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Independent sector mental health care: a 1-day census of private and voluntary sector placements in seven Strategic Health Authority areas in England

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Abstract
The aims of this study were (i) to map the extent of all mental health placements in the independent sector, for adults of working age, and elderly people (excluding those with a diagnosis of dementia placed in Local Authority care homes), on a census date, across the areas in which the study was commissioned; (ii) to identify the characteristics of the population in placements; (iii) to explore some of the characteristics of the placements and the patterns of use within the private and voluntary sectors; and (iv) to identify the funding source of placements, and cost differences between the private and voluntary sector. The study took place in seven Strategic Health Authority areas, and information was sought from all Primary Care Trust and Social Services commissioners of mental health services, including regional secure commissioning teams, within those areas. A cross-sectional sample was used. Information was requested in relation to every individual meeting the inclusion criteria, placed in independent (private or voluntary) psychiatric hospitals, registered mental nursing homes and care homes on a specified study 'census date' of 28 June 2004 in six of the Strategic Health Authority areas, and 7 October 2004 in the seventh. Information was recorded on a standard questionnaire specifically designed for the study. Information was obtained on 3535 adults and 1623 elderly people in private or voluntary facilities. The largest groups of adults and elderly people had diagnoses of severe mental illnesses (42.1% and 30.5%, respectively), and placements were described as 'continuing care' or rehabilitation, with a 'niche' in specialist forensic care. Around four-fifths of units were in the private sector, which for adults was significantly more expensive than the voluntary sector. A large proportion of units (47.2% of adult placements and 59.3% of placements for elderly people) had only single placements from particular commissioning authorities, whilst others had large numbers, raising issues for effective commissioning. The distance of placements from patients' area of origin, is also an issue highlighted by the study. The study findings are discussed in relation to commissioning practice, and the development of the independent sector in mental health care.

Keywords: commissioning, independent sector, mental health, private sector, voluntary sector

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Introduction

The radical changes in the public sector in England over the last three decades have followed a policy agenda that emphasises consumer choice, the contestability of public monopoly provision, and the encouragement of independent providers of services, purchased or commissioned by public authorities. This agenda has been particularly controversial in the field of health and social care.

The *NHS and Community Care Act (1991)* created the foundation for a commissioner-provider separation in both the National Health Service (NHS) and Social Services Departments. For both organisations, the changes highlighted the place of 'commissioning' from a diverse marketplace of providers (Wistow *et al*. 1994, Lewis & Glennerster 1997, Knapp *et al*. 2001). For Social Services Departments, the changes also involved the disposing of facilities previously owned by Local Authorities to become self-managing independent units (Department of Health 1989).

The market reforms in health and social care were accompanied by the development of 'new public management' systems of accountability and centralised control in public services (Exworthy & Halford 1999), and a network of regulatory and performance management systems now exist across all health and social care provision (Department of Health 1998, Vellenoweth 1999, Commission for Healthcare Audit and Inspection 2003, Griffiths 2004).

Throughout the 1980s and 1990s, the policy framework was explicitly established within which independent sector providers could operate in competition with the statutory services, and the present Labour government has actively promoted this approach (Department of Health 2000, Dixon *et al*. 2003, Field & Peck 2003). A 'concordat' between the government and the independent sector states the government's commitment to

> … the use of private and voluntary healthcare providers, not only at times of pressure but also on a more proactive longer term basis where this offers demonstrable value for money and high standards for patients. (Department of Health/Independent Healthcare Association 2000, p. 1)

The role of the private and voluntary sectors continues to receive powerful government endorsement throughout the NHS (for example see Department of Health 2004, 2005a, Lewis & Dixon 2005), buttressed by the 'patient choice' agenda (Department of Health 2006).

A comparative perspective

Although health and welfare systems and health economies differ markedly between developed countries, all experience problems and challenges that come from similar sources, namely, ageing populations and low birth rates, rising expectations of health services and technologies, and limited economic growth coupled with the demands of a global economy (Becker & Vazquez-Barquero 2001, Cochrane *et al*. 2001, Rutz 2001). However, the role of the independent sector in health and social care provision appears to be less contentious in, for example, other European nations, and in the USA.

