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# The Economic Evaluation of Mental Health Care : A Review

by

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December 1988

## **DISCUSSION PAPER 51**



University of York  
Centre for Health Economics

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### Acknowledgements

The authors would like to acknowledge the financial assistance of the Economic and Social Research Council.

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## Abstract

This paper consists of a review of economic evaluations of mental health care. The conclusion which emerges from this review is that the existing literature is lacking in both quantity and quality. Only seven evaluations of both the costs and effects of alternative forms of mental health care have been carried out in the UK. None of these have involved the appraisal of what is currently the most important choice faced in mental health care, that between institutional and community care, and different types of community care, for individuals with a chronic mental illness. More studies have been completed in other countries, particularly North America, but the evidence provided by these evaluations cannot be expected to always be valid in the UK.

The lack of evidence on the efficiency of alternative uses of mental health care resources is even greater than that indicated by the small number of studies carried out, since a number of these evaluations are deficient in design and so do not provide valid evidence.

Given this state of the art in economic evaluation of mental health care, there can be little hope that the resources available to provide mental health care in the UK are currently being used most effectively. It appears that choices between competing care options for the mentally ill are usually made in the absence of information on the relative costs and effectiveness of these alternatives.

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## The Economic Evaluation of Mental Health Care: a review

### Introduction

The resources available for improving or maintaining mental health are scarce. But this is no different from all of life's activities. Resources are scarce in whatever we have to do. The logical consequence of this universal scarcity is choice. Since we cannot, either as individuals or as a society, do everything we wish to do, we must choose. Economics is concerned with the ways in which people can and do choose to allocate scarce resources to competing ends.

Choice involves sacrifice. In choosing to do one thing we are sacrificing the benefits of doing other things. This is true whether we individually choose to purchase one commodity rather than another or pursue one activity rather than another or whether we collectively decide to allocate resources to one public service rather than another. To devote more resources to meet the objectives of better mental health means sacrificing more health care for other people. To devote more resources to health care means sacrificing the benefits to be received from other public services.

Given that choices have to be made, we must decide the criteria on which they are to be based. One main criterion in economics is that of efficiency which entails that society tries to maximise the benefits it achieves for the resources it consumes. Efficiency is not the sole criterion for assessing the merits of resource use, but it is an important one and forms the main focus of this paper. Practically, the essential message in the search for efficiency is to measure the costs and benefits of goods and services and choose those which produce the greatest net

benefit (benefit minus cost). Economic evaluation of health care is in effect concerned with the measurement of costs and benefits of alternative ways of achieving objectives and the main aim of this paper is to review the state of the art of economic evaluation in the field of mental health.

Economic evaluation follows a carefully worked-out methodology which entails:

- (i) A specification of the objectives of the policy to be evaluated.
- (ii) An identification of the alternative methods of achieving that objective.
- (iii) The measurement and evaluation of the costs and benefits of the alternatives.
- (iv) Differentiating the times at which costs and benefits occur.
- (v) Identifying the major uncertainties in the measurement and impact of costs and benefits and setting out the likely effects of these uncertainties on the results and application of the evaluation.

The studies reviewed in this paper are assessed in terms of how well they have been able to keep to this exacting set of tasks (see O'Donnell et al, 1988 for a more detailed description of the methodology of economic evaluation as applied to mental health care).

The scope for economic evaluation is large but its application in the field of mental health has been very limited. There are few studies of major policy questions such as the balance of facilities between community and hospital care or on many major aspects of treatment. Secondly, the geographical scope of the studies is limited, for example, some of the



evaluations carried out in the United States have not been attempted in Britain and similarly, British studies have not been replicated in other countries. Thus, the policy-makers in any one country have very little evaluative work to aid resource allocation decisions in the field of mental health.

