



# Mental health and housing:

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**Potential economic benefits of improved transitions along the acute care  
pathway to support recovery for people with mental health needs**

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## housing & health

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## Key Points

- The acute inpatient bed sector is operating at capacity with occupancy rates currently exceeding safe levels of 85% of beds in many inpatient wards.
- Conservatively every 1% reduction in acute inpatient bed days potentially frees up £16.5 million; this can only be realised if there is sufficient investment in alternative mental health service provision including different forms of residential and community support.
- Conservatively if all delayed discharges could be eliminated, with appropriate care for this time provided in other forms of supported accommodation net resources of more than £54 million might be freed up for alternative use within the mental health system. These resource savings would be greater if individuals are able to move to even more independent living arrangements.
- A 10% reduction in readmissions within 30 days of discharge from inpatient care might mean that about 900 admissions could be avoided; at an approximate cost of £11,500 per admission £10.35 million per annum in resources could be used for other purposes. These efficiencies would in part need to be offset by greater investment in community mental health services to support individuals and reduce the risk of readmission.
- The use and overall cost of out of area placements has been rising. The cost of out-of-area placements in just 30 providers rose from £51.4m to £65.2m with 88% of these placements were due to full occupancy of beds in the local area. Other analysis in 2012/13 suggested that between 4% and 5% of all emergency admissions were out of area. Out of area placements tend to be more expensive, although the cost differential appears to be falling, with one trust having mean costs per placement in 2014/15 of £13,129 and another paying approximately £500 per day per placement, considerably higher than mean mental health currency costs of £361 per day. In addition to excess costs to the public purse, there are also substantive financial out of pocket costs and emotional costs for both people with mental health needs and their families, given that there may be a need to travel very long distances, sometimes several hundred miles, on a regular basis in order to maintain contact.
- The economic benefits of reducing out of area placements will vary. For instance if a trust which made 372 out of area placements in 2014/2015 were able to substitute all of these with local alternative accommodation this could make available £3.5 million that could be used for other purposes.

## 1. Introduction

This brief paper looks at some of the potential economic benefits that may be realised through the inclusion of housing services as part of the acute care recovery pathway for people with mental health problems. The paper identifies some potential opportunities for freeing up resources from inpatient care which *might then be used to invest in alternative community and residential support services that may be provided by or supported by housing organisations*. These community services and residential supports may be provided at a lower cost to specialist inpatient care; if housing organisations can contribute towards better support for the recovery of individuals from acute mental health needs then there are also potential benefits to be gained from the avoidance of future repeat admissions to inpatient care. Housing organisations may also be able to play an important role in reducing the need for out-of-area placements, which not only tend to be expensive, but can be very detrimental to the quality of life of service users and their families.

The paper stresses that for cashable savings to be realised, local service commissioners and providers must be able to move resources away from traditional inpatient care towards community based alternatives. In practice, when looking at any reduction in the use of beds this may only become feasible if occupancy rates can fall sufficiently to justify the closure of a ward or unit without having a detrimental impact on service availability. It also potentially implies a period of time when it may be necessary to develop alternative services whilst maintaining the existing infrastructure. The more flexible that alternative service provision, the shorter this potential period of double funding may be.

We focus here on adult mental health services, making use of data on activity across 17 of the 21 mental health currency clusters that are now being used to help with the allocation of resources within the mental health system. The way in which data have been collected have also recently changed; we are not able to identify individuals with learning disabilities some of whom who will feature within some these 17 care clusters. We have though excluded clusters 18-21 which focus on cognitive impairment and dementia; nonetheless similar potential economic arguments might also be made for these client groups, and a first step in doing this is to get a sense of the scope for moving resources away from inpatient care.

Firstly we provide a very brief background on the acute care pathway and possible areas where economic efficiencies can be made. We then look briefly at some current trends in the provision of mental health services and their implications for further potential economic efficiencies. We then go to describe and quantify some of the potential benefits of reduced use of specialist acute inpatient care services and identify potential opportunities for the housing sector.

