S28. Evaluating modern community mental health services

Chairmen: JL Vasquez-Barquero, G Thornicroft

BUILDING AN INTERNATIONALLY-VALID APPROACH TO ECONOMIC EVALUATION

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The growth of multi-site, and particularly multi-country evaluations offers many opportunities but poses additional problems. The purpose of this presentation will be to describe the basic principles of economic evaluation, as applied in practice in mental health contexts, with an especial focus on the challenges of multi-country studies.

Economic evaluations look at both the cost or resource side as well as the effectiveness or outcome side. Some of the best economic evaluations in health care have been fully integrated with clinical evaluations, giving them the benefits of good quality, relevant outcome measures. If a completed evaluation is to have the opportunity to reflect on the efficiency and equity implications of alternative mental health treatments or interventions, it is imperative that good quality cost or resource data are collected alongside the outcome information.

This paper will summarise the main stages of an economic evaluation, giving illustrations from completed and on-going research. It will particularly address some of the difficulties-as well as the joys-of trying to complete these evaluative stages in multi-country evaluations.

The paper will draw upon on-going research at the Centre for the Economics of Mental Health, Institute of Psychiatry, and at the Personal Social Services Research Unit, London School of Economics and University of Kent at Canterbury. Some of the multi-country evaluative work is being conducted under the auspices of ENMESH.

STANDARDISING MEASURES OF MENTAL HEALTH SERVICE UTILIZATION

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Mental health service utilization has been a key measurement in assessing the effects of alternatives to mental hospitals ever since the dawn of the deinstitutionalization period. In the beginning of mental health service evaluation research utilization of services was measured as admission rates, readmission rates, length of hospital stay and number of outpatient and dayhospital visits — all based on utilization of health services.

As the development of community based mental health care alternatives have progressed and includes services other than health services, utilization of mental health services is only part of the pattern of utilization of mental health care facilities used by the severely and persistent mentally ill. It is therefore necessary to develop a comprehensive set of standardized measurements of service utilization based on both health services and non-health services providing mental health care.

The presentation will review the literature on service utilization methods and measurements applied in evaluative research projects in Europe and the United States during the last thirty years. The development of a standardized and comprehensive assessment of service utilization will be presented, which will be included in an EU-Biomed II concerted action project regarding the development and standardization of measurements in mental health service research within five European countries.

THE CONSEQUENCES OF PSYCHIATRIC DISORDERS FOR FAMILY MEMBERS: A COMPARISON BETWEEN SCHIZOPHRENIA AND DEPRESSION

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The consequences of psychiatric disorders are a major topic in times of deinstitutionalization. The theme has been studied for about four decades, but most of the studies use relatives of diagnostic heterogeneous patient samples. During the last five years we did two studies on homogeneous samples:

(1) among 700 family members of schizophrenic patients,
(2) among 252 family members of depressive patients.

For these studies we used the Involvement Evaluation Questionnaire (IEQ), a 90 item questionnaire, which takes about 25 minutes.

Aim: (1) to study the differences between family structure of these two patient samples, (2) to study the consequences for relatives of these two psychiatric disorders, and (3) two further develop and validate the IEQ.

Results: with schizophrenia the system mostly concerns parents and children, with depression it mostly are couples. Factor analyses on the two samples shows that the consequences for both categories can be summarized in terms of tension, worrying, supervision and urging and a total score as well. The consequences in terms of 'burden' are somewhat higher for schizophrenia. Further information will be given on the relationship between burden, coping and severity of disorder.

Conclusion: the concept of caregiving burden seems to hold for these different patient categories. The IEQ seems to be a questionnaire which can be used for these two categories of relatives.

TWO DECADES OF EVALUATING TARGETED SERVICES IN SOUTH-VERONA

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The aim of this paper is to present the results of a series of long-term evaluative studies conducted in South-Verona, Italy, where a new Community-based Psychiatric Service (CPS) was set up in 1978, to provide care and support to all patients in the at-risk population, but targeted to Severely Mentally Ill (SMI) patients. This service is not experimental and was implemented by national law; it avoids restrictive selection procedures for patients and includes a 15-bed ward in a general hospital, as well as out-patient departments, a Community Mental Health Centre, apartments, a 24 hour supervised hostel, an emergency service, rehabilitation programmes, etc. Continuity of care and a longitudinal perspective are ensured and it is hospital psychiatry which complements community care and not vice versa. For *monitoring* the provision of psychiatric care a Psychiatric Case Register (PCR), which covers the same geographical area of the South-Verona CPS (75 000 inhab.), has been operating since 31 December 1978. The study of patterns of care shows that hospital care is consistently decreasing (more than 20% decrease in admission rates and more than 60% decrease in mean N. of occupied beds), while out-patient and community care are steadily increasing. After almost 20 years the situation is not yet stable and this confirms that community care needs long time to be implemented. For *evaluating* community-based services the assessment of outcome of psychiatric

