To psychiatric service administrators and clinicians:

1. deinstitutionalisation, based on a perception that hospitalisation damages psychiatric patients, has been disastrous;
2. the perception is based on faulty research which failed to identify the true reasons for higher morbidity in hospital patients;
3. ESMEC (Evaluation of Single and Multiple Episode Care), a new service evaluation process, has identified the main reasons as
   (a) patients being hospitalised with diagnoses which are more effectively treated in other care settings,
   (b) hospitalisation being preferred for the more severely or chronically ill, regardless of diagnosis, often after non-hospital care had been tried and failed,
   (c) misinterpretation of high morbidity in the unrecovered as invariably indicative of ineffective management when, in fact, it may be a "concentration effect" of highly effective management, i.e. As unrecovered patients are invariably more ill than the already recovered, the higher the recovery rate, the higher the concentration of morbidity in the unrecovered, with the last to recover usually being those most ill to begin with,
   none of which have anything to do with hospitalisation itself;
4. ESMEC shows which types of care setting are most effective for different types of psychiatric illness, at different levels of severity and chronicity;
5. ESMEC shows that, regardless of diagnosis and severity, morbidity increases, and the likelihood of recovery decreases, with increasing chronicity, so that it is imperative to choose the most effective setting at the earliest stage, rather than selecting, regardless of diagnosis, one setting type for "new" cases, and the other only after this has failed;
6. services based on the belief that one setting type is invariably superior to others, damage all patients by providing ineffective treatment for some, diluting the resources available for effective treatment of others, and denying all the most effective management at the earliest stage, when they can best benefit from it;
7. effective services require adequate provision of both hospital and community care, in amounts sufficient to allow early access of patients to settings shown to be most effective in treating their illnesses;
8. ESMEC uses routinely collected clinical information and has been comprehensively trialled. It provides the means for identifying sociodemographic, clinical and service usage (settings, medications, procedures) as predictors of outcomes, gender- and diagnosis-specifically and, ultimately, for distinguishing local from generally applicable, potential "benchmark" effects. It is the only currently available process for accurate, comprehensive, clinically and administratively relevant, ongoing evaluation of psychiatric services, and essential for the development of maximally clinically- and cost-effective services to replace the present unsatisfactory arrangements;
9. ESMEC is the intellectual property of the Institute of Psychiatric Evaluation, PO Box 75, Berowra Heights, NSW 2082, Australia, and is available in three versions:
   (a) "basic": for small data sets and/or local use: major diagnostic group-specific evaluation of psychiatric care settings,
   (b) "standard": for medium-sized data sets and/or regional use: diagnostic combination-specific evaluation of care settings, medications, procedures and tests, and including basic sociodemography,
   (c) "advanced": for large data sets and/or state or national use: ndividual diagnosis-specific evaluation of care settings, incorporating efficiency measures, standardised severity scores, medications, procedures and tests, and additional sociodemographic detail, and generating diagnosis aggregate groups (DAGs) to provide an empirically derived alternative to currently available diagnosis-related groups (DRGs),
   all versions providing a full menu of summary descriptive statistics;

10. the Institute of Psychiatric Evaluation will ESMEC-analyse and report on psychiatric data sets submitted for this purpose. Enquiries should be made to the above address.

PO Box 75
Berowra Heights
NSW 2082
[redacted]

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Draft Press Release

In the last decades of the twentieth century, a large number of studies found that long-term psychiatric inpatients were much more disabled than long-term outpatients. Without investigating previous setting usage or other possible causes, it was concluded that, while outpatient care facilitated recovery, hospital treatment impeded it through the "institutionalisation" process.

Accepting these findings at "face value", health administrators and clinicians implemented wholesale "deinstitutionalisation", redirecting patient from hospital to community care, which administrators agreed to resource from funds no longer required for hospitals. Hospitals were run down, and in some cases sold off, while much money was spent providing treatment resources and residential facilities for the psychiatrically ill in the community.

However, instead of the expected improvement, results were catastrophic. Severely ill patients were maintained in the community by the use of the newly developed depôt medications, which controlled their symptoms without allowing them to improve their coping skills and achieve an acceptable quality of life.

