Intensive case management was as effective as standard case management in severe psychotic illness


QUESTION: In patients with serious mental illness, is intensive case management effective and is it more effective in Afro-Caribbean patients and in severely socially disabled patients (2 preplanned subgroup analyses)?

Design
Randomised (allocation concealed*), unblinded*, controlled trial with 2 years of follow up.

Setting
4 inner city mental health services in London and Manchester, UK.

Patients
708 patients between 18 and 65 years of age (mean age 38 y, 57% men) with a psychotic illness (diagnosis by structured examination of case notes and based on the presence of hallucinations, delusions, or thought disorder) for ≥2 years. Exclusion criteria were organic brain damage or a primary diagnosis of substance abuse.

Intervention
353 patients were allocated to intensive case management (10–15 patients to each case manager) and 355 patients to standard case management (30–35 patients to each case manager).

Main outcome measures
The primary outcome measure was hospital use. Secondary outcome measures were clinical symptoms and social functioning.

Main results
All analyses compared patients in their randomised groups, irrespective of the form of case management received. Hospital use did not differ between the 2 treatment groups (p = 0.97) (table). Afro-Caribbean patients showed the same mean length of stay in hospital as patients of other ethnic origins as did severely socially disabled patients compared with those less socially disabled, with no differential effect from intensive case management (table). The study had an 80% power to detect any substantial difference at 1 and 2 years of follow up. Other effectiveness trials have suggested that higher numbers of staff are not automatically associated with better outcomes (eg, PRISM Psychosis Study). Indeed, within community oriented models of care, the quality of staff (and what the staff actually do) is more important than its quantity—provided that a “minimum” quantity is ensured. Unfortunately, we still do not know where this minimum lies. In other words, what is the threshold below which there is likely to be a deterioration in the quality of care and in selected outcome indicators.

From an evidence-based perspective, it is also important to emphasise that expertise is more important than experience, and expertise is associated with staff quality, not quantity.

However, one aspect of the study by Burns et al deserves attention: the authors say that during the 3 years of the study a substantially similar number of staff in the 2 groups left the service and moved on. The “burn out” literature has clearly shown that caseload size is one of the critical variables for burn out occurrence. Therefore, the difference between different caseloads of patients, possibly measured on a longer time scale (in many countries nursing staff have an average work life of 30 years), should not be overlooked.

Main preventive strategies for burn out, focusing on job structure, consists of limiting “the number of clients for whom staff are responsible at any one time.”

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COMMENTARY
This study by Burns et al is a major effectiveness trial, aimed at establishing whether an intensive case management model (10–15 patients to each case manager) is more effective for the management of severe psychotic patients compared with a standard regimen (30–35 patients to each case manager). According to various outcome indicators (eg, hospital use, clinical and social functioning, etc), these 2 patient-staff ratios were not associated with any substantial difference at 1 and 2 years of follow up. Other effectiveness trials have suggested that higher numbers of staff are not automatically associated with better outcomes (eg, PRISM Psychosis Study). Indeed, within community oriented models of care, the quality of staff (and what the staff actually do) is more important than its quantity—provided that a “minimum” quantity is ensured. Unfortunately, we still do not know where this minimum lies. In other words, what is the threshold below which there is likely to be a deterioration in the quality of care and in selected outcome indicators.

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Intensive case management v standard case management in patients with severe psychotic illness

| Outcome at 2 years | Intensive case management | Standard case management | Mean difference (95% CI) *
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<tbody>
<tr>
<td>Mean (SD) days in hospital (n=679)</td>
<td>73.5 (124.2)</td>
<td>73.1 (111.2)</td>
<td>0.4 (-17.4 to 18.1)</td>
</tr>
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Subgroup analyses

<table>
<thead>
<tr>
<th>Subgroup analyses</th>
<th>Intensive case management</th>
<th>Standard case management</th>
<th>Mean difference (95% CI)</th>
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</thead>
<tbody>
<tr>
<td>Afro-Caribbean (n=194)</td>
<td>72.3</td>
<td>72.4</td>
<td>-0.1 (-30.6 to 30.5)</td>
</tr>
<tr>
<td>Other ethnic origin (n=485)</td>
<td>74.0</td>
<td>73.4</td>
<td>0.6 (-21.2 to 22.3)</td>
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<td>Severity of illness (DAS total)</td>
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<tr>
<td>&lt;1 (n=306)</td>
<td>67.9</td>
<td>66.9</td>
<td>1.0 (-25.9 to 27.9)</td>
</tr>
<tr>
<td>≥2 (n=363)</td>
<td>75.1</td>
<td>81.0</td>
<td>-5.9 (-30.1 to 18.3)</td>
</tr>
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</table>

DAS = disability assessment schedule. *Not significant.

Therapeutics

EBMH Volume 3 February 2000 11