## 2. Background: The acute care pathway and opportunities for housing

Acute care pathways for individuals who require urgent mental health care will vary a little between different local areas but in broad terms the process consists of a number of linked stages. Following referral from a GP or other health care provider related to mental health an assessment will be made of an individual's needs by a specialist mental health team. Names will vary from area to area, for example, Assessment, Single Point of Access teams, Access and Assessment teams or Crisis and Home Treatment Teams. Several outcomes of assessment are possible, including signposting to psychological counselling services and local non-government organisations for individuals with low level mental health needs, as well as to be referred back to the care of a general practitioner.

Individuals assessed as having more serious mental health needs may be referred to the ongoing care of a specialist team such as an early intervention team for psychosis, a community based crisis resolution / home treatment care team, or a more general community mental health team. Only a relatively small number of cases will be admitted on a voluntary or involuntary basis to a psychiatric inpatient unit. In 2014/2015 they accounted for 5.8% of all individuals in contact with specialist mental health and learning disability services (Health and Social Care Information Centre, 2015). The vast majority of cases are supported in the community, with increasing pressures on community caseloads which must be borne in mind if the focus is on providing even more opportunities for community-based recovery.

As Table 1 indicates, there are potentially several different opportunities at all stages of the care pathway where the housing sector could make an impact. This might be to help prevent deterioration of mental health, provide alternatives to inpatient care, provide support to reduce delayed discharge, and provide ongoing support for recovery. We go on to look at some of the economic benefits associated with reduced inpatient activity.

**Table 1. Selected potential for improved outcomes at each stage of the care pathway**

Care Pathway Stage	Potential Opportunities
<b>Initial (and subsequent) referral for assessment</b>	Opportunities to develop services to reduce risk of deterioration in initial mental health state, and in ongoing mental health following recovery from acute poor mental health event.
<b>Admissions to psychiatric inpatient unit</b>	Making use of appropriate alternatives to hospital admission. Greater avoidance of admission to out-of-area placements.
<b>Treatment by specialist home treatment teams</b>	Greater collaboration with housing services in provision of home treatment
<b>Discharge from inpatient care</b>	Opportunities for improved discharge planning, including greater involvement of specialist housing support services. Increase availability of step-down / crisis beds delivered by housing sector. Reduce delays in discharge due to lack of appropriate accommodation and support
<b>Post discharge from inpatient or home treatment teams</b>	Provision of appropriate support services in community to aid in recovery and reduce risk of relapse and readmission.

### 3. Current state of the mental health system

One potential way of impacting on resource use would be to reduce the use of acute inpatient beds within the acute care pathway. This could be achieved by a reduction in the number of new and repeat admissions and also by a reduction in length of stay when admitted. As Table 1 indicates this in part might be achieved through an assessment process that considers more community based alternative services to admission, include services such as floating support and crisis home care provided by the housing sector.

This might therefore suggest that there is scope for a reduction in acute inpatient care beds. In the current context however it is important to be aware that there is probably only a limited scope for further reduction in bed numbers and the situation will vary considerably between different localities. Recent data across Great Britain (England, Scotland and Wales) points to continued reductions in available beds coupled with very high occupancy rates within existing inpatient services with improved levels of efficiency in mental health services (NHS Benchmarking Network, 2015). There has been a 17% reduction in adult acute mental health beds in the three years to April 2015, while admission rates to inpatient units have remained steady. The average length of stay in adult acute mental health wards was 32 days in the year 2014/15.

94% of available bed days are typically occupied, higher than the 85% safe standard rate. A survey conducted by the Commission on Acute Adult Psychiatric Care of 119 inpatient wards reported that 91% were operating above the recommended level, with a rate of 138% reported in some wards (Commission to Review the Provision of Acute Inpatient Psychiatric Care for Adults, 2015). This lack of beds has been highlighted as they key reason by local service funders for the increase in the use of out of area placements seen in recent years..

