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The Mental Health Research Review

This first issue of the Mental Health Research Review describes some of the PSSRU research in the mental health field. The aim is to present the research objectives, methods and findings in a concise and readable form. The Review also serves as a reference point for the concepts and tools which we frequently employ in our studies of the economics of mental health — the four principles of cost research, opportunity and marginal long-run cost, the Client Service Receipt Interview, modes of data interrogation and interpretation — as well as a source of up-to-date information about current work.

The Review is sent free of charge to local authorities and health authorities and to interested individuals in the United Kingdom. Further copies can be ordered from Maureen Weir at the PSSRU. It is also available worldwide in electronic format (see box below).

Readers’ comments on the Review are invited and should be addressed to the editor, Justine Schneider (e-mail: js18@ukc.ac.uk). Specific enquiries about individual articles should be made to the authors concerned. The views expressed are not necessarily shared by the Unit’s funding bodies.

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**Economics and Mental Health**

Martin Knapp

Health economics is appearing as a topic and set of issues with increasing frequency in the media, in medical journals, and in the health service generally. Its influence on mental health services and policies is small but growing. It is increasingly recognised that health economics has a positive contribution to make to policy decisions relating to the structure and organisation of community psychiatry, and to evaluations of treatment interventions and policies.

Much of the PSSRU’s mental health research programme starts from or employs ideas or frameworks borrowed from health economics. Equally, the evidence we gather can be fed back to health economics.

**Topic and discipline**

More than a decade ago, Anthony Culyer stressed the distinction between topic and discipline. The topic of economics is very familiar through, for example, media reports of rates of inflation and unemployment, political squabbles over the Exchange Rate Mechanism, annual battles between health service managers and clinicians over budgets and levels of discretionary spending, and daily decisions about the location of resources.

Less familiar is the discipline of economics. The discipline is not confined in its application to the topic. At its core is a concern about decision-making in the face of scarcity. Health economics has relevance to mental health care, both in relation to particular topics, such as employment, income and costs, and through its discipline-based interpretations of demand and supply, its utilisation of efficiency criteria in analysing health care policies and practices, and so on.

It should therefore be clear that the relevance of health economics does not stem solely from the challenges of a recession-bound economy or because recent UK governments have been committed to the extension of market forces. Its relevance is undeniable because there is always a scarcity of resources relative to wants and needs. Indeed, economics has been dubbed the ‘science of scarcity’.

**The Review**

The research studies described in this first issue of *Mental Health Research Review* address both the topic and discipline of economics. They illustrate the calculation and analysis of costs, spending and employment. And they use the experiences and insights of economics to examine incentives, rationing and market mechanisms.

But the PSSRU’s mental health programme is certainly not exclusively a health economics programme. It seeks to combine ideas, insights and evidence from a range of disciplines and traditions. This can be illustrated by looking briefly at two areas: costs and markets.

**Costs**

During the 1960s and 1970s, there were few more heinous offences than to utter the words care and cost in the same breath. The UK economy was growing fast, public spending on health and social services was growing faster, and — by today’s standards — there was little agonising over budget constraints.
Cost-influenced planning, much less cost-dominated planning — whether of cases, services or whole systems — was anathema to clinicians, social workers and many others. In those far-off halcyon days, mental health service goals such as efficacious treatment, rehabilitation or independence were, of course, not pursued at any cost, but financial decisions were by today’s standards of comparatively little concern to the consultant psychiatrist, the head of a residential home or the community nurse.

Over the same period, there was no great push from accountants and treasurers to get involved in the detail of mental health service processes and outcomes. Agency accounts were pored over by treasurers but ignored by most other people except at the annual budget meeting. There was no ‘value for money auditing’ and little systematic performance review, and suggestions to price services for sale in some internal market, or to put public responsibilities out to competitive tender, were largely confined to low-circulation, polemical pamphlets. There was little cost evaluation, though when undertaken it was often of a high standard.

Today, all of these things — contexts, assumptions, policy evaluation — look rather different. Costs appear in the most unlikely places and work their way into all manner of decision-making situations. The demand for cost information has grown enormously. But the supply response has to date been inadequate. The result has generally been poor quality data which are often inappropriately employed, and policy and practice recommendations which over-play their relevance or misdirect their efforts.

Many of the research studies described in this Research Review have been designed in the hope of raising the standard of costs research: to broaden and deepen the costs information base for policy and practice decisions.

Markets

Central to the 1991 health service reforms was the creation of the internal market, separating purchasers and providers. This new market is intended to promote competition among private, voluntary, independent public (Trust) and public (directly managed units) providers. Today’s contracts between purchasers and providers are largely agreed at a block level, but in time it is likely that more specific and more flexible arrangements will be introduced. Competition is meant to raise efficiency and promote choice. Health authority and other purchaser’s priorities are made more explicit, and managers and clinicians are more readily publicly accountable for their actions. Primary and hospital services might be better integrated, and generally information could flow more freely around the system.

This massive market reform in health care delivery has obviously stimulated much debate. Health economics has contributions to make to the debate. In particular, and in addition to the definition, analysis and interpretation of costs and cost-effectiveness data, health economics is concerned with:

- competition;
- political and social opportunities and constraints which might influence the effects of market forces;
- efficiency and equity;
- embedded inefficiencies within organisational, cultural and professional practices;
- contracting, information needs and transaction costs;
- definition and measurement of needs and outcomes;
- incentives and disincentives in the developing mixed economy;
- the roles of consumers of health care decision-making; and
- pricing policies and practices.
These are simply examples of topics which economics regularly addresses. They are being addressed in health care contexts. In the main, however, they are not being addressed in mental health care research.

**Outward and upward**

Health economics has to date made few contributions to the understanding, evaluation or planning of community psychiatry, or mental health care more generally. Yet it has a great deal to contribute. Economic theory, reinforced by empirical evidence, suggests criteria for evaluating alternative allocations of scarce resources. The techniques of economic evaluation are of obvious interest to service planners and providers faced with growing levels of need and static or declining budgets.

At the same time, some of the seemingly intractable problems associated with mental health problems, including unemployment, a shortage of accessible and affordable housing, low incomes and inadequate or inappropriate social security benefit systems, have frequently been studied by economists in broader contexts. Economics also has a long tradition of work on the interpretation and analysis of market forces.

In many ways, therefore, health economics has the potential to complement other disciplines and approaches in understanding the demands upon, and supplies of community psychiatric services. It only remains for somebody to get on with the work.

**Future Research**

In forthcoming work we hope to include the following topics:

- analysis of the OPCS Survey of Psychiatric Morbidity, looking at service utilisation, costs (both descriptive and predictive), and funding and the mixed economy (contact: Shane Kavanagh)
- the role of employment and meaningful occupation for people with severe mental health problems, a study of the costs and short-term benefits of several different work schemes (contact: Angela Hallam)
- monitoring the development of the mixed economy of mental health care, new providers, new funding and new incentives (contact: Justine Schneider)
- long term follow-up of former long-stay patients; the costs after five years of the fifth cohort of the TAPS study (contact: Jeni Beecham)
- cost-effectiveness analyses of the DLP controlled study from 30 to 45 months after entry (contact: Martin Knapp)

Some of the research under way at the Centre for the Economics of Mental Health (CEMH), Institute of Psychiatry, will also benefit from links with the PSSRU.