In France, Italy, Germany and the Netherlands health care is provided within insurance-based systems, with private and not-for-profit organisations contributing to hospital provision (Maio & Manzoli 2002, Elkan 2003, Blank & Burau 2004). Sweden has a long history of public provision of health and welfare services (Blomqvist 2004, Harrison 2004) and in this sense has more in common with the British system. During the 1990s the imperative to contain costs within Sweden led to the development of 'quasi-markets' in health, and the creation of a 'purchaser-provider' split, modelled on parallel developments in the UK. Contracting out mechanisms have led to a level of independent provision that includes hospitals and primary care, and there is some suggestion that these are more likely to provide services to the better off (Blomqvist 2004).

The health system of the USA stands in marked contrast to those of the European Union states in that private (for-profit) provision dominates. However, the proportion of private 'for-profit' provision has declined since 1997 (Ham 2005) suggesting that diversification in health services may have market limits.

It is evident that an active independent sector is a longstanding feature of most health economies. However the transition from a near-state monopoly of health and social care in response to economic pressure, such as in the UK and Sweden, may be more problematic as the culture and the structures for health service delivery may need to undergo substantial change if the development of diversity is to be effectively managed (Harrison 2004).

Mental health services in England

The focus of this paper is an analysis of independent (private and voluntary) provision of psychiatric hospital and mental health nursing home and care home services contracted within seven English Strategic Health Authorities (SHA). In the field of mental health, the philosophical commitment to de-institutionalisation has led to the closure of NHS psychiatric beds on a large scale, official figures showing that between 1994/1995 and 2004/2005 the number of NHS beds fell by 23.5% from 41 380 to 31 645 while between 1994/1995 and 2000/2001 the number of private sector beds rose by 103.4% from 47 980 to 97 600 (Department of Health 2005b).

Policy has been to develop a range of services in the community that particularly support people with serious and longer-term mental health problems (Department of Health 2002a, Chisholm & Ford 2004). However, for the most vulnerable a range of 24-hour services is still needed, both for acute episodes and for longer-term care. The scale of closures of NHS beds has led to an increasing use of the private and voluntary

sectors by health and social services commissioners, a process that has been described as 're-institutionalisation' as opposed to 'de-institutionalisation' (Priebe & Turner 2003, Priebe *et al*. 2005). This has generally been an individual response on an unplanned or emergency basis, without strategic planning for the use of the independent sector; there are indications that this has led to patchy monitoring of placements (Poole *et al*. 2002, Ryan *et al*. 2004) and exclusion of individuals in some independent placements from the care management process (Cambridge *et al*. 2005). The development of 'niche markets' in specialist areas (e.g. medium secure provision) is also a feature of independent sector activity (Moore 2001). The proportion of private mental nursing homes has also increased, and in 2001 the number of beds in private hospitals and nursing homes was 28 776 (Department of Health 2002b).

The independent sector includes both private (for profit) and voluntary (charitable not-for-profit) organisations. A recent review of social care in England (Commission for Social Care Inspection (CSCI) 2005) identifies that Local Authority and voluntary providers for adults with mental illnesses outperform private providers when evaluated against established service standards. In England, the larger mental health charities play a role in the provision of hospital and residential services and there is increasing interest in the role of the 'third sector' in flexible local provision (e.g. Freedland 2006, Robb 2006). However, large companies are also moving into the field of mental health care, as a market opportunity.

The shift over recent years in the USA, from independent not-for-profit services to for-profit services, has been explored in one study (Rosenau & Linder 2003). The study synthesised evidence from a systematic review of the literature that sought to compare the performance of the two types of providers. Overall the not-for-profit providers had superior performance on access, quality and cost-efficiency than the for-profit providers. Performance comparisons between the two sectors may merit further study in England.

A final issue of concern has been the number of placements made outside the normal geographical catchment area of the commissioner. These may be either within the NHS or to independent providers, but are the result of insufficient local capacity (Glover & Bindman 2001). The issue of vulnerable people being dislocated from their usual community, sometimes on a long-term basis, is an important one, which we return to later.