Another challenge has been the reduction in the availability of crisis resolution and home treatment (CHRT) teams, many of whom have been subsumed into generic community mental health teams rather than remaining as separate specialist teams. Recent analysis from the Care Quality Commission also noted that only 14% of individuals who experience a crisis felt that they received appropriate support; they have also noted a reduction in access to out of hours care from these teams (Care Quality Commission, 2015). In 2014/15 the number of contacts CRHT teams had with patients fell by 6 per cent (Health and Social Care Information Centre 2015b). The ongoing CORE study at UCL in a fidelity analysis of 75 CHRT teams surveyed, did not find any aspect of performance that could be rated as 'good'.

More than 50% of all Early Intervention for Psychosis Teams in England have reported a decline in resources and staff (Rethink Mental Illness, 2014). This is at a time when national waiting time standards for psychosis services (implying greater demands for these teams) are being introduced which while welcome will increase the demands being placed on these teams. In short there is a consensus in many recent reports on the mental health system on the challenges now being faced by specialist community mental health teams.

## 4. Making the economic case for action

This brief analysis is mindful of the challenges facing the mental health system. Given the current pressures on the system, with high levels of bed occupancy, a continuing reduction in the availability of inpatient beds and pressures on community services limits the scope for immediate reductions in the provision of acute inpatient care beds. Earlier analysis of the potential economic benefits of acute care pathway reform in 2010 estimated scope for a 12% - 15% reduction in bed days over a three year period; in fact there has been a 17% reduction in the number of beds available, while occupancy rates for remaining beds have increased. There has also been a 10% increase in sections under the Mental Health Act in 2014/15 which suggests that the balance may be increasing towards more severe cases being in inpatient care, which also limits room for reform. This however also presents opportunities to demonstrate how investment in alternative supports can help the mental health system to achieve high quality service user focused outcomes often at lower cost than existing services. The scope and need for change will vary from area to area; in particular opportunities may exist in areas with very high admission levels, even after taking account of differences in clinical need; this report notes that some commissioners aim to close up to 50% of beds over a five year period.

### **Potential economic benefits of reduced admissions to inpatient wards**

Our analysis of the potential for savings related to inpatient activity looks at 17 of the 21 mental health care currency clusters. These relate to the new system of activity based payments for mental health care that are being introduced in England. These 17 clusters highlighted in yellow in Table 2 along with reported inpatient activity rates for each cluster in 2014/2015 shown. Clusters highlighted in red which focused on symptoms of cognitive impairment and/or dementia are excluded from our analysis. We did though include inpatient activity for patients who were not assessed or assigned to a cluster. In total these 19 groups had more than 4.5 million days in admitted patient care in 2014/15. These included 3.1 million in clusters 10-17 that were experiencing psychotic symptoms. This is a very conservative estimate of bed use; in total in 2014/15 there were 8.5 million bed days; this upper number includes all cognitive impairment and dementia related beds, as well as bed days not allocated to any of the 21 cluster groups for both mental health and learning disabilities. We do not have a breakdown of the additional 2.7 million inpatient bed days and so have not included in our economic analysis.

**Table 2: Mental health care clusters and bed days 2014/2015**

Mental Health Currency (Cluster) Description	Cluster days in admitted patient care 2014/2015
Cluster 00: Variance (Unable to assign mental health care cluster code)	29,364
Cluster 01: Common mental health problems (low severity)	16,384
Cluster 02: Common mental health problems (low severity with greater need)	24,146
Cluster 03: Non-psychotic (moderate severity)	109,095
Cluster 04: Non-psychotic (severe)	215,370
Cluster 05: Non-psychotic (very severe)	227,811
Cluster 06: Non-psychotic disorders of over-valued ideas	53,248
Cluster 07: Enduring non-psychotic disorders (high disability)	186,171
Cluster 08: Non-psychotic chaotic and challenging disorders	270,779
Cluster 10: First episode psychosis	241,346
Cluster 11: Ongoing recurrent psychosis (low symptoms)	317,154
Cluster 12: Ongoing or recurrent psychosis (high disability)	598,736
Cluster 13: Ongoing or recurrent psychosis (high symptom and disability)	852,648
Cluster 14: Psychotic crisis	476,371
Cluster 15: Severe psychotic depression	94,610
Cluster 16: Dual diagnosis	170,835
Cluster 17: Psychosis and affective disorder (difficult to engage)	364,835
Cluster 18: Cognitive impairment (low need)	60,874
Cluster 19: Cognitive impairment or dementia (moderate need)	186,717
Cluster 20: Cognitive impairment or dementia (high need)	380,935
Cluster 21: Cognitive impairment or dementia (high physical or engagement)	195,062
Cluster 99: Patients not assessed or clustered	316,719
<b>Total: 0-17</b>	4,248,903
<b>Total: 0-17 plus Cluster 99</b>	4,565,622
<b>Total: 18-21</b>	823,588
<b>Total: All Clusters</b>	5,389,210