Collecting Information: The Client Service Receipt Interview

Jennifer Beecham

The Client Service Receipt Interview (CSRI) is a flexible research instrument developed at the PSSRU to collect information on service receipt, service-related issues and income. It is the basis on which the costs of care packages can be calculated. In one guise or another, the CSRI has been used in more than three dozen evaluations of mental health care.

The CSRI (developed in conjunction with Martin Knapp and Judy Renshaw) was based on previous research, particularly PSSRU research on child care and young offender services in the early 1980s, and on the Economic Questionnaire of Weisbrod and colleagues (1980). An early requirement was flexibility, for the CSRI as such was first employed in the evaluation of the 28 different projects funded by the Care in the Community Initiative of 1984-88. Under this programme more than 800 people left long-stay hospitals for community residence (Knapp et al., 1992). In 1986, two piloting exercises were undertaken within this project, affording the chance to test the instrument under different conditions. Employing a similar format, the CSRI has been used for over seven years in the economic evaluation of psychiatric reprovision in the North East Thames region (Beecham and Knapp, 1992).

The questions of the CSRI are largely structured with a multiple-choice format but, to contend with the complexity of community care arrangements, a few open-ended questions are also asked. A series of ‘prompt cards’ supplements the CSRI and contains indicative lists of accommodation and service types, and social security benefits. The questionnaire was originally designed for administration by interview with a principal carer, though in other research projects, such as the cost-effectiveness evaluation of the Daily Living Programme (Knapp et al., 1994), it has been successfully completed with service users. Elements of the CSRI have been incorporated into other schedules, but experience has confirmed that a trained interviewer is often needed to tease out accurate information.

Time periods

The CSRI collects retrospective information, where the period chosen is a compromise between the accuracy that comes from easy recall of recent activities and the comprehensive picture which emerges over time. For the Care in the Community and North East Thames projects this dilemma was resolved by dividing the service use questions into two parts; one covering the month prior to interview and the other asking about less regularly received services (such as out-patient or GP appointments) since discharge, nine or twelve months previously, depending on the context. In one study of people with schizophrenia, a single period of three months was used (Allen et al., 1994). For the evaluation of a new community support team in Greenwich, data were collected at three points. The CSRI was designed so that data collected at baseline and for the periods between interviews were recorded on the same schedule (McCrone et al., 1994; see page 23).

Structure

The first section of the CSRI covers background and client information, recording case number, gender, marital status, date of birth, date and place of interview,
and identifies the interviewee and the interviewer. The second section concentrates on accommodation, usually a major component in both provision and costs of community care. Accommodation is described along the following dimensions:

- address,
- tenure,
- facility size,
- number of residents,
- amount paid for accommodation by the individual or household,
- receipt of housing benefit,
- staffing arrangements, and
- managing agency.

Each of these has a bearing on the costs of the accommodation facility, but where several people live in the same unit some of these questions need be completed only once and can be separated from the other parts of the schedule.

This design was used in the evaluation of Domus care (see page 16). For the evaluation of community care in Northern Ireland we asked for a broad description of the dependency level of residents and activities undertaken in the facility (HHCRU, 1992). The CSRI has also been adapted for use where people are more likely to live in domestic accommodation, often with other family members. Changes of address are recorded, including hospital re-admissions. Instability of accommodation complicates cost calculation, but more importantly for some people it can have dire consequences for ability to work, social security entitlements or mental health itself.

Research shows that concerns about money can have an adverse effect on some mental health conditions (Brugha et al, 1985). Many people with mental health problems have low incomes, due in part to the heavy reliance on social security benefits but also to problems associated with unstable work patterns and low wages. Information over time on employment, earnings and other personal resources provides an important data source. In strict economic terms social security benefits should be considered as transfer payments and are often therefore excluded from an evaluation, but they can also make good proxies for living expenses. More detailed information is collected by the CSRI where employment and its loss are likely to be important facets of service-effectiveness and costs.

The service receipt section is at the core of the CSRI, and can take up most of the interview time. The ‘fragmented’ nature of the community care system ensures a deal of variation between different people’s packages of care, so individual use of generic or specialist health and social care services is recorded.

For each service located outside the place of residence (for example, out-patient appointments), the CSRI collects information on:

- type;
- name and location of the service;
- the providing agency;
- the frequency and duration of attendance or contact;
- travel arrangements; and
- any charges made to users for the service.

For domiciliary services the CSRI also asks for the number of service users sharing the service. This allows costs to be appropriately allocated when a visiting professional holds a group session (as with occupational therapy) or to see people sequentially (as with GP visits). The level of detail collected about any service will vary depending on the focus of the research.

Three questions complete the interview. First, there is a question about use of personal aids (for example, a Zimmer frame) or adaptations to property (such as
a wheelchair ramp). Second, the CSRI includes questions on the input of informal carers; the frequency and duration of visits and the tasks undertaken. The availability of informal care for people leaving long-stay hospitals appears to be limited but more weight is given to this dimension for other client groups.

Finally, two aspects of satisfaction with services are covered in the interview. Although we do not employ a detailed approach, service availability and quality of contact are assessed on a broad four-point scale (compare Attkison and Zwick, 1985 or Warner and Huxley, 1993). Gaps in service receipt are also identified. The NETRHA schedule uses an open format but, for other projects, such as the long-term follow-up of people with learning difficulty (Cambridge et al, 1994) a more structured approach is taken which identifies barriers to service use such as distance or expense. Aggregation of these individual-level responses can point to service provision gaps within a particular locale.

Adaptability

A central core of information is required to calculate the comprehensive costs of care packages: accommodation, income, and service receipt must all be adequately described at the individual level. Despite increasing use of care management or care programming and despite the inherent importance of service receipt information for ensuring good quality care packages, these data are rarely collected in one place. The Client Service Receipt Interview, therefore, provides a structured format within which these data can be collected. It can be easily adapted to meet the diverse demands of costs research.

The research reported in this article was undertaken with Paul Cambridge, Amanda Dansie, Angela Hallam, Martin Knapp and personnel from Research and Development in Psychiatry, the Institute of Psychiatry and the Hester Adrian Research Centre. Grateful thanks are also extended to the staff and users of each service.

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Maintenance Treatment for Depression

Alan Stewart

Depression is by far the most commonly diagnosed psychiatric condition in general and hospital practice. It can place great burdens on individual sufferers, their families and the community. It may be necessary for a number of health and social services interventions to be provided.

