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Conflicting Bureaucracies, Conflicted Work: Dilemmas in Case Management for Homeless People with Mental Illness

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This ethnographic study finds a case management agency torn between the rules of two conflicting bureaucracies. Funded by a federal grant, the agency is administered by the county, and the regulations of the two systems turn out to be incompatible. This conflict creates dilemmas in providing services to clients: meeting eligibility criteria for services from the federal grant meant the clients did not meet the eligibility criteria for many County services. Agency staff reacted to this dilemma by bending rules, finding loopholes, and investing extra time and emotional labor in each client. The role-conflict engendered by bureaucratic disjunction creates frustration, resentment, and burnout within the agency.

CASE MANAGEMENT IN THE MENTAL HEALTH SYSTEM

Prior to deinstitutionalization, institutions provided all needed services under one roof, including food, shelter, clothing, medical care, and psychiatric treatment. By contrast, outside of the institution, these services were fragmented and spread across the medical and social service systems (Grob, 1994). For persons with mental illness such services were difficult to access. Even with symptoms under control with medication, many patients lacked the skills necessary to negotiate these complex service systems, leaving many with no services at all (Freedman & Moran, 1984).

In 1977, the National Institute of Mental Health began the Community Support Program in an attempt to coordinate these

diverse services in ways that were not covered under the 1963 Community Mental Health Centers Act. This program created a federal and state partnership to develop community support programs. The program sought to increase the availability of housing, income support, psychiatric treatment, medical treatment, and other services by encouraging states to change their own mental health systems. Though the Community Support Program later refocused on evaluation, in its inception we see the roots of intensive case management programs for persons with severe mental illness (Grob, 1994).

Over the past decade case management has become one of the most widely used methods to deliver services to persons with severe mental illness. At the most basic level, the role of the case manager is to determine the needs of clients, connect them to services, and help to ensure a reasonable quality of life in the community. Case managers in intensive service agencies provide services at a much higher level, including teaching skills of daily living, arranging transportation, and providing services outside of traditional locations and hours. The tasks of case managers vary widely depending on the environment in which they work, with some located in agencies that provide most services in-house, and others drawing primarily on resources in the community (Robinson and Toff-Bergman, 1990). The common denominator is that case managers serve as liaison, advocate, and resource for persons with mental illness and their families (Rog, 1988).

Most of the research on case management for people with severe mentally illness has focused on measuring client outcomes as a determinant of efficacy, usually in terms of keeping people out of the hospital and living as independently as possible. However, the results of these studies are difficult to interpret because the definitions of case management and the conditions under which case managers practice are variable (Solomon, 1992, Rubin, 1992, Chamberlain and Rapp, 1991). As a result, it is impossible to determine if cross-sectional client outcome variables are even measuring the same things (Solomon, 1992, Spicer et al., 1994).

Addressing problems such as this is one of the greatest strengths of ethnography. Through naturalistic observation and unstructured interviews, the researcher can illuminate the con-

tents of the "black box" of interventions, (Corbin & Strass, 1990) and determine what is really happening in the course of service delivery. The initial intent of this study was just that: to illuminate the crucial activities of case management and clarify what those activities accomplish in the eyes of the workers. However, as is often the case with qualitative research, the questions proved more complicated than anticipated. This case study demonstrates the extremely influential nature of the social work context, that is, the resources, bureaucratic rules, and politics of social systems in which the agency is embedded. The agency in this study was forced into a "catch-22" situation, in which the rules regulating its operation prevented it from delivering the services it was being funded to provide. This vulnerability to vagaries of local conditions may give us a clue to why case management services are not only so difficult to measure, but frequently difficult to provide.

Despite the growing importance of case management, few have done ethnographic research of this part of mental health care system. The experiences of people in other parts of the health care have been well documented, some in extremely well-known studies. In *Asylums*, Goffman (1961) examines life in the mental hospital. In *On the Ward*, Coser (1959), tells the story of both patients and staff in non-psychiatric hospital, while Becker et al. in *Boys in White* do the same for physicians-in-training in medical school (1961). Estroff (1981) in *Making It Crazy*, brings to light the lives of clients of one of the first Assertive Community Treatment Programs. More recently, Hopper (1998) and Liebow (1993) have brought to life the once invisible experiences of homeless people, many of whom suffer mental illness.

