Adult mental health services in primary care
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Background
Those working in primary care settings have had increasing responsibility devolved to them since the late 1980s. Fundholding GPs emerged under the last Conservative government, and Primary Care Trusts now have a central role in commissioning services, including those for people with mental health problems. Primary Care Trusts are responsible for spending £45.3 billion on health care, of which £5.3 billion (11.85%) is allocated for mental health services (Glover, 2003). Although the bulk of this money is likely to be spent on hospital services there are incentives to develop services within primary care settings.

Economic evaluations of primary care based mental health services
A number of interventions have been developed to treat mental health problems in primary care settings. The need to establish whether these are effective is clearly understood, but it is also crucial that cost-effectiveness (or relative cost-effectiveness) be demonstrated before such interventions enter widespread use. The CEMH has been, and is currently, involved in a number of economic evaluations of innovative service interventions, some of which are described below. (The names of project leaders are given — they are all based at King’s College London, unless indicated otherwise.)

Counselling for depression
Widespread use has been made of counselling in general practice but there has been little evidence as to its cost-effectiveness. This trial was led by Sharon Simpson and Roz Corney from the University of Greenwich and compared depressed patients receiving GP care with those receiving GP care plus therapy from practice counsellors. Total service costs were not significantly different between the groups and there was only limited evidence of improved outcomes for the group receiving counselling relative to the control group (Simpson et al., 2003).

Computer-delivered cognitive behavioural therapy for anxiety and depression
In this randomised study, led by Judy Proudfoot (now University of New South Wales) and Jeffrey Gray, a computer programme — Beating the Blues, BtB — was compared to usual care from GPs. BtB consisted of an introductory video and eight sessions of cognitive behavioural therapy (CBT), usually accessed weekly by patients attending the GP surgery. Initial outcome results show that BtB results in significant improvements for anxiety and depression and in work and social adjustment (Proudfoot et al., 2003). Comprehensive measures of service use and lost employment were recorded for each group of patients before and after the intervention. Costs have been calculated and combined with outcomes in a cost-effectiveness analysis, the results of which will be available later in 2003.

Treatments for chronic fatigue
CBT and graded exercise have been compared with each other in a randomised trial that included patients from GP practices in London and the south of England. Patients receiving either of these two treatments were also compared to a group of patients receiving usual GP care plus a self-help booklet. The results of the study — led by Leone Ridsdale — have been submitted for publication and an economic evaluation is near completion. Baseline economic results have been published (McCrone et al., 2003) and these showed that the average cost of chronic fatigue over three months was £1906, with 90% of this figure accounted for by informal care and lost employment. Patients with the more severe chronic fatigue syndrome had costs that were on average £1406 higher than those with chronic fatigue.
Cognitive behavioural therapy vs drug treatment for irritable bowel syndrome  Irritable bowel syndrome effects around 17% of adults in the UK and can lead to relatively high levels of service use, with patients often referred to gastroenterologists. One efficacious treatment is the anti-spasmodic mebeverine, but there may be better ways of treating cognitive aspects of the syndrome. A recently completed randomised trial, led by Tom Kennedy, compared cognitive behavioural therapy plus mebeverine to mebeverine alone. The study measured service costs after treatment to see whether resource savings were generated. The results of the study will be published in a Health Technology Assessment report.

Pharmacological treatment of mild to moderate depression  Led by Tony Kendrick from the University of Southampton, this three-year study compares the use of fluoxetine to supportive care alone for primary care patients with mild to moderate depression. This is a particularly important topic, as adequate evidence does not yet exist for the effectiveness of SSRIs in the treatment of less severe depression. Cost-effectiveness and cost-utility analyses are being conducted and the results should be published after 2006.

Primary-secondary care liaison  Although not an intervention at the patient level, developing appropriate means of liaison between primary and secondary care staff is seen as essential for delivering effective patient care, particularly to those with more serious conditions. Shared care arrangements pose particular challenges for economic evaluations. The results of two recent studies will be published in 2003. The first of these, in Kensington, Chelsea and Westminster, was an observational study of the impact of different levels of shared care on patient outcomes and service costs. The other (the Link Study) was led by Richard Byng and evaluated the impact of a programme designed to improve the quality of communication between primary and secondary care workers.