Depression is most prevalent among older people. As far back as 1964, one study showed that in the over-65 age group 10 per cent of the population suffered from severe depression and a further 10 per cent from milder forms (Kay et al, 1964). A longitudinal community study in Liverpool, covering 1070 individuals aged 65 and over, showed a prevalence rate of 11.2 per cent for depressive illness (Davidson et al, 1988). The three-year follow-up study showed that 43 per cent remained ill, demonstrating a persistent quality to this illness.

A particular problem with depression is the frequency of relapse and recurrence. A three-year follow-up study of people discharged from hospital treatment showed 26 per cent made a lasting recovery, 37 per cent had recurrences and 37 per cent remained ill over the study period (Post, 1972). This highlights the potential scope for improvements in preventing relapse or recurrence.

As well as being pervasive and widespread, depression also represents a major burden on health care resources, as evaluated by some ‘cost of illness’ studies. Stoudemire et al (1986) estimated costs in the United States, in 1980 prices, of $2.1 billion per year for direct costs (i.e., costs to health service and social care services of diagnosis and treatment), $10 billion due to lost productivity and $4.2 billion as a result of increased mortality. Kind and Sorenson (1993) estimated the direct health service costs of depressive illness in England and Wales as approximately £420 million per year.

There is strong evidence from various studies that anti-depressant drugs are effective in the treatment of depression in old age (e.g. Cohn et al, 1990). However, one problem with this mode of treatment is that elderly people are often more sensitive to drug therapy, hence there may be problems with the use of many classes of anti-depressants due to the frequency and severity of side effects. This aspect of the therapy must therefore be monitored and controlled. Side-effects of drugs are a significant health problem and consequently a significant factor in weighing up the real costs and benefits of using this category of therapy.

The use of antidepressants has been of particular interest in recent years since the introduction of a new class of drugs known as the Selective Serotonin Reuptake Inhibitors (SSRIs). They have a very different pharmacological profile to the older, more commonly used class of drugs known as the Tricyclic Antidepressants (TCAs). The relative merits of the two groups of drugs have been extensively debated recently (Song et al, 1993; Freemantle et al, 1993). Much of the debate has been driven by the very significant variations in the prescription costs of these drugs.

Differences in the mode of action and side effect profiles of the SSRIs, compared to the TCAs, have opened up much interest in the area of maintenance therapy, where medication is prescribed over long periods of time as a prophylactic measure to prevent relapse or recurrence of depressive illness. This contrasts with the traditional use of antidepressants for short-term, episodic therapy to tackle a specific bout of depressive illness. While there are many studies available of pharmacotherapy in episodic use, there is a shortage of studies of maintenance...
therapy and particularly of studies considering economic aspects of the treatment.

The PSSRU is involved with Pfizer Ltd in the economic analysis of maintenance pharmacotherapy for depression, evaluating the clinical and economic effects of this area of treatment. Pfizer manufactures sertraline (marketed as Lustral™), an SSRI that is now undergoing a major trial of its use in maintenance therapy for elderly people. The study is a clinical trial involving over 200 elderly people living in Liverpool, with their progress being monitored for just over two years.

A wide range of clinical information will be collected about the participants, as is normal for clinical trials. However, this will be supplemented by the use of an additional, costs-orientated, Case Record Form. Like the CSRI (see page 6), this gathers information on many aspects of service usage, such as practitioners seen, medical and social care received and home accommodation. On entry to the study these people are all resident in the community and so will come from a wide variety of backgrounds and be receiving a wide range of services.

The analysis of this information will be on several dimensions and will use a range of alternative methods. At the most direct level straight cost comparisons will be made with regard to the health and social care services used by the three groups. Cost effectiveness analysis will also be carried out, with the measure of efficacy taken as responsiveness to therapy, measured by the HAM-D (Hamilton Depression Scale; Hamilton, 1967), MADRS (Montgomery-Asberg Depression Rating Scale) and CGI (Clinical Global Impression) ratings. These will be used in assessing effectiveness in achieving a prolonged reduction in the levels of depressive illness and in the avoidance of relapse or recurrence, comparing the efficacy of the treatment against the resources consumed.

This analysis also has problems in that it aggregates much information that has more explanatory power at the level of individual people. We need to look at the varieties of combinations of circumstances, treatments received and resources used for individual participants in the study. These variations will be explored by the use of multivariate analysis. This process is intended to highlight the various interventions and their efficacies, with the principal intention being to answer the questions centred on the contribution of drug therapy and its comparison against the other interventions available.

The clinical trial has now been in progress for almost two years and recruitment should be completed in early 1994. Thus, after completion of all phases of the trial, data will be available for final analysis in autumn 1996. A preliminary publication is planned, covering the methodology and statistical procedures.

References


Economics and Child Psychiatry
Scott Gilchrist and Martin Knapp

Until recently, children who receive psychiatric treatment rarely came to public attention through the media, unlike their adult counterparts. Growing concern about juvenile crime and a small number of high profile cases may be changing public perceptions. Certainly there is concern that the level of psychiatric morbidity in children and young people is relatively high, and that many remain untreated (Williams, 1993). Evidence suggests that psychiatric disorder is common among children who frequently see their general practitioner with physical symptoms (Bowman and Garralda, 1993). At the same time, child and adolescent psychiatric services seem to be under threat in the face of cost constraints (Rutter, 1991). Resisting this trend, a case has been made for investing in mental health services for children, arguing that these not only produce immediate health gain, but also reduce long-term social and financial costs (Light and Bailey, 1993).

Arguments such as these raise a number of methodological and policy issues, for anti-social behaviour has implications which are not directly related to health care. Failure to take these broader implications into account when considering whether to invest in child psychiatry could produce a dangerously partial understanding of its impact and may distort decision-making.

Nature of the problem

Anti-social behaviour is a serious social, personal and clinical problem. Unlike most psychological characteristics, anti-social behaviour in childhood exhibits substantial continuity (Rutter, 1989). The term anti-social behaviour encompasses a broad range of activities such as aggressive acts, stealing, vandalism, cheating, lying and truancy. ‘Conduct disorder’ is used for anti-social behaviour that is clinically significant and clearly beyond the realm of ‘normal’ functioning (Kazadin, 1987). It has a low rate of remittance compared to other childhood disorders and often persists into adult life (Robins, 1966; Robins and Ratcliffe, 1979). A substantial proportion of children with conduct disorder go on to have mental disorder in adult life. Anti-social behaviour in childhood is also a predictor of similar behaviour in one’s offspring (Rutter and Madge, 1976).

Economics and child psychiatry

Economic evaluation in health care faces a number of methodological and practical challenges. Of particular importance for child psychiatry are:

- the inclusion of relevant costs and consequences;
- the agency perspective adopted by the study;
- the measurement of outcomes; and
- adjustment for differential timing.

