MENTAL HEALTH AND THE PRODUCTIVITY CHALLENGE

Improving quality and value for money

Chris Naylor
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Centre for Mental Health

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Published by
The King's Fund
11–13 Cavendish Square
London W1G 0AN
Tel: 020 7307 2591
Fax: 020 7307 2801
www.kingsfund.org.uk

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First published 2010 by The King's Fund

Charity registration number: 1126980

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ISBN: 978 1 85717 606 3

A catalogue record for this publication is available from the British Library

Available from:
The King's Fund
11–13 Cavendish Square
London W1G 0AN
Tel: 020 7307 2591
Fax: 020 7307 2801
Email: publications@kingsfund.org.uk
www.kingsfund.org.uk/publications

Edited by Fiona Weston

Typeset by Grasshopper Design Company

Printed in the UK by The King's Fund

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Acknowledgements

This report has been produced in association with the Royal College of Psychiatrists and the Mental Health Network at the NHS Confederation. We would like to express our gratitude to both organisations for the valuable insights and support they have provided throughout the project, and in particular to Chris Fitch, Richard Meier, Dinesh Bhugra and Sue Bailey at the Royal College of Psychiatrists, and to Rebecca Cotton and Steve Shrubb at the Mental Health Network.

The contributions made by a number of other individuals were also greatly appreciated, in particular Ian McPherson of the National Mental Health Development Unit, Geraldine Strathdee of NHS London, Martin Knapp of the London School of Economics and Political Science, Robert Dolan of East London NHS Foundation Trust, Anne Beales of Together UK, Dr John Hague, and colleagues at The King's Fund and Centre for Mental Health.

Finally, we would also like to thank all those who attended the expert seminar that provided the foundation for this work.

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Summary

The National Health Service (NHS) faces a productivity gap of some £14 billion over the next three years, as a result of which it needs to make productivity improvements of around 4 per cent per year. Mental health accounts for 12 per cent of the commissioning budgets of primary care trusts (PCTs) and will need to play its part in responding to the financial challenge.

The evidence presented in this report demonstrates that there is scope to improve productivity in mental health care, and that there are also opportunities for mental health services to support productivity improvements in other areas of the NHS and in public spending more widely.

The report focuses on opportunities to improve productivity under four broad headings:

- immediate priorities for improving productivity in existing mental health services
- what mental health services can offer to improve productivity in the NHS as a whole
- the economic benefits beyond the NHS of improved mental health care
- the longer-term challenge of building a preventive and empowering mental health system.

Of the improvement areas highlighted in the report, we consider that the following are the most promising targets for immediate attention:

- reducing unnecessary bed use in acute and secure psychiatric wards
- establishing systems to review the use of highly expensive out-of-area treatments
- improving workforce productivity
- strengthening the interface between mental and physical health care, particularly for older people and people with long-term conditions.

If these opportunities are to be realised successfully, it is vital that service users and carers are enabled to help make the changes alongside mental health professionals, service providers and commissioners.

Support will also be needed from national government, for example, to foster pooled funding arrangements between public services and to encourage investment in long-term preventive measures and in research.

Mental health services can help to meet the financial challenge facing the NHS, but they cannot do this if they are targeted disproportionately for spending reductions or if short-term expediencies lead to the so-called salami-slicing of high-value, well-performing services.

By grasping the opportunities highlighted in this report, mental health commissioners and providers will be better placed to build on the work of recent years, and to meet the financial challenge by improving rather than sacrificing quality of care.

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Recommendations for clinical teams

- Mental health professionals need to see the productivity challenge as being their responsibility. As part of this, they should be encouraged to:
  - develop quality dashboards to support improvement
  - make use of comparative performance information to reduce unwarranted variations in practice
  - take advantage of opportunities to become more involved in redesigning processes of care and developing new service models.
- General practitioners (GPs) can play a key role by developing improved forms of care to meet the mental health and psychological needs of people with long-term conditions or medically unexplained symptoms.

Recommendations for provider organisations

- NHS, private and voluntary sector providers must all play a role in improving the efficiency and effectiveness of mental health services.
- Providers should work with commissioners to develop more cost-effective service models, such as integrated acute care teams, better community services and innovative approaches to substance misuse and complex needs.
- Providers will also need to tackle productivity within existing services, for example, by taking action to develop a healthier and more efficient workforce.
- Providers need to benchmark their performance against that of other trusts and take action to reduce unwarranted variation, for example, in the use of acute psychiatric beds. Comparative data on productivity must be interpreted with reference to data on quality, to ensure that both are promoted together.
- Providers of physical health care must work closely with mental health service providers to deliver more integrated and cost-effective care to people with co-morbid physical and mental health problems, in particular older people and people with long-term conditions.

Recommendations for commissioners

- Commissioners can avoid making premature cuts to mental health services by seizing the opportunities that exist to improve productivity. Salami-slicing or cutting back on evidence-based services will increase costs to the system as a whole over the next decade.
- Commissioners should exploit the opportunities to make savings across the NHS budget by responding more effectively to mental health needs in the primary care, accident and emergency (A&E) and acute hospital settings.
- A high priority for commissioners should be reducing unnecessary bed use in acute and secure psychiatric wards. This can be achieved by strengthening crisis resolution teams, developing alternatives to admission, improving services for people with complex needs, and improving step-down options, particularly for people in medium-secure services.
- Commissioners should take urgent action to cut back on clinically unjustified out-of-area treatments. This will require collaborative working at the regional level.

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- In the longer term, commissioners can achieve significant savings by investing in preventive work and services that promote recovery and independence. This should include promoting better mental health in childhood and old age as well as improving support with employment and services for offenders.
- It will be important for PCTs to support the development of mental health commissioning skills in the new GP commissioning consortia, or alternative models for co-ordinating mental health commissioning across multiple consortia and in association with local authorities.

Recommendations for government

- Pooled-funding mechanisms will be critical if opportunities for improving quality and productivity are to be realised in practice, and the government must support and encourage the use of these.
- Research is needed to provide further evidence of which models are the most cost-effective in mental health, and how we can effectively prevent mental health problems from developing. Research on mental health in childhood and the prevention of dementia should be given high priority.
- The NHS Outcomes Framework needs to include a range of suitable indicators to ensure that equal weight is given to mental health services as to other areas of health and social care. This should include the important contribution that mental health care can make to our physical health.
- Work to create a tariff system for mental health services should build on the experience of using tariffs in physical health care. A system based on whole packages of care, and the outcomes they achieve, may be better than one based on individual episodes of care.
- Action to tackle myths about mental health and fears about the risks posed by people with mental health problems needs to be sustained to help reduce inappropriate provision of care in unnecessarily restrictive and expensive settings.

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1 Introduction

The National Health Service (NHS) is facing a daunting financial challenge. Unless there is a change in how services are delivered, there will be a substantial gap between the actual funding available and that required to improve the quality of patient care and to respond to demographic changes and other cost pressures. This is the case even with the small real-terms increases in funding for the next four years announced in the government's Comprehensive Spending Review.

The most recent estimates by The King's Fund put the size of this gap at around £14 billion by 2013/14. If it is to be closed, the NHS will need to improve productivity consistently – doing more each year with the same or similar resources. Annual productivity improvements of around 4 per cent will need to be found (Appleby *et al* 2010).

Spending on mental health accounts for more than 12 per cent of the commissioning budgets of primary care trusts (PCTs) (Appleby and Gregory 2008), and the mental health sector will be expected to play a key part in responding to the financial challenge. There is evidence that when the NHS has faced financial challenges in the past, funding has been diverted from mental health budgets to other parts of the system (Sainsbury Centre for Mental Health 2006).

There is also strong evidence that the prevalence of mental health problems can increase during periods of economic recession and high unemployment, putting the NHS and other public services under increasing pressure (Dorling 2009). Mental health problems are intimately connected with many of the social issues that governments must respond to during times of economic austerity, and in England were estimated to have had economic and social costs of £105 billion in 2009/10, including £30 billion in lost economic output (Centre for Mental Health 2010a). In this context, it is important to find ways to improve the delivery of mental health services within existing budgets.

In May 2010, The King's Fund and the Centre for Mental Health (then known as the Sainsbury Centre for Mental Health) jointly convened a half-day seminar with a range of experts on mental health and productivity to explore opportunities to deliver mental health services in a different and more cost-effective way. The consensus was that there is scope to improve productivity in mental health care, and that there are also significant opportunities for mental health services to support productivity improvements in other parts of the NHS and beyond.

This report is based on an analysis of the ideas developed during that expert seminar, supported by a wide-ranging review of related research evidence and extended consultation with key stakeholders. It has been produced as a collaborative endeavour and is supported by The King's Fund, the Centre for Mental Health, the Royal College of Psychiatrists and the NHS Confederation's Mental Health Network.

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The report covers the following areas:

- immediate priorities for improving productivity in mental health (Section 4)
- opportunities for mental health services to support wider productivity improvements in the NHS and other public services (Sections 5 and 6)
- longer-term opportunities to build a preventive and empowering mental health system (Section 7)
- how these proposals can be implemented in practice (Section 8).

It concludes by giving recommendations for action, for both national decision-makers and those working in the NHS and its partners.

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2 Background

Spending on adult mental health services in England increased in real terms by 58 per cent between 2001/02 and 2009/10 (Mental Health Strategies 2010), which was partly a response to historic underfunding. The additional funds have allowed for a considerable increase in the number of people working in mental health, and the introduction of a range of new services in line with the blueprint laid out in the *National Service Framework for Mental Health* (Department of Health 1999). For example, between 1997 and 2007, the number of consultant psychiatrists increased by 55 per cent, along with 69 per cent more psychologists and 24 per cent more mental health nurses (Appleby 2007).

Despite these funding increases, significant quality issues remain to be addressed. Although community mental health services have expanded rapidly, the life chances of people with mental health problems remain poor. For example, too few people who use mental health services are supported to achieve their employment aspirations (Sainsbury Centre for Mental Health 2009d), and primary mental health care is only now beginning to grow as a result of the Improving Access to Psychological Therapies programme (Department of Health 2007).

The new community services established have not always adhered to the models outlined in the National Service Framework, and in some cases funding has not reached the proposed levels (National Audit Office 2007a; Boardman and Parsonage 2009). Large disparities exist in the use of inpatient beds and compulsory treatment under the Mental Health Act by different ethnic groups (Care Quality Commission 2010). Services for the 10 per cent of the prison population in England that has a severe mental illness are highly limited (Sainsbury Centre for Mental Health 2009c).

Figure 1 overleaf illustrates the current allocation of resources in the mental health system (*see* Appendix A for further details). Apart from the data on child and adolescent services, this is based on reported spending on services for working-age adults. It shows that, despite the shift to community-based models of care, considerable resources are still spent on inpatient and secure beds. Conversely, very little is spent on preventing mental health problems or on mental health promotion.