In order to calculate the potential savings related to any potential reductions in bed days we have used the official NHS Reference Costs for each of these mental health clusters for 2014/ 2015. The overall mean inpatient bed day cost for 0-17 plus Cluster 99 is £361 with costs per bed day per cluster ranging from £324 for Cluster 0 to £396 for Cluster 14 for individuals experiencing a psychotic crisis (Table 3). In comparison the average cost of a non-inpatient cluster day is approximately £13.

**Table 3: NHS Reference Costs - Mental Health Cluster Currencies 2014-2015**

<b>Currency Description</b>	<b>Unit cost per occupied bed day</b>
Cluster 00: Variance (unable to assign mental health care cluster code)	324.20
Cluster 01: Common mental health problems (low severity)	346.87
Cluster 02: Common mental health problems (low severity with greater need)	329.05
Cluster 03: Non-psychotic (moderate severity)	345.37
Cluster 04: Non-psychotic (severe)	345.82
Cluster 05: Non-psychotic (very severe)	342.54
Cluster 06: Non-psychotic disorders of over-valued ideas	342.70
Cluster 07: Enduring non-psychotic disorders (high disability)	347.85
Cluster 08: Non-psychotic chaotic and challenging disorders	369.13
Cluster 10: First episode psychosis	361.55
Cluster 11: Ongoing recurrent psychosis (low symptoms)	348.94
Cluster 12: Ongoing or recurrent psychosis (high disability)	369.27
Cluster 13: Ongoing or recurrent psychosis (high symptom and disability)	357.64
Cluster 14: Psychotic crisis	396.39
Cluster 15: Severe psychotic depression	369.63
Cluster 16: Dual diagnosis	366.93
Cluster 17: Psychosis and affective disorder (difficult to engage)	360.05
Cluster 18: Cognitive impairment (low need)	372.72
Cluster 19: Cognitive impairment or dementia (moderate need)	388.42
Cluster 20: Cognitive impairment or dementia (high need)	389.80
Cluster 21: Cognitive impairment or dementia (high physical or engagement)	383.16
Cluster 99: Patients not assessed or clustered	354.14

Here we present conservative scenarios looking at potential savings if bed days can be reduced by as much as 5% overall. Each 1% reduction in bed day use, a decrease of 42,489 bed days or 116 bed years across all clusters from 0-17 would potentially reduce costs by £15.4 million; realisable cost savings would depend on the number of wards that could be closed. 116 bed years equates to 6 fully occupied wards with between 15 and 20 beds; adding in cluster 99 would potentially reduce costs by

£16.5 million per annum, with 125 bed years saved, equivalent to more than 6 twenty bed wards. This is also equivalent to 1,427 fewer admissions to acute care. If a 5% reduction in bed days were achieved, then 625 bed years would be avoided, equivalent to a reduction of 31 wards. This would free up budgetary resources of £82.5 million. This a gross rather than net cost saving, as the additional costs of providing community support or alternative stepped down care or supported accommodation need to be taken into account. The analysis is conservative as it does not include all mental health related bed days, only those that have been allocated to a mental health currency cluster for payment.

Table 4 summarises financial resources that may be freed up for a 1% reduction in bed days for clusters 0-17 and 19. It should be stressed that actual resource savings would depend on whether there is sufficient further reduction in bed day use to allow a full inpatient unit, which may typically have between 15 and 20 beds, to be phased out of service and on investment in additional community supports and alternative forms of accommodation to help both those individuals who could be diverted away from inpatient care, as well for those who may be discharged more quickly into the community. These alternatives to inpatient care need to be available at the same time as inpatient beds, allowing the possibility for acute ward beds to be phased out.

