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1. The issue: fragmentation and integration of care in mental health care delivery

As a result of the deinstitutionalisation of psychiatric service users, fragmentation in mental health care delivery systems has become a public mental health issue in many Western countries (Morrissey 1999; Glasby and Dickinson 2008). Fragmentation contributes to inefficiency and ineffectiveness in healthcare delivery, and to health inequalities (Fiscella et al. 2000). There is in particular a lack of continuity and coordination in health and social care delivery, due to many structural divisions, separate administrative and policy sectors, complex and diverse funding schemes, and distinct professional backgrounds. This particularly affects people with chronic, multiple, and complex needs, such as socially marginalised people with mental health disorders.

Vulnerable patients require care of both a medical and social nature within a multidisciplinary integrated approach, covering a wide variety of physical, mental health, and social care interventions. However, in a fragmented delivery system, care is provided by separate agencies, with few effective partnership agreements. The overall quality of care therefore depends on the effectiveness of each agency but also on the ability of agencies to collaborate in order to provide high quality integrated care. In the health and human services sector, outcomes such as integrated care delivery are understood to be emergent properties of interagency collaboration (See hereunder).

Research has been investigating how to improve integration of care delivery for such vulnerable groups (Bickman 1996; Fleury and Mercier 2002; Freeman and Peck 2006; Goldman et al., 1992; McGrew et al. 2003; Morrissey et al. 1985; Rosenheck et al. 2002). Integration of care can be achieved with the help of tools and interventions at three different levels: the level of the user, e.g. case management or individualised care planning, the level of the services, e.g. comprehensive community mental health centres, and the level of the whole system, e.g. referrals or managed care (Morrissey 1999). Most studies have

focused on processes and outcomes at the user and service levels. At these levels, there is a lack of consensus on how to define integration of care, how to measure it, and which data sources best capture the concepts measured. For example, a systematic literature review of methods in integrated healthcare delivery identified twenty-four different measurement methods in the 24 references included (Strandberg-Larsen and Krasnik 2009).

At the system level, a few studies have been carried out on mental healthcare delivery programmes, such as the Robert Wood Johnson Foundation (RWJF) programme on care integration (Morrissey et al. 1994; Lehman et al. 1994) and the ACCESS programme for mentally ill homeless persons (Goldman et al. 1992; Rosenheck et al. 2002). Although a better integration of care reduced redundancy in service provision at the system level, these studies failed to detect a measurable effect of strategies for system integration at the level of the user. All these results indicate that the fragmentation issue in mental health and social care delivery systems should not be assessed at the user or service levels alone. A system perspective is required.

Unlike the RWJF and ACCESS programmes which restricted integration of care to intensive coordination of clinical, fiscal, and administrative aspects of care, Leutz (1999) described three levels of integration within health and social care delivery systems based on a review of policies in the USA and the United Kingdom. The three levels are: linkage, a direct connection between health and social services; coordination, where an agent in a central position organises contacts and exchanges; and full integration, where health and social care delivery is integrated in one single specialised organisation. He suggested that these three levels of integration correspond to different users' needs, such as severity of the user's disorders, stability, urgency, or self-management. These levels also allow different integration policy operations, such as information exchanges, case management, and care funding. Leutz did not however indicate how to empirically assess these patterns of relations between services.

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2. A framework for evaluating public-sector organisational networks, the work of Provan and Milward

At the intersection between the organisational studies by scholars of the administration and management field, and public mental health studies, a theoretical framework on networks in mental health was developed by Milward, Provan, and their colleagues (PM). They also brought the Social Network Analysis methods (SNA) into the field of inter-organisational networks (ION), and apply it particularly to the health and human services sector. Their main findings are presented here. However, two limitations to their work are to be mentioned: first, as they come from the management field, they paid little attention to health outcomes. Second, they carried out their studies in the United States. The US care system is obviously very different from EU systems, and raises similar but also different types of issues.

PM started developing a preliminary theory of networks in mental health (Provan and Milward, 1995), by comparing 4 Community Mental Health networks. These networks were implemented in the USA after the 1960 deinstitutionalisation reform. They suggested that three levels of analysis (user, service, and network) have to be taken into account to assess network effectiveness. Moreover, network effectiveness is linked to structural and contextual factors, specifically network integration, external control, system stability and environmental resource munificence. The four networks investigated are situated in Tucson (AZ), Albuquerque (NM), Providence (RI) and Akron (OH). Over time, PM have published several studies on the Tucson network, in longitudinal or cross-sectional comparative settings.