Recently, the question of how mental health services can deliver better value for money has come to the fore. In 2009, a report produced jointly by the Royal College of Psychiatrists, the National Health Service (NHS) Confederation's Mental Health Network and the London School of Economics and Political Science explored the implications of the economic downturn for mental health services (Royal College of Psychiatrists *et al* 2009). The key messages of this report were:

- the economic downturn can be expected to increase the prevalence of some mental health conditions, while at the same time increasing constraints on the funding available for services
- commissioners may face stark choices regarding local services and where to prioritise funding

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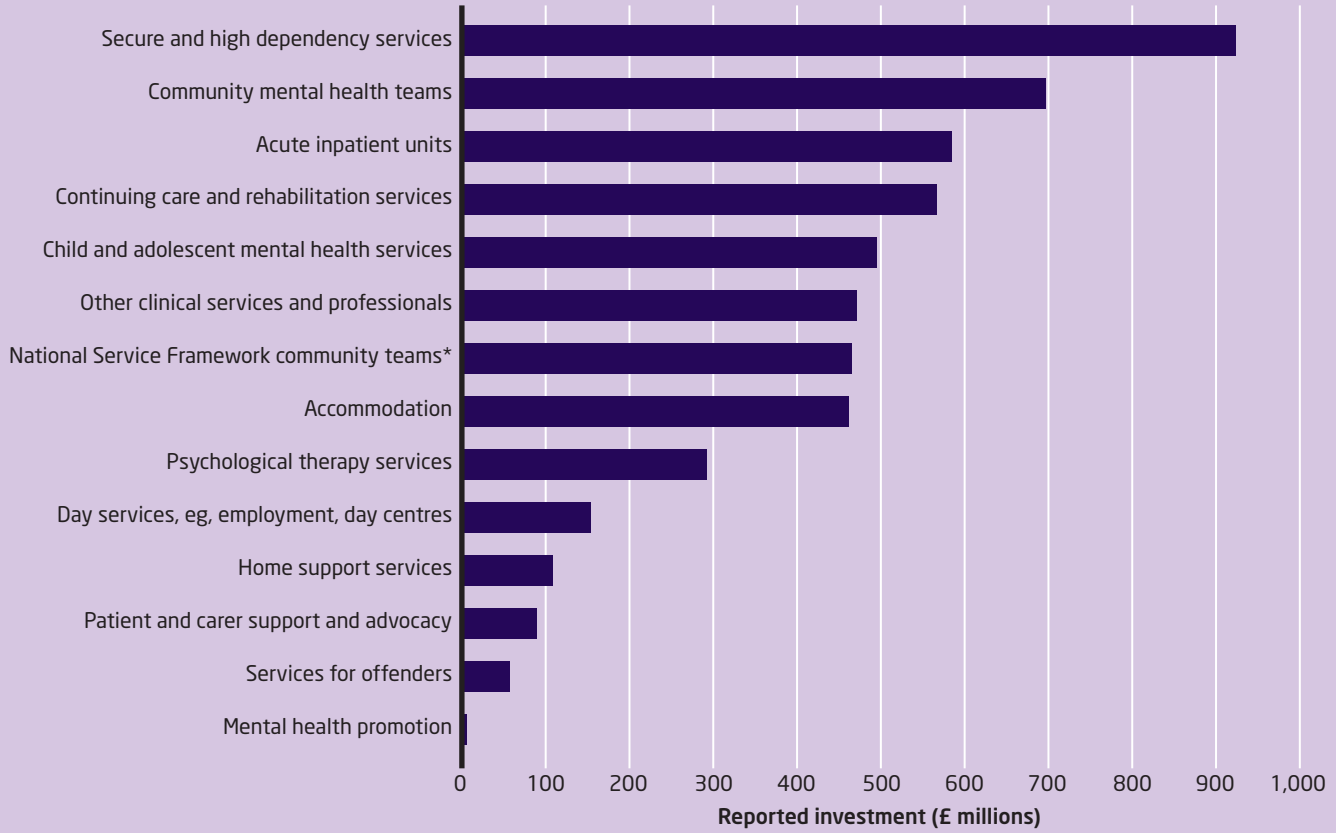
Figure 1 Cost of mental health services in 2009/10



Sources: Mental Health Strategies (2010), Children's Service Mapping (2010)

*Crisis resolution, assertive outreach and early intervention in psychosis teams

- opportunities exist at a number of levels to improve productivity within mental health
- pressure on mental health budgets can be expected to have knock-on effects on other public services, including other health services, social care and the criminal justice system, and vice versa.

In the year since that report, the Royal College of Psychiatrists has held a high-level enquiry examining the potential to redesign mental health services with a particular emphasis on productivity (Royal College of Psychiatrists 2010a), and the NHS Confederation has been working to include mental health within the Department of Health's quality, innovation, productivity and prevention (QIPP) programme. Through the latter, commitments have been made by the Department of Health, strategic health authorities, the National Mental Health Development Unit, the Audit Commission and the NHS Confederation's Mental Health and Primary Care Trust Networks to work collaboratively to meet the QIPP challenge in mental health.

This report aims to complement and build on this existing work by elaborating on specific opportunities to improve productivity within mental health, and drawing on a wide-ranging evidence base and examples of good practice. It also describes the contribution that mental health services can make in helping to realise efficiency savings in the wider NHS and other sectors.

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3 Strategies for improving productivity

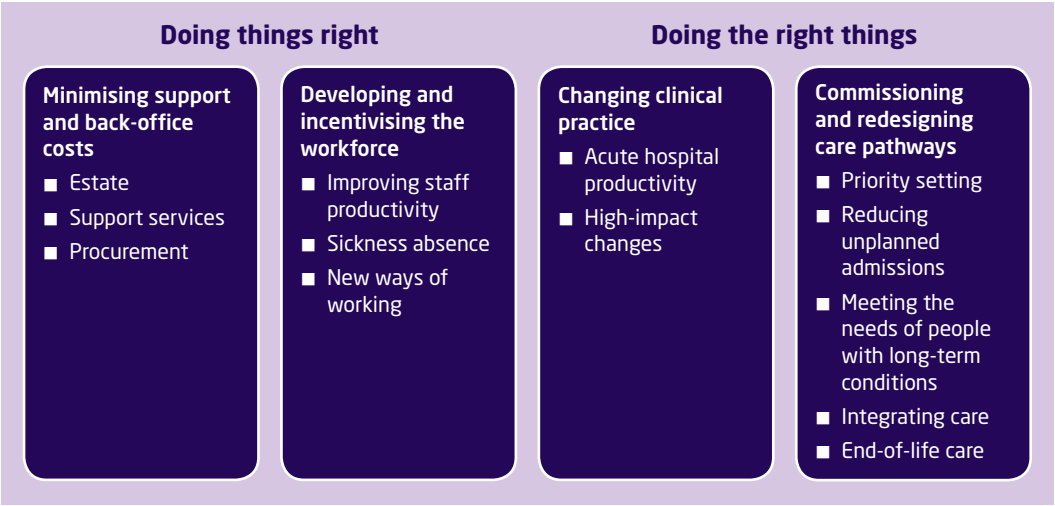
The King's Fund's quality in a cold climate programme has examined the productivity challenge across the National Health Service (NHS), assessing the size and nature of the challenge and the opportunities posed by different approaches to tackling it. A recent report from this programme discussed productivity in terms of 'doing things right' and 'doing the right things' (Appleby *et al* 2010, p 11), and described four levels at which there is potential for productivity improvement:

- back-office costs
- workforce
- clinical practice
- commissioning and redesigning care pathways (*see* Figure 2 below).

Although much attention has been focused on cutting management and administrative costs, a key finding from the quality in a cold climate programme is that altering clinical practice – and specifically the widespread variation that exists in clinical practice – holds the greatest hope for improving productivity (Appleby *et al* 2010). This emphasis resonates with many of the opportunities within mental health that are identified in the following sections.

It is important to recognise that the identification of opportunities to make savings does not, in itself, lead to improved productivity. What matters is what is done with the resources saved. The focus of any strategy to improve productivity must therefore be on how resources can be invested in activities that create more value for service users and carers, and that deliver more and/or better care for the same cost.

Figure 2 Key productivity approaches in the NHS



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4 Productivity within mental health: immediate priorities

This section focuses on opportunities to improve productivity *within* mental health services over the next five years. It describes the areas identified as priorities for immediate action during our expert seminar. Later, we discuss opportunities for mental health to help make savings in other sectors (Sections 5 and 6) and long-term opportunities (Section 7).

The opportunities that exist in each area are discussed, and quantified where possible, with reference to wider research evidence. The following priorities for action are described:

Action across the care pathway	1. Improve assessment processes 2. Reconfigure community services 3. Reduce unnecessary use of acute beds 4. Improve discharge and step-down arrangements
Effective responses to complex needs	5. Reduce out-of-area treatment 6. Respond effectively to substance misuse 7. Improve secure services
Changing ways of working	8. Build peer support 9. Maximise workforce productivity

Improve assessment processes

The assessment of individuals' mental health needs is an early and crucial determinant of their subsequent pathway through the system, and their consequent use of resources. The way assessments are conducted varies markedly between different teams, and significant inefficiencies appear to exist. For example, service users often undergo multiple assessments, involving a high level of duplication of the information gathered and creating a considerable bureaucratic burden for mental health teams (Garcia 2006). Inaccurate assessment can lead to inappropriate treatment decisions and wasteful use of resources.

There is an increasingly strong consensus that the most efficient way of conducting assessment is to 'front-load' the patient pathway so that the expertise of the most highly skilled staff is used early on, particularly for people with complex needs, and in rapid review for service users experiencing a crisis (Royal College of Psychiatrists 2010a). This approach, used internationally by organisations such as Kaiser Permanente, is designed to maximise the likelihood that people will be directed to the most appropriate care pathway from the outset, meaning that service users gain fast access to effective care and that the need for repeat assessments is reduced. The Choice and Partnership Approach (CAPA) provides a model for implementing such an approach and has been used in many Child and Adolescent Mental Health Services (CAMHS) teams in the United Kingdom and elsewhere (*see* box opposite).

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Assessment processes: The Choice and Partnership Approach

CAPA is a method for improving care processes that is used by CAMHS teams across the United Kingdom and in several other countries. It includes a strong focus on improving assessment processes. The initial assessment or 'choice appointment' is conducted in an exploratory, user-centred style. Rather than assessing suitability for a particular treatment, it focuses on identifying the family's own objectives, and thinking broadly and creatively about what services might help them achieve these objectives.

This approach requires assessment to be conducted by skilled staff with sufficient clinical experience and knowledge of the strengths and aptitudes of team members and of other local services to allow families to be matched with the most appropriate support. Professionals from outside the team, such as the referrer, are sometimes invited to attend the first assessment to provide a broader, multidisciplinary perspective on the person's needs.

For further information on CAPA, visit the CAMHS website – www.camhsnetwork.co.uk – or contact Ann York at: rowe.york@btinternet.com or Steve Kingsbury at: steve.kingsbury@hertspartsft.nhs.uk. Further details are also given in the box on p 33.

Reconfigure community services

Community mental health teams (CMHTs) account for some of the highest spending in mental health. The annual direct cost of CMHTs across England is £696 million for working-age adults and £227 million for older people. Across the country, there is considerable variation in how CMHTs function and how they interact with primary care, specialist community teams and inpatient services, and there may be several opportunities for improving productivity.

An important area to focus on is the relationship between CMHTs and specialised community teams, including the three 'functional' teams established by the National Service Framework for Mental Health (Department of Health 1999): assertive outreach; early intervention; and crisis resolution and home treatment (CRHT) teams. In some areas, these nationally mandated services have been accompanied by a range of other specialised community teams commissioned locally. Several trusts have been concerned about inefficiencies created by this multiplicity of community teams, for example, in terms of replication of management structures, and also about problems related to the interfaces between different teams and the question of how the burden of demand is shared between them.

Sharing managerial and administrative functions across community teams may offer a way of tackling this inefficiency while also creating a more seamless experience for service users. A more radical approach, already taken by some trusts, would be to examine alternative models for some specialist functions that require fewer or smaller dedicated specialised teams. For example, a participant in our expert seminar suggested that many of the people seen by assertive outreach teams could be appropriately supported by CMHTs, leaving a smaller, separate, assertive outreach function focused mainly on the highest-risk service users.

Trusts considering these sorts of reorganisations should be aware of the benefits of specialist teams that may be lost if they are merged with generic CMHTs. Although there is limited consensus about the overall impact of the National Service Framework teams, some evaluations suggest that CRHT and early intervention teams can be highly effective,

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particularly in reducing unplanned admissions to hospital (Craig *et al* 2004; Johnson *et al* 2005a, 2005b; Birchwood *et al* 2006; Glover *et al* 2006). Early intervention teams have also been found to improve the employment prospects of their users (Garety *et al* 2006; Major *et al* 2010). Abandoning specialist services that are known to be effective could create long-term inefficiencies by delaying the provision of support, increasing hospital admissions and slowing down discharges.

A second area being explored by some trusts is reducing duplication of management structures by merging CMHTs to create larger teams covering several localities. It is not yet clear whether such mergers have any impact on the quality of care.

