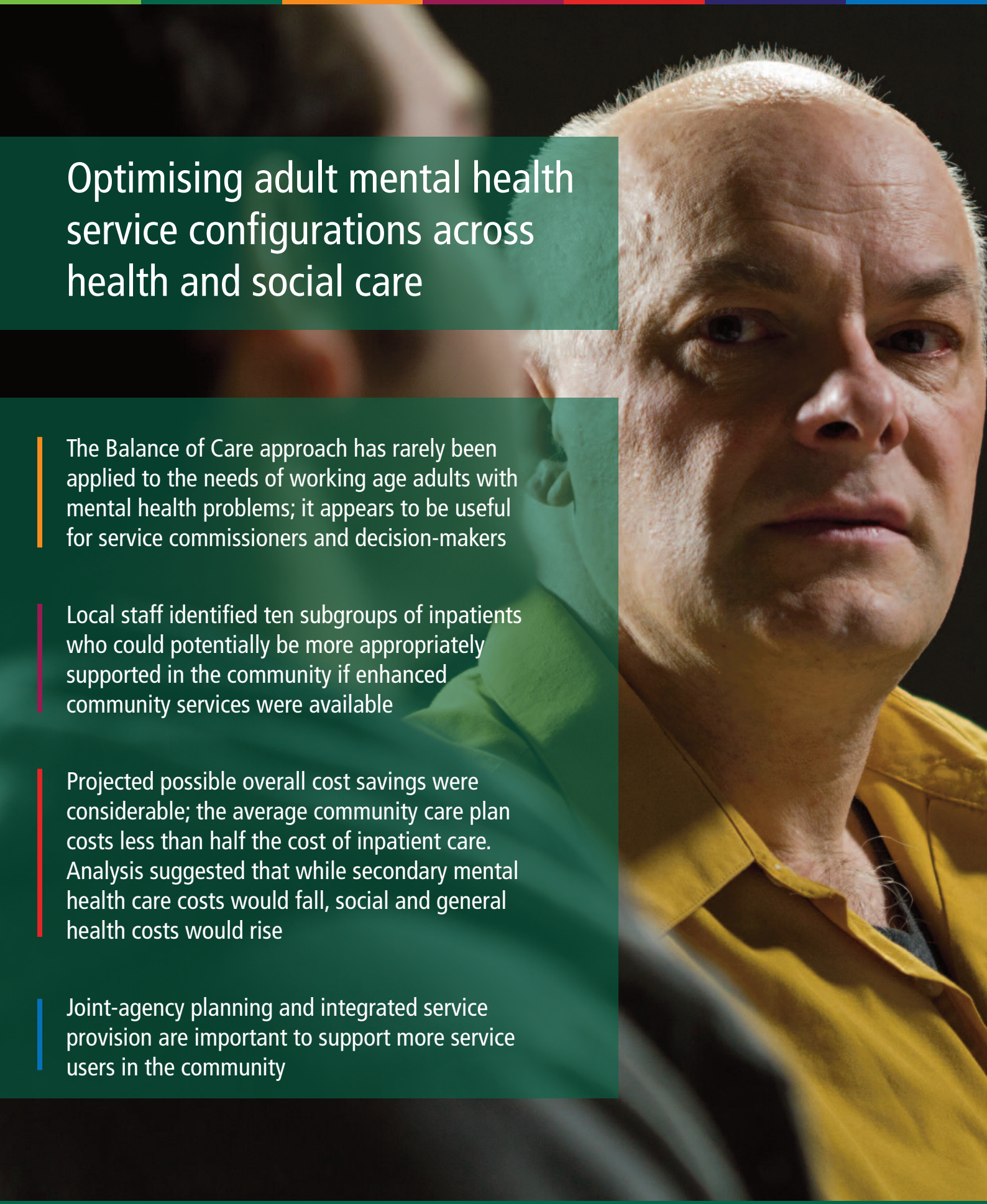
Optimising adult mental health service configurations across health and social care



The Balance of Care approach has rarely been applied to the needs of working age adults with mental health problems; it appears to be useful for service commissioners and decision-makers

Local staff identified ten subgroups of inpatients who could potentially be more appropriately supported in the community if enhanced community services were available

Projected possible overall cost savings were considerable; the average community care plan costs less than half the cost of inpatient care. Analysis suggested that while secondary mental health care costs would fall, social and general health costs would rise

Joint-agency planning and integrated service provision are important to support more service users in the community

School for Social Care Research

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Personal Social Services Research Unit at University of Manchester

BACKGROUND

Government policy for the care of working age adults with mental health problems has long been committed to the principle of community care. This is not to suggest that inpatient beds are not necessary. On the contrary, it is generally agreed that there will always be a significant minority of people who need hospital admission, with the intensive levels of assessment, monitoring and treatment this offers.

