommended that integrated treatment approaches be comprehensive and incorporate assertive outreach, case management, individual and group and family interventions, while assuming a longitudinal, step-wise motivational enhancement approach to substance abuse treatment (Drake, Mercer-McFadden, Mueser, McHugo, & Bond, in press).

There have been relatively few case management interventions for dually diagnosed homeless persons, although there is a recent trend toward increased program development and research. The literature includes an example of social network therapy/intensive case management which promotes referral and linkage to existing substance abuse treatment...