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Evidence Brief

Case management and importance of caseload size

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What is case management?

Case management, as a tool for increasing work participation of those with poor health or disabilities, is used in a number of programmes. The basic functions within any case management model are:

- assessing client needs
- developing a comprehensive service plan
- arranging for services to be delivered
- evaluating and following up with clients
- advocating for service improvements.

'Case management' still lacks a consensus among users regarding its components and how it is best applied. There are several different models of case management. For example:

- the 'broker model' – for information and referral only. It does not involve any direct provision of service.
- the 'generalist case manager' – someone who provides coordinated services and direct service functions such as advocacy, casework, and development of support systems.
- the 'primary therapist as a case manager' – this focuses on a therapeutic relationship with the client and supplements this intervention with traditional case management functions (Hanson et al. 2006).

Does case management work?

Despite a lack of consensus on what constitutes case management, there is general support for case management approaches when working with people with poor health or disability.

Clients generally support the case management approach in which personal support and advice is given alongside appropriate services to meet client needs (Hasluck & Green, 2007).

The impact of case management as a discrete activity is difficult to isolate. Case management occurs within the context of some expectation of a client to exit a benefit, and of the case manager to facilitate access to services not directly related to employment. The activities that constitute 'case management' are in many ways inseparable from their wider context.

There is mixed evidence on the effectiveness of case management as a means of moving benefit recipients with health and disability problems into work (Butler et al. 2012; Hasluck & Green, 2007; Miller, 2006):

- Corden and Thornton (2002) argue there are few strong indicators of who case management works best for, and a lack of robust evidence about which factors contribute to positive outcomes for clients.

- No meaningful comparison can be made between different case management models (Miller, 2006).
- There is moderate evidence that personal advice and support which incorporates a case management approach is an effective method of delivering employment services to clients with a disability or chronic illness (Hanson et al., 2006, Waddell et al., 2008).
- With regard to work or vocational rehabilitation with people with musculoskeletal disorders, Hanson et al (2006) argue there is moderate evidence that case management approaches are effective, and can yield a variety of benefits which are cost effective. This evidence pertains to using case managers as 'brokers' or 'generalists', but not as 'primary therapists'.

See also the appendix to this report.

What features of case management are important?

Hanson et al (2006) identified the following components of successful and cost-effective case management:

- an individual has their own case manager
- Case manager facilitates safe and sustainable return to work by recognising and addressing personal and occupational obstacles to secure a safe and sustainable return to work
- Case manager interfaces with healthcare services, but does not directly provide healthcare services
- best clinical practice guidelines are followed
- Case manager monitors all aspects of treatment – appropriateness, timeliness, adherence, outcome, and cost
- Case manager makes treatment funding decisions
- duration management techniques are available (eg the case manager identifies when a case has exceeded a typical absence period, and reviews that case)
- Case manager liaises directly with employer (where this is possible) about return to work
- Case manager negotiates transitional work arrangements
- early intervention focus.

The manner in which case managers deliver their service may be as important as the content of the service. Friendly staff, a welcoming setting, and a sense of shared purpose are not just desirable, cosmetic features of a service but may be essential elements. (Hasluck & Green, 2007). They add that for the most disadvantaged jobseekers, the research suggests that the circumstances and the context of engagement between case manager and client is as important (if not more so) than the specific types of provisions.

Peterson et al 1997 (in Miller, 2006) said "the future of case management is in the custom-tailoring of services to fit the individual at each point in

his or her illness and rehabilitation". The evidence also indicates that more intensive services are generally needed to produce impacts on employment and earnings for those experiencing ill-health or disability (eg supported employment initiatives such as IPS – see Appendix) (Rangarajan et al., 2008; Hasluck & Green, 2007).

How important is the size of a case manager's caseload?

Caseload size is important for two reasons:

- it influences the effectiveness of assistance to a client as it dictates how much time and effort a case manager can devote to each client, and
- it is a key driver of the administrative cost of the policy, since lower caseloads require employing more case managers (Hainmueller et al. 2011).