However, if the studies which have been published are analysed they give useful pointers to the methodological problems which confront cost-effectiveness analysis in mental health and allow the ways of taking the work forward to be determined. Economic appraisal has been applied to the following issues:

- institutional versus community care;
- in-patient versus out-patient versus day care treatment;
- treatment in various types of hospitals;
- various types of treatment for schizophrenics;
- nurse therapist versus medical or psychiatrists' treatment of neurosis.

Each of these issues is considered in turn in terms of validity of the evidence available from studies of the efficiency of these mental health care alternatives; the economic methodology used; and the lessons they provide for development of economic appraisal in mental health.

### Institutional versus Community Care

The initial evaluations of institutional versus community care, carried out in the United States, were deficient in a number of ways which preclude them from providing valid evidence on the efficiency of the alternatives compared. Pasamanick et al (1967) carried out a good clinical study, based on a randomised controlled trial (RCT), of home-based

treatment with a drug or placebo for individuals suffering from schizophrenia versus hospital-based treatment. Unfortunately, the costing part of the study was not rigorous, only costs to the hospital sector were identified. This is not satisfactory, since it leaves the possibility that a shift in the burden of costs, from the hospital sector to other providers of care, will be interpreted as a reduction in total costs. Comparing the efficiency of alternative treatments requires carrying out an evaluation from a societal perspective, the costs and benefits of each treatment to all sectors of society must be identified.

Cassel et al (1972) and Sheehan and Atkinson (1974) also evaluated hospital versus community care alternatives, but both studies only involved a comparison of relative costs and so provided no evidence on relative efficiency. The efficiency of a programme is determined by the relation between costs and outcome. The lowest cost alternative is not necessarily the most efficient, since its outcome may also be low and indeed may be less than its cost. The least costly alternative will usually be to 'do nothing', but having this information is not likely to prove useful in trying to achieve the most effective provision of mental health care.

Although Sharfstein and Nafziger (1976) did identify both the costs and benefits of various forms of institutional and community care, their results were based on the experiences of only one individual suffering from chronic schizophrenia. The results are, therefore, more likely to reflect the particular needs of that one individual, rather than provide valid evidence on the relative efficiency of the treatment evaluated.

Murphy and Dattel (1976) addressed the question of whether the benefits of a particular model of deinstitutionalisation were greater than its costs. They discovered that this was the case for all patients except those with the most severe illness and the greatest care needs. In addition to the monetary benefits of deinstitutionalisation outweighing the costs, there were also psychological benefits to the subjects and the community. However, these results may not be valid given that methodology of the evaluation was flawed in a number of respects. The most severe limitation is that the study was not based on a RCT but on an uncontrolled before and after study. Deinstitutionalisation and maintenance in the community may, therefore, be the cheaper alternative because the individuals were healthier, and so had less care needs, than when they had experienced the institutional care. Additionally, the costs and benefits of the alternatives were compared over a 10-year period, but 90% of the data consisted of projections derived from the results obtained in the initial follow-up period. Making these projections required a large number of assumptions about how the service would be expected to develop. For every one of these assumptions which proved incorrect the results of this study would become more inaccurate. Given this potential for inaccuracy, the results of this study would have been more useful had their sensitivity to these assumptions been tested. For these reasons it is not possible to generalise these results to reach conclusions about the efficiency of deinstitutionalisation in general.

Rather than comparing institutional with community care, Mosher and Menn (1978) evaluated different types of community care for young, unmarried, first admission schizophrenic patients. They emphasise the importance of defining what meaning is being given to 'community care' in studies which evaluate such an option. For Mosher and Menn 'true' community care involves "treatment programmes that are community based,

that is, the participants have an ongoing interaction with the local neighbourhood" (ibid p.715). These are to be distinguished from other programmes which merely change the location of in-patient treatment, which continues to be based on the traditional medical model. They compare what is considered to be a 'true' community care programme with a less community orientated one and find the former more cost effective. The validity of this result remains in doubt however, since the evaluation was not based on a RCT, the sample size was small ( $n = 44$ ), and no detail was provided of what costs were identified.