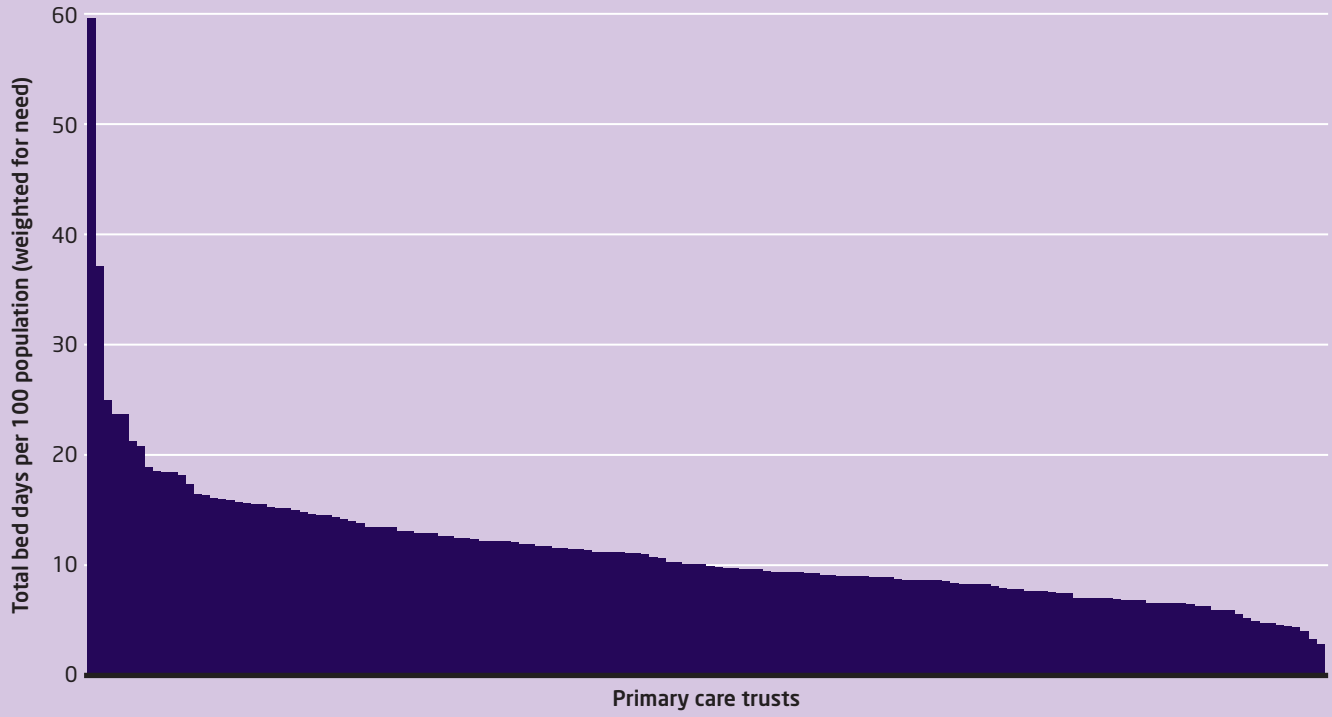
Whatever structures are developed for community services, it will be important that the roles and responsibilities of different teams are clear to referrers and people working in the system.

Reduce unnecessary use of acute beds

Despite the shift to community-based mental health care, inpatient services continue to account for a large proportion of the spending on mental health, with the cost of adult acute inpatient wards alone totalling £585 million per year (Mental Health Strategies 2010). Analysis by the Audit Commission (2010) suggests that the use of inpatient care varies widely between trusts. After adjusting for population characteristics such as levels of deprivation, the Audit Commission found:

- a 20-fold variation in total bed days (*see* Figure 3 below)
- a 6-fold variation in admission rates
- a 15-fold variation in average length of stay.

Figure 3 Twenty-fold variation in total bed days for mental health admissions



Source: Audit Commission (2010)

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These figures suggest that, if trusts with high levels of bed days reduced their use of inpatient beds to the average, an annual saving of £215 million nationally would be generated. Realising savings on this scale may be difficult as providers face practical barriers in releasing resources, and some of the variation will be clinically warranted or accounted for by the varying composition of bed types in different areas (for example, acute versus rehabilitation). However, other evidence confirms that significant opportunities do exist to reduce acute bed use further. The National Audit Office, for example, suggests that one in five admissions could be avoided (National Audit Office 2007a).

It is important to stress that the imperative to reduce unnecessary or overly long inpatient stays is not only a financial one: time spent as an inpatient can weaken people's connections to their family, community and support networks. In order to reduce this, action is needed on several fronts:

- strengthening crisis resolution and home treatment
- integrating acute care teams
- developing alternatives to admission
- targeting high-risk groups.

Strengthening crisis resolution and home treatment

CRHT teams were introduced by the National Service Framework for Mental Health (Department of Health 1999) in order to help people remain in the community as long as possible during periods of mental health crisis, and to return them home from inpatient units in a timely manner. Studies conducted since their introduction indicate that spending on CRHT services delivers substantial returns on investment by reducing admissions to acute wards (Glover *et al* 2006; National Audit Office 2007a). However, the National Audit Office found that, in some areas, CRHT teams were not delivering their full potential as a result of inappropriate skill-mix, ineffective management arrangements, limited access to psychiatric expertise, inadequate capacity to provide 24/7 coverage, and limited awareness and understanding of CRHT among referrers. Their economic modelling suggested that between £12 million and £50 million could be saved annually by expanding the use of CRHT and reducing variation between areas.

Integrating acute care teams

There is evidence to suggest that integrated acute care teams, in which CRHT or other community teams work together with inpatient staff within a common management structure, can deliver further reductions in bed use while also increasing the quality of care. Norfolk and Waveney Mental Health Trust has taken this approach and has had promising results, which, if repeated across all mental health trusts in England, would represent total savings of £58 million (*see* box overleaf).

The National Audit Office recommended the use of staff rotation, joint roles, integrated training and, potentially, co-location to encourage close working between CRHT and inpatient teams (National Audit Office 2007a).

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Reducing unnecessary bed use: Integrated acute care pathway in Norfolk and Waveney

Norfolk and Waveney Mental Health National Health Service (NHS) Foundation Trust has introduced an innovative model for adult acute services in which each locality has an integrated team led by a consultant psychiatrist. The team aims to deliver a seamless service to patients by providing home treatment, crisis resolution and inpatient care.

This service structure helped the trust reduce its use of inpatient beds by almost one-third between 2005 and 2008, by reducing both admission rates and length of stay, and generating a saving of around £1 million per year (Audit Commission 2010).

Staff motivation levels are also reported to have improved within the new structure.

Developing alternatives to admission

The number of alternatives to traditional acute inpatient wards has grown markedly over the past decade, and these now comprise 10 per cent of overall inpatient provision (Johnson *et al* 2009). Examples include wards applying innovative therapeutic models, and 'crisis houses' run by health professionals, third sector organisations or service users themselves. A recent evaluation found that, although there is no definitive evidence on the cost-effectiveness of these alternatives, they are generally less expensive than standard acute wards and associated with higher service-user satisfaction. Their impact in terms of clinical outcomes is less clear, but service use one year after discharge does not differ between traditional inpatient wards and alternatives, suggesting that the long-term financial impact of alternative provision might be cost-reducing (Lloyd-Evans *et al* 2009).

Targeting high-risk groups

In attempting to reduce unnecessary or overly long inpatient stays, it might be useful to focus particularly on groups of service users that are currently over-represented in inpatient units.

It is now well established that some minority ethnic groups are significantly over-represented in these settings (Care Quality Commission 2010). Services can work with local community groups, voluntary sector providers and peer support workers to offer more appropriate support for people from black and minority ethnic groups in the community.

Personality disorder might represent another area to focus on: beds in some assessment wards are currently being used by people with low-level personality disorders who may be better served in community settings.

Improve discharge and step-down arrangements

A key issue highlighted during our expert seminar was inefficiencies created by barriers to discharge. If processes for transferring clinical responsibility to lower-dependency services are unclear, or if the supply of these services is scarce, people can remain in costly, high-dependency services for an unnecessary length of time.

There is evidence that delayed discharge from mental health inpatient services is a common problem, with at least 7 per cent of psychiatric beds for adults and 16 per cent

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of those for older people being lost to delay. This rises to as much as 25 per cent in some trusts (Lewis and Glasby 2006). There are multiple causes of delay, including limited availability or awareness among clinicians of appropriate community services such as supported accommodation, rehabilitation services and intermediate care for older people (Paton *et al* 2004).

Community teams can play an important role by retaining responsibility for people in inpatient facilities, by being more proactive in engaging with their care after admission, and by planning how and when they can be discharged and supported in the community. The National Audit Office found that many CRHT teams are already playing a key role in this and appear to be successfully facilitating earlier discharge where they are involved. However, involvement was not universal, and many ward staff were not aware of the role CRHT teams can play in discharge, indicating scope to improve communication and joint working (National Audit Office 2007a). The introduction of electronic care records and greater availability of technology may make it easier for community staff to continue to engage in care planning after admission.

In order to be willing to transfer clinical responsibility to less intensive services, professionals need to have confidence in the quality of the support provided by other levels in the system. In some cases, there may be a need for shared care arrangements, for example, between mental health specialists and primary care (*see* Section 6).

The high level of aversion to risk present in both the mental health system and society generally is another major barrier to increased use of step-down services.

Improving discharge processes

Bradford District Care Trust

A number of approaches to improve discharge processes have been adopted in Bradford. Currently, each psychiatric ward is led by a dedicated inpatient consultant. This fixed point of contact allows professionals in community mental health teams and CRHTs to establish stronger relationships with inpatient teams, and makes it easier for nursing teams to organise discharge. CRHT staff proactively review patients with ward nurses on a daily basis. New technology is used to underpin joint working between inpatient and community teams: electronic patient records and progress notes give community professionals real-time information on service users who have been admitted, allowing them to stay informed of any developments, such as changes to care plans or risk assessments.

For further information, contact Robert Armstrong at: robert.armstrong@bdct.nhs.uk.

Chesterfield Royal Hospital

Staff at the Hartington Unit at Chesterfield Royal Hospital used the NHS Institute's productive mental health wards quality improvement tool (see box on p 33) to redesign care processes within the unit. They achieved a four-fold increase in early discharge over a five-month period, while also reducing re-admission rates and releasing time for nurses to spend on more direct patient care (NHS Institute for Innovation and Improvement 2009b).

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Reduce out-of-area treatment

There is an urgent need to reduce the use of highly expensive out-of-area treatment in mental health care. As many as 10,000 people are currently placed outside their local area in psychiatric hospitals, residential settings and secure units, often for several years at a time (Ryan *et al* 2004; Royal College of Psychiatrists 2010b). In some cases, these placements are entirely appropriate. However, research indicates that for many – perhaps more than half – there may be little clinical justification for the placement (Killaspy *et al* 2009).

The use of out-of-area treatment is an expensive way to support people with mental health problems. The average annual cost of an out-of-area placement has been estimated to be £34,000, compared with around £21,000 for an equivalent local placement (Brindle 2010; Royal College of Psychiatrists 2010b). There are also personal costs, since being treated away from one's neighbourhood can involve being separated from one's family, carers and other forms of support.

Rather than being driven by clinical need, out-of-area placements are often the consequence of the limited availability of local services, particularly supported accommodation and other residential options, rehabilitation services and, in the case of forensic out-of-area treatment, step-down services that allow people to be treated in progressively lower security settings as they recover. Out-of-area treatment can also be necessary because of gaps in the regional commissioning of services for people with complex needs.

The high cost of out-of-area treatment is partly related to the fact that it is often bought in from the private sector in an *ad hoc* way using spot-purchasing arrangements. Much of the money spent is accounted for by a relatively small number of referrals to high-cost forensic units.

Given the costings cited above, if 50 per cent of those currently receiving out-of-area treatment were 'repatriated' to their home area and supported by appropriate local services, this would represent a net saving of around £65 million, while also giving several thousand people care that was more fitting to their needs.

To realise this opportunity, the following steps might be necessary.