Methods

The specific aims of the study were

- to map the extent of all mental health placements in the independent sector, for adults of working age, and elderly people (excluding those with a diagnosis of dementia), on a census date, across the areas in which the study was commissioned;
- to identify the characteristics of the population in placements;
- to explore some of the characteristics of the placements and the patterns of use within the private and voluntary sectors; and
- to identify the funding source of placements, and cost differences between the private and voluntary sectors.

The study was commissioned because of widespread concerns about the escalating numbers and burgeoning costs of people placed in the independent sector, and the broad aim of the study was to inform local development needs in relation to commissioning practice, that in turn would contribute to service and system development. Given the current prominence of the role of the independent sector in national policy, the study also aimed to contribute to a developing understanding of the implications of this policy 'on the ground'.

The study took place in seven SHA areas in England, and information was sought from all Primary Care Trust (PCT) and Social Services commissioners of mental health services, including regional secure commissioning teams, within those areas. A cross-sectional sample was used. Information was requested in relation to every individual meeting the inclusion criteria, placed in independent (private or voluntary) psychiatric hospitals, registered mental nursing homes and care homes on a study 'census date' of 28 June 2004 in six of the SHA areas, and 7 October 2004 in the seventh.

The seven SHAs were not selected randomly. Six were encompassed within National Institute for Mental Health England (NIMHE) regional boundaries for the North-west and West Midlands regions, respectively. The seventh was an individual SHA area in the North-east, where the study took place slightly later. The choice of sites reflected the interest and financial support for the study from the two NIMHE regions, and the individual SHA. Although the results from the study cannot be generalised to the whole country, the population within the seven SHA areas comprises around a quarter of the population of England – it is likely that the issues identified are not unique to these areas.

A standard questionnaire was developed in collaboration with the study sites, and was subject to intensive piloting before a final version was agreed. Commissioners of mental health services were asked to complete the finalised questionnaire in respect of all individuals in placement on the census date. Information collected

Table 1 Study cases in the seven Strategic Health Authority (SHA) areas: number and rate/100 000 population

SHA area	Number of adults (16–64 years)	Number/100 000 population*	Number of elderly people (65 years and over)	Number/100 000 population*
A	585	23.0	194	7.6
B	903	38.4	563	23.9
C	487	25.7	166	8.8
D	778	33.9	275	12.0
E	254	17.4	160	10.9
F	344	22.5	193	12.6
G	184	16.3	72	6.4
Total	3535		1623	

* Populations based upon GP-registered adjusted populations 2003 (Department of Health, 2003b). SHA not recorded in 13 cases (0.4%) adults and 1 case (0.1%) elderly people. GP, General Practitioner.

included basic demographic details, information about the placement, geographical distance from home area, and costs of the placements. Support from the research team to study sites was provided as necessary to ensure that returns were made in respect of all individuals meeting the study inclusion criteria.

The study was approved across all seven SHAs by the North-west Multi Research Ethics Committee and by the University of Manchester Senate Committee on the Ethics of Research on Human Beings.

Data analysis

Data were analysed using SPSS (release 12). Analysis is principally descriptive. Costs are compared using *t*-tests, and as data are skewed median costs are also reported. There is disagreement in the literature about the most appropriate method of analysis for skewed cost data (e.g. Rascati *et al*. 2001); it should be acknowledged that the use of *t*-tests in this study may be less than ideal.

Results

Numbers and response rate

A total of 82 PCTs, 42 Local Authority social services departments, and three specialist forensic commissioning teams were identified within the seven participating SHA areas. Together these span 26.6% of the population of England. All provided information in relation to all adults under 65 years of age meeting the inclusion criteria. In two Local Authority areas (covering five PCT areas), elderly people meeting the specific inclusion criteria of the study could not be identified separately from the larger population of elderly people in hospital and care environments. Information in relation to elderly people was therefore provided by only 77 PCTs and 40 social services departments (94.3% of all sites), spanning 23.8% of the population of England. The numbers of elderly people meeting the study inclusion criteria in the two areas excluded from the study are not known. However, both areas were large metropolitan cities, and it must be acknowledged that their exclusion may have resulted in some bias within the sample of elderly people. Altogether, information was obtained in relation to 3535 adults and 1623 elderly people.

