Accounts Commission for Scotland

A shared approach

Developing adult mental health services

OCTOBER 1999

ABOUT THE ACCOUNTS COMMISSION

The Accounts Commission is a statutory, independent body, which, through the audit process, assists local authorities and the health service in Scotland to achieve the highest standards of financial stewardship and the economic, efficient and effective use of their resources.

The Commission has five main responsibilities:

- securing the external audit
- following up issues of concern identified through the audit, to ensure satisfactory resolutions
- reviewing the management arrangements which audited bodies have in place to achieve value for money
- carrying out national value for money studies to improve economy, efficiency and effectiveness in local government and the NHS
- issuing an annual direction to local authorities which sets out the range of performance information which they are required to publish.

The Commission secures the audit of 32 councils, 34 joint boards (including police and fire services), 15 health boards, 28 NHS trusts and six other NHS bodies. Local authorities spend over £9 billion of public funds a year and the NHS in Scotland spends over £4 billion.

The Commission's Health and Social Work Studies Directorate is responsible for managing a national programme of value for money studies. Part of this programme included a review of mental health services for adults, managed by Barbara Hurst and Sara Twaddle, under the general direction of Caroline Gardner, Director of Health and Social Work Studies. Ian McBean was seconded to the project from Falkirk Council's social work services. Further support was provided by Karen Jack.

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Summary

Adult mental health services are changing, with a gradual move towards comprehensive community-based services in line with the objectives outlined in the '*Framework for mental health services in Scotland*' and the care in the community policy. No area in Scotland yet has a comprehensive range of social and health care services for adults with mental health problems, but some are making more progress than others.

Changing the focus of a service can be difficult, particularly when:
- it requires co-ordinated action by a range of commissioning bodies and providers
- resources need to be re-distributed
- information on the use of resources is not readily available.

To change the way in which mental health services for adults are delivered, and to ensure that local needs are met, requires:
- the active involvement of users and their carers
- the identification of all resources available for mental health services
- genuine partnership working between local agencies, as no single agency can commission or provide all the elements of a comprehensive service
- the efficient use of mental health resources
- the shared development and use of robust information on local needs; the quality, cost and efficiency of services; and outcomes for individual users. This would enable the cost-effectiveness of services to be properly evaluated.

In many respects user and carer involvement in mental health services for adults is better developed than for other areas of health and social care, but there are some areas for improvement. These include support for sustained involvement in the planning process, involvement in service evaluation and in the development of care plans and outcome measures. These could be achieved with minimal additional resources.

Sources of funding for mental health services are complex and diverse. Between them statutory health and social work agencies spent over £320 million on adult mental health services in 1997/98, with the health service responsible for four-fifths of this expenditure. In-patient services (intensive care, acute, rehabilitation and long stay beds) account for 78% of the expenditure on secondary mental health services for adults. Current expenditure does not appear to be matched to need and is still more likely to reflect historical patterns of expenditure.

Effective joint planning requires, among other things, transparency about the current level and use of resources, and agreement on the financial implications for all planning partners in changing services. This requires a cultural shift into thinking of the 'community care £' rather than thinking in terms of separate health and local authority budgets. As the number of long

stay beds reduces, and people are moved from hospital to the community, there is a need to re-invest in a range of alternative community services: social care, primary care and community health services. However, in a number of areas there is uncertainty and potential conflict between local agencies over how the money released from long stay bed closures is calculated and used. This should be resolved by open discussion on the reduction of long stay beds, as part of the local mental health strategy, with joint agreement on the amount of money which will be released by bed closures and which alternative services should be provided.

Trusts vary in the degree to which they target acute in-patient beds on people with the most severe mental health problems. Re-admission rates within 28 days of discharge are high in some trusts, ranging from 5% to 15% of all admissions. Some of these may be part of a planned programme of care but the wide range suggests that discharge planning and the level of community support available to people being discharged could be improved. Trusts should review their use of in-patient beds and ensure that protocols are in place for discharge and aftercare arrangements.

In Scotland as a whole, the targeting of community mental health resources on people with the most severe and/or enduring mental health problems is relatively good, although there are a few trusts which do not appear to be managing these resources well. Some community mental health staff are carrying large and complex caseloads. Clear operational policies should be in place to ensure that resources are targeted appropriately and that staff are supported and have caseloads which enable them to respond to users' needs.

Achieving value for money in mental health services requires valid and reliable information on the cost, quality, and efficiency of services, the extent to which they meet identified need and the outcomes achieved for individuals. At present there is limited information available on mental health services, particularly those delivered in the community, although there are a number of national initiatives in this area. Care should be taken to ensure that these initiatives are co-ordinated, that both health and social care measures are developed, and that local examples of good practice are widely disseminated. Further attention needs to be paid, at both a national and local level, to developing integrated information systems which are user-centred and can support the recording of activity by different agencies, and help identify the clinical and social outcomes of care. Inter-agency, multi-disciplinary community mental health teams provide a useful focus for this work.

There are a number of policy initiatives, which should help agencies in the task of developing performance measures and thus improving quality of care. In particular, Best Value in local government, and clinical governance in the NHS, introduce a framework and culture for reviewing services and focusing on continuous improvement.

The '*Framework for mental health services in Scotland*' has been instrumental in moving the mental health agenda forward. The challenge is to maintain the momentum and build on examples of good practice in planning and delivering services and involving users and their carers.

Introduction

Mental health problems are common, and many of us will have such problems at some time in our lives. Some estimates put this as high as one in four of the population[1]. The largest and most comprehensive survey found that 14% of the adult population in Scotland had significant mental health problems in the week prior to the survey[2].

Some people with a mental health problem have no contact with the health service. Others are treated by their GP. Only a relatively small proportion of people come into contact with specialist mental health services, and less than 0.5% of the population need to be admitted to a psychiatric bed[3].

For the past four years mental health has been identified as a priority area for the NHS in Scotland[4] and, more generally, care in the community is a priority for social work, housing and health agencies. A key objective of care in the community is to enable people with mental health problems to live as normal and independent a life as possible in their own homes, or in homely settings, rather than in institutional care. This means moving away from the large psychiatric asylums of the past, and providing instead a range of community-based services which are more flexible in meeting individuals' needs.

> *"[the] planning assumption should be that, wherever practicable and possible, the local service will be provided as a home-based service or in small facilities as close as possible to an individual's home."*
> *The Scottish Office: A framework for mental health services in Scotland*

In response to the 1994-95 Scottish Affairs Committee report which looked at '*The closure of psychiatric hospitals in Scotland*', the Scottish Office published a '*Framework for mental health services in Scotland*'[5]. This considered the way in which comprehensive local services can be achieved and provided a template against which local priorities for action can be developed and evaluated.

Other specific central government mental health initiatives include:

- the Millan Committee which has been set up to review the Mental Health (Scotland) Act 1984 and is due to report by the summer of 2000
- the launch of the Mentally Disordered Offenders Strategy which, although about forensic services, includes general psychiatrists providing a substantial component of the forensic input
- the establishment of the Scottish Development Centre for Mental Health Services on a three-year programme of tapered funding from the Health Department and the Social Work Services Group
- a Mental Health Development Fund of £3 million each year for three years which was established by the Scottish Office
- a Mental Illness Specific Grant of £18 million each year which is available to local authorities.

There are also other policies and changes in the way in which services are structured that will directly affect the development of mental health services. These include the introduction of:

- primary care trusts which incorporate hospital and community mental health services in addition to a range of other functions[6]
- new planning mechanisms for health bodies – Health Improvement Programmes and Trust Implementation Plans – and the abolition of the internal market in healthcare[7]

"The Best Value initiative emphasises the importance of delivering services that offer the best balance of cost and quality and closely match people's needs and wishes."
The Scottish Office: Aiming for excellence[9].

- clinical governance in NHS trusts whereby the Chief Executive is accountable for quality of care, staff training and support, and addressing poor performance
- a requirement of local authorities to ensure Best Value in the services they commission and provide. This involves consideration of both the cost and quality of services, and the active involvement of service users and local communities in assessing services. Although directed at local authorities the principles of Best Value apply equally to the NHS in Scotland.
- the social inclusion strategy for Scotland which highlights the importance of involving and empowering individuals and communities[8]. The emphasis on an inclusive society provides potential opportunities for addressing the stigma still attached to mental illness.

It is a challenging time for planners and providers of services, but the key messages are clear. In order to provide comprehensive local mental health services which meet users' needs, they need to:

- actively involve users and carers
- assess individual needs from the perspective of services required, rather than merely services available
- develop good information on the cost, quality and effectiveness of services
- work in partnership with other agencies.

The Accounts Commission's study

The Commission has previously published two bulletins on adult mental health services[10]. These examined the NHS resources available for services, and the extent to which users and their carers are actively involved in planning and monitoring. This report builds on and develops themes from these bulletins by:

- considering the development of comprehensive services to meet the needs of users and carers (chapter 2)
- providing a picture of expenditure on adult mental health services by the NHS and local authorities in Scotland (chapter 3)
- analysing how NHS mental health resources are being used, and the extent to which they are targeted, in line with government policy, on people with the most serious and enduring mental health problems (chapter 4)
- examining the way in which health bodies, local authorities and other agencies are working jointly to plan and provide comprehensive mental health services (chapter 5).

Our study focuses on mental health services for adults. It does not examine services for older people, nor specialist provision such as forensic or drug and alcohol services.

Local audits were carried out in 13 health boards and 17 community NHS trusts. From April 1999, the 13 new primary care trusts in Scotland have become responsible for delivering the services previously provided by the community trusts. In addition, financial, activity and planning information was collected from all 32 local authorities, and interviews were carried out in a sample of ten local authorities.

This report is aimed at commissioners, planners and providers of adult mental health services. We hope that it will also be of interest to users of these services and their carers.

Meeting the needs of users and carers

The Commission's previous bulletin on user and carer involvement identified the importance to them of comprehensive mental health services, which can meet their social and health needs in a non-stigmatising way[11].

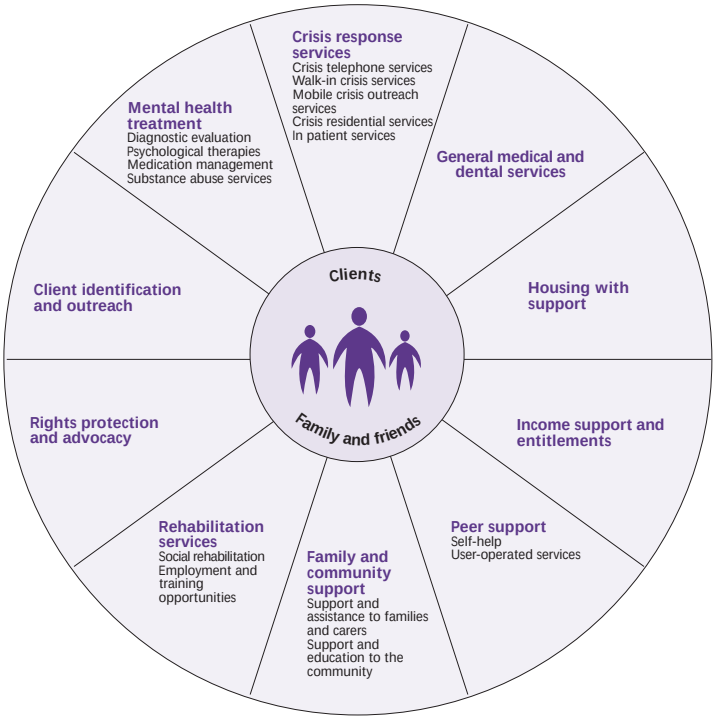
No area of Scotland yet has in place the comprehensive range of mental health services envisaged by the '*Framework for mental health services in Scotland*' (Exhibit 1). This is not surprising given the scale of change required in moving from long term institutional care towards the development of community-based mental health services. However, some areas are making more progress than others.

Key factors affecting the pace of change, and agencies' ability to deliver this range of services, include:

- the resources they allocate to adult mental health services and the efficiency with which they use them
- the ease and speed with which money tied up in institutions can be released for re-investment in local community-based services
- good inter-agency working with a shared understanding of local need.

> *"... people with mental health problems share the common basic human needs for good housing, education, recreation, paid employment consistent with their ability, personal and community relationships".*
> *The Scottish Office: A framework for mental health services in Scotland.*

Exhibit 1: Elements of a comprehensive service



Source: Adapted from *'Reshaping mental health services'*[12]

Involving users and carers

In order to move from a service-led to a needs-led approach to commissioning and providing mental health services, it is essential that service users' and their carers' views and experiences are heard and acted upon[13].

"Individuals and communities should be supported to express their needs and aspirations and to influence decisions made on their behalf."
The Scottish Office: Social inclusion.

The challenge for local agencies is to involve people with mental health problems and their carers fully in planning, evaluating and delivering services, and to reshape services in line with identified needs. Agencies should be supporting and involving people with mental health problems in the development of:

- mental health strategies and services
- service evaluations
- independent collective and individual advocacy[14]
- their own care plans.

All areas of Scotland have involved users and carers in the planning process to some degree, although the extent of this varies and some approaches appear to be one-off rather than sustained. Involvement ranges from participation in user and carer conferences and focus groups, the results of which have been used to inform the planning process, to user and carer representation on different planning groups.

Auditors found that participation in monitoring and evaluating mental health services is the least developed aspect of user involvement despite evidence to show its value[15].

In addition, practical support for user and carer groups and access to independent advocacy services vary across the country, although there are examples of high levels of user engagement in areas such as Highland (see box below).

Developing user-led advocacy services

Highland Users Group is a well established and respected network of users in the Highland area. It provides a range of services including the production of reports on local services, mental health awareness training for professionals, and user representation on relevant committees. The group is jointly funded and actively supported by Highland Health Board and Highland Council.

"... we expect people who use services and their carers to be central to all decisions made about themselves and the services planned."
The Scottish Office: Modernising community care[16].

Although the involvement of people with mental health problems in service planning is essential, it is likely that involvement in planning their own care is even more important for service users. Auditors found that people on the Care Programme Approach (CPA), which is designed for people in need of complex packages of care, were more likely to be fully involved in the development of their own care plans than people not in receipt of CPA. Some users are still reporting that they are not given enough information about treatments and services, and that this prevents them from playing an active part in planning their own care. The Commission noted in its bulletin on user and carer involvement that this is an area where improvements can be achieved with minimal extra resources.

Informal care for people with mental health problems in Scotland has been estimated as costing in the region of £280 million, and most of this cost is borne by families and friends[17]. Carers therefore play an important part in the delivery of mental health care. Although having many of the same needs as service users, carers also have their own distinctive needs, such as access to support networks. An analysis of carers' needs, and ways of meeting them, should be included in mental health plans and strategies.

Recommendations

Commissioning bodies should:

- *involve people with mental health problems and their carers in the development of local mental health strategies. To be of value this involvement needs to be on an on-going basis.*
- *provide practical support for advocacy services*
- *ensure that mental health plans and strategies include an analysis of carers' needs and the means of addressing these.*

Providers should:

- *involve users and carers in monitoring and evaluating services*
- *provide information about treatment options and services to all users*
- *ensure that users are actively involved in developing their own care plans*
- *provide sustained and consistent support to carers.*

Expenditure on mental health services for adults

This chapter provides a picture of the current level and distribution of resources allocated to adult mental health services. It starts with an overview of the total amount of expenditure by statutory health and social work bodies across Scotland. These are the public bodies responsible for much of the expenditure on people with mental health problems. It then looks in more detail at the different elements of this expenditure:

- primary health care
- secondary (or specialist) NHS mental health services
- social care.

Finally, we examine whether resources are currently matched to need, and consider the type of information needed to plan services effectively.

Voluntary organisations make a large contribution to the delivery of mental health services, ranging from self help groups through to providing high levels of support to people with mental health problems. An examination of voluntary organisations was outwith the scope of the study. Many of the services they provide are commissioned by social work and, to a much lesser extent, health boards and expenditure on these services is therefore covered in the relevant sections.

