1. INTRODUCTION

1. I have not tested the effectiveness of a case management model in this study. According to standard measures, case management works to keep people out of hospitals. For my purposes it is not important to review this now extensive literature; there are many excellent summaries. The best source for a quick overview of case management is the 1999 Surgeon General’s Report (chapter 4): http://www.surgeongeneral.gov/library/mentalhealth/chapter4/case and the report is also available in hardcopy (Mental Health: A Report of the Surgeon General, 1999). For the most recent and comprehensive reviews of case management research see Mueser et al. (1998), Bedell et al. (2000), and Gorey et al. (1998). There are numerous articles and books that compare and describe six models of case management: broker, clinical case management, assertive case management, intensive case management, strengths, and rehabilitation. Although most comparisons include the broker model, there is very little written about it; scholars typically portray it as a primitive form of case management. And it is often contrasted to other models in order to underscore linking as singularly insufficient and backward. Like the broker model, clinical case management is not popular; its lack of use, however, is due to reasons different from those that devalue the broker model. Joseph Walsh (2000) has articulated a version of the clinical model that is the most detailed. Other important supporters of clinical perspectives are Harris and Bergman (1987, 1993), Kanter (1989), and Lamb (1980). Clinical case management combines psychodynamic theory and practice
with everyday management functions. I think the cultural and professional skepticism about psychodynamic theory acts to silence advocates of clinical case management. Taken together, the remaining models make up the bulk of the literature and research. For a comparison of the models highlighting the strengths version, see Rapp (1998). William Anthony et al. (1993, 2000) and the Center for Psychiatric Rehabilitation (Boston University) are leading proponents of the rehabilitation model. The intensive case management model is well articulated in Borland et al. (1989). Assertive case management (ACT) has been highly visible both in the literature and in research; Stein and Test (1980, 1985; see also Stein and Santos 1998) are among its architects. See Thompson et al. (1990) and Scott and Dixon (1995) for good reviews of ACT principles and research evaluations. Pescosolido et al. (1995) show how the dominant models aim interventions at organizing formal and informal social supports.


3. Adrienne Chambon and others (1999) recently translated one of the few essays by Foucault dealing specifically with social work practice.

4. Jerome Wakefield has provided a comprehensive critique of Margolin’s Foucauldian approach to the study of social work (Wakefield 1998).

5. See appendix A for a detailed description of my research methods.

6. In order to protect the identity of the institution and individuals studied, I will not refer to the actual mental health center, the address, or the community. I have assigned fictitious names to the mental health center and to all research participants.
The Kansas Mental Health Reform Act required that every mental health center appoint at least one consumer and one family member to its governing board.

2. FORMATION OF COMMUNITY SUPPORT SERVICES

1. Council on Social Work Education.
2. Policy studies of implementation are an exception; see Brodkin (1990) for a discussion of the importance of investigating policy implementation.
3. Thresholds, a not-for-profit group, was organized in the 1960s by practitioners who rejected the medical model. Its founders believed that rehabilitation models and other normalizing interventions would better serve the long-term mentally ill. Chicago-based Thresholds and New York's Fountain House organized services long before community mental health services; the latter needed the inducements that occurred in the early 1980s.
4. Double funding tended to increase mental health budgets (Lerman 1982), thus savings occurred only if hospitals closed.
5. Let me provide anecdotal evidence for this argument. In the 1994 Kansas election a Republican governor, senators, and representatives were swept into office. The new legislators lacked even the most basic knowledge of mental health issues. Some, for example, were not aware that Kansas had passed a mental health reform bill (1990) that mandated the closure of state hospitals and the transfer of patients to local community mental health centers. Advocates for community support services lobbied and not to my surprise, they used a “cost-savings” discourse. On most matters social workers find themselves in opposition to Republican initiatives. Here, however, they can all agree that community support services are fiscally prudent.
6. Kansas Department of Social and Rehabilitation Services, Division of Mental Health and Retardation Services, personal correspondence (1995).
7. For summary discussions of the body, disability, and mental illness, see Lowe’s *The Body in Late-Capitalist USA* (1995, especially, pp. 149–171) and Susan Wendell’s *The Rejected Body* (1996).
8. Their benchmark article, “The NIMH Community Support Program: Pilot Approach to a Needed Social Reform” (1978), is often cited by community advocates. The article provided me with important insights into the formation of the CSS social field.
9. For recent examples of this genre of work, see: *We’ve Had a Hundred Years of Psychotherapy and the World’s Getting Worse* by James Hillman and Michael Ventura (1992) and *Therapy’s Delusions* by Ethan Watters and Richard Ofshe (1999).
3. THE RISE OF THE CASE MANAGER

1. The data here and throughout chapter 3 were taken from High County Mental Health Center quarterly reports, letters, and documents. In order to assure confidentiality, I have disguised the actual name of the mental health center. In the reference section, I have listed all reports and documents under High County Mental Health Center.

2. The staff hours reported here reflect those tabulated on daily event forms. Between 1983 and 1989 the number of staff averaged sixteen.

3. The calculation was as follows: client time (192,504 hours) multiplied by the proportion of their group time (67 percent), divided by the total staff time (52,088 hours) multiplied by their proportion of case management work (63.4 percent). Thus, 128,977 divided by 33,023 equals 3.9, or approximately one staff hour to 4 client hours.

4. CSS would later (1990s) expand downward into the younger population (below eighteen) and upward into the over fifty crowd.