- Local services need to be staffed by people who have the appropriate skills in working with those with complex needs, such as people with substance misuse problems, personality disorder, neurodevelopmental disorders or learning difficulties alongside mental health problems.
- Commissioners need to invest in supported accommodation and other residential options to create sufficient capacity to place people locally, along with step-down and intensive community services for people in forensic placements.
- There may need to be accompanying cultural change in some services so that practitioners and managers accept that supporting people with complex needs is part of their responsibility and ensure that appropriate training is provided. Attitudes among referrers with regard to where people with complex needs should be seen may also need to change accordingly.
- The role CRHT teams can play in reducing the use of out-of-area treatment must be fully realised. The introduction of CRHT teams was associated with a reduced use of out-of-area treatment in some areas, but it is not clear that this has been a priority for CRHT teams everywhere.

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- Commissioners and/or providers need to put in place robust systems for reviewing people who have been placed outside their areas. Currently, only 30–50 per cent of primary care trusts (PCTs) employ someone to perform this role (Royal College of Psychiatrists 2010b).

Further good practice guidance on out-of-area treatment will be made available from 2011 in an implementation kit to be published by the National Mental Health Development Unit. The box below describes how out-of-area treatment was reduced in two PCTs.

Reducing out-of-area treatments

The experience in Islington

Of 40 people placed in non-forensic out-of-area treatment by Islington PCT and the local authority, 25 were assessed as being potentially able to relocate back to their local area. Of these, 13 moved successfully, mainly to independent accommodation.

The savings resulting from relocation were reinvested into local supported accommodation services. The assessment indicated that these people had been oversupported in their previous placements (Killaspy *et al* 2009).

Forensic out-of-area treatment in north-east London

In 2002, there were around 70 people from north-east London in forensic out-of-area treatment. These were mainly people who were perceived as being chronic patients with complex needs that could not be met by local forensic teams, and who were instead receiving care in expensive medium-secure units provided by the independent sector.

Over a five-year period, the number of people in such placements was reduced to just two. This was achieved by building expertise in rehabilitation and recovery, substance misuse and learning disabilities in local forensic teams, and by working with referrers to change referral pathways.

Respond effectively to substance misuse

Between a quarter and a half of people with severe mental health problems also use substances – most commonly alcohol or cannabis – in a way that is problematic and can impede recovery from mental ill health (Graham *et al* 2001; Weaver *et al* 2003). Such co-morbidities significantly increase the cost to the health service and other sectors by, for example, reducing adherence to treatment and increasing the risk of relapse of mental health problems, admission to psychiatric hospital or imprisonment (NHS Confederation 2009b).

Despite the development of specialist dual-diagnosis teams in some areas over the past 10 years, care for this group is still highly fragmented, with some mental health services excluding patients with co-morbid substance-abuse problems. Service users can experience disjointed care with repeated assessments and ineffective treatment. At worst, they can be passed from service to service, receiving little support at all.

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Evidence suggests that integrated approaches that bring treatment for problematic substance use together with treatment for mental health problems can be more cost-effective, improving outcomes at little or no extra cost in the short term and reducing costs in the medium term (Haddock *et al* 2003; Judd *et al* 2003). Developing more integrated treatment therefore represents an opportunity to improve both productivity and quality of care. The Royal College of Psychiatrists recommends that mental health services currently excluding people with a dual diagnosis from treatment should remove this criterion and provide staff with appropriate substance-abuse training (Royal College of Psychiatrists 2010a). Training is needed to develop skills and to address attitudes towards substance use: given the prevalence of co-morbidity, mental health professionals need to see substance use as part of their core business, and should be proactive in addressing the impact that drug and alcohol use might be having on the mental health of people using their services (Maslin *et al* 2001). To support this, a dual-diagnosis training-resource kit has recently been published by the National Mental Health Development Unit (2010).

There are particular problems around commissioning for alcohol interventions, with responsibility often falling between PCTs, drug and alcohol action teams and, for offenders, probation services. Developing joint responses to identify people in need of support and to intervene early is vital to improve quality and reduce later cost (Centre for Mental Health in press).

The box below highlights one approach to substance-use services.

Substance-use services: The COMPASS service in Birmingham and Solihull

In Birmingham and Solihull Mental Health NHS Foundation Trust, the combined psychosis and substance use (COMPASS) programme provides an integrated approach to supporting people with dual diagnosis. The programme was established 10 years ago on the principle that it would be more effective to embed substance use skills across existing teams rather than to create a specialist service for people with a dual diagnosis.

The COMPASS team provides training and clinical support to other mental health teams. Training is adapted to the needs of the team. For example, assertive outreach teams are provided with particularly intensive training because of the high prevalence of substance-use problems among the population they serve. The COMPASS team monitors the impact of the training on clinical practice, and when needed is involved in direct work with patients in teams where training has been provided.

Evaluations of the COMPASS programme indicate that the service has been successful in increasing the skills and confidence of mental health professionals at dealing with substance-use issues, and reducing problematic alcohol use among people using the service (Graham *et al* 2006).

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Improve secure services

Secure services are a huge area of cost – more than £1.2 billion was spent on just 4,500 places in secure and high-dependency services for working-age adults in 2009/10 (Mental Health Strategies 2010). Pressure to reduce the use of high-security places has led to increased use of medium-secure facilities over recent years. In particular, there has been a major growth in private-sector provision, which some have argued is part of an under-recognised process of 're-institutionalisation' in mental health care, in which the reduction in statutory inpatient beds has been accompanied by increased use of beds in the private sector and elsewhere (Poole *et al* 2002; Priebe and Turner 2003).

As with acute-care beds, there is scope to reduce the use of secure beds, particularly in medium-secure units, by ensuring admissions are made to the right level of security, reducing length of stay, improving the skill mix of staff so that effective interventions can be offered, and facilitating discharge. There is wide variation across the country in the use of secure services, their criteria for admission, and patterns of service between levels of security. The pathways people take between services are varied and complex, with little continuity of care between institutions. Furthermore, the outcomes achieved by secure services in, for example, reducing further offending, are poorly recorded (Centre for Mental Health, forthcoming).

Discharge and step-down arrangements are a particular problem. For secure services, discharge processes are complicated by the need for all changes in a person's leave and care arrangements to be approved by the Ministry of Justice, a process that can take several months and tends to involve a highly cautious approach to risk (*see* box below). The availability of low-security beds for people who no longer require intensive treatment in medium-secure beds is limited, while community-based services for people discharged back home are scarce (Centre for Mental Health forthcoming).

Perceptions regarding the risk posed by people with severe mental illnesses or personality disorders can make it more difficult to achieve good value for money from secure services. Beliefs are commonly inaccurate and exaggerated, both among the general public and within the NHS (Thornicroft 2006). As a result, services often operate in a highly risk-averse manner. There is a perception among some mental health professionals that many people are treated in overly secure and expensive settings. Some clinicians report that decision-making processes have become heavily bureaucratised as a means of managing risk. The result is that efficient working is inhibited and both service users and professionals are disempowered.

Addressing this situation will require a mature discussion within the NHS, as well as with the Ministry of Justice and the wider public, in order to strike an appropriate balance between managing risk and delivering a high-quality and efficient service. Mental health services should regard this as a fundamental part of their role in their communities.

As part of its programme of work on the Department of Health's quality, innovation, productivity and prevention (QIPP) agenda, the National Mental Health Development Unit is undertaking a major project examining how people access medium-secure care, the criteria for and the effectiveness of admission and discharge, and the interfaces medium-secure care has with other parts of the secure and non-secure system. It will review the need to redesign the pathway through medium-secure care, with an emphasis on the outcomes that achieve recovery and reduce risk, removing disincentives from the system and ensuring people are detained in medium security only when they need it.

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Secure services: Discharge from forensic services in East London

East London NHS Foundation Trust agreed with commissioners that it would double discharges from forensic services in one year in exchange for an investment of £700,000 to help overcome barriers to discharge. Commissioners worked with clinicians to identify barriers, and benchmarked discharge rates at the level of individual clinicians to allow comparison. After one year, the discharge target was exceeded, allowing the overall number of beds to be reduced and generating significant cost savings.

Build peer support

Peer support offers a means by which service users' own experience can be employed to help others through distress, and also presents opportunities for people using services to get into paid work as part of their recovery journey. The term can refer to a number of different practices, including:

- mutual support groups
- employment of people with direct experience of mental ill health to provide services to others; these could be conventional services such as case management, or services designed to make more explicit use of peer providers' personal experience (Davidson *et al* 2006).

There is a growing evidence base, mainly from outside the United Kingdom, that various forms of peer support can reduce the likelihood of psychiatric hospitalisation and demand for other services (Solomon 2004; Min *et al* 2007; Lawn *et al* 2008; Landers and Zhou 2009). Satisfaction rates among people using peer support services are often high, and an expansion in peer support is something that many user groups have advocated for a number of years.

Further research is needed on cost-effectiveness, but some evidence suggests that net savings can be made at the same time as increasing the quality of care (Lawn *et al* 2008). Further research to identify which models of peer support are the most effective is also needed. Existing research suggests that the following characteristics could be important:

- combining emotional support with information-sharing, for example, on how to manage your condition (Dale *et al* 2008)
- peer support might be particularly helpful at times of transition, for example, during and after discharge from hospital (Forchuk *et al* 2007)
- there could also be a particularly strong case for using peer support to deliver care to specific populations, such as homeless people, or minority groups (Solomon 2004).

Peer support is an important component of efforts to make services more focused on recovery (Shepherd *et al* 2008). In the longer term, peer support could play a central role in striking a new balance in the mental health system between professional intervention and other forms of support (Perkins 2010). For this to be possible, there will need to be considerable expansion in the number of peer supporters.

Two approaches to peer support are considered in the box opposite.

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Peer support

The Peer 2 Peer Group

The Peer 2 Peer Group is partnership between Together UK, the National Survivor User Network, and a national network of organisations providing peer support services in their local areas. The group shares best practice, provides leadership and works with academics, health professionals and others to develop innovative models of peer support.

Further information is available at: www.together-uk.org/about-us/who-we-are/peer-2-peer-group.

Recovery Innovations in Arizona, United States

Recovery Innovations is a US mental health care provider that has transferred a substantial proportion of the functions traditionally performed by professionals to peer support specialists. Two-thirds of its workforce is comprised of peer support specialists, trained at its Recovery Education Centre. The results of the change included a dramatic fall in hospitalisation rates, as well as increased employment for people using the service and a better understanding among other staff of the needs and wishes of their clients (Johnson 2009).

Other examples

Other examples of peer support initiatives have been documented as part of the National Mental Health Development Unit's personalisation programme. Further details are available at: www.nmhdu.org.uk/.

Maximise workforce productivity

Various aspects of everyday working practices and conditions can prevent the health care workforce from being as productive as it could be. Our expert seminar identified several promising approaches towards improving workforce productivity.

Increasing direct care time

Mental health teams working in a range of settings have found it is possible to release more time for direct patient care by using process mapping tools such as LEAN, the productive mental health wards programme, or the choice and partnership approach. These tools can be used to identify inefficient working practices, and evidence suggests that they can also help deliver other opportunities discussed in this report, for example, reducing unnecessary bed use. The use of these tools is discussed more fully in Section 8.

Identifying inefficiencies in nursing rosters

Nursing rosters present an important opportunity for improving productivity. Several trusts have found that there is large variation between different services in terms of how rosters are structured and organised, and that in some cases rosters are managed in a way

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that neither makes most efficient use of nurses' time nor delivers care to patients when they need it most. Savings of almost £2 million have been made by changing the way rosters are managed in order to match the supply of nursing care more closely to demand (*see* box opposite).

Improving the health of the workforce

The Boorman review highlighted considerable problems in terms of the health and well-being of the NHS workforce (Department of Health 2009c), estimating that better management of the health of the workforce could save the NHS £555 million annually, principally by reducing sickness absence. Other estimates have placed the cost of mental ill health among the NHS workforce at £1.3 billion per year (Sainsbury Centre for Mental Health 2007), mainly because of so-called presenteeism (reduced productivity caused by being at work when unwell).

The coalition government has stated its intention to implement the Boorman review's recommendations, and several trusts have already succeeded in making substantial reductions in sickness absence.