More recent evaluations of hospital versus community care carried out in the United States (Weisbrod et al, 1980), Canada (Fenton et al, 1982) and Australia (Hoult et al, 1984) provide better evidence on the relative efficiency of such alternatives. In each of these evaluations samples of at least 120 individuals presenting to a hospital for treatment, were randomly allocated to either standard in-patient care with community after care, or directly to some form of community care. All three studies excluded individuals with a diagnosis of organic brain disorder or alcoholism from the evaluation and schizophrenics made up at least 40% of each of the samples. The community care alternatives evaluated in the studies were consistently found to be the most efficient, producing a greater net monetary benefit than hospital care and also being more effective.

The notable feature of the study carried out in the USA (Weisbrod et al, 1980) was its attempt to enumerate, quantify and evaluate explicitly the resources used in the different forms of care. This contrasts with several other studies, such as Pasamanick et al (1967), which have focused narrowly on a particular organisation's cost and therefore grossly

underestimate the total cost of any procedure or which have presented monetary values of costs which do not show the real resource use from which they are derived (e.g. Mosher and Menn, 1978). One major limitation of this work is the costing of informal care. There is no generally accepted methodology for valuing the time that patients' relatives and friends spend caring so this problem affects the costing of most community care programmes (Wright, 1987). As with most other evaluations, the costing of informal care in Weisbrod et al was restricted to recording the lost earnings of relatives and friends, due to the patients' illness. This excludes other costs such as the loss of non-labour market production, leisure activities and expenses (e.g. travel costs) incurred. Unless informal care is costed comprehensively there will remain a possibility that community care only appears a more efficient alternative because it transfers part of the burden of care from statutory providers to informal carers, it is more difficult to identify costs to the latter than the former, and so a change in the distribution of costs may be falsely interpreted as a reduction in total costs.

The results of the Canadian study (Fenton et al, 1982) will not generalise as easily as those from the US study because entry to the former study was restricted to individuals who were in close contact with friends or relatives and so had access to informal care. Unfortunately, the costing of informal care was not any more detailed than in Weisbrod et al. Generally, the costing methodology employed by Fenton et al was less rigorous than that adopted in the American study. In effect, costs in this study were restricted to the application of unit costs to the manpower and operational services of in-patient and out-patient visits. All other costs were examined in terms of the percentage of each group incurring them. This is likely to be an unreliable method of measuring costs since it ignores all information on the intensity with which resources are utilised.

The general conclusion from the Weisbrod et al, Fenton et al and Hault et al studies is that community care programmes are cost effective. However, there are certain caveats concerning the different groups of people for whom this is true and the precise definition of community care. Community care embraces many different approaches to caring for people with a mental illness. A whole range of residential, day care, rehabilitation, training, employment and counselling services come within this all-embracing term. There is, therefore, a need to look at which mix of facilities most efficiently meets the needs of people with different personal characteristics and diagnostic conditions. Existing studies tend to examine broad groups of patients and do not distinguish differential costs and effects of alternative forms of care.

Accurate measurement of costs is still absent in many studies of alternative forms of care and subsequent work (Cannon et al, 1985) on the Weisbrod et al (1980) study has shown how sensitive costings can be to the measurement of costs of capital (building and land). However, the greatest problem in these evaluative studies is the measurement of effectiveness or outcome. All of the present set of studies have attempted to measure effectiveness along dimensions such as symptom relief, social functioning, family burden, and to compare these along with the costs of alternative forms of care. The problem with this method is that it can produce considerable confusion when the more effective treatments are also more costly, since it is not possible to single out one alternative as the dominantly efficient procedure. As has been pointed out elsewhere (O'Donnell et al, 1988), cost-effectiveness analysis depends upon one procedure being more effective but not more costly than another to identify the most efficient alternative. Once a procedure is more effective and

more costly, it is necessary to move into the realms of cost-utility or cost-benefit analysis to ascertain efficiency.