Nevertheless, much still needs to change. Six-fold variations have been found in inpatient admission rates, while the development of specialist community care teams has delivered very good care in some areas, but fragmented, inefficient services in others. Indeed, it is commonly believed that if the 'right' services were available, significant gains could be made in quality of life and service efficiency (Audit Commission 2010, DH 2011).

THE BALANCE OF CARE APPROACH

The BoC approach is a systematic strategic planning framework to help service planners and commissioners identify the most efficient use of health and social care resources. At its core is the identification of those service users whose care needs could be met in more than one location (for example hospital or home), and an exploration of the likely costs and consequences of the different care options.

Service planning is difficult in mental health care, however, as multiple organisations provide treatment and support for a heterogeneous population; outcomes are complex and difficult to measure; and little is known about the relative cost-effectiveness of institutional and non-institutional services. The allocation of resources has thus often been based on historical funding patterns and the piecemeal application of changing local and national priorities.

The study addressed the broad question: can the needs of certain service users receiving inpatient and community mental health team services be met in alternative ways which maximise independence and safeguard service quality? In so doing it sought to identify the characteristics of these service users at care margins (for example age, diagnosis and living arrangements); the alternative services they would require; and their cost.

METHODS

The study was conducted in partnership with a mental health Trust between June 2013 and December 2014 and employed a BoC approach. There were eight interlinked activities:

1. A systematic literature review identified the utility of the approach to assist decision-makers plan mental health services for working age adults with mental health problems.

2. Routinely collected health and social service data were used to benchmark local services against that in other areas.

3. A profile of service users cared for by inpatient and community services was developed from service user records.

4. The sample was categorised into subgroups on the basis of five characteristics deemed likely to be important in determining the setting and costs of their care: diagnosis, risk, psychotic symptoms, drug/alcohol problems and relationship difficulties.

5. A series of anonymous case studies was formulated to represent the most prevalent subgroups.

6. Separate groups of practitioners, service user representatives and carers identified those subgroups for whom alternative services would be preferable and specified the care they needed.

7. The potential costs and consequences of the alternative options were explored using economic modelling.

8. The likely impact of the suggested changes was identified through consultation with local interest groups.

There are several reasons to treat the study's findings with caution, including its reliance on routinely collected data; possible changes in unit costs in community and in-patient settings; and lack of knowledge on service user outcomes.

FINDINGS

How has the Balance of Care approach been used to date?

A systematic literature review identified 38 examples of the BoC's use spanning more than 40 years. The majority of examples were undertaken in the UK and explored the services needed by frail older people on the cusp of care home or hospital admission. There have also been a number of recent applications in Canada.

Several methodological challenges were observed in past studies. These included reliance on time-consuming bespoke data collections and a lack of analysis as to how reallocating resources in one sector might affect costs elsewhere.

What is the utility of the BoC approach for planning services for working age adults with mental health problems?

Just one BoC study was identified that considered the needs of working age adults with mental health problems. This was conducted more than 20 years ago, and focused on the potential for substitution between hospital and a then relatively uncommon form of specialist residential facility (Knapp *et al.* 1997).

Analysis suggested that the approach may have several advantages for mental health planners. These included the provision of detailed information on the potential to release resources; data on the profile of those users likely to be affected by service reconfiguration; specification of the required service mix; and the production of a comprehensive cost framework.

What is known about the current use of inpatient services?

As part of this study, anonymised routinely collected information was extracted from electronic data systems about 315 inpatient admissions in one Trust (43% women, 57% men). Just under 30% were aged 18–30, and none were over 65. Approximately 60% had a psychotic disorder and most presented with a complex mix of clinical and social problems: almost 60% were low in mood; nearly 40% displayed aggression; over 50% had relationship difficulties; and more than 40% had drink/drug problems.