Despite the contributions of each of these studies, none of them truly explores the delivery of *social* services in mental health. With the decline of the psychiatric institution, such services have become cornerstones of the community mental health system. Case management, with its growing role in this system, offers an ideal point of entry to study how mental health service delivery occurs. A qualitative approach allows for an assessment of this process without the imposition of preconceived hypotheses. That is, the providers themselves have the opportunity to tell the story of their own experiences on case management teams. As will become evident in the pages to follow, this allows the participants

in the study to provide not only the answers, but the questions as well.

The research questions for this study developed in two stages. Initially I sought to uncover in more detail some of the crucial components of the social services intervention that is case management. However, the issues which emerged in the course of the fieldwork proved to be more interesting than the original question. The results reported in this paper thus address two concerns: 1) what activities comprise intensive case management, and 2) how does the system environment affect their implementation? The data presented in the following pages give at least one possible answer to the second question, and indirectly, to the first research question as well.

DATA: ETHNOGRAPHY OF AN INTENSIVE CASE MANAGEMENT AGENCY

The Research Site. The research site for this study is an agency providing intensive case management services to homeless persons who suffer from mental disorder and substance-abuse. This agency, called REACH, (a pseudonym) is located in a moderately large city in the Southeastern U.S., and is funded by a federal grant as part of an on-going multisite national demonstration project. The purpose of the demonstration was to investigate means of integrating and defragmenting community mental health service systems. Despite federal funding, however, the administration of REACH was under the jurisdiction of the county community mental health system.

The organization and mission of REACH were nontraditional. The agency was made up of two teams of service providers rather than autonomous case managers. Each client was assigned to a team, rather than a single case manager, and worked with all members of each team. In addition, both teams were familiar with each others' clients. Morning staff meetings each day reviewed all new material, problems, or achievements, so that all staff of the agency were updated and capable of handling emergencies for any client of REACH. All staff members (teams and administration) shared revolving 24 hour on-call support duties.

The REACH teams had not only case managers, but consumer-staff members and nurses. At the time of the research,

there was one consumer-staff person on each team, both with histories of addiction and homelessness or near homelessness. Ideally, each team was supposed to have five members, including a nurse on each team, but due to a budget freeze by the County, the teams were working only partially staffed, each with three members plus one shared nurse.

The mission of the agency was very client-directed, with active follow-ups of clients, an emphasis on client choice, and a requirement that clients be included in all formal discussions of their cases. Meetings with clients took place *in vivo*, that is, where the client was. This frequently required appointments at the clients' residences, on park benches, or at the local drop-in center, wherever the client was able to be. Clients who missed appointments were sought and rescheduled. Emphasis was on keeping clients in services, despite the formidable obstacles to achieving continuity with an inherently transient population. To maintain this intensive level of service, caseloads were very small, about 50 clients per team, or roughly 15 clients per team member.

Data Collection. As a study of process, this project was done ethnographically, with data coming primarily from participant observation of case management work and unstructured interviews with the team members. This includes an inventory and description of the daily activities that comprise case management for service recipients. Over a five month period, I attended staff meetings, participated in daily agency activities, and accompanied every team member on at least two days when they provided services out of the office. I had opportunities to see my participants working both with clients in a variety of settings, and with staff from other parts of the social services system. On an average day, I arrived in time for the morning staff meeting and review of clients. I then accompanied the team I was "shadowing" that week into their team room for their team meeting. I spent the rest of the day with a single team member, who would explain paperwork, relate phone calls, and take me along on visits to clients.