Clinicians blamed the poor outcomes on administrators failing to honour their promises to adequately fund community services, which administrators then attempted to redress by further "starving" the remaining hospital services. Neither group, in its adherence to deinstitutionalisation dogma, questioned the research on which the dogma was based, and the problem worsened.

More recently, much more powerful evaluation techniques have become available. ESMEC (Evaluation of Single and Multiple Episode Care) is a new, more precise and more comprehensive method which uses routinely collected clinical and background information to evaluate psychiatric services. It identifies factors , not previously studied in this context, which predict outcomes, especially recovery rates and morbidity levels in the unrecovered, and shows the picture to be much more complicated than the earlier research had indicated.

Among the factors identified are sociodemography (patients' genetics, development and current environment), pre-illness personality and pre-treatment illness (type, severity and chronicity) which, though affecting outcomes, are outside direct clinical control. Their effects must, however, be understood, and taken into consideration when reaching diagnosis and deciding where and how to treat. Treatment interventions (types and amounts of care, including medications, procedures and, especially, settings themselves) are, of course, directly under the control of health administrators and clinicians, and evaluation focuses mainly on how these affect outcomes, taking pre-treatment factors into account.

Analysis reveals that, though different types of illness respond better to different types of care settings, no care setting type is consistently superior to others, other factors, especially illness severity and chronicity, being equal. Of similar importance is the finding that no setting type is inherently more morbidogenic ("institutionalising") than any other, though may appear to be so if it treats patients whose illnesses would be more effectively treated elsewhere, or who are more severely ill to begin with, or whose illnesses are more entrenched (chronic), than those treated elsewhere.

This is not to deny that any setting, if poorly managed or inadequately resourced, may produce poor outcomes, but this is a sporadic, not a systematic event, similar to inept performance of a generally beneficial procedure, or inappropriate use of a generally effective medication, or even misdiagnosis within a valid diagnostic system. No intervention is immune to human error, in psychiatry or elsewhere.

These findings contradict those on which the deinstitutionalisation movement is based, in particular that hospitalisation invariably has worse outcomes than non-hospital care, and that this is due to an inherent morbidogenicity of inpatient care. The new findings explain why, when severely ill patients, who would once have been hospitalised, are instead treated in the community, they remain as disabled as their pre-deinstitutionalisation hospital counterparts, and because more visible, may appear to be even more so.

Treatment of many others, less severely ill, in the community deprives them of the more effective care they would have received had hospitalisation been an option. Burdened with the severely ill and those whose illnesses respond less well to non-residential care, community services must redirect resources from patients they have the potential to help most, to others who would be better managed in hospital. Consequently, restriction of access to hospitals ultimately penalises all patients, rather than, as was originally believed, helping them.

Clearly, the situation can be corrected only by providing enough hospital and community places to allow the best available care for all psychiatric patients, with access matched to the most effective setting for the illness concerned, rather than to severity, adherence to a debunked dogma, exaggerated concerns for containment, or the cheapest setting options. Psychiatric services are not run most economically by providing cheap but ineffective care, requiring continuing expansion of services to treat the ever-expanding morbidity burden of the "new chronic". It is usually more effective, economically as much as clinically, to provide high quality appropriate care, minimising the duration and degree of long-term treatment and freeing resources for managing the continuing flow of new referrals within existing services. Variety and appropriate use of care settings should be the keywords.

Containment may be a priority for the few patients in danger, for the time being, of self-harm or harm to others, but with modern medications and intensive inpatient treatment, perhaps in general hospital units, they should be relocated in whatever settings best "fit" their illnesses, as soon as the need for containment has passed.

Once appropriate infrastructure and staffing are in place, ongoing evaluation is essential to ensure it remains so, in the light of changing illness patterns, such as may result from population ageing and migration, and the development of new treatments. Administrators, clinicians, mental health review tribunals and patient advocacy groups must be continually vigilant to correct abuses and maintain standards within an affordable context, but require a valid, accurate and easily usable system to inform them. ESMEC is such a system.