The basic structure of those networks is a 'coordinated model', with one core agency coordinating services through case management. Network effectiveness is measured through client outcomes as quality of life, satisfaction, psycho-medical status and functioning. They also introduce the use of SNA metrics,

particularly density of ties, centralisation, fragmentation, and multiplexity. Multiplexity refers to the inter-connected network structures resulting from different relations, i.e. referrals, joint programmes, care coordination, information sharing, or funding. The framework for the measurement of the network structure is developed in 1998 (Milward and Provan, 1998). They argue that network structure is a critical issue, particularly for networks in the not-for-profit and public sectors, in which the overall effectiveness of the network may be far more important to funders, policy makers, and service professionals, than the impact of the network on the individual organisations involved. Data were collected from clients, families and clinicians, and analysed to form one index, correlated to the structural measures.

In their first studies, results on the measure of density do not give significant relation between integration and effectiveness, and a non significant tendency would, at the contrary, indicate a better effectiveness with a lower density. However, a higher centralisation seems to be correlated with a higher effectiveness. The clear linear relationship between measures of centralisation and client and family assessments of effectiveness might lead to the conclusion that a positive tie between network integration and effectiveness is most likely when coordination occur from the top down. However, qualitative results give another impression on these results. In their conclusions, authors state different propositions: 1) Network effectiveness is enhanced when the network is more centralised. 2) Network effectiveness is highest when mechanisms of external control are direct and not fragmented. Low network effectiveness will result when external control is indirect and when strong local mechanisms for monitoring and control are absent. 3) Network effectiveness is enhanced under conditions of general system stability. Networks that have recently undergone substantial change will be significantly less effective than stable ones. 4) When a network is embedded in a resource-scarce environment, network effectiveness will range from low to moderate. When a network is embedded in a resource-rich environment, network effectiveness will range from low to high.

In 1998 (Provan and Sebastian, 1998), they confirmed that in contrast to the generally held wisdom that "more integration is better," results indicate that high integration among provider agencies does not result in more favourable outcomes, but that services integration is most effective when coordinated through a single core provider. Effectiveness, measured as client outcomes, was negatively related to the integration of full networks. However, effectiveness was positively related to integration among small cliques of agencies when these cliques had overlapping links through both reciprocated referrals and case coordination. This was extended in another study in 2007 (Huang and Provan, 2007).

This lead PM to develop a comprehensive framework for studying networks of services in the public sector (Provan and Milward, 2001; Provan, 2004). This framework was extended within a literature review on whole networks in 2007 (Provan, Fish, and Sidow, 2007). They pointed out that very few studies have been carried out on the whole network of analysis and synthesize the main issues to investigate: overall network structure and processes, network characteristics and outcomes, cross-comparisons of whole networks and over time. Among the 26 studies identified, 10 were centred on health delivery networks, and 6 of them on mental health networks. Among these 6 studies, 3 were longitudinal and 3 were cross-sectional. The main topics investigated in those mental health networks studies were: governance and network change, network effectiveness, environmental factors in network change, embeddedness (the effects of cliques), and conflict management through networks. Relevant findings were:

- density tends to increase over time,
- centralisation facilitates coordination and integration,
- density and centrality cannot be simultaneously maximised,
- differentiation is correlated to low centralisation,

- central nodes have a major role on network development,
- the nature of ties is more predictive of network evolution than their stability,
- finally, resource availability strongly influences network development and legitimacy.

Network governance

One specific issue of concern by PM has been governance of networks (Provan and Kenis, 2008; Milward, Provan, Fish and al., 2010). Network effectiveness was here defined as the attainment of positive network level outcomes that could not normally be achieved by individual organisational participants acting independently. In the public sector, many networks are "goal-directed", that is build formally to address a purpose, either by those who participate in the network or through mandate, and not "serendipitous", as they usually appear in the private sector.