Over the course of the study, I also conducted detailed individual unstructured interviews with all ten staff members in the agency to gather insight into their views on the different constraints and resources under which staff members and teams operate. These staff members comprise the ten subjects in this

study, including six team members, a nurse, an outreach worker, the project manager, and the project director. In total, the data are comprised of five months of fieldnotes, 10 interviews, and program documents. As with many case studies, the sample size for this study is quite small due to the limited size of the agency, however, the detail and length of data collection lend credibility to the results. These data were transcribed as text onto a computer, and qualitatively coded analyzed using HyperResearch, a text analysis program.

RESULTS: THE CONTRADICTIONS OF THE CASE MANAGEMENT ROLE

I originally entered the field with a general question: *What is case management, and what, in their own eyes, do case managers do?* I soon found this question to be inadequate. My respondents all gave answers couched in terms of what they would like to do as managers, what they intended to do, or what they were supposed to do by the terms of the agency's federal grant funding. However, nearly all then went on in the next breath to tell me why it was very difficult to do the activities they had just described to me. Indeed, they spent much more time telling me why they were not able to provided the services they wanted to or felt they were supposed to, than they did telling me about what they did do. That is, what they really wanted to talk about was their frustration.

This frustration has become the topic that has emerged from this analysis, and the main subject of this paper. My main question here is: *Why is it so difficult in this agency to deliver their intensive case management services to homeless persons with mental illness, and what are the consequences of this difficulty?* Such a question is tightly tied to the immediate circumstances of this particular agency, and as such appears to have little generalizability. However, the broader implications of structural and bureaucratic conflict has repercussions for social workers throughout the field of human services.

REACH was a federally funded project that had been inserted into an already functioning county system. This position of being juxtaposed between two systems created tensions from the day the agency opened its doors, and interfered with the agency's

ability to serve their clients. REACH was designed and federally funded to develop nontraditional approaches to engaging a difficult population, but they were stymied by more traditional expectations and structures at the local level. REACH staff often found themselves torn between the rules of the two systems — federal and county — and the needs of the clients. That is, they could not meet all three points simultaneously.

An example of this was that the agency was funded by their grant to provide services for homeless people with mental illness, especially those with substance abuse problems as well. To provide these services, REACH was supposed to draw on local resources. Homeless services in the County wanted only clients whose mental illness had been stabilized and who did not abuse substances. Yet the mental health treatment available to stabilize clients through Community Mental Health Services assumed that the client had not only transportation, but an address and phone number — in other words, that they be housed. And many substance abuse services frequently had mental illness as an exclusion criterion from their residential programs, or required that clients have housing and transportation to attend their outpatient programs. In other words, in order to get housing, you had to be already treated, but in order to get treated, you had to have housing. Thus the County system had services set up for people who were homeless *or* mentally ill *or* substance abusers, but not all three. So the federal grant regulations and the County system in practice often had mutually exclusive targets: eligibility for the grant sometimes created automatic ineligibility for many County services. As one case manager protested, they were often caught between the two government bureaucracies with which they had to deal:

> The way [our program] is set up, we're caught in not just one bureaucracy but two. So it's like [we were funded with] the understanding was that [we] were going to be able to do some creative things. But when we attempted the creativity, the County system was like: oh, no, you can't do that. . . . And then we also have [federal] guidelines and their bureaucracy and criteria and you run against some things with them. So in between here we are, and it's like we're being squished. And what's happening is that the client is getting lost in all this.

As a result, there was a pervasive sense among the case managers that neither of the two systems were really concerned about whether their clients were actually getting any help.

This feeling was repeatedly reinforced by the contradictions between system rules and client needs. For instance, the eligibility criteria for many services excluded the very people most in need of the service. One concern was that a grant that had been allocated to the county to provide housing for homeless people stipulated that clients be homeless when they applied, and that they remained homeless until they receive the housing certificate. However, the process of sending an application through County bureaucracy often took three or four months. The case managers were simply not willing to leave their clients with no housing that long just so they would stay eligible for a particular source of housing. After all, housing was only the first step in a long road to improvement. According to one team member:

> We can't just leave them out there on the streets with wolves and not place them somewhere safe. . . . So while we're trying to get them to move forward, I've crossed the boundaries to the [housing] status now, and so I've jeopardized their housing. And so now I'm going to have to come up with another strategy on how I'm going to find you housing because you're not eligible for the certificate anymore.

