General practice care of enduring mental health problems: an evaluation of the Wellington Mental Health Liaison Service
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Record Status
This is a critical abstract of an economic evaluation that meets the criteria for inclusion on NHS EED. Each abstract contains a brief summary of the methods, the results and conclusions followed by a detailed critical assessment on the reliability of the study and the conclusions drawn.

Health technology
A new programme of general practice-based mental health care was assessed. The programme aimed to provide appropriate and effective mental health care for a well-defined consumer group, by developing routine primary care services in conjunction with mental health consumers, specialist clinicians and general practice staff. The programme provided:

- joint governance arrangements;
- a new specialist team staff role, the primary care liaison worker, who supported the consumer in the transfer from specialist care to primary care;
- education and support for general practice staff;
- free general practitioner (GP) consultations; and
- new interface protocols between primary and secondary care.

Type of intervention
Other: Management care.

Economic study type
Cost-effectiveness analysis.

Study population
The study population comprised mental health consumers who had been predominantly cared for by a specialist service. The inclusion criteria for the programme were:

- a Diagnostic and Statistical Manual of Mental Disorders Axis 1 diagnosis;
- a clear need for ongoing mental health support;
- review by a psychiatrist within the last 6 months;
- holder of a community services card (entitling them to partial patient subsidies for GP visits); and
- consent to join the programme.

Setting
The setting was primary care. The economic study was carried out in New Zealand.
Dates to which data relate
The dates to which the effectiveness and resource use data related were unclear. The authors reported that the programme was introduced in 1999, with an initial evaluation report in 2000, and the collection of data has continued since then. A price year was not reported.

Source of effectiveness data
The effectiveness data were derived from a single study.

Link between effectiveness and cost data
The resource use data were derived from a sub-sample of the study sample that provided the effectiveness evidence. It appears that the costing has been conducted prospectively.

Study sample
The method of sample selection was unclear. Of the 370 patients who met the inclusion criteria, 163 agreed to participate in the study.

Study design
This was a within-group comparison that was carried out in different sites. The baseline outcomes were compared with outcomes assessed at 3, 6, 12 and 18 months after inclusion in the programme. No blinded assessment was reported. The authors did not clearly report the losses to follow-up at each assessment period.

Analysis of effectiveness
Although not clearly reported, it appears that only patients who provided all the information requested have been considered in the effectiveness study. The health outcome measures assessed were the Health of the Nation Outcomes Scale (HoNos), which measured the problem severity, and the Life Skills Profile (LSP). The analysis of HoNos was based on a sub-sample of patients who were suffering physical illness or disability problems, had problems with depressed mood, or had problems with activities of daily living.

Qualitative interviews were also conducted to assess the respondents' views about the information they received prior to transfer, their care plan, the transfer process, the care received in general practice, and their general satisfaction and preference with the new arrangements. These data were derived from a sub-sample of 100 patients.

The authors did not report any summary statistics for the study participants.

Effectiveness results
The results of the qualitative interviews are not reported in this abstract (the reader is referred to the original paper).

LSP scores were stable and did not significantly differ over time. The mean LSP was 142.5 (95% confidence interval, CI: 140.4 - 144.6) at baseline, 142.0 (95% CI: 136.9 - 147.1) at 6 months, and 145.8 (95% CI: 142.5 - 149.1) at 18 months.

The proportion of consumers in the lowest severity category remained stable, within 95% confidence limits, over an 18-month period.

Clinical conclusions
The consumers' LSP and HoNos scores were stable after entry into the programme. In addition, consumers reported no deterioration in their clinical condition while under the care of GPs, and they were largely satisfied with GP care. GPs were initially ambivalent about the programme, but were more supportive after 12 months had elapsed. The education
Measure of benefits used in the economic analysis
No summary measure of benefit was used. The study was, in effect, a cost-consequences analysis.

Direct costs
The direct costs included in the analysis comprised psychiatry services, community mental health team, inpatient acute unit, crisis assessment triage team contacts, GP capitation payment, and primary care liaison worker transfer costs. Training costs, support costs and administration costs of primary and secondary care services were not included in the analysis. The quantities and the unit costs were reported separately. The resource use data were derived from a single study. The unit costs for the screening protocol were likely to have been taken from the authors' setting. The costs were not discounted, which was relevant since they were incurred during less than 2 years. The price year was not reported.

Statistical analysis of costs
The authors did not report any statistical analyses of the costs.

Indirect Costs
The indirect costs were not reported.

Currency
New Zealand dollars (NZ$).

Sensitivity analysis
No sensitivity analysis was reported.

Estimated benefits used in the economic analysis
See the 'Effectiveness Results' section.

Cost results
The annual costs were calculated for a sub-sample of 60 patients or a caseload of 60 transfers per annum.

The annual cost before implementation of the programme was NZ$2,707.25.

The annual cost of the programme in the first 12 months after transfer was NZ$2,385.91, resulting in a cost-saving of NZ$321.34 when compared with no programme.

The annual cost of the programme for subsequent years was NZ$490.14, resulting in a cost-saving of NZ$2,217.11 when compared with no programme.

Synthesis of costs and benefits
Not relevant.

Authors' conclusions
It is possible for general practice to provide high-quality mental health care in the community to a group of consumers with high needs. Consumers remained in a good state of both physical and mental health after they had transferred to
the programme, and the general practice-based service appears to have been no more expensive than that based within specialist services.

**CRD COMMENTARY - Selection of comparators**
A justification was given for the comparator used. It reflected standard practice in the authors' setting before the implementation of a new programme of general practice-based mental health care. You should judge whether this is relevant in your setting, or whether other comparators could also have been relevant.

**Validity of estimate of measure of effectiveness**
The effectiveness data were derived from a single study. The study design, a time series, was appropriate to study process of change. However, a large sample size would have been more appropriate and the authors should have investigated heterogeneity in the patients. These facts may limit the validity of the study. As there was no strict sample selection, the reader should decide if the exclusion criteria made the study sample representative of the study population of mental health consumers.

**Validity of estimate of measure of benefit**
The authors did not derive a summary measure of health benefits. The health benefits were therefore those associated with the effectiveness outcomes. The reader is referred to the comments in the 'Validity of estimate of measure of effectiveness' field (above).

**Validity of estimate of costs**
The paper did not state the economic perspective used, thus it was not possible to assess whether all the relevant categories of costs were included in the analysis. The authors did not calculate the costs incurred by the patients, nor did they include the cost of training, support and administration of primary and secondary care services. Therefore, it is possible that the authors have underestimated the cost of the new programme. All the costs were reported separately from the quantities, which will increase the generalisability to other settings. The resource use quantities were taken from the study, while the prices were taken from the authors' setting. No statistical or sensitivity analyses of the quantities or prices were carried out. These facts limit the interpretation of the results. No price year was given, which will prevent any possible inflation exercises. Discounting was not relevant and, appropriately, was not carried out.

**Other issues**
The authors did not compare their results with the findings from other studies. In addition, the issue of generalisability to other settings was not addressed. The authors did not present their results selectively and their conclusions would appear to reflect the scope of their analysis. The authors acknowledged that their results were limited. In particular, the low response rate could have introduced a reporting bias, and the cost analyses have used easily obtainable data rather than a formal economic evaluation. Those facts may have had a huge impact on the results.

**Implications of the study**
There were no specific recommendations for future practice or research. The authors suggested that financial incentives for GPs may need revision if the programme is to be sustainable.

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**Bibliographic details**