They suggested a typology on modes of governance, distinguishing three types:

- Shared-governance: Governance in this form can be accomplished either formally; for instance, through regular meetings of designated organisational representatives, or more informally, through the ongoing but typically uncoordinated efforts of those who have a stake in network success. It is highly decentralised, involving most or all network members interacting on a relatively equal basis in the process of governance. Shared participant-governed networks depend exclusively on the involvement and commitment of all, or a significant subset of the organisations that comprise the network. When network governance is shared, the collectivity of partners makes all the decisions and manages network activities. Power in the network regarding network-level decisions is symmetrical, even though there may be differences in organisational

size, resource capabilities, and performance. There is no distinct, formal administrative entity, although some administrative and coordination activities may be performed by a subset of the full network. In theory, the network acts collectively and no single entity represents the network as a whole.

- Lead governance: In lead organisation governance, all major network-level activities and key decisions are coordinated through and by a single participating member, acting as a lead organisation. Thus, network governance becomes highly centralised and brokered, with asymmetrical power. A lead organisation provides administration for the network and/or facilitates the activities of member organisations in their efforts to achieve network goals, which may be closely aligned with the goals of the lead organisation. The lead organisation may underwrite the cost of network administration on its own, receive resource contributions from network members, or seek and control access to external funding through grants or government funding.
- NAO (Network Administrative Organisation) governance: The NAO model is centralised. The network broker plays a key role in coordinating and sustaining the network. But the NAO is not another member organisation providing its own services. Instead, the network is externally governed, with the NAO established either through mandate or by the members themselves for the exclusive purpose of network governance. An NAO may be modest in scale, consisting only of a single individual often referred to as the network facilitator or broker, or it may be a formal organisation. This latter form may be used as a mechanism for enhancing network legitimacy, dealing with unique and complex network-level problems and issues, and reducing the complexity of shared governance. These more formalised NAOs typically have board structures that include all or a subset of network members.

Table 1
Key Predictors of Effectiveness of Network Governance Forms

Governance Forms	Trust	Number of Participants	Goal Consensus	Need for Network-Level Competencies
Shared governance	High density	Few	High	Low
Lead organization	Low density, highly centralized	Moderate number	Moderately low	Moderate
Network administrative organization	Moderate density, NAO monitored by members	Moderate to many	Moderately high	High

There are four key structural contingencies that determine the likeliness of a form of governance to be successful: trust, size, goal cohesion, and network-level competencies. Trust not only can be viewed as a network-level concept but also that network governance must be consistent with the general level of trust density that occurs across the network as a whole. About size, there is no correct number of members that corresponds to one specific form of governance, but when the number of members increase, it is more likely that shared-governance converts into a brokered form of governance, or goes to the clique model. With a large network, the NAO model fits better as governance become a complete task. About network-level competencies, organisations join for a variety of reasons, but regardless of the specific reason, all network organisations are seeking to achieve some end that they could not have achieved independently. Two issues are critical here: what is the nature of the task being performed by network members, and what external demands and needs are being faced by the network? Shared governance does not correspond to forms of networks where interdependence is high.

Finally, network managers have to face three tensions inherent in network governance. How these tensions are managed will be critical for network effectiveness. The first tension is **efficiency versus inclusiveness**: it concerns the tension between the need for administrative efficiency in network governance and the need for member involvement, through inclusive decision making.

Although network members participating in shared-governed systems may be enthusiastic about their involvement during the early stages of network evolution, "burn-out" can readily set in as network activities and involvement takes an increased toll on their time and energies. To increase efficiency, networks can shift to a lead organisation model: this form of governance is far more efficient, but the trade-off may be a reduction in the commitment of participants and a focus on the needs of the lead organisation, thereby potentially reducing overall network effectiveness. The second tension is **internal versus external legitimacy**. The legitimacy of a network manager comes from the trust he receives from the network partners, but also from the mandate he receives externally. Finally, the third tension is **flexibility versus stability**. In 1995, PM had indicated that stability was a major factor for explaining network effectiveness regarding client services, even when network-wide resources were inadequate.

The evolution of forms of governance is determined by these characteristics and tensions, the NAO appearing the most formalised and no return back form of governance. Thus, network governance is likely to evolve in a predictable pattern from shared governance to a more brokered form and from participant governed to NAO governed. Evolution from shared governance to either brokered form is significantly more likely than evolution from a brokered form to shared governance. Once established, evolution from an NAO to another form is unlikely (i.e., inertia is strongest when the governance form is more formalised).