The relevant costs and consequences for child psychiatry are not only those to the health service but also any burden (financial or otherwise) placed on other sectors of society. The evaluation of psychiatric services for conduct disorder would need to consider, for example, costs for special education requirements and greater involvement in the criminal justice system, as well as the financial costs of treatment. Failure to include all the relevant cost implications from society’s perspective could result in misleading conclusions. A programme that is unattractive from one viewpoint may look significantly better when a broader perspective is adopted.
The financial burden of any decision is also unequally distributed across agencies. The NHS is responsible for funding the majority of services for child psychiatry but can expect only modest benefits in terms of financial savings from the avoidance of downstream costs. These savings may actually accrue to a number of other public sector agencies. The nature of public sector funding arrangements and the considerable emphasis on value for money, offer few incentives or means to sponsor early interventions.

The outcomes of child and adolescent psychiatric interventions are also likely to be both short and long-term. They will be multidimensional, based on the scales and indicators which clinical research has developed, but also ranging over the possible long-term effects on social behaviour. Certainly there is little likelihood of a simple outcome measure such as the Quality Adjustment Life Year (QALY) being developed for child psychiatry in the immediate future.

Purchasers are faced with the choice of early intervention costs for anti-social behaviour, which are typically expensive and for which the responsibility can fall exclusively on the health service, or of providing no treatment with the consequent high potential social costs. Current investment in services may be justified in order to avert a greater financial burden on society in future years. The differential timing of these costs raises the issue of discounting, and the rate at which individuals are prepared to trade resources used to realise current health gain for future health gain. A high discount rate will favour incurring costs in the future and avoid expenditure on preventive treatment. This time trade-off is one of the major obstacles to preventive interventions and health promotion.

Incentives in the present health care system are not well-tuned to remedy the problem of costs and benefits which are unequally distributed over time. Perverse incentives exist to shunt costs from one agency to another, and from one year to another. The challenge for research concerning the long term consequences of anti-social behaviour among young children — or child and adolescent psychiatric interventions more broadly — is to find ways to bring the long term social costs and benefits into the same equation as the short term treatment costs of the NHS. Economic evaluation provides a framework within which the problem of differential timing and unequally distributed financial burdens can be reconciled. Of course it would be absurd to argue that economics alone can judge whether psychiatry is effective or cost-effective in ameliorating mental health problems in children; close collaboration with clinicians and an understanding of what each discipline has to contribute are indispensable components of economic evaluations of mental health services.

References
Voluntary Organisations in Mental Health
Justine Schneider

Debate about the role of voluntary organisations has focused attention on the many groups which make up this sector. Who are they and how are they affected by the mixed economy? A small survey of voluntary organisations active in the mental health area carried out at the PSSRU sheds some light on this question by mapping their functions and finances. The survey forms part of the UK component of the Comparative Nonprofit Sector Project, a 13 country study directed by Jeremy Kendall and Martin Knapp.

Focus on the voluntary sector

The voluntary sector in mental health is argued to be important for many reasons, some of which promise direct benefits to service users, and some of which are organisational in nature:
- for the individual the voluntary sector promises to be creative and innovative, with a clear commitment to user involvement;
- it can also appear to be less stigmatising than traditional services; and
- it may represent greater potential for individual choice.
- From an organisational perspective, voluntary organisations are seen to be more responsive and flexible than statutory authorities;
- they play a key role in diversifying care provision, which is one of the aims of health and social services reforms; and
- they seem to have access to donative income, free labour and other resources to augment dwindling central funding.

There is not universal agreement on each of these potential advantages of the voluntary sector, but few people would deny the sector's importance in the developing mixed economy. This article adopts the organisational perspective, and draws on new empirical evidence to discover how far voluntary organisations in mental health are willing and able to assume the provider responsibilities which are being thrust in their direction.

We identified 51 national or regional groups in the UK working in the field of mental health. Eleven failed to fit our definitions of ‘voluntary’ or ‘mental health’, which excluded housing associations since these were covered by another survey in the broader cross-national project. Of the remaining 40 organisations, 20 responded to our survey, providing information about their perceived functions, their finances and their opinions of the mixed economy.

The survey

Since the cross-national survey collected data pertaining to 1990, newer bodies, and in mental health this means especially survivors’ groups, were not represented, but there are plans to conduct a follow-up survey in 1994. Meanwhile, this 1990 survey tells us something about the functions of the organisations, and their roles in relation to statutory services, and perhaps most importantly at this juncture, the real scale of their activities in financial terms. In this way it offers a baseline against which to compare the impact of the mixed economy of mental health care.

Here, we shall look briefly at some of the survey findings and discuss their implications for the organisational issues identified above: flexibility, diversity of provision and resources.
Findings

Functions and staffing — The aims of the organisations are shown in Table 1. Fifteen groups had multiple functions; the five which gave only one role all cited service provision. Although ‘campaigning’ was not listed as a principal function, half the groups spent some time lobbying or campaigning. Resources were mostly tied up in more than one activity. The input of volunteers was estimated to be about 8 whole time equivalent workers per organisation, as compared to a mean of 37 paid employees.

Financing — From the data collected, we made global estimates of the scale of voluntary organisations in mental health in the UK, which indicate that in 1990 national voluntary organisations in mental health had a total income of about £40m. Although none of our respondents only provided housing, expenditure was dominated by housing provision, which entailed considerable capital investment and accounted for 65% of total expenditure. It may be surprising that only 37% of income was from donations, either by individuals or by companies. Indeed, our respondents were more dependent on statutory sources such as: grants, contracts and social security benefits paid to their residents, from all of which they received 48% of their total income in 1990.

The impact of change — The survey presented a number of statements about the present situation of voluntary organisations, and asked them to measure their degree of agreement. The results are shown opposite. There was neither agreement nor disagreement with many of the statements about the changes to public sector funding, and the way the voluntary sector functions internally. Such equivocal results may reflect a genuine divergence of opinion on the part of our respondents. There was resounding disagreement with some of the basic tenets of government policy, such as the role of the market in social care. Experience of collaboration with statutory bodies was also negative. However, the groups did not feel that grassroots support had declined, nor that their aims had been distorted by government funding. Although voluntary organisations defended their ‘responsiveness’ by comparison with government, they were pessimistic about prospects for the next two years.

Discussion

Flexibility — Flexibility and responsiveness can be measured in many ways, but this survey enables us to make some observations about the potential for adaptation among voluntary organisations in mental health. The finding that their functions span a range of activities suggests that there is scope for changing the emphasis from one function to another. However, the assertions that contracts undermine autonomy and that more resources are being devoted to fund-raising suggest that while voluntary organisations are proving flexible in the face of political and economic change, this may undermine their responsiveness to service users.

Diversity of provision — Service provision, in particular accommodation, was an important function of the organisations which responded to our survey. This reflects the existence of an already well developed mixed economy of mental health care provision in 1990, prior to the reforms. However, it is not known whether provision of services by the voluntary sector represented a genuine choice for service purchasers or whether other providers were effectively absent.