These latter types of analyses require moving from measurement of outcomes along several dimensions to the integration of these dimensions into a composite score or index. Such a move is fraught with difficulties.

Cardin et al (1985) compared the efficiency of different forms of community care. Outcome, represented by three different dimensions, i.e. psychopathology, social functioning and family functioning, was collapsed into a single index. Each individual received a score of 0, 1 or 2 for each dimension, which was a function of their initial impairment and the improvement experienced over time. The three scores were added together for each individual to provide a summary index of outcome ranging from 0 to 6. The total cost of each programme of care was then divided by the total number of units scored on the index to arrive at a cost per unit of outcome (op.cit., p.122). A similar procedure was followed by Coates et al (1976). For each treatment the number of dimensions of outcome, which showed significant changes over the study period, were summed to arrive at a summary index of outcome. Again the cost of each treatment was divided by the number of units of outcome to arrive at the cost per unit of change achieved. The cost-effectiveness of the alternatives were compared on the basis of these figures.

The unsophisticated nature of these indices of outcome can be made apparent by comparing their construction to the approach usually adopted in the development of a summary measure of health care outcomes (e.g. Quality Adjusted Life Years (QALYs), Kind et al, 1982; Gudex and Kind, 1988). Constructing a health index such as the QALY involves eliciting, from representative samples of the population, the valuations they place on

different states of health. In contrast, the outcome indices constructed by Cardin et al and Coates et al involve the imposition of values by the researchers. In both studies the different dimensions of outcome receive equal weight. That this value judgement is implausible is implied by Coates et al themselves, who refer to "the two most important outcome domains" (Coates et al, 1976, p.32 emphasis added). Coates et al only give weight to the change in a dimension of outcome and not to the magnitude of that change. Whilst Cardin et al do adjust the weighting for the degree of change and the level of initial impairment, the adjustment is crude and unlikely to correspond to the weighting which would be attached by a representative sample of the population.

Summary indicators of outcome, such as these, should not be used in evaluations of mental health care, since the information they provide has very little meaning. A treatment which achieves the highest score on an index, such as the one used by Cardin et al, is not necessarily the most effective alternative, since it may produce little improvement in the dimension of outcome considered to be the most important, the high score merely reflecting the fact that the treatment achieved a marginal improvement in all of the other dimensions. A lot of information is lost in collapsing the information on each dimension of outcome into a single index. For a summary outcome measure to be of any use in an evaluation of health care, it must reflect the preferences of a sample of individuals for different states of health, and not consist of a number of rather arbitrary and implausible value judgements imposed by the researchers.



It is noticeable from the review of hospital versus community care evaluations that there is an absence of a British study of these alternatives. This is worrying because the little evidence which is available from evaluations carried out in other countries cannot be expected to be valid in the British context. The relative efficiency of hospital versus community care in Britain will only be determined by carrying out evaluations of these alternatives in Britain.

The lack of such a study has left decision makers in Britain without evidence on the relative efficiency of the broad alternatives, which currently form the most important policy choice in mental health care. Community care has been a goal in the provision of mental health care for thirty years. There can be little hope of the policy being introduced with the greatest effectiveness whilst there is such a dearth of evidence on the costs and benefits of community compared to institutional care, to say nothing of the lack of evidence on the efficiency of different types of community care. An evaluation of the closure of the Claybury and Friern hospitals is currently being carried out (Knapp et al, 1987), but this study will not be sufficient to correct the situation. Not every type of patient will be included in the study, nor will every form of community care be evaluated. The peculiarities of provision and costs in London also limit the scope for generalising the results to other parts of the country. This study will not answer all of the questions surrounding the discharge of mentally ill people into the community in Britain.

