

## Contents

Research Clusters	2
Research Update	3
Research Findings	7
Research Reports	15
Research Reports: Focus on Methods	23
Visitors Update	25
In the Media	26
News & Events	27
New Projects	29

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## Introduction

Welcome to the first issue of 2008. As we move forward with PSSRU's programme of research in 2008, there have been a number of developments in social care to which our research is or will be contributing.

### Developments in social care

'Personalisation' is one of the buzz words of government social care policy, and the commissioning models that give service users greater choice and control over the services they get and who delivers them are central to this aspiration. Current government policy has been geared towards providing service users with greater choice, as evidenced with the 2007 Green Paper on Social Care and the "Putting People First" Concordat for Adult Social Care (introducing personal care budgets, among other things).

### Research activities

PSSRU staff are actively contributing to the policy debate around adult social care. We have just completed our evaluation on the Individual Budgets Pilot Schemes (jointly with the Universities of Kent, Manchester, York and King's College London), although the findings will not be available until they have been peer-reviewed and discussed with government ministers. Findings from our work thus far on the National Evaluation of the Partnership for Older People Projects (POPP) were released towards the end of 2007, with the evaluation due for completion towards the end of this year.

The work from our recent evaluation of the Direct Payments Development Fund, including surveys of both local authorities and support organisations, has also now been summarised in two reports (a summary of one follows in the Research Reports section).

Another important theme in some of our newer projects is prevention. The POPP evaluation is obviously in this area, as is our evaluation of the Brighter Future's initiative in Kent. PSSRU LSE staff are also members of the Health England subgroup on social care prevention and the social care and health interface.

Following publication of the Wanless Social Care Review report, which was written by PSSRU staff, Julien Forder and Jose-Luis Fernandez have worked with HM Treasury and the Department of Health in a major review of social care funding for older people. This analysis helped to underpin the Government's announcement in the 2007 CSR of a Green Paper on social care funding, and the launch of a national consultation. Current work is exploring a range of funding options and their long-term implications, led by Jose-Luis Fernandez and Raphael Wittenberg.

*Professor Martin Knapp,  
Director, PSSRU @ LSE*

*Dr Jose-Luis Fernandez  
Deputy Director, PSSRU @ LSE*

The PSSRU conducts research and analysis on equity and efficiency in health and social care across three branches (LSE, Universities of Kent and Manchester). PSSRU's mission is to conduct high quality research on social and health care to inform and influence policy, practice and theory.

The PSSRU receives funding from a number of organisations but would particularly like to acknowledge the continued support and funding we receive from the Department of Health for our core research and related activities.



Research at the LSE branch is focused around three core research programmes which, between them, comprise eleven research clusters. Three of these clusters are outlined below:

### Informal care

Informal or unpaid care is a key building block of current community care policy in the UK and there is considerable policy interest in the provision of informal care, particularly its future supply. The main aim of the

informal care research cluster is to undertake analyses of demand for and supply of informal care for adults, particularly older people, now and in future years. Key aspects of the analyses of informal care are the distinction between

care provided by different sources (spouses, adult children, parents) and the use of a wide variety of data, including the General Household Survey, the English Longitudinal Study of Ageing and the 2001 Census.

### European social care

Research within this cluster is comparative across a number of European countries. It includes an evaluation of assistive technology for older people and people with

disabilities (the MonAMI project); a study exploring the impact on social care system performance of recent changes in the role of the state as service provider/regulator;

and a study of the comparative costs and effectiveness of community and institution-based services across 28 European countries.

### UK mental health

The core DH-funded programme includes work exploring the links between childhood mental health problems and adulthood economic implications, and what can be done to address the problem; links between employment and mental health; and evaluations of a number of policy initiatives. Recent or current work has included an evaluation of the Choose Life

suicide prevention programme in Scotland. An examination of income-related inequalities in prevalence and service use is underway. A long-term theme has been the link between mental health problems and social exclusion, working collaboratively with the Centre for the Analysis of Social Exclusion at LSE. Mental Health problems in old age have

been studied in three projects: the prevalence and costs of dementia, age discrimination in mental health service use, and the impact of needs assessments on care patterns and performance. Current work includes a number of contributions to the government's Foresight programme on mental capital and well-being.

For further information on the PSSRU or any of its research projects visit <http://www.lse.ac.uk/collections/PSSRU/> or contact [pssru@lse.ac.uk](mailto:pssru@lse.ac.uk).



