Significant amounts of information and prior research is available, looking at the situation of mental health disorders within populations, and considering the most cost effective way for treatment.

In this evaluative report, the author aims to consider two of these studies. The first paper by Heller, Gemmell, and Patterson (2006) analyses four treatment methods provided within clinical guidelines, for effectiveness from the perspective of preventing further hospital readmissions and relapses for both depression and schizophrenia.

The second paper by Chen, Killeya-Jones, and Vega, (2005) considers the extent to which mental disorders exist within the United States (US) adolescence, and the likelihood of any clusters of mental disorder co-occurring.

Helping to prioritise interventions for depression and schizophrenia: Use of Population Impact Measures. *Clinical Practice and Epidemiology in Mental Health:* (Heller, R; Gemmell, I; Patterson, L; 2006)

The paper by Heller, Gemmell and Patterson (2006), aimed to investigate the impact of implementing a 'best practice' approach on reducing the number of hospital admissions and relapses for patients suffering from both depression and schizophrenia. A 'best practice' approach can be defined by The National Institute of Clinical Excellence (NICE) as integrating "pharmacological agents…specific psychological interventions…[and]…service delivery systems…to provide [the] best…care of individuals with a diagnosis of [disorder]" (NICE Guidelines, 2007). The paper focuses on the impact and efficiency of a multiplicity of treatment methods observed over a one year period.

The number of events prevented in a population (NEPP) is calculated within the paper for a variety of treatments. These are anti-depressant therapy, screening, cognitive behaviour therapy (CBT), increased care management for depression, early intervention, adherence to medical advice, family intervention, and relapse prevention for schizophrenia.

Data for prevalence is derived from external publications, with central tendency measures installed for those with discrepancies. Overall, the study found that the culmination of all treatments resulted in one hundred and nineteen cases of schizophrenia, and nine hundred and thirty one of depression did not experience

relapse or hospital re-admission as a result of their treatment, although the significant factor here is the large disparity between the two disorders.

Whilst guidelines often give relevant information, the authors recognise these are limited when showing the potential benefit of each to the actual population. NICE guidelines on depression show that 'recommendations for routine screening are frequently made without reference to empirical data' (NICE Guidelines, 2007: 74) however, do not show the benefits of such screenings. Therefore, the study aims to 'plug this research gap'. Similarly, on Schizophrenia, NICE recognises that 'Oral atypical antipsychotic drugs' (NICE Guidelines, 2007: 38) may be used as an initial treatment; however, this does not demonstrate the long term health effects of these drugs when treating the disorder within the general population.

The results from the study are apparent and succinct, and are clearly separated into subsections, indicating that only 48% of those with depression are formally diagnosed, and that 50% of those experienced relapse. NEPP calculations from the studies data show that those receiving CBT as part of their treatment programme were least likely to experience relapse in the future. Powell et al. (2007: 74) whose literature review found CBT to be 'one of the therapeutic modalities' with high empirical efficacy further support this finding. Despite this, according to Heller et al., (2006) only 5% of patients received CBT as a treatment.

Similarly, for schizophrenia, it was found that early intervention was the most effective approach to be taken as an initial treatment, although there was less significance between this and the other treatments analysed than those with

depression. However, it is possible that logistical problems are borne when this method is in use. As early diagnosis must occur, for this to happen, the patient or a relative must notice that changes in behavioural patterns do already exist, and seek medical advice about these changes. Thus, it is possible that this assistance is not gained, and the window for early intervention is closed as a result.

Moreover, from a historical perspective, patients noticing signs of depression, or being told they have the symptoms of depression by others, would typically attend a General Practioners (GP) surgery where they would be given a 'traditional' tablet treatment for the symptom. However, this could be perceived as a major disadvantage, since the route cause of the depression is not necessarily being diagnosed. The results from this study show that CBT, a treatment that does deal with the cause of the illness is the most effective, and would certainly appear true.

Finally, there are treatments mentioned within the NICE guidelines that this study fails to analyse, leaving little comparison for those receiving them. For example, a suggested schizophrenia treatment is rapid tranquilisation, especially upon hospitalisation. Whilst NICE cites evidence showing why this treatment is used, the study by Heller et al (2006) does not directly take into account this form of treatment; consequently, this could reduce its overall application level.