With the introduction of managed care, PM compared the governance characteristics of two networks, a non-profit organisation governed versus a for-profit governed network (Milward, Provan, Fish and al., 2010). They argued that Arizona is a "hollow state", that is a state where it uses sub-contractors to deliver services instead of delivering these services directly by the state. However, they suggested that it could be in transition to a "state of agents" (some form of corporatist model) In these conditions, to what point are the networks responsive

to control by the state? What is the evolution of their structures? The for-profit governed network covered a larger territory and population, and although it included fewer agencies at the starting point, it increased more and was more centralised. Conversely, the non-profit network included a larger number of agencies, and evolved towards a less centralised pattern. Authors attribute these differences to the characteristics of the networks as they were initially formed. Moreover, the non-profit NAO received higher scores of trustworthiness (subjective on a 4 point lickert scale) than the for-profit NAO. According to this study, PM argue that network structure regarding client referrals and shared information ties evolves in ways that are consistent with the evolution of formal, contractual ties. Specifically, the more decentralized the contract network, the greater the increase in nonfinancial network ties like referrals and shared information.

Sustainability, stability, and conflict response

PM have also addressed issues on sustainability, and the stability of networks in a managed care environment. Sustainability of networks was largely dependent on both internal and external legitimacy and support in the early stages of evolution. Moreover, networks that were formally constructed and did not emerge out of previous relationships were more likely to fail (Human and Provan, 2000). They suggest some directions for future research: relations between network structure and effectiveness, the role that policy entities play in shaping and constraining the structure of relationships within ION, especially those that are formed through mandate, comparative structure evolution, network governance and relations with other characteristics, characteristics of network development and evolution.

In 2002 (Provan, Milward, and Isett, 2002), PM studied the effect of introducing managed care on the Tucson network, concluding that managed care increased the level of integration between agencies without having an important impact on

outcomes at the user level. Whereas costs for high costs users decreased, particularly for inpatient admissions, costs for low and middle cost users increased. Moreover, in 2004 (Provan, Isett, and Milward, 2004), new data were collected on the same network of services. They also stressed in that study that ION could be a strategy to face pressures, particularly on funds, coming from public authorities, as well as to cope with institutional conflicts. To remember, the Tucson network was coordinated and managed by a network administrative organization (NAO) that monitored both costs and quality. Their results tend to show that ION was an adapted strategy to continue offering quality care to patient's needs while facing financial pressures from the authorities. However it resulted in a more centralised pattern of interconnections.

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3. Individual care plan: the case of Psychiatric Advance Directives

Psychiatric Advance Directives (PADs) are documents that allow users with severe and chronic mental illnesses to notify their treatment preferences for future crisis relapses and to appoint a surrogate decision-maker for a period of incompetence. PADs are supposed to offer a series of clinical and organisational benefits, such as improving the feeling of empowerment of the user; improving the relationships between users, health providers and families; reducing hospitalisations, bed days and the resort to coercion or inpatient compulsory admission (Henderson et al. 2004). It is hence a promising tool as an individualised care plan, centred on the needs on the users, aiming to facilitate coordination of care and building alternatives of care in the community. This should reduce the number of involuntary commitments (Lorant et al., 2007).

However, several authors have pointed out numerous clinical and operational barriers to their use (Van Dorn et al. 2008), the reluctance of a number of stakeholders such as psychiatrists (Atkinson et al. 2004), and the lack of capacity of the care system to organise partnerships and continuity of care around the user's preferences (Van Dorn et al. 2006). A Cochrane systematic review of the effects of advance treatment directives for people with severe mental illnesses examined their effectiveness through two available randomised controlled trials (Papageorgiou & al., 2002; Henderson & al., 2004; Campbell & Kisely 2009). Contrary to expectations, the review provided little evidence on the benefits of PADs for final outcomes, such as psychiatric admissions (voluntary or involuntary), bed days, compliance with mental health treatments, self-harm, violence, formal assessment under the Mental Health Act, or service use. However, it stated that PADs were well-suited for conveying patients' preferences in mental health and that more intensive intervention such as Joint Crisis Plans (a type of PAD involving the user, clinicians, and possible third parties in a negotiation process around its completion) may be more beneficial. In any case, PAD completion rates remain very low (Henderson et al. 2008).