## Mainstreaming Ambient Technology (MonAMI)

The Mainstreaming Ambient Technology (MonAMI) is a fairly new European Research project, funded by the European Commission, which links technology with older and disabled people. PSSRU members at LSE are actively involved in the project. The project is now in its second year (of five).

### Objective

The overall objective of MonAMI is to mainstream accessibility in consumer goods and services, including public services, through applied research and development, using advanced technologies to ensure equal access, independent living and participation for all in the Information Society.

### Aim


The MonAMI project will examine how accessible, useful services for elderly persons and persons with disabilities living at home can be delivered in mainstream systems and platforms. This will be done in close cooperation with users and by involving key mainstream actors throughout the whole process.

### Key tasks

During Year 1 project partners have met regularly to plan the overall work programme, with efforts having been put into development of a sociological and economic framework, which can be used to check the needs of users and to try to match these with the services, which are available.

The technologies themselves cover a wide range of topics from home security, time joggers such as medicine reminders, alarm systems which allow users to contact local support services, portable notepads which guide the user along a path or map to their meeting place, and movement sensors which detect when the occupant does not move in their house or flat for a long time. Other technologies will be introduced during the project.

Staff at the LSE have been working on the evaluation and a possible methodology to be used with the available technology. They have been assisted on this by the PSSRU LSE Service User Advisory Group which has helped with the finalisation of a practical group of questionnaires. These will be used across the EU with Users in all the Centres. The project team (Jacqueline Damant, Margaret Ellis and Martin Knapp) would like to thank the Service User Advisory Group for their assistance and advice on the design of the questionnaires.

Currently the different Centres are sorting out their specification and selection of services they will provide with the technology. These services will now be tested and evaluated by the local users who will be asked to complete our questionnaires. 

There are 14 partners involved in the project based in 7 EU countries

Swedish Institute of Assistive Technology* (SIAT)	Sweden
Electricité de France (EDF)	France
Europ Assistance France (EAF)	France
France Telecom (FT)	France
HMC International (HMC)	Belgium
London School of Economics (LSE)	United Kingdom
OpenHub	United Kingdom
Siemens IT Solutions and Services	Germany
Telefónica I+D (TID)	Spain
The Royal Institute of Technology (KTH)	Sweden
The Technical University of Košice (TUKE)	Slovakia
The University of Passau (UP)	Germany
The University of Zaragoza (UZZ)	Spain
Trialog	France



## The APOLLO project – now in its second year

Funded by the European Commission and led by the University of Athens, the project is looking at strategies and best practice to reduce the health and social-economic costs and consequences of injuries, both accidental and self-inflicted.

The LSE – led by David McDaid with assistance from A-La Park – is leading a systematic review on costs and effectiveness of strategies to reduce the socio-economic cost of injuries and the potential for implementation in different context and settings across Europe.

The principle objectives of work undertaken in the second year by LSE have been to map what is known about the socioeconomic impact of injuries, both intentional and unintentional, primarily in Europe, but also in other parts of the world where relevant. This has primarily involved the completion of systematic reviews undertaken to identify the economic impact of injuries and the cost-effectiveness of interventions and strategies to prevent/and or reduce their impact. Results of the review are being coded and catalogued in a relational database. A third component of work looking at the economic costs of implementing effective strategies in different settings and contexts across Europe will be the principle task to be completed in the final year of the project.

The review by David McDaid and A-La Park included studies from all OECD countries and all those within the WHO European Region within our analysis. Authors from the USA dominate research into the economics of injury prevention being present in 53% of all included studies. UK authors account for a

Table 1 Areas of injury prevention

Area	Number of studies	Percentage
Accidents in the Home	27	3.1
Agricultural	12	1.41
Alcohol abuse	32	3.76
Burns/Fire	37	4.35
Child abuse	11	1.29
Domestic Abuse	13	1.53
Drowning	6	0.71
Falls	209	24.59
Health system based injuries	14	1.65
Motor Vehicle Safety	147	17.29
Natural Disasters	1	0.12
Other Road Traffic Safety	34	4.00
Other Transport Safety	11	1.29
Pollution/toxicity	39	4.59
Self inflicted harm	37	4.35
Sexual Abuse	6	0.71
Sports and Leisure Injuries	42	4.94
Unknown cause of injury	266	31.29
Violence	62	7.29
Workplace Injuries	181	21.29

Note: percentages add up to more than one as more than one group may be targeted

further 10% of studies; elsewhere in Europe Sweden (6%) and Switzerland (3%) appear to have significant capacity and interest in injury prevention, while a significant body of work (10%) is authored by those based in the old UK Commonwealth countries of Australia, Canada and New Zealand.


