

Inpatient care cost of schizophrenia in Ireland: underestimation due to non-inclusion on data on new long-stay patients

Dear Editor, Re the letter in the September 2009 edition of *Ir J psych Med* (2009; 26(3): 151-154), by Behan et al.

Many thanks to Behan et al for clarifying their methodology. They agree that the €32.1 million figure they arrived is still an underestimate. This figure is based on the data reported by the Health Research Board, Dublin.¹

I wish to add to this figure in view of the new audit information on new long stay patients, reported by Daly and Walsh, of the Health Research Board (HRB) team, published in the same edition of the *Irish Journal of Psychological Medicine*.²

Annual reports published by the HRB, have consistently not considered the length of stay and bed-days data on the patients staying in the psychiatric units over one year.¹

The audit of new long-stay patients, patients staying between one to five years in inpatient psychiatric services, has identified 548 in the national census on March 31, 2006. After exclusions, such as for the patients residing in private psychiatric hospitals, data on 460 patients was available for the calculation of the length of stay (LOS). Of those patients 42% (192/460) of patients had a diagnosis of schizophrenia.

The median length of stay in these patients was approximately 33 months (~1,000 days). If averaged out for five years it comes to approximately 200 days. For simplicity of calculations we will consider the average cost of a bed as €250 per day. This is the figure considered by Behan et al, for bed cost per day for a patient admitted in a psychiatric unit attached to a general hospital; as according to HRB annual report of 2006 nearly 53% of psychiatric admissions are to the psychiatric units based in a general hospital.^{2,3}

The average cost of these new long-stay patients with schizophrenia, will be approximately €10 million (192 × 200 × 250). Thus the 'at least' cost of inpatient care for schizophrenia in Ireland would be approximately €42 million. As suggested by Behan et al, this is still an underestimate as the data reported by the Health Research Board of new long-stay patients still excludes patients (n = 67) residing in private psychiatric hospitals.²

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Response to Dr Dixit regarding the economic cost of schizophrenia in Ireland

Dear Editor, We thank Dr Dixit for his ongoing interest in our study and in the economic cost of schizophrenia in Ireland.¹ While we concur with Dr Dixit's overall view, we need to clarify some of the figures he attributes to our paper.² The €32.1 million Dr Dixit quotes in his letter was actually our estimate of just the inpatient costs alone, we estimate the overall cost of schizophrenia to Ireland was €460.1 million in 2006. In his calculations Dr Dixit quotes our inpatient cost as €250 in 2006. In fact, the cost of an inpatient unit in a general hospital we used, was €247. The cost of a bed day in a psychiatric hospital was €313. Using an average of the two, this is a cost per bed day of €280. Private hospital costs were even more expensive. Nevertheless, Dr Dixit's further work on this theme emphasises how important this matter is and further emphasises our conservative estimate.

Costs of illness studies are useful in providing an estimate of the costs of an illness to the patient, their family and to society. However, by their nature they have their limitations, including the omission of intangible costs, often the most important cost to the patient and their families. Intangible costs include the cost of suffering and quality of life. It is unfortunate, even aside from human suffering and lost human potential, that obvious measures to reduce costs, such as introduction of early intervention services to reduce the duration of untreated psychosis, have not been adopted in Ireland as they have in other countries around the globe to such good effect.

Recent studies in the UK, Scandinavia, Canada and Australia comparing early intervention services with treatment as usual show reduced costs in the short-term, mainly due to a reduction in inpatient costs.³⁻⁶ A recent study from EPPIC in Australia showed that costs, and benefits such as increase in remission and greater numbers in paid employment, persist over the longer-term.⁷

The recovery model of treating mental health disorders, in line with prevention models such as screening in the treatment of physical health disorders, would suggest that recovery from an illness is faster, more effective and potentially cheaper if an illness is caught early when the individual is often less unwell. This makes sense in any climate, let alone our current one. Introduction of early intervention services in Ireland, as proposed in *Vision for Change*, can best be done by joint initiatives from primary care and secondary care.

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The Dissociative Experiences Scale: Replacement items for use with the profoundly deaf

Dear Editor, A range of self-report instruments now exist to measure frequency and types of dissociative experiences. The Dissociative Experiences Scale (DES¹), a 28-item instrument that measures a wide variety of dissociative phenomena (eg. absorption, imaginative involvement, depersonalisation, derealisation, amnesia) is the most frequently used.²

Recently, Lewis et al³ have argued that as dissociation is associated with altered sensory perceptions, current instruments designed to measure dissociation, including the DES, are unsuitable for use with the visually impaired given the wording of a number of items, as they make reference either directly or indirectly to the sense of vision. They proposed that in such cases, the DES be amended by replacing six items identified by three clinicians as being unsuitable for this population (items 1, 7, 11, 17, 26, and 28) with suitably equivalent ones re-written by the authors to be functionally equivalent to the original items, and be appropriate for use among the visually impaired. Exploratory psychometric research using the replacement items has provided satisfactory results in terms of reliability and validity of such an amended form of the DES and this revised version has been recommended for use in clinical settings.⁴

Since undertaking this work,^{3,4} it has become apparent within our clinical practice that the initial focus of our research, namely amending the DES for use with the visually impaired was too limited and unnecessarily restricted in scope. Specifically, as dissociation is associated with altered sensory perceptions, current measures of dissociation, including the DES, are unsuitable not only for use with the visually impaired, but also for those who have other sensory impairments, including those who are profoundly deaf.

Therefore there was a clear rationale to revise the DES for use among the profoundly deaf. One clinician and one clinical researcher independently identified three of the 28 DES items as being unsuitable for the profoundly deaf, as they made reference either directly or indirectly to the sense of hearing (2, 21, and 27). These three items were subsequently rewritten by the authors to be functionally equivalent to the original

Table 1: Three items of the DES (original and revised versions items)

Original item 2: Some people find that sometimes they are listening to someone talk and they suddenly realise that they did not hear part or all of what was said.

New equivalent item 2: Some people find that sometimes they are watching someone talk and they suddenly realise that they did not take in part or all of what was said.

Original item 21: Some people sometimes find that when they are alone they talk out loud to themselves.

New equivalent item 21: Some people sometimes find that when they are alone they communicate 'out loud' to themselves, as if they were speaking to another person.

Original item 27: Some people sometimes find that they hear voices inside their head that tell them to do things or comment on things that they are doing.

New equivalent item 27: Some people sometimes find that they hear things inside their head that tell them what to do or comment on what they are doing.

items, and be appropriate for use among the profoundly deaf. *Table 1* contains the three original items alongside the new items that were designed to replace them.

Further work is now required to examine the reliability and validity of the three new replacement items. This would involve the administration of the original 28 items of the DES, along with the three new items, to a sample with normal hearing. This would allow for the statistical examination of the association between each of the three new items with those items they were designed to replace. Providing the three new items were found to be valid replacements, the amended version of the DES can be recommended for use among the profoundly deaf, either by clinical administration or by self-report.

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