Case Management and Assertive Community Treatment in Europe

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Objective: **Case management studies from Europe and the United States continue to yield conflicting results. At a symposium at the World Psychiatric Conference in Hamburg in 1999, researchers from four European countries explored the possible reasons for differences in outcome. They also examined reasons for the differing foci of case management studies across the different cultures. The authors summarize the symposium's findings.** ***Methods:*** **Individual case presentations were given of studies and services from the United Kingdom (three studies), Sweden (two studies), Germany, and Italy (one each). Outcomes, methodologies, and national service context were examined.** ***Results and conclusions:*** **A significant influence of national culture is evident both in the acceptability of case management and in approaches to researching it. Case management is perceived as an "Anglophone import" in Italy but is now national policy for persons with severe mental illness in the other three countries. Studies from the United Kingdom emphasized methodological rigor, with little attention to treatment content, whereas those from Sweden accepted a less disruptive research approach but with a more prescriptive stipulation of treatment content. Studies from Italy and Germany emphasized the importance of differing descriptive methodologies. Marked differences in the range of social care provision were noted across Europe. Overall, European researchers are less concerned than U.S. researchers with studying the impact of case management on hospital use. (*Psychiatric Services* 52:631–636, 2001)**

A symposium at the World Psychiatric Conference in Hamburg in 1999 considered the state of case management practice and research in England, Italy, Germany, and Sweden. In this paper we summarize a range of issues in European case management that occupy clinicians and researchers. These concerns include not only the impact of case management on psychiatric hospitalization but also its cultural acceptability, the impact of model programs on morale among surrounding services, the need to distinguish essential from nonessential aspects, and the nature of specific treatments that should be provided.

The stimulus for the symposium was the continuing controversy in Europe about the status of case management and of assertive community treatment. Unlike in the United States, where these approaches are well established (1), viewed from Europe the research literature remains contradictory (2). Two recent systematic reviews of assertive community treatment and case management published in the Cochrane Collaboration (3,4) suggest that the one is successful and the other not. A more detailed examination of the individual studies contained in these two reviews gives little confidence that the two approaches are so different and might even suggest that the same clinical approach may be producing different outcomes in the United States and Europe.

At least three explanations of these different findings are plausible. It could be that Europeans do not implement assertive community treatment properly—that is, that program fidelity is not achieved (5). It could also be that the context in which the various types of case management are conducted modifies their impact (6). A significant factor in successful case management is the integration of patients into available social and welfare services (7); the same service in different situations could lead to different outcomes. A third possibility is that different services provided to control groups are responsible for the different outcomes. Crucial aspects of case man-

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agement may be incorporated into routine services.

Whereas the U.S. endorsement of case management for persons with severe mental illness reflects local research findings, a similar endorsement of assertive outreach in the United Kingdom by the Health Minister lies in stark contrast to a series of local research studies that have shown no benefit from it, either in reducing hospitalization or in improving clinical status or social functioning (8–10). The government endorsement of assertive outreach in the United Kingdom comes at a time when many European countries are reevaluating their community care policies.

The aim of the symposium was to generate an overview of published studies of case management in Europe. One goal was to characterize the various approaches and identify local factors that may have generated modifications. Perhaps more important was that the symposium offered an opportunity to explore the questions about case management that are currently exercising European researchers. The intense emphasis on bed management that characterizes research and writing in the United States and the United Kingdom is less prominent in settings that are comparatively well provided, such as Germany and the Scandinavian countries.

Data presented

Data were presented at the symposium from studies in Britain, Germany, Italy, and Sweden. Although not representative of all Europe, these studies do reflect the current state of published research. Research into assertive community treatment and case management closely follows the development of community psychiatry, which is not consistent across Europe.

Three studies from Britain using very traditional methodologies were presented. Holloway and Carson's randomized controlled trial (10) of intensive case management versus standard care demonstrated no gains for patients receiving case management other than significantly improved satisfaction. Patients receiving case management also showed a trend toward greater bed use.