One aspect of the review focused on areas of injury prevention. Table 1 provides a breakdown of different areas of injury prevention. The most common area for analysis relates to

fall prevention (25%) and is one of the few areas where pharmaceutical interventions e.g. to tackle osteoporosis, often in their economic evaluations might also specifically look at the prevention of hip fractures. There are also a number of other studies available which look at the role of hip protectors in reducing the consequences of falls. The other major area of evaluation concerns road safety, and in particular that of motor vehicle occupants, where a range of interventions including

traffic calming measures and the use of protective devices including seatbelts, airbags and helmets have been assessed. In addition, the economic costs of injuries on the road have been well documented in a number of countries. Other evaluations include several studies on the use of rollover protection structures to prevent serious injury in tractors and other agricultural vehicles.

Another area where a large number of studies have been identified is the very broad category of workplace injuries (21%); this largely refers to accidents at the workplace and common musculo-skeletal problems. It should be noted that we excluded stress from our analysis – if we had included stress as an injury the number of studies identified would have increased substantially. A significant number of studies in our analysis report the costs of certain injuries, but do not specifically state the cause of injury; this may be the case in studies looking at the costs of spinal cord injuries and those presenting in accident and emergency departments with major trauma.

In addition to finalising the database and analysis thereof, a third component of work looking at the economic costs of implementing effective strategies in different settings and contexts across Europe will be the principle task to be completed in the final year of the project. This will include some threshold analytical modelling to identify key factors in different European settings that may impact on the potential cost effectiveness of strategies.

Contact David McDaid ([d.mcdaid@lse.ac.uk](mailto:d.mcdaid@lse.ac.uk)) for further information about this project. 

## The National Evaluation of Partnerships for Older People Projects (POPPs)

### Interim findings recently submitted to the Department of Health

In 2006 the Department of Health established the Partnerships for Older People Projects (POPP), with 19 pilot local authority sites and 48 (at the time) PCT partners. The aim of each of the projects was to shift resources and 'culture' away from the focus on institutionalised and hospital-based crisis care towards earlier and better targeted interventions within community settings. The research is led by the University of Hertfordshire. The National Evaluation team consists of researchers from the University

of Keele, University College London, the London School of Economics (Julien Forder, Catherine Henderson, Martin Knapp, Gerald Wistow), and John Moores University.

PSSRU has undertaken an analysis of impact of the projects on the use of hospital bed-days. The expectation was that POPP would generate a reduction in use of emergency bed-days per month for people over 65 from the 5000 or so PCT average (up to December 2006).

#### Interim findings from the project indicate the following:

- There are early indications that POPP pilot sites are having a significant effect on **reducing hospital emergency bed-day use** when compared with non-POPP sites: a reduction in emergency beds-days of 137 per month (or approximately £16,000 per month). Put in cost terms, a £1 increase in spend on the average POPP project would result in around a £1 reduction in the cost of emergency bed-day use in hospital.
- Pilot sites are reporting **improved access** for excluded groups through proactive case finding, greater publicity and links with the voluntary sector.
- **Partnerships** between statutory organisations and the community and voluntary sectors have improved if compared with the perceived quality of partnerships prior to the initiation of POPP.
- Pilot sites are reporting that older people's involvement has increased within steering groups, commissioning, recruitment, provision and evaluation.
- Older people's health (including mental health) and well-being needs are **becoming better integrated within the wider strategic agenda**.


The findings within the report are based on the first six months of data from the POPP projects. POPP does have a statistically significant effect on hospital use (coming mainly through reductions in admission). Although there are current limitations to the study

design and some issues are still to be resolved, overall the results are more than encouraging and certainly justify continuation of the pilots. They make a strong case for specific randomized controlled trials at individual level.



Final outcomes will be provided in October 2008. In the longer term the findings from the national evaluation will help to develop the existing evidence base on the effectiveness of initiatives aimed at

promoting independence and prevention as highlighted in the Health and Social Care White Paper 'Our Health, Our Care, Our Say: A new direction for community services'.

Contact Julien Forder (j.forder@lse.ac.uk) for further information about this project. 

## Completion of Mental Health Economics European Network Phase II

Decision makers in Europe are facing both challenges and opportunities in the mental health arena. Economic evidence and insight can help to address each such challenge by providing a platform of relevant data to inform key decisions. Policy makers need to be encouraged to consider the broad, immediate and longer-term implications of their actions.

Europe needs a body of expertise to help tackle the many challenges facing mental health systems. That expertise can help to design the collection of better information on economic aspects of mental health and illness in Europe, and to develop policies for the funding, prioritisation and evaluation of services.

