Cost-effectiveness of an early intervention service for people with psychosis
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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.

CRD summary
The objective was to assess the cost-effectiveness of an early intervention service, compared with standard care, for people with psychosis. The authors concluded that the early intervention service did not increase cost and was highly likely to be cost-effective. A few issues with the clinical analysis mean that uncertainty remains in the results.

Type of economic evaluation
Cost-effectiveness analysis

Study objective
The objective was to assess the cost-effectiveness of an early intervention service, compared with standard care, for people with psychosis.

Interventions
The early intervention service was provided by a team of psychiatrists, psychologists, occupational therapists, nurses, and health care assistants. It included low-dose medication, cognitive-behavioural therapy, family therapy, and vocational rehabilitation. Standard care was provided by community mental health teams, with no extra training in dealing with early psychosis.

Location/setting
UK/community.

Methods
Analytical approach:
The analysis was based on a randomised controlled trial (RCT), conducted in Lambeth, South London, with a follow-up of 18 months. The authors reported that a public sector perspective was adopted.

Effectiveness data:
The effectiveness data were from a single-centre RCT (Craig, et al. 2004, See ‘Other Publications of Related Interest’ below for bibliographic details). People aged 16 to 40 years, who were referred to specialist mental health services, with a probable diagnosis of non-affective psychosis, were eligible for inclusion, and were randomised, using sealed envelopes, in blocks of two to six people, to receive the early intervention (71 patients) or standard care (73 patients). The primary outcome measures were the rates of relapse and hospitalisation; secondary outcomes included quality of life and vocational recovery, defined as a return to or taking up full-time employment or education.

Monetary benefit and utility valuations:
Not relevant.

Measure of benefit:
The primary outcomes were quality of life and vocational recovery. Quality of life was estimated, using the Manchester Short Assessment of Quality of Life survey, given to study participants.

Cost data:
The analysis included health care (primary and hospital), social care, and criminal justice services. The resource use was from participants in the RCT, and was collected for the first and third six-month periods of follow-up. Local hospital data were available for the full 18 months. Service use was measured, using an adapted version of the Client Service
Receipt Inventory. The unit costs were from a published source. The cost differences were adjusted, using a bootstrapped regression model, for patient characteristics and baseline costs (during the six months prior to randomisation). The price year was 2003 to 2004.

Analysis of uncertainty:
The analysis of uncertainty involved a net benefit approach. This consisted of varying the theoretical amount that society would be willing to pay for a one-unit improvement in quality of life or someone making a vocational recovery, to assess the likelihood of the intervention being cost-effective. Standard deviations were provided for the individual costs and benefits.

Results
Data on vocational recovery was available for 64 people receiving the early intervention service and 62 receiving standard care. With the early intervention service, 21 people (33%) made a full recovery and with standard care, 13 people (21%) made a full recovery; this difference was not statistically significant (p=0.162).

Quality of life scores were available for 52 patients (73%) receiving the early intervention service and 40 (55%) receiving standard care. The mean score was 59.3 for the early intervention service and 53.3 for standard care; a statistically significant difference (p=0.025).

Follow-up costs were available for 65 patients (92%) receiving the early intervention and 61 patients (84%) receiving standard care. At follow-up, the costs were £2,318 lower in the early intervention group, after adjustment for baseline costs. After adjustment for differences in participant characteristics, this difference was reduced to £1,756.

The early intervention service dominated standard care, as it was less costly and more effective. If society was not willing to pay anything for a vocational recovery, there was a 76% likelihood of the intervention being cost-effective.

Authors’ conclusions
The authors concluded that early intervention did not increase costs and was highly likely to be cost-effective, compared with standard care.

CRD commentary
Interventions:
The intervention was relatively well reported, and the comparator seems to have been appropriate as it was the usual practice in the authors’ setting.

Effectiveness/benefits:
The effectiveness data were from a RCT. Full details of the trial were reported elsewhere, making it difficult to meaningfully comment on its internal validity. The authors stated that no adjustment was made for loss to follow-up, which could bias the results if those who dropped out were different to those who did not drop out. Loss to follow-up was higher with standard care than with the intervention. The authors adjusted for differences between the two groups, but few details were provided on the sample. The follow-up period of 18 months should have been long enough to capture the main effects of the intervention. The outcome measures of vocational recovery and quality of life were appropriate, but they cannot be easily compared with the outcomes of other interventions.

Costs:
The authors reported the perspective and appear to have included all the relevant costs. The estimates and sources for the resource use and unit costs were described. The costs were not discounted, despite some occurring after one year. This might have influenced the cost results, as the timing of some services differed between the two groups.

Analysis and results:
The authors did not conduct an incremental analysis; a net benefit approach was adopted. This assessed the probability of the intervention being cost-effective, at particular values that society might place on health outcomes. The uncertainty in specific costs and effectiveness estimates was not explored. The authors discussed a number of limitations to their study, particularly relating to the clinical data.
Concluding remarks:
A few issues with the clinical analysis mean that uncertainty remains in the results.

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