"Once the overall level of funding is established, the current and projected balance between in-patient and community resources should be confirmed and the financial, physical and infrastructure resources that each agency is able to commit to mental health services should be made explicit."
The Scottish Office: A framework for mental health services in Scotland.

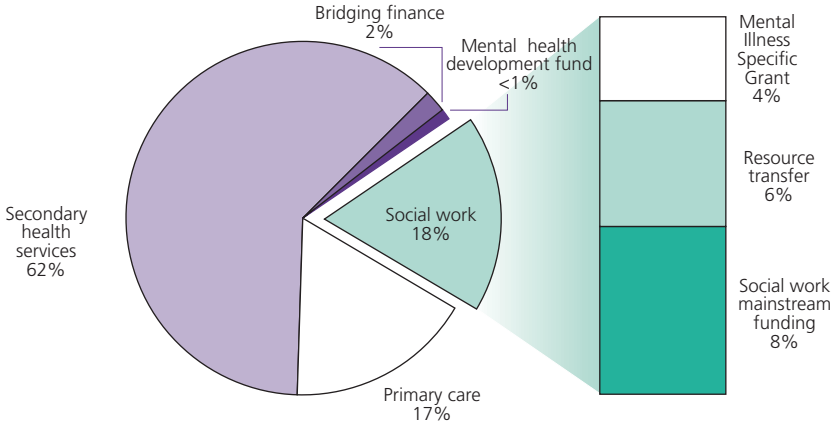
Health and social work expenditure

Health and social work authorities between them spent over £320 million on adult mental health services in 1997/98, with the health service responsible for four fifths of this expenditure (Exhibit 2).

Sources of funding for mental health services are complex and diverse. They include mainstream health and social work funding, special grants (such as the Mental Health Development Fund and the Mental Illness Specific Grant), resource transfer from health boards to social work bodies, and bridging finance to cover transitional costs associated with hospital closure and the development of alternative community services.

Exhibit 2: Health and social work resources for adult mental health services, 1997/98

The health service is responsible for four fifths of expenditure on adult mental health services.



Note: This picture excludes expenditure on mental health promotion, which is not aggregated at a national level.

Expenditure in primary care

Most people with mental health problems who make contact with the health service are treated by a GP and not referred to specialist mental health services. The '*Framework for mental health services in Scotland*' conceptualised four tiers of mental health care (since extended to five tiers) depending on the needs of the individual for care packages of varying levels of complexity (Exhibit 3). Primary care plays an important part in this overall structure.

Exhibit 3: Tiers of mental health care

The tier structure is based on the need of users for different levels of care depending on the severity of their mental health problems.

Tier	Mental health care
0	The community, including self help groups and counselling support from voluntary organisations.
1	The primary healthcare team and associated local authority social work area teams.
2	Individual mental health worker offering support to primary care and often acting as a link between a group of general practices and the community mental health team.
3	Community mental health team comprising multi-disciplinary, inter-agency staff. Could also include care such as supported accommodation, mental health officers (MHOs), day services and respite care.
4	Specialist mental health service - in-patient hospital care (acute, forensic), intensive psychiatric care units and MHO input.

Source: Adapted from the *'Framework for mental health services in Scotland'*

Costing the primary care element of mental health care is difficult. However, we know that the sum of money involved is likely to be significant:

- During 1998 GP prescriptions for psychiatric drugs (excluding hypnotic drugs) cost £45 million[18].
- Approximately 1.5 million GP consultations have a mental health component[19] which, at a conservative estimate, costs the NHS in Scotland around £11.2 million per year[20].
- A small proportion of the Primary Care Development Fund may have been spent on mental health services in 1997/98. It is difficult to obtain a detailed

breakdown, as some of the monies are allocated centrally and some on a *per capita* basis to individual health boards. None of the centrally allocated funds were allocated to mental health services in 1997/98, although some health boards may have used part of the fund for mental health service development.

GP prescribing of psychiatric drugs

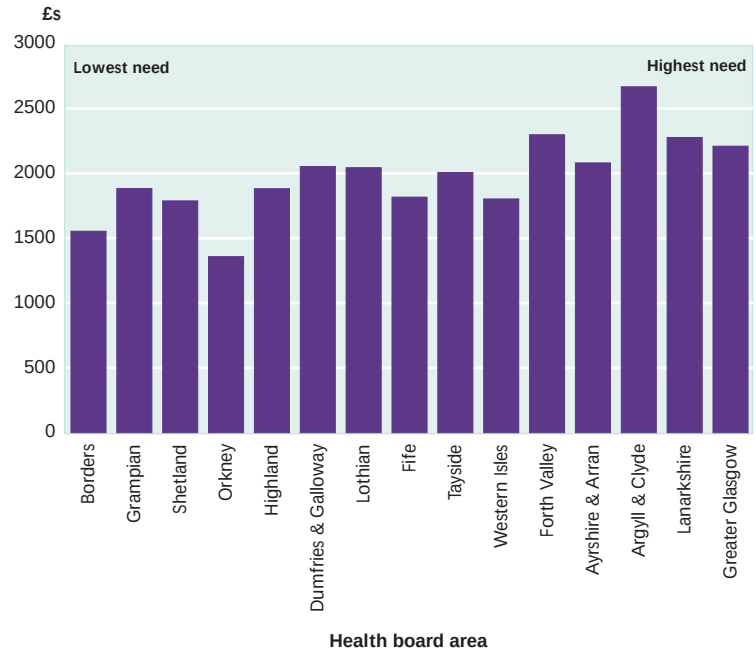
The £45 million spent on psychiatric drugs prescribed by GPs represents 8% of the total GP drugs budget. Just over 80% of this expenditure is on anti-depressants. There is some variation in the costs of psychiatric drugs prescribed by GPs by health board area (Exhibit 4). This warrants further investigation to examine whether there is a link between the rate of prescribing and the level of mental health services in an area, particularly those services which offer direct support to primary care. Some GP practices are already examining their own prescribing, and are actively developing services for people with mental health problems (see box below).

Improving primary care services for people with mental health problems

A GP practice in West Lothian has reviewed its services to people with mental health problems. An audit of GP prescriptions for psychiatric drugs has been carried out. In addition, a triage system for treating people with mental health problems has been established. Training has been given by a community psychiatric nurse to the practice nurses and health visitors.

Exhibit 4: Costs of psychiatric drugs prescribed by GPs per 1000 patients

There is a two fold variation in the cost of psychiatric drugs prescribed by GPs.



Notes:
1 Health boards shown in ascending order from lowest to highest need for mental health services using the morbidity and life circumstances index cited in the Arbuthnott report[21].
2 A standardised unit for practice populations taking account of age and sex distribution and temporary residence (SCOTR PU) has been used.

Source: Pharmacy Practice Division of the Common Services Agency, 1998

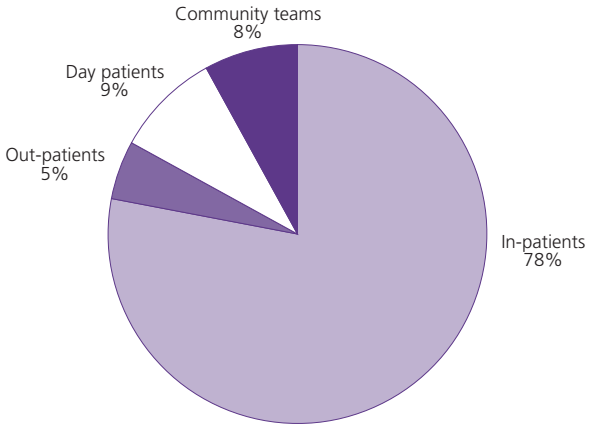
Expenditure on secondary NHS mental health services

The Scottish Executive Health Department's *Performance monitoring template* shows that from 1996/97 to 1998/99 there has been a 10% increase in the NHS in Scotland's total revenue expenditure on hospital and community services. Over the same period the total expenditure on all NHS mental health services (including resource transfer) has increased by 7%.

Figures for NHS providers show that just over £204 million was spent on secondary adult mental health services in the year 1997/98 (excluding expenditure on the State Hospital)[22]. In-patient provision accounts for nearly 80% of this expenditure (Exhibit 5). We have not been able to break this in-patient expenditure down between different types of bed - acute, rehabilitation and long stay beds.

Exhibit 5: NHS expenditure on secondary adult mental health services, 1997/98

Hospital provision continues to account for most of the £204 million spent by the NHS on secondary adult mental health services.



Notes:
1 Excludes resource transfer which is reflected in social work expenditure.
2 The way in which the costs are presented does not enable a split between community team members working with adults up to 65 years and those working with older people or children and adolescents. We have apportioned 60% of total community expenditure to adult services, based on the proportion of the adult population in Scotland.
3 NHS provider costs were used to compile this exhibit. Total NHS expenditure may be slightly under-stated.

Source: Scottish Health Service Costs, 1997/98

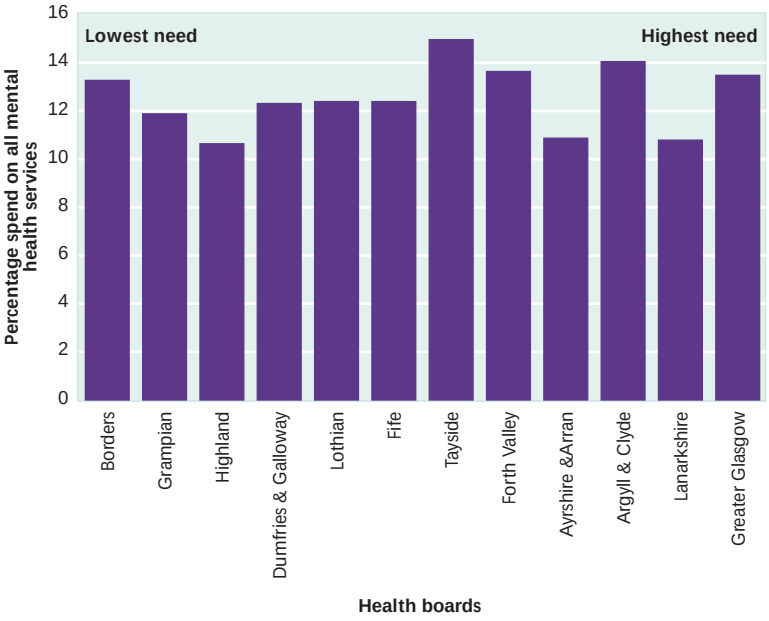
In 1997/98 expenditure on secondary adult mental health services was supplemented from two sources:

- bridging finance which is a contribution towards the transitional costs associated with hospital closure and the development of alternative community services. Of the total £18 million bridging finance, £5.5 million was available for adult mental health services.
- £3 million Mental Health Development Fund. This money is to support *'quicker progress towards the development of local community focused, comprehensive services which better meet the needs of people with mental health problems'*[23].

Not all health boards were able to separate expenditure on adult mental health services from total mental health expenditure. Exhibit 6 shows the variation among health boards, with expenditure on all mental health services (including services for older people, children and adolescents) ranging from 11% to 15% of hospital and community healthcare revenue expenditure. This is most likely to result from historical expenditure patterns but may also reflect the different priorities given to mental health services.

Exhibit 6: Mainland health boards' spend on all mental health services as a percentage of total revenue expenditure

There is significant variation in spending on all mental health services among health boards.



Note: Health boards shown in ascending order from lowest to highest need for mental health services, using the Morbidity and life circumstances index cited in the Arbuthnott report.

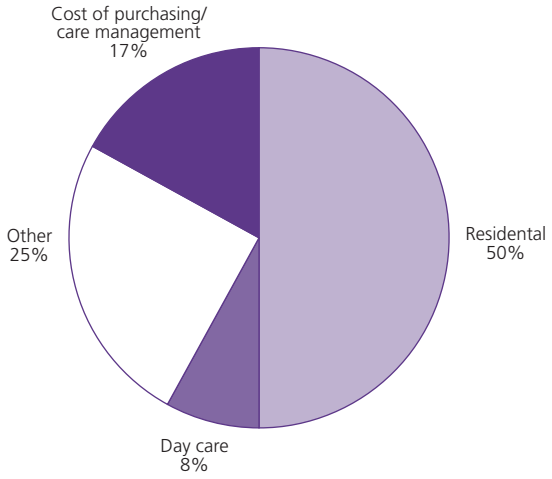
Source:Scottish health service costs, 1997/98

Expenditure on social work services

In 1997/98 just over £59 million was spent by social work departments on services for adults with mental health problems[24]. This figure was offset by an element of the Mental Illness Specific Grant and resource transfer funds (discussed later in this section), and a small amount of income from service users. It includes spending on care management but does not include all the costs associated with mental health officer work. Nor does it include spending on substance abuse services. Half of social work expenditure is on the provision of residential services, primarily supported accommodation (Exhibit 7). Services in the 'other' category include community services such as home care, advocacy and employment and training initiatives.

Exhibit 7: Social services provision

Half of social work expenditure is on residential services.

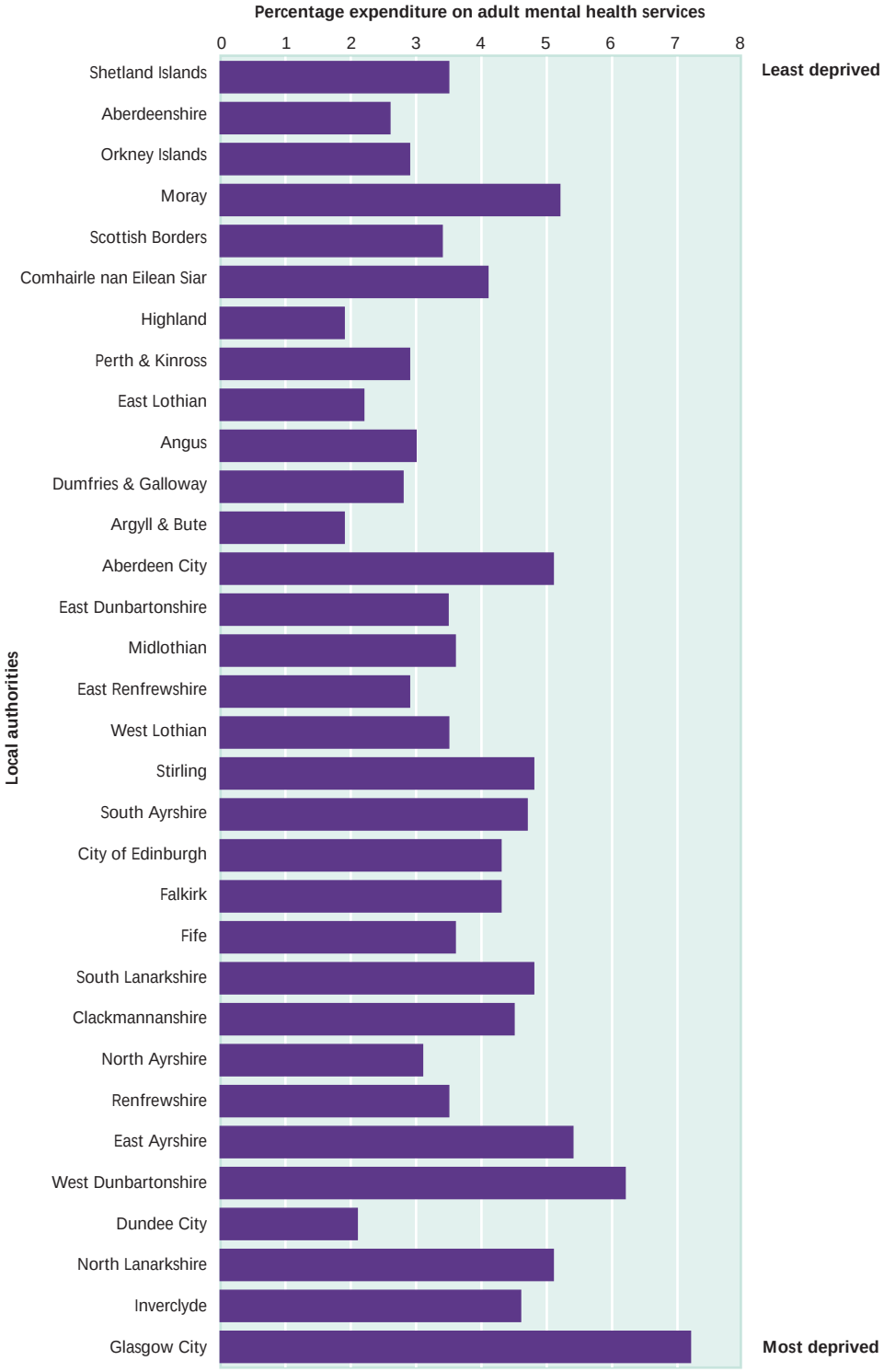


Source: CIPFA Statistical Information Service, Personal Social Services Statistics, 1997-98 Actuals

Exhibit 8 shows the variation among local authorities, with expenditure on adult mental health services ranging from just under 2% to 7% of the gross social work budget. Research has shown that high levels of deprivation are linked with high incidence of mental health problems[25]. The variation in spending does not appear to reflect local needs, and is more likely to reflect differences in local authority priorities.