However, considering the PAD as a complex and multistage intervention, including a stage for its definition, a stage for its drawing up, and a stage for its honouring when the crisis occurs, it shows promising results in terms of therapeutic alliance and coordination of care, although it was designed in the first place to enhance the user's autonomy (Nicaise, Lorant, and Dubois, 2012).

Indeed, the Cochrane review stated that the best measured outcomes have been obtained with JCPs, where the document definition and content are negotiated among the user, clinicians, and third parties. Similarly, many studies show that f-PADs, where facilitation features are designed to assist users in completing the PAD, are feasible, respond to user's interest and needs, increase the rates of uptake and improve the working alliance. Even if the PAD was designed to enhance user's autonomy, its endorsement by clinicians is decisive for its effectiveness. Studies indicate that the endorsement of the PAD is higher when mental health professionals are involved in producing the document, and that they are less likely to override the directives in such cases, especially in relation to treatment refusals. Another decisive element in supporting the use of the PAD is the designation of a surrogate decision- maker. It indicates that the PAD is being used to facilitate relationships.

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Alonso,J., Codony,M., Kovess,V., & al. (2007) Population level of unmet need for mental healthcare in Europe. *British Journal of Psychiatry* **190**, 299-306.

The ESEMeD Project: highlights

Mental disorders are increasingly recognized as a major source of disability in the world. Nevertheless, population-based knowledge about the prevalence and distribution of mental disorders, their risk factors and their social and economic consequences is still

limited. As is evidence about the efficiency of health services in managing the burden of these disorders.

A number of previous population-based studies of mental disorders have been carried out in European countries. Although they have provided valuable information on the epidemiology of mental disorders within Europe, each was conducted in one country or addressed a narrower scope of mental disorder, somewhat limiting their usefulness for informing health policy across Europe as a whole.

The variation in the way European countries deliver their care to people with mental disorders is high. There are huge differences in personnel, settings, financing, as well as liaison with the wider health system across Europe. Several mental health policy reforms are ongoing on the continent. Successful policies must be based on valid and reliable knowledge of the relative efficiency of alternative organizational systems in order to reduce mental health disability.

The European Study of the Epidemiology of Mental Disorders (ESEMeD) project was conceived to overcome some of the aforementioned gaps in the knowledge of prevalence, burden and care of individuals with mental disorders in Europe. Data were collected in representative samples of the adult general population of six European countries: Belgium, France, Germany, Italy, the Netherlands and Spain. ESEMeD can be considered the largest comparative study of the epidemiology of mental disorders in Europe if we consider the size of the sample of participating individuals (more than 21 400) and the population represented in the study sample (about 213 million adult Europeans), as well as the range of mental disorders assessed and the comprehensiveness of the information collected.

The instrument used to assess mental disorders in ESEMeD was the most recent version of the Composite International Diagnostic Interview (CIDI), a comprehensive, fully-structured diagnostic questionnaire to be administered by trained interviewers who are not mental health professionals.

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Length of hospitalisation for people with severe mental illness, Cochrane Database of Systematic Reviews: Highlights

Background

In high income countries, over the last three decades, the length of hospital stays for people with serious mental illness has reduced drastically. Some argue that this reduction has led to revolving door admissions and worsening mental health outcomes despite apparent cost savings, whilst others suggest longer stays may be more harmful by institutionalising people to hospital care.

Objectives

To determine the clinical and service outcomes of planned short stay admission policies versus a long or standard stay for people with serious mental illnesses.

Search strategy

We searched the Cochrane Schizophrenia Group's register of trials (July 2007).

Selection criteria

We included all randomised trials comparing planned short with long/standard hospital stays for people with serious mental illnesses.

Data collection and analysis

We extracted data independently. For dichotomous data we calculated relative risks (RR) and their 95%confidence intervals (CI) on an intention-to-treat basis based on a fixed effects model.We calculated numbers needed to treat/harm (NNT/NNH) where appropriate. For continuous data, we calculated fixed effects weighted mean differences (WMD).