The Psychiatric Research in Service Measurement (PRiSM) study (11), in which Holloway was the physician responsible for the services provided to the control group, was a much larger study. It was an epidemiologically based, parallel-design trial of specialized case management for psychotic patients, with a two-year follow-up of 514 patients. This study also failed to demonstrate any reduction in hospitalization or any significant clinical or social gains. Indeed, administrative data collected at the end of the study showed that the control service had less staff turnover and was markedly less costly overall than the intensive service.

The UK700 trial (9) monitored 708 psychotic patients in four centers over two years. This randomized controlled trial attempted to compare the impact of varying only one component of case management—caseload size. The experimental service had caseloads of 12 to 15 patients, and the control service had caseloads of 30 to 35 patients. In all other respects the two services were identical. This study also found no difference in hospitalization or in clinical or social outcomes.

Fioritti (12) presented a descriptive study of the introduction of assertive community treatment in an Italian service. Introducing the new concepts generated considerable resistance, expressed as a skepticism that Italy needed case management given its high-profile tradition of radical community psychiatry (13). It was frequently asserted that Italy "was already case-managed." Fioritti outlined how the approach challenged the traditional hierarchical relationship between physicians and nurses but was soon accepted by the case management team. A one-year outcome evaluation found significant improvement in the domains of psychopathology, use of beds, costs, and to a lesser extent, disability. However, because of the service's erosive effect on morale in the surrounding services, it was not sustainable. Consequently the unit has evolved into one where case managers work half-time on the assertive community treatment team and half-time on routine outpatient activities.

Rössler outlined a study of case management conducted in Germany (14) after the introduction of deinstitutionalization (15). The provision of health care in Germany as well as in the other German-speaking countries of Central Europe is characterized by a strong federalism in political structure and hence a separation of social welfare and health care. The concept of case management as a key coordinating mechanism thus seemed to be quite useful in such fragmented care systems.

The study presented was a case-control study of four catchment services in different parts of Germany. During a two-and-a-half-year observation period, services with and without case management programs were compared, and detailed patient characteristics and process variables were recorded. Again, no significant benefits could be demonstrated for case management in terms of rehospitalization. The same was found for a subgroup of the sample with schizophrenic disorders (16): no significant effects were found for case management on the risk of rehospitalization or on the length of stay for those rehospitalized. These negative results should be viewed against a relatively small number of psychiatric inpatient beds and high levels of resources in outpatient care available for patients who did not receive case management (15); these circumstances might have diluted the expected differences.

Malm (17) discussed the current situation in Sweden on the basis of a ten-site, noncontrolled efficacy trial from the National Board of Health and Welfare and two randomized controlled trials, one completed and one ongoing. In the randomized controlled trials, the 100 patients with schizophrenia in the assertive case management condition received a comprehensive care program combining medication and psychosocial interventions (18). The ten-site trial of 176 patients with schizophrenia and other severe mental illnesses, with a follow-up period of 18 months, confirmed the reduction in hospitalization and improvement in quality of life reported earlier (19), along with some additional social and clinical gains.

On the basis of these trials, Sweden

has emphasized the need for the case manager to be a fully trained clinician, usually a nurse or a social worker. Case managers work in interdisciplinary teams that include psychiatrists, and they have a high degree of budgetary control and a significant coordinating role. In urban settings, teams often have a high degree of specialization.

Emerging themes

The variety of contexts, services, and research approaches contained within the symposium do not lend themselves to a traditional meta-analysis, but they afford some insight into a potential agenda for research on case management. The European presenters' data and conclusions generated a lively debate with non-Europeans at the symposium, which suggests that some of the emerging themes could be considered in the wider international context of case management research.

An overarching difference emerging between the U.S. and European contexts is that of services versus programs. Much of U.S. research derives from self-contained, targeted programs for specific patient groups, usually with clinical and budgetary independence. European research operates within a wide range of funding arrangements, including the tax-funded monopoly National Health Service in Britain and Sweden; a similar national system alongside state, trade union, and church nonprofessional organizations providing health care and social support in Italy; and insurance-based plans in Germany.

