NICE National Institute for Health and Care Excellence

Guideline

Transition between inpatient mental health settings and community and care home settings

Economics, Evidence review, Appendix 1

– Selecting areas for economic analysis

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This report was produced by the Personal Social Services Research Unit at the London School of Economics and Political Science. PSSRU (LSE) is an independent research unit and is contracted as a partner of the NICE Collaborating Centre for Social Care (NCCSC) to carry out the economic reviews of evidence and analyses.

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1 Introduction – Economic work as part of guideline development

The economic work is comprised of 2 main components. The first is the critical appraisal and review of existing cost-effectiveness literature and interpreting the results to make recommendations for the UK context. These can be found in Appendices C1 and C2 and are not the focus of this report.

The second component is undertaking new economic analyses. This report shows the decision-making process leading up to the decision to conduct new economic analyses. Those new analyses are presented in economic Appendices 2 and 3 and are not covered in this report.

2 Methods to select areas for new economic analysis

New economic analyses are useful where the existing cost-effectiveness literature is not sufficient to make recommendations for the UK context. However, decisions must also take into account data availability and whether it is feasible to conduct new analyses. Also, as there are potentially many areas on which to do new analyses, prioritisation is necessary. Prioritising one area over another is based on the expectation that the new analysis will help reduce uncertainty associated with an intervention's cost-effectiveness and that the recommendations coming from the analysis has a significant impact on social care outcomes and costs. These criteria are also considered alongside Guideline Committee preferences.

3 Results – Economic analysis for this guideline

The two economic analyses carried out for this guideline relate to review questions 4 and 5. They look at interventions that improve the discharge process and reduce readmissions to hospital. The rationale is that recommendations would have significant impact on social care costs and outcomes. Evidence was of good methodological quality, data was available for the analysis and the Guideline Committee expressed agreement and preference for these areas.

The other review questions were not prioritised for economic analysis because:

- There was a lack of economic evidence and the single effectiveness paper identified (Goldberg et al. 2013) planned to publish an economic analysis (email communication with study authors) and the Guideline Committee did not express preference for this area.[1]
- There was a lack of both effectiveness and economic evidence.[2]

[1] Review Question 4: Approaches to care planning and assessment for admission to hospital.

[2] Review Questions 7, 8, 9, 10: Interventions to support people living with dementia during transition/Interventions to support children and young people/Interventions to support carers/Learning and development for mental health and social care staff.

- The review questions did not involve a decision between interventions and therefore are not relevant for economic analysis.[3]

3.1 Review Questions 4 and 5 – selecting interventions for economic analysis

Due to the timing of the evidence review, the first economic analysis was agreed with the chair in advance of the Guideline Committee meeting. If a decision had been left until the seventh and eighth Guideline Committee meetings (29/30 September), there would only have been enough time for one analysis. However, if one analysis were to be agreed beforehand (based on the studies already available to the economist) there would be enough time to complete two analyses. Such an approach was agreed with the chair.

1. Rationale and method for selecting the first economic analysis

Based on the available evidence, the first economic analysis was based on Kessing et al. (2013), a moderately sized RCT from Denmark (n=158) rated as having moderate quality internal validity (+) and good external validity (++). It focuses on bipolar patients in the early stages of the disorder. The study was selected on the basis that the intervention was associated with significant reductions in the use of hospitalisation and the time horizon was sufficiently long (2.5 years). It was thought that economic analysis would be useful because there was some evidence (but not definitive) that patients in the earlier stages of bipolar disorder have greater potential to benefit (Reinares 2014 citing Colom et al. 2010; Scott et al. 2006).[4] Furthermore, there was uncertainty as to the trade-offs between the costs of the intervention (which is relatively resource intensive, as it is delivered over a 2-year period) and whether the benefits of such an intervention would be cost-effective in the English context. For in-depth rationale, please refer to the economics Appendix 2, under the section, 'Background – why the analysis is important'.

2. Rationale and method for selecting the second economic analysis

The second analysis was decided with the Guideline Committee on the seventh and eighth meetings. At the time, the Guideline Committee had reviewed the available evidence and had decided to make a general recommendation on peer support workers; there was some discussion as to the type of peer support, as some members of the Guideline Committee had various experiences and ideas of types of peer support, which could be provided in particular contexts. Some of this discussion touched on the one moderate quality US RCT on the use of peer support on discharge (Sledge et al. 2011). There was some discussion on the role of peer-delivered programmes. The Guideline Committee had a strong preference that the economic analysis focus on peer support because this topic, which potentially benefits the person giving support as well as the recipient, is consistent with recovery and recovery-oriented interventions. To aid the Guideline

[3] Review Questions 1, 2, 3: Views and experiences from service users, families and carers, and practitioners.

[4] Specifically, interventions become less effective in reducing time until next relapse or the time spent ill as the number of bipolar episodes increases.

Committee, we searched through three recent systematic reviews that looked at peer support. Unfortunately, none of the reviews were specifically about transition, but interventions were still relevant. Of the three systematic reviews, one review synthesised the evidence more narrowly, meaning that similar interventions were grouped together, and results were reported using meta-analytic techniques (Fuhr et al. 2014). The other two systematic reviews grouped interventions that had fewer similarities and so these were considered unsuitable for use in an economic analysis (Lloyd-Evans et al. 2014; Pitt et al. 2013).

Meta-analytic results were available for a peer-delivered self-management intervention (as identified in Fuhr et al. 2014). The results were based on three high-quality non-UK studies where samples and interventions were of acceptable similarity. The studies in the meta-analysis measured impact on quality of life, hope and clinical symptoms but did not measure readmissions to hospital. The intervention is delivered among a sample of community-dwelling individuals (and not necessarily those recently discharged from hospital) but the Guideline Committee did not think that was a problem, as they believed that discharged patients could still benefit from this intervention as a part of improving the discharge process. Economic analysis was considered useful due to the lack of cost-effectiveness evidence for this type of intervention. It was thought that the economic analysis could clarify the trade-offs between the additional costs of the intervention alongside reported benefits.

3.2 Conclusion

Both economic analyses were used to support ‘consider’ recommendations in the guideline. This was due to the nature of the evidence base, primarily that studies were non-UK.

Economic analyses of both interventions are found in Appendix 2 (Kessing et al. 2013) and Appendix 3 (Fuhr et al. 2014).

The following recommendations were made with the support of the economics work.

The economics report set out in Appendix 2 supported the following recommendations:

Recommendation 1.6.4

Consider a staged, group-based psychological intervention for people with bipolar disorder who have had at least 1 hospital admission and are being discharged from hospital. This should include:

- evaluation by a psychiatrist within 2 weeks of discharge
- 3 sequential sets of group sessions led by trained practitioners that focus on, respectively:

  - people's current mental health and recent experiences in hospital
  - psychoeducation or cognitive behavioural therapy
  - early warning signs and coping strategies
- group-based psychoeducation sessions for families and carers.

Recommendation 1.6.6

During discharge planning offer carers group psychoeducation support. Ensure this is tailored to the specific condition of the person they care for.

The economics report set out in Appendix 3 supported the following recommendation:

Recommendation 1.6.10

For people being discharged from hospital consider a group-based, peer-delivered self-management training programme as part of recovery planning. Sessions should:

- continue for up to 12 weeks
- be delivered in groups of up to 12 members
- provide an opportunity for social support
- cover:
  - self-help, early warning signs and coping strategies
  - independent living skills
  - making choices and setting goals.

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