Given that more than 50% of the costs of inpatient bed days are for individuals with psychotic symptoms – to achieve resource savings mental health trusts must place a strong focus on determining and providing alternative supports, with appropriate risk management, for people with psychosis. This means that potential opportunities for reorganisation and savings will need to be assessed within each CCG, to determine what may be feasible, such as opportunities to work with housing sector organisations to provide crisis houses, which may be run at lower cost than inpatient care or the Link House for women and Crisis House for men in Bristol which both provide 24 hour supported accommodation for up to 10 people for up to 4 weeks. There is some English evidence suggesting that crises houses can lead to better longer term outcomes and lower costs to health and social care services compared to traditional inpatient services. Per bed day costs in one crisis house in Tower Hamlets in 2012/13 were £220 – more than £100 less per day than the costs of acute inpatient care. However in formal evaluations the differences in costs (taking other factors into account such as the wider use of health and social care services), have not been statistically significant, reflecting the small scale of these evaluations and diversity in what is actually considered to be a crisis house (Knapp et al., 2014).

**Table 4: Potential budgetary impact (resources saved) of a 1% reduction in bed days by mental health cluster activity rates 2014-15.**

	1% bed day reduction	Potential Budgetary Impact	% of total saving
Cluster 00: Variance (unable to assign mental health care cluster code)	294	95,197	0.01
Cluster 01: Common mental health problems (low severity)	164	56,831	0.00
Cluster 02: Common mental health problems (low severity with greater need)	241	79,452	0.00
Cluster 03: Non-psychotic (moderate severity)	1,091	376,784	0.02
Cluster 04: Non-psychotic (severe)	2,154	744,787	0.05
Cluster 05: Non-psychotic (very severe)	2,278	780,337	0.05
Cluster 06: Non-psychotic disorders of over-valued ideas	532	182,481	0.01
Cluster 07: Enduring non-psychotic disorders (high disability)	1,862	647,594	0.04
Cluster 08: Non-psychotic chaotic and challenging disorders	2,708	999,523	0.06
Cluster 10: First episode psychosis	2,413	872,593	0.05
Cluster 11: Ongoing recurrent psychosis (low symptoms)	3,172	1,106,672	0.07
Cluster 12: Ongoing or recurrent psychosis (high disability)	5,987	2,210,934	0.13
Cluster 13: Ongoing or recurrent psychosis (high symptom and disability)	8,526	3,049,392	0.18
Cluster 14: Psychotic crisis	4,764	1,888,291	0.11
Cluster 15: Severe psychotic depression	946	349,710	0.02
Cluster 16: Dual diagnosis	1,708	626,844	0.04
Cluster 17: Psychosis and affective disorder (difficult to engage)	3,648	1,313,587	0.08
Cluster 99: Patients not assessed or clustered	3,167	1,121,635	0.07
<b>0-17</b>	<b>42,489</b>	<b>15,381,009</b>	
<b>0-17+99</b>	<b>45,656</b>	<b>16,502,644</b>	

### **Economic impact of reducing delays in discharge**

One area where there are clear opportunities for housing sector organisations to reduce mental health care costs and improve outcomes concerns delayed discharges or transfers of care. The costs of acute inpatient care can be reduced by supporting early discharge through better community services and effective liaison with social services on supported accommodation.

The recent NHS benchmarking analysis in Great Britain suggested that delayed transfer of care for adult mental health inpatient services represented 4.7% of all bed days in 2014/15. This continues to be a pressing issue; looking at all mental health and learning disability services in England in October

2015 delays in transfer of care accounted for 3% of all bed days (Health and Social Care Information Centre, 2016).

One major factor in delayed discharges is lack of stable accommodation. Offering housing options, advice and support within acute inpatient wards has the potential to significantly reduce these undue delays, particularly as only 42% of individuals who had inpatient stays in 2014/2015 stated that they had stable accommodation.