One particular emphasis might be to research further the complex relationships between mental health and employment. Governments should also be encouraged to introduce promotion and prevention policies for mental health in the workplace as well as evaluating services that promote employment for individuals with more severe mental health problems, emphasising strategies aimed at gaining and retaining paid work.

The establishment in 2002 of the Mental Health Economics European Network (MHEEN) fell squarely into the policy-targeted 'supra-national' category of endeavours that we discussed above. Its broad aim was

to build a base for mental health economics information and subsequent work in 17 countries.

A second phase of MHEEN commenced in the latter part of 2005, with the European Commission awarding funding to the London School of Economics and Political Science, again working in collaboration with Mental Health Europe and Network partners. This further funding has allowed us to extend the scope of our activities and to expand the Network from 17 to 32 countries.

The primary overarching aim remains the same: to gather and analyse information and knowledge in respect of economic aspects of mental health, and in that way to contribute to the promotion and protection of public health across Europe. Activities for the 2005–2007 programme were organised into five broad categories:

- Collection of data for cross-country comparison on mental health economic issues in the 32 countries.
- Analysis of barriers and incentives to mental health system improvements with specific focus on de-institutionalisation, employment, housing and schools.
- Analysis of the cost-effectiveness of mechanisms and strategies to promote good mental health

and alleviate onset of mental health-related problems.

- Development and application of a short tool for the assessment of mental health service utilisation and costs within a small catchment area.
- Continuing inputs to training and capacity building in mental health economics across Europe.

Results from the project are now available and can be downloaded from the MHEEN website at [www.mheen.org](http://www.mheen.org).

### MHEEN II Policy Briefings

**1** Knapp M, McDaid D, Medeiros M, Becker T, Johnson S, Kilian R, Salvador-Carulla L, Simon J, Tatar M, on behalf of the MHEEN Group (2008) *Economics, Mental Health and Policy: An Overview, Report summarising findings presented at a MHEEN seminar (London, September 2007) and MHEEN symposium (Brussels, December 2007)*, MHEEN II Policy Briefing 1, Personal Social Services Research Unit, London.

**2** Knapp M, McDaid D, Evers S, Salvador-Carulla L, Halstein I, the MHEEN Group (2008) *Cost-effectiveness and Mental Health*, MHEEN II Policy Briefing 2, Personal Social Services Research Unit, London.

**3** McDaid D, Zechmeister I, Kilian R, Medeiros H, Knapp M, Kennelly B,




the MHEEN Group (2008) *Making the Economic Case for the Promotion of Mental Well-being and the Prevention of Mental Health Problems, MHEEN II Policy Briefing 3*, Personal Social Services Research Unit, London.

**4** Medeiros H, McDaid D, Knapp M, the MHEEN Group (2008) *Shifting Care from Hospital to the Community in Europe: Economic Challenges and Opportunities, MHEEN II Policy Briefing 4*, Personal Social Services Research Unit, London.

**5** McDaid D, Knapp M, Medeiros H, the MHEEN Group (2008) *Employment and Mental Health: Assessing the Economic Impact and the Case for Intervention, MHEEN II Policy Briefing 5*, Personal Social Services Research Unit, London.

**6** McDaid D, Medeiros H, Knapp M, Lai T, Murauskiene L, Oliveira M, Prot-Klinger K, Salvador-Carulla L, Zechmeister I and the MHEEN Group (2008) *Financing of Mental Health Care in Europe, MHEEN II Policy Briefing 6*, Personal Social Services Research Unit, London.

**7** Johnson S, Salvador-Carulla L, Tibaldi G, Ruud T, Kallert T, Adamowski T, Nawka P (2008) *Development and Application of a Short Tool for the Assessment of Mental Health Service Utilisation and Costs within a Small Catchment Area, MHEEN II Policy Briefing 7*, Personal Social Services Research Unit, London. 

## The economic costs of autism: £28 BILLION A YEAR

Findings detailed in the Economic Consequences of Autism report reveal that children with autism cost £2.7 billion a year, yet for adults the figure is £25 billion – more than eight times as much. There are approximately 540,000 people with autism in the UK – 433,000 adults and 107,000 children.

Funded by the Shirley Foundation and led by Professor Martin Knapp the research shows that for adults with autism the highest costs are those generated by health and social care provision (59 per cent), followed by lost employment (36 per cent) and family expenses (5 per cent).