Deploying specialist skills more effectively

In low- to middle-income countries there has been a push to use specialist resources less in the direct delivery of services and more as a means of skilling-up primary care and other generic frontline workers in the identification and low-level treatment and support of those with mental health difficulties. Lower threshold workers are provided with systematic support and consultation by mental health specialists who make this consultative activity a core part of their work. This approach is called 'scaling up' and is seen as a means of not only improving the quality of care to more people but also preventing the escalation of mental health difficulties into more costly crises (Lancet Global Mental Health Group *et al* 2007). There are already a few examples of the use of this approach in the United Kingdom (*see* box opposite).

Conclusions

This section has shown that there are real opportunities to make short-term changes to the way mental health services are delivered in order to achieve more within existing budgets. Across the areas we have identified, there is a number of common themes.

- Large variations exist in clinical and management practices between different services, some of which are unlikely to be clinically justified. Measuring and exploring these variations can illuminate areas where savings could be made.
- There are win–win cases where the financial and quality improvement arguments for change are aligned, for example, reducing unnecessary hospital stays or out-of-area placements.
- Many of the opportunities that exist relate to the interface between different teams rather than the working of any single team.
- Several of the opportunities relate to innovative alternative service models that challenge the traditional relationship between the service and the user, for example, crisis houses and peer support.

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Workforce productivity

Nursing rosters in East London

East London NHS Foundation Trust found considerable variation between the nursing rosters used in different services provided by the trust. The senior management team worked with front-line staff to establish how rostering practices could be simplified and harmonised across services, and how nursing time could be deployed in an efficient way that responded more effectively to patients' needs. By making changes to shift patterns and other practices, savings of £1.8 million were achieved.

Sickness absence in Rampton Hospital

Staff morale can be particularly problematic in secure wards and other challenging environments. In one ward in Rampton, a high-security hospital, sickness absence rates were reduced from 14 per cent to 2 per cent after using the productive mental health wards approach. The success was attributed to new processes (eg, for managing violent incidents) having created a less stressful workplace, and to a stronger focus on personal development planning for staff (NHS Institute 2009a).

Shift patterns in Derbyshire

As part of the productive mental health ward approach, staff in a CRHT team in Derbyshire used an activity follow tool to understand better the different demands placed on the team at different times. A new shift system designed around this analysis gave more cover at peak times, while also reducing sickness absence rates from 11 per cent to 6 per cent and saving money by reducing unsociable hours pay (NHS Institute for Innovation and Improvement 2009b).

Scaling up in Telford and Wrekin

Historically, Telford and Wrekin had a number of teams serving the needs of families and children and these were organised according to disciplinary background and funding streams. Three years ago, multidisciplinary teams were established to deal with lower-level needs and to act as an initial triage when families and children were facing problems. Workers were provided with consultation and support from specialist CAMHS teams where necessary. This approach had a knock-on effect of a two-thirds reduction in referrals to specialist CAMHS teams in the area.

- The role of CRHT teams will be particularly important. Some areas have not achieved the full potential of these teams to reduce unnecessary bed use, improve discharge processes and reduce the use of out-of-area placements.
- Secure services represent a huge area of spend in which there is a considerable need for change. Part of the challenge concerns the tension between managing risk and creating a nurturing, clinically effective environment.
- Barriers to obtaining supported accommodation placements represent a significant bottleneck in the system. The problem relates to both the limited supply of supported accommodation and to bureaucratic processes involved in getting a placement.

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5 Productivity in the wider NHS: what can mental health offer?

The previous section described opportunities to improve productivity within the mental health system. There are also opportunities to make savings across the wider National Health Service (NHS) by responding to mental health needs more effectively in primary care, accident and emergency (A&E) and acute hospital settings (NHS Confederation 2009a). Mental and physical health problems are strongly interdependent, and co-morbidities are common. Research demonstrates that intervening to improve mental health can improve the prognosis of physical disease and reduce associated costs.

The King's Fund's Quality in a Cold Climate programme has highlighted the opportunities that exist to achieve improved productivity through a closer integration of health and social care services (Appleby *et al* 2010). This section demonstrates that there are similar opportunities for improvements in the interface between mental and physical health care to deliver productivity gains across the system. Supporting productivity improvements across the wider NHS requires:

- claiming the long-term conditions dividend
- addressing medically unexplained symptoms
- improving services for older people.

Claiming the long-term conditions dividend

Improving the management of long-term conditions represents one of the best opportunities to improve productivity in the NHS, particularly by reducing unplanned hospital admissions (Appleby *et al* 2010). A core component of this will involve responding more effectively to the mental health and psychological needs of people with long-term conditions.

There is a strong association between mental ill health and physical health problems such as diabetes, arthritis or cardiovascular disease (Chapman *et al* 2005; Evans *et al* 2005; Roy-Byrne *et al* 2005; McVeigh *et al* 2006). For example, depression has been associated with a four-fold increase in the risk of heart disease, even when other risk factors such as smoking are controlled for (Hippisley-Cox *et al* 1998; Osborn *et al* 2007). The presence of co-morbid mental health problems can lead to poorer-quality care for the physical condition, decreased adherence to treatment, increased health service costs and poorer outcomes (Chapman *et al* 2005; Evans *et al* 2005; McVeigh *et al* 2006; Kisely *et al* 2007; Nuyen *et al* 2008; Unützer *et al* 2009). The size of the financial impact of co-morbidity can be significant – in the case of diabetes, the costs to the health service of each person with diabetes and co-morbid depression is up to 4.5 times greater than for a person with diabetes alone (Egede *et al* 2002).

In addition to the presence of distinct mental health problems in people with long-term conditions, there is often a psychological component to physical illness that can

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be addressed using standard mental health interventions such as cognitive-behavioural therapy (CBT). There is evidence that addressing mental health and psychological needs can produce sustained reductions in admissions to hospital for people with a range of long-term conditions, including angina, diabetes and irritable bowel syndrome (Creed *et al* 2003; Moore *et al* 2007; Simon *et al* 2007). The savings associated with avoided admissions can be considerable, and well in excess of the cost of intervention.

The interface between mental health specialists and primary care will be crucial in reaping this long-term conditions dividend. This interface needs active management to improve communication between professionals and to enable general practitioners (GPs) to feel confident in engaging with the mental health and psychological needs of people with long-term conditions. Shared care arrangements, such as those in the collaborative care model, present opportunities to improve the management of mental health in primary care (Katon and Seelig 2008; Richards *et al* 2008).

Psychological support for people with physical long-term conditions

Support for angina in Liverpool

An innovative disease management programme based on cognitive behavioural therapy has been provided by the UK National Refractory Angina Centre in Liverpool since 1997. The programme aims to tackle patients' misconceptions about angina and associated maladaptive behaviour and to improve their psychological well-being. Evaluation has demonstrated that as well as reducing symptoms and improving quality of life, the intervention is associated with a 33 per cent reduction in hospital admissions over the following year. This represents a reduction in hospital costs of £1,337 per patient per year (Moore *et al* 2007).

Diabetes in Salford

In Salford, the Improving Access to Psychological Therapies (IAPT) service has developed a new care pathway for people with diabetes and co-morbid depression or anxiety. The service provides sessional input into the community diabetes clinic, and has trained diabetes professionals in screening for mental health problems (Department of Health 2008).

Participants at our expert seminar identified the following actions as important:

- implementing existing National Institute for Health and Clinical Excellence (NICE) guidelines recommending the use of the collaborative care model to support people with long-term conditions and co-morbid depression in primary care (*see* box overleaf)
- expanding screening and early intervention for depression and anxiety in primary care, A&E and other settings among people with long-term conditions
- training in motivational interviewing to allow GPs to give well-being advice more effectively
- continued investment in the IAPT programme to ensure these services are available in all areas and to retain or increase the level of service currently available at IAPT implementation sites.

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NICE guidelines on collaborative care for people with depression and a chronic physical health problem

NICE recommends that collaborative care be considered for people with moderate to severe depression and a chronic physical health problem whose depression has not responded to initial treatment. This should normally include:

- provision of a case manager responsible for overseeing and co-ordinating all components of care, with supervision from a senior mental health professional
- close collaboration between primary and secondary physical health services and specialist mental health services
- a range of interventions including patient education
- long-term co-ordination of care and proactive follow-up.

Source: National Institute for Health and Clinical Excellence (2009)

Addressing medically unexplained symptoms

Medically unexplained symptoms are physical symptoms that lack a medically identifiable organic cause. Around 20 per cent of initial appointments with GPs concern symptoms that appear to be of this kind (Burton 2003), and for a significant proportion of these the symptoms are caused or exacerbated by mental health or psychological issues.

The costs associated with medically unexplained symptoms are considerable. Patients thus affected tend to access primary care services frequently and are often subject to high levels of diagnostic investigation and unnecessary and costly referrals (Page and Wessely 2003; van der Weijden *et al* 2003). Outpatient costs are 20–50 per cent higher for these patients, and admissions 30 per cent higher (Fink 1992a, 1992b; Reid *et al* 2001; Reid *et al* 2002). Recent estimates place the total cost to the NHS at £3.1 billion per year, and the costs to the wider economy at £18 billion (Bermingham *et al* 2010).

There are three main components to the effective management of medically unexplained symptoms. The first concerns consultation techniques in general practice (Hatcher and Arroll 2008). Good practice appears to involve:

- focusing on the symptoms and their effect on functioning rather than on applying a diagnostic label
- offering reassurance
- providing explanations that integrate physical and psychological perspectives
- avoiding overuse of diagnostic investigations
- generating ideas about how patients can manage their symptoms effectively.

The second component of an effective response to medically unexplained symptoms concerns providing appropriate interventions to help people manage their symptoms where necessary. Evidence-based interventions include CBT, physiotherapy or exercise therapies (Koes *et al* 1991; Singh *et al* 1997; Morley *et al* 1999; Kroenke and Swindle 2000; Price and Couper 2001).

Finally, some patients with medically unexplained symptoms have underlying mental health problems such as depression or anxiety that might be linked to their physical

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symptoms. Screening followed by appropriate treatment is therefore necessary (Hatcher and Arroll 2008).

Psychological therapy services are well placed to play an expanded role in supporting people with medically unexplained symptoms, both by providing treatment for co-morbid mental health problems, and perhaps also by offering services tailored to people with medically unexplained symptoms, using CBT-based interventions to give them the skills to manage their symptoms more effectively.

One approach to medically unexplained symptoms is examined in the box below.

Medically unexplained symptoms in Suffolk

Suffolk Mental Health Partnership has developed a training programme for local GPs on the identification and effective management of medically unexplained symptoms. At least one GP from each practice will attend the training over the next two years.

Suffolk IAPT is also working with the general acute-hospital sector, NHS Suffolk and local GPs to develop several projects aimed at limiting the flow of specific groups of patients with medically unexplained symptoms to secondary care. These include:

- primary care pain management groups to reduce referrals to the pain clinic
- earlier psychological intervention for irritable bowel syndrome, using IAPT low-intensity workers and CBT therapists.

Improving services for older people

Mental health problems among older adults constitute a huge and growing burden on NHS and social care services. Dementia, in particular, is associated with high service costs (*see* Section 7, pp 29–30), but depression is even more prevalent and highly disabling for older people. It has been estimated that at any given time in a typical 500-bed district general hospital, 220 beds are occupied by older people with mental health problems: 102 with dementia and 96 with depression (Anderson *et al* 2009).

The potential for older people's mental health services to play a role in reducing this burden is currently underexploited. There is considerable scope to reduce costs by providing specialist input into care homes, A&E departments and acute wards, and by providing access to crisis resolution and home treatment (CRHT) services (Anderson *et al* 2009):

- delivering services to care homes can reduce the use of primary and secondary health services, and can also reduce unnecessary prescribing of antipsychotic drugs, which are currently estimated to be overprescribed to the value of £14 million per year
- mental health liaison services can help increase productivity in acute hospitals by improving older people's clinical outcomes while reducing length of stay and re-admission rates
- provision of specialist older people's CRHT services can reduce hospital admission rates by up to 31 per cent, as well as reducing length of stay and admission to care homes (Anderson *et al* 2009).