We present different scenarios looking at the potential reduction in bed day costs that may be achieved, including a scenario focusing on individuals without stable accommodation only, as well as the total elimination of delayed discharges, an objective that has been previously been demonstrated to be feasible to achieve in pilot studies.

Again restricting the analysis solely to bed days that have been linked to the mental health cluster codes for 2014/2015 if delayed discharges account for 3% of all inpatient bed days then eliminating all delayed discharges for the 0-17 and 99 cluster codes would free up 136,969 bed days while if delayed discharges account for 4.7% of all bed days then potentially 214,584 days of inpatient care could be avoided. These scenarios would generate cost reductions of £66 million or £75.5 million respectively, but the costs of alternative accommodation have to be included. The costs of providing alternative supported housing for this time period would vary between £15 million and £28 million. This assumes that costs would be 930 or £760 per week (£132 and £109 per day), making use of unit cost estimates for local authority and private/voluntary sector residential care homes for people with mental health needs taken from the 2015 Unit Costs of Health and Social Care (Curtis and Burns, 2015).

Tables 5 and 6 summarises the potential inpatient costs avoided, additional supported housing costs incurred and net savings under different scenarios. There is a minimum saving of £21 million if additional discharge planning efforts are targeted solely at a 3% reduction in bed day use by service users without stable accommodation who are then transferred to high cost supported accommodation. There will be net savings of £54 million if a 4.7% reduction in bed days is achieved for all service users and the lower cost estimate for supported accommodation is used.

While this analysis does not take account of the additional costs associated with employing housing related staff as part of the mental health system to aid in discharge planning, it is also conservative as not all of the delayed transfers of care will require supported accommodation, but rather accommodation through the general rental market.

**Table 5: Potential net savings through reduction of 3% bed days related to delayed transfers of care**

<b>Addressing Delayed Discharge (3% reduction in bed days)</b>			
<b>Targeted at all service users</b>			
<b>High and Low Supported Housing Costs</b>	<b>Inpatient Costs Avoided</b>	<b>Supported Housing Costs</b>	<b>Net Costs Avoided</b>
<b>£132 per day</b>	49,507,933	18,079,863	31,428,070
<b>£109 per day</b>	49,507,933	14,929,584	34,578,350
<b>Targeted only at service users without stable accommodation</b>			
<b>High and Low Supported Housing Costs</b>	<b>Inpatient Costs Avoided</b>	<b>Supported Housing Costs</b>	<b>Net Costs Avoided</b>
<b>£132 per day</b>	33,665,395	12,294,307	21,371,088
<b>£109 per day</b>	33,665,395	10,152,117	23,513,278

**Table 6: Potential net savings through reduction of 4.7% bed days related to delayed transfers of care**

<b>Addressing Delayed Discharge (4.7% reduction in bed days)</b>			
<b>Targeted at all service users</b>			
<b>High and Low Supported Housing Costs</b>	<b>Inpatient Costs Avoided</b>	<b>Supported Housing Costs</b>	<b>Net Costs Avoided</b>
<b>£132 per day</b>	77,562,429	28,325,119	49,237,310
<b>£109 per day</b>	77,562,429	23,389,682	54,172,748
<b>Targeted only at service users without stable accommodation</b>			
<b>High and Low Supported Housing Costs</b>	<b>Inpatient Costs Avoided</b>	<b>Supported Housing Costs</b>	<b>Net Costs Avoided</b>
<b>£132 per day</b>	52,742,452	19,261,081	33,481,371
<b>£109 per day</b>	52,742,452	15,904,983	36,837,468

## Reducing readmission rates

Another area where economic benefits potentially might be achieved is through a reduction in readmission rates. The latest NHS Benchmarking report found a 9% readmission rate within 30 days of discharge (NHS Benchmarking Network, 2015). In 2014/15 there were over 119,000 discharges from inpatient mental health and learning disabilities care services. If we crudely assume that about 100,000 of these discharges are not related to dementia or learning disabilities, then about 9,000 readmissions would be expected within 30 days. Applying a mean cost per bed day of £361 and assuming that a subsequent admission would have a 32 days length of stay (the average), with a cost per admission of approximately £11,500 then a 10% reduction in annual readmissions would potentially avoid inpatient costs of approximately £10.35 million. Net savings would be lower as resources would have to be invested in community mental health services to support individuals and reduce the risk of readmission. Key questions remain as to what are the most effective and cost effective ways to reduce readmissions rates and the role of different stakeholders, including housing organisations, in delivering effective interventions. This is currently being explored as part of guidelines being developed by the National Institute for Health and Care Excellence (NICE) on *“Transition between inpatient mental health settings and community and care home settings”* (National Institute for Health and Care Excellence, 2014).

