

Contents

Research Update	2
Research Findings	3
Research Reports	8
Research Methods Report	14
In the Media	16
News & Events	20
New Projects	22

Contacts

Director

Professor Martin Knapp
Tel: +44 (0) 20 7955 6225
Fax: +44 (0) 20 7955 6131
Email: m.knapp@lse.ac.uk

Deputy Director

Dr Jose-Luis Fernandez
Tel: +44 (0) 20 7955 6160
Fax: +44 (0) 20 7955 6131
Email: j.fernandez@lse.ac.uk

Administrator

Anji Mehta
Tel: +44 (0) 20 7955 6238
Fax: +44 (0) 20 7955 6131
Email: a.mehta3@lse.ac.uk

www.pssru.ac.uk

www.lse.ac.uk/collections/PSSRU/Default.htm

Introduction

There are two main policy strands in health and social care policy for children and young people; early intervention to prevent childhood problems becoming more serious in adolescence and adulthood, and provision of good quality accessible supports for those with high needs. Working closely with other institutions, PSSRU takes a much needed economic approach to evaluating services for vulnerable children and young people. In the current economic climate, increasing scarcity of resources through budget constraints is likely to be the norm giving greater impetus to demands for evidence on costs, cost-savings and cost-effectiveness.

Typifying the prevention strand is PSSRU research on the economics of parenting programmes. Parenting programmes have a high policy profile and are considered to be good investment for future decades (by averting future high costs) as well as for supporting families today. Parenting programmes can be delivered in many ways – from leaflets and advice to area-wide intervention: our research with the National Academy of Parenting Practitioners has found a 100-fold variation in their costs. Another stream of PSSRU children's research focuses on transition services that aim to help young people with disabilities or mental health problems move from child to adult services, including

collaboration with the Centre for Housing Policy at the University of York to evaluate the cost-effectiveness of better supports for teenage mothers.

PSSRU research also includes economic studies of services for young people with very high needs or serious conditions. One example is the five-year NIHR-funded research undertaken with the Institute of Psychiatry Eating Disorders Unit. This includes studies of web-based or email-supported treatments, as well as more intensive in- and out-patient therapies and carer supports. We are also undertaking a cost-effectiveness analysis of the innovative multi-family day treatment. Following a report for the Bercow Review, we have recently embarked on a four-year DCSF-funded research programme with the Universities of Warwick and Newcastle to evaluate service responses to children's speech, language and communication needs and to set clear guidelines for their economic evaluation.

To date the paucity of costs and cost-effectiveness evidence means that the PSSRU research programme on children and young people's services will make an important contribution to children's policy today as well as that for tomorrow's adolescents and adults. More information from these studies will be available in the 2010 *Research Bites* series. ■

Research team

Jennifer Beecham J.Beecham@lse.ac.uk
Ruth Puig-Peiro R.Puig-Peiro@lse.ac.uk

Eva Bonin E.Bonin@lse.ac.uk
Madeleine Stevens M.Stevens@lse.ac.uk

The PSSRU conducts research and analysis on equity and efficiency in health and social care across three branches (LSE, Universities of Kent and Manchester). PSSRU's mission is to conduct high quality research on social and health care to inform and influence policy, practice and theory.

The PSSRU receives funding from a number of organisations but would particularly like to acknowledge the continued support and funding we receive from the Department of Health for our core research and related activities. All opinions expressed in Research Bites are, however, those of PSSRU and not necessarily of our funding bodies.

Mainstreaming on Ambient Intelligence (MonAMI) project

Martin Knapp, Jacqueline Damant, Margaret Ellis, Paul Freddolino, Eve Mitleton-Kelly

The European Commission-funded MonAMI project is examining how accessible, useful services for elderly persons and persons with disabilities living at home can be delivered in mainstream systems and platforms..

The project presented a poster – led by Paul Freddolino and presented by Jackie Damant – at the International Association of Gerontology and Geriatrics in July 2009.

A Research Agenda to Support Policy Development on ICT-Based Assistive Technology for Older Adults presented findings from a review of published literature on new technologies (in various stages of development, testing, and marketing) that may enable older adults and disabled people to remain in their homes and communities longer. The review aimed to address the question: What do we need to know to make good policy decisions concerning the use of (and payment for) these potentially valuable yet potentially expensive new technology solutions?

The literature review revealed that there are few randomised clinical trials definitively supporting the impact or cost effectiveness of these technology applications. There is a vast number of small-sample, non-experimental studies utilising unique combinations of technology applications and support components (for example, in-person, telephone, or web-assisted support from caregivers and/or professionals). The review concluded that there is inadequate

information available at present – at least in published and easily accessible literature – to support the development of policy that maximises benefits while keeping costs minimal.

An adequate base of relevant up-to-date information in the following areas is needed to support policy development:

User information

- current number of older adults and people with disabilities
- location
- characteristics such as socioeconomic status, current living situation, family support, etc.
- needs to maintain or improve quality of life
- patterns of ICT usage and adoption of new technology
- preferences for technology solutions

Technology solutions

- all hardware
- all software
- human (support) components
- best information available on
- technology solutions expected in the next 2–3 years

Projection analyses, including:


- number, location and characteristics of future users
- future needs of users
- future patterns of technology usage
- future user (and potential user) preferences

Costs

- payment structures and costs for users' current technology (how much is being paid now, and by whom?)
- total (additional) cost for solutions including initial installation + ongoing operating costs + costs for staffing the human support components
- effectiveness and efficiency (cost-effectiveness) studies related to current solutions
- current third-party support programs – subsidies, tax credits, incentives, etc.
- the ability and willingness of potential payers to purchase these technology solutions. What criteria would have to be met?

Stakeholders

- identification of stakeholders to be included in policy development
- level of stakeholder awareness and perception of solutions.

These data would provide the necessary information required to permit rational policy development based on the best empirical evidence, aimed at maximising benefit for the lowest cost. Even with all of this information, however, it might not be possible to develop such policies due to conflicts of interest, cost constraints, and similar barriers. 

Further information about the project is available at www.monami.info.

Further reading

Blaschke CM, Freddolino PP, Mullen EE (2009) Ageing and technology: A review of the research literature, *British Journal of Social Work*, 39, 4.



Analysing the costs and benefits of social care funding arrangements in England: technical report

Forder J, Fernández JL (2009)
Discussion Paper 2644, Personal Social Services Research Unit, London

This report outlines the analytical work that was commissioned by the Department of Health to feed into the development of the recent Green Paper on care and support. It describes the methods and assumptions underlying the model used for analysing long-term funding systems. The paper gives details of potential and actual users of care, their levels of need, and their income and assets. It models the system of support currently available, its funding arrangements and parts of the disability benefits system. The report provides an assessment of the costs and outcomes of the system now and in the future.

www.pssru.ac.uk/pdf/dp2644.pdf

Housing services for people with mental disorders in England: patient characteristics, care provision and costs

Priebe S, Saidi M, Want A, Mangalore R, Knapp M (2009)
Social Psychiatry and Psychiatric Epidemiology, 44, 805–814

Abstract

Background and aims

Since de-institutionalisation, housing services have taken a central role in the care of patients with severe mental illness. Yet, little is known about the characteristics of patients in different housing services, what care they receive, and what costs are generated. This study aimed to assess patient characteristics, care provision and costs in different types of housing services in England.

Methods

In 12 representative local areas in England, 250 housing services were randomly selected. Information on services, characteristics of randomly selected patients and care received were obtained from managers.

Results

Data from 153 services (61% response rate) and 414 patients were analysed. Most patients receive support with activities of daily living and are involved in some sort of occupational activities. 52% have a care coordinator in a community mental health team. Care provision and costs differed significantly between care homes, supported housing services and floating support services.

Conclusions

Quality standards may have to be defined and applied to ensure that all patients in housing services receive appropriate care. More input of mental health services may be required for the rehabilitation and recovery of patients.

Integrating mental health into primary care in Sverdlovsk

Jenkins R, Bobyleva Z, Goldberg D, Gask L, Zacroeva AG, Potasheva A, Krasnov V, McDaid D (2009)
Mental Health in Family Medicine, 6, 29-36

Introduction

Mental disorders occur as frequently in Russia as elsewhere, but the common mental disorders, especially depression, have gone largely unrecognised and undiagnosed by polyclinic staff and area doctors.