A diagnosis of substance abuse could complicate matters even more by reducing the already small number of housing options available to the clients. Another team member described these difficulties:

> I set up two interviews for [supported housing]. But you have to have 6 mos. clean time. . . . Some of these people are not going to meet these criteria. I mean, you can have the ideal drunk, and you can say stop drinking and he's going to get better. It doesn't work that way. Things don't fit like that.

Often the case managers resort to bending, or even breaking the rules in order to do their jobs: that is, to provide services to their clients.

> The way everything's set up doesn't make sense. You can't do this because this person doesn't meet this criteria, so you almost have to make it fit. Be flexible and break some rules . . . you have to look

at it and say, this didn't happen exactly like this, but if he's eligible for this, and then we start getting picky about things and find little loopholes and stuff. Sometimes the system doesn't work.

This working around the rules holds even for the federal requirements of REACH. For example, many of their clients suffer from severe addictions, to the point that this problem overshadows everything else, even their mental illness. Indeed, this sometimes seems to be the norm for homeless people with severe mental illness, at least among the REACH participants. But substance abuse — or even related personality disorders — could not be their primary diagnosis, due to the eligibility criteria of the grant. So rather than disqualify someone in need of their help, they would find a way to make that person eligible.

> Interviewer: I'm thinking of this morning, when the assistant director said to the psychiatrist 'we need a different diagnosis in order to make him eligible.'
>
> Respondent: Yes, like I'm doing the medical records, and a lot of the people have substance abuse diagnoses. Well this program is set up for homeless, severely and persistently mentally ill people. . . . These people have mental illness, but we cannot put it as the substance abuse is what we're treating. We've got to put it that we're treating major depression, or something. And really . . . we are, even though they do need the substance abuse treatment too. [So] these people, either you change their diagnoses, or they don't meet the criteria. I mean, it's not like they don't have a mental illness, but the substance abuse is something that's coming up front moreso than the mental illness. The system says, 'we want it this way,' we'll get it this way.

So agency staff are often torn between their clients and the system. If they are unable to "make it fit," they lose clients and the ability to provide for their needs. Such an outcome goes against their mission and their funding. As a result, the agency is caught in a sort of a case management "Catch-22" between system rules and client needs.

> You do feel powerless, because you promise to support someone who is mentally ill and who's without a home, and that's a big task. Because . . . there's always administrative stuff that you have

> to adhere to, it's like, you really don't have any power. It's like a hierarchy, it's the administrators, it's [our agency] and it's the participants. And they look at you as the one with the power, and it's like, but I really don't have power. And they don't understand that. All they see is one system.

Another team member:

> [But] what's going to happen is, if you tell them "I can help you," and then as it turns out you can only help them for three months, you know, they're going to be like, "you're not meeting my needs."

The result is that the agency has difficulty keeping clients. With clients who are extremely hard to engage, and who can disappear if they feel no need to be visible, the lack of means to keep them engaged adds aggravation to the frustration the REACH teams already experience. To forestall client drop-outs, team members invest themselves personally through persuasion and emotional labor (Hochschild, 1983) to keep each client on board while the case managers struggle with the system. Such conditions are unsurprisingly a cause of burnout.

> I don't think that there are many elected representatives that will understand that Shawn going to an ice hockey game with friends from the DropIn Center, is a better place for him to be than where he was. And the fact that he was there, is going to make a difference, and it was money well spent. We don't know how to quantify those stories . . . and it's because [they're all unique and individual]. And we cherish individuality, and it's part of what our nation calls our own, but it's also something that we don't know how to support.