<table>
<thead>
<tr>
<th>Principal activity</th>
<th>No. of organisations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service provision</td>
<td>15</td>
</tr>
<tr>
<td>Giving information</td>
<td>14</td>
</tr>
<tr>
<td>Raising awareness</td>
<td>10</td>
</tr>
<tr>
<td>Research</td>
<td>8</td>
</tr>
<tr>
<td>User advocacy</td>
<td>6</td>
</tr>
<tr>
<td>Mutual aid or self-help group</td>
<td>3</td>
</tr>
<tr>
<td>Intermediary or coordinating body</td>
<td>3</td>
</tr>
</tbody>
</table>
### Survey of UK voluntary organisations in mental health

There was an equivocal response to the following statements:
- Our organisation has become too dependent on government money.
- We are increasingly becoming more like a (for-profit) business enterprise.
- The public sector often views organisations like ours with suspicion and distrust.
- Administering contracts diverts resources away from care activities.

There was overall disagreement with the following statements:
- The public sector provides adequate funding for voluntary organisations.
- The public sector makes adequate provision to involve voluntary organisations in its policy formation and review.
- The next two years promise to be much easier for our organisation compared to the last two years.
- A ‘market based’ approach to social care is the most effective way of achieving society’s aims.
- Local grassroots support has decreased in recent years.
- Receipt of government funds has distorted our organisation’s purposes.

There was overall agreement with the following statements:
- The government has not provided sufficient resources to implement its community care policies.
- In recent years we have had to devote a much larger share of our resources to fundraising.
- On balance, the advantages of public sector support outweigh the disadvantages.

PSSRU Survey of Voluntary Organisations in Mental Health, October 1993.

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in those areas where voluntary organisations were active.

**Resources** — Voluntary organisations in mental health have access to resources which are not available to statutory purchasers, but less than might perhaps be expected. Moreover, there is little evidence that such income will increase significantly. While volunteers could represent a valuable contribution, this must be weighed against the costs to the organisation of their recruitment, training and retention, and constraints on the supply of volunteers.

The data from this survey are preliminary and will benefit from further discussion and from comparisons with other areas within the voluntary sector, such as learning disability and physical disability. Nevertheless, they challenge some of our preconceptions and offer unique insights into the operation and financing of voluntary organisations in mental health.

### References


Three Cost Evaluations
Jennifer Beecham

Policy and practice initiatives designed to improve care services are regularly launched. Only a few are evaluated, and for even fewer is there information on their costs. This article considers the results from three small cost studies of mental health service developments. Each examines an innovative service and draws some comparisons with services previously received by study members. Each study used a version of the Client Service Receipt Interview (see page 6) to collect service and cost-related data, and each ran parallel with a wider study on quality of care. Each costs study followed, as closely as the design and timing of the studies allowed, the four costs rules described on page 22. Cost levels have been adjusted to 1992-93 prices.

Domus care

The run-down of hospital in-patient services has long been on the policy agenda and many people have made the successful move to new lives in the community (see for example, p. 19 below). There are still many elderly people with mental health problems in hospital. Their needs for health and social care services can be considerable. The ‘domus philosophy’ pioneered in a joint initiative by a district health authority and a housing association ensures that residents have a home for life. The service provides two registered mental health nursing homes for 24 people under secure tenancy arrangements. Residents’ charges (mainly funded through social security allowances) cover much of the service costs but the district health authority provides extra revenue. Each facility has 16 to 18 full-time staff, and working practices ensure that residents receive between 17 and 25 hours per week of individual, one-to-one support.

We found that use of services outside the domuses was limited; hospital in- and out-patient attendances were the most common, each used by four residents. However, staff noted that off-site day care, if available, would be appropriate for some clients. Domiciliary visits were more common. Psychiatrists, psychologists, and the general practitioner visited at least fortnightly and other peripatetic staff made less frequent but regular visits. Accommodation and the services provided within each facility, therefore, dominated the total costs of care (96 per cent). Median total community care cost was £951 per week for the residents of one domus and £909 for the other (Beecham et al, 1993), both more costly than the hospitals from which the residents came. The results from the outcomes study, however, suggest that there were improvements in residents’ self-care and communication skills and that there were substantially higher levels of activities and interpersonal interactions in the domuses than had been found in the hospital wards (Dean et al, 1993).

Maudsley Outreach Support and Treatment Team

Current community care policy aims to improve user and carer quality of life by developing and providing access to more and better services and targeting services on needs (Department of Health, 1989). The Maudsley Outreach Support and Treatment Team has responded to these policy demands by providing peripatetic support for adults with mental health problems who are considered ‘hard to reach’ by other services in the area. The Team aim to provide an acceptable and accessible service for people who find it difficult to use the current configuration of services, despite their need for on-going support.
The average comprehensive cost of community care for the 26 clients studied was £486 per week. Accommodation and hospital services accounted for 63 per cent of the total. Study members mainly lived in domestic accommodation rented from the local authority and 18 people had used some form of hospital services over the previous year. Many had been admitted to a psychiatric hospital in the previous year. Inputs from the Team accounted for approximately 27 per cent of the total costs, with staff spending, on average, an hour a week with clients. This may not appear to be a great deal but it represents a continuity of care which clients had not previously received. The costs of all other services used, such as day care, contact with social workers, general practitioner, probation officers and the police, amounted to only 10 per cent of the total costs of care. These services were used sporadically by few clients, with little evidence that they made up a coherent care package.

Unfortunately, the results from the outcomes study were not available to set the context for the costs data but we found that the Team undertook a wide range of support activities, acting as substitutes for other professional services, and often improving residents’ living standards by dealing with housing matters, social security entitlements and debt management. They provided a considerably enhanced community psychiatric nursing service to a group of people whose care had typically depended on crisis admissions to hospital with little support in between (Beecham et al, forthcoming).

SENSE-in-the-Midlands

A third study focuses on a 24-hour residential and rehabilitative service for 38 people with dual sensory impairments and learning difficulties. The SENSE-in-the-Midlands facility is managed by a registered charity and mainly funded by charges levied on the placing authority. It is expected that users ('students') will remain there for approximately 5 years. A range of further education facilities are provided on-site aiming to ‘maximise the potential of students by providing individually structured and intensive programmes of rehabilitation and training in social and life skills’ (SENSE, 1991).

Using the CSRI, 15 people between the ages of 18 and 39 were interviewed during the four months preceding their admission to the SENSE facility and between four and six months after entering the service.

Despite its campus-style environment, the SENSE facility provided a more independent setting for many students who now lived in small flats and were expected to help with domestic tasks. Previously, 12 entrants had lived in boarding schools, hospitals or residential care, and half of these placements were felt to be inappropriate. However, contact with non-accommodation-based services was reduced. Day care and education were provided on site, and after admission fewer people saw psychologists, social workers, or medical specialists. Only one resident attended an off-campus social club. In contrast, there was an increase in the input of professionals from outside the accommodation unit in case reviews.