#### In-patient versus Out-patient versus Day Care Treatment

There is some evidence to suggest that out-patient or day care treatment offer an efficient alternative to standard in-patient care. But there are a number of problems with the studies producing this evidence,

requiring that qualifications be placed on the results. Washburn et al (1976) examined the in-patient and day hospital alternatives for a sample of female patients, half of whom suffered from schizophrenia. The subjects were randomly assigned to either treatment but only 50, out of a total of 165 individuals suitable for inclusion in the study, agreed to participate. The results may therefore be distorted by any bias introduced by this low participation rate. The day hospital alternative was found to dominate on both costs and outcomes. But this comparison may have been further distorted by estimating the direct costs of treatment solely by the charges incurred by patients. Using private sector charges exclusively as proxies for costs resulted in some resource consequences being omitted from the analysis. All resources employed in treatment outside the private sector (public, voluntary, informal) were excluded. In addition, charges may not cover all of the resources used in the private sector. If some resources had been donated, which is likely in the 'not for profit' sector, they may be regarded as 'free', and so prices may not be set to cover their use. To be correct, cost should be allocated to those resources.

Endicott et al (1978) also compared in-patient with day care but, in addition, they included an alternative of out-patient care and both of the latter treatments were preceded by a period of brief hospitalisation. All resource uses were measured in physical units, and only if these differed significantly between the treatments was an attempt made to place a monetary value on these costs. This approach is sufficient to provide an accurate comparison of the costs of alternative treatments as long as the unit costs do not vary between the alternatives, reflecting differences in the opportunity costs of using different facilities.

The results showed that the day care and out-patient alternatives were cheaper than the standard in-patient treatment and although there were few differences in effectiveness over the two-year follow-up period, any differences favoured the brief stay groups. However, these results only hold for individuals with families willing to take them back into their own homes after in-patient care and so they are not indicative of the efficiency of in-patient versus out-patient or day care treatment in general.

The British study carried out by Dick et al (1985) of replacing in-patient care by day care found that about a fifth of people suffering from neurotic behaviours could be treated more efficiently in day care than in full hospital care. Unfortunately, the study did not identify the characteristics of the "suitable" or "unsuitable" groups. The study did try to produce accurate estimates of the costs of care, although, like all other studies, it did not overcome the problems of costing informal care. Studies which attempt to look at the effect of substituting for hospital care always face the problem of estimating and valuing the resources which will be freed in a hospital when small numbers of beds are released. In effect, this means identifying the marginal costs of care for this group of patients. Marginal costs are those which change with small changes in the provision of a service. Great care is needed to identify how a small reduction in beds will free resources, e.g. medical staff, nursing, catering and distinguish these from resource uses which are scarcely affected by small changes in workload (e.g. heating, lighting, cleaning, building maintenance, administration). These costs are specific to locations and often make it difficult to generalise costs to other hospital sites. In this study it was claimed that the main resources which could be freed by a reduction in hospital in-patient care were junior medical and nursing staff. Measurement of outcome was based on separate dimensions

of psychiatric state, social performance and consumer satisfaction with services provided. The day patient group showed a greater decrease in severity and reported greater satisfaction with the services received.

### Alternative Forms of Hospital Care

There have been three UK studies of different approaches to full-time hospital based care. One of these (Jones et al, 1980) was concerned with the use of a psychiatric ward in a general hospital compared to specialised area mental hospital care and the other two with care in a hospital ward or in a hostel within the grounds of a hospital (Wykes, 1982, Hyde et al, 1987).

In the former study (Jones et al, 1980) there were problems about the measurement of effectiveness which was based on a retrospective study of two cohorts of patients treated four years previously rather than on a controlled trial. The study suggested that treatment of first episode of illness for people with a diagnosis of schizophrenia was likely to be more efficient in the general hospital than the area mental hospital.

The identification of the resource costs to the providers of services includes those to voluntary agencies as well as the statutory authorities, but there was no identification of capital costs. The omission of capital cost from this study is a potentially serious defect, since capital costs are likely to differ significantly when comparing treatments provided in quite different types of building.