Methods

This paper describes the impact and sustainability of a multi-component programme to facilitate the integration of mental health into primary care, by situation appraisal, policy dialogue,

development of educational materials, provision of a training programme and the publication of standards and good practice guidelines to improve the primary care of mental disorders in the Sverdlovsk region of the Russian Federation.

Results

The multi-component programme has resulted in sustainable training about common mental disorders, not only of family doctors but also of other cadres and levels of professionals, and it has been well

integrated with Sverdlovsk's overall programme of health sector reforms.

Conclusion

It is possible to facilitate the sustainable integration of mental health into primary care within the Russian context. While careful adaptation will be needed, the approach adopted here may also hold useful lessons for policy makers seeking to integrate mental health within primary care in other contexts and settings.



Economic impact of early intervention in people at high risk of psychosis

Valmaggia LR, McCrone P, Knapp M, Woolley JB, Broome MR, Tabraham P, Johns LC, Prescott C, Bramon E, Lappin J, Power P, McGuire PK (2009)
Psychological Medicine, 39, 1617–1626

Abstract

Background

Despite the increasing development of early intervention services for psychosis, little is known about their cost-effectiveness. We assessed the cost-effectiveness of Outreach and Support in South London (OASIS), a service for people with an at-risk mental state (ARMS) for psychosis.

Method

The costs of OASIS compared to care as usual (CAU) were entered in a decision model and examined for 12- and 24-month periods, using the duration of untreated psychosis (DUP) and rate of transition to

psychosis as key parameters. The costs were calculated on the basis of services used following referral and the impact on employment. Sensitivity analysis was used to test the robustness of all the assumptions made in the model.

Results

Over the initial 12 months from presentation, the costs of the OASIS intervention were £1872 higher than CAU. However, after 24 months they were £961 less than CAU.

Conclusions

This model suggests that services that permit early detection of people at high risk of psychosis may be cost saving. ■

Caring for people with depression or with schizophrenia: are the consequences different?

van Wijngaarden B, Koeter M, Knapp M, Tansella M, Thornicroft G, Vázquez-Barquero JL, Schene A (2009)
Psychiatry Research, 169, 62–69

Attention to caregiver consequences has been mainly restricted to caregivers of patients with schizophrenia. The few studies done in depression were conducted on small samples and/or with non-validated instruments. Caregiver consequences in depression and schizophrenia were measured with the validated Involvement Evaluation Questionnaire (IEQ). IEQ scores of caregivers of 252 mainly outpatients with depression and caregivers of 151 mainly outpatients with schizophrenia were compared. IEQ scores were quite similar for depression and schizophrenia.

Caregivers of patients with schizophrenia worry more and have more nursing tasks; in case of depression caregivers experience more tension between spouses. In case of many consequences caregivers live close to a patient who has more acute symptoms. They have more additional expenses on behalf of the patient, and report higher distress scores. In case of depression caregivers report less social support, and less coping abilities. Caregiver consequences of depression and schizophrenia are very similar. Differences reflect the context in which caregiving takes place: In schizophrenia mostly elderly mother caring for their ill (adult) child, in depression mostly spouses caring for their partner. Caregivers of patients with depression should be given more attention and support by professionals. ■

How can European states design efficient, equitable and sustainable funding systems for long-term care projects for older people?

Fernandez JL, Forder J, Trukeschitz B, Rokosova M, McDaid D (2009)
World Health Organisation, Copenhagen

Assessing different options for the funding of long-term care requires knowledge about:

- the future need for long-term care services across the population, and its broader socioeconomic repercussions
- the objectives associated with a public system for funding long-term care, and how they vary with a specific country context
- the link between specific funding arrangements and equity and efficiency in the support system.

Within the above context, this policy brief provides a general analytical framework for assessing the pros and cons of alternative funding systems, illustrated with evidence from the recent international experience in reforming long term care. The brief is part of a new series aimed at supporting policy makers in the decision making process. ■

The full brief is available at <http://www.euro.who.int/Document/E92561.pdf>.

Conference abstract: Residential services in Europe – findings from the DECLOC study

1st International Conference on Bridging Knowledge in Long Term Care and Support. Crossing Boundaries between Ageing and Disability, Barcelona, Spain, 5–7 March 2009

Beadle-Brown J, Mansell J, Knapp M, Beecham J, the DECLOC group
International Journal of Integrated Care, 9, 22 June 2009

Abstract

Background and aims

This study aimed to collate and summarise statistical information on the number of people with disabilities living in all types of residential care but with a particular focus on those living in institutional care within 28 countries in Europe to analyse the costs and outcomes of the transition to community-based services in order to provide recommendations for agents in these countries to help bring about the change. The rationale for the study was to inform the political debate, to provide evidence and recommendations to support the move to community-based living for people with disabilities. The study aimed to collect data across client groups (intellectual disability, physical and sensory disability and mental illness) and across different age groups (children, adults and older adults).

Description of project

There were two phases to this study – the first provided a description of service types in each country and collated existing official statistics on the number of people with disabilities in the different types of residential services; the second phase analysed the existing body of knowledge on costs and outcomes of institutional

and community-based services to provide conclusions and recommendations.

Conclusions

More than 1.45 million people with disabilities in Europe still live in residential care with 70% of these living in services with over 30 places. Data was better on people with intellectual disabilities than for other user groups but figures collated are none-the-less an underestimation. Drawing together such a mass of information served to highlight the extent of the work still needed to achieve the UN Convention on the Rights of People with Disabilities in almost all the countries included in terms of community-based services for all. It also highlighted the gaps in the available data. Challenges in the task of collating information included the lack of information collated at national level, the issue of varying definitions in use and inconsistency in how and where data was available.

Discussion

Most countries in Europe still have some way to go to be able to meet Article 31 of the UN Convention on the Rights of Persons with Disabilities. Recommendations focuses are offered to help bridge the gaps in data available on the situation of people with disabilities. ■

Equity in mental health and mental health care in Britain: concept, definition and empirical evidence

Mangalore R (2009)
VDM Verlag
ISBN 978-3-639-20110-9

Equity in mental health is an important social goal. The need for developing concepts, theories and methods appropriate for measuring equity in this field has been recognised by many.

This book addresses these issues by developing a conceptual structure to define equity in mental health and by analysing data from three national psychiatric morbidity surveys for Britain.

Income-related inequalities are measured with reference to indicators of mental health which represent different levels of needs for services. Inequity in mental health services is examined by relating use of services to needs.

The empirical work includes three separate strands of research, covering analyses for the general population, the minority ethnic groups of Britain, and a comparison of 1993 and 2000 to see if the policy and practice changes that have taken place in the health and social care sectors since the beginning of the 1990s have had an impact on equity in mental health.

This book should be of interest to students, teachers, policy makers or professionals in the mental health field, and to any one who has an interest in equity issues in general. ■

Presentation slides available from:

http://www.bridgingknowledge.net/Presentations/Symp10_BeadleBrown.pdf

<http://www.ijic.org/>



DOMINO-AD protocol: donepezil and memantine in moderate to severe Alzheimer's disease – a multicentre RCT

Jones R, Sheehan B, Phillips P, Juszczak E, Adams J, Baldwin A, Ballard C, Banerjee S, Barber B, Bentham P, Brown R, Burns A, Denning T, Findlay D, Gray R, Griffin M, Holmes C, Hughes A, Jacoby R, Johnson T, Jones R, Knapp M, Lindsay J, McKeith I, McShane R, Macharouthu A, O'Brien J, Onions C, Passmore P, Raftery J, Ritchie C, Howard R for the DOMINO-AD team (2009)
Trials, 10, 57. Open-access paper

Abstract

Background

Alzheimer's disease (AD) is the commonest cause of dementia. Cholinesterase inhibitors, such as donepezil, are the drug class with the best evidence of efficacy, licensed for mild to moderate AD, while the glutamate antagonist memantine has been widely prescribed, often in the later stages of AD. Memantine is licensed for moderate to severe dementia in AD but is not recommended by the England and Wales National Institute for Health and Clinical Excellence. However, there is little evidence to guide clinicians as to what to prescribe as AD advances; in particular, what to do as the condition progresses from moderate to severe. Options include continuing cholinesterase inhibitors irrespective of decline, adding memantine to cholinesterase inhibitors, or prescribing memantine instead of cholinesterase inhibitors. The aim of this trial is to establish the most effective drug option for people with AD who are progressing from moderate to severe dementia despite treatment with donepezil.