Numbers of placements identified and population rates are shown in Table 1.

Although overall response rates are high, a feature of the study was the amount of information that individual commissioners were unable to supply because it was not known to them. This affected some areas of the questionnaire more than others, and some organisations more than others. Findings are only reported in this paper where justified by the amount of information available.

Characteristics of individuals in placements

Adults (16–64 years)

The majority of individuals in placement on the census day were men (63.3%); mean ages were 46 years for men and 47 years for women. 'Ethnicity' was one of the domains where many commissioners (28.4% of cases) were unable to complete the questionnaire. Of those completed, in only one SHA area is the proportion of white adults placed less than 90% of the total. Numbers of black and ethnic minority individuals were broadly proportional to local populations.

Psychiatric diagnoses of individuals placed were mostly known to commissioners. The largest group (42.1%) consisted of people with diagnoses of the more severe (psychotic) disorders, mainly schizophrenia with smaller numbers of people diagnosed with schizo-affective disorder or bipolar disorder. The next largest group was of people described as having a 'nonspecific' mental illness, i.e. where no specific diagnosis was recorded. A smaller group consisted of people with diagnoses of

less common organic disorders such as Huntington's Chorea and Korsakoff's syndrome, and acquired brain injuries. Additional problems of alcohol dependence were identified in 9.4% of cases, drug dependence in 4.3% of cases, and learning disability in 9.8% of cases.

Elderly people (65 years and over)

The majority of elderly people in placement on the census day were women (62.3%); mean ages were 79 years for women and 75 years for men. 'Ethnicity' was unrecorded in 28.9% of cases, and in 98.3% of known cases was described as 'white British' or other white.

Psychiatric diagnoses for elderly people were most commonly the psychotic disorders and 'nonspecific' mental illness. Additional problems of alcohol dependence were identified in 1.8% of cases, deafness in 3.6% of cases, and learning disability in 2.7% of cases.

Characteristics of placements

Number of units with placements

The number of units with individuals in placement on the census days is shown for each SHA area in Table 2. The number of units for each SHA area that only had one individual in placement on the census days is also shown.

Overall, almost half of units used for adult placements had only one person from that particular SHA area on the census days. For elderly people, the proportion with only single placements was even higher. At the other end of the spectrum, a number of units had large numbers of placements from particular SHA areas: one establishment had 77 individuals in placement, whilst a number had between 40 and 50.

Type of placement

It was hypothesised that placements were likely to be broadly of two types: those that indicated a demand for beds for particularly specialised (and possibly rare) mental health needs, and second, a demand for more general placements, for whom there was insufficient capacity within local statutory provision. Commissioners were asked to describe the placement of each individual in the study, using a list developed by the research team. Table 3 below shows the responses for adults (under 65 years).

Table 3 shows that the large majority of placements are in facilities either described as 'continuing care' or 'rehabilitation', and this is quite consistent across the seven SHA areas. There is also a clear 'cluster' of low and medium-secure forensic placements mostly returned by the specialist forensic commissioning teams. Acute and less common mental health needs are represented in much smaller proportions, and there is variation between SHA areas. However, it must be noted that the nature of the sample (a cross-section of the population at a point in time) will result in some over-representation of longer-term cases.

Placements for elderly people are shown in Table 4. Placements for elderly people were overwhelmingly described as 'continuing care', although as indicated above this may partly be an artefact of the sampling method. Only a handful of placements were described as 'rehabilitation units'. In four SHA areas there were a few placements in forensic care.

Registration categories

Hospitals and care homes were registered with the regulatory bodies the Healthcare Commission and CSCI. In terms of registration categories, only 19.5% of adults were placed in facilities registered as 'independent hospitals', 32.9% were placed in 'care homes with nursing' whilst 46.1% were placed in 'care homes'. The forensic placements were heavily concentrated in the 'independent hospitals' category (150 out of a total of 153 forensic placements). Apart from the forensic placements, adults placed in the independent sector were placed in facilities that reflected needs for social care as much as for specialised clinical resources. Whilst there is some variation between SHAs in the proportions

Table 2 Numbers of units per Strategic Health Authority (SHA) area with placements on census days