Main results

We included six relevant trials. We found no significant difference in hospital readmissions between planned short stays and standard care at one year (n=651, 4 RCTs, RR 1.26 CI 1.0 to 1.6). Short hospital stay did not confer any benefit in terms of

'loss to follow up compared with standard care (n=453, 3 RCTs, RR 0.87 CI 0.7 to 1.1). There were no significant differences for the outcome of 'leaving hospital prematurely' (n=229, 2 RCTs, RR 0.77 CI 0.3 to 1.8). More post-discharge day care was given to participants in the short stay group (n=247, 1 RCT, RR 4.52 CI 2.7 to 7.5, NNH 3 CI 2 to 6) and people from the short stay groups were more likely to be employed at two years (n=330, 2 RCTs, RR 0.61 CI 0.5 to 0.8, NNT 5 CI 4 to 8). Economic data were few but, once discharged, costs may be more for those allocated to an initial short stay.

Authors' conclusions

The effects of hospital care and the length of stay is important for mental health policy. We found limited data, although outcomes do suggest that a planned short stay policy does not encourage a 'revolving door' pattern of admission and disjointed care for people with serious mental illness. More large, well-designed and reported trials are justified.

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Becker,T. & Kilian,R. (2006) Psychiatric services for people with severe mental illness across western Europe: what can be generalized from current knowledge about differences in provision, costs and outcomes of mental health care? *Acta Psychiatrica Scandinavica* **113**, 9-16.

Psychiatric services for people with severe mental illness across western Europe: Highlights

Objective: To report recent findings regarding differences in the provision, cost and outcomes of mental health care in Europe, and to examine to what extent these studies can provide a basis for improvement of mental health services and use of findings across countries.

Method: Findings from a number of studies describing mental health care in different European countries and comparing provision of care across countries are reported.

Results: The development of systems of mental health care in Western Europe is characterized by a common trend towards deinstitutionalization, less in-patient treatment and improvement of community services. Variability between national mental healthcare systems is still substantial. At the individual patient level the variability of psychiatric service systems results in different patterns of service use and service costs. However, these differences are not reflected in outcome differences in a coherent way.

Conclusion: It is conceivable that the principal targets of mental healthcare reform can be achieved along several pathways taking into account economic, political and sociocultural variation between countries. Differences between mental healthcare systems appear to affect service provision and costs. However, the impact of such differences on patient outcomes may be less marked. The empirical evidence is limited and further studies are required.

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Providing continuity of care for people with severe mental illness - A narrative review: Highlights

Background Service users and providers have stated that delivering continuity of care to people with severe mental illness should be a service priority. We reviewed literature on continuity of care for people with severe mental illness (SMI) in order to identify factors that promote and impede this process.

Method A systematic search of electronic databases, sources of grey literature and contact with experts in the field. Two reviewers independently rated all papers for possible inclusion. Data extracted from papers formed the basis of a narrative review.

Results We identified 435 papers on continuity of care, of which 60 addressed the study aims. Most did not define continuity of care. Available evidence suggests that assertive community treatment, case management, community mental health teams and crisis intervention reduce the likelihood of patients dropping out of contact with services.

Conclusions Evidence on which to base services that enhance continuity of care for people with SMI is limited because previous research has often failed to define continuity of care or consider the patient's perspective.

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Intensive case management for severe mental illness, Cochrane Database of Systematic Reviews: Highlights

Background

Intensive Case Management (ICM) is a community based package of care, aiming to provide long term care for severely mentally ill people who do not require immediate admission. ICM evolved from two original community models of care, Assertive Community Treatment (ACT) and Case Management (CM), where ICM emphasises the importance of small caseload (less than 20) and high intensity input.

Objectives

To assess the effects of Intensive Case Management (caseload <20) in comparison with non-Intensive Case Management (caseload > 20) and with standard community care in people with severe mental illness. To evaluate whether the effect of ICM on hospitalization depends on its fidelity to the ACT model and on the setting.

Search strategy

For the current update of this review we searched the Cochrane Schizophrenia Group Trials Register (February 2009), which is compiled by systematic searches of major databases, hand searches and conference proceedings.

Selection criteria

All relevant randomised clinical trials focusing on people with severe mental illness, aged 18 to 65 years and treated in the community care setting, where Intensive Case Management, non-Intensive Case Management or standard care were compared. Outcomes such as service use, adverse effects, global state, social functioning, mental state, behaviour, quality of life, satisfaction and costs were sought.