Method

DOMINO-AD is a pragmatic, 15 centre, double-blind, randomized, placebo controlled trial. Patients with AD, currently living at home, receiving donepezil 10 mg daily, and with Standardised Mini-Mental State Examination (SMMSE) scores between 5 and 13 are being recruited. Each is randomised to

one of four treatment options: continuation of donepezil with memantine placebo added; switch to memantine with donepezil placebo added; donepezil and memantine together; or donepezil placebo with memantine placebo. 800 participants are being recruited and treatment continues for one year. Primary outcome measures are cognition (SMMSE) and activities of daily living (Bristol Activities of Daily Living Scale). Secondary outcomes are non-cognitive dementia symptoms (Neuropsychiatric Inventory), health related quality of life (EQ-5D and DEMQOL-proxy), carer burden (General Health Questionnaire-12),

cost effectiveness (using Client Service Receipt Inventory) and institutionalisation. These outcomes are assessed at baseline, 6, 18, 30 and 52 weeks. All participants will be subsequently followed for 3 years by telephone interview to record institutionalisation.

Discussion

There is considerable debate about the clinical and cost effectiveness of anti-dementia drugs. DOMINO-AD seeks to provide clear evidence on the best treatment strategies for those managing patients at a particularly important clinical transition point. ■

Making an economic case for prevention and promotion

Knapp M, McDaid D (2009)

International Journal of Mental Health Promotion, 11, 3, 49–56

The scarcity of resources relative to the needs and demands for them leads inevitably to some difficult choices. Economic analysis aims to support those choices. Techniques such as cost-effectiveness analysis are concerned with the link between, on the one hand, the human and other resources expended and, on the other, the problems averted and the outcomes achieved.

Most of the economics work in the mental health field has concentrated on treatments for recognised disorders, but the techniques of analysis are equally relevant to promotion and prevention.

The paper briefly describes the methods of cost-effectiveness and related analyses, and then discusses their potential in relation to promotion of well-being (particularly for children and in the workplace), early intervention services for psychosis and suicide prevention strategies.

Economists most certainly do not have simple answers to the tough questions faced by decision makers, but the techniques of economic evaluation can help by providing useful evidence to inform responses to those questions. ■

A comparison of SF-6D and EQ-5D utility scores in a study of patients with schizophrenia

McCrone P, Patel A, Knapp M, Schene A, Koeter M, Amaddeo F, Ruggeri M, Giessler A, Puschner B, Thornicroft G (2009)
Journal of Mental Health Policy and Economics, 12, 27–31

Background

Economic evaluations of healthcare interventions increasingly measure outcomes using quality-adjusted life years (QALYs). The SF-6D and the EQ-5D are alternative ways of generating utility scores for use in QALY estimations, but it is unclear which is most sensitive to change in psychiatric symptom severity. There are also limited data on the sensitivity of these measures to changes in existing clinical indicators in long-term mental health conditions like schizophrenia.

Aims of the Study

To: (i) assess the relationship between SF-6D and EQ-5D utility scores for patients with schizophrenia at two points in time, (ii) assess the relationship in the change scores of these two measures, (iii) measure the sensitivity of these measures to changes in an established measure of symptomatology.

Methods

Patients with schizophrenia were recruited and the SF-36 and EQ-5D were administered at baseline and one-year follow-up and utility scores were computed and compared. Standardised response mean (SMR) scores were calculated for the SF-6D and EQ-5D and compared for patients who improved or deteriorated by at least 25% on the Brief Psychiatric Rating Scale.

Results

EQ-5D ratings were available for 394 patients at baseline, 368 at follow-up and 358 at both time points. The respective figures for the SF-6D were 383, 367 and 345. Mean utility scores were very similar at baseline (EQ-5D 0.68, SF-6D 0.67) and follow-up (EQ-5D 0.71, SF-6D 0.68). Median scores were markedly higher for the EQ-5D (0.76 v 0.66 at baseline, 0.80 v 0.68 at follow-up). The SF-6D scores followed a normal distribution whilst the EQ-5D scores were negatively skewed with a clustering at 1.00. There were few differences in sensitivity to change between the EQ-5D and SF-6D.


Discussion

From an analytical perspective the SF-6D has advantages over the EQ-5D due to its normal distribution and lack of ceiling effect. However, both measures produce similar mean utility scores. Overall the SF-6D appears more suitable as a measure of utility in this patient group.

Implications for health policies

Decisions made on the basis of cost-effectiveness results need to consider the method by which QALYs have been calculated.

Implications for further research

Further comparisons of the EQ-5D and SF-6D are required. 



Clinical and cost effectiveness of services for early diagnosis and intervention in dementia

Sube Banerjee, Raphael Wittenberg

This study analysed the costs and benefits of commissioning memory services for early diagnosis and intervention for dementia. The findings helped to inform the recent National Dementia Strategy, which recommended the development of memory clinics to promote the early diagnosis of dementia.

The study involved the development of a model to analyse the impact on health, social care and societal costs in the case of early diagnosis and intervention services designed to successfully reduce or delay care home admissions. The model includes a projection over the next decade of the numbers of publicly and privately-funded admissions of people with dementia to care homes in England. It estimates the future costs to health and social services and to individuals if a proportion of those admissions are delayed, or avoided, with home care substituting for residential care.

The development of memory clinic services for the early diagnosis of dementia is estimated to cost around £220 million extra per year nationally. This would cover:

Memory service – estimated costs of £95 million per year, on the basis of 10.0 WTE multidisciplinary team members for a population of 50,000 over 65s;

Extra support for existing community mental health teams for older people – estimated cost £70 million per year for a further 7.5 WTE multidisciplinary team members;

Enhancement of social care services –

£55 million per year for the equivalent of 7.0 WTE care managers per average PCT population.

There is a range of evidence from previous studies in the UK and USA that early identification of dementia can lead to reduced use of residential care. A brief programme of carer support and counselling at the point of diagnosis alone has been demonstrated to reduce care home placement by 28%, with a median delay to placement of 557 days compared with those not receiving the intervention (Mittleman et al 2006). Data suggest that early provision of in-home support can decrease institutionalisation by 22% (Gaugler et al 2005), and reductions of 6%, in more severe cases with a highly active control, have been reported for case management (Challis et al 2002).

If 10% of care home admissions were prevented, in ten years the estimated savings would be around £120 million in public expenditure (social care) and £125 million in private expenditure (service users and their families), a total of £245 million. Under a 20% reduction, the annual cost would, within around six years, be offset by the savings to public funds alone. In ten years all people with dementia will have had the chance to be seen by the new services.

A gain of between 0.01 and 0.02 QALYs per person year would be sufficient to render the early identification service cost-effective (in terms of positive net present value). These relatively small

improvements seem very likely to be achievable. The evaluation of the Department of Health national early intervention in dementia pilot (the Croydon Memory Service) found that, at 6 month follow-up, there were statistically significant improvements in both self-rated and proxy-rated quality of life using the DEMQOL quality of life instrument for dementia. The improvement represents around 4% of the interval between the lowest and highest states on the DEMQOL instrument (Smith et al 2007). It should be recognised that the evaluation did not include a control group.

These analyses suggest that, to be cost effective, the service need only achieve a modest increase in average quality of life of people with dementia, plus a 10% diversion of people with dementia from residential care. The net increase in public expenditure would then, on the assumptions discussed, be justified by the expected benefits. This modelling provides strong support for the development of nationwide services for the early identification and treatment of dementia in financial and quality of life terms.

References

Challis D, von Abendorff R, Brown P, Chesterman J, Hughes J (2005) Care management, dementia care and specialist mental health services: an evaluation, *International Journal of Geriatric Psychiatry*, 17, 315–325.