Lost earnings and travel expenses incurred by patients were included in the appraisal but there was no attempt to identify the production losses by those not in paid employment. Similarly, included in the benefits

deriving from improvements in functioning were increases in the paid production of patients and their relatives, but there was no attempt to monitor the effect on unpaid production. In the main the total costs of an episode of treatment was lower in the general, than in the area, hospital.

The study by Wykes also was not controlled but consisted of a "before and after" study. The approach was rather crude and the usefulness of the results were limited not only by the design of the study but also by the narrow approach to costing. The more recent evaluation of hostel versus traditional hospital inpatient care (Hyde et al, 1987) is superior in a number of respects. The most important difference is that the later study was controlled. Individuals in a psychiatric unit of DGH with a length of stay of at least six months, aged 16-65 years and in need of intensive nursing care were identified. Their consent to participate in the study was sought and from the sample available two groups of matched pairs were formed. A flip of a coin was then made to decide which group would be allocated to care in the hostel.

The costing in this study is also superior to that carried out by Wykes. Costs to the local authority and the Home Office (for stays in prison) were included, in addition to those to the NHS. Costs borne by the families of the individuals were also identified, but it was noted that these were very small and not significantly different between the groups, and so they were not reported. This omission means there is no way of knowing how comprehensive the identification of costs to the families was. For example, whether subsistence costs were included. However, even if the costing of informal care was not comprehensive, this is unlikely to have influenced the conclusions derived from the study because the DGH option was both more expensive and patients in this group spent a greater number of nights at home. Therefore, it is likely that a more comprehensive

identification of informal care costs would only add to the cost advantage of the hostel care.

Hyde et al included capital as well as revenue costs, but no sensitivity analysis was conducted with respect to the assumptions made about the length of life of capital or the discount rate used. The sensitivity of the results to the assumptions made about the nursing establishment and the degree of full capacity in the hostel were tested however. The greatest difference in the NHS costs between the groups was in the utilisation of general services (heating, lighting, catering, cleaning and administration). This was explained by the fact that the hostel groups did a lot of their own housekeeping and so the therapy adopted in this hostel offers the opportunity of simultaneously increasing the residents domestic skills and directly reducing the costs of care to the health service.

The results showed the hostel alternative to be dominant. Individuals in this care alternative experienced less psychotic impairments, developed superior domestic skills and were more likely to engage in constructive activities. This option was also cheaper. The authors are quick to point out that these results are not sufficient to establish the greater cost effectiveness of hostel relative to hospital inpatient care in general. The validity of the evidence is weakened by the fact that the research team was also involved in the provision of care and so the assessments made were not independent. The most limiting feature of the study is the small size of the sample ( $n=22$ ), which is far from sufficient to reach valid results on the relative efficiency of the alternatives. Acknowledging this, the authors call for similar evaluations to be carried out in other areas, in order that data can be pooled and policy formulated on the basis of more robust evidence than that provided by a single small study.

### Various Treatments of Schizophrenia

In a study carried out by May (1971) 228 first admission schizophrenic patients were randomly assigned to treatments comprising either psychotherapy; ataractic drug; psychotherapy plus ataractic drug; ECT or milieu. The second treatment method of ataractic drug alone was found to be dominant, being the cheapest and the most effective. Unfortunately, the usefulness of this result is limited by the very narrow costing employed, only the relative costs to the hospital being measured.

This result is not supported by another study which adopted a similarly narrow perspective (Karon and Vanden Bos, 1976). In the later study individuals suffering from schizophrenia were randomly assigned to psychotherapy provided by either a psychologist or a psychiatrist or to a control group receiving medication. Psychotherapy provided by a psychologist was found to be the dominant treatment, being the least expensive and achieving an outcome as good as the others. Besides the narrow costing employed, the usefulness of the results of this study are further limited by only comparing the outcomes of the treatments by their effect on a single symptom, that being the individual's ability to think logically.

### Use of Nurse Therapists

There has been one pilot study and two full appraisals of using nurses to substitute for doctors or psychiatrists in the treatment of people suffering from neurotic behaviour. Since the pilot study was a first attempt, the most useful results emerge from the two full appraisals.