Exhibit 8: Percentage of total social work budget spent on adult mental health services

There is a wide variation in local authority spending on adult mental health services.



Note: A similiar mental health needs analysis used for health expenditure is not available for local authorities. In this exhibit local authorities are ordered using area deprivation scores provided by the Scottish Executive Central Research Unit. We have used these scores as a proxy measure of mental health needs.

Source: Accounts Commission Performance Indicators for Social Work, 1997/98

Mental Illness Specific Grant

A total of £18 million is made available to local authorities each year through the Mental Illness Specific Grant (MISG). Local authorities must apply for the grant on an annual basis. Central government meets 70% of the costs and local authorities contribute the remaining 30%. The grant was originally allocated in proportion to each council's share of the total population of Scotland. At the time of local government reorganisation, the MISG was allocated on the basis of the distribution of resources by the former regional councils.

The aim of the grant is to assist local authorities to provide facilities which will reduce the number of people needing psychiatric hospital admission, and to enable more people with mental health problems who have been discharged from hospital to live with suitable support in the community[26].

The MISG is a significant element of funding, amounting nationally to just over 20% of social work authorities' total expenditure on adult mental health services. In 1997/98 £12.42 million of MISG funds were spent on projects for adults with mental health problems, with the voluntary sector managing two thirds of these projects. Recent research has shown that the grant has been significant in helping to develop a range of community-based services, which have made an important difference to the lives of users[27] (Exhibit 9).

Exhibit 9: Types of general mental health projects approved for Mental Illness Specific Grant

MISG projects provide a diverse range of community services.

Type of service	Number of projects providing the service
Community development	111
Self help	75
Domiciliary	61
Drop in	55
Day centre	48
Resource centre	45
Housing/residential	38
Other	17

Notes:
1 Information on 1996/97 projects most recent published data available.
2 A project may provide more than one service and may therefore appear more than once in the table above.

Source: The Scottish Office, *'Community Care Scotland'*, 1997

The grant has remained at the same level for the past four years. This has created difficulties for some local authorities in maintaining services funded through this mechanism, and had a significant impact on some voluntary organisations whose project budgets may have been frozen.

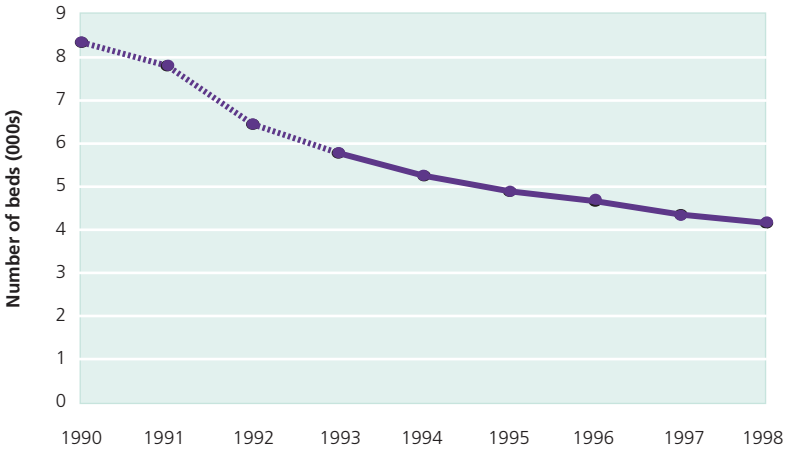
The MISG was introduced before the publication of the *'Framework for mental health services in Scotland'*. It is important therefore that new and existing MISG funded projects are included in, and reflect the overall aims of, local mental health strategies.

Resource transfer

Since 1990, when the Community Care and NHS Act gave local authorities lead responsibility for community care, the number of hospital beds for adults with mental health problems has fallen from just over 8,000 to just over 4,000 in 1998 (Exhibit 10). In the early 1990s some of these beds were reclassified as 'psychogeriatric' beds although it is not possible to put an exact figure on this.

Exhibit 10: Reduction in adult mental health beds, 1990-1998

Mental health beds for adults have reduced by nearly 2000 since 1993.



Note: Between 1990 and 1993 there was a reclassification of some mental illness beds as 'psychogeriatric' beds.

Source: Information and Statistics Division of the NHS In Scotland

Many of the people moving from these long stay hospital beds will need NHS mental health services in the community. The Scottish Executive Health Department has encouraged health boards to re-invest some of the savings from bed closures in developing community mental health and primary care services, and improving the care and surroundings for those for whom care in the community is not an option. The proportion of NHS expenditure on community mental health services has increased marginally over the past few years, suggesting that re-investment in community mental health services is beginning to happen, albeit slowly.

Resource transfer is the mechanism by which the remaining savings released by long stay hospital bed closures are transferred from health boards to local authorities. This should contribute towards the cost of social care services required to resettle patients in the community and provide an alternative to hospital provision.

In 1995/96, £9.4 million was transferred from health boards to local authorities in relation to adult mental health bed closures up to that period[28]. Because resource transfer information was not available by care group in all health boards, we have used the same proportion, as that identified in 1995/96, to estimate resource transfer for adult mental health bed closures. This gives an estimate of £20 million for the year 1997/98, representing over a third of social work departments' total expenditure on adult mental health services nationally. This recent growth in resource transfer may be a more realistic recognition of the costs involved in the re-provision of services in the community than in the earlier years. It may also reflect the closure of whole wards or hospitals. The closure of a few beds is likely to release only marginal savings, whereas a ward or hospital closure should mean resources, more closely reflecting the gross reduction in costs, can be transferred.

Although there have been some improvements in negotiations over resource transfer since the Commission's report, *'Shifting the balance'*, there remain potential conflicts over:

- the true number of bed closures since 1990
- the calculation of the cash saving
- the amount retained by health boards.

There are different practices across Scotland in the way in which resource transfer is calculated. In some areas separate agreements are negotiated for each project, in other areas a standard cost per bed closure has been agreed. The actual variation in resource transfer among health boards is considerable, ranging from under £8,000 to just over £25,000 per bed closed[29]. Some variation in the rate of transfer payments per bed closure might be expected, reflecting the differences in community mental health provision across the country and the consequent need for some boards to re-invest more heavily in these services, and the scale of bed closures. The degree to which these factors explain the variation is, however, unclear.

Transparency and openness about bed unit costs, and about the distribution and use of resources released by bed closures, will be necessary for effective inter-agency planning and working, joint commissioning and the achievement of Best Value. This is an essential part of the mental health framework planning process.

Expenditure on other local authority services

We have already seen that a comprehensive mental health service requires more than health and social work services (see Exhibit 1). For the most part, in addition to health and social care, people with mental health problems want the rights and opportunities which most of us take for granted and which give us a stake within the community:

- suitable and affordable housing
- a secure income and financial and benefits advice to maximise that income
- leisure, education and training opportunities
- access to transport.

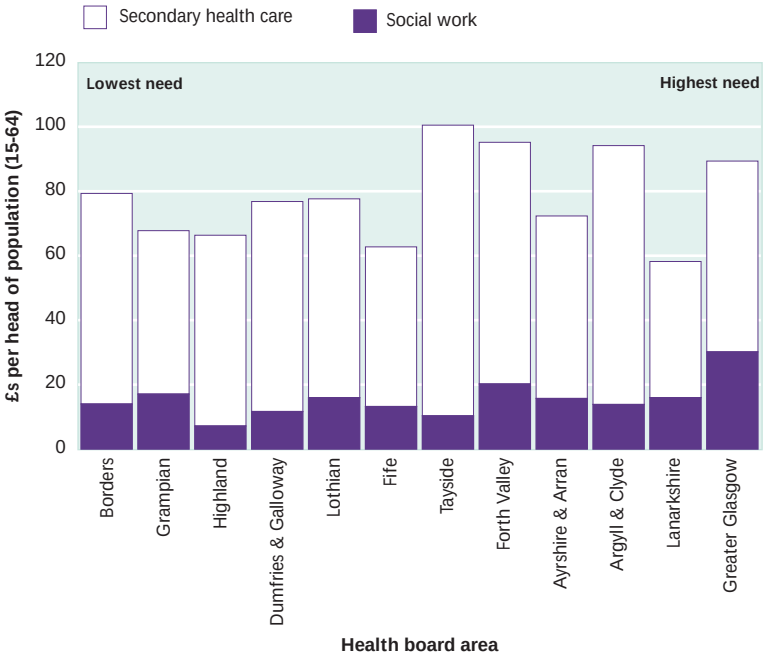
Local authorities commission or provide many of these services; for example, housing, benefits advice, 'passports' to leisure services for people who are unemployed or have a disability, community education courses and concessionary fares. It is difficult to obtain accurate costs for the mental health element of generic local authority services because they are not routinely collected. Nevertheless, estimates should be possible. Only eight of the 32 social work departments were able to provide estimated costs of services provided by other local authority departments for people with mental health problems.

Matching resources to needs

Combining secondary health and social work expenditure at a health board level provides a varied picture across Scottish mainland health board areas. This is not matched to need and is more likely to reflect historical patterns of expenditure (Exhibit 11). Reducing inequalities in mental health in Scotland requires a wide range of measures, only one of which may be changing expenditure patterns. Nevertheless, the variation warrants further investigation.

Exhibit 11: Allocating resources to need

Expenditure on specialist adult mental health services does not reflect need.



Notes
1 NHS provider costs used to compile this exhibit.
2 Because of problems with co-terminosity, social work expenditure was apportioned on the basis of population in each health board area.
3 Health boards shown in ascending order from lowest to highest need for mental health services using the morbidity and life circumstances index cited in the Arbuthnott report.

Source: Scottish health service costs 1997/98, reports 044, 40LS, 048 and 500R and Accounts Commission Performance Indicators for Social Work 1997/98

Evaluating the cost effectiveness of services

Managing the effective use of the different funds identified in this chapter requires genuine joint working and openness between agencies, and a commitment from all bodies to developing and maintaining services which are proven to be cost effective.

"The process of securing the most cost effective solution in any area is best informed by a thorough analysis of what is already available and planned by all agencies including health, housing, social services, voluntary and independent sectors."
Thornicroft & Strathdee: Commissioning mental health services

Commissioners and service planners need access to information on the relative costs of, and outcomes associated with, different services. However, there is limited evidence available on the cost effectiveness of community mental health services. This lack of information is shared by many other community-based services, and is a major challenge in the effective planning and management of resources.

In order to assist agencies involved in the commissioning and providing of adult mental health services, we undertook a comprehensive review of research literature which provided information about the cost effectiveness of different mental health services (Appendix 1). In addition, social work departments and local audits have supplied further costing information (Appendix 2). This information provides a broad picture of the range of costs. Caution is advised in its use as different costing methodologies are likely to have been used, the quality of care may vary, and individual services may well be targeted at people with different levels of need.

Recommendations

To match services more effectively to local needs there should be complete transparency on current expenditure by all agencies. A detailed examination of all available resources for mental health should be carried out. Local agencies should jointly:

- *review the current balance of expenditure on different services*
- *examine the possibility of substituting alternatives to maximise cost effectiveness, especially within a full range of supported accommodation*
- *agree and detail current and projected bed numbers (by type of bed - intensive care, acute, rehabilitation and long stay) to ensure that there is no confusion about the current or proposed in-patient service*
- *agree and detail the services to be provided in primary care, community mental health and social care as long stay beds are closed*
- *ensure that grant-aided projects are compatible with local mental health framework plans and strategies*
- *identify estimated costs of, and funding sources for, any proposed service developments.*

A standard methodology for calculating service costs should be used to ensure like-for-like comparisons.

Primary care trusts should examine the link between the rate of prescribing psychiatric drugs and the level of mental health service provision available locally. This information should be fed into the joint planning process.

Targeting NHS mental health resources

'… individuals with severe and/or enduring mental health problems, including the small number who present either a danger to themselves or others, should be the service's first priority.'
The Scottish Office: A framework for mental health services in Scotland.

This chapter examines the way in which NHS specialist mental health resources, which account for nearly two thirds of total health and social work expenditure, are targeted on people with the most serious mental health problems, in line with government policy. Specifically we consider the use of acute psychiatric in-patient beds and community mental health services.

The information which is available at a national level is of limited use:

- Information on discharges from psychiatric beds can be obtained from the national SMR04 data collection system. This is of some use in making comparisons between trusts but data refer only to those discharged. In addition, it does not allow the important distinction to be made between types of bed; for example, acute or long stay beds. Linked SMR04 data provides an opportunity to map the hospital career of individuals, but again would exclude those who remain in hospital.
- The quality of information on community health and social services is poor. Information available locally is not necessarily compiled on a consistent basis across Scotland, making comparisons and benchmarking difficult.

This lack of robust performance information is an issue which must be addressed, particularly with the increasing emphasis on achieving best value in public services.

Psychiatric in-patient beds

In this section we consider:

- the role of acute beds in a comprehensive mental health service
- the extent to which acute beds are targeted on people with the most serious mental health problems
- referral sources for admission to hospital
- re-admission rates
- compulsory admissions and detentions.

Auditors in nine trusts collected information on the use of in-patient beds over a six month period. They included a wide range of trusts covering urban, mixed and rural communities. Trusts which did not provide complete information have been excluded from the relevant exhibits. Appendix 3 provides further details on the information collected.

Role of acute beds in a comprehensive mental health service

A comprehensive mental health service consists of a network of different provision - in-patient beds, rehabilitation services, supported accommodation, community mental health teams, outreach services, advocacy projects and day services to mention but a few. If one or more of these elements are not available, which is the case in all areas of Scotland, greater pressure is put on existing services. This means that users may receive less appropriate services and creates difficulties for commissioners of services and providers in reconfiguring or changing the use of services.

The use of in-patient beds may reflect these difficulties. They are an important, but expensive, element of a comprehensive mental health service. Nearly £160 million was spent on in-patient services in 1997/98 - 78% of the total spend on secondary mental health services[30]. It is widely accepted that beds should be used primarily to treat people with the most severe mental health problems. If community services are not in place then people who could be treated at home or in a community setting will have to be admitted to hospital. This is both more expensive and less suited to their needs.

Developing community-based services will not necessarily mean that acute beds can be reduced immediately. People moving from long stay beds to the community may need short periods of acute in-patient care. In addition, research has shown that developing community services leads, at least initially, to increased pressure on acute beds as previously undetected needs are identified[31]. In the medium to longer term, well-developed community services may increase the number of admissions but can reduce people's lengths of stay in hospital.