The service providers in this study were torn between three disjunctive sets of expectations: the rules of the two systems, and the needs of their clients. They to try to find a workable compromise and frequently do not succeed. One of the three sets is often left unmet. This is a constant source of frustration for the team members, especially when it is the client that loses out.

DISCUSSION

The present research is a case study of a single agency located in a single county mental health system, which raises questions about its generalizability to social services. What can we learn

from the case managers of REACH? While on the surface this analysis only illuminates the personal agonies of the workers in one agency, the results have broader theoretical and practical implications. In terms of my first research question on the activities of case management, we see that case managers engage in more than the concrete services identified in the literature, they invest emotional labor as well. The stress literature identifies both of these activities as forms of social support, instrumental and socioemotional (Thoits, 1986). Instrumental support includes all the basic services considered part of case management: money, food, shelter, clothes, transportation, medical care, etc. Socioemotional support, on the other hand, includes more invisible aid in the form of talking about problems, listening, encouraging, and applauding success.

The staff in this study most likely provided more socioemotional support than most workers in their position, as they used it as a means of making up for shortcomings in the instrumental support they had to offer. Nonetheless, most social service providers engage in this as a sort of "invisible service," to their clients. Empathy, rapport, and understanding are overtly part of social work training, and are highly valued skills in the profession. Their influence appears even in the accomplishment of more instrumental tasks. For instance, the staff at REACH did not merely link their clients to other services, but negotiated barriers to services in a politically charged system. In addition, like all case managers, they were perpetually engaged in trying to tailor a general system to the unique needs of individual clients. Such efforts entail diplomacy, sensitivity, and rapport, all of which have sizable emotional components. Intensive case management, then, entails service linkage, advocacy, *and* socioemotional support as crucial elements of service delivery.

Regarding my second research question, the results on the difficulty of delivering services illustrate possible consequences of bureaucratic conflict for any agency straddling two or more systems. Weber lists as the first characteristic of a bureaucracy that "[t]here is the principle of fixed and official jurisdictional areas, which are generally ordered by rules, that is, by laws or administrative regulations" (Gerth and Mills, 1946). These rules and areas circumscribe the duties and powers of those

working within the bureaucracy, maintaining and supporting its authority. As Weber points out, in a well-ordered bureaucracy, these duties are routinized and well-regulated, and conflict seldom arises.

Yet, in this study, we see an example of two routinized bureaucracies coming into conflict within a single agency. As a result, duties are no longer clear cut, and powers even less so. Merton captures this dilemma nicely in his conception of role-conflict within a role-set (1957, 1967). The case manager holds a social position — a role — within a social system, that is, the system of county mental health. To the degree that the case manager has incongruent expectations between the roles defined by each bureaucracy, the role occupant, the case manager, is conflicted.

Such a situation illustrates rather well a partial answer to a question raised by Merton himself:

> "the assumed structural basis for potential disturbance of a role-set gives rise to a double question: which social mechanisms, if any, operate to counteract the theoretically assumed instability of role-sets, and, correlatively, under which circumstances do these social mechanisms fail to operate, with resulting inefficiency, confusion, and conflict?

This study provides a partial answer, the overlap of bureaucracies, institutions, or social systems more generally, sets up conditions under which expectations collide, and role-sets become unstable.

Such a notion adds a new dimension to existing work on the difficulty of providing services to persons with severe mental illness. Previous research has focused on barriers to service delivery. (e.g., as described by Boyer, 1987; Rog, 1988; and Morrissey et al., 1986), such as fragmentation in the system, or noncompliance and lack of resources among the service population. The case managers in this study did not see their frustration in that light, however. To them, the source of the frustration was their perception of being caught between disparate federal and county systems. In particular, the case managers experienced a sense of being bound in a web of bureaucratic contradictions, such that their own service system was itself preventing them from providing services. Under the rules of these two systems, they had contradictory work expectations.

In other words, the case managers experienced this conflict between two bureaucracies as conflict within their occupational role.

