The care of patients with chronic schizophrenia: a comparison between two services

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
Chronic schizophrenia care.

Type of intervention
Treatment; Health care organisation.

Economic study type
Cost-effectiveness analysis.

Study population
Chronic schizophrenia sufferers. The Syndrome Check List (SCL)(Wing et al, 1974) was used to confirm the clinical diagnosis of schizophrenia.

Setting
The practice setting was both in primary care (treatment) and within a hospital setting (control). The economic study was carried out in Manchester, UK.

Dates to which data relate
Effectiveness data were mainly collected over a 2 year period following the implementation of the multi-disciplinary community team as well as during a subsequent 2 year follow-up period. Resource data for the effectiveness study samples were collected over the same period. No prices were stated.

Source of effectiveness data
The estimates for the effectiveness of care provided from both services were derived from a single study.

Link between effectiveness and cost data
Prospective costing was collected from the effectiveness study sample.

Study sample
Patients with a clinical diagnosis of schizophrenia who had had a contact with South Manchester mental health services over the previous 2 years were identified, as well as patients who were out of touch with specialist services and who were identified through computerised GP records. No power calculations were stated. Treatment group subject characteristics were as follows (control group subject characteristics are given in parenthesis): number agreeing to take part = 42 (47); refusals = 9 (10); mean age = 47 years (43); female = 31% (51%); time since first recorded contact with psychiatric services = 15 years (14); past history of illness = 95% (94%); single = 41% (50%); living alone = 26% (21%); employed = 16% (9.5%). Note: the greater percentage of women shown did not reach
significance (at the 5% level) according to the authors.

**Study design**
The study was a randomised controlled trial. The duration of follow-up was over a two year period. At this time, 35 treatment and 41 control subjects, others were lost due to death or moving out of the area. 31 treatment and 32 controls agreed to be assessed further.

**Analysis of effectiveness**
The analysis of the clinical study was based on treatment completers only. The primary health outcomes assessed were patient's current problems and needs.

**Effectiveness results**
Met needs scores as percentages of meetable need were as follows for the treatment (and control) subjects:

- psychotic symptoms = 92 (76);
- underactivity = 80 (22);
- medication side-effects = 88 (65);
- neurotic symptoms = 70 (20);
- physical disorder = 70 (66);
- behaviour difficulties = 100 (45);
- distress = 80 (36);
- daily living skills = 83 (61);
- use of public amenities and transport = 83 (44);
- vocational skills = 26 (25);
- communication skills = 45 (16);
- managing finances and affairs = 68 (47).

**Clinical conclusions**
Better quality care was provided at 2 years (as well as 4 years) through the multi-disciplinary mental health team.

**Measure of benefits used in the economic analysis**
Primary health outcomes as well as resource usage represented benefits within this study.

**Direct costs**
Direct cost computations included in-patient attendances, out-patients, day hospital, depot clinic, psychology services, community nursing, occupational therapy, and other primary care costs. Local authority costs were also computed. Resource information was obtained from a combination of service registers, health authority computers (containing community staff activity), medical notes, and patient interviews. No discounting was performed.
Statistical analysis of costs
Not stated.

Indirect Costs
Indirect costs included financial costs to families and patients both in terms of time and money. No discounting was stated.

Currency
UK pounds sterling (£).

Sensitivity analysis
Not performed.

Estimated benefits used in the economic analysis
As well as resource usage, the primary health outcomes specified in the effectiveness results reported earlier, represented benefits within this study.

Cost results
Overall health service costs during the study year were: treatment group = 1,406; control group = 1,199. Indirect costs incurred over a 12 month period: treatment group = 4,403; control group = 3,849.

Synthesis of costs and benefits
A synthesis of costs and benefits was not performed. The per capita cost of services received was 245 higher in the treatment group (not significant due to high individual variability).

Authors' conclusions
Multi-disciplinary community-based teams provide better quality care for chronic schizophrenics and distribute resources more effectively than traditional hospital-based services.

CRD COMMENTARY - Selection of comparators
The choice of multi-disciplinary community-based and traditional hospital-based mental health teams as comparators was justified.

Validity of estimate of measure of benefit
The measures of economic benefit expressed within the study may not be internally valid given that the authors used primary health outcomes and costs to express benefits. As such a cost-consequences study was performed.

Validity of estimate of costs
Resource data were adequately referenced (the authors invites readers to obtain more specific costing information from them).

Other issues
No power calculations, sensitivity analysis or discounting was performed. As such the robustness of the findings was not tested.

Implications of the study
More comprehensive studies around the care of chronically mentally ill patient are required in order to evaluate the full
extent of any benefits that are to be obtained from operating under multi-disciplinary community-based mental health teams. This will require power calculations and valid measures of (economic) benefit in order to validate claims of (cost-) effectiveness.

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