None of the case management services reported here have an independent, fixed, freestanding budget. They are components of a single comprehensive service for a geographically defined mental health service, unlike many U.S. programs. All take advantage of collaborative clinical activities—for example, night duty, emergency services, and inpatient cross-coverage—that are not financially accounted.

Despite the considerable variation among European clinicians and researchers, they are all embedded in systems requiring comprehensive responsibility based on catchment areas. Essentially one service is accountable for all the mental health care in a geographical area, and it cannot easily exclude patients from services, either on the basis of patient characteristics or because the service is full. The implications of such a difference go far beyond simple issues of efficiency or study design.

European researchers, within this context, seem resigned to not replicating earlier studies that found massive advantages in favor of case management in the U.S. and Australia. They have turned their attention to trying to identify what works, for whom it works, and how they can make it work. Assertive community treatment is recognized as an invaluable heuristic concept, focusing thought in both practice and research. However, little support has been generated for assertive community treatment as fundamentally distinct from other forms of case management—or indeed, from a broader range of integrated approaches to community care.

At the symposium, skepticism was expressed about the benefits of repeated trials of "genuine assertive community treatment" against other forms of care. In particular, comparing either assertive community treatment or case management against hospital-based care is redundant in Europe, given the widespread availability of community mental health team approaches in routine care.

From a European perspective, the features probably responsible for much of assertive community treatment's success are the team's acceptance of a broad therapeutic responsibility; continuity of care and treatment over extended periods; and provision of practical help and social care. Where these core conditions are present, practitioners have questioned how important so many of the "brand" characteristics of assertive community treatment (5) are. Research into varying individual components, as in the UK700 study, was proposed as a means of validating, rather than replicating, the approach. Researching assertive community treatment and case management in Europe has become particularly helpful in highlighting many of the social assumptions that often go unrecognized in such mental health services research. Trying to understand the impact of the overall context (6) on program implementation and outcome can help identify the factors to be researched.

Patient variables influence both the research context and outcomes. Recognition is growing on both sides of the Atlantic that certain patient groups show little added benefit from specialized case management services—for example, patients with primary personality disorders, patients who are offenders, dual diagnosis patients, and, perhaps more difficult to define, the most disabled patients with intractable disorders and persistent behavioral problems. European psychiatrists not only have greater difficulty excluding such patients from studies but also must work within a clinical context in which they are dealing with them, and in which care structures are adapted to having to deal with them, whether or not they consider themselves very successful in that treatment. The inability to select patients or to declare a service full probably has a more powerful impact on broader assumptions than has been acknowledged.

Hierarchy and professional status issues interact with any attempt to reorganize the structure of care. At the symposium the expectations of the relationship between physicians and nurses—the two disciplines most likely to form the core of a case management team in Europe—were contrasted for Italy and the United Kingdom. Traditionally in Italy, where the supply of physicians has been greater, mental health nurses have been more directly guided by the physicians, and thus clinical responsibility has been left almost entirely to the latter. The relative dearth of psychiatrists in the United Kingdom, by contrast, led early on to a professional emancipation of nurses, who routinely assume considerable clinical responsibility.

The situation is quite different in the German-speaking countries of Central Europe. Most of the clinical responsibility in outpatient care has been assigned to social workers. As these countries have almost no psychiatric community nurses, the men-

Table 1

Characteristics and outcomes of studies presented at a symposium on case management research and practice in Europe

Study	Type	N	Outcomes for case management groups						
			Diagnostic and other requirements	Follow-up (months)	Hospital use	Clinical status	Social functioning	Satisfaction	Quality of life
United Kingdom									
Holloway and Carson, 1998 (10)	RCT[1]	70	Psychosis	18	nd[2]	nd	nd	Better	Better
PRiSM (Thornicroft et al., 1998) (11)	Case-control	555	Psychosis	24	nd	nd	Worse	Better	nd
UK700, 1999 (9)	RCT	708	Psychosis, frequent hospitalization	24	nd	nd	nd	nd	nd
Germany									
Rössler et al., 1992 (14)	Case-control	162	Mixed sample; frequent hospitalization	30	Better	na	na	na	na
Rössler et al., 1995 (16)	Case-control	97	Psychosis; frequent hospitalization	30	Better	na	na	na	na
Italy									
Fioritti et al., in press (12)	Cohort, pre-post	42	High service users, any diagnosis	12	Better	Better	Better	na	na
Sweden									
Bjorkman and Hansson, in press (17)	Cohort	176	Severe mental illness, mostly psychoses (73%)	18	Better	na	nd	Better	na
Aberg-Wistedt et al., 1995 (19)	RCT	40	Schizophrenia	24	Better	na	nd, but increased social network	na	Better