Gaugler JE, Kane RL, Kane RA, Newcomer R (2005) Early community-based service



utilization and its effects on institutionalization in dementia caregiving, *The Gerontologist*, 45, 177–185.

Mittelman M, Haley WE, Clay OJ, Roth DL (2006) Improving caregiver well-being delays nursing home placement of patients with

Alzheimer Disease, *Neurology*, 67, 1592–1599.

Smith S, Lamping D, Banerjee S, et al (2007) The development of a new measure of health related quality of life for people with dementia: DEMQOL, *Psychological Medicine*, 37, 737–746. ■

of studies were conducted by authors from the US (31%), followed by the UK (16%), Sweden (11%), Australia (5%), and France, Belgium, Canada, Spain (3%).

Country context

More than one third of all fall prevention studies are set in a US context. Clearly this raises questions about the extent to which findings from the US can be transferred to the very different contexts and settings found in Europe. Research in Europe is dominated by studies undertaken in the UK and Sweden.

Type of economic analysis

Almost half of all studies identified focused solely on the cost of injury. The quality of many of these costing studies appears poor: only one in five reported indirect costs. Moreover, where reported there was a great variation in non-health costs ranging from less than 1% to more than 400% of direct health care costs. There was a strong positive relationship between medical expenditure and increasing age. Productivity losses in retirees and those engaged in unpaid work can be difficult to quantify. One fifth of all studies were cost utility analyses and reported outcomes in Quality Adjusted Life Years (QALYs). This reflects the high number of studies looking at pharmaceutical treatment. International comparisons of economic evaluations across different countries require caution in interpretation as patterns of health care utilisation and determinants of costs differ.

A systematic review of the economic costs and consequences of fall prevention interventions for older people

A-La Park, David McDaid

Injuries are one of the most serious public health problems facing the European Union, not only claiming over 230,000 lives per year, but also placing a major economic burden on health and social welfare to deal with the rehabilitation and recovery from serious injury.

The personal and economic costs of injury are profound. As the recent launch of *Injuries in the European Union 2003–2005* indicated, they remain a major cause of premature mortality and have a substantial impact on the use of health care resources. But these costs are often dwarfed by economic impacts outside the health care sector.

Premature death, long-term physical disability and behavioural and emotional impairments, all contribute to what economists call 'productivity costs', the lost opportunity to engage in work and other productive activities. For instance, in Ireland, in 2008 the direct and indirect cost of care attributable to fractures is €225 million per annum. In Sweden, in 2004, the mean fracture-related costs the year after a hip, vertebral and wrist fracture were estimated at €14,221, €12,544 and €2,147, respectively.

In assessing how best to develop strategies to help prevent and or reduce their impact, it is essential to not only know what works and in what context, but also at what cost. Policy makers have to choose how best to make use of the scarce resources at their disposal. How, for instance, can they weigh up investment in preventive measures against investment in health care services to deal with the consequences of falls that will inevitably arise?

As part of the European Commission supported APOLLO project, two concurrent systematic reviews were undertaken to map what is known about the economic impact of injuries, both intentional and unintentional, and the cost effectiveness of interventions and strategies to prevent/and or reduce their impact. The focus is primarily in Europe but also considers evidence from other parts of the world where relevant.

Results

The review identified 127 papers looking at fall prevention in older people; a few studies also looked at other population groups, for example, children. About one-third


What do we know about the case for investment in fall prevention?

Approaches to prevention/ minimisation of impact of falls identified included pharmaceuticals,

environmental modifications, lifestyle changes, hip protectors, bone mineral density screening and regulations on home and institutional safety. Some fall prevention interventions appear not only cost effective, but often cost saving if carefully targeted to populations such as postmenopausal women over 75 years old, people who have previously fallen or people with low bone density and co-morbidities.

For instance hip protectors can be highly cost effective in ideal conditions, but in practice they may be uncomfortable to wear reducing uptake. There is also increasing evidence that exercise programmes can help both prevent falls and reduce the consequences of impact. Universal bone mineral density screening can be cost-effective if the underlying risk of fracture in the population is high such as in Sweden. Most studies

indicated that targeted approaches to high risk groups with low mineral density, 75+ age group, fracture history, and co-morbidities were either cost-effective or cost-saving.

However much of this evidence is US dominated, raising questions on generalisability across Europe and economic models are required to adapt studies to different European contexts. 

This report follows from a poster presentation at the International Health Economics Association Conference, Beijing for the APOLLO project (co-financed from the EU Public Health Programme 2003-2007; Grant #2004119)

Further information is available at www.eurosafe.eu.com/csi/eurosafe2006.nsf/wwwVwContent/12apollo.htm.

Using new information and communication technologies in an intervention to reduce isolation and loneliness in older adults: a randomized control trial

Paul P. Freddolino, Amanda Woodward, Christina Blaschke-Thompson, Mary Fox, Dona Wishart

Public policy in the UK, European Union, Hong Kong, and other parts of the world has already embraced concerns with the digital divide by highlighting the status of disadvantaged groups (for example, immigrants, low income residents, and older adults). They have also begun to address the challenges of unequal access to computer skills, the Internet, and the information and services available online through policies of e-inclusion, community programs providing access to technology resources, and similar strategies.

At the same time, social care professionals have begun to realise the importance of technology in 21st century practice. Access to technology is seen as valuable not only in terms of correcting a social injustice, but also because of the potential value of information and communication (ICT) technologies to assist clients in attaining

traditional mental health and social care goals. For example, in the US the National Association of Social Workers and the Association of Social Work Boards (2005) issued a set of Standards for Technology in Social Work Practice. The Standards highlight the need for social workers to learn how to use various technology tools in their own practice, as well as to advocate for increased client access to technology, the more traditional approach to the digital divide.

One does not have to look far to find examples in current media – online and in print – of the uses of technology for various client populations ranging from children through to older adults. Much of the work, especially for older adults, is focused in telehealth, telecare, and assistive technology, but the literature is far from clear in terms of documenting benefits for these recipients (Blaschke et al. 2009).

What is absent from the current research literature are empirically tested intervention models using technology tools by social care practitioners in their work addressing the needs of various types of clients. It is this area that the present study has been designed to address.

The Technology and Aging Project (TAP) is the first stage of what is seen as a multi-stage effort to address the need for empirically-validated intervention models using ICTs. TAP explores an intervention using ICTs to strengthen older adults' social networks, and through these strengthened social ties positively influence quality of life, reduce loneliness, and depression. Our hypothesis is that increasing ICT use and self-efficacy will increase social support, improve quality of life, and ultimately decrease loneliness and depression.

Methods

For this first study – conducted in the US – we have recruited, assessed, and provided services to 36 randomly assigned older adults (age 65+) to evaluate the efficacy of a six-month (November 2008 – April 2009) technology-based supportive intervention with at least weekly contact. There is a control group of 34 additional randomly assigned participants. Experimental group participants have been assigned to one of two core service models based on baseline ICT knowledge and skills – a beginners' group and a more advanced group. They have been receiving instruction in ICT applications such as simple email (low skills), instant messaging (more advanced skills), and social networking websites (more advanced skills). Data are being collected at baseline, three months, and six months, as well as a nine-month follow-up (three months post intervention).

Results

This report is based on bivariate analyses of data from baseline (T1) and three months (T2). There were no statistically significant differences on demographic or dependent variables at baseline. After three months of ICT training the experimental group showed a significant increase in perceived social support and computer efficacy and scored significantly higher on these measures than the control group. The control group reported no significant change on any of the measures compared between T1 and T2. In terms of the use of specific ICTs, experimental group participants consistently reported an increased use of technologies emphasised during the training such as email, instant messaging, searching web pages, and downloading pictures. While

some control subjects reported more use of certain technologies at T2 as well, their responses were varied. In fact, some reported a decline in the use of some ICTs. This is consistent with literature suggesting that older adults who find no benefit from or support for using new technologies may stop using them.