Data collection and analysis

We extracted data independently. For binary outcomes we calculated relative risk (RR) and its 95% confidence interval (CI), on an intention-to-treat basis. For continuous data we estimated mean difference (MD) between groups and its 95% confidence interval (CI). We employed a random-effects model for analyses. We performed a random-effects meta-regression analysis to examine the association of the intervention's fidelity to the ACT model and the rate of hospital use in the setting where the trial was conducted with the treatment effect.

Main results

We included 38 trials (7328 participants) in this review. The trials provided data for two comparisons: 1. ICM versus standard care, 2. ICM versus non-ICM.

1. ICM versus standard care

Twenty-four trials provided data on length of hospitalisation, and results favoured Intensive Case Management (n=3595, 24 RCTs, MD -0.86 CI -1.37 to -0.34). There was a high level of heterogeneity, but this significance still remained when the outlier studies were excluded from the analysis (n=3143, 20 RCTs, MD -0.62 CI -1.00 to -0.23). Nine studies found participants in the ICM group were less likely to be lost to psychiatric services (n=1633, 9 RCTs, RR 0.43 CI 0.30 to 0.61, I²=49%, p=0.05). One global state scale did show an improvement in global state for those receiving ICM, the GAF scale (n=818, 5 RCTs, MD 3.41 CI 1.66 to 5.16).

Results for mental state as measured through various rating scales, however, were equivocal, with no compelling evidence that ICM was really any better than standard care in improving mental state. No differences in mortality between ICM and standard care groups occurred, either due to 'all causes' (n=1456, 9 RCTs, RR 0.84 CI 0.48 to 1.47) or to 'suicide' (n=1456, 9 RCTs, RR 0.68 CI 0.31 to 1.51).

Social functioning results varied, no differences were found in terms of contact with the legal system and with employment status, whereas significant improvement in accommodation status was found, as was the incidence of not living independently, which was lower in the ICM group (n=1185, 4 RCTs, RR 0.65 CI 0.49 to 0.88).

Quality of life data found no significant difference between groups, but data were weak. CSQ scores showed a greater participant satisfaction in the ICM group (n=423, 2 RCTs, MD 3.23 CI 2.31 to 4.14).

2. ICM versus non-ICM

The included studies failed to show a significant advantage of ICM in reducing the average length of hospitalisation (n=2220, 21 RCTs, MD -0.08 CI -0.37 to 0.21). They did find ICM to be more advantageous than non-ICM in reducing rate of lost to follow-up (n= 2195, 9 RCTs, RR 0.72 CI 0.52 to 0.99), although data showed a substantial level of heterogeneity ($I^2=59%$, $p=0.01$). Overall, no significant differences were found in the effects of ICM compared to non-ICM for broad outcomes such as service use, mortality, social functioning, mental state, behaviour, quality of life, satisfaction and costs.

3. Fidelity to ACT

Within the meta-regression we found that 1). the more ICM is adherent to the ACT model, the better it is at decreasing time in hospital ('organisation fidelity' variable coefficient -0.36 CI -0.66 to -0.07); and 2) the higher the baseline hospital use in the population, the better ICM is at decreasing time in hospital ('baseline hospital use' variable coefficient -0.20 CI -0.32 to -0.10). Combining both these variables within the model, 'organisation fidelity' is no longer significant, but 'baseline hospital use' result is still significantly influencing time in hospital (regression coefficient -0.18 CI -0.29 to -0.07, $p=0.0027$).

Authors' conclusions

ICM was found effective in ameliorating many outcomes relevant to people with severe mental illnesses. Compared to standard care ICM was shown to reduce hospitalisation and increase retention in care. It also globally improved social functioning, although

ICM's effect on mental state and quality of life remains unclear. ICM is of value at least to people with severe mental illnesses who are in the sub-group of those with a high level of hospitalisation (about 4 days/month in past 2 years) and the intervention should be performed close to the original model.

It is not clear, however, what gain ICM provides on top of a less formal non-ICM approach. We do not think that more trials comparing current ICM with standard care or non-ICM are justified, but currently we know of no review comparing non-ICM with standard care and this should be undertaken.

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Highlights: The EUNOMIA project

Previous national research has shown significant variation in several aspects of coercive treatment measures in psychiatry. The EUNOMIA project, an international study funded by the European Commission, aims to assess the clinical practice of these measures and their outcomes. Its naturalistic and epidemiological design is being implemented at 13 centres in 12 European countries. This article describes the design of the study and provides preliminary data on the catchment areas, staff, available facilities and modalities of care at the participating centres.