5. The idea that clients are at different levels remains a vexing problem for case management models and programs. The newest management paradigm, the recovery model, for example, has four levels: dependent/unaware, dependent/aware, independent/aware, and interdependent/aware. What instrument instructs participants that they have moved a level up or down? Movement among levels, case managers will confirm, can vary daily, depending on the life task at hand.

4. STRENGTHS CASE MANAGEMENT

1. The University of Kansas School of Social Welfare homepage (http://www.socwel.ukans.edu) links to a strengths perspective site that states:

The KU School of Social Welfare has devoted 13 years to the development and testing of a strengths perspective for social work and other helping professions. The strengths perspective is drawn from social work’s commit-
ment to building on people’s strengths, rather than focusing on their deficiencies, problems, or disabilities. As an orientation to practice, emphasis is placed on uncovering and reaffirming people’s abilities, talents, survivor skills, and aspirations. This approach assumes that an unswerving focus on strengths found in individuals and communities will increase the likelihood that people will reach the goals they set for themselves.

(University of Kansas School of Social Welfare, Strengths Perspective, online at http://www.socwel.ukans.edu/htdocs/strength.htm, June 25, 2000)

2. For example, I am currently conducting research on an Ohio Department of Mental Health initiative to introduce (statewide) a new case management model called recovery.

3. Rapp’s recent book, The Strengths Model: Case Management with People Suffering from Severe and Persistent Mental Illness (1998), is the most comprehensive discussion of the model.

4. During my ethnography, I never heard a case manager use this phrase.

5. LANDSCAPE FOR A CASE MANAGER: THE CARLESS MENTALLY ILL

1. See Elizabeth Lunbeck (1994) for an excellent historical discussion of the role of social work in creating outpatient treatment within the context of the Boston Psychopathic Hospital.

2. The economic data reported in this chapter is from the “High County Demographic Update,” High County Planning Office, November 1992.

6. ORAL AND WRITTEN NARRATIVES OF CASE MANAGERS

1. The only texts that do not appear in sequence are the February progress notes. Other progress notes, not concatenated in the case record, I gathered and reordered chronologically with the oral accounts of the same management event.

2. In his study of school professionals, Hugh Mehan makes a similar argument about written reports and “learning disability” subjects (Mehan 1996:276).

3. For fifty of approximately four hundred clients I found this same monthly goal, written in similar fashion: “I want to stay out of the hospital.”

4. I have used the abbreviation CM to mean case manager; CM1, CM2, etc., refer to specific case managers.
7. MONEY

1. A med drop is a delivery of daily medication.
2. Ted has a federally supported Section 8 voucher.
3. Program for Achieving Self-Sufficiency (PASS) is a social security program that eligible consumers use to buy automobiles. The program requires strong evidence for work capability, however.

8. MEDS

1. Antiparkinsonism drugs are not included in table 8.1; they are for side effects.
2. These data represent a synchronic view. At a single point in time, I counted the number of prescriptions among 329 consumers.
3. Commonly reported side effects are: dizziness, drowsiness, weight gain, constipation, headache, akathisia (restlessness), tremors, neuroleptic malignant syndrome (high fever, muscle stiffness, rapid heart rate or breathing, sweating, and seizures, sometimes fatal), tardive dyskinesia (uncontrollable movement of the muscles, especially repetitive motions of the tongue and mouth or involuntary finger or hand motions).
4. Although the establishment of a CSS social field did not undermine psychiatry’s authority over medicine, it was compromised. Physicians dominated in gatekeeping roles in hospitals. Not at CSS. Consumers were admitted to the program with the diagnostic consent of social workers. And for the first time, the 1990 Kansas Mental Health Act empowered both psychiatrists and master’s level social workers to authorize emergency hospital admissions. Psychiatry was a necessary part of the medication division of labor, and it was a precondition for the circulation of drugs.

9. THE HELPER HABITUS: SITUATED KNOWLEDGE AND CASE MANAGEMENT

1. Ann Dill (1995:106) noted that “doing with” and “doing for” are common case management terminology that she feels has cultural determinants.
2. Anthony Giddens (1992) argues in *The Transformation of Intimacy* that Western society produces the need to continually improve the self.

3. In fact, females had a slightly higher average salary ($34,617) than males ($33,922). They had exactly the same median salaries ($34,382), however.


10. CONCLUSION

1. In contrast to strengths management, by combining ego psychology with everyday management functions, “clinical” case management offers a way to bring a theory of the self back into management work; in particular, I am thinking of the work of Joseph Walsh (2000), Maxine Harris and Helen Bergman (1993), and Joel Kanter (1995, 1989).

2. See chapter 1, note 2 for a list of these works.

3. Elizabeth Townsend (1998), Deborah Connolly (2000), Michael Rowe (1999), and Lorna Rhodes (1991) have used ethnography to examine both written and oral narratives of occupational therapists, social workers, nurses, and psychiatrists. Gerald A. J. de Montigny (1995) studied child welfare workers in action and used both kinds of narratives in his analysis. Dorothy Smith’s (1987) method of institutional ethnography is well equipped to study disciplinary and situated practice; Townsend and de Montigny, for example, produce significant contributions with Smith’s method. Although Smith is not using the language of disciplinary and situated knowledge/power, I think her theory could enhance our understanding of how social work power is articulated with dominant, extralocal social relations.