Targeting acute beds on people with serious mental health problems

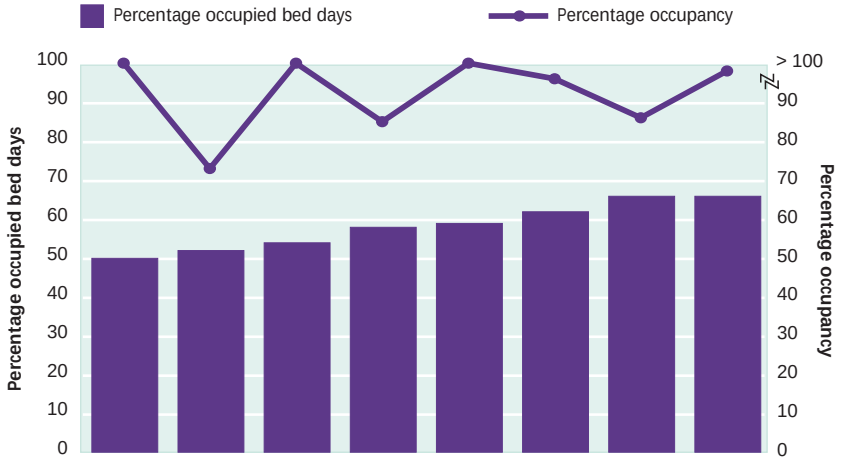
The proportion of occupied bed days in acute wards accounted for by people with severe mental health problems is one measure of how well targeted the in-patient service is to need. For the purposes of the following analyses we have taken diagnoses of schizophrenia, affective disorders and other psychoses as a proxy for severe and enduring mental health problems. This is not ideal; there are likely to be people who do not have a diagnosis of psychosis, who nevertheless have serious mental health problems and may need hospital care, but it does provide an indication of how well beds are used.

The average percentage of occupied bed days on acute wards for people with the most serious mental health problems across all trusts was 59%. Some trusts used beds more effectively than others, with a few trusts having a relatively low percentage of bed days occupied by people with serious mental health problems (Exhibit 12). These trusts should examine their admissions policies and procedures to ensure that beds are being used appropriately, and this information should be fed into the planning process.

Three of the nine trusts have average occupancy levels on acute wards of more than 100%. This may be, in part, a reflection of the use of 'leave of absence' from hospital whereby a person leaves hospital for trial periods but remains classified as an in-patient. Nevertheless, it indicates serious pressure on acute beds in these trusts. There is no apparent link between occupancy levels and the proportion of beds used by people with serious mental health problems.

Exhibit 12: Percentage of occupied bed days for people with severe and/or enduring mental health problems and occupancy levels on acute wards

There is no apparent link between occupancy levels and bed use for those with severe mental health problems.



Note: Wards include acute, intensive care and high dependency units.

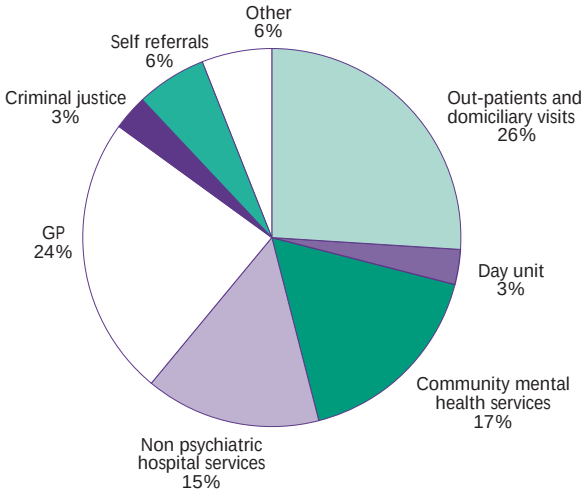
Source: Auditors' data collection

Referrals to hospital

One way of helping to ensure that only people who need hospital care are admitted is actively to manage the referral process. Most people admitted to psychiatric beds were referred by GPs or by secondary mental health services, such as out-patient clinics or community mental health teams (Exhibit 13).

Exhibit 13: Referrals for admission to psychiatric beds

The main referral routes are via out-patients, GPs and community mental health services.



Source: Auditors' data collection

Many people with mental health problems are seen by GPs. It is not surprising, therefore, that almost a quarter of referrals to psychiatric beds came from GPs.

There is a need to ensure good liaison between secondary mental health services and GPs. The introduction of primary care trusts provides an opportunity to strengthen operational links between primary and secondary mental health services and improve support for GPs. For example, the development of referral and admissions protocols should be more easily facilitated by the new trust structures.

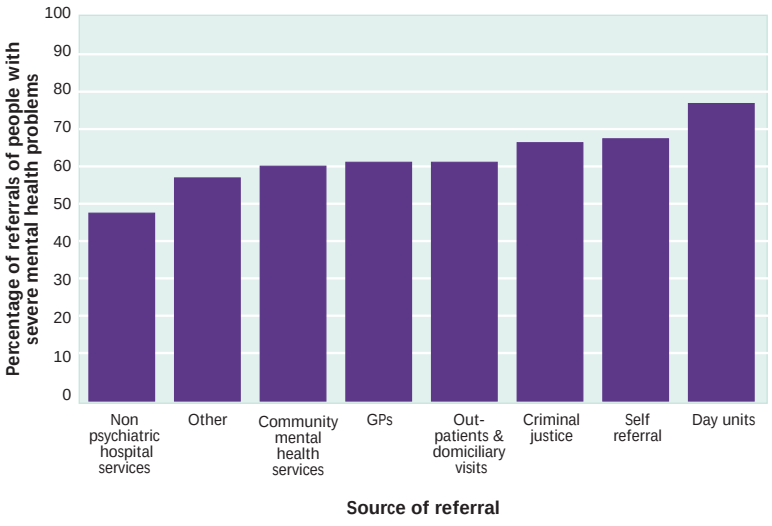
Almost 40% of referrals to psychiatric beds came from GPs and non-psychiatric hospital services. This may reflect the restricted availability of community psychiatric services. For example, if community services operate a 9 am-5 pm service, or are limited in availability, it is more likely that people in crisis out-of-hours will have to access other services, such as accident and emergency departments or their GP. Trusts should undertake regular audits to examine the source and timing of hospital admissions so that services can be developed in line with identified need.

The provision of a crisis out-of-hours service does not necessarily mean a comprehensive 24-hour service. The previous community trust in Ayrshire and Arran found that the majority of out-of-hours calls were received between 5pm and 9pm. The trust therefore targeted resources on this time period.

Examining referral sources by diagnostic groupings can also provide useful management and clinical information (Exhibit 14). GPs, psychiatrists and community mental health services refer similar percentages of people with severe and/or enduring mental health problems to in-patient services. In contrast, the non-psychiatric hospital services (such as A&E) are more likely to refer people with less serious mental health problems. Eighteen percent of admissions to acute wards were people with alcohol and drug related problems placing pressure on the general psychiatric services. These data suggest that there could be a need for trusts to look at this in more detail in order to manage admissions effectively.

Exhibit 14: Referral source

The percentage of GP referrals to in-patient care for people with severe and/or enduring mental health problems match those of psychiatrists and community mental health staff.



Source: Auditors' data collection

Re-admissions to hospital

We know from users and carers that the quality of discharge planning can directly influence a person's readiness for living in the community, and the likelihood of them being readmitted to hospital (Exhibit 15).

Exhibit 15: Discharge from hospital - personal views

Helping to prepare? ...

"It helped that I was able to spend a short time in the flat - it needed a lot of redecoration, so I couldn't stay long. The staff nurses took me down regularly, then when I moved I had two nights at a time for the first week."
Service user

"I was unceremoniously discharged. My medication was waiting for me when I went to the day room. I felt as if I was being rushed out. I had no time to say goodbye to anyone. I had to rush for my razor and cough bottle. None of the staff was helpful."
Service user

Recognising the importance of sorting out finances prior to discharge? ...

"It helped to have time to discuss my discharge from hospital, and to have practical help to fit back in the community. Staff at the drop-in organised a benefits check for me with the CAB."
Service user

"Our son was discharged to accommodation with no electricity for cooking and heating, and no benefits in place to purchase food or electricity meter cards. He was too ill to care about the upkeep of the flat."
Parent

User centred or service led? ...

"I was given five days notice of discharge. I was given the choice - if I had wanted to stay longer I could, and when I left I was told they would keep a bed free for me."
Service user

"It is not the policy locally to form a care plan if a person is in hospital for less than six months."
Parent

Source: Reproduced from *'Survey of service users' and carers' experience of hospital discharge'* with kind permission of NSF Scotland

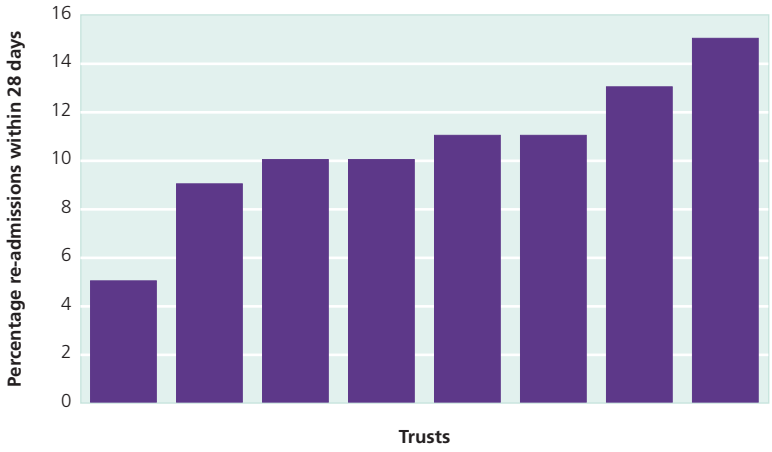
The rate of re-admissions within 28 days of discharge from an acute bed can be used as a proxy measure for the adequacy of discharge planning and for how well people are being supported in the community. Although our data do not distinguish between planned and unplanned re-admissions, they do provide a starting point for examining the use of beds and the adequacy of community support.

In our survey, 9% of all admissions were re-admissions within 28 days. Excluding people on leave of absence and day patients, 398 people were re-admitted within 28 days of discharge, of whom more than 60% had a serious mental health problem. Eighty two of these people were re-admitted two or more times over a six month period.

The rate of re-admission within 28 days varies among trusts, ranging from 5% to 15% of all admissions (Exhibit 16). This could reflect different practice in the use of planned re-admissions, or it could indicate differences in the adequacy of discharge and after care arrangements.

Exhibit 16: Percentage of re-admissions within 28 days of discharge from an acute bed

There is a threefold variation in re-admissions.



Source: Auditors' data collection

Trusts should examine the reasons for re-admissions where they are not part of a person's planned programme of care. Protocols, subject to regular audit, should be in place for discharge and after care arrangements. Action should be taken where audits identify re-admissions which are the result of inadequate discharge arrangements or failure to provide appropriate community support.

Compulsory admissions

Current mental health legislation permits compulsory admission and detention in hospital, in specific circumstances, of a 'mentally disordered' person. The Mental Welfare Commission for Scotland has identified a significant variation in the number of compulsory detentions between areas[32]. There does not appear to be a correlation between rates of compulsory admission and detention and levels of psychiatric morbidity. This suggests that variation in rates may be more to do with practice issues, of both doctors and mental health officers, rather than being directly related to psychiatric morbidity in different areas of Scotland. For users, quite apart from the loss of liberty and the implications of treatment against their will, formal detention can have long-term emotional, social and employment consequences. It is important, therefore, that factors which can affect local rates of detention (such as the availability of alternative facilities, the level of substance abuse, competence in administering the Act, and liaison between health and social work professionals) are monitored at a local level.

Recent Social Work Services Inspectorate (SWSI) research notes that currently there is no common format for the collection of data on mental health officer (MHO) activity[33]. Although compulsory admission and detention is triggered by doctors, recording MHO activity in a consistent way would provide further understanding of the process. This would allow for valid and reliable comparisons of practice, and give a helpful insight into the experience of people who are compulsorily admitted and detained.

Use of NHS community mental health resources

In this section we consider:

- the quality of information held by community mental health staff
- whether community mental health staff are focusing on people with the most serious and enduring mental health problems
- the size and composition of community caseloads
- the extent to which people with severe and enduring mental health problems are receiving co-ordinated packages of care.

Auditors collected information from 166 community mental health staff on just under 5000 people in Scotland who were receiving community services during 1997 and 1998. Most of the staff were community psychiatric nurses (86%) with a small number of psychologists and occupational therapists. Appendix 3 details the information requested. Some of these staff work in multi-disciplinary community mental health teams, some in community psychiatric nurse teams and others work alone.

Quality of information

The quality and comprehensiveness of the information provided varied widely (Exhibit 17). It was not clear whether community mental health staff knew about key elements of the psychiatric history or packages of care of significant numbers of people on their caseloads.

Exhibit 17: Information not reported by community mental health staff

Information not provided on:

- diagnosis - one in eight people
- compulsory admissions to hospital - one in five people
- admission (and re-admission) to hospital in the last five years - one in eight people
- contact with other services - one in 24 people

Source: Auditors' data collection

The lack of comprehensive patient information in the community may indicate poor co-ordination of patient information between the acute and community mental health services in some trusts. It may also suggest that the co-ordination of care between health services and other agencies is not well established in all areas. Without common information 'joined-up' care within and between agencies is unlikely to be achieved in practice.

Focusing on people with the most serious problems

The information was analysed to identify the extent to which community mental health staff are targeting resources on people with the most severe and/or enduring mental health problems. People on caseloads were placed into one of four categories on the basis of diagnosis and service use (Exhibit 18). These categories were developed and used by the Audit Commission in its study of mental health services[34].

Exhibit 18: Mental health categories for people treated in the community

Category A - people with severe long-term mental health problems
Psychotic or organic illness or injury AND previous compulsory admission

OR

Aggregate one year stay in hospital in past five years

OR

Three or more admissions in past five years.

Category B - people with severe problems
Psychotic or organic illness or injury

OR

Any previous admission in past five years.

Category C1 - people who have disabling mental health problems but who have not been admitted to hospital
No record of hospital admissions

AND

Formal psychiatric diagnosis of:

Severe depression, severe anxiety, obsessive compulsive disorder, phobic state, anorexia or bulimia.

Category C2 - people with less severe mental health problems
No record of hospital admissions

AND

None of the above psychiatric diagnoses.

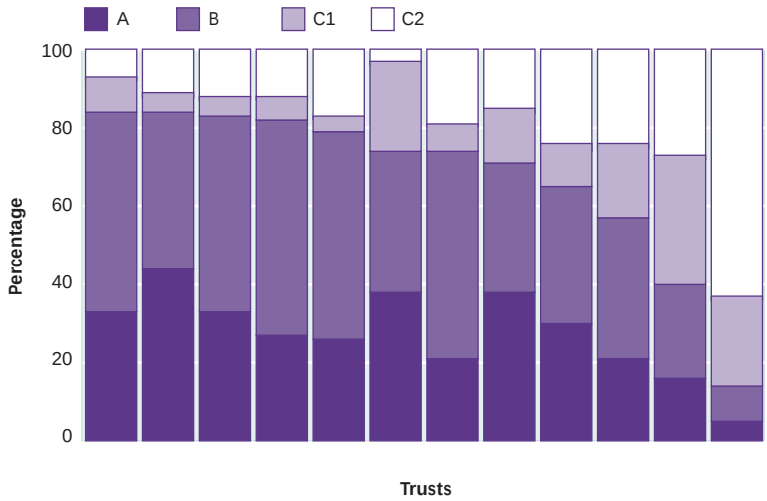
Source: Audit Commission

Overall in Scotland the targeting of community mental health resources on people with the more severe and enduring mental health problems is good. Nearly 70% of people on community caseloads are in categories 'A' and 'B'. This compares to 58% in trusts in England and Wales[35].

A few trusts are not focusing community resources on people with the more severe and enduring mental health problems (Exhibit 19). In some areas this could mean that people with the most severe mental health problems might not be receiving a community mental health service.

Exhibit 19: Targeting community mental health resources

There is variation among trusts in targeting community mental health resources on people with severe and/or enduring mental health problems.



Note: Trusts ordered in descending order of A+B percentages.

Source: Auditors' data collection

There are different ways of ensuring that people with severe and/or enduring mental health problems are prioritised. These include:

- specialist (multi-disciplinary, inter-agency) community mental health teams working only with this group of users
- generic (multi-disciplinary, inter-agency) community mental health teams, or single profession teams, which have targets for the proportion of their caseload which should be devoted to people with severe and/or enduring mental health problems.