Prevalence and co-occurrence of psychiatric symptom clusters in the United States, adolescent population using DISC predictive scales", *Clinical practice and epidemiology in mental health: CP and EMH,* vol. 1, pp. 22. Chen, K.W., Killeya Jones, L.A., and Vega, W.A. (2005)

The paper by Chen, Killeya-Jones and Vega (2005), aimed to establish two levels of prevalence of co-occurrence of mental illness within American adolescents aged between twelve and seventeen years. The study obtained data from the National Household Survey of Drug Abuse (NHSDA) and formed a random sample of 19,430 teenagers, which were not isolated for demographic features. 'Face to face' however, computer aided interviews were conducted with participants, and their responses were analysed to assess whether or not they were classed as having a mental disorder, and if so, the number of these that co-occurred.

Mental Illness was placed in clusters based on Diagnostic Interview Schedule for Children (DISC) scales. These were Anxiety Clusters, Affective Clusters, Substance Use Disorders (SUD), Disruptive behaviour Clusters, and Other Disorder Clusters. Results from the study show that over the twelve month period, 58.1% of adolescents screen positive for at least one cluster of mental disorder.

Prior research, included within the introduction to the paper, provides a large body of information showing the extent to which mental disorder is believed to be a problem within US adolescents. It recommends, 'About 20% of US children…have at least one…mental…disorder'(Chen et al; 2005: 2). However, the figures used within the introduction do contain significant differences between prior studies. Despite this, the introduction does maintain an excellent structure, guiding the reader through the

relevant topics. Although the paper is considerably protracted and the use of acronyms could have the effect of withdrawing the reader's attention.

Similarly, the method can be evaluated in both a positive and negative light. Whilst the random nature of the data collection process did enable an unbiased sample, increasing the application of the studies findings, the data was not demographically discrete. This means that it is hard to establish whether differences of mental disorders within races, locations, and other demographic features are evident.

Moreover, the interview strategy employed could lead to incorrect information being given by the participant, although these were computer aided and generated to help reduce the effects. In addition, the study made use of a clear scaling system to determine whether a participant should be considered as having a diagnosable mental illness. This means the findings should hold a greater level of validity within the field.

In addition, the results to the study show that three in five US adolescents tested positive for mental illness clusters, a much higher rate than expected. For example, Lerner and Steinberg (Lerner, and Steinberg, 2004: 71) found that only 9% of school age children had a current mental disorder. However, within this, the authors recognise some interesting points, for instance that whilst females report a lower usage of substances, they have a greater dependence upon them. Overall however, it was found that co-occurrence of clusters is high. 58% have one cluster of illnesses, nevertheless 37.7% of those are in at least two, and 17% are within four clusters.

Both papers do have a level of similarity to allow comparison; they both study some aspect of mental disorder within a population. The paper by Chen et al. (2005) shows the level of undiagnosed mental disorder within the US adolescent population, whilst the paper by Heller et al. (2006) shows the most efficient treatment methods for both depression and schizophrenia.

However, they do both have significant differences and weaknesses, which must be taken into consideration. Whilst the Heller et al. (2006) paper focuses on the whole population, the Chen et al. (2005) paper considers only those aged between twelve and seventeen years. Therefore, the application of results from the Chen et al. (2005) paper is dramatically reduced. Moreover, the most efficient treatment method considered within the Heller et al. (2006) paper may be different when applied to adolescents experiencing mental health disorders. However, collectively, the papers have a large epidemiological significance. They show the importance of recognising the level of mental disorder within a given population, and then treating it using the appropriate methods.

In conclusion, both papers intent is at assessing some form of mental disorder within the populace, and have evidently been written to target the clinician or specialist as the audience. Heller et al. (2006) wished to asses the most effective method of treating depression and schizophrenia, given that clinical guidelines, in general, only state which treatments should be used. They found for schizophrenia, the correct use of treatment could prevent one hundred and nineteen cases of hospital readmission or patient relapse, and that for depression, the figure increases to nine hundred and thirty one. Moreover, the paper by Chen et al. (2005) aimed to show the prevalence and co-

occurrence of mental disorder within the US adolescent population. They found that 58% of twelve to seventeen year olds could be classed as having some form of diagnosable mental disorder, much greater than expected.

Therefore, in order to improve the epidemiological situation, it is essential to ensure that cases of mental disorder are accurately diagnosed, and treated in the correct comportment.

Word Count - 1563

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