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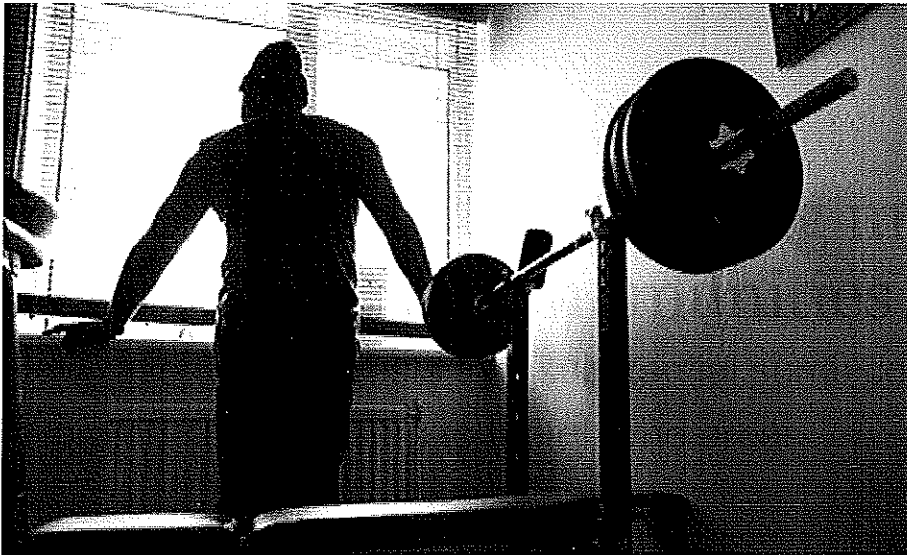
Millions wasted on treating mentally ill away from their communities

New research suggests that substantial sums could be saved by returning service users to their home areas



David Brindle
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'George', back in his home area and now in his own flat, takes a break from a fitness workout. Photograph: Felix Clay

Slowly but methodically, George is rebuilding his life after a long period of mental health problems. He has his own flat in the community where he grew up, is working on his fitness, and is doing a couple of small voluntary jobs to get back into the rhythm of employment.

It's a protracted process, and not all days are as good as others. But it's a big change for someone who was previously sent to deal with his illness in an adult foster care placement in a different local authority. He spent six years there.

George (not his real name) was one of anything up to 10,000 people with mental ill-health who are subject to "out of area treatments" (Oats). It is often assumed that since the closure of long-stay mental hospitals, users of mental health services are all treated

in their own communities. This is emphatically not so. In a rising trend that has evaded policy-makers' radar, NHS primary care trusts (PCTs) and local authorities in England are spending an estimated £330m a year on placements elsewhere.

Some placements are justified on clinical grounds and are the right choice for the individual. Many, however, are not. And new research suggests that substantial sums – perhaps as much as £100m – could be saved by reviewing Oats and returning service users to their home areas.

"It's really important to stress that some Oats are appropriate," says Helen Killaspy, chair of the faculty of rehabilitation and social psychiatry at the Royal College of Psychiatrists (RCP). "But the degree to which this phenomenon has grown in recent years does not match clinical need, and a large proportion of the extra cost is unnecessary."

Some critics have likened the growth of Oats to the creation of a vast "virtual asylum", as people with more serious illnesses, typically schizophrenia, are judged not suitable for community services and are sent to placements often some distance from their home areas, usually "spot-purchased" by a PCT or local authority as a one-off from a private sector provider.

Not only can the care and support offered be lacking, despite the generally relatively high cost, but the individual risks becoming isolated. One study of people placed in Oats by a PCT and its corresponding local authority found that the average stay was four years and that half the service users never visited their area of origin or received visits from relatives.

George, a 37-year-old former electrical technician with a diagnosis of schizophrenia, was not quite so cut off. He was sent from Islington in north London to neighbouring Tottenham and was able to return to his parental home for Sunday lunch. He has no criticism of his adult foster placement, which he shared with another service user and other lodgers, but he says that he had little to do and saw few people, apart from, periodically, his social worker and psychiatrist.

When he was asked if he would like to return to Islington, initially to supervised accommodation and subsequently to a place of his own, he "jumped at the chance". He says. "I've got a bit more still to do, but I've slowly got my mind back."

George was returned under a scheme by which Islington's health and social care agencies reviewed 40 Oats and decided that 25 of the individuals could potentially be "repatriated". Of the 40, 13 were receiving family visits no more than once a year, nine had never been visited, and 16 had never visited anyone outside their placement other than mental health professionals.

In the end, George and 12 others were moved, all but one to more independent accommodation and all but two back to Islington. Some others of the 25 were reluctant to return because of negative past experiences, social links they had established in their placements, or lack of encouragement from health and care professionals. However, repatriating just 13 individuals is estimated to have pumped an additional £1m a year into the local health and housing economy.

Killaspy, a senior lecturer and honorary consultant in rehabilitation psychiatry at University College London, has been involved in a Freedom of Information request by the RCP's policy unit to all English PCTs and local authorities to try to get a clearer picture of the number and cost of Oats.

On a usable response rate of 62%, the survey found a total of 6,280 Oats, costing some £220m. The average cost was £35,000 a year, compared with £22,000 for an equivalent placement in a local rehabilitation service. Extrapolated to take account of non-respondents, overall spending on Oats is calculated at £330m, and their net extra cost is put at £134m.

Although not all Oats are deemed replaceable, Killaspy thinks that almost all those (half the total) made by local authorities are likely to be so, as well as "a significant proportion" of those more complex cases handled by PCTs. On this basis, much of the £134m extra cost could be saved.

A major obstacle to this, however, is the lack of availability of rehabilitation services in many areas. Psychiatric rehabilitation is an unfashionable concept in a sector where the dominant model of care has come to be seen as pushing the individual along a time-limited care pathway. Service users with longer-term needs do not easily fit this approach.

Closure of units

It is thought that at least a quarter of the former community rehabilitation teams were turned into assertive outreach teams under the 1999 national service framework for mental health. And in an RCP survey in 2006-07, 18% of rehabilitation services reported closure of wards or entire units, and a further 18% reported planned closures or cuts in bed numbers.

There is no nationally agreed service specification for psychiatric rehabilitation, but the RCP's rehabilitation faculty has recently produced a template for a model service of the future. This would include a full range of inpatient services, perhaps provided by the independent sector, as well as supported accommodation, multidisciplinary teams, work and education opportunities, advocacy, and peer support.

Killaspy says such a model would provide local services for local people, delivering personalised care tailored to their needs and promoting their recovery and social inclusion. She says: "It is hard to find another example in the NHS where a patient has to leave their home town and move to a facility many miles away for a number of years, merely to access a standard treatment environment."

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