Conclusions and next steps

After three months of training, programme participants reported increased computer self-efficacy and more frequent use of the specific ICT applications emphasised in the training. Overcoming the digital divide for older adults is an important first step in the developmental process envisioned in the intervention design. In addition, participants reported higher perceived social support as hypothesised. Future analysis with T3 and T4 data will determine sustainability of these trends, and if hypothesised effects on other dependent variables materialise. However, even these initial findings suggest that a technology-related intervention can impact older adults, and they raise challenging questions about social work's role in facilitating that involvement. At its most elemental level, one could ask whether or not it is social work's role to address these issues just because it is possible to develop interventions that can be effective. This, however, is not a research question but rather an issue of policy, politics, and values.

The findings also lend credibility to the search for viable, sustainable models of social care intervention that incorporate the use of technology by disadvantaged groups, including older adults. Although preliminary results from TAP are positive, the service delivery model is labour intensive and thus very expensive to undertake with paid staff. Even while the remaining data analyses are in progress we have begun a second project. This second phase will build on TAP to explore the effectiveness of a "train the trainer" approach. Participants from the original TAP project will be recruited as trainers for their older adult peers, and subjects will be recruited from the control group of the original TAP project.

We expect to report the results from T3 and T4 data in the original project early in 2010, and from the train-the-trainer second phase after the intervention ends in mid-2010.

References

- Blaschke C, Freddolino P Mullen E (2008) Ageing and technology research: Findings and implications, *British Journal of Social Work*, 39, 4, 641–656.
- National Association of Social Workers and the Association of Social Work Boards (2005) *NASW and ASWB Standards for Technology and Social Work Practice*. www.socialworkers.org/practice/standards/NASWTechnologyStandards.pdf (accessed 7 October 2009). 

Paul P. Freddolino: Personal Social Services Research Unit, London School of Economics and School of Social Work, Michigan State University, East Lansing, MI USA

Amanda Woodward and Christina Blaschke-Thompson: School of Social Work, Michigan State University, East Lansing, MI USA

Mary Fox and Dona Wishart: Otsego County Commission on Aging, Gaylord, MI USA



Older people and hearing loss: its impact on families

Dr R.A. 'Kitty' Morgan-Jones, Visiting Research Fellow

Eleven years ago I completed my PhD at the LSE. I had explored the

impact of hearing loss on family life and the social network around the family. I conducted 150 in-depth intensive interviews with eleven couples where one partner was hearing impaired. Children were also included in the interviewing. I also interviewed five single hearing impaired people who had been bereaved in some way. In my conclusion I suggested that further work was required to look at the needs of people with Age Related Hearing Impairment (ARHI) as this is such a neglected problem.

ARHI is the third most common chronic condition affecting older people, after arthritis and hypertension (Fook and Morgan 2000). But unlike those conditions, hearing loss has a strong social/psychological dimension as it strikes communication which is at the heart of human life. Without good communication, individuals become isolated and lose the capacity to become fully social human beings (Jones et al 1987; Oyer and Oyer 1984).

Worldwide it is estimated that approximately 300 million people currently suffer from ARHI. This is expected to increase to 900 million by 2050 as a result of population ageing (Vio and Holmes 2005; WHO 2006).

The Royal National Institute for the Deaf (RNID) has looked at the big picture as well as to tease out different levels of ARHI. Their current statistics report that 71% of people over the age of 70 will have some kind of hearing loss (see Box)

Box : Percentage of people aged over 70 with hearing loss

Mild	26.7%
Moderate	36.8%
Severe	6.3%
Profound	1.3%
Total	71.1%

Gender also appears to play a part with men having more difficulties hearing than women. In a study of people over 65, it was found that 55% of men and 39% of women felt they had a hearing problem (Wilson et al 1993). This difference has been fairly consistent over time and may be connected to the fact that, although changing slightly, men are more likely to come in contact with superfluous sound in their lives than women.

Another major factor impacting on people with ARHI is the difficulty involved in acquiring and effectively using hearing aids, the device seen to be the best way of managing ARHI. The art and skill of lip-reading is undoubtedly a close second. However, both coping strategies are difficult to master late in life because they require individuals to learn new ways of managing communication – specifically openness, directness and amplification. Lastly, the cochlear implant market is much smaller than the hearing aid one. Implants require a detailed assessment by an audiologist ending with surgical intervention and the transformation of lives in some cases.

Case Study

To illustrate the impact of ARHI on family life, I am enclosing a brief paraphrased excerpt from the life of one of my research respondents. Max was the Head of a secondary school for twenty years. Now in his eighties, he is having difficulty hearing at the dinner table. In a family interview without Max present, Margaret, his adult daughter, gave an example:

At the table (my father) will sometimes say, "Are you speaking to me? And I say, 'No, not at the moment'. And I feel bad about it because I feel he's not included... even in the circle of five of us eating together... unless we speak directly to him...

It is well documented that 'the dinner table', the symbol of family togetherness and the primary forum for the socialisation of children among middle class families, may become the symbol of isolation and even alienation for many individuals with ARHI.

Max's family was certainly aware of the problem as Margaret's husband, Colin, recounted:

(Max) likes to know what's going on like most of us do... he feels excluded because you're not always conscious of his deafness... because when (we're) having a conversation, we tend to ... drop our voices... and we talk about something that has happened between the two of us which really isn't for his ears anyway... (maybe something quite trivial)... But then he says, 'What's happening? (or) 'Am I missing out on something?'

Max's grandson, Greg, underlined this point. He said:

If I say something like... 'Can I have an extra tin of peas for lunch? ... my granddad will think it is something important and start saying, 'What did you say?'

This case study highlights the problematic paradox at the heart of the matter with many English families and their elderly hearing impaired relations. Max knew implicitly that English middle-class domestic norms dictate by way of their conversational style (Tannen 1989; Fox 2004). Feelings of belonging are generated by unstated meanings and being privy to the mundane details of everyday domestic life. When a hearing loss prevented their absorption, the situation became more complex because of the traditional English dislike of 'repeating' unless a subject is really important.

ARHI is a very serious problem indeed for many older people and their families. It strikes at the heart of communication and affects emotional cohesion within and between generations.

References

An Aging World (2008) Census, International Population Reports, Issued June 2009, P95/09-1

Fook L, Morgan R (2000) Hearing Impairment in older people: a review, *Postgraduate Medical Journal*, 76, 537-541.

Fox K (2004) *Watching the English, The Hidden Rules of English Behaviour*, Hodder and Stoughton Ltd, London.


Jones L, Kyle J, Wood P (1987) *Words Apart: Losing your Hearing as an Adult*, Tavistock Publications, London.

Oyer HJ, Oyer EJ (1985) Adult hearing loss and the family, in Orlans H (ed.) *Adjustment to Adult Hearing Loss*, College Hill Press, San Diego, pp. 139-154.

Tannen D (1989) *Talking Voices, Repetition, Dialogue and Imagery in Conversational Discourse*, Cambridge University Press, Cambridge.

Vio M, Holmes R (2005) Hearing loss and tinnitus: 250 million people and US\$10 billion potential market, *Drug Discovery Today*, 10, 1263-1265.

World Health Organization (2006) *Fact sheet No 300: Deafness and Hearing Impairment* www.who.int

Wilson P, Fleming D, Donaldson I (1993) Prevalence of hearing loss among people aged 65 years and over: screening and hearing aid provision, *British Journal of General Practice*, 43, 406-409. 

Making the case for investment: how can economics help?

David McDaid, A-La Park, Martin Knapp

Scarcity in resources and increases in demand lead to questions about how those resources can best be deployed. Economics always takes scarcity as a 'given', and then seeks to provide decision-makers with information to assist the difficult task of allocating resources. Economics is therefore concerned with how resources are generated and utilised, how decisions are taken about how to make use of those resources, and what criteria might be employed to inform those decisions.

Decision makers are looking for answers to two questions when considering whether to recommend or purchase a particular intervention, such as a new psychosocial intervention to tackle behaviour problems in school age children. The first is the 'does it work' question:

Is it effective in preventing and/or alleviating (e.g.) behavioural problems and generally improving health-related quality of life and/or other outcomes such as educational performance?

If the answer to this effectiveness question is 'yes', then there is a second question:

Is it worth it? That is, does the psychosocial intervention achieve the improved outcomes at a cost that is worth paying? This is the cost-effectiveness question.