The first approach requires clear protocols for accessing the specialist team and frequent review to ensure that the team is not over committed. Both approaches, or any hybrid of the two, require active management of all caseloads to ensure that services are targeted appropriately.

Some trusts, such as those in Glasgow and Ayrshire and Arran, actively manage community caseloads (see box below). Both trusts have a high percentage of people with serious mental health problems on their caseloads.

Managing caseloads to ensure targeting on people with severe mental health problems

Community mental health services in Ayrshire and Arran, now provided by Ayrshire and Arran Primary Care Trust, have used the Audit Commission categories A - C2 to analyse the composition of community caseloads. This analysis has been used to develop targets for people in the A and B categories on their community teams' caseloads.

Prioritising people with serious mental health problems is not enough in itself. Workloads need to be kept under review to ensure that they are manageable, and that users receive a level of service matched to their individual needs.

In order to examine this further, we have analysed the information on community mental health workers' caseloads specifically to look at the:

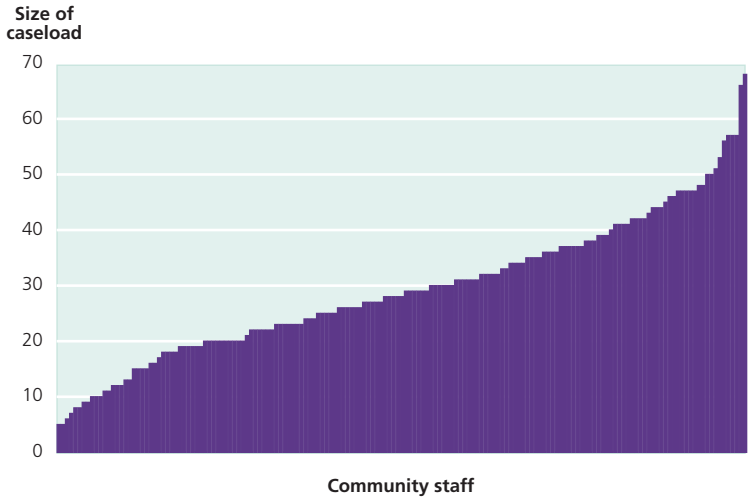
- size and composition of caseloads
- length of time people remain in contact with community mental health services
- frequency of contact with community mental health staff.

The size and composition of caseloads

There is a wide variation in caseload size (Exhibit 20). Some staff work part time which will account for some of the smaller caseloads. However, at the other end of the scale some staff have caseloads of 50+ people.

Exhibit 20: Caseload size of community mental health staff

Some community mental health staff have very large caseloads.

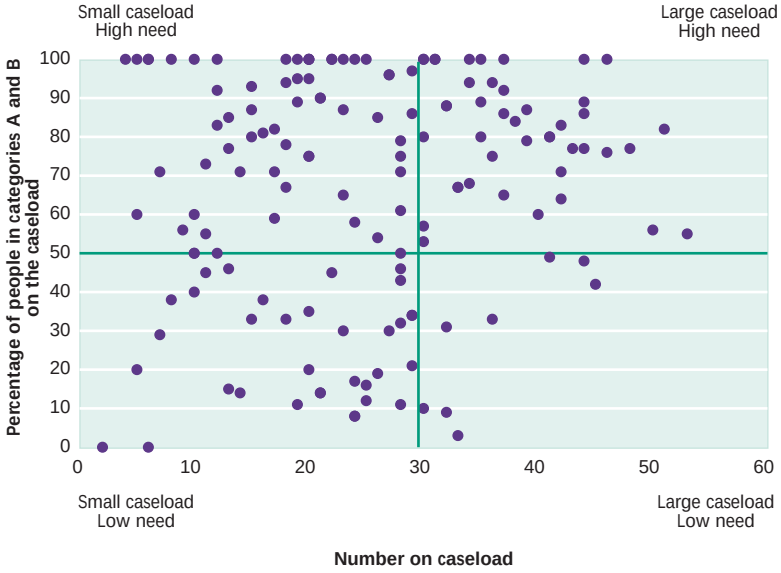


Source: Auditors' data collection

It might be expected that staff with large caseloads would be working with people with the less serious mental health problems. However, the size of caseload does not appear to be related to the complexity of people's mental health problems (Exhibit 21). Some community mental health staff are carrying large and complex caseloads. This inevitably means that some people with severe and/or enduring mental health problems will receive very little time from community mental health staff, and also increases the pressure on staff themselves.

Exhibit 21: Relationship between need and size of caseloads

There is no relationship between the number of people on community mental health staff's caseloads and the level of need.



Source: Auditors' data collection

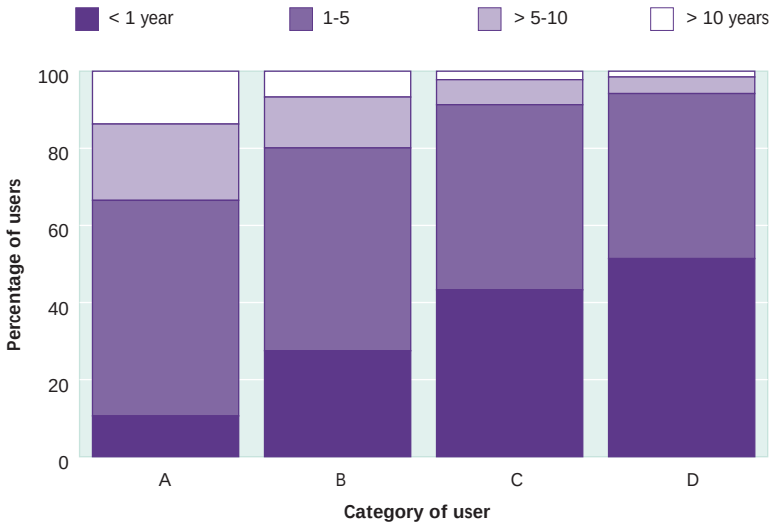
Length of contact with community mental health services

Another important aspect of caseload management is ensuring that people on community caseloads are those who have a continuing need for the service. Some people with serious but short-term problems, or less serious mental health problems, will need community mental health services, but are likely to need them for less time than people with the more severe and enduring problems.

As might be expected, people with severe mental health problems are more likely to have long-term contact with community mental health services. However, a significant percentage of people with less serious problems have also been in contact for over a year (Exhibit 22). This will be clinically appropriate for some people, but it does suggest that workloads could be more actively managed and monitored. This is reinforced by the large size of some caseloads.

Exhibit 22: Length of contact with community mental health services

A significant percentage of people with less serious mental health problems have been in contact with specialist services for more than a year.



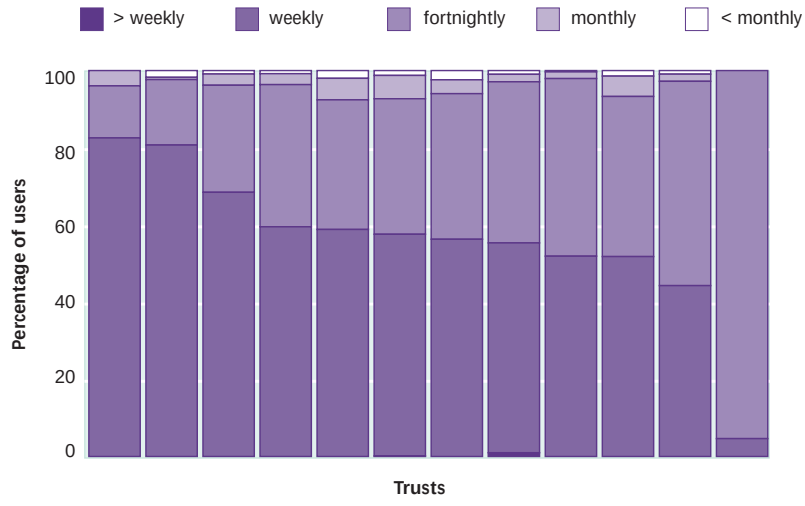
Source: Auditors' data collection

Frequency of contact

If caseloads are being actively managed there is likely to be a mix of frequency of contact according to people's different needs. This is not the case in all trusts. For example, in one trust 95% of people are seen fortnightly, suggesting this is service-led rather than responsive to individual needs (Exhibit 23).

Exhibit 23: Frequency of contact with community mental health staff

Some trusts appear to have standardised frequency of contact.



Source: Auditors' data collection

In the main, trusts are prioritising people with serious mental health problems but caseloads need to be managed effectively. Clear operational policies for community mental health staff should be in place, and the workload of these staff should be regularly monitored and reviewed. This will help ensure that resources are being targeted appropriately[36], staff are adequately supported and have caseloads which enable them to respond to users' needs.

These data provide a snapshot picture of community mental health caseloads. Similar analysis could be applied usefully to social work caseloads. These types of comparisons could be developed by NHS trusts, and others, into benchmarks to examine the operational reasons for differences in performance[37].

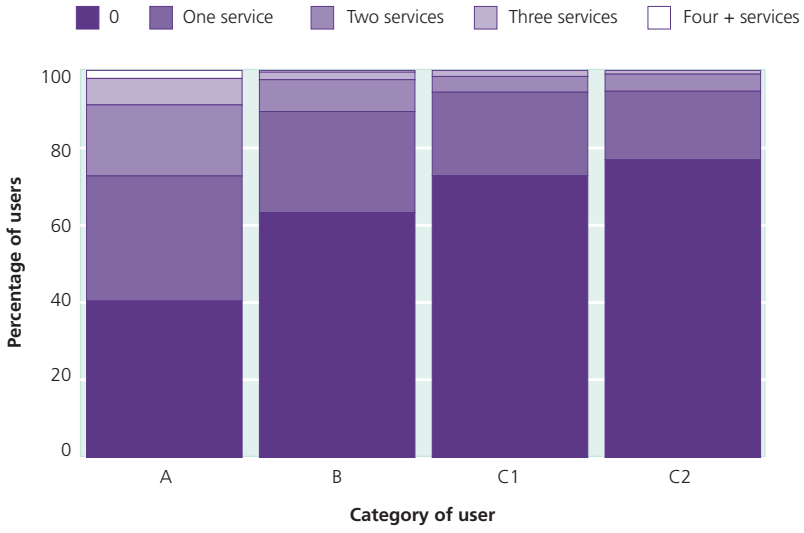
Users' contact with other community services

Community mental health staff were asked to provide information about the other community services (excluding contact with GPs and psychiatrists) that people on their caseload received. These ranged from debt counselling and attendance at drop-in centres and training schemes to intensive supported housing. The data are not weighted for the importance of the other services, but they do provide a starting point for examining community provision.

Of the people for whom information was provided, two in five were reported as receiving other services, with the majority of these receiving one additional service. There was little variation between trusts. People with severe mental health problems were more likely to be receiving other community services. However, overall many people were reported as receiving a limited number of services in the community (Exhibit 24).

Exhibit 24: Number of other community services received

A large percentage of people with severe mental health problems were reported as receiving no other community service.



Source: Auditors' data collection

People on the Care Programme Approach

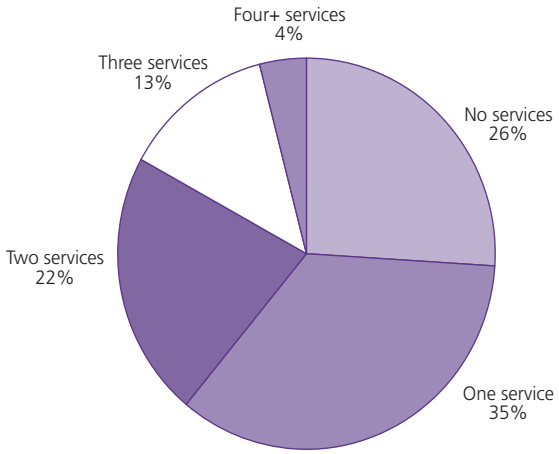
The Care Programme Approach (CPA) is designed to support people with major mental health problems who require a complex, inter-agency, multi-disciplinary package of care. A joint survey carried out by SWSI and the Accounts Commission found that just under 900 adults were in receipt of the CPA in 1997, and that there was wide variation across Scotland in the extent to which the CPA had been implemented[38].

In our survey, of nearly 300 people with a CPA, community mental health staff reported that just over a quarter receive no other community service (Exhibit 25). Since it is unlikely that someone who needs the CPA would be receiving no other community service, this suggests that community mental health staff may be unaware of the other services received by those on their caseloads. This raises concerns about the quality of inter-agency co-ordination of care for some people on the CPA – the very group of vulnerable people who have been identified as most needing 'joined-up' care.

"A vulnerable person should not be more vulnerable because more than one agency is involved. In fact if we target services to meet particular needs, each person should receive better care."
The Scottish Office: Modernising community care.

Exhibit 25: The number of community services received by people with a CPA

Just over a quarter of people on the CPA were reported as receiving no other community service.



Source: Auditors' data collection

Recommendations

Clinical governance provides a framework and culture for reviewing practice. Primary care trusts should be ensuring that secondary mental health services are targeted on those with severe and/or enduring mental health problems.

Regular reviews and, where necessary, action should be undertaken on:

- *the use of in-patient beds, distinguishing between acute, rehabilitation and long stay beds*
- *the source and timing of hospital admissions*
- *reasons for re-admissions*
- *reasons for compulsory admissions and detentions.*

Clear operational policies for community mental health staff should be in place. The workloads of community mental health staff should be monitored to ensure that:

- *people with severe and/or enduring mental health problems are prioritised*
- *the size and composition of community caseloads are manageable and staff are adequately supported*
- *the time spent on the caseload and the frequency of contact reflect individual need.*

The above information on the use of in-patient beds and community mental health services should be used to inform service planning and development, and facilitate benchmarking between trusts.

The secondary mental health services should work closely with primary care to ensure that appropriate referral policies to secondary care are in place. In addition, support should be provided to primary care in managing mental health problems.

The quality of community information needs to be improved. Providers should ensure that the care plans of people who need complex inter-agency packages of care are integrated. The plans should clearly identify who is providing which elements of care (in both the statutory and independent sectors) and demonstrate an inter-agency approach to monitoring and review. Care planning should be regularly audited.

Factors which can affect the rate of detention should be monitored at a local level.

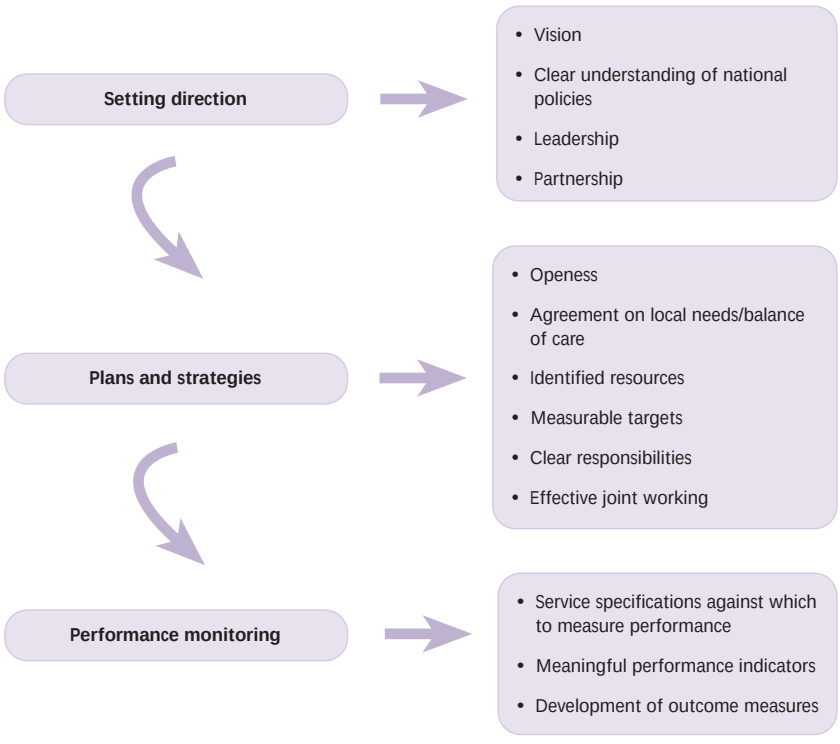
Joint planning and performance monitoring

This chapter examines the way in which local agencies work together to plan services and monitor performance. No single agency can commission or provide all the elements of a comprehensive mental health service. Thus, in order to develop services which meet users' needs in a flexible and responsive way, agencies must have a co-ordinated approach to commissioning and delivering local mental health services.