## Reducing out of area placements

In the absence of beds in a locality mental health service users may be admitted to inpatient facilities outside their local area. These service users can be a mixture of short and long stay individuals. As bed numbers have fallen in England the issue of out of area placements has risen to prominence in discussions on the mental health system. One recent analysis found that 37 NHS mental health providers had funded 4,447 out of area placements in 2014/15 – almost 25% higher than in the previous year (McNicoll, 2015). The cost of out-of-area placements in just 30 of these 37 providers rose from £51.4m to £65.2m. 88% of these placements were due to full occupancy of beds in the local area. Other analysis in 2012/13 suggested that between 4% and 5% of all emergency admissions were out of area.

Estimating the average cost of an out of area placement is complex. Placements can be of very different length. In 2010 the average annual cost of an out-of-area placement was estimated to be £34,000, compared with around £21,000 for an equivalent local placement, about 65% higher in cost (Brindle, 2010). Obtaining more recent figures can be difficult, as private providers are significant providers of out of area placements and may enter in contractual arrangements with mental health trusts which may be deemed to be too commercially sensitive to disclose (Northamptonshire Healthcare NHS Trust, 2015). As the primary reason for out of area placement now appears to have become a lack of suitable local accommodation rather than because of the complexity of cases, the mean costs of cases can be expected to be lower. One trust responding to a recent FOI request reported that in 2013/2014 it made 372 placements all of which were due to local bed pressures. The total cost of these placements to the trust was £4.884 million or £13,129 per placement. In 2012/2013 it made 171 placements at a cost of £1.982 million or £11,590 per placement (Southern Health NHS Trust, 2016). Recently it has been reported that Lancashire Care NHS Foundation Trust

are currently paying about £500 per client per day for out of area placements (Magill, 2016), which is considerably more than the mean cost of £361 for clusters 0-17, plus cluster 99, when looking at the current NHS reference costs for mental health services. In addition to excess costs to the public purse, there are also substantive financial out of pocket costs and emotional costs for both people with mental health needs and their families, given that there may be a need to travel very long distances, sometimes several hundred miles, on a regular basis in order to maintain contact.

Tables 7 and 8 summarise our estimates of potential cost savings for different levels of reduction in out of area placements. In these tables we have used the cost of £500 per day of out of area placement reported in Lancashire to look at the potential economic benefits of avoiding some out of area placements through use of local inpatient facilities, as well as through the provision of alternative residential accommodation from the private or voluntary sectors. We have assumed that at best there might be a 50% reduction in placements and have very conservatively assumed that the only out of area placements are the 4,447 placements reported by 30 trusts. There are more than 20 further NHS mental health trusts that may have to make use of out of area placements and such placements are not included in our analysis.

Table 7 assumes a very short length of stay on average of only 5 days; one Leeds trust reported that more than half of all its placements were 5 days or less (Pritlove, 2012). Net savings if all out of area placements were of this duration would be modest at about £4 million. In Table 8 we look at potential savings assuming that the mean length of stay is equivalent to that for acute inpatient care of 32 days. These tables suggest savings of up to £26 million that may be realised through reductions in out of area placements.