Case management is undertaken in a variety of circumstances and caseload sizes vary considerably.

- Community mental health case managers may have caseloads of 1:40 or 1:50. Case managers providing intensive mental health case management can have caseloads of 1:10 (Case Management Society of America & National Association of Social Workers, 2008).
- A review undertaken by the Centre for Social Research and Evaluation on the optimal caseload size in best practice case management for social services targeting at-risk young people found the caseload sizes varied by intensity of service. Recommended caseload sizes range from 20 to 30 cases or more for low-intensity services, 10 to 20 cases for moderately intensive services, and from five to 10 cases for highly intensive. The average caseload size quoted in the articles reviewed is 15-20 cases. The limit is 20 families or 35 children/young adults, and the optimum caseload size should be no more than 15 cases. However the actual caseloads were often not reflective of the optimal case load size¹.
- However, much higher caseloads are common for workers dealing with people in receipt of incapacity benefits (Shaheen et al, 2003).

¹ See Literature Review on Caseload Size in Best Practice Case Management, MSD 2011.

There is no agreement on what the ideal caseload should be, but there is evidence that having a large caseload has a negative impact on the ability of case managers to work effectively with clients² (King, 2009; Perkins, 2007).

Research suggests that having a lower caseload is particularly important when working with those who face significant barriers to employment, eg health and disability problems (Case Management Society of America & National Association of Social Workers, 2008, Perkins, 2007).

Large caseloads reduce the scope for intensive help which is often needed when dealing with disability issues. With high caseloads, there is a greater chance that services provided later in the support programme will be left out, especially when pre- and post-employment support is meant to be provided (Kellard et al, 2002; Miller, 2006).

What impacts caseload size?

Case Management Society of America & National Association of Social Workers, (2008) identified the following elements as having an important impact on caseload size:

- the context and situation in which case management takes place, particularly the business environment, market segment, regulatory and legal requirements, the clinical practice setting, individual case manager factors (such as skill levels), types of medical management, services, and technology support.
- factors associated with the care of the client based on a comprehensive needs assessments. Four sets of elements are important:
 - the presence and severity of clinical factors for the client
 - psychosocial factors for the client
 - considerations related to the primary caregiver (carer) and other members of the client's informal support system, and
 - the environment in which the client resides.
- The nature of the case management interventions

What don't we know?

The evidence on the effectiveness of case management in assisting those possessing significant barriers to employment into work is limited. There is even less evidence on the importance of caseload size.

² A German study looking at the impact of lower caseloads found they resulted in a decrease in the rate and duration of local unemployment and a higher re-employment rate. Cost-benefit calculations suggested that the cost of employing additional Case Managers was offset by the savings from decreased benefit expenditures after a period of about 10 months (Hainmueller et al. 2011). This study did not focus on people with health and disability problems.

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Appendix

Programme	Description	Effectiveness
Project NetWork (US)	<ul style="list-style-type: none"> • Participation was voluntary, but only 5% of the eligible group participated. • Case management was intensive and assessment was formal with medical, vocational, and psychological assessments purchased for a number of clients. • The programme was more effective for those closest to the labour market. • Case managers had caseloads of between 73 to 114 clients. 	<ul style="list-style-type: none"> • A modest increase of earnings and months employed occurred for those moving into employment, but this was generally not enough to lift them above the poverty line. Thus reliance on a benefit was not significantly reduced.
Minnesota 2 Tier Programme – long term beneficiaries (US)	<ul style="list-style-type: none"> • This programme targeted long-term beneficiaries and featured 1) lower caseloads 2) clients received in-depth assessments to uncover problems affecting them and their families 3) greater emphasis on referral for problems 4) placement in supported employment where people couldn't get jobs. The evaluation used a random assignment design with a cohort of beginning in 2002 – followed for two years (LeBlanc et al., 2007, Butler et al. 2012). 	<ul style="list-style-type: none"> • The programme had little impact on employment, off-benefit or earnings outcomes. Lower caseloads on their own were not enough to change the outcomes for clients with complex or higher needs. Clients did not take up service referrals (for domestic violence, substance abuse, mental health) (LeBlanc et al., 2007, Butler et al. 2012).
State Partnership Initiative (SPI)	<ul style="list-style-type: none"> • SSI/SSDI claimants 18-65 years old received: benefits counselling, case 	<ul style="list-style-type: none"> • Increases in employment in some sites, but