The '*Framework for mental health services in Scotland*' required all areas to develop local mental health strategies and plans. For these plans to be effective there should be a clear direction or vision. There also needs to be enough detail to provide assurance that plans can be achieved in practice, and to allow for progress and service performance to be monitored (Exhibit 26).

"Different agencies and services must, as far as possible, work together as if they were one organisation, driven by the needs of clients; and their programmes must be designed to contribute to an effective, integrated approach."
The Scottish Office: Social inclusion.

Exhibit 26: Aligning direction, mental health strategies and performance monitoring



Source: Adapted from '*The measures of success*', Accounts Commission, 1998

"Local authorities and their partner agencies need to introduce arrangements which develop a joint strategic view of goals and intended results. They then need to make sure that joint spending and other decisions achieve these goals."
The Scottish Office: Modernising community care.

Setting direction

The service elements section of the '*Framework for mental health services in Scotland*' is intended to be used as a template by which local agencies can measure progress in reconfiguring services, and could be used as a benchmark for service provision across Scotland.

There will be differences in the way mental health services are prioritised and implemented at a local level. Irrespective of local differences, the process of setting direction should involve not only officers of the different agencies, and users and their carers, but also elected members who have key decision making powers over resource allocation, and non-executive directors of health boards.

Plans and strategies

In this section we consider how agencies are working together in the areas of:

- planning
- needs assessment
- service reviews
- setting targets in plans.

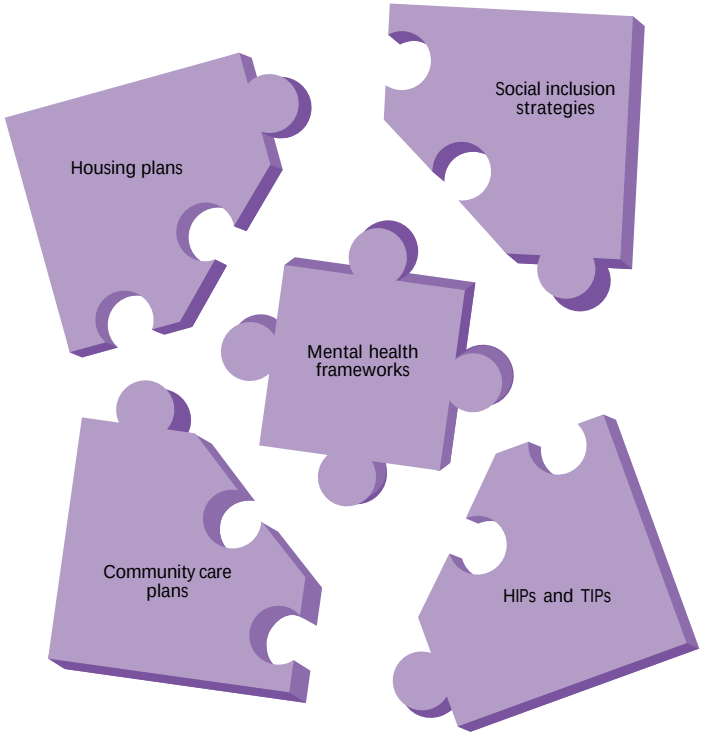
Joint planning

Over the past few years the number of formal plans required of health boards, trusts and local authorities has increased. Those which involve mental health service planning include mental health framework plans and strategies, community care plans, housing plans, health improvement programmes (HIPs), trust implementation plans (TIPs) and community plans. Drug action strategies and the learning disability framework are also national planning requirements that will affect mental health services.

Lead agency responsibility varies between these plans, as do financial planning cycles, and yet similar information is needed for each (Exhibit 27).

Exhibit 27: Integration of plans

Mental health service planning should be integrated and complementary.



Given this multiplicity of planning, care must be taken to minimise the risk of parallel planning, where a few groups or agencies move in the same general direction but do not properly integrate their activities. This leads to duplication and risks missing the most effective way of developing services. Our review found limited involvement by local authorities in the production of the early HIPs and TIPs.

One way to simplify the planning task is for agency-based mental health plans and associated resources to be detailed in the joint mental health framework plan. All other planning documents can then cross refer to this document. Grampian Health Board and Aberdeen City Council have taken this approach. This is more complicated where health board, NHS trust and local authority boundaries are not coterminous.

The needs of people with the most severe mental health problems should take priority when planning services. However, it is important that local mental health strategies and plans cover the whole spectrum of mental health services, including primary care and health promotion. The development of local health care co-operatives provides health boards, and their planning partners, with identifiable groupings of GPs to consult with on planning and improving mental health service delivery at a local level. Local health promotion targets for mental health, aimed at increasing understanding and reducing stigma, can also contribute to social inclusion strategies.

Adequate housing strategies for people with mental health problems are particularly important. Most people with mental health problems, including those with severe mental illness, live in ordinary housing, although they may need help to continue to do so. In addition, as long stay beds close, in line with government policy and agreed local mental health strategies, there is a need for a range of supported accommodation options. It is important that sufficient 'lead in' time is allowed for developing housing projects, as they can take several years to come on stream because of a range of factors including:

- consultation with local communities
- different funding arrangements
- time needed to adapt housing.

"Care packages count for nothing without good housing, and the best housing is to no avail without appropriate care."
Audit Commission: 'Home alone: the role of housing in community care'

Local mental health and housing plans should therefore include detailed assessments of the need for supported accommodation and other housing support required by people with mental health problems in their area, with realistic time scales given for developing these services[39]. Indicative costings, collected in a standard way, should also be included, with sources of funding jointly identified by planning partners (see Appendix 2 for some indicative costs of supported accommodation projects).

More generally, in order to be useful working documents, mental health plans should include details of:

- the level of current and projected resources and activity
- the need for services
- service reviews in line with Best Value
- the way in which services are to be developed with clear targets and identified people/agencies responsible for implementation.

"The links have not been strong enough between strategic and resource decisions and decisions about people's needs.."
The Scottish Office: Modernising community care.

Needs assessment

Assessing the level of mental health need in a population is a basic pre-requisite for effective service planning. It requires a mix of 'top down' information – epidemiological, prevalence and morbidity data – and 'bottom up' analysis of the needs of current service users and those who are not currently in contact with services[40, 41].

Epidemiological data are useful as they can help to provide an overall estimate of needs in the community. Adjustments can be made using deprivation-weighted indicators for circumstances which may affect local need, such as a large homeless population or higher than average levels of unemployment. These data have their limitations; they are broad and cannot indicate which services are needed.

Comparing information on local service use with national data can also be useful in assessing the relative number of contacts for specific elements of local service provision. The limitation of this approach is that national figures relating to service use cannot be assumed to represent ideal levels of provision, as they will be affected by the pattern of local services and clinical and other professionals' practices.

Our review found that local needs assessment is primarily based on extrapolation from national prevalence and morbidity data, although some areas, such as Glasgow[42], have carried out more detailed needs assessment work.

In addition to epidemiological and service use data, planners need information about the needs of current users, including a record of their unmet needs and outcomes of care. Attempts should also be made to identify (through channels such as GPs and housing agencies) people with serious problems who are not currently in contact with specialist mental health services, but who may require services in the future. This process requires an inter-agency approach to needs assessment. Agreement is also required on a practical definition of severe and enduring mental illness, which is required as a basis for setting priorities and allocating resources.

Commissioners and providers need to share information from a variety of sources including individual care plans, subject to the Caldicott guidelines[43]. This is no easy task:

- information is recorded in different ways between and within different agencies
- information systems are not necessarily compatible
- care plans will vary in their level of detail and whether they record information on outcomes and unmet needs, and
- confidentiality needs to be assured.

CPA, for those with the most severe problems, and multi-disciplinary, inter-agency community mental health teams provide a focus for the development of shared care plans and data sets. These data can be aggregated to inform the planning process.

Service reviews

In order to prevent duplication of services or gaps in provision it is necessary to have a clear map of existing provision across all agencies. At the time of our review, with the exception of one health board and its planning partners, all areas had carried out such a mapping exercise.

Commissioners of services also need robust information on the quality, cost and efficiency of local services in order to change and develop services. This information is not always readily available, limiting commissioners' ability to plan effectively (see Appendix 2 for further information on costs of mental health services).

Best Value provides a framework for evaluating services with an emphasis on:
- providing the most effective services to meet need
- developing and using performance indicators on quality, cost and service efficiency
- achieving continuous improvement in services through techniques such as benchmarking
- an inclusive approach to working with users, carers, local communities and providers.

The four core questions for a Best Value service review are:
- How do we know we are doing the right things?
- How do we know we are doing things right?
- How do we plan to improve?
- How do we account for our performance?

These questions are applicable to health and social care services. As few local authorities have prioritised mental health services for review an important opportunity remains for local agencies to take joint commissioning a stage further, and undertake an integrated review of local social and health care services for people with mental health problems.

Setting targets in plans

Commissioners of services should monitor mental health plans to ensure delivery against stated objectives. Plans, therefore, need to provide information about:
- how services will be reconfigured or developed
- time scales for completion
- who is responsible for ensuring that any action outlined in the plan is completed.

The quality of plans reviewed as part of this study was mixed. It is often harder to change or re-configure services than it is to develop new ones. Although some plans provided enough information on this, many plans provided very little detail on the process by which major changes in service delivery were to be achieved; how new services were to be financed; and the time frame within which these changes were to happen. Many plans were also weak on providing mechanisms by which progress could be monitored, and agencies held accountable for performance.

Performance monitoring

Performance monitoring needs to take account of the complex inter-agency, multi-disciplinary environment in which mental health services are delivered, and the potential difficulties that this can create for users and their carers in accessing services and obtaining integrated packages of care.

Effective monitoring requires:

- clear and focused service specifications based on proven effectiveness and good practice
- robust performance indicators, including standards relating to access to services and joint working
- participation of users and carers
- valid outcome measures.

Service specifications

Service specifications serve two distinct purposes. They give providers a clear statement of the service they should provide, and purchasers formal standards against which performance can be monitored.

The '*Framework for mental health services in Scotland*' states that service specifications should be in place for mental health services. Auditors found that two thirds of health boards did not have service specifications for adult mental health services and not all were prioritising the development of these. Some of these boards had general service quality standards that were applied to all services; others had none that could be related to mental health.

Over the past few years the Clinical Resources and Audit Group (CRAG) has published a number of good practice guidelines on care and treatment in the health service of people with mental health problems[44, 45, 46]. These provide agreed quality standards against which practice can be measured. Less than half the health boards are using these in their local agreements with trusts, or monitoring whether they are being implemented.

More specifically, a number of health boards had no formal agreement that trusts implement the Care Programme Approach (CPA) despite this being a national requirement. However, we did find some examples of good practice in using the CPA to improve standards of care and inter-agency working (see boxes below).

Using the CPA to develop inter-agency working

Within Clackmannanshire the three existing community mental health teams (CMHTs), comprising health, housing and social work staff, were used as a basis for developing the CPA and agreeing a joint assessment protocol. Planning is further underway to extend the CMHTs' remit to include an intensive assessment and provision service for all people with severe and enduring mental health problems who require rehabilitation in the community.

Auditing the implementation of the CPA

An inter-agency audit has been carried out in Fife to evaluate the effectiveness of CPA in:

- providing a network of care to prevent people being lost to the service
- providing early intervention in the case of relapse
- minimising hospital admissions and maintaining people for longer periods in the community.

As a result of the audit, action has been taken to improve the implementation of some aspects of the CPA locally.

Local authorities are developing their commissioning role. There is an opportunity, in the context of Best Value, to develop a shared approach to commissioning and the specification of services in the mental health field. The Commission is currently undertaking further work on local authorities' arrangements for commissioning community care services.

Performance indicators and outcome measures

Performance measurement is essential for demonstrating accountability, value for money, best value and for measuring improvements in services. Identifying valid and reliable performance and outcome measures for mental health services is difficult, and consequently they have been slow to develop. As discussed in the previous section, Best Value service reviews provide a framework and opportunity for developing quality, cost and efficiency standards for individual services.

Currently, many of the measures used are agency specific and focus on things that can be easily counted, such as the number of:

- community care assessments for people with mental health problems
- assessments of carers' needs
- community mental health staff contacts with patients
- out-patient appointments
- finished consultant episodes.

Although useful as broad indicators of service activity, these give no information on the quality of the service, the effectiveness of local inter-agency working or the outcome of the interventions.

There are several national initiatives considering performance and outcome measures for mental health services. These include:

- groups looking at management information, performance indicators and clinical information systems
- the development of a national dataset to allow benchmarking
- the development of clinical quality standards
- a study of outcomes in adult mental health, using the Health of the Nation Outcome Scale (HoNOS)[47] and the Avon Mental Health Measure[48].

It is important that these initiatives are co-ordinated and that consideration is given to both health and social care services.

Significant work on indicators for mental health services and joint working has also been carried out in other parts of the United Kingdom[49, 50, 51]. Local initiatives, such as the use of time limits for assessments in East Ayrshire Council and Lothian Primary Care Trust, quality standards for MHO work in Falkirk Council and the development of care pathways led by Fife Health Board (see box overleaf), also need to be more widely shared. In addition, the indicators used in this report provide a starting point for assessing the extent to which services are targeted on people with the most serious and enduring mental health problems.

Developing care pathways for people with mental health problems

Fife Health Board has established mental health specialty liaison groups to prepare detailed service specifications – 'care pathways' – for enduring mental illness and depression. These groups have representation from clinicians, including GPs, and service users. The care pathways specify the total service that a user should receive from the initial visit to primary care through to treatment by the secondary care services. This forms the basis of quality standards to be delivered.

Auditing these care pathways and identifying where, and why, care differed from that outlined is a valuable means of achieving continuous improvement in service delivery.

Some of the performance indicators on service efficiency can be used as proxy measures of quality, for example time from referral to assessment to the receipt of services. Although these provide a good basis for working with providers to compare performance and benchmarking between different providers, there is also a need for more robust quality and outcome measures, which are user centred. The value of involving users in identifying quality standards is illustrated by the Patients' Council at the Royal Edinburgh Hospital, which has produced useful literature and training materials for improving standards in hospital services to meet users' needs[52].

"Action to promote social inclusion must be based on a solid understanding of 'what works'."
The Scottish Office: Social Inclusion

A previous working group looking at outcomes for mental health services[53] recommended that desired outcomes are best established by users themselves. For this to be achieved in practice users must:

- be involved in their own care planning
- receive full information on service options
- be involved in evaluating the services they receive
- have access to an advocate if desired.

Recipients of services, and those who care for and support them, have a key role to play in identifying how well services meet their needs.

Recommendations

Mental health plans should cover the whole spectrum of mental health services, including primary care and health promotion. They should include:

- *an analysis of the mental health needs of the local community*
- *a comprehensive picture of current services, including the range of supported housing*
- *the way in which services address local needs*
- *the cost of existing services (discussed in more detail in chapter 3)*
- *current service utilisation*
- *unmet needs and gaps in services*
- *proposed service development including time scales for completion (particularly important for housing services which may take longer to develop than than other services), indicative costs and funding sources*
- *clear targets with an identification of those responsible for implementation.*

Elected members of local authorities and non-executive members of health boards should be actively involved in setting strategic direction for mental health services.

Parallel planning should be avoided. The mental health component of different plans should derive from the local mental health framework. A corporate approach should be taken to developing mental health plans and services, and ensuring that these link to other strategies such as those for promoting social inclusion and local community plans.