The two appraisals share a common costing methodology in the sense that one uses the results developed from the other to cost all of the

services, except those provided by the nurse therapists themselves. Such an approach is acceptable provided that care is taken to ensure that the original costings can be validly transferred to other settings. Each study used different types of nurses in rather different settings. One (Mangen et al 1983) is concerned with the use of community psychiatric nurses to treat chronically neurotic patients usually treated in out-patient departments by a psychiatrist. The costings used were very comprehensive and included costs falling on the health service and on the patient and relatives in so far as trips to the treatment centre were concerned. Outcomes were measured along the separate dimensions of symptom relief, social performance, family burden and consumer satisfaction. There was no difference in outcome along the first three dimensions between the two procedures but consumer satisfaction was greater with the nurse provider. Generally, the costs of psychiatric care were lower for the group receiving therapy from the nurses and so the study was able to point out an important extension to nursing status but also pointed out that nurses worked as part of a team which included specialist psychiatric back-up.

Similar support for the use of nurse therapists arose in the second study where nursing services substituted for general practitioner care (Ginsberg et al 1984). The results of these two studies indicate that there is general scope for using nurses to substitute for medical and psychiatric specialists in helping patients overcome problems of neurotic behaviour but they are very specific to the situations in which they were operated and therefore difficult to generalise into common practice. The further problem of giving nurses special training for specific conditions and the affect this might have on their other duties or the organisation of the profession have not been examined.



## Conclusion

At the beginning of this paper it was argued that mental health care resources are inevitably scarce, making choices between alternative claims on these resources unavoidable. If individuals with a mental illness are to obtain the greatest benefit from resources available to provide mental health care, then the most efficient uses of these resources must be identified and chosen. Identifying the most efficient therapies requires the possession of information on the costs and benefits of these alternatives.

The review of the existing economic evaluations of mental health care has revealed that there is little evidence on the efficiency of alternative programmes of mental health care. Currently most choices between alternative uses of mental health care resources must be made in ignorance about the relative efficiency of the alternatives. Under these circumstances it will be difficult to obtain the maximum benefit, for individuals with a mental illness, from the resources available. There is likely to be scope for redistributing resources, from treatments/care which have little effect on the health status of individuals with a mental illness, to other treatments which are more effective. Identifying the potential for such re-allocations of resources requires more economic evaluations of mental health care in order to make more information available on the costs and effectiveness of alternative therapies.

The lack of evidence on the relative efficiency of institutional versus community care and the policy relevance which this choice currently has makes the evaluation of these alternatives a priority for future research.

At present, there are no estimates of what the resource consequences of shifting substantial amounts of the care, for persons with a mental illness, into the community would be in Britain. It is likely that the costs of this policy would be large, as the economies of scale in providing care in large institutions are lost and more care must be delivered to the individual. Without even a very rough estimate of these costs, there can be little hope that adequate funds will be made available to introduce the policy successfully. If there is an attempt to introduce community care without sufficient resources to provide a comprehensive service in the community, then it will be the individuals discharged from institutional care who suffer the consequences. An alternative scenario is that the substantial resources requirements of community care will be realised and subsequently less urgency will be given to the introduction of the policy. Without evidence of the relative effectiveness of community care it would then not be possible to identify the benefits individuals with a mental illness would be deprived of by not experiencing community care. Increased costs to the rest of society could be avoided without making explicit the forgone benefits to the mentally ill.

Economic evaluation of mental health care is not about identifying the minimum cost alternative, the cheapest option is to do nothing which is usually not an appropriate response. Rather, the objective is to collect the information required in order to ensure that individuals with a mental illness receive the most effective care possible, given the constraint of there being a limited amount of resources available to provide this care. At present this objective is not met as most therapies and policies are unevaluated and maintained not because of demonstrable efficiency but because of received wisdom and customary practices. Such inefficient behaviour is both unscientific and unethical.

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