A survey conducted in Lincolnshire by the National Audit Office found that patients in general hospitals were significantly more likely to experience discharge delay if they had

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dementia. Overall, more than two-thirds of patients with dementia were assessed as no longer needing to be there. This represented a total of £6.5 million that could be invested more appropriately in community provision, non-acute beds, or other services (National Audit Office 2007b). Extrapolated over the whole of England, this would equate to more than £300 million that could be allocated more productively.

The current provision of older people's mental health services is patchy, with evidence suggesting there is considerable underfunding relative to services for working-age adults (Beecham *et al* 2008; Forder 2008). Liaison services to care homes, A&E departments and acute hospitals are provided in only a minority of areas, and access to specialist CRHT services is limited (Anderson *et al* 2009).

In 2009, the Department of Health published a national dementia strategy aimed at reducing the unnecessary use of acute beds by people with dementia and redirecting savings to early diagnosis and intervention in people's own homes (Department of Health 2009a). However, the National Audit Office has been critical of the limited progress made in implementing the strategy to date. Key problems appear to be: limited local leadership on the issue; a lack of co-ordinated working between health and social care services; and inadequate training, resourcing or performance monitoring to support implementation (National Audit Office 2010). Full implementation of the dementia strategy, as well as improvement of older people's mental health services more generally, should be a high priority for policy-makers and the NHS.

Three approaches to supporting older people with mental health problems are described in the box below.

Supporting older people's mental health

Hospital liaison in Leeds

A mental health liaison service for hospitals in Leeds, created as part of the national partnerships for older people projects, succeeded in reducing admissions and facilitating early discharge for older people. The average length of stay for people with dementia fell by 54 per cent, saving 1,056 bed-days per year.

Care home liaison in Doncaster

A specialist liaison team was established in Doncaster in 2006 to provide mental health support to local care homes. After the first year, admissions from care homes to hospital had been reduced by 75 per cent. The team has also been highly active in delivering training to care-home staff and co-ordinating the work of care homes, mental health services and social services.

Crisis resolution for older people in West Suffolk

In 2006, the crisis resolution and home treatment team in West Suffolk expanded its remit to include the provision of services to older adults in addition to those of working age. Admissions to hospital for older people were reduced by 31 per cent without any adverse impact on patient or carer satisfaction.

Source: Anderson *et al* (2009)

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6 Economic benefits beyond the NHS

Redesigning mental health services and improving public mental health will be beneficial not only for the National Health Service (NHS) budget, but also for the wider economy, with considerable potential for reducing public spending in other departments. The cost to England's economy of mental ill health is around £30 billion per year in terms of lost earnings alone (Centre for Mental Health 2010a). Much of the financial burden of mental ill health falls outside the health sector. For example, 43 per cent of those on incapacity benefit in the United Kingdom receive it mainly on mental health grounds (Department for Work and Pensions 2009). The impact of mental ill health on the criminal justice system, which is currently facing a national budget reduction of 23 per cent over four years, is also significant.

This section looks at some of the major gains that could be achieved if health and social care services formed partnerships with other public services to tackle mental health problems, working together being more effective than working separately.

The two areas focused on in particular are:

- providing effective employment support
- supporting mental health in the criminal justice system.

Providing effective employment support

Being in paid work is one of the most important factors in achieving recovery from mental ill health. There is strong evidence that supporting people with severe or enduring mental health problems to gain or stay in employment improves their prognosis significantly by breaking 'a downward spiral of worklessness, deterioration in mental health and consequent reduced chances of gaining employment' (Waddell and Burton 2006, p 22). Furthermore, 70–90 per cent of people who are out of work as a result of severe mental health problems want to be employed (Grove 1999; Secker *et al* 2001).

There is also clear evidence that certain approaches to supporting employment are more cost-effective than others. The individual placement and support (IPS) approach has consistently been found to outperform traditional train-then-place or sheltered work schemes, and succeeds in helping more than half of its participants to return to employment (Sainsbury Centre for Mental Health 2009d).

The defining features of IPS are that people are supported to find competitive employment (as oppose to vocational training placements) as quickly as possible, and then provided with support and training when in post. The key principles are:

- competitive employment is the primary goal
- everyone who wants employment support is eligible for it
- job search is rapid and consistent with individual preferences
- employment specialists and clinical teams are co-located and work together

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- tailored in-work support is available for as long as necessary
- counselling on welfare benefits supports the individual through the transition from benefits to work (adapted from Bond *et al* 2008).

The annual cost of implementing IPS across the NHS is estimated to be about £67 million. The current annual spend on day and employment services for people with mental health problems is £184 million. This suggests that a national roll-out of IPS could be afforded within existing budgets by diverting some resources from less effective models (Sainsbury Centre for Mental Health 2009b).

Evidence suggests that one-third of IPS participants become regular workers, some of whom will no longer need state benefits. A further one-third become occasional workers. Both of these groups will enjoy higher incomes and greater independence and are likely to require fewer hospital admissions over time, thus reducing costs to the NHS in the long term. There is growing evidence that savings to the NHS alone could more than cover the cost of providing IPS (Sainsbury Centre for Mental Health 2009b). An example of employment support based on the IPS model is described in the box below.

Employment support: South West London and St George's Mental Health NHS Trust

Since 2003, employment specialists have been integrated within many of the trust's community mental health teams to deliver an IPS service which offers both employment support and welfare benefits advice. A 12-month study found that the IPS service helped 37 per cent of service users to gain or maintain paid work, compared with just 17 per cent in a comparable non-integrated service, at one-sixth of the cost of the traditional approach (Rinaldi and Perkins 2007).

As well as investing in employment support for people who are out of the labour market, it is also crucial to ensure that people who are in work and experiencing mental distress do not lose their jobs. Workplace-based programmes such as line manager training, screening and early intervention based on good evidence will not only reduce the costs of mental ill health to employers, but also improve productivity in the NHS by encouraging prevention and early treatment (Seymour 2010).

Supporting mental health in the criminal justice system

The prison population of England and Wales now numbers more than 85,000 people. In England, 10 per cent of prisoners have a severe mental illness, and there is a large backlog of people waiting to be transferred from prisons to mental health facilities. Most prisoners have a complex mix of mental health and substance misuse problems alongside a range of other difficulties. In addition, at least half of the 200,000 people who receive community sentences each year have mental health needs.

Mental health services for people in the criminal justice system are underdeveloped. All of England's prisons now have specialist in-reach teams, but funding for these is at only one-third of the level required to offer a service that is comparable with that provided outside (Brooker *et al* 2008). Meanwhile, primary mental health care in prisons is very limited, and mental health support to released prisoners and people on probation is often lacking.

The Bradley report (Bradley 2009) made some 82 recommendations for improving the support offered to people with mental health problems or learning disabilities

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in the criminal justice system. The report concluded that these improvements could be made by changing the way money is spent within the system rather than spending additional money.

Among Bradley's recommendations was the creation of criminal justice mental health teams to provide liaison and diversion support at every police station and court in England. It is estimated that diverting a single offender from a short prison sentence (less than 12 months) to a community order with effective mental health treatment can result in net savings of £20,000 by reducing the risk of future offending (Sainsbury Centre for Mental Health 2009e).

Currently, around £10 million is spent annually on diversion services for the whole of England, well short of the £50 million it is estimated it would cost to provide comprehensive diversion support nationwide. Local joint commissioning of diversion services between the NHS and the National Offender Management Service could help to share the cost and enable diversion teams to bridge the two systems (Sainsbury Centre for Mental Health 2009c). This needs to be supported by the development of robust alternatives to imprisonment that include the provision of mental health care to people on community sentences, for example, through the mental health treatment requirements that can be attached to community sentences (Khanom *et al* 2009).

Diversion and liaison must also be provided to children and young people (*see* box below). People in the youth justice system have especially high levels of mental ill health, often emergent and hard to label diagnostically. They are also highly likely to re-offend. Age-appropriate triage in police custody, followed by assertive support to make and sustain contact with services, are vital to ensure children and young people at risk of further ill health and offending are diverted as early and effectively as possible.

Mental health in the criminal justice system: Youth justice liaison and diversion

The Department of Health is funding six pilot schemes to test youth justice liaison and diversion, a model developed by the Centre for Mental Health. Each scheme provides workers to visit children and young people in police custody suites. Where mental health and other needs are identified, workers liaise with the relevant services to build packages of support. They also make recommendations to the police, the Crown Prosecution Service and the courts.

Diverting young people away at this earlier stage to restorative justice and sometimes to mental health support not only improves the life chances of the young people, but it also allows workers to pick up emerging mental health difficulties and other complex needs at an early stage.

There appear to be knock-on savings to the criminal justice system. In one pilot site, court throughput has dropped to such an extent that it has been decided to close the court one day a week. Custodial rates have dropped by around one-quarter to one-third for children and young people. In another area, an analysis of youth offending team caseloads shows an overall drop of around 50 per cent.

A full evaluation of these schemes is being conducted by the University of Liverpool and will be available by the end of 2011.

Further information can be found at: www.centreformentalhealth.org.uk.

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7 The longer-term challenge: building a preventive and empowering mental health system

The previous chapters have focused on opportunities for improving productivity in mental health and wider public services in the short to medium term. Although the scale of what could be achieved within this timescale is substantial, there is even greater scope to develop a more cost-effective mental health system in the longer term.

The challenge is to build a system that is able to prevent mental illness and promote mental well-being within the general population, as well as respond well when people need support. Key steps to achieving these longer-term opportunities include:

- improving the mental health of children and young people
- preventing or reducing the prevalence of dementia
- moving towards a system that promotes independence, self-management and recovery rather than encouraging dependency on statutory services.

This chapter highlights the opportunities that exist in each of these areas.

Improving the mental health of children and young people

Research evidence strongly indicates that the most cost-effective way to prevent the development of mental health problems and promote mental well-being and resilience is to focus on childhood and adolescence (Zechmeister *et al* 2008). Half of all mental health problems begin in childhood, and three-quarters appear by the mid-20s (Department of Health 2009b). Effective interventions for the prevention or treatment of childhood mental health problems do exist, but availability is often limited (Meltzer *et al* 2003; British Medical Association 2006). The enduring and costly consequences of these problems mean that the benefits of intervention could be substantial.

Longitudinal studies demonstrate a high level of continuity between mental health problems in early life and adverse outcomes in adulthood. For example, a diagnosis of the most common childhood mental health problem, conduct disorder, is strongly predictive of adult mental health problems, substance misuse, smoking, teenage pregnancy, poor performance at school and in the workplace, poor-quality relationships and criminal behaviour (Scott *et al* 2001; Fergusson *et al* 2005; Stewart-Brown 2005). Indeed, 80 per cent of crime is committed by people who had conduct problems as children (Sainsbury Centre for Mental Health 2009e).

The cost of failing to address childhood mental health problems is considerable and falls on a range of public services. For example, lifetime costs for a single case of untreated childhood conduct disorder have been estimated to be around £150,000, with around

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£20,000 of this sum falling on the health and social care sector. These costs are related to a range of health and other problems that would be obviated if conduct disorder in childhood were prevented or successfully treated (Friedli and Parsonage 2007).

Research suggests that a number of interventions might offer a significant return on investment by preventing later problems (Friedli and Parsonage 2007; US Department of Health and Human Services 2007; Waddell *et al* 2007; McCabe 2008). These include:

- nurse–family partnerships during pregnancy and the first 18–24 months of life
- parenting programmes
- pre-school education and support programmes
- school-based programmes for social and emotional learning
- multisystemic therapy.

There is strong evidence to indicate that these early preventive interventions can more than pay for themselves in the long term. The challenge is to devise funding mechanisms that make it possible to justify short-term investment on the grounds of longer-term returns.

Further progress towards prevention could be made by addressing the wider determinants of mental health and well-being in childhood. The Marmot review into health inequalities in England placed a major emphasis on the effects of social and economic factors during childhood, particularly in the pre-school years (Marmot 2010). Jonas *et al* (2010) also found that adverse experiences in childhood can play a powerful role in generating later mental health problems. To tackle the wider determinants of ill health, the Marmot review called for 'a second revolution in the early years' (Marmot 2010, p 94), including increased investment in parental leave, childcare and education during the first years of life.