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Around-the-clock mobile psychiatric crisis intervention: Another effective alternative to psychiatric hospitalization: Highlights

This retrospective study evaluates the effect of the addition of a mobile psychiatrist to a 24-hour crisis intervention team, on the number of admissions, to the local state and private hospitals, of residents of the team's catchment area. During the Program period, the psychiatrist was available at the site of the crisis to provide immediate psychiatric treatment. The number of admissions to the hospitals during the Program period was then compared to those of the corresponding periods of the two previous years and of the year after, by means of a time series statistical analysis. When the onsite services of a psychiatrist were added to the mobile crisis intervention program a sharp decrease in state hospital admissions took place, without any increase in private hospital admissions. This decrease was followed by a definite rebound, after the on-site services of the psychiatrist were terminated, and throughout the following year.

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Involving users in the delivery and evaluation of mental health services: Systematic review: Highlights

Objectives: To identify evidence from comparative studies on the effects of involving users in the delivery and evaluation of mental health services.

Data sources: English language articles published between January 1966 and October 2001 found by searching electronic databases.

Study selection: Systematic review of randomised controlled trials and other comparative studies of involving users in the delivery or evaluation of mental health services.

Data extraction: Patterns of delivery of services by employees who were current or former users of services and professional employees and the effects on trainees, research, or clients of mental health services.

Results: Five randomised controlled trials and seven other comparative studies were identified. Half of the studies considered involving users in managing cases. Involving users as employees of mental health services led to clients having greater satisfaction with personal circumstances and less hospitalisation. Providers of services who had

been trained by users had more positive attitudes toward users. Clients reported being less satisfied with services when interviewed by users.

Conclusions: Users can be involved as employees, trainers, or researchers without detrimental effect. Involving users with severe mental disorders in the delivery and evaluation of services is feasible

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Highlights: Assertive Community Treatment

A conceptual model for the development of community-based treatment programs for the chronically disabled psychiatric patient was developed, and the results of a controlled study and follow-up are reported. A community-treatment program that was based on the conceptual model was compared with conventional treatment (i.e, progressive short-term hospitalization plus aftercare). The results have shown that use of the community program for 14 months greatly reduced the need to hospitalize patients and enhanced the community tenure and adjustment of the experimental patients. When the special programming was discontinued, many of the gains that were attained deteriorated, and use of the hospital rose sharply. The results suggest that community programming should be comprehensive and ongoing.

Evaluation of ACT programmes has demonstrated that they are highly effective in reducing the need for psychiatric hospitalization of chronic mentally ill patients. However,

the programmes also tend to cost more than traditional outpatient care, and their impact on other areas of patient functioning is not clear. The authors believe more rigorous studies of the programmes are needed before policymakers can properly evaluate their role in the overall mix of services. Future studies should extend previous research by comparing the programmes to current state-of-the-art treatment in community mental health centres or county mental health programmes; assessing the total system costs of ACT programmes, as well as the amount of cost shifting by payers; analysing outcomes of clients in mature programmes over long time periods; standardising the measurement of various client outcomes; and determining the impact of individual programme elements –alone and in combination– on different sub-groups of clients.

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Components of a modern mental health service: A pragmatic balance of community and hospital care. Overview of systematic evidence: Highlights

Background There is controversy about whether mental health services should be provided in community or hospital settings. There is no worldwide consensus on which mental health service models are appropriate in low-, medium and high-resource areas.

Aims To provide an evidence base for this debate, and present a stepped care model.

Method Cochrane systematic reviews and other reviews were summarized.

Results The evidence supports a balanced approach, including both community and hospital services. Areas with low levels of resources may focus on improving primary care, with specialist back-up. Areas with medium resources may additionally provide out-patient clinics, community mental health teams (CMHTs), acute in-patient care, community residential care and forms of employment and occupation. High-resource areas may provide all the above, together with more specialised services such as specialised outpatient clinics and CMHTs, assertive community treatment teams, early intervention teams, alternatives to acute in-patient care, alternative types of community residential care and alternative occupation and rehabilitation.

Conclusions Both community and hospital services are necessary in all areas regardless of their level of resources, according to the additive and sequential stepped care model described here.

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