	Adults (16–64 years)			Elderly people (65 years and over)		
SHA area	Number of units	Number of units with one placement from SHA area	Percentage of units with only one placement	Number of units	Number of units with one placement from SHA area	Percentage of units with only one placement
A	121	51	42.2	98	66	67.4
B	142	51	35.9	144	80	55.6
C	149	70	47.0	106	72	67.9
D	132	66	50.0	60	31	51.7
E	104	65	62.5	72	47	65.3
F	144	75	52.1	66	34	51.5
G	59	24	40.7	19	5	26.3

Table 3 Types of placement (adults up to 64 years)

Type of placement	SHA area A number (%)	SHA area B number (%)	SHA area C number (%)	SHA area D number (%)	SHA area E number (%)	SHA area F number (%)	SHA area G number (%)	Total areas number (%)
Acute inpatient ward	18 (3.1)	2 (0.2)	10 (2.1)	7 (0.9)	13 (5.1)	0	0	50 (1.4)
PICU	2 (0.3)	9 (1.0)	2 (0.4)	1 (0.1)	4 (1.6)	14 (4.1)	2 (1.1)	34 (1.0)
Low secure (forensic)	27 (4.6)	14 (1.6)	6 (1.2)	4 (0.5)	6 (2.4)	12 (3.5)	3 (1.7)	72 (2.0)
Medium secure	29 (5.0)	13 (1.4)	31 (6.4)	49 (6.4)	20 (7.9)	40 (11.7)	5 (2.8)	187 (5.3)
Rehabilitation unit	108 (18.5)	105 (11.7)	52 (10.7)	99 (12.8)	27 (10.6)	12 (3.5)	13 (7.2)	416 (11.8)
Continuing care service	372 (63.7)	729 (81.1)	370 (76.1)	596 (77.3)	171 (67.3)	261 (76.1)	130 (72.2)	2629 (74.8)
Psychotherapy inpatient unit	1 (0.2)	1 (0.1)	3 (0.6)	5 (0.6)	1 (0.4)	0	0	11 (0.3)
Eating disorder unit	5 (0.9)	5 (0.6)	7 (1.4)	1 (0.1)	3 (1.2)	4 (1.2)	0	25 (0.7)
Mother and baby unit	0	2 (0.2)	0	0	0	0	0	2 (0.1)
Women-only unit	11 (1.9)	0	1 (0.2)	3 (0.4)	0	0	0	15 (0.4)
Specialist LD service	0	0	0	0	0	0	26 (14.4)	26 (0.7)
Other service	11 (1.9)	19 (2.1)	4 (0.8)	6 (0.8)	9 (3.5)	0	1 (0.6)	50 (1.5)

Percentages (in parentheses) are column percents. Data not recorded in 18 (0.5%) cases. PICU, psychiatric intensive care unit; LD, learning disability; SHA, Strategic Health Authority.

Table 4 Types of placement (elderly people 65 years and older)

Type of placement	SHA area A number (%)	SHA area B number (%)	SHA area C number (%)	SHA area D number (%)	SHA area E number (%)	SHA area F number (%)	SHA area G number (%)	TOTAL areas number (%)
Acute inpatient ward	0	1 (0.2)	0	1 (0.4)	1 (0.6)	0	0	3 (0.2)
PICU	1 (0.5)	2 (0.4)	0	0	0	4 (2.1)	0	7 (0.4)
Low secure (forensic)	4 (2.1)	3 (0.5)	1 (0.6)	3 (1.1)	0	0	0	11 (0.7)
Medium secure	0	2 (0.4)	3 (1.8)	2 (0.7)	0	0	0	7 (0.4)
Rehabilitation unit	6 (3.1)	7 (1.2)	2 (1.2)	5 (1.8)	4 (2.5)	0	4 (5.6)	28 (1.7)
Continuing care service	180 (92.8)	490 (87.2)	160 (96.4)	263 (95.6)	155 (96.9)	189 (97.9)	68 (94.4)	1505 (92.8)
Other service	3 (1.5)	56 (10.0)	0	1 (0.4)	0	0	0	60 (3.7)

Percentages (in parentheses) are column percents. Data not recorded in 2 (0.2%) cases. PICU, psychiatric intensive care unit; SHA, Strategic Health Authority.

placed in differently registered facilities, the general pattern is evident in all SHA areas.

