

### Assertive outreach could be cost-effective

We read with interest the findings of the UK700 Group (2000) and were particularly struck by the presentation of the results. The authors start with a premise that intensive case management was thought to be of benefit in terms of quality but was considered an expensive form of care delivery. However, their findings suggest otherwise, that intensive case management can be justified in terms of cost.

That the patients who were part of smaller case-loads did not fair better may reflect the criteria for entry to the study. Having a psychotic illness of at least 2 years with two admissions to hospital could be described as representing a fairly typical cohort of general psychiatry patients, who would not meet criteria for acceptance by most current assertive outreach teams. By being more selective and focusing on a more disabled group, our service has significantly reduced local bed usage. Many of the patients' difficulties previously centred around engagement with services and it is in this area that the team had to work hardest. We have found that it is often only after 2 years of working with patients that many begin to be able to cope with the transition to independent living and to reduce their use of resources, including hospital admissions.

At a time when community mental health teams nationwide are struggling to provide a reasonable standard of care for their patients, assertive outreach can also provide satisfaction and opportunities for learning for all team members. In our experience, the knowledge that patients are receiving an acceptable standard of care rather than just 'fire-fighting' can lead to a maintenance of staff moral – a factor which does not come cheap but which the UK700 study shows can be no more expensive.

**UK 700 Group (2000)** Cost-effectiveness of intensive v. standard case management for severe psychiatric illness. UK700 case management trial. *British Journal of Psychiatry*, **176**, 537–543.

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### Relevant training for case managers in severe mental illness

The UK700 Group (2000) case management trial demonstrated that there were "no clear beneficial effects on costs, clinical outcome or cost effectiveness" by reducing the case-loads of case managers working with patients with psychotic disorders. However, they went on to advise that the policy of intensive case management for patients with severe psychosis is not justified. The findings of this study do not support such a conclusion. The key issue studied (i.e. intensive case management) was determined purely by numbers of patients on the manager's case-load. No attempt is made to describe the level of training of the case managers in techniques and skills needed for effective working with patients who have a severe mental illness. The need for relevant training for case managers in severe mental illness has been addressed in the Clinical Standards Advisory Group report on schizophrenia (Gournay & Beadsmore, 1995). An alternative explanation for the findings of this study may be that without specific training in severe mental illness, purely reducing case manager's case-loads is not effective. It is most disappointing and surprising that this issue has neither been addressed in a study of this magnitude nor referred to in the discussion.

**Gournay, K. & Beadsmore, A. (1995)** The report of the Clinical Standards Advisory Group: standards of care for people with schizophrenia in the UK and implications for mental health nursing. *Journal of Psychiatric and Mental Health Nursing*, **2**, 359–364.

**UK700 Group (2000)** Cost-effectiveness of intensive v. standard case management for severe psychotic illness. UK700 case management trial. *British Journal of Psychiatry*, **176**, 537–543.

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**Authors' reply:** The training and expertise of the case managers involved in the UK700 case management trial have been described in a previous publication (UK700 Group, 1999) and discussed in subsequent correspondence (Burns *et al*, 1999). The clinical staff providing both intensive and standard case management were equally experienced in terms of training and skills, had considerable expertise in working with severe mental illness, and were representative of the staff working in

community mental health teams throughout the UK. All staff received courses in case management, and intensive case managers additionally received training in outreach practice from a team leader in assertive community treatment.

The recommendations made by Gournay & Beadsmore (1995), such as implementation of the Care Programme Approach and emphasis on post-qualification training, are ones we would agree with, and were in place in the collaborating sites during the period of the trial. They are, however, general recommendations and there is currently no research or strong clinical consensus to suggest which specific skills or training components are required for effective or cost-effective care in this area.

Although we agree that the skills of case managers working with people who have severe mental illness are an important issue in need of research, Martin has misunderstood the purpose of the UK700 case management trial. We aimed to test rigorously one component of intensive case management – reduced case-load size – in a pragmatic situation representative of clinical services within the UK. We stand by the conclusions of our paper, which relate to the cost-effectiveness of low case-load size within the framework of current clinical expertise in the UK.

**Burns, T., Fahy, T., Thompson, S., et al (1999)** Intensive case management for severe psychotic illness (authors' reply). *Lancet*, **354**, 1384–1386.

**Gournay, K. & Beadsmore, A. (1995)** The report of the Clinical Standards Advisory Group: standards of care for people with schizophrenia in the UK and implications for mental health nursing. *Journal of Psychiatric and Mental Health Nursing*, **2**, 359–364.

**UK700 Group (1999)** Intensive versus standard case management for severe psychotic illness: a randomised trial. *Lancet*, **353**, 2185–2189.

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### Neurocognitive deficits in infants of mothers with schizophrenia

Yoshida *et al* (1999) demonstrate the need for further longitudinal observational studies of the mother–infant relationship when mothers have schizophrenia that