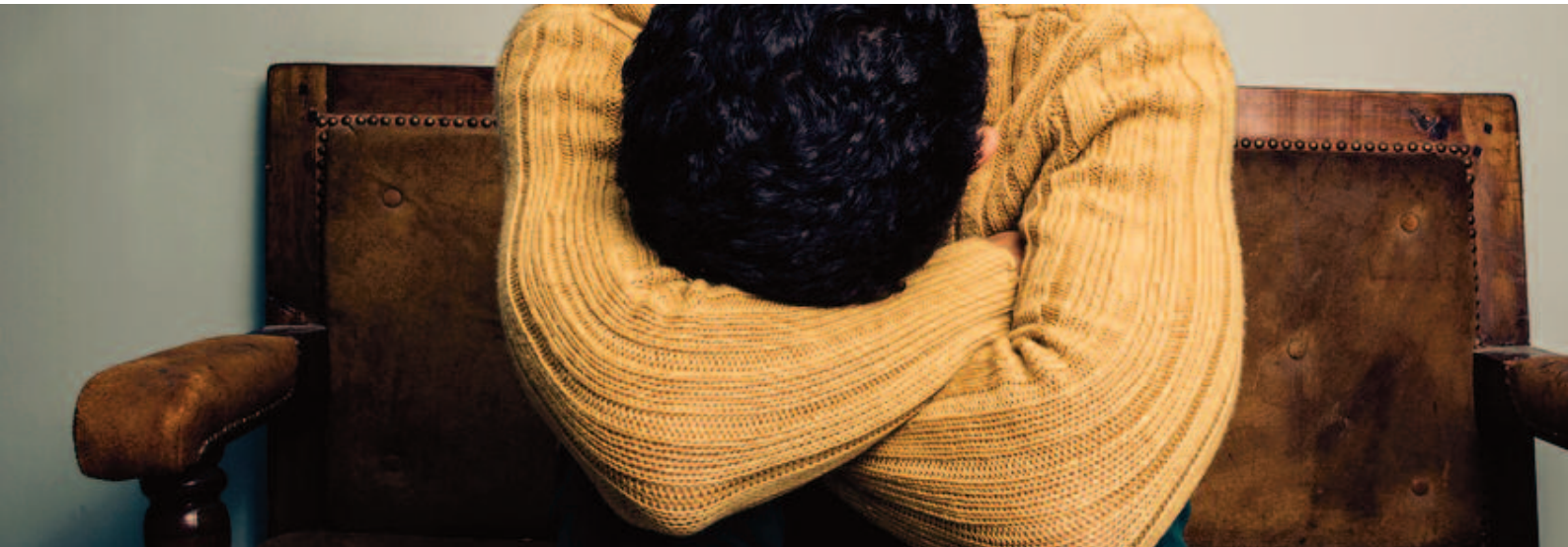
The majority of admissions (80%) occurred on weekdays. However, almost 60% were outside normal working hours (9am – 6pm). The two most common sources of referral were A&E departments and specialist mental health teams based in general hospitals. The average length of stay was 39 days.

Could some current inpatient users be more appropriately supported in the community?

In a subsequent stage of the study, 50 local practitioners, managers and commissioners each assessed the needs of a subset of 17 commonly found inpatient groups ('typical' admissions) depicted in a series of brief case studies.

The majority of staff believed seven of these would be most appropriately supported in hospital. However, if enhanced community services were available, almost all staff thought four would be more appropriately supported in the community (deemed 'definitely' appropriate for community care) and a large majority favoured community care for a further four (deemed 'probably appropriate' for community care). Views about the remaining two were more mixed, albeit most staff favoured community support.

Those service users considered most appropriate for hospital admission were generally diagnosed with schizophrenia and posed a high risk to themselves or others. They were typically reluctant to comply with medication; had problems with drug or alcohol use; and little or no social support. Projections suggested there were approximately 550 such admissions in the Trust annually.



FINDINGS

In contrast, those individuals considered definitely appropriate for community care had mild-moderate depression in combination with an eating or personality disorder, or schizophrenia which had deteriorated in the presence of life stress. None were considered at high risk or had any history of substance abuse, and all had reasonably settled social circumstances. Analysis suggested there were around 210 such admissions in the Trust each year.

Those service users deemed probably appropriate for community care or about whom views were mixed typically had more marked depression against a background of either a previous serious suicide attempt and recent life stress, a history of repeat self-harm, volatile relationships and multiple admissions, or schizophrenia with active psychotic symptoms. Projections indicated that there were about 365 such admissions in the Trust annually.

What services are needed to enable more service users to be supported in the community?

Working in small groups, staff constructed 42 alternative care plans for those service users for whom most staff favoured community support. The main services these drew on are listed in the Box.

What would this cost?

The cost to health and social care services of supporting one service user in a mental health inpatient bed was estimated at £2,450 per week using 2012/13 costs. In contrast, the average cost to health and social care services of the 42 suggested community care plans was estimated at just under £900 per service user per week. This included the cost of those social care services likely to be provided by the independent and voluntary sectors. Only three of the community care plans were projected to cost more than hospital care.