Because of the conservative assumptions adopted these cost savings will be an underestimate; there is potential for greater levels of savings. This is achievable; it is partly about management of existing accommodation, but also about improving links with local organisations including housing associations. In a recent Parliamentary debate in December 2015 the care minister, Alastair Burt, cited the example of Sheffield which *“has almost entirely eliminated adult acute out-of-area treatments, and has reduced average bed occupancy to 75% by redesigning the local system, That has included investing in intensive community treatment, and working in partnership with housing.”*

If we take the concrete example of the Southern Health Foundation Trust which made 372 out of area placements in 2014/2015; and assuming a length of stay of 26 days so as to approximate their mean cost of just over £13,000 per placement, providing local alternative accommodation for all of these placements would avoid costs of £3.5 million alone.

**Table 7: Potential economic payoffs related to a reduction in out of area placements – short length of stay**

Out of area placements						
		Potential reduction in out of area placements				
Number of placements	4447	10%	20%	30%	40%	50%
Out of area daily placement cost £	500	1,111,750	2,223,500	3,335,250	4,447,000	5,558,750
National reference costs mean bed day cost £	361	802,684	1,605,367	2,408,051	3,210,734	4,013,418
Private / voluntary sector supported accommodation day cost £	132	293,502	587,004	880,506	1,174,008	1,467,510
Mean length of stay	5					
Net saving if switched to in-area inpatient treatment		309,067	618,133	927,200	1,236,266	1,545,333
Net saving if switched to in-area private / voluntary sector supported accommodation		818,248	1,636,496	2,454,744	3,272,992	4,091,240

**Table 8: Potential economic payoffs related to a reduction in out of area placements – average length of stay of acute inpatient units**

Out of area placements						
		Potential reduction in out of area placements				
Number of placements	4447	10%	20%	30%	40%	50%
Out of area daily placement cost	500	7,115,200	14,230,400	21,345,600	28,460,800	35,576,000
National reference costs mean bed day cost	361	5,137,174	10,274,349	15,411,523	20,548,698	25,685,872
Private / voluntary sector supported accommodation day cost	132	1,878,413	3,756,826	5,635,238	7,513,651	9,392,064
Mean length of stay	32					
Net saving if switched to in-area inpatient treatment		1,978,026	3,956,051	5,934,077	7,912,102	9,890,128
Net saving if switched to in-area private / voluntary sector supported accommodation		5,236,787	10,473,574	15,710,362	20,947,149	26,183,936

## 5. Conclusions

We have highlighted a number of examples of how it may be possible to make efficiency savings along the acute care pathway whilst focusing on improving recovery outcomes for mental health service users. We have been very conservative in our analysis, and levels of potential costs avoided are likely to underestimate what might be achieved. However, we have also stressed that some of these potential efficiency savings can only be achieved if it is possible to reorganise resources so that entire inpatient wards can be replaced by alternative accommodation and community support. This may prove challenging; recent and ongoing work recognises the challenges the mental health system faces, perhaps more sharply when looking at acute care. There has been a strong focus on provision of community based, recovery orientated support over the last decade, with the development and roll out nationwide of specialist mental health teams, including CHRTs and early intervention teams for psychosis, as well as expanded access to services often intended to support individuals with lower levels of need through the use of counselling and psychological therapies. Only about 5% of individuals in contact with the mental health system are admitted as inpatients and psychiatric bed numbers within the NHS continue to fall.

This is welcome, but it must be accompanied by sufficient provision of alternative supports. Caseloads for community mental health teams continue to rise – since 2011 the total number of contacts with the mental health system that do not involve admissions have risen from 1.1 million to 1.7 million in 2014/15. This has happened at a time when community mental health team budgets have come under pressure. We have noted that specialist services such as early intervention for psychosis have seen budgetary cuts, and teams may not have their full complement of staff. At the same time the number of admissions to inpatient beds has remained stable, but with a reduced stock of beds this has led to extremely high, indeed potentially dangerous, rates of occupancy. There has also been a growth in the use of out of area placements; they may be detrimental to recovery as well as being expensive.

All of these challenges make the case for the mental health system to collaborate even more closely with housing sector providers to provide alternative forms of residential support and risk management in the community even more compelling. Most of these decisions need to be taken at a very local level and circumstances will differ, but there is an opportunity to use evidence on the effectiveness and cost effectiveness of housing organisation interventions, to make the case for greater collaboration with the housing sector as part of the investment in mental health recovery.

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