[1] RCT, randomized controlled study
[2] nd, no difference

tal health care community lacks a common language; even more significant, it lacks a unified disease concept. This development was promoted by the strict separation between social welfare and health care. Even today, whether—and if so, how far—psychiatrists should be integrated into case management services remains contentious. Social workers in German-speaking countries feel that the concept of case management has been reimported by psychiatrists despite its always having been a core element of their work. Today this controversy has receded as cost containment has forced community psychiatrists and social workers into an alliance. Such differences in roles and expectations are of enormous importance in interpreting work practices and service outcomes.

Fioritti (12) described how the introduction of an assertive community treatment team approach in Bologna resulted in a radical and challenging shift in both the style and the content of the doctor-patient relationship. This study also dealt with the impact on the surrounding service of the changing relationships within the assertive community treatment team. European visitors to U.S. services are often struck by how self-contained most programs seem. In Europe services are invariably jointly run and managed, with staff working across them and often sharing premises and obligations. The introduction of a specialized team can sit uncomfortably with a generic service. Jealousy about the new team was marked in the Bologna experience—usually expressed by dismissing the approach as an unnecessary U.S. import—and was followed, as the team flourished, by a sagging of morale. Very similar experiences have been repeatedly reported in the United Kingdom, with the case management service being dismissed as "elitist" and "protected." As noted earlier, the Italian solution to this problem was that the same staff worked half-time in each setting. In short, in the European setting the service surroundings are not neutral.

The Italian presentation was the one that focused most on cultural issues and expectations, although these factors are relevant wherever case management is introduced and studied. The availability of, and commitment to, evidence-based psychosocial interventions varied widely across cultures. Interventions such as behavioral family management and psychoeducation for schizophrenia were neither routinely available nor highly regarded in Italy. In the United Kingdom they are highly regarded but not available, whereas the Swedish case management service was predicated

Table 2

Health care context of the studies presented at the symposium

Study	Integration of inpatient and community services	Integration of health care and social services	Funding mechanism	24-hour coverage	Staffing
United Kingdom					
Holloway and Carson, 1998 (10)	Full	Partial	Integrated	Shared	Contract specific–employment general[1]
PRiSM (Thornicroft et al., 1998) (11)	Full	Partial	Integrated	Shared	Contract specific–employment general[1]
UK700, 1999 (9)	Full and partial	Partial	Integrated	Shared	Contract specific–employment general[1]
Germany					
Rössler et al., 1992 (14)	None	None	Integrated	Shared	Social workers independent contract
Rössler et al., 1995 (16)	None	None	Integrated	Shared	Social workers independent contract
Italy					
Fioritti et al., in press (12)	Full	Partial	Integrated	Extended (8 a.m. to 8 p.m.) and shared	Shared
Sweden					
Bjorkman and Hansson, in press (17)	Partial	Partial	Integrated	No	Independent
Aberg-Wistedt et al., 1995 (19)	Partial	Partial	Integrated	Shared	Contract specific–employment general[1]

[1] The hospital is the employing authority, but the contract stipulates that the staff member will work on the specified team—that is, the team does not employ the staff member directly.

on their provision. In Sweden the case manager has been identified as the "ambassador" for the government's reforms, and case management is recognized as essential to comprehensive community psychiatry. Case managers' functioning fits well the decentralized public welfare systems common to Nordic countries, and their implementation of evidence-based health and social care has ensured them powerful central support. It is difficult to dismiss this aspect as simply a resource or training issue; there are important and enduring differences in health care cultures that need to be taken seriously.