While the vast majority of the community care plans reduced secondary mental health service costs, social care costs rose in approximately 60 per cent of options, and general health costs in half. The potential overall annual savings that might be achieved by preventing hospital admission were nevertheless considerable. For example, analysis suggested that in the event that it proved possible to divert all those admissions in the biggest subgroup considered definitely appropriate for community care, local agencies might achieve savings of over £650,000 per annum (based on the median cost community care plan and length of inpatient stay).

BOX: THE MAIN SERVICES USED IN THE ALTERNATIVE CARE PLANS

Services used in weeks 1 and 2

- Intensive home treatment teams
- Community mental health teams
- Mental health support workers
- Consultant psychiatrists
- Carer support services
- GPs

Additional services used in weeks 3 to 8

- Psychology
- Welfare rights, housing and employment services
- Community groups, drop-in centres and peer support services
- Wellbeing coaches and health trainers

PUBLIC ENGAGEMENT IN THE STUDY

A Lay Reference Group arose out of public engagement in the research proposal development process. Members had experience as users of primary and secondary mental health services and carers of relatives with severe and enduring mental health problems. They also had links with multiple user and carer forums. All lived within the Trust's catchment area; had previous experience of public involvement activities; knowledge of local services; and expertise in communicating with other service users and carers.

The group was involved throughout the whole study process and contributed to its design, management and implementation, including data analysis and dissemination activities.

CONCLUSIONS & RECOMMENDATIONS

This study is one of very few to have applied the BoC approach to the needs of working age adults with mental health problems. It suggests that if enhanced community services were available, a number of individuals currently admitted to inpatient care could be more appropriately supported in the community at a cost that is no greater than that currently incurred, although the burden of costs would change.

Despite being conducted in just one Trust, the findings are likely to be of interest to service planners and commissioners nationally, and highlight the importance of joint planning and integrated service provision if benefits are to be achieved.

There are, however, a number of reasons to treat the results with caution. These include the study's reliance on routinely collected data. Furthermore, nothing has been said about the capacity of preventative approaches to mitigate the need for inpatient admission; the proportion of existing community service users who would be more appropriately supported in hospital; the consequences of the findings for the resultant inpatient mix and costs; or the effects of any changes on user outcomes.

References

Audit Commission (2010) *Maximising Resources in Adult Mental Health Care,* Audit Commission, London.

Department of Health (2011) No Health without Mental Health: A Cross-government Mental Health Outcomes Strategy for People of all Ages, Department of Health, London.

Knapp M, Chisholm D, Astin J, Lelliott P, Audini B (1997) The cost consequences of changing the hospital-community balance: the mental health residential care study, *Psychological Medicine*, 27, 3, 681–692.

PARTICIPANT STATEMENT

HOW I GOT INVOLVED

I first attended the preliminary meeting, outlining the intention of the study, where Jane Hughes presented to the Service User and Carers' Forum, a year before funding was granted. I was then interviewed by the Forum to join the Lay Reference Group as a past recipient of primary care services.

MY CONTRIBUTION TO THE RESEARCH PROJECT

I thought the work was important to help find ways forward, to improve out of hospital service user experience, in financially challenging times and for the future of mental health service delivery in the Pennine footprint, and possibly elsewhere. I felt I could make a valid contribution as I had also studied on mental health levels 2 and 3; and facilitation and other shorter courses.

I attended all the meetings throughout the study, completed all the tasks, contributed to the discussions, giving an insight into problems facing primary care service users and helped facilitate the workshops. I helped other service users and carers at the forum understand what we were doing and explained how they could help.

I also introduced a secondary care ex-service user to the group when the original one felt unable to continue. This person had done similar activities before and was better suited to the commitments.

HOW DID IT FEEL?

I felt comfortable and appreciated and that my contribution was validated. It was enjoyable and mentally stimulating and I felt like part of a team.

The research staff were friendly, helpful and understanding.

Publications exploring these and other aspects of the study are available on the PSSRU at Manchester's website: http://research.bmh.manchester.ac.uk/pssru/nihrsscr/projects/adultmentalhealthservices

School for Social Care Research

The School for Social Care Research was set up by the National Institute for Health Research (NIHR) to develop and improve the evidence base for adult social care practice in England in 2009. It conducts and commissions high-quality research.

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Linda Davies of the Division of Population Health, Health Services Research and Primary Care at the University of Manchester was a collaborator.

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