The pattern for elderly people's placements is different; 3.0% are placed in registered 'independent hospitals', 55.9% in 'care homes with nursing' and 39.0% in 'care homes'. This reflects greater levels of need for nursing care. There is variation between SHAs in the proportions of elderly people placed in 'care homes with nursing' and 'care homes', but in all SHA areas, the proportion placed in 'independent hospitals' is low.

Cost burden

The cost burden of placements in the study fell upon either PCTs or Local Authority Social Services Departments, or was dealt with via joint or 'pooled' arrangements. There is marked variation between SHA areas in terms of the distribution of costs. Table 5 shows how placements were funded for adults under 65 years.

Across the seven SHA areas, just under half of all adult placements were funded by the Social Services Departments, whilst around a quarter were funded by PCTs. However, there is considerable variation between areas; in SHA area E, the PCTs fund almost half of placements and Social Services funds a quarter. Jointly funded placements account for between 7% and 42% of all placements whilst pooled funding is only a major feature in SHA area A.

Despite the higher number of placements that were the responsibility of Social Services Departments the overall cost burden was greater for PCTs, as the more expensive placements tended to be PCT-financed. Placements in independent hospitals were approximately four times as expensive as those in care homes and care homes with nursing.

For elderly people with mental health problems, sources of funding are shown in Table 6.

Table 5 Sources of funding (adult placements)

	Source of placement funding			
SHA area	PCT number (%)	LASSD number (%)	Joint PCT and LASSD number (%)	Pooled/other number (%)
A	115 (19.7)	226 (38.6)	39 (6.7)	205 (35.1)
B	225 (25.8)	506 (58.0)	138 (15.8)	3 (0.3)
C	112 (23.1)	236 (48.7)	137 (28.2)	0
D	153 (19.8)	462 (59.8)	156 (20.2)	1 (0.1)
E	125 (49.2)	60 (23.6)	68 (26.8)	1 (0.4)
F	91 (26.5)	175 (51.0)	77 (22.4)	0
G	56 (30.8)	46 (25.3)	76 (41.8)	4 (2.1)
Total	877 (25.1)	1711 (49.0)	691 (19.8)	214 (6.2)

* Data not recorded in 55 (1.6%) cases. PCT, Primary Care Trust; LASSD, Local Authority Social Services Department; SHA, Strategic Health Authority.

Table 6 Sources of funding (elderly people's placements)

	Source of placement funding			
SHA area	PCT number (%)	LASSD number (%)	Joint PCT and LASSD number (%)	Pooled/other number (%)
A	9 (4.6)	146 (75.3)	25 (12.9)	14 (7.2)
B	108 (19.2)	333 (59.3)	120 (21.4)	1 (0.2)
C	17 (10.2)	129 (77.7)	20 (12.0)	0
D	68 (24.7)	96 (34.9)	110 (40.0)	1 (0.4)
E	38 (23.9)	113 (71.1)	8 (5.0)	0
F	38 (20.2)	36 (19.1)	114 (60.6)	0
G	15 (20.8)	11 (15.3)	45 (62.5)	0
Total	293 (18.1)	864 (53.5)	442 (27.4)	16 (1.0)

* Data not recorded in 8 (0.5%) cases. PCT, Primary Care Trust; LASSD, Local Authority Social Services Department; SHA, Strategic Health Authority.

Just over half of all placements were Social Services funded, whilst over a quarter were joint funded. A lower proportion of placements were solely PCT funded (18.1%). PCT-funded placements for elderly people were on average almost twice as expensive as Social Services-funded placements, and included most placements in independent hospitals.

Sector of placement

Almost four-fifths (79.0%) of adult placements were in the private sector. This pattern was fairly consistent across all seven SHA areas. The voluntary sector provided higher proportions (although lower numbers) of placements in units registered as 'independent hospitals' and 'care homes'. In terms of type of unit, both sectors provided larger numbers of 'continuing care' placements.