The above two questions define what an economic evaluation is concerned with: the outcomes – changes in symptoms and quality of life, for example – of each of the different treatments or

interventions or policies that are being considered; and the costs of achieving them.

Types of economics evaluation

Economic evaluations seek to provide evidence to inform both professional practice and strategic decisions (for example, at national or regional level) about how to allocate available resources. There are different types of economic evaluation. They have a lot in common – for instance, they share a common approach to the conceptualisation, definition and measurement of costs. But there are some important differences between them in how they define and assess outcomes, primarily because they seek to answer slightly different questions.

If the question to be addressed by an economic evaluation is essentially about what is the most appropriate treatment for someone with particular needs in particular circumstances information will be needed on the comparative costs of the different treatments available (and also on the no-treatment option) and the comparative outcomes measured in terms of symptom alleviation, improved functioning and well-being and so on. A *cost-effectiveness analysis* would then be an appropriate type of economic evaluation.

But the question might be broader. It may be that the decision maker has to choose whether to treat behavioural problems rather than spending the funds elsewhere in the health system. In these circumstances, decision makers need to know the costs, but they

also now need an outcome measure that uses a common metric across different health domains. It may be that tackling behavioural problems is one option and dental hygiene is another, so that a measure of behavioural symptoms is not going to be very useful when making such a comparison. The most common such metric is 'utility' and a *cost-utility analysis* would be undertaken.

An even wider decision-making perspective would be to ask whether to increase expenditure in the health system to allow (e.g.) more children with health problems to be treated or whether instead to spend more money to improving schools or to invest in the transport infrastructure. It can also be used to help compare the impact of investing in mental health promotion measures that take place outside the health sector with other uses of resources. In this case, an evaluation again needs to ask about the comparative costs and impacts of the different options, but now it needs to make sure that the definition and measurement of 'impact' are relevant across all of these public policy areas. The usual choice for such a broad impact measure is money, leading to a form of evaluation called *cost-benefit analysis*.

The question to be addressed thus influences the type of evaluation needed. But these choices do not have to be mutually exclusive: a single study can support more than one approach if the right combination of evaluative tools is used. Basically, the broader the

question, the lower the likelihood that the outcome measure will be sensitive to the particular circumstances of any specific disorder, but the greater the usefulness in terms of resource allocation decisions.

Economic costs and measurement

There are many different types of cost. How broadly costs are measured will depend upon the purpose of the study. Some are directly associated with services to prevent or treat a disorder, such as staff costs, specialist education, foster care, training course fees, supervision time for preparation, administration and follow-up, venue costs, transport etc.

Some costs are more indirect: lost productivity due to inability to undertake normal activities in life such as reduced employment of children when they reach adulthood, lost employment opportunities of parents or other family members because of the need to provide extra care, the costs of travel for their children to visit specialist facilities, or the disruptive impact on the educational performance of other children in the classroom.

The intangible costs that are associated with pain, suffering and adverse outcomes may also be estimated.

All economic evaluations will measure and treat costs in the same way; they differ in the way that they measure outcomes.

Cost effectiveness analyses and cost consequences analyses use one or more specific mental health problem related outcomes such as changes in symptoms or

improvements in behaviour. They are of limited use if policymakers want to compare investment in CAMH with investment elsewhere in the health system.

Cost utility analysis uses a common outcome measure, the quality adjusted life year (QALY), allowing comparison between investment in all parts of the health system. However to date QALY instruments have only been validated for use with adolescents and not younger children.

Cost benefit analysis measures both costs and benefits in monetary terms. It has most often been used when looking at interventions to improve both mental health and other outcomes such as educational performance.

Models can be used to synthesise data from previously publication effectiveness studies alongside data on the costs of different interventions, and present different scenarios to decision makers, varying the level of costs and effectiveness estimates used to illustrate how this impacts on the potential cost effectiveness of interventions. In the absence of long term effectiveness data, models can be used to project the potential long term costs and benefits into adulthood of improving the mental health of children and adolescents.

Not all studies that claim to be economic evaluations actually contain an economic analysis! Checklists exist which can be used to assess the quality of economic evaluations. Studies should discuss the context in which interventions are implemented – without this information it may be difficult to judge how generalisable results are.

Further reading

Knapp M (2009) Mental well-being of older people: making an economic case (editorial), *Australian eJournal for the Advancement of Mental Health*, 8(2), 5pp.

Knapp M, McDaid D (2009) Making an economic case for prevention and promotion, *International Journal of Mental Health Promotion*, 11, 49–56.

Knapp M, McDaid D, Dhanasiri S (2009) Money matters: funding care, in Martin A, Volkmar F (eds) *Lewis's Child and Adolescent Psychiatry: A Comprehensive Textbook*, Fourth Edition, Lippincott, Williams and Walters.

McDaid D, Park A, Knapp M, Kilian R, Losert C (2009) *Making the case for investing in child and adolescent mental health: how can economics help? A brief decision support tool to aid in the use and understanding of economic evaluation*, Personal Social Services Research Unit, London.

McDaid D, Zechmeister I, Kilian R, Medeiros H, Knapp M, Kennelly B, the MHEEN Group (2008) *Making the Economic Case for Promotion of Mental Well-being and Prevention of Mental Health Problems*, MHEEN Policy Briefing 3, Personal Social Services Research Unit, London School of Economics and Political Science, London. 



Recession sparks mental health crisis

Demand for mental health services has increased over the past 12 months as people struggle to cope with unemployment, debt, home repossession and threat of redundancy, according to a new study

<http://www.euractiv.com/en/health/recession-sparks-mental-health-crisis/article-187407>

Euractive,
18 November 2009

The World at One

Professor Martin Knapp, LSE, discussed the bill which will provide free support for elderly and disabled people to be cared for in their homes.

BBC Radio 4,
18 November 2009

Parents of autistic children not giving up

Parents of autistic children refuse to give up their fight to save an intensive program that helps make their kids productive taxpayers.

The London School of Economics calculated this year that the lifetime costs for someone with autism without intellectual disability is \$1.4 million, and more than \$2 million for someone with autism wh...

http://www.kelownadailycourier.ca/stories_local.php?id=219712

*Kelowna Daily
Courier,*
24 October 2009

Adult social care green paper

The Department of Health is due to publish a green paper setting out proposals for the long-term reform of adult social care funding early on 14 July, 2009.

The government held nine events for stakeholders and five for citizens around the country to raise awareness of the issues facing the care system. It also commissioned the London School of Economics t...

<http://www.communitycare.co.uk/Articles/2009/07/14/110185/adult-social-care-green-paper.html>

Community Care,
14 July 2009

Professor Martin Knapp on the future of social care

http://www.bbc.co.uk/radio4/womanshour/03/2009_28_tue.shtml

*Woman's Hour, BBC
Radio 4,*
14 July 2009

Social care green paper delayed again

The Department of Health commissioned the London School of Economics to model six approaches to social care funding, ranging from making no changes to a system where the state pays for all care.

<http://www.hsj.co.uk/news/primary-care/social-care-green-paper-delayed-again/5003427.article>

*Health Service
Journal,*
2 July 2009

ABC Australia, Australia Talks, Mental Health Care

Professor Martin Knapp took part in a discussion on Australian radio about a range of issues related to mental health care provision, community programmes, and whether there is still a stigma attached to mental illness.

<http://www.abc.net.au/rn/australiatalks/stories/2009/2606398.htm>

ABC Australia,
25 June 2009

For further press releases and updated information visit PSSRU Press Releases.



Queen's Anniversary Prize awarded to LSE Health and Social Care

LSE Press Release



The Queen's Anniversary Prizes for Higher and Further Education are separate from but sit alongside the Queen's Awards for Enterprise in the National Honours System. They were founded and are administered by an independent charity, The Royal Anniversary Trust. The Prizes are awarded every two years. They were first awarded in 1994 and originated out of the commemorations for the 40th anniversary of the Queen's reign.

To read LSE Health and Social Care's Queen's Anniversary Prize brochure visit: www.pssru.ac.uk/pdf/2009_11_19_queens_prize_brochure.pdf

The London School of Economics and Political Science has been awarded a Queen's Anniversary Prize for Higher and Further Education for the work of LSE Health and Social Care [of which PSSRU is a part], an innovative international research centre whose work has influenced government policy in the UK and beyond.