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care should be carried out and should integrate quantitative and qualitative variables, including measures such as quality of life, unmet needs, satisfaction with services and costs. In the last few years we developed an integrated model for assessing the outcome of care *routinely:* the South-Verona Outcome Project (OUT-*pro*). According to this model, variables belonging to four main dimensions are considered: clinical variables, social variables, variables concerning the interaction with services (specifically, needs for care, satisfaction with services, family burden) and data on service utilisation and costs. Most of the assessments are actually completed, after a short training, by the clinicians themselves, some other assessments are made by the patients, with the help of research workers. A comparison of results obtained in the group of psychotic patients (those with a diagnosis of schizophrenia, schizotypal and delusional disorder; affective disorder and organic psychosis) and non-psychotic patients will be presented. These data indicate that in South-Verona the diagnosis of psychosis is not necessarily a marker for unfavourable life conditions and that the South-Verona CPS meets the demands of psychotic patients. Moreover, they indicate that the perspective of patients and professionals convey complementary point of views.

TRUE VERSUS TREATED PREVALENCE OF PSYCHOSIS — THE PRISM CASE IDENTIFICATION STUDY

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In a defined population of 47, 800 for one mental health sector in the Camberwell Health Authority in South London, a comprehensive case identification study was carried out. There were two aims. First, to establish baseline service contact for a prospective study of the outcomes of introducing community mental health teams. Second, to establish more precise data on true one year prevalence of psychosis in the community. The method used was to find possible cases from contacts within the index year with mental health, general health and primary care and social services. In addition, church ministers, probation officers, users groups and a wide range of housing, voluntary and homeless agencies were contacted. Possible cases were screened using the OPCRIT system [1] to define ICD-10 and DSM IIIR cases. From 718 initial possible cases, less than half were confirmed, using this research diagnostic procedure, as having a functional psychosis. The characteristics of the social and demographic patients will be described, along with their history of psychiatric service contact, with particular reference to differences between the three main patient groups: current-contacts (mental health services), past-contacts, and never-contacts. The implications of these results for data from other studies, based only upon current secondary service level contacts, will be discussed.

[1] McGuffin P, Farmer A. And Harvey I. (1991). A Polydiagnostic Application of Operation Criteria in Studies of Psychotic Illness. Arch. Gen. Psychiatry, 48, 764–771.

S29. Conceptual obstacles to research progress in affective disorders

Chairmen: GA Fava, P Bebbington

THE CONCEPT OF RECOVERY IN AFFECTIVE DISORDERS

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The definition of recovery is a current pressing need of psychiatric research and practice. It is hindered by conceptual and methodological problems and by the relative paucity of studies on the psychobiological assessment of patients judged to be remitted, particularly in affective disorders. Only a very small percentage of patients, regardless of the affective disorder (bipolar illness, unipolar depression, panic, agoraphobia, social phobia and obsessive-compulsive disorder) and the therapy involved (whether psychotherapeutic or pharmacological or both), appears to be fully asymptomatic after treatment. The majority of patients experience residual symptoms, which are among the most powerful predictors of relapse or recurrence. There is preliminary evidence suggesting a relationship between prodromal and residual symptoms in affective disorders (the rollback phenomenon) and that improving these subclinical symptoms may ameliorate outcome. Clinicians treating patients with affective disorders often have partial therapeutic targets, neglect residual symptomatology and equate therapeutic response with full remission. A reassessment of the concept of recovery, which may provide new directions for therapeutic efforts specifically directed to residual symptomatology, is presented. Examples of such novel strategies are provided.

PSYCHOTHERAPY AND PHARMACOTHERAPY IN ANXIETY DISORDERS

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Many myths stand in the way of advancing treatments for anxiety disorders. Evidence will be presented against common illusions that:

1. treatment can be matched tightly to diagnosis;
2. disorders with physical bases require physical treatment (usually meaning medication) and disorders with psychological causes need psychotherapy;
3. brief, appropriate and effective psychotherapy is less cost-effective than medication;
4. it is hard to learn to do brief effective psychotherapy;
5. years of ongoing treatment can be justified from brief trials lasting a few weeks or months (the idea that chronic treatment need not to be based on results from chronic trials);
6. results from randomised controlled trials are always a reliable basis for clinical decisions;
7. patient satisfaction is unimportant in deciding which treatment to give.

RELAPSE AND CHRONICITY IN DEPRESSION

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In the last ten years it has become clear that, although with modern treatment the immediate outcome of depression is generally good, on longer term follow up there are high rates of symptom return.

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