Voluntary sector placements were funded by PCTs and Social Services authorities in similar proportions. Private sector placements were on average more expensive: the mean cost of adult placements was £895 (SD = £1050; median cost £420) per week in the private sector and £787 (SD = £783; median cost £424) per week in the voluntary sector (2004 costs), a significant difference (independent samples t-test: $t = 2.98$, d.f. = 1389.4, $P = 0.003$). Further analysis shows that the cost difference is principally accounted for by the higher costs of private independent hospitals.

For elderly people, a higher proportion of placements were in the private sector (83.6%), with the voluntary sector providing just over 15% of placements. There was much greater variation between SHA areas in the relative proportions of private and voluntary sector placements. SHA area B had over 30% of placements in the voluntary sector, whilst at the other end of the range SHA area C had only 3%. Once again, the voluntary sector had higher proportions of units registered as 'independent hospitals' or 'care homes'. Both sectors provided a large proportion of placements in placements described as 'continuing care', but the voluntary sector provided slightly higher proportions of rehabilitation units.

Social Services authorities funded around half of placements for elderly people in each sector. PCT-funded placements and joint-funded services were concentrated

Table 7 Distance from area of origin

	Adults < 65 years		Elderly people (65 years and over)	
SHA area	Placements 0–20 miles away Number (%)	Placements over 20 miles away Number (%)	Placements 0–20 miles away Number (%)	Placements over 20 miles away Number (%)
A	481 (83.9)	92 (16.0)	183 (94.3)	11 (5.7)
B	633 (71.3)	255 (28.7)	438 (78.1)	123 (21.9)
C	232 (47.9)	252 (52.0)	122 (74.4)	42 (25.6)
D	681 (87.8)	95 (12.2)	264 (96.0)	11 (4.0)
E	115 (45.5)	138 (54.5)	95 (59.4)	65 (40.7)
F	194 (57.4)	144 (42.7)	133 (70.0)	57 (30.0)
G	133 (72.7)	50 (27.3)	68 (94.4)	4 (5.6)
Total	2469 (70.6)	1026 (29.3)	1303 (80.6)	313 (19.4)

Data not recorded in 53 (1.5%) cases (adults) and 8 (0.5%) cases (elderly people). SHA, Strategic Health Authority.

Table 8 Types of unit and distance from area of origin

	Adults < 65 years		Elderly people (65 years and over)	
SHA area	Placements 0–20 miles away Number (%)	Placements over 20 miles away Number (%)	Placements 0–20 miles away Number (%)	Placements over 20 miles away Number (%)
Acute inpatient ward	17 (34.7)	32 (65.3)	1 (33.3)	2 (66.7)
PICU	8 (24.2)	25 (75.8)	3 (42.9)	4 (57.1)
Rehabilitation unit	291 (70.8)	120 (29.2)	26 (92.9)	2 (7.1)
Continuing care service	2029 (77.9)	577 (22.1)	1212 (80.9)	287 (19.1)
Low secure (forensic) unit	34 (47.2)	38 (52.8)	8 (72.7)	3 (27.3)
Medium secure (forensic) unit	15 (8.2)	169 (91.8)	1 (14.3)	6 (85.7)
Other specialist units	50 (49.5)	51 (50.5)	52 (85.2)	9 (14.8)

Data not recorded in 64 (1.8%) cases (adults) and 8 (0.5%) cases (elderly people). PICU, psychiatric intensive care unit; SHA, Strategic Health Authority.

in the private sector. Mean weekly costs of placements for elderly people were £416 (SD = £263; median cost £397) in the private sector and £500 (SD = £645; median cost £361) in the voluntary sector (2004 costs) (independent samples *t*-test: not significant, $t = 1.84$, d.f. = 213.4, $P = 0.068$).

Distance from home area

Analysis revealed that 54.9% of the adults placed, and 65.6% of the elderly people placed were in units that were within the geographical boundaries of the funding PCT or local authority. The proportions of placements more than 20 miles distant from the funding authority in each of the SHA areas are shown in Table 7.

Almost 1 in 3 placements for adults and 1 in 5 placements for elderly people were more than 20 miles distant from the address of the funding agency.