It is the second time LSE has won this prestigious prize which recognises outstanding achievement in UK universities and colleges. The School's Centre for Economic Performance was honoured in 2002.

LSE Health and Social Care won the prize for 'applying research to the advancement of global health and social care policy'. The citation says that its work is 'widely seen as unique in its continuing ability to bridge the gap between research and policy. It is widely and frequently referenced by policy makers and has contributed to raising the quality of evidence-based policy making within government.'

Examples of recent policies that are based substantially on the Centre's research include:

- Improvements in choice, competition and accountability in the NHS;
- Developing community care models which have helped the resettlement of hundreds of long-stay hospital patients;
- Research commissioned by the Swedish EU Presidency on how to stimulate production of new drugs to tackle resistance to antibiotics;
- Forecasts of the future living conditions of older people in Europe that have fed into the

government's imminent paper on long-term care;

- A radical overhaul of stroke services, which has improved the lives of patients and carers.

Howard Davies, Director of LSE, said: *This award is a great honour which recognises the exceptional contribution made by LSE Health and Social Care in producing world-class policy-relevant research over many years. I would like to congratulate this talented group of staff whose cutting-edge work continues to play a key role in developments in health and social care in the UK and many other countries.*

LSE Health's director, Professor Elias Mossialos, added: *We are very honoured and proud to receive this prestigious award, which reflects the rigorous academic standards and systematic approach to bridging research and policy that we apply to our work. It is a particularly commendable achievement given that we are such a young centre, having been operating for less than 15 years.*

'All credit must go to our talented and dedicated staff at LSE, and the European Observatory on Health Policies and Systems, for their hard work which has led to LSE Health and Social Care's exceptional work having a truly significant impact on research and policy both domestically and globally.


Martin Knapp, director of the Personal Social Services Research Unit at LSE Health and Social Care, added: *LSE Health and Social Care is a vibrant group of very busy researchers, teachers and students. We are delighted that our efforts and achievements have been recognised with this highly prestigious award.*

Professor Alistair McGuire, Head of the department of Social Policy within which the Centre is housed,

said: *This is a great recognition of the Centre's achievements over the years. The Centre has made several important contributions in the area of health and social care, always addressing relevant and topical policy questions, drawing on a wide range of academic disciplines. The work of the European Observatory is especially noteworthy as its work feeds into a large number of government and policy-making bodies. This award is both merited and deserved. Congratulations.* Professor Dame Sally Davies, Director General Research & Development at the Department of Health, commented: *The contribution of the Centre to the economics of social care is unrivalled. It has an established national and*

international reputation for the quality of its analytical models and analyses.

Goran Hagglund, Sweden's Minister for Health and Social Affairs, added: *LSE Health is truly a centre of excellence and has the best reputation in Europe for policy relevant work.*

Karen Davies, President of the Commonwealth Fund in USA, said: *The Centre has unparalleled depth of knowledge and networks in international health system comparisons and outstanding analytical capacity. It is the leading academic centre in the world for European comparative research on health systems.* 

This press release was written by Jo Bale of LSE's Press and Information Office.

New report investigates links between economic crisis and increasing mental health problems

LSE press release

Read the full report 'Mental Health and the Economic Downturn' at http://www.lse.ac.uk/collections/PSSRU/pdf/mental_health_downturn121109.pdf.

Demand for treatment for mental health problems has increased over the past 12 months as people struggle to cope with unemployment, debt, home repossession, threat of redundancy and other problems caused by the recession.

As pressure mounts on the government to reduce levels of spending in public services, a major new report, *Mental Health and the Economic Downturn*, warns against "short-term gain for longer-term pain" and sets out ways of making mental health services more efficient without adversely affecting patient care.

The joint publication from the LSE, the Royal College of Psychiatrists and the NHS Confederation's Mental Health Network says that mental health problems cost £110 billion a year, which is currently greater than the costs of crime and is projected to double over the next 20 years.

Numerous studies have linked unemployment, debt and other problems caused by recession with poor mental health, and there is significant anecdotal evidence from mental health providers, it says, that demand for services has increased over the past 12 months. Local councils are also being forced to make cuts in social care, which is resulting in delays in discharge from psychiatric hospitals, reducing the capacity to deal with new cases.

The report explains: "While many people are suffering materially from the downturn, the harm to the population's psychological well-being is not only caused by actual financial strain, but worries caused by the fear of financial strain and job loss."

It suggests that mental health services can be made more efficient by a radical redesign of care services led by health care staff and managers. Avoiding situations where individuals are repeatedly assessed by different professionals

is one area that could be addressed, it says. It is inevitable that this will involve reductions in staff, preferably through natural wastage, and the merging of back-office functions.

The report argues that research should be a priority for investment because we need to understand the effectiveness of some types of interventions better in order to prioritise investment. "There is a palpable gap in the evidence for some mental health interventions," it concludes.

Initiatives that could save money elsewhere in the system should include investing in mental health diversion schemes for people with mental health problems who come into contact with the criminal justice system, it says.

The government should also give more support to employers to keep people with mental health problems in work and to treat those on incapacity benefit to help them get back to work.

Early intervention, particularly with children and young people, should also remain a priority, as this has proven long-term savings.

The report concludes: "Significant disinvestment in mental health services would, without doubt, deliver immediate, medium and long-term pain for the NHS and other public services. Most importantly, it would have a negative impact on people experiencing mental distress and illness, as well as their carers and families. Such shortcut commissioning would not only increase their burden, but would ultimately result in a larger economic burden for the nation."

Martin Knapp, Professor of social policy at LSE who co-authored the


report, commented: *Unemployment, debt and poverty cause enormous stress. This would be absolutely the worst time to cut prevention budgets or treatment services. The NHS needs to work together with many other public bodies - and with employers and communities - to help prevent as well as treat these needs.*

Steve Shrubbs, director of the Mental Health Network, which represents the majority of NHS mental health trusts, added: *The NHS is facing a once in a generation challenge as it heads into a spending squeeze because of the recession. In the past, we have tended to react to reduced spending by cutting services across the board. We know such 'slash and burn' tactics will not work.*

Mental health services, which are not paid through the same tariff system the rest of the NHS uses, are especially susceptible to these tactics which carry serious long term consequences.

We have to see this spending squeeze as an opportunity to look again at how we offer support and, with clinicians and managers working together, develop services that are not only better for patients but also better value for taxpayers.

Professor Dinesh Bhugra, President of the Royal College of Psychiatrists, concluded: *It's all too easy in times of economic hardship for commissioners and providers of services to see short-term cuts as the solution. However, such action would be grossly short-sighted and would undoubtedly deliver long-term pain.*

During these times of economic downturn, it's vital that careful investment is made in mental health services and prevention programmes. Clinicians and managers need to work together to address these challenges. 

This press release was written by Jo Bale of LSE's Press and Information Office.

Dr Jose-Luis Fernandez

Dr Jose-Luis Fernandez was appointed as Specialist Adviser to the House of Commons Health Committee as it carries out its Social Care Inquiry. The Inquiry is looking at the future of social care services following the publication of the Government's Green Paper, *Shaping the Future of Care Together*.

New member

Dr Florence Baingana – a Research Fellow at the Makerere University School of Public Health – joins PSSRU at LSE from September 2009 to look at costing mental health care in Uganda as part of a Masters Fellowship from the Wellcome Trust.

Investors in People for PSSRU

PSSRU at LSE was recently re-accredited by Investors in People. The PSSRU Group at LSE is the first research group within LSE to receive the accreditation (and for the second time!). The assessor's report commented that 'PSSRU displayed an impressive number of strengths... and a number of good practices'.

Promotion Tihana Matosevic

Congratulations to Tihana who was recently promoted from a Research Officer to a Research Fellow. Tihana's research interests include provision of care home services for older people in England mainly focusing on social care actors' motivations, changes in their motives over time, and relationships between local authority commissioners and care providers. She has also been involved in a European study that explored strategies for integrating people with disabilities into labour market. Recently, she was working on Health England project looking at prevention and promotion of social care for older people. Tihana is currently working on the Knowledge Transfer in Social Care (KT Social Care) project and the European study on Social Services of General Interest (SSGI).