The Italian experience provided another insight into cultural assumptions in the area of social support and quality of life. Published research confirming the better quality of life overall of patients with major mental illness in some countries (20,21) points to differences in the provision of social support. In the United Kingdom and in Germany, as in the United States, case management is often seen as a surrogate family support system for the most severely mentally ill, who are generally isolated and have lost contact with their families. Such isolation is rarely the case in Italy, where families still generally retain contact with patients and provide for their survival needs. Case management services are therefore tasked with supporting current networks and taking a more ambitious approach to enhancing quality of life. Doing so may also have been easier than in Anglophone and Germanic cultures because of the persisting respect for professionals in Mediterranean countries.

Table 1 gives an overview of the studies presented at the symposium. Along with providing basic information on the studies, it also highlights some of the national variations in mental health provision that could have affected efficacy in the studies. However, no international consensus has been reached on which aspects of service provision and context are needed to interpret community psychiatry studies (6).

In Table 2, integration of inpatient care and community services is classified as full if the case management team members retained full clinical responsibility for inpatient care. Usually this means the same medical responsibility with some active "in-reach," in which case managers visit patients frequently and contribute actively to inpatient management decisions. Partial integration means that medical responsibility is handed over but case managers retain a significant role in decision making. No integration means that the team loses all contact with patients until they are ready for discharge. None of the services reported here had total loss of responsibility, although services in some earlier European studies did, and this was almost the case at two of the UK700 sites.

Integration of social care is complex in Europe, where social services are often highly politicized and decentralized. In the United Kingdom and the Scandinavian countries, fundamental changes are occurring in the level of integration of health and social care. In Table 2, full integration means that social workers and health care staff are employed and managed by the same organization. Partial integration indicates that social workers are employed by social services but are physically based in the mental health team; usually they also write in the same notes. No integration indicates that the services are provided in parallel, requiring referrals between the two.

For funding, an integrated mechanism is one in which funding is part of the total negotiated mental health care budget. A distinct mechanism is

one in which the case management service has an independent, negotiated budget that it has to manage. None of the services received either a strict per capita funding or item-for-service funding.

European services rarely strive for internal 24-hour coverage for patients. Many operate office hours and use the same 24-hour coverage arrangements as local community mental health teams (indicated as "shared" in Table 2); others have extended hours but rely on local provision at night ("extended"), but none are totally self-contained. Only the Swedish care managers in Bjorkman's study (17) were independently employed. All others were employed by the generic local provider either with a generic contract or a specific contract that stipulated their job on the team (indicated in Table 2 as "contract specific–employment general"). In Italy staff worked half-time in case management services and half-time in standard services ("shared").

Conclusions

Case management and assertive community treatment are considered enormously valuable heuristic concepts in European mental health services research, but we are more skeptical than our U.S. colleagues of their specificity. Research on these treatment approaches generates vital questions about which treatments and care systems work, but they are not substitutes for effective treatments. We are less interested in the whole than in its components and what it delivers. Greater objectivity about the components of the services is essential if case management is not to be self-defining. Participants at our symposium expressed a strong wish for evaluation studies in which a plurality of outcome measures were culturally sensitive and locally relevant. Quality of life, social networks, and user evaluations are probably as important in the current academic and political climate as clinical outcome measures. The social consequences of modern community-based care—for example, violence, disruptive behavior, and stigma—should increasingly be measured when mental health services are compared.

We see the major research agenda for case management as the need to disaggregate and evaluate individual components of complex interventions. Little can be gained from repeated head-to-head evaluations of case management against control services, least of all traditional hospital-based services. Our symposium, and the vigorous debate it generated, demonstrated that shifting the agenda would not be easy. In few areas of health services research are the difficulties of disentangling academic and clinical commitment more obvious. The potential for confounders from local service configurations is enormous, and researchers invariably have to be engaged in the development of a program to see it through and foster adequate staff collaboration. The very enthusiasm and commitment of involved parties required for good research in this area is a major impediment to its interpretation.

We anticipate a new generation of research into case management that uses it as a vehicle to ask questions that are more precise and more difficult to answer but that are likely to have more far-reaching import for community mental health generally. ♦

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