<p>(US)</p>	<p>management, limited employment supports.</p> <ul style="list-style-type: none"> • It ran between 1999 and 2004. The programme featured four models of employment-focused intensive case management (one of lower intensity) across three sites. It included waivers to allow claimants to retain more earned income (Rangarajan et al, 2008). 	<p>no changes in earnings or benefit amounts (Rangarajan et al., 2008).</p>
<p>New Deal for Disabled People (1998 – 2008) (UK)</p>	<ul style="list-style-type: none"> • NDDP was a voluntary programme with a national network of job brokers to help people on incapacity benefits into sustained employment (Orr, Bell and Lamb, 2007, Stafford et al 2007). Job brokers were incentivized to get people on the programme and to into sustained employment (13 weeks in employment). Case-load of job brokers varied between 100 and 400. Job brokers become more specialised as the programme continued. Job brokers assessed clients, came up with individual plans and also offered some of the following: vocational guidance, job search skills, financial advice, in-work support, and training and job placement. Job brokers worked on contract to Jobcentre+ (the public employment service) • Changes to the policy from 2004, included an expectation that 25 percent of participants would move into work, there would be an individual plan for each client, and job brokers would work with clients six months post-placement. 	<ul style="list-style-type: none"> • Impact estimates, based on propensity-matched clients on non-NDDP sites, are available for several cohorts of recipients. The maximum follow-up cohort shows positive impacts on off-benefit outcomes and employment up to 36 months for both existing and new claimants. • Impacts were more pronounced at six months for a later cohort following policy changes, compared with an early cohort.

	<p>Fees for participation went up, and the definition of sustained employment changed so job brokers could claim a fee for placing a client in sustained employment after 13 weeks instead of 26.</p> <ul style="list-style-type: none"> • Low take-up. 	
Arbeitsassistentz (Austria)	<ul style="list-style-type: none"> • Arbeitsassistentz was primarily for those with mental health problems and severe disabilities. • Case managers provided assessments, career planning advice, job brokering services, interview preparation services, vocational training and job search assistance. • Job assistants had caseloads of only 20 people • Job assistants had little experience of business matters, which was criticized by evaluators. 	<ul style="list-style-type: none"> • Over 40 percent of clients had been placed in jobs and 16 percent stayed in employment for six months or more.
Case management interviews (Denmark)	<ul style="list-style-type: none"> • Case management interviews are undertaken relatively early in the period of sickness. It was therefore expected that the interview would have a motivational effect on return to the pre-injury or illness employer. It was thought that the case management interview would support transfer of information between the employee and the employer 	<ul style="list-style-type: none"> • Case management interviews had a positive 10 percent significance level to returning to work. On more detailed analysis it was found case management interviews had a positive and strong impact on returning to work for the pre-illness employer. However, there was minimal impact on returning to work for a new

		employer (Høgelund & Holmb, 2006).
Individual Placement and Support (IPS)	<ul style="list-style-type: none"> • IPS makes employment a high priority in the consumer's treatment and rehabilitation plan by including employment specialists, who can assist with rapid job searches, as part of the case management or mental health treatment team. 	<ul style="list-style-type: none"> • There is strong evidence that IPS is the most effective method of helping people with severe mental health problems to achieve sustainable competitive employment (Rangarajan et al., 2008, OECD 2012; Waghorn et al 2012).
Enhanced Case Management (NZ)	<ul style="list-style-type: none"> • The programme targeted clients on incapacity benefits in 2003. The caseload numbers were not reduced as intended and there was a lack of specialised services to refer people with health and disability issues to (MSD, 2005). 	<ul style="list-style-type: none"> • It did not have a significant impact on the number of clients exiting a benefit. • Declarations of earnings increased 1.15 percentage points in the participant group.