NIHR School for Social Care Research Annual Conference 30 March 2010

The NIHR School for Social Care Research is pleased to announce that its first annual conference will take place between 10.15am and 4.15pm on 30 March 2010 at the London School of Economics and Political Science. The event will focus on key themes in adult social care practice research.

The conference is open to all, with a small registration fee. Further full details including conference programme and registration processes will be available shortly on the NIHR SSCR website. For queries email sscr@lse.ac.uk.

The School for Social Care Research is a partnership between the three branches of PSSRU, the Social Care Workforce Research Unit at King's College London, the Social Policy Research Unit at the University of York, and the Tizard Centre at the University of Kent, and is part of the National Institute for Health Research (NIHR).

International Conference on Evidence-Based Policy in Long-term Care 8–11 September 2010

PSSRU is pleased to be hosting the first International Conference on Evidence-based policy in long-term care. The conference aims to provide a forum for exchanging the latest international evidence on key Long Term Care policy topics such as how to organise, deliver, fund and regulate services. The emphasis is therefore on evaluative research with clear impact on policy.

Further details on the conference and submission of abstracts available online at <http://www.lse.ac.uk/collections/PSSRU/events/ltc2010conf/ltc2010default.htm>.

Some recent presentations **Jeni Beecham** and **Martin Knapp** – *Seminario Economía de la Salud y Política Sociosanitaria* (economic assessment and socio-health policy course) sponsored by Carlos III Institute, Ministry of Health Social Policy and the Department of Health, Generalitat de Catalunya. Martin presented on social policy and economics focusing on adults and older people; Jeni presented on social policy and economics focusing on children and adolescents. The event was held in Barcelona in December.

David McDaid – *The costs of failures, and benefits of successes to governments enterprises and workers* at the British Swedish Conference on Work and Wellbeing in Stockholm in December.

Martin Knapp – *Mental health, multiple perspectives and multiple challenges* as part of the Social Policy Research Unit's Seminar series in York in November.

Jeni Beecham – A session on cost effectiveness of services for children and families social care services at the ESRC and DCSF Public Policy Seminar *What Works, what counts and what matters: costs and cost effectiveness of Family-focussed interventions for children* in November.

David McDaid – *The cost of poor health & addressing the longer term effects of the economic crisis* at the Baltic Policy Dialogue in Riga in November.

David McDaid – *The economic case for investing in suicide prevention interventions* at the 2nd European Public Health Conference in Lodz in November.

Jeni Beecham – A seminar on *Assessing the cost-effectiveness of parenting programmes* as part of the Academy Seminar Series: Messages from Research, Kings College London in October.

David McDaid – *The cost of poor mental health and suicidal behaviour* at the EC Presidency Conference Mental Health & Suicidal Behaviour in Times of Economic Crisis: Impact & Prevention in Stockholm in October.

David McDaid – *Harnessing the power of the new media and electronic information systems as a tool to aid policy transfer* at the European Health Forum conference in Gastein in September.

David McDaid – *The recession and the mental health of workers: a mainly English perspective* at the Kirby Mental Health Commission of Canada Economics Roundtable in Ottawa in August.

David McDaid with **Iben Van den Berg** – *Money Talks: making the case for child mental health* at the European Society for Child And Adolescent Psychiatry Conference in Budapest in August. He also presented *Making the case for greater investment in child and adolescent mental health promotion and prevention services* with **Reinhold Kilian, Caroline Losert** and **A-La Park** at the same conference.

Jeni Beecham – *Indications of cost-effective services for children and young people* at a HM Treasury seminar on Cost-effective Services for Children and Young People in July in London.


Martin Knapp was invited to present on care for the *Ministerial Research Summit on Dementia* at the Royal Society, London in July. The report from the event is available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_107955.

David McDaid – *Money talks: asking the case for child mental health* at the Child and Adolescent Mental Health in Enlarged European (CAMHEE) project conference in Budapest in August. He also presented another session jointly with Iben van den Berg at the conference.

Roshni Mangalore – *Can Rawlsian Maximin be the social choice for equity in the health domain?* at the International Health Economics Association in Beijing in July.

SOCIONICAL

www.socionical.eu/index.php


SOCIONICAL is an Information and Communication Technologies Project funded under European Seventh Framework Programme (FP7), aiming to develop Complexity Science based modelling, prediction and simulation methods for large scale socio-technical systems. This is a joint project with the LSE's Complexity Group, led by Margaret Ellis. 

BRIDGE


www.euro.who.int/observatory/Studies/20090909_1

Scoping study of approaches to Brokering knowledge and Research Information to support the Development and Governance of health systems in Europe

Led for PSSRU by David McDaid, this scoping study will explore:


- Existing knowledge brokering approaches and what is known about their effectiveness
- Use of these approaches in Europe and the organisational arrangements that support them
- Policy making itself and the way it intersects with technical inputs. 

Evaluation of Supported Housing Pilot for Teenage Parents (SHPTP)


Funded by the Department for Children, Schools and Families, this project is a collaboration between the Centre for Housing Policy, University of York, BMRB Social Research, and PSSRU at LSE. This evaluation focuses on the Supported Housing Pilot for Teenage Parents (SHPTP), and aims to assess the effectiveness of enhanced support packages in terms of the impact on outcomes for teenage parents and provide greater understanding of what the key components of an enhanced support package should look like. The LSE component – led by Martin Knapp and Jennifer Beecham - involves assessing the cost effectiveness/value for money of each pilot authority's enhanced support package delivery model. 

KT Social Care

www.lse.ac.uk/collections/PSSRU/researchAndProjects/KTSocialCare/default.htm

The project is a two-year collaboration between PSSRU and the Social Care Institute for Excellence (SCIE) with the overall aim of improving links between research bodies, such as PSSRU, and social care organisations, users, practitioners, carers and policy makers. The project seeks to do this through improving dialogue between the different agencies and across government, ensuring greater involvement from service-users, practitioners and policy makers in the research process, and disseminating research findings through a range of media to a large number of different audiences. The LSE team comprises Martin Knapp, Julien Forder, David McDaid and Tihana Matosevic. 

Money for Medication


Led by Queen Mary University of London with funding from the Health Technology Assessment programme, this project aims to establish the effectiveness and cost effectiveness of using financial incentives (MfM) to improve adherence to anti-psychotic maintenance medication in patients with poor adherence when conventional methods to achieve adherence have failed through a cluster randomised controlled trial. This LSE component is led by Martin Knapp. 

Care Questions Study

The purpose of this study is to develop clear and robust questions for use in social surveys and economic evaluations about receipt of care and support services by older people; payment for social care for older people; receipt of unpaid, informal care by older people; and provision of unpaid, informal care.

Phase I of the study was funded by the Department of Health, with the Nuffield Foundation funding Phase II. 

Child Care Reforms in Europe: Lessons for Italy

Led by Dr Cristiano Gori at LSE, this project aims to examine national reforms in child care in European countries since the mid-nineties, compare the outcome of different reforms and draw lessons for the design of new child care policies in Italy. As part of the project A-La Park is preparing reports on developments in child care reform in four European countries: England, the Netherlands, Spain and Sweden. This project is funded by the Collegio Carlo Alberto, Italy. 

EC Thematic Conference Support

A consortium, including David McDaid from the LSE, have been awarded a contract to help the European Commission in preparing and monitoring thematic conferences related to the European Pact for Mental Health and Wellbeing. Four thematic conferences are being supported: prevention of depression and suicide (December 2009 — Budapest); mental health for older people April 2010, Spain); Combating stigma and social exclusion (Lisbon, second half 2010); mental health in workplace settings (Berlin, first half 2011).

More information at http://ec.europa.eu/health/ph_determinants/life_style/mental/index_en.htm 

Acknowledgements

This issue of Research Bites has been edited by PSSRU LSE Dissemination Group (Tihana Matosevic, Martin Knapp, David McDaid, Juliette Malley and Anji Mehta).

The editors acknowledge all members of PSSRU LSE who have contributed to this issue.

Designed and produced by Sarah Moncrieff at Westminster European westminster.european@btinternet.com