Implications for local decision makers  Most mental health care work for primary care teams remains with the so-called common mental health problems. The accumulating evidence suggests that psychological or pharmacological treatments can be effective but that there do not seem to be benefits in terms of reduced utilisation of health care resources. This is in stark contrast to the evidence on treatments for schizophrenia and bipolar disorder where effective treatment often results in reduced costs due to the impact on bed days. Where costs savings are apparent for more common conditions they are usually in the form of a reduction in lost productivity. Therefore, for the economy as a whole treatments such as SSRIs and CBT might well save costs by their impact on employment, but for the health care sector costs would most likely increase.

Whether treatments that cost more and are more effective than comparators are cost-effective is a value judgment that policy makers need to make. The article on page 39 discusses the use of cost-effectiveness acceptability curves to inform the decision making process. One particular challenge of this approach is to determine the clinical meaning of a unit change in any clinical outcome measure, such as the Beck Depression Inventory. Given the plethora of outcome measures that are available for any single disorder — let alone for all disorders seen in primary care settings — an alternative approach would be to use a generic measure of outcome such as the quality adjusted life year (QALY). This would allow cost-effectiveness acceptability curves for different conditions to be compared and in theory would allow for a more rational approach to priority setting. However, there are major concerns about the appropriateness of QALYs in mental health care evaluations (Chisholm et al., 1997). First, QALYs do not appear to be sensitive to changes in mental health status, and for some conditions change may take place over a long period. Second, the methods by which QALY
are calculated differ across studies, as do costs. QALYs may be useful for comparing two or more treatments within the same study, but we need to be cautious about making comparisons between treatments in different areas.

Conclusions
Until recently, economic evaluations in mental health care have predominantly focused on services for patients with serious mental illness in secondary care settings. There is though an increasing amount of research being conducted in primary care and at the interface between primary and secondary care. New treatments are being developed for a number of conditions and results are encouraging. However, given that these treatments seem to result in increased health care costs, one of the main challenges (for economists and for primary care professionals) is to investigate the value of the outcomes that are attained and how these relate to the cost of producing them.

References

Other studies of adult mental health problems
CBT for bipolar disorder
The aim of this Department of Health study, led by Dr Dominic Lam, is to evaluate a cognitive therapy for patients with bipolar disorder. Approximately 150 outpatients were randomly allocated to receive cognitive therapy or standard care. A parallel economic evaluation will seek to provide a comprehensive picture of resource use and cost with the aim of assessing the cost-effectiveness of the alternative interventions. Contact: Paul McCrone

Relapse prevention in psychosis
The Wellcome Trust has funded this RCT comparing (i) CBT and standard care for patients with psychosis who do not have a close carer, and (ii) CBT, family therapy and standard care for those with close carers. The principal investigators are Professors Philippa Garety and Elizabeth Kuipers (both Institute of Psychiatry). The primary outcome measures are rates of relapse and days in hospital over the two-year period. Service use and costs will be linked to outcomes via a cost-effectiveness analysis. Contact: Paul McCrone

Evaluation of Health Living Centres
Two complementary evaluations of the UK’s 400+ Healthy Living Centres, are underway. HLCs have a strong emphasis on health and mental health; activities include arts and crafts, after school clubs and community cafés. The first study, for the Department of Health, is led by the Tavistock Institute, with PSSRU input. The second evaluation, funded by the New Opportunities Fund, is led by the Tavistock Institute in association with four UK universities, the PSSRU at LSE and the All Ireland Institute of Public Health. Contact: David McDaid

Pharmaco-Economic study of Major Depressive Disorder in general practice
Funded by Lundbeck, this study was based on a clinical trial of the drugs Escitalopram and Venlafaxine. The analysis estimated differences in average indirect and direct costs for patients, and estimated through multivariate regression which patient-level factors were associated with variations in costs. Overall, the analysis suggested somewhat lower costs for the Escitalopram group, particularly when indirect costs were excluded. There were no significant quality of life differences between the two groups. Contact: José Luis Fernández