According to Merton's theory of the "role-set," each position in the social structure has not just one associated role, but a set of roles reflecting the various obligations vis-à-vis relevant others. His own example of a teacher has one set of expectations regarding interactions with students, and entirely another set regarding her interactions with the school principal or superintendent (1957). This is roughly comparable to a case manager who has three sets of role-expectations, one with each of two funding agencies, and one with clients. To the degree that these expectations are mutually incompatible, the case manager experiences conflict between roles within a set, what Merton calls role conflict. Thus role set theory provides a vocabulary for discussing the process whereby the structural becomes personal, and the external conflict of systems becomes internalized.

Stryker (1980) describes how external conflict can have psychological and emotional effects through our roles. According to Stryker, roles are the material which we use to identify who we are. Engaging in actions that are in keeping with our role-identities reinforces our sense of self. Expanding on Stryker's work, Heise (1978, 1987) argues that if conflicts within established roles endure and cannot be argued away, these conflicts will lead to change in the role-identity. If the conflicts are comprised of negative or disempowering information, the change in the role-identity will be negative as well. By this argument, the role-conflict experienced by the case managers may have been more than frustrating, it may have been threatening to their sense of self. By preventing the case managers from doing what they wanted to do, the systemic contradiction could potentially prevent them from being who they want to be. That is, by constraining their actions, the systems also prevented them from enacting their chosen occupational role-identities in a positive way (Stryker,1980). This bred a range of discontents, including anger, defensiveness, bitterness, powerlessness, and apathy. If frustration was the short term result of contradiction, its long term consequence was occupational demoralization among the very people striving to ameliorate the despair of others.

Such a conflict between bureaucracies is hardly unusual in the social services. Indeed, multiple funding sources and overlapping bureaucracies may be more the norm than the exception. If this is the case, then the role conflict illuminated in this study may be widespread indeed. While such conflict may not consistently reach the same proportions as in this case — indeed, exacerbating factors were rife in this site— the conflict appears quite likely to exist.

The lesson for program planners and policymakers then is, this: bureaucratic disjunctions may well be played out in occupational role conflict for program staff. Burnout is not merely personal, it is structural as well. When designing new programs, a hostile or conflicted system can make the most well-planned program go awry. To limit such disjunctions, planners must take into account both flaws in the existing system, and degrees to which the existing system may not match with the program to be implemented.

CONCLUSION

This agency's untenable position between two systems obviously makes a difference in the effectiveness of its services. The fact that the agency's targets are, by definition, extremely difficult clients to serve is a contributing factor to the dilemma as well. REACH found itself torn between the rules and resources of two conflicting bureaucracies. This conflict created dilemmas in providing services to client: meeting eligibility criteria for services from the federation grant meant the clients did not meet the eligibility criteria for many County services. REACH staff reacted to this dilemma by bending rules, finding loopholes, and investing extra time and emotional labor in each client. Despite this, it remained very hard to provide desired services to their clients, and many slipped away. Aware of the bureaucratic conflict, but unable to find recourse for their dilemmas, the REACH staff grew frustrated, angry, and resentful of the county system.

EPILOGUE

The agency's untenable situation between two incompatible bureaucracies was, as evident in this paper, inherently unstable.

It, combined with budgetary complications in the system, lead to increasing resentment between the County and REACH. Toward the end of my fieldwork, the County abruptly took advantage of a quiet offer from the State to take over administration of the program. REACH staff arrived at work one day to find a letter informing them that they were suddenly State, rather than County employees. Despite the shock and consternation produced by the change, it turned out to be an improvement for all concerned. A few months after my departure from the field, REACH had moved into its new role at the outreach and community service arm of the local State Psychiatric Hospital. Oddly enough, despite the expected greater ideological conflict between an in-patient hospital and an intensive community support program, the combination worked. The reduction in bureaucratic conflict (largely due to the fact that the State had few pre-existing community service regulations to conflict with those of REACH), seemed to more than compensate for the surface disparities. REACH continued in this position through the end of its federal funding, obtaining stability that it had been unable to achieve when dealing with the County, its apparent systemic peer.

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