The average cost of care for the pre-SENSE period was £780 per week, 85 per cent of which was accounted for by accommodation. While resident at the SENSE facility the average cost per week was £1038 per week with 99 per cent attributable to accommodation costs, an increase of 33 per cent (Beecham et al, 1992). But again we can begin to examine the implications of this increase with evidence from the parallel study on service quality (Emerson and Cooper, 1992). The results suggest that, since moving to the SENSE-in-the-Midlands facility, students spent more time in constructive activities, interacted more frequently with other residents, and showed a decrease in problem behaviours. Most parents
were extremely satisfied with the service.

**Lessons from this research**

It is of particular interest to note that one of the main results from each of these studies was that the new services meant increased client contact with staff. In turn, this appeared to be related to improved abilities to undertake relevant day-to-day tasks, or, in the case of people using the MOST service, improvements in their basic standard of living.

We cannot tell, of course, whether an even higher level of expenditure on the new services would bring about greater positive changes for individuals, or whether a slightly lower level of expenditure would bring about the same level of improvement. None of the studies is large enough to undertake the complex analyses required to address this question. Nevertheless, the importance of setting the context for costs data, even at the descriptive level, is demonstrated. Even the information currently available for the MOST study allows us to draw some conclusions about the care people are receiving. Above all, whilst the new services appear more costly than those previously used, they do provide models within which people with a variety of needs can be supported. The new services and the associated increase in the costs of care have brought about improvements in user quality of life and perhaps point the way forward for service development.

**References**


@REF = Emerson, E. and Cooper, J. (1992) *An evaluation of the quality and costs of residential further education services provided by SENSE-in-the-Midlands*, Hester Adrian Research Centre, University of Manchester.


Psychiatric Reprovision in North London

Angela Hallam

What happens to the long-stay patients of psychiatric institutions when they leave hospital and move into the community? What sort of accommodation units do they live in and how much staff support do they receive? How do the districts which take responsibility for these clients attempt to coordinate the range of services which the hospitals formerly provided? Above all, what does it all cost and what lessons can be learned as hospital-based services are relocated in the community? These are questions which we are attempting to answer in our work in North London.

For the past eight years the PSSRU has been conducting an economic evaluation of the reprovision programme of the Friern and Claybury hospitals in North London. The research has been funded by North East Thames RHA. We work closely with the Team for the Assessment of Psychiatric Services (TAPS), who record clients’ demographic details and monitor their psychiatric and physical wellbeing and quality of life in hospital and at intervals after they have moved into the community (O’Driscoll and Leff, 1993). Clients in the study have all been in-patients for a minimum of one year and, if over 65 years old, do not have a diagnosis of dementia.

The Client Service Receipt Interview (CSRI; see page 6) is used to collect the data which allow us to describe the services each client receives in the community in the first and fifth year after leaving hospital. The CSRI is supplemented by facility-specific accounts information, capital valuations and other local and national service cost data; and from these details we are able to cost individual service packages.

The costs of community care

Table 1 shows the average weekly cost of a complete package of care (accommodation facility costs and all other services) for members of the first six annual cohorts of leavers after one year in the community. All costs are expressed at 1992-93 price levels. The upward trend in costs over time is due to the increasing needs of the group leaving hospital. Clearly the development of good community services takes time and involves elements of personal, professional and political risk. To reduce the risk and because it was easier to find them community placements, residents with fewer service needs moved in the earlier cohorts (Knapp, 1994).

We found that approximately 80 per cent of the total cost of providing community care is taken up by accommodation facility costs. Therefore, the size of a unit, its managing agency, levels of staffing and the services provided on site all have a major influence on the cost of supporting the people who live there. Forty per cent of all clients in the evaluation moved from hospital to residential or nursing homes. This high number is not surprising: homes in this category provide a high level of support on-site, often caring for people with the greatest needs, and are more similar to in-patient care than other community facilities.

However, there are as many differences as similarities. A community-based unit with 24-hour staff cover for 20 people provides a very different living environment from a long-stay psychiatric hospital with several hundred patients living in large

<table>
<thead>
<tr>
<th>Table 1: 1-year costs</th>
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<tbody>
<tr>
<td>Cohort</td>
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<tr>
<td>--------</td>
</tr>
<tr>
<td>Cohort 1 (n=43)</td>
</tr>
<tr>
<td>Cohort 2 (n=110)</td>
</tr>
<tr>
<td>Cohort 3 (n=115)</td>
</tr>
<tr>
<td>Cohort 4 (n=74)</td>
</tr>
<tr>
<td>Cohort 5 (n=148)</td>
</tr>
<tr>
<td>Cohort 6 (n=55)</td>
</tr>
</tbody>
</table>
wards. At the other end of the scale, 17 per cent of people were living independently, usually in housing rented from a local authority.

Although their contribution to the total cost of client care is usually small, services based outside the accommodation unit may be vital in helping clients adapt to their new environments. It is worrying, therefore, to identify a marked fall in use of certain services by successive cohorts, particularly when it appears that scarcity of resources, rather than reduced client need, is responsible. For example, 50 per cent of clients in Cohort 1, but only 5 per cent in Cohort 6, had contact with a field social worker. Almost everyone in our sample saw a general practitioner during the first year after leaving hospital, but no other service was used by as many people.

Planning to meet the cost of community care

Naturally it would be useful for planning purposes to be able to predict community costs. We have recently examined the associations between service use and costs of people now living in the community and the characteristics of those same people when they were hospital in-patients. Clinical diagnosis was found to be a useful predictor of neither service utilisation nor cost; however, more than one third of the variation in community care costs could be explained by symptoms, behavioural and personal characteristics at least one year earlier (when assessments were made in hospital).

The main characteristics which predict the cost of community care were found to be the following:
- Costs are higher for single people who have never married and for divorced or separated men. These groups are less likely to receive informal support from family members, so look to staff to meet their day to day care needs.
- Age has a negative effect on cost, possibly because older people are less likely to receive rehabilitation, industrial therapy or further education services.
- In terms of psychiatric symptoms, greater needs as indicated by higher sub-scores on the Present State Examination (PSE) for non-specific neurotic syndrome and negative symptoms and higher staff-reported ratings of abnormal behaviour were found to predict higher costs (Knapp et al, 1994).

The long-term cost consequences of psychiatric repriorisation

We have now costed the packages of care received by the first two cohorts of leavers after five years in the community. Results indicate that the total cost of care has increased, on average by £60 per week, in the four years since this group was last interviewed. The number of client packages of care costed at two interview points is still small, but we assume that a trend has been established. The cost of caring for people in the later cohorts, whose needs are known to be greater, will continue to rise.