Local Best Value mental health service reviews should cover both social and health care services. These reviews offer the opportunity to adopt an inter-agency approach to:

- *commissioning*
- *developing service specifications*
- *involving users and their carers in setting quality standards*
- *agreeing, in liaison with providers, service costs and performance indicators on service efficiency.*

Existing good practice, such as the CRAG guidelines on the care and treatment of people with mental health problems, should be used as a basis for developing service specifications in the health service.

Health boards and local authorities should explicitly require all statutory providers to implement the care programme approach for people with complex health and social care needs. Providers and commissioners should monitor compliance.

Performance indicators for joint working in mental health services should be developed and monitored.

Users should determine outcome measures for their own care plans. These should be used, in conjunction with other clinical and social care outcome measures, to judge the effectiveness of individual care packages. Care plans should include a record of unmet needs for planning purposes.

CPA and community mental health teams should be central to the development of shared information, which can be aggregated for use in needs assessment and planning.

Looking forward

Adult mental health services are in a period of development and change, with a move towards comprehensive community-based provision in line with the care in the community policy and the objectives outlined in the '*Framework for mental health services in Scotland*'. This development is likely to be hampered by a lack of full and accurate information on resources, service performance and outcomes for individuals.

In order to achieve positive change in adult mental health services, and ensure that resources are used effectively with an appropriate balance and mix of services, the principles of Best Value and clinical governance provide useful frameworks.

"... [Best Value's] principles extend to other agencies, including health boards. Developing sound strategic frameworks, other frameworks and financial infrastructures, focusing on the community care £, and effective working arrangements are even more important across the agency boundaries in community care."
The Scottish Office: 'Modernising community care'.

Although Best Value is currently focused on local authorities the inter-agency nature of community care, and moves towards joint commissioning between health boards and local authorities, make it equally applicable to other agencies. The emphasis should be on:

- developing services which are cost effective
- achieving continuous improvement in services by comparing the performance of different providers (for both health and social care)
- assessing quality from the perspectives of those who receive services, thus emphasising the role of service users and their carers in planning and delivering services
- being openly accountable to local communities for decisions made and services provided.

For clinical governance to work effectively, a structured framework needs to be in place, linked to the trust's corporate agenda. This framework should cover all the trust's activities, including service provision, training, action on poor performance, and the implementation of evidence-based practice.

The achievement of Best Value and effective clinical governance in adult mental health services relies on the provision of full, accurate and shared information between agencies, and people who use services, on:

- local needs
- available resources
- cost and quality of current services
- efficiency of services, using agreed performance measures
- outcomes for individual service users.

Without this information it is difficult to plan and manage services effectively, to ensure accountability or to argue the case for more resources from an evidence-based perspective – particularly relevant in mental health services where the pace of community development has been relatively slow.

In practice, however, collecting information on needs, services and users can be expensive and time-consuming. Focusing activity on areas of most importance and sharing information locally can help to prevent duplication and reduce costs. For example, some local authorities and health bodies are working closely together to identify needs, and already share full information on the level and use of resources across agencies. Some local authorities and a few health boards and trusts are developing standards for the services they provide or commission, although few of these relate to inter-agency working.

Further action is now required, at both national and local levels, to develop user-centred information systems, which can provide information on the costs of individual care packages, outcomes and the unmet needs of people with mental health problems.

The Framework has been instrumental in moving the mental health agenda forward. The challenge is to maintain the momentum, and build on examples of good practice in planning and delivering services and involving users and their carers. Alongside this, there is a need to ensure that:

- the plans required of local agencies are co-ordinated
- special funding mechanisms are co-ordinated so that the development of local services is not fragmented
- local progress continues to be encouraged and monitored.

The focus of this report has been on specialist adult mental health services provided by health and social care agencies, and the way in which they are targeted at people with the most severe mental health problems. Given the scale of primary care activity in the field of mental health, there is also a need to develop the support available to primary care and ensure that local mental health strategies and plans cover the whole spectrum of mental health care.

The final challenge is to ensure that services meet the needs of all people with mental health problems so that they can play an active role in their communities and live as independently as possible.

Action plan

User and carer involvement

Commissioning bodies should:

- *involve people with mental health problems and their carers in the development of local mental health strategies. To be of value this involvement needs to be on an on-going basis.*
- *provide practical support for advocacy services*
- *ensure that mental health plans and strategies include an analysis of carers' needs and the means of addressing these.*

Providers should:

- *involve users and carers in monitoring and evaluating services*
- *provide information about treatment options and services to all users*
- *ensure that users are actively involved in developing their own care plans*
- *provide sustained and consistent support to carers.*

Expenditure

To match services more effectively to local needs there should be complete transparency on current expenditure by all agencies. A detailed examination of all available resources for mental health should be carried out. Local agencies should jointly:

- *review the current balance of expenditure on different services*
- *examine the possibility of substituting alternatives to maximise cost effectiveness, especially within a full range of supported accommodation*
- *agree and detail current and projected bed numbers (by type of bed - intensive care, acute, rehabilitation and long stay) to ensure that there is no confusion about the current or proposed in-patient service*
- *agree and detail the services to be provided in primary care, community mental health and social care as long stay beds are closed*
- *ensure that grant-aided projects are compatible with local mental health framework plans and strategies*
- *identify estimated costs of, and funding sources for, any proposed service developments.*

A standard methodology for calculating service costs should be used to ensure like-for-like comparisons.

Primary care trusts should examine the link between the rate of prescribing psychiatric drugs and the level of mental health service provision available locally. This information should be fed into the joint planning process.

Targeting resources

Clinical governance provides a framework and culture for reviewing practice. Primary care trusts should be ensuring that secondary mental health services are targeted on those with severe and/or enduring mental health problems.

Regular reviews and, where necessary, action should be undertaken on:

- *the use of in-patient beds, distinguishing between acute, rehabilitation and long stay beds*
- *the source and timing of hospital admissions*
- *reasons for re-admissions*
- *reasons for compulsory admissions and detentions.*

Clear operational policies for community mental health staff should be in place. The workloads of community mental health staff should be monitored to ensure that:

- *people with severe and/or enduring mental health problems are prioritised*
- *the size and composition of community caseloads are manageable and staff are adequately supported*
- *the time spent on the caseload and the frequency of contact reflect individual need.*

The above information on the use of in-patient beds and community mental health services should be used to inform service planning and development, and facilitate benchmarking between trusts.

The secondary mental health services should work closely with primary care to ensure that appropriate referral policies to secondary care are in place. In addition, support should be provided to primary care in managing mental health problems.

The quality of community information needs to be improved. Providers should ensure that the care plans of people who need complex inter-agency packages of care are integrated. The plans should clearly identify who is providing which elements of care (in both the statutory and independent sectors) and demonstrate an inter-agency approach to monitoring and review. Care planning should be regularly audited.

Factors which can affect the rate of detention should be monitored at a local level.

Joint planning and performance monitoring

Mental health plans should cover the whole spectrum of mental health services, including primary care and health promotion. They should include:

- *an analysis of the mental health needs of the local community*
- *a comprehensive picture of current services, including the range of supported housing*
- *the way in which services address local needs*
- *the cost of existing services*
- *current service utilisation*
- *unmet needs and gaps in services*
- *proposed service development including time scales for completion (particularly important for housing services which may take longer to develop than than other services), indicative costs and funding sources*
- *clear targets with an identification of those responsible for implementation.*

Elected members of local authorities and non-executive members of health boards should be actively involved in setting strategic direction for mental health services.

Parallel planning should be avoided. The mental health component of different plans should derive from the local mental health framework. A corporate approach should be taken to developing mental health plans and services, and ensuring that these link to other strategies such as those for promoting social inclusion and local community plans.

Local Best Value mental health service reviews should cover both social and health care services. These reviews offer the opportunity to adopt an inter-agency approach to:

- *commissioning*
- *developing service specifications*
- *involving users and their carers in setting quality standards*
- *agreeing, in liaison with providers, service costs and performance indicators on service efficiency.*

Existing good practice, such as the CRAG guidelines on the care and treatment of people with mental health problems, should be used as a basis for developing service specifications in the health service.

Health boards and local authorities should explicitly require all statutory providers to implement the care programme approach for people with complex health and social care needs. Providers and commissioners should monitor compliance.

Performance indicators for joint working in mental health services should be developed and monitored.

Users should determine outcome measures for their own care plans. These should be used, in conjunction with other clinical and social care outcome measures, to judge the effectiveness of individual care packages. Care plans should include a record of unmet needs for planning purposes.

CPA and community mental health teams should be central to the development of shared information, which can be aggregated for use in needs assessment and planning.

Appendix 1 Cost effective mental health services

In order to assess whether services are cost effective both the costs and outcomes of care must be considered. We reviewed the UK literature since 1990 for economic evaluations of alternative forms of care in mental health, excluding those relating to comparisons of drug interventions. We found that there is a dearth of easily accessible information upon which to base planning decisions.

Our literature review found only a small number of economic evaluations which dealt with care in different settings. These are shown in Exhibit 1. The lack of evaluations in this area is surprising, reflecting possibly the lack of formal analysis of innovative models of care. In the light of this, evidence-based planning is likely to be difficult.

Exhibit 1: Economic evaluations of alternative forms of mental health care

Intensive case management (ICM) vs. standard mental health services (in-patient, out-patient, day care and CPN service)
No difference in clinical outcomes, but a higher proportion were still in contact with the service after 18 months. ICM increased level of service use and was associated with average costs three times higher than standard services. ICM teams may be necessary for most severely ill but achieve limited improvements in outcomes for very high costs (Ford et al 1997).

Daily living programme (DLP - problem oriented multi-disciplinary home-based care for people with severe mental health problems) vs. standard in-patient care with out-patient follow up
In the short term (up to 45 months) DLP is associated with lower costs and similar outcomes. No shift in responsibility to other agencies or patients / families. DLP is therefore cost effective in the short term (Knapp et al 1994). In the longer term, the cost effectiveness advantage may be lost (Knapp et al 1998).

Day vs. in-patient hospital care
No significant differences in outcomes. Costs for day hospital patients were significantly less than IP care. Day care therefore found to be cost effective for the 30% of patients who are appropriate for this type of care (Creed et al 1997).

Case management by community support teams (CST) vs. generic CPN care
Minor differences in clinical outcomes, CST costs lower than generic care. In short term therefore CST more cost-effective. In long term no cost/outcome advantage (McCrone et al 1994).

CMHT vs. hospital-based follow up
No significant difference in outcomes, greater patient satisfaction with CMHT. CMHT significantly lower costs, hence CMHT is cost effective. Total cost of CMHT service is higher because a greater number of patients are treated with CMHT follow up (Goldberg et al 1996).

Home-based care by CMHTs vs. standard mental health care (routine or urgent out-patient assessment or domiciliary visits as clinically indicated)
No significant differences in clinical or social outcomes. Significantly lower treatment costs for CMHT care, hence CMHT care is cost effective, even in the medium term (Burns et al 1993).

Counselling vs. usual GP care for patients with minor mental health problems
No difference in outcomes at four months and no clear cost advantage. Hence, counselling is not cost effective (Harvey et al 1998).

Only day hospital care when compared to in-patient care, and community mental health teams compared to generic CPN care and standard care, have been shown to be cost effective. Other services, such as case management by community support teams and the daily living programme, when compared to standard care, are cost effective only in the short term. Counselling in primary care and intensive case management were shown not be cost-effective, although the authors of the case management study conclude that '*ICM teams may be necessary for the most severely ill*'.

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Appendix 2 Costs of adult mental health services

Introduction

As the focus of adult mental health services shifts from hospital to community-based care, a major issue for service planners is the provision of high quality information relating to costs of mental health services. Knapp & Beecham (1990a) suggested that cost evaluations should be based on four principles:

- costs should be comprehensively measured across all relevant services
- cost variations should be examined
- like-with-like comparisons should be made
- cost information should be integrated with information on outcomes.

Using these principles as a guide, this section provides an overview of the current availability of cost information and aims to identify a range of cost estimates which could inform the planning of alternative service provision. Integrating cost information with outcomes is the least developed aspect as shown in appendix 1.

Two major sources of information were used to derive estimates of costs of adult mental health services:

- the UK literature since 1990, including published papers, reports and conference proceedings relating to service provision and costs
- information from the Commission's own audit of mental health services in Scottish trusts, health boards and social work authorities.

"Despite its central importance, there is a dearth of information on the costs of different forms of residential accommodation, both direct costs and the consequences for other budgets."
Chisholm et al. 1997b

This type of information allows those planning services to identify the likely cost consequences of changing the current pattern of service delivery. A similar exercise in London used estimates of relative costs for different services to construct scenarios indicating the cost consequences of a number of alternative service configurations under different sets of assumptions (Chisholm et al, 1997a).

Costs of individual services

Exhibit 2 shows the range of costs of individual services. These figures must be interpreted with a good deal of caution:

- there is no assessment of the quality of care provided
- the items included in cost estimates may range between settings and the handling of overheads may vary
- actual reported costs have been updated to current values using the standard inflation rate. This rate may be different to the actual inflation rate experienced in the various settings
- some of the services costed may no longer exist, or have changed materially over the period.

At best, therefore, these should be considered as indicators of the order of magnitude of costs. All costs relate to services in Scotland unless otherwise stated. In each section the services are grouped by provider and then by cost.

Description of service (reference)	Provider	Type of clients	Year	Units	Cost estimates (1998/99 values)	General comments
Support provided in own home						
Community mental health team worker (Netten & Dennett 1996)	NHS	Adult MH	1995/96	cost per hour of user contact	£66	Based on study in England by Onyett et al. Client contact: non client contact 1: 1.8
Community psychiatric nurse visits (ISD 1998)	NHS	Unknown	1997/98	cost per visit	£34	Average of 25 providers. Range £19-£80
Home support and day service (SWSI 1995)	Voluntary	Unknown	1995	cost per user / week	£20	Average 200 users per week.
Intensive case management (Ford 1997)	NHS	Clients with severe and persistent difficulties	1990/91	cost per user per 18 months	£11,492	Multi-disciplinary assertive community care in London. Did not provide specific treatments and did not have a psychiatrist on the team n=39.
Out of hours crisis response (Auditors' data)	NHS	Adult MH	1995/96	cost per contact	£242	
Out of hours crisis service (Auditors' data)	NHS	Adult MH	1995/96	cost per contact	£31	Majority of calls 5-9pm, but 24-hour cover provided by two CPNs.
Outreach support team (AC review)	Voluntary	Mental illness	1998/99	cost per user / week	£174	Six people who get more than ten hours visiting per week.
Outreach support team (AC review)	Voluntary	Mental illness	1998/99	cost per user / week	£230	Less than ten hours per week.
Transitional intensive home care post discharge (Auditors' data)	NHS	Adult MH	1995/96	total cost	£15,972	Support lasts between six weeks and one year, provided by ward staff. Usually only one patient at any one time.
Peripatetic day and home support service (SWSI 1995)	Local authority	Unknown	1995	cost per user / week	£70	Average 45 users per week.