Reducing the prevalence of dementia

Dementia accounts for a large and increasing proportion of public spending on mental health. An analysis commissioned by The King's Fund found that more is spent on providing support for dementia than for any other category of mental health problem. The combined costs of health, social, residential and informal care in 2007 were estimated to be £14.9 billion, compared with £1.7 billion for depression, £1.2 billion for anxiety disorders, and £2.2 billion for schizophrenia. In the absence of significant developments in the prevention and treatment of dementia, these costs are predicted to rise to £24 billion by 2026 (at 2007 prices) (McCrone *et al* 2008).

In the long term, if innovations in prevention or treatment were to succeed in reducing the prevalence of dementia by even 10 per cent, this would deliver substantial savings. Modelling suggests that a 10 per cent reduction would save around £800 million per year, while a 30 per cent reduction could save £2.4 billion, largely in reduced residential and informal care costs (McCrone *et al* 2008).

Although much remains unknown about the potential for preventing or delaying the onset of dementia, recent research indicates that tackling a number of risk factors could have some effect. In particular, it has been estimated that reducing the prevalence of diabetes and depression among older people and increasing fruit and vegetable consumption could reduce the prevalence of dementia by up to 21 per cent (although reductions on this scale would require the elimination of all diabetes and depression in older age) (Ritchie *et al* 2010). Increasing physical and intellectual activity may also be protective (Eggermont and Scherder 2006).

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Questions remain about the causal relation between these risk factors and the development of dementia, and about the age at which preventive interventions should be targeted. Investment in further research on the prevention and treatment of dementia should be given a high priority.

Promoting independence and recovery

Government policy increasingly recognises the importance of creating a mental health system that promotes independence, in which staff see the ultimate goal of their work as being to help people maintain or regain independence (Department of Health 2009b). This approach is intended to improve quality of life by giving people control over their own process of recovery and avoiding the development of disempowering dependency relationships between service users and staff (Perkins 2010). It is possible that radically rethinking the way services are provided and reducing people's reliance on them might also offer better value for public money.

A range of self-management tools exist and have been found to be effective in giving people better skills for managing their condition (Perkins *et al* 2006; Van't Hof *et al* 2009). However, the change that would be required to create a mental health system truly focused on promoting independence goes well beyond the wider use of these sorts of tools. It would represent a dramatically different way of working for frontline clinicians, requiring development not only of new skills but, crucially, of attitudes, values and assumptions about the nature of mental illness and the role of health professionals in tackling it (Boardman and Shepherd 2009). A number of services based on this recovery-oriented model are currently being developed at sites across England as part of a collaboration between the Centre for Mental Health, the NHS Confederation's Mental Health Network, and the National Mental Health Development Unit.

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8 Making it happen

So far we have described a number of opportunities to deliver mental health care in a more cost-effective way. Some of these relate to 'doing the right things', while others are a case of 'doing things right'. Many of the opportunities identified will not be simple to implement in practice, but the case studies demonstrate how much is achievable. To realise the opportunities, action will be needed at all levels and will need to involve all stakeholders, including:

- service users and carers
- clinical teams
- provider organisations
- commissioners
- regional organisations
- national decision-makers.

What role can service users and carers play?

The success of efforts to improve productivity in mental health will depend crucially on service users and carers co-producing the change with mental health professionals. Their direct experience will be invaluable in identifying how to maximise value for money at the front line without damaging the quality of care. Commissioners and providers must find ways of working meaningfully with service users and carers on improving productivity.

A recommissioning exercise evaluated by the Centre for Mental Health found that for service user involvement in service redesign to be meaningful, it is vital to:

- involve service users from the start to agree the principles of the process
- allocate sufficient resources to support service users' involvement throughout the process
- be clear about the scope of the process and the roles of all those involved
- communicate the results of the process clearly (Sainsbury Centre for Mental Health 2009a).

What can clinical teams do?

Clinical leadership will be crucial, given the key role that clinical decision-making plays in determining National Health Service (NHS) expenditure (Appleby *et al* 2010). Secondary care clinicians and managers will need to be proactive in redesigning processes of care within their teams, for example, to improve assessment processes or maximise direct care time. They will also need to be involved in rethinking the relationships between teams,

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for example, exploring the possibilities for reconfiguring community teams or developing integrated acute care teams.

Primary care professionals have an equally important role to play. A priority for general practitioners (GPs) should be to identify the means by which to achieve the substantial savings that could be generated by responding better to the mental health and psychological needs of people with long-term conditions such as diabetes, arthritis or cardiovascular diseases. Similarly, improving the way medically unexplained symptoms are managed in primary care should be a priority for action.

A number of tools may help clinical teams to take greater responsibility for these issues. The planned shift of commissioning responsibilities to GPs might encourage them to engage with the challenge of improving the productivity of services beyond their immediate clinical practice (*see* p 34). Within provider organisations, increased use of service line management provides a promising way of giving clinical teams increased responsibility for controlling budgets and tackling variations in clinical practice within and between teams.

A growing number of mental health teams across the country have used quality improvement tools developed through the NHS Institute's productive mental health wards programme and the Choice and Partnership Approach (CAPA) to improve the productivity and quality of the service they provide (*see* box opposite). These tools offer the means of achieving a number of the opportunities discussed earlier in this report, including improving workforce productivity and reducing unnecessary bed use. Their power appears to lie in their focus on giving front-line staff the information, skills and power they need to identify and implement practical improvements in their working practices.

Some of the ideas discussed in this report, for example, an expanded role for peer support, may challenge the traditional roles of some professionals. It is vital that people understand that alterations to their roles are not about devaluing their contribution but about making better use of their skills and competencies.

What can provider organisations do?

In order to tackle the productivity challenge effectively, providers – including NHS, private and voluntary sector organisations – will need a more sophisticated and detailed understanding of the variation that exists between different organisations. Providers need to know how they perform relative to others in terms of key indicators such as the use of psychiatric acute care beds, coverage of crisis resolution teams and levels of sickness absence. The Audit Commission's Mental Health Benchmarking Club, to which the majority of mental health trusts in England now belong, is one positive example showing how comparative performance data and best practice can be shared between organisations.

Having collected comparative performance information, providers will need to know how to make use of it. They will be most effective in doing this if information is shared with clinical teams in order to harness their desire to improve the quality of the services they provide. Service line-management arrangements can help support this, as described above.

Providers will have an important role in developing new service models such as integrated acute care teams, new models for community services, integrated approaches to substance misuse and alternative step-down services from secure care. This will need to be done in partnership with commissioners and with the clinical workforce. They will also need to make sure that the productivity of existing services is maximised, for example, by identifying opportunities to organise nursing rosters more efficiently, improving staff

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Using quality improvement tools to increase productivity

Productive mental health wards

Around 80 per cent of mental health trusts have signed up to the NHS Institute's productive mental health wards programme, which has pioneered the use of process mapping in inpatient wards. Evaluations indicate that the programme has been successful in achieving:

- increased direct patient-care time
- decreased staff stress levels and sickness absence
- reduced inpatient bed use through shorter lengths of stay and lower re-admission rates.

The CAPA for Child and Adolescent Mental Health Services (CAMHS)

CAPA is a method of improving care processes used by at least 97 CAMHS teams across the United Kingdom as well as in Australia, New Zealand and Belgium. The overall intention is to create a smoother experience for service users through developing more efficient, streamlined processes. The approach emphasises:

- involving young people and families in planning their care
- using a formal process for mapping the skills and capacity present in the team
- collaborative assessment conducted by highly skilled staff (*see* Section 4).

Evaluations of CAPA suggest it can help reduce demands on services and create more efficient working processes, with outcomes that include:

- increased caseload per team member
- improved attendance rates for appointments
- significantly reduced waiting times
- improved staff and service-user satisfaction (York and Kingsbury 2009).

Although designed for CAMHS, many of the principles of CAPA are applicable to adult services, and it has been used by adult community teams in New Zealand.

For further information on CAPA, visit: www.camhsnetwork.co.uk or contact Ann York at: rowe.york@btinternet.com or Steve Kingsbury at: steve.kingsbury@hertspartsft.nhs.uk.

productivity by promoting the use of quality improvement tools such as those described in the box above, and engaging the workforce in all aspects of change using techniques such as listening into action.

Providers will need a systematic workforce strategy to ensure that the right staff are deployed in the right place at the right time. Organisations should examine the skills in their workforce and, if necessary, provide training or make changes to the skill mix, for example, to improve substance misuse skills or to increase the role of peer support. Organisations will also need information technology systems that are fit for purpose, for example, to allow information to be shared between teams and the need for repeat assessments to be reduced.

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What can commissioners do?

Commissioners will need to take a leading role in reviewing existing service provision, identifying low-value interventions and stimulating providers to replace outdated services and approaches. They will need access to high-quality comparative performance information to identify and challenge poor practice.

A clear priority for commissioners should be to reduce the use of out-of-area placements. By redirecting current spending on these placements into local services, commissioners can achieve substantial savings while also improving the quality of care received by people currently placed unnecessarily outside their local area.

Another high priority in many areas should be to invest in expanding the coverage and improving the functioning of crisis resolution and home treatment (CRHT) teams. These teams play a vital role in minimising unnecessary use of expensive acute beds. Commissioners need to ensure CRHT teams have access to psychiatric expertise, are able to provide 24/7 coverage, and are actively involved in facilitating earlier discharge and reducing the use of out-of-area placements.

An important challenge for commissioners will be to exploit the significant opportunities that exist to make savings across the NHS by responding to mental health needs more effectively in primary care, accident and emergency and acute hospital settings. The difficulty here will be that the savings will accrue to different budgets. This is even more problematic when the financial returns from investing in improved mental health care often fall entirely outside the NHS. The Total Place initiative and other place-based funding mechanisms present a way of collaborating across traditional sector boundaries to overcome this problem. Place-based budgets have particular potential to improve the efficiency and quality of support for people with the most complex (and expensive) needs that silo-based services have been unable to meet adequately.

The planned transfer of commissioning responsibilities from primary care trusts (PCTs) to GP consortia will present both opportunities and challenges for mental health. There is likely to be considerable variation between consortia in terms of mental health expertise, with some consortia containing a critical mass of GPs with an interest in mental health, and others having less capability in this area. Some GPs might seize the chance to improve primary care support for mental health problems, but a recent survey showed that many GPs feel less confident in their ability to commission specialist services for people with mental health problems than they do for people with physical health conditions (Rethink 2010). This suggests that they will need considerable support if they are to do this effectively. Consortia will be able to buy commissioning support services from a range of organisations, but using such support effectively is not straightforward and will require consortia to have sufficient prior understanding of the commissioning process (Naylor and Goodwin 2010).

There is a significant risk that the organisational transformations associated with the shift to GP commissioning will detract from the challenge of improving NHS productivity such that the opportunities described in this report and elsewhere are not acted upon (Appleby *et al* 2010). This must be avoided, and the ongoing commitment of PCTs to improving productivity in mental health during the transition period will be critical in ensuring that this does not happen.

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What can regional organisations do?

Strategic health authorities have played a leading role in efforts to improve productivity in the NHS, and this needs to continue over the next two years. Many of the necessary changes described in this report will be highly complex for PCTs and providers to tackle on a purely local basis, and would benefit from additional oversight at the regional level.

Although the government's proposed structural reforms leave it unclear what, if any, regional structures will exist beyond 2013, there will continue to be a critical role for organisations acting at this level to broker and co-ordinate the wider service change that local commissioners will not be able to effect, such as strategic redesign in the provision of secure and other specialist mental health services.

What should national decision-makers do?

Providers and commissioners will require support from the national and regional level in order to implement the necessary changes. Policy-makers will need to make it easier for local organisations to use pooled funding mechanisms that bridge the gap between where investments are made and where savings are delivered. There also needs to be support for investing in longer-term preventive measures that will not deliver benefits immediately. Full implementation of the dementia strategy should be prioritised, and there will need to be funding for further research on:

- interventions in childhood that can prevent development of problems later in life, both by treating childhood mental health problems and by creating wider circumstances in which children can thrive
- prevention and treatment of dementia.