Figure 1 shows some key services and the percentage of people who used each of them at the two interview points. The fall in contact with field social workers is as marked over time as it was with successive cohorts. After five years in the community, the contribution to cost shows that, even when a social worker has been involved, the contact is brief. Although hospital in-patient services have been used by fewer people in the fifth year than in the first, they are being used more intensively: when they occur, in-patient stays are now much longer. We can tell this from the increase in cost per week of the in-patient component of users’ packages of care. More thorough costs analyses will be possible as the sample size increases.
Early findings from the long-term outcomes research suggest there are improvements in clients’ neurotic symptoms, verbal and non-verbal behaviour and, most notably, in negative symptoms after five years. During their first year after leaving hospital, clients reported an increasing number of friends and, although these social networks did not expand further over the next four years, an increase in the number of confidants was recorded, so relationships appear to be deepening (Leff et al, 1993).

Although the reprovision of hospital-based services in North East Thames has been well planned and well financed, a relocation programme on this scale is not accomplished without problems. Shortage of personal money for clients is cited by carers as a major barrier to integration in the community. If buying a burger snack and two packets of cigarettes uses up a client’s weekly allowance, how is it possible to live a ‘normal’ life? Where is the money to be found for clothes, or holidays? This is a financial burden that carers are often obliged to bear.

While most clients express positive feelings about their new homes, a few are reported to be grieving for the hospital. From a service perspective, although long-stay hospital residential services have been relocated, our data make it clear that the demand for services such as day-patient, out-patient and short-stay in-patient facilities still exists and should be acknowledged. In general, however, results indicate that the increasing cost of community provision is linked with favourable outcomes, both in the short term and five years after the move from hospital.

The research reported in this article was undertaken with Jeni Beecham, Andrew Fenyo and Martin Knapp in association with the Team for the Assessment of Psychiatric Services (TAPS), and its Honorary Director, Julian Leff. Grateful thanks are also extended to the staff and users of each service.

References

Principles of Costing

THE FOUR PRINCIPLES OF COST RESEARCH

Four basic principles should be followed in applying and analysing costs

1. Costs should be comprehensively measured to range over all relevant service components of the programmes or treatments under consideration

2. Cost variations between service users, facilities and sectors should be explored to provide policy and practice insights through comparisons and contrasts, but ...

3. Comparisons should only be made on a like-with-like basis to ensure that they are valid

4. Costs should be placed in context by presenting relevant evidence about individual characteristics, needs and outcomes

OPPORTUNITY COST

Economic theory advocates using long-run marginal opportunity cost in measuring the costs of health and social care. 'Opportunity' means that costs are reckoned as opportunities forgone, rather than money expended. The opportunity cost measures the true private or social value of a resource, based on its value in its best alternative use. 'Marginal' means the addition to total cost attributable to the inclusion of one more client. 'Long-run' moves us beyond a specific service under experimental conditions to the costs of setting up a new service. In practice, short-run average revenue cost, plus capital and overhead elements, is often used as a proxy for long-run marginal opportunity costs.

A fuller discussion of costing principles and opportunity cost is presented in the PSSRU book Care in the Community: Challenge and Demonstration (1992) by Martin Knapp et al, published by Avebury, Aldershot (see especially pages 268-70).
The Daily Living Programme

The Daily Living Programme (DLP) offered home-based care for people with severe mental health problems facing emergency admission to the Bethlem-Maudsley Hospital in London. The DLP model was built on a number of earlier experiments with intensive community care support teams, particularly the innovative community services developed in Madison and Sydney. The multi-disciplinary DLP team acted both as direct provider and liaison with other services. Each person supported by the DLP team was allocated a key worker.

Researchers at the PSSRU examined the costs and cost-effectiveness of the DLP when compared to standard hospital-based care. This work was conducted in parallel with the main process and outcomes evaluation by Professor Isaac Marks and colleagues at the Institute of Psychiatry.

A randomised controlled study compared the DLP service with standard treatment based initially on in-patient care. The DLP was significantly less costly, both over the full evaluation period (extending approximately 21 months from admission) and during the final phase of that period (12 to 21 months after admission — see figure). The relative long term cost saving accrued almost exclusively to the NHS in terms of reduced inpatient expenditure, with a small but significant relative saving in local authority social services expenditure.

Isaac Marks and colleagues had found superior outcomes for the DLP sample over the initial 21 months, so that the DLP was certainly a cost-effective alternative to in-patient based care over this period.

However, these cost-effectiveness advantages need to be examined beyond the 21 month period, and this is the focus of some further work in 1994.

Some related work has examined the admission point predictors of medium-term costs and the links between costs and outcomes.

References


CPN Case Management

An initiative was taken in Greenwich to reorganise the Community Psychiatric Nurse (CPN) service, with individual staff acting as case managers and client advocates. The new arrangement, which is clearly in line with central government policy changes for community care although it predated the reforms, was compared within a controlled study with the standard organisation of 'generic' CPN services.

The PSSRU study concentrated on service utilisation and cost, and ran alongside the study of social and clinical outcomes by Muijen et al (1992). Comprehensive data were gathered on service use, accommodation and income for clients supported by the (new) Community Support Team (CST) and the generic CPN service. Costs were calculated for each person in the study. Information concerned a three month pre-referral period and three consecutive evaluation periods of six months.

People included in the randomised controlled trial had diagnoses of psychotic disorder (schizophrenia or affective psychosis) excluding organic disorders; duration of illness of more than two years; more than two hospital admissions during the previous two years; and were aged 18-64. Everyone had been referred to the specialist psychiatric services by consultant psychiatrists or ward teams at the point of discharge from hospital (usually after short stays) or during community residence at the point at which CPN support was considered necessary.

Comprehensive data were collected on all services used in the three months before referral and during three consecutive treatment periods of six months. Care package costs for those people supported by the 'generic' CPN team were £110 per week higher than for those supported by the new Community Support Team (1992-93 prices). However, the difference was only significant in the first six month treatment period. In the longer term, as the figure above shows, cost-effectiveness differences were not significant.

The CPN input was significantly greater and more costly for the CST group, and CPNs worked on a wider range of tasks. The ability of these case managers to target services on client needs reduced reliance on specialist accommodation, substituting more appropriate and less costly alternatives. The overall cost difference was due entirely to differences in accommodation costs. Utilisation and costs of all other services were no different between the two groups.

References


The Costs of Schizophrenia
Shane Kavanagh

Although schizophrenia is a rare condition, it receives considerable public attention due to its long-term prognosis, the detrimental effect on the quality of life of both sufferers and their families, and some well-publicised cases where sufferers have caused physical harm or even death to themselves or others. A diagnosis of schizophrenia means that sufferers experience ‘positive’ symptoms such as hallucinations and delusions during the first episode of their condition, followed by longer-term ‘negative’ symptoms such as slowness, under-activity and social withdrawal.