Further examination of the types of unit shows that for both adults and elderly people, rehabilitation and continuing care units tend on average to be closer to the home area, whereas acute and intensive care units, and forensic units tend to be more remote (see Table 8). For adults, other specialist units also tend to be at greater distance.

Discussion

Rapid diversification of mental health care provision has occurred in recent decades in England, fuelled by large-scale closures of public hospitals and care homes, and by a sustained political emphasis on the contestability of public services. The study suggests that this has not been an even process, and there are marked variations between areas in the rates of use of the independent sector.

Issues for commissioning

'Commissioning' within a diverse market is a relatively new activity for NHS staff, and has a rather longer

history in social care. In the areas studied, commissioners were using a wide range of providers. A substantial proportion of these had only one placement from within an SHA area on the census day, whilst a smaller group had a large number of placements. Both of these reflect commissioning issues; first, the need to have some knowledge about placements used, which is difficult if use is rare; and second, the need to be able to select an appropriate placement for an individual, which is difficult if commissioners are committed to use 'blocks' of placements from particular providers. Some of this work may be delegated to care co-ordinators, and where this is the case, the linkage between them and commissioners will be crucial in ensuring appropriateness and quality. A strategic approach and a level of local experience and expertise in managing and potentially shaping the diverse market of providers is necessary to ensure that needs are appropriately addressed. Opportunities for collaborative commissioning may be missed where large numbers of trusts and local authorities are placing people singly.

Commissioners appear to be using the independent sector mainly to deal with issues of capacity as placements are overwhelmingly described as either 'continuing care' or 'rehabilitation' of individuals with longer-term needs. The exception to this is a marked 'niche' of forensic care. The use of care homes and care homes with nursing suggests that the independent sector is responding as much to needs for social care, rather than for specialised psychiatric input, and this is also suggested by the fact that the larger proportion of placements is funded by social services organisations. The level of joint or 'pooled' funding arrangements varies between areas, with some organisations clearly having been more pro-active in developing shared arrangements than others.

Care Programme Approach

The care programme approach (CPA) is a central feature of mental health policy in England, that requires systematic monitoring and review of the care of individuals with continuing needs. It is of particular importance when vulnerable individuals are placed in 24-hour care. The study identified that a minority of individuals in the study were accommodated in units that were remote from their home base. In some cases this may be a considered decision in individual circumstances. However, in other cases it may raise issues about the appropriateness of the care setting in terms of individuals having meaningful contact with their families and communities of origin. It also makes the monitoring of placements under the CPA more problematic, particularly if these responsibilities are not transferred to local services in the provider area. Again, this points to the need for strategic development of a local market, to address shortfalls in capacity.

Private and voluntary providers

Charitable organisations have a long history of providing a range of care resources, from the basis of an ethic of altruism, and their role is substantial in much of the European Union. In this study the private sector is dominant in independent sector mental health care, suggesting that the conditions for diversification in England are currently more conducive to private organisations entering the market, rather than charities. Further incentives to voluntary organisations to become more substantial providers of mental health care might contribute to a greater balance within the diverse economy, and may also lead to provision that is more clearly reflective of local needs.

Limitations of the study

A cross-sectional sample of the type used in this study is likely to over-represent cases that are longer term. It also has the limitation of describing the field at a single point in time, and may run the risk of identifying transient features.

The study was not resourced to examine public sector provision, and it is therefore not possible to identify to what extent the issues discussed are unique to the independent sector.

The fact that two major sites could not identify the population of elderly people meeting the inclusion criteria means fewer sites were used (than for adults under 65 years), and the scale of the consequent loss of cases is not known. The sample of elderly people is as a result less comprehensive and has bias towards rural and small town areas compared with the sample of adults under 65 years.

Conclusions

There are relatively few published studies on the role of the independent sector in mental health care in England. Despite its limitations, this study has described the scale and nature of activity in the sector, in around a quarter of English health jurisdictions, and has highlighted issues for those commissioning services. Implications for the strategic development of the sector might include measures to 'pump-prime' voluntary sector involvement. Future studies might usefully focus on issues of quality and outcomes for individuals placed in independent sector facilities.

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