Description of service (reference)	Provider	Type of clients	Year	Units	Cost estimates (1998/99 values)	General comments
Community services						
Befriending (AC review)	Voluntary	Adult MH	1998/99	cost per user / week	£35	
Clubhouse (AC review)	Local authority	Severe and enduring mental illness	1998/99	cost per user / week	£150	
Clubhouse model (Hallam & Schneider 1999)	Unknown	Long term mental illness	1994/95	gross cost per place	£7051	English service. 31 places, average hours worked = 20
Day care (Netten & Dennett 1996)	Local authority	MH problems	1995/96	cost per user / day	£36	Based on returns from 54 English LAs. Average occupancy 80%. Interdecile range £11 to £41.
Day service (SWSI 1995)	Voluntary	Unknown	1995	cost per user / week	£27	Average 25 users per week.
Day service and drop in centre (SWSI 1995)	Housing Association	Unknown	1995	cost per user / week	£14	Average 75 users per week.
Day service and some drop in (SWSI 1995)	Voluntary	Unknown	1995	cost per user / week	£15	Average 140 users per week.
Daycare - OT horticulture and rehab (Auditors' data)	NHS	Adult MH	1995/96	cost per contact	£69	
Employment scheme (Auditors' data)	NHS	Adult MH	1995/96	total cost	£86,250	Covers furniture restoration, garden maintenance, clerical and shop work for 50 users per day.
Employment scheme 1 - industrial therapy offering full time work, relying on contracts (Hallam & Schneider 1999)	Unknown	Long term mental illness	1994/95	gross cost per place	£5479	English service. 21 places available, mean number hours worked per week = 35.
Employment scheme 2 - industrial therapy offering full-time work, relying on contracts (Hallam & Schneider 1999)	Unknown	Long term mental illness	1994/95	gross cost per place	£7292	English service. 50 places available, average hours worked = 32
Employment scheme 1 - range of productive activities including catering, printing, light assembly and packing (Hallam & Schneider 1999)	Unknown	Long term mental illness	1994/95	gross cost per place	£7487	English service. 54 places, average hours worked = 22.
Employment scheme 2 - range of productive activities including catering, printing, light assembly and packing (Hallam & Schneider 1999)	Unknown	Long term mental illness	1994/95	gross cost per place	£9095	English service. 56 places, average hours worked = 19.
Employment scheme 3 - range of productive activities including catering, printing, light assembly and packing (Hallam & Schneider 1999)	Unknown	Long term mental illness	1994/95	gross cost per place	£4338	English service. 60 places, average hours worked = 16.
Vocational rehabilitation scheme, providing training and acclimatisation to the structure of a working day (Hallam & Schneider 1999)	Unknown	Long term mental illness	1994/95	gross cost per place	£4612	English service. 41 places, average hours worked = 34.

Description of service (reference)	Provider	Type of clients	Year	Units	Cost estimates (1998/99 values)	General comments
Supported accommodation						
Residential care (group home) (Netten & Dennett 1996)	Local authority	MH problems	1995/96	cost per user / week	£68	Based on study of 23 group homes in England. Average 85% occupancy.
Residential care (staffed hostel) (Netten & Dennett 1996)	Local authority	MH problems	1995/96	cost per user / week	£310	Based on study of 20 hostels in England. Average 85% occupancy.
Residential care (group home with visiting staff during the day and on call/no night cover) (Lelliott et al 1996)	Mixed	Long term severe mental illness	1993/94	cost per resident / week	£158	Average across eight areas in England and Wales. Six or more residents.
Residential care (high staffed hostel with on call / no night cover and regular but not constant day cover) (Lelliott et al 1996)	Mixed	Long term severe mental illness	1993/94	cost per resident / week	£195	Average across eight areas in England and Wales. Six or more residents.
Residential care (high staffed hostel with sleep in night cover) (Lelliott et al 1996)	Mixed	Long term severe mental illness	1993/94	cost per resident / week	£268	Average across eight areas in England and Wales. Six or more residents.
Residential care (high staffed hostel with waking night cover) (Lelliott et al 1996)	Mixed	Long term severe mental illness	1993/94	cost per resident / week	£321	Average across eight areas in England and Wales Six or more residents.
Residential care (staffed care home with sleep in night cover) (Lelliott et al 1996)	Mixed	Long term severe mental illness	1993/94	cost per resident / week	£416	Average across eight areas in England and Wales. Six or more residents.
Dispersed Intensively Supported Housing Scheme (DISH) (Sainsbury Centre 1998)	NHS	Enduring MH problems and high support needs	1998	cost per user / year	£12,000	English service. 63 clients served by a seven-day service 9am-9pm, with telephone support out-of-hours. Clients receive at least three visits per week from their key worker or a small team of co-workers. Excludes housing costs.
Residential care (staffed hostel) (Netten & Dennett 1996)	Private	MH problems	1995/96	cost per user / week	£193	Based on sample of 33 hostels in England. Average occupancy 85%
Supported accommodation (not registered) (AC review)	Statutory (LA & Health)	Enduring mental illness	1998/99	cost per user / week	£472	
Supported accommodation (not registered) (AC review)	Statutory (LA & Health)	Enduring mental illness	1998/99	cost per user / week	£563	
Cluster accommodation (registered) long term (AC review)	Voluntary	Enduring mental illness	1998/99	cost per user / week	£121	
Residential care (group home) (Netten & Dennett 1996)	Voluntary	MH problems	1995/96	cost per user / week	£150	Based on survey of 33 homes in England. Average 95% occupancy.
Supported accommodation (registered) (AC review)	Voluntary	Severe and enduring	1998/99	cost per user / week	£215	48 places. Less than ten hours support.
Residential care (staffed hostel) (Netten & Dennett 1996)	Voluntary	MH problems	1995/96	cost per user / week	£277	Based on survey of 31 staffed hostels in England. Average 90% occupancy.
Supported accommodation (registered) long term care (AC review)	Voluntary	Unknown	1998/99	cost per user / week	£281	Five beds, 80% occupancy.

Description of service (reference)	Provider	Type of clients	Year	Units	Cost estimates (1998/99 values)	General comments
Supported accommodation (continued)						
Supported accommodation (registered) short / long term care (AC review)	Voluntary	Enduring mental illness	1998/99	cost per user / week	£335	Nine people, 37% occupancy.
Supported accommodation (registered) long term care (AC review)	Voluntary	Mental illness	1998/99	cost per user / week	£357	Six people, 89% occupancy.
Residential specialist care (registered) long term care (AC review)	Voluntary	Mental illness	1998/99	cost per user / week	£378	
Specialist respite care (registered) (AC review)	Voluntary	Enduring mental illness	1998/99	cost per user / week	£434	
Supported accommodation (registered) short / long term care (AC review)	Voluntary	Enduring mental illness	1998/99	cost per user / week	£453	Five people, 100% occupancy.
Supported accommodation (registered) (AC review)	Voluntary	Severe and enduring	1998/99	cost per user / week	£493	Nine places, 95% occupancy.
Supported accommodation (registered) long term care (AC review)	Voluntary	Chronic mental illness	1998/99	cost per user / week	£504	Ten people.
Supported accommodation (registered) long term care (AC review)	Voluntary	Enduring mental illness	1998/99	cost per user / week	£528	Six people 100% occupancy.
Supported accommodation (registered) (AC review)	Voluntary	Very severe and enduring	1998/99	cost per user / week	£576	Eight people (in mixed development), 100% occupancy.
Supported accommodation (registered) long term care (AC review)	Voluntary	Chronic mental illness	1998/99	cost per user / week	£664	Eight people, 100% occupancy.
Supported accommodation (registered) long term care (AC review)	Voluntary	Enduring mental illness	1998/99	cost per user / week	£732	Six people 100% occupancy.
Secondary healthcare services						
Out-patient clinics	NHS	Adult mental illness	1997/98	cost per attendance	£60.91	Average across 91settings. Range £6 to £786.
Day hospital care (ISD 1998)	NHS	Adult mental illness	1997/98	cost per attendance	£53	Average of 57 day hospital sites. Range £22 to £204.
In-patient care (ISD 1998)	NHS	Adult mental illness	1997/98	cost per IP week	£708	Average of 50 hospitals, includes all types of beds (acute, long stay etc). Range £559 to £1451.
Rehabilitation (day staffed accommodation) (Auditors' data)	NHS	Adult MH	1995/96	total cost for nine beds	£153,656	
Rehabilitation (day staffed accommodation) (Auditor's data)	NHS	Adult MH	1995/96	total cost for three places	£10,648	

One way of overcoming these problems is to use a standard method for calculating costs, such as that employed by Netten & Dennett in producing '*Unit costs of health and social care*' (PSSRU, 1996).

Methodology used by Netten & Dennett

- unit costs are derived from a variety of sources
- costs presented are national averages
- capital costs are based on assumptions of a 60 year lifespan for buildings and a discount rate of 6%
- capital costs are adjusted to reflect occupancy levels
- staff costs are based on the WTE staff in post, including employers on costs
- direct overhead costs include day-to-day expenses such as supplies, heating, stationery etc.
- indirect overheads include managing agency costs.

Costs of packages of care

As with the costs of individual services, there is a dearth of literature providing information on the costs of packages of care. The PSSRU and the Centre for the Economics of Mental Health (CEMH) have costed packages of care for patients leaving long stay psychiatric care. As part of this work, the Client Service Receipt Interview (CSRI) has been developed to ensure that like-with-like information is collected. CSRI is a research instrument to collect information on services received, service related issues and income. The resulting information forms the basis of calculation of the cost of care packages.

"Some of the most pressing questions about the replacement of long term hospital services with community-based care relate to the comparative costs of care in the two locations and the resource needs of people who are to be discharged."
Beecham et al. 1996.

CSRI structure

- background and client data
- accommodation (address, tenure, facility size, number of residents, amount paid by individual, receipt of housing benefit, staffing arrangements and managing agency)
- employment (earnings and other personal resources)
- service receipt (type, name and location of service, providing agency, frequency & duration of attendance, travel arrangements and charges made
- personal aids and appliances
- input of informal carers
- satisfaction

Exhibit 3 shows the relative costs for mental health service provision, identified using the CSRI. Community costs tend to be lower than hospital costs, although as patients with more complex needs are discharged, community care becomes increasingly expensive. This work identifies clearly the large number of services received in the community, although five core services accounted for more than 95% of costs. Overall, provision of supported accommodation was the biggest cost. The cost of such accommodation was found to be highest in NHS provision and lowest in voluntary provision.

Exhibit 3: Examples of care packages calculated using the CSRI

Reference (Year)	Location	Client group	Findings
Knapp et al (1990b)	London	• 136 patients in continuous residence for more than one year followed up for 12 months after discharge • Excluded those with dementia	• Community costs lower than hospital costs • Estimated mean community cost per week per person £321 (1986/87 prices) for full hospital population • Cost per patient per week in hospital was £434 / £384 (1986/87 prices) • Conclude that projected costs of community care are lower/ marginally lower than hospital costs
Knapp et al (1993) Hallam et al (1994)	London	• 341 long stay patients (continuous residence of more than one year) aged 23-98 • Excluded those with dementia	• Approximately 50% patients living in highly supported residential homes 12 months post discharge • Provision of accommodation accounts for more than 85% of total community care cost • Over 40 different services were used • 95% of costs accounted for by just five core services • 75% of people used GP services in first year, but contribution to total cost was <1% • Cost of community care estimated at £493 per week (1992/93 prices) • Steady increase in costs year on year as severity of illness of those discharged increased
Chisholm et al (1995) Knapp et al (1998)	England and Wales - eight districts	• 1904 residents with functional mental illness • Aged 18-65 • Study covered 340 facilities • Excluded nursing homes, learning disabilities facilities, hostels for homeless and forensic.	• Costs were compared across sectors and cost variations examined in relation to characteristics of residents • Costs are higher in NHS and LA facilities than in voluntary and private facilities, even after adjustment for resident characteristics • Total costs of packages of care per week (1993/94 prices) for residents outside London were £849 (NHS), £374 (LA), £272 private sector and £268 (voluntary)
Beecham et al (1996)	Northern Ireland	• 133 people with mental illness. • Covered nine hospitals	• Community care found to be substantially less costly than hospital cost • Mean weekly hospital cost was £563, compared with mean weekly community cost of £295 (1994/95 prices) • Wide range in costs of community care, partly explained by patients characteristics before they left hospital • Community care costs did not relate to subsequent outcomes

The following care packages are based on real case histories (Exhibit 4 overleaf). Names have been changed to maintain anonymity. The care packages illustrate the mix of services and the associated costs to support a person with significant mental health problems in the community. Actual costings were used where available, supplemented by additional information from Exhibit 2.

Costs of periodic hospital admissions and primary care are excluded from the costs, as are costs to users and their carers.

Conclusion

The Commission's work in this area has identified estimates which may give some idea of the orders of magnitude, but the figures need to be interpreted with a good deal of caution. There is a need for information to be made available which is collected in a systematic manner, using clear definitions and a standard method of costing.

Exhibit 4: Costed care packages

Fiona is a 30-year-old single woman. She has been in contact with mental health services since the age of 20, following the death of her mother. She is diagnosed as having manic depressive illness. From 1987 to 1996 she had numerous admissions to psychiatric hospitals, often precipitated by self-harming behaviour. She was detained in terms of the Mental Health (Scotland) Act 1984 in hospital for two years from 1994. On her discharge she moved to 24-hour staffed supported accommodation, administered by a housing association. Fiona moved to her own tenancy in February 1998, but this lasted only two months. Fiona moved to her present tenancy in April 1998. This is a shared flat owned by a housing association. She has remained very well and has had only three hospital admissions of two days duration in the past year. Fiona is very settled and has a good quality of life.

Her current care package is shown below:

Care package	Cost per week
Supported accommodation	Housing benefit
Care management (includes supervision 1 hour)	£33.55
Senior support worker 2 hours	£35.50
Support worker 7 hours	£70.00
Concessionary fares	£5.00
On call pager	£10.00
Befriending service	£35.00
Drop in centre	£14.00
CPN (1 visit per week)	£34.00
Medication	£2.00
Friendship club	£5.00
Out-patient appointment (three monthly)	£4.68
Total	**£248.73 + housing benefit**

Joan is a 46-year-old divorced woman. She has a daughter and one grandchild. She first came into contact with mental health services in 1995 having been referred by the pain management service. Joan was diagnosed as suffering from depression. She was in hospital from March 1995 until August 1995. Since that time she has had four short admissions, usually lasting approximately two weeks. She has discharged herself, against medical advice. She has never been compulsorily detained. Joan has her own tenancy, which she has maintained. Joan remains unwell.

Her care package is shown below:

Care package	Cost per week
Care management (includes supervision - 1 hour)	£33.55
Home help	£21.99
Crossroads	£13.00
Support worker	£13.40
Befriender	£35.00
Alarm system	£10.00
Drop in Centre	£14.00
Taxi to drop in centre	£8.00
Concessionary travel	£5.00
Out-patient appointment (monthly)	£14.06
Medication	£4.85
Support group	£6.30
Total	**£179.15**

Hamish is a 32-year-old man, separated from his wife in 1998. He first came into contact with mental health services in 1989, with an initial diagnosis of manic depression. In 1995 he was diagnosed with schizophrenia. Since the separation Hamish has found it increasingly difficult to cope alone and has requested a move to supported accommodation.

His care package is shown below:

Care package	Cost per week
Supported accommodation	£230.00
Care management	£40.00
CPN (1 visit per week)	£34.00
Medication	£4.00
Drop in centre	£30.00
Out-patient appointment (monthly)	£14.06
Supported employment scheme - one afternoon per week	£50.00
Total	**£402.06**

John is in his early 40s and is unmarried. He has good support from his parents, who live nearby. John lives alone in his own flat for which he pays full rent. John was diagnosed with schizophrenia in 1984.

His care package is shown below:

Care package	Cost per week
Activity centre - 3 sessions	£90.00
Community carer	£18.60
CPN (1 visit per week)	£34.00
Social worker	£10.00
Medication	£28.00
Out-patient appointment (monthly)	£14.06
Total	**£194.66**

Source: AC review

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Appendix 3 Information collected from NHS trusts

In-patient beds

For each patient on an adult psychiatric ward over a six month period the following information was collected:

- age
- primary diagnosis
- referral source
- admission date
- discharge date (if relevant)
- whether admitted under a section of the Mental Health (Scotland) Act.

These data were analysed to establish the pattern of usage in each of the participating trusts.

Comprehensive data were not available from all trusts. Thus some trusts may be missing from one or more of the exhibits.

Community caseloads

For each person with mental health problems on the staff member's caseload (4838 people), information was collected on:

- diagnosis
- frequency of contact
- length of contact
- history of mental health service use such as previous hospital admissions and contact with other services. Respondents were asked to list all other community services received by people on their caseloads.
- whether the person was considered to be at risk to themselves or others
- whether the person was on the Care Programme Approach.

Nearly a half of the total sample of people had been admitted to psychiatric hospital. Just under 200 people had spent more than an aggregate of one year in the past five years as an in-patient; and nearly one in five had been previously admitted to hospital under a section of the Mental Health (Scotland) Act.

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Responsibility for the contents and conclusions rests solely with the Accounts Commission.

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