Little has hitherto been known about the balance of care and service use for people with a diagnosis of schizophrenia. No single source of information is available to provide the necessary data, so data from a variety of sources such as epidemiological surveys, psychiatric case registers, large scale community health surveys and specialist surveys of the prison population and the homeless have been synthesised in a Department of Health-funded PSSRU study to yield an estimate of the balance of care (Kavanagh et al, 1994a,b). Given the general paucity of available data, the estimates presented in table 1 are the best possible, but should still be viewed as indicative rather than absolute.

The balance of care

People with schizophrenia move between the different classifications outlined in table 1 as their degree of morbidity and their social circumstances alter. However, at a system level the number of people in each category will remain broadly the same over short periods of time. Each of the rather wide categories outlined in table 1 includes people with differing care needs. For some people the place of accommodation and the care provided may well be inappropriate.

Although it is beyond the scope of this article to comment fully on current care arrangements, the presence of people with schizophrenia among the homeless and prison populations is obviously a major cause for concern. Criticism of the failure of health and social care services to provide a ‘seamless’ service has led to the introduction of the care programme approach, reports such as that of the Reed Committee on mentally disordered offenders, the enquiry into homeless people with mental illness, the debate about community supervision orders, and the introduction of supervised discharge from hospital.

Service utilisation

The estimated costs of current provision of services for people with schizophrenia were also calculated in our study, using information on service receipt derived from a number of sources, and costed using approximate long-run marginal opportunity costs (Netten and Beecham, 1993). Table 2 allocates these costs by

<table>
<thead>
<tr>
<th>Care setting</th>
<th>Estimated No. of people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private households — GP care</td>
<td>18,000</td>
</tr>
<tr>
<td>Private households — specialist care</td>
<td>60,000</td>
</tr>
<tr>
<td>Specialist accommodation</td>
<td>21,000</td>
</tr>
<tr>
<td>Hospital inpatients</td>
<td>20,000</td>
</tr>
<tr>
<td>Homeless (including hostels, lodging houses, etc.)</td>
<td>15,300</td>
</tr>
<tr>
<td>Prison (remand and sentenced)</td>
<td>1,300</td>
</tr>
<tr>
<td>Total</td>
<td>136,000</td>
</tr>
</tbody>
</table>

Sources: Kavanagh et al (1994a,b)
agency. Figure 1 shows that the costs of care for the relatively small proportion of people accommodated in hospital is disproportionately high compared to other care settings.

Implications

This article presents a summary of the preliminary results. Revised estimates, fuller discussion of the issues raised and analyses of the impact on agency resource requirements and the balance of care of introducing a number of innovative arrangements are contained in a number of forthcoming papers (Kavanagh and Opit, 1994, Kavanagh et al a,b, 1994). The costs presented here illustrate a public health problem that has considerable impact on the budgets of public care providers. The total estimated economic impact of schizophrenia is even greater when the costs of lost production and informal care are considered.

Table 2: The annual cost of schizophrenia by agency (1992/93 prices)

<table>
<thead>
<tr>
<th>Agency</th>
<th>Cost (£m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>District health authorities</td>
<td>1242</td>
</tr>
<tr>
<td>Family health services agencies</td>
<td>13</td>
</tr>
<tr>
<td>Law enforcement agencies</td>
<td>55</td>
</tr>
<tr>
<td>LA social services departments</td>
<td>149</td>
</tr>
<tr>
<td>Department of Employment</td>
<td>1</td>
</tr>
<tr>
<td>Voluntary sector</td>
<td>43</td>
</tr>
<tr>
<td>Dept of Social Security/clients</td>
<td>885</td>
</tr>
<tr>
<td>Total</td>
<td>2388</td>
</tr>
</tbody>
</table>

Sources: Kavanagh et al (1994a,b)

References


New publications

Copies of PSSRU Discussion Papers (DPs) mentioned are available for purchase from the Unit: contact the PSSRU Librarian, Lesley Banks, on 0227 764000 ext. 7773.

Economics and mental health

Reduced-list costings: examination of an informed short cut in mental health research

Programme level costs and considerations

Policy and finance for community care: the mixed economy

Community mental health services: towards an understanding of cost-effectiveness

The Economic Evaluation of Mental Health Services

The health economics of schizophrenia treatment

Care in the Community — Five Years On

The Care in the Community demonstration programme

Assessing costs and benefits

Residential care as an alternative to long-stay hospital: a cost-effectiveness evaluation of two pilot projects

The costs of accommodation and care: community provision for former long-stay psychiatric hospital patients

The costs of community care for people with long-term mental health problems

Predicting costs from needs and diagnoses: community mental health care for former hospital in-patients

Care programming in mental health: assimilation and adaptation

Costing the care programme approach

Care programming in mental health: a study of implementation and costs in three health districts

Elderly people with cognitive impairment: costing possible changes in the balance of care

Costing changes in the balance of dementia care

Elderly people with advanced cognitive impairment in England: resource use and cost

The costs of schizophrenia care in England: revised estimates

Inefficiencies and inequities in the support of people with schizophrenia in the community

Community mental health services: towards an understanding of cost-effectiveness

A controlled study of home- versus hospital-based care for people with serious mental illness: service use and costs

Predicting the downstream costs of psychiatric treatment: the DLP and standard hospital-based care

Community psychiatric nurses in an intensive Community Support Team: cost-effectiveness comparisons with generic care

The costs of MOST

Leaving Long-stay Hospital in Northern Ireland: Care in the Community for People Discharged from Psychiatric and Mental Handicap Hospitals
The PSSRU

Established in 1974 at the University of Kent at Canterbury, the Personal Social Services Research Unit is now the largest social care research unit in the UK, with some 40 staff members. Its work is funded by the Department of Health, and other government departments, the Economic and Social Research Council, charitable trusts and international social welfare organisations.

PSSRU research focuses on needs, resources and outcomes in social care and mental health care: its concerns are resourcing, equity, and efficiency from the perspective of users, agencies and others. A distinctive analytical framework called the ‘production of welfare approach’ has been developed by the Unit to illuminate such research.

The PSSRU applies the approach in studies of a wide range of areas. Most of its work has been on what is loosely described as ‘community care’, but it has also worked on other areas such as in-patient health care, housing, income maintenance, criminal justice services, and the voluntary sector.

The PSSRU Bulletin, giving details of recent research on these topics, is available free of charge from Anne Walker at the Unit, who will also be glad to send lists of PSSRU books, monographs and discussion papers.

CEMH — Centre for the Economics of Mental Health

In November 1993, Martin Knapp moved, on a half-time basis, to be Professor of Health Economics and Director of the new Centre for the Economics of Mental Health at the Institute of Psychiatry, University of London. From early 1994 both Jeni Beecham and Justine Schneider will also be employed part-time at CEMH. All three remain part-time at PSSRU. These are examples of a number of exciting links being forged between PSSRU and the Institute of Psychiatry.

CEMH is a small research centre currently working on some two dozen studies. It brings health economics perspectives and expertise to multidisciplinary research on mental health services in the UK and abroad. Future issues of this Research Review will be jointly produced by PSSRU and CEMH.