Measuring outcomes in mental health

It is important that mental health features prominently in the proposed NHS outcomes framework. Standardised outcome measures will allow providers and commissioners to measure and compare performance effectively. If measures are chosen that capture aspects of performance that are of highest priority to people who use mental health services, the increased emphasis currently being placed on measuring outcomes could refocus services on what matters most to those who use them.

The NHS outcomes framework consultation document (Department of Health 2010b) suggests measuring the performance of mental health services by:

- effectiveness, measured in terms of:
  - the gap in mortality rates between people with and without mental health problems
  - employment rates for people with mental health problems
- patient experience, measured using standardised instruments
- safety, measured in terms of suicide rates on inpatient units.

These measures are focused largely on serious mental illness in adults. The outcomes framework would also need to include appropriate measures for children and adolescents, and for people with common mental health problems such as depression and anxiety. These should be focused on high-level outcomes such as promoting independence and quality of life.

In addition to the NHS outcomes framework, the government proposes to develop a commissioning outcomes framework that the NHS Commissioning Board will use

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to hold GP commissioning consortia to account. This should include more detailed measures of mental health outcomes, such as how effectively services support people's self-defined recovery aspirations, or how well they prevent re-offending among people diverted to mental health services from the justice system. It is important that both the commissioning outcomes framework and the overarching NHS outcomes framework create an equivalence in the way mental and physical health services are performance-managed, and that they focus on the outcomes that matter most to the people who use them.

There will also be a need to continue measuring performance in terms of processes of care as well as outcomes. For example, the proposals discussed in this paper suggest that providers should measure and benchmark their use of acute and forensic beds, out-of-area placements and staff sickness rates. Measurement of how quickly services are able to intervene, for example, in treating a first episode of psychosis or in offering psychological therapy for depression, are also important.

Measuring employment rates for mental health service users will be enhanced by also testing how well employment services meet the fidelity criteria for the individual placement and support model, as well as the state of the local labour market and the needs of the people entering the service (Shepherd *et al* 2009).

Reforming payment mechanisms

The government proposes to develop a set of national currencies for adult mental health services for use from 2012/13 (Department of Health 2010a). This could encourage better performance and give providers with above-average costs a strong incentive to improve productivity, as well as ensuring mental health services are commissioned on the same basis as other areas of care. However, it is important that the lessons from the current use of national tariffs are learnt in developing an equivalent system for mental health. For example, it may be beneficial to create a system that is structured in terms of whole packages of care rather than individual episodes, that relates payments to the achievement of outcomes for service users, and that creates incentives for closer integration between services.

Tackling stigma

Finally, the Department of Health must continue to show leadership on tackling stigma in mental health. This has a direct bearing on the productivity of mental health services by generating significant and disproportionate risk aversion within the system. The Time to Change programme has begun to achieve tangible results from its high-profile, nationwide campaign to change public attitudes about mental health. As the first phase of Time to Change comes to an end, it is vital that the progress it has made is sustained through further work of this kind with a similar level of funding.

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9 Conclusions

It is clear from the evidence that by doing things differently, and in some cases by doing different things, better value for money in mental health care can be achieved. The case studies cited in this report illustrate how much is possible with strong leadership and commitment.

It is also clear that mental health services can play an important role in delivering efficiency savings in other areas, from hospitals to prisons. Providing better mental health support to people with physical illnesses, and using more effective means to help people with mental illnesses return to the workplace, for example, will help the National Health Service (NHS) to do more within existing budgets, at the same time as strengthening public finances more broadly. Failure to capitalise on this potential would represent a major lost opportunity in our efforts to adapt to the new economic environment.

The improvement areas discussed in this report all present significant opportunities, and specific priorities will need to vary in different localities. However, our assessment is that the following are the most promising targets for immediate attention:

- reducing unnecessary bed use in acute and secure psychiatric wards
- establishing systems to review the use of highly expensive out-of-area treatments
- improving workforce productivity
- strengthening the interface between mental and physical health care, particularly for older people and people with long-term physical conditions alongside mental health problems.

Two key challenges need to be overcome if mental health services are to fulfil their potential to support productivity gains in other sectors. The first is the question of how to commission services which will generate savings that will accrue to other budgets. This will require pooled funding mechanisms and an overarching pan-organisational approach. Central government must do all it can to encourage the adoption of such approaches.

The second issue is the time lag before financial returns on investment are delivered. Although some of the ideas in this report can be implemented immediately and will give quick returns, others will take longer. Nonetheless, it is important not to lose sight of the substantial savings that could be made in the longer-term, for example, by investing in promoting positive mental health and resilience in childhood, or by funding research into prevention and early intervention for dementia. Investments need to be made now if these savings are to be realised later.

General practitioners (GPs) will need to play a leading role in improving the critically important interface between mental and physical health services, as both commissioners and providers. The devolution of commissioning responsibilities to GP consortia may represent an opportunity to improve the way the NHS meets the mental health and psychological needs of people in primary care, particularly those with co-morbid

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physical health problems, long-term conditions or medically unexplained symptoms. However, there is also a danger that some GP commissioners will lack the necessary skills or interest in mental health, particularly with regard to serious mental illness. During the transition to the new system, it will be crucial that mental health commissioning skills are developed in consortia, in the proposed Health and Wellbeing Boards, and in other organisations that will be able to support commissioners of health and social care in their work.

Mental health services are usually provided by partnership trusts that bring together acute care and a range of community services. Despite this, there are still cases of poor joint-working between teams and of resources not being invested in the most appropriate settings, for example, overuse of acute beds and underprovision of community alternatives. An important lesson for the rest of the NHS, therefore, is that integration at the organisational or administrative level does not lead automatically to more co-ordinated behaviour at the clinical level or a more seamless experience for patients.

The NHS will, over the coming years, be under increasing pressure to deliver at a time when other public services are experiencing reductions in funding. Local authorities, welfare benefits, children's services and the justice system will all be cutting back dramatically and will depend upon health services to fill the gaps in support their retrenchment will create. The impact of this could be profound – this report has described, for example, how the limited availability of supported accommodation already leads to a significant waste of resources in the mental health system by causing discharge from inpatient units to be delayed. There is a danger that situations of this kind will be exacerbated as social care, welfare and housing budgets shrink.

In this context, mental health services will play a crucial part in offering support to some of the most disadvantaged people with some of the most complex needs. By means of place-based budgets or other forms of pooled funding, they could achieve a great deal and at the same time reduce the overall costs to the taxpayer of supporting people who too often do not get the assistance they need until their problems have become complex and highly expensive to address.

Mental health services should neither be targeted disproportionately for spending reductions nor protected from the productivity challenge the rest of the NHS will have to face. But, as this report makes clear, there remains untapped potential to respond better to the mental health needs of the whole population and the specific needs of people with mental health problems.

By grasping these opportunities, mental health commissioners and providers will be better placed to build on the work of recent years and to meet the financial challenge by improving rather than sacrificing quality of care. More can be achieved with existing resources, but that will not happen unless we plan ahead and make changes based on evidence rather than cutting back as a short-term expediency without a view to its longer-term impact.

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10 Recommendations

- There are substantial opportunities to improve productivity in mental health care, and to deliver savings across the National Health Service (NHS) and elsewhere by investing in mental health services.
- All work to improve productivity in mental health services needs to be carried out with the full and equal involvement of service users, carers and practitioners.

For clinical teams

- Mental health professionals should see the productivity challenge as being their responsibility. As part of this they should be encouraged to:
  - develop quality dashboards to support improvement
  - make use of comparative performance information to reduce unwarranted variations in practice
  - take advantage of opportunities to become more involved in redesigning processes of care and developing new service models.
- General practitioners (GPs) can play a key role by developing improved forms of care to meet the mental health and psychological needs of people with long-term conditions or medically unexplained symptoms. In doing so, they will need to work closely with local Improving Access To Psychological Therapies services.

For provider organisations

- NHS, private and voluntary sector providers must all play a role in improving the efficiency and effectiveness of services.
- Providers should work with commissioners to develop more cost-effective service models such as integrated acute care teams, better community services and innovative approaches to substance misuse and complex needs.
- Providers will also need to tackle productivity within existing services, for example, by taking action to develop a healthier and more efficient workforce. There is a variety of tools to support this.
- Providers need to benchmark their performance against that of other trusts and take action to reduce inappropriate variation, for example, in the use of acute psychiatric beds. Comparative data on productivity must be interpreted with reference to data on quality to ensure that both are promoted together.
- Providers of physical health care must work closely with mental health service providers to deliver more integrated and cost-effective care to people with co-morbid physical and mental health problems, particularly older people and people with long-term conditions.

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For commissioners

- Commissioners can avoid making premature cuts to mental health services by seizing the opportunities that exist to improve productivity. Salami-slicing or cutting back on evidence-based services will increase costs to the system as a whole over the next decade.
- Commissioners should exploit the opportunities to make savings across the NHS budget by responding more effectively to mental health needs in primary care, accident and emergency and acute hospital settings.
- A high priority for commissioners should be reducing unnecessary bed use in acute and secure psychiatric wards. This can be achieved by strengthening crisis resolution teams, developing alternatives to admission, improving services for people with complex needs, and improving step-down options, particularly for people in medium-secure services.
- Commissioners should take urgent action to cut back on clinically unjustified out-of-area treatment. This will require collaborative working at the regional level.
- In the longer term, commissioners can achieve significant savings by investing in preventive work and services that promote recovery and independence. This should include promoting better mental health in childhood and old age, as well as improving support with employment and services for offenders.
- It will be important for primary care trusts to support the development of mental health commissioning skills in the new GP commissioning consortia, or alternative models for co-ordinating mental health commissioning across multiple consortia in association with local authorities.

For government

- Pooled funding mechanisms will be critical if opportunities for improving quality and productivity are to be realised in practice, and the government must support and encourage the use of these.
- Research is needed to provide further evidence of which models are most cost-effective in mental health, and how we can effectively prevent mental health problems from developing. Research on mental health in childhood and the prevention of dementia should be given a high priority.
- The NHS outcomes framework needs to include a range of suitable indicators in all domains to ensure that mental health services are given equal weight to other areas of health and social care. This should include the important contribution mental health care can make to our physical health.
- Work to create a tariff system for mental health services should build on the experience of using tariffs in physical health care. A system based on whole packages of care and the outcomes they achieve might be better than one based on individual episodes of care.
- Action to tackle myths about mental health and fears about the risks posed by people with mental health problems needs to be sustained to help reduce inappropriate provision of care in unnecessarily restrictive and expensive settings.

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Appendix A: Service costs for working-age adults

Table A1 shows National Health Service (NHS) and local authority spending on mental health services for working-age adults in 2009/10. The figures were compiled as part of an annual finance mapping exercise conducted by Mental Health Strategies on behalf of the Department of Health (Mental Health Strategies 2010).

Table A1 NHS and local authority spending on mental health services for working-age adults, 2009/10

Mental health services for working-age adults	Reported investment (£ million)
Secure and high-dependency	924
Community mental health teams	696
Acute inpatient units	585
Continuing care and rehabilitation services	566
Accommodation, eg, care homes and supported housing	462
Psychological therapy services: – Improving Access to Psychological Therapies services – Non-Improving Access to Psychological Therapies services	293 (120) (173)
Crisis resolution and home treatment teams	239
Day services, including day centres and employment services	156
Assertive outreach teams	129
Home support services	110
Early intervention in psychosis teams	98
Specialist mental health services	94
Patient/carer support services, eg, peer support and advocacy	90
Psychiatric outpatient clinics	83
Services for people in the criminal justice system	59
Primary care mental health workers	45
Personality disorder services	30
Direct payments	18
Mental health promotion	3
Other clinical services and professionals	201
Total direct costs	**4,881**
Total including indirect costs, capital charges and overheads	**6,001**

Source: Mental Health Strategies (2010)

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