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From the Editor's desk

By Peter Tyrer

Efficiency savings

The biblical exhortation to give and not to count the cost is individually delightful but collectively obtuse. Almost all countries are counting costs at present and going through a period of retrenchment, retreating behind their battlements and preparing for the full economic storm. No matter what airy promises are given, health services cannot be immune from these buffetings. Mental health is in danger of suffering more than most from the often arbitrary decisions of politicians and managers, and this can happen even when times are good.[1] So it behoves us to take even more notice of our balance sheets than usual and, wherever possible, to employ strategies that really are efficiency savings rather than convert the meaning to the universal bottom line, 'cuts'. Much of our recent research now focuses less on greater efficacy and more on cost savings[2–6] and this may influence our decision makers more than other evidence of greater efficacy but at more cost.[7,8] Ideally, we want the virtuous double-plus of both less cost and greater efficacy that has recently been enthusiastically promulgated by Andrews;[9] but in today's weary world innovation is more of a spectator than a player and much of our activity is taken up by initiatives such as the energetic one of the Royal College of Nursing (http://frontlinefirst.rcn.org.uk/) (also open to doctors) where cuts and waste in services are identified and solutions found that really are efficiency savings, and which can be genuinely novel. Some years ago in developing the principles of nidotherapy[10] we were treating a patient whose flat needed redecorating. He had unusual colour requirements, with a penchant for dark pink walls and grey doors and skirting boards, and these were not considered entirely proper by the council responsible for the flat. In the end our team agreed to redecorate the flat exactly to his requirements. After some official resistance we completed this task to the patient's satisfaction at less than one tenth of the cost of the proposed council redecoration, a true example of efficiency savings whose real importance was its manifest triumph of patient autonomy.

So how do the papers in this issue stack up in the Efficiency Savings Stakes. Petrou *et al* (pp. 395–404) make a good start by showing that child psychiatric disorders are expensive, with cognitive impairment and autistic disorders showing the greatest excess costs. They also present the salutary data that the total costs of any psychiatric disorder exceed those of childhood asthma. These data can act as templates for 'cost-effectiveness models of preventive and treatment interventions' and it does not take much thought to realise that even a small advance here will carry great economic gain. Many of our other papers hint at how the loss of efficiency due to psychiatric disorder might be corrected, including those concerned with war theatres (Mulligan *et al*, pp. 405–410), the choice of treatment for depression in NICE guidelines, where computerised interventions are hovering at the edge but still remain to be incorporated (Kendrick & Peveler, pp. 345–347), early intervention and psychological treatments for psychosis (Bird *et al*, pp. 350–356) where a full economic study of the long-term benefits still needs to be completed, and, perhaps strongest of all, the effect of childhood adversity, where Kessler *et al* (pp. 378–385; see p. 383) imply that the screening of children in routine medical settings could lead to cost-effective interventions before (highly expensive) adult pathology has developed. But someone has to put up the prize money for the Efficiency Savings Stakes to take place and it will need bold and far-sighted decisions to get them galloping forward.

Measuring recovery

At a conference in Australia, I recently took part in a debate about the best measure of 'recovery', and I realise that this word still needs to be put in quotation marks as we still do not know exactly what it is. The concept of recovery is a very strong one, and is closely embraced by patients, but we have far to go in getting it properly defined, never mind assessing it with an agreed measure. The importance of the subject is illustrated by Roberts & Wolfson's paper[11] being the most cited one in our sister journal *Advances in Psychiatric Treatment*, but here 'recovery' is expressed more as a philosophical model than as a specific treatment with measurable outcomes. My worry was that developing a specific measure of recovery at this stage in knowledge was rather like recording the shape of a blancmange – everything could be made to fit any way we wished but it would all collapse in a heap afterwards. But we must not boast that other areas of psychiatric outcome measurement are much better. The real success of a measure is its widespread applicability, and is this respect the EQ–5D[12] has been a dramatic success as it has allowed comparison with other diseases far removed from psychiatry, and so helped to show that mental disorders are far from trivial and represent major causes of suffering. Yet the paper by Saarni *et al* (pp. 386–394) shows clearly that the EQ–5D is not enough; a single question on mood does not encompass pathology, and a new equivalent hinted at by Brazier (pp. 348–349) is urgently needed. So a new 'PsychoQol' measure, recording quality of life, the most desired of all the outcomes in those who support recovery, is really what we need for all mental illness, but it should be used equally by our medical colleagues if it is going to succeed convincingly.

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12 The EuroQol Group. EuroQol – a new facility for the measurement of health-related quality of life. *Health Policy* 1990; **16:** 199–208.