Autism has life-time consequences with a range of impacts on the health, economic well-being, social integration and quality of life of individuals with the disorder, and also on their families and potentially the rest of society. Many of those impacts can be expressed as economic costs. The purpose of this research was to estimate the full costs of autism spectrum disorders in the UK.

There is no single, nationally representative data set that would allow us to estimate prevalence, service use and costs for the same group of people. The research therefore adopted a modular approach with four elements – prevalence, level of functioning, place of residence, and cost per individual – and sought to obtain the best and most up-to-date UK estimates for each. In this way the authors were able to calculate the aggregate costs of autism spectrum disorders.

Data came from a variety of sources, including: national surveys, published research, our own

previous studies and expert advice.

### Costs for children

Annual costs for children with low-functioning ASD who are living in residential or foster placements were estimated to be £16,185 (for children aged 0–3 years), £40,578 (aged 4–11) and £62,536 (aged 12–17). Costs were considerably lower if children with low-functioning ASD lived with their families: £585 (if aged 0–3), £23,869 (aged 4–11) and £36,474 (aged 12–17). Average annual costs for children with high-functioning ASD ranged from £1,214 to £21,090. These costs exclude informal care by families.

### Costs for adults

For adults, we again made the distinction between low- and high-functioning ASD. Imputed costs for lost employment were included for both the individuals with ASD and their parents, where these are appropriate. We estimated that an adult with high-functioning ASD living in a private household cost £32,681 per annum. For a high-functioning adult living in supported accommodation or a care home, costs are much higher (£84,703 and £87,299 respectively). Mean annual costs for low-functioning adults were found to be £36,507 for those living in private households, £87,652 in supported accommodation, £88,937 in residential care, and £97,863 in hospital.

### Total annual UK costs

We then multiplied these individual-level costs by estimates of prevalence rates, distinguishing type of accommodation, level of functioning and age group. The aggregate national costs of supporting children with ASD were estimated to be £2.7 billion each



year. Most of this cost is accounted for by services used. For adults, the aggregate costs for adults amount to £25 billion each year. Of this total, 59% is accounted for by services, 36% by lost employment for the individual with ASD, and the remainder by family expenses.

#### Lifetime costs

The (undiscounted) lifetime cost for someone with high-functioning autism was found to be £3.1 million, and £4.6 million for someone with low-functioning autism.

#### Relevance of these estimates

What makes these new cost estimates so relevant today? There are four broad reasons. In the first place, our estimates span all areas of public sector expenditure, including education and housing, demonstrating not only the high support costs for people with ASD

but also the breadth of those costs. Second, this analysis recognises the high cost to families, in terms of out-of-pocket expenses, lost income and lost employment opportunities. We could not include the time costs for family members who care for an individual with ASD, but there is no doubt that these will also be considerable. This recognition of the high support costs for ASD leads to two further reasons why these new estimates are important. There are early interventions available that help alter behaviour patterns: would increased investment in these reduce high support costs in adulthood? Greater availability of effective early interventions may reduce the impact of ASD on the UK economy as well as improve quality of life for people with ASD and their families.

The report says that more

supported employment opportunities for people with autism are needed. Lost productivity for people with autism and their families costs the UK economy almost £10 billion. At a time when the government is emphasising the need for higher rates of economic activity, and is trying to support people with disabilities and long-term conditions to move into paid employment, these high costs stand out. Very few people with autism are in employment - it will be no easy task to achieve higher employment rates among this group but the figures suggest that the government should most definitely try.

*The report is available to download from [www.learningdisabilities.org.uk](http://www.learningdisabilities.org.uk).*



## BBC Care Calculator

### What care is received by older and disabled people in England? What financial contributions might they be expected to make to their care?

*The PSSRU at LSE, in collaboration with the BBC, launched a Care Calculator and a Care Questionnaire in January 2008. These are on the BBC website (<http://news.bbc.co.uk/1/hi/health/7183594.stm>).*

The aim of the Care Calculator is to give an approximate idea of the level of social care – both public and private – currently provided in England. It sets out what is likely to be received by somebody with a particular profile of needs – and there are six hypothetical profiles on the website – and what financial contribution would be expected of them given what usually happens in social care services across the country.

The Care Calculator was developed by Jose-Luis Fernandez and Martin Knapp. It does not attempt to determine levels of entitlement but

to reflect what currently happens in England. This is then the basis for a very simple short questionnaire which gives people an opportunity to comment on what they feel about levels of support currently offered to disabled and older people. They are also asked their opinions about how care should be funded, whether an individual's level of savings should affect what they pay, how informal care could be encouraged and which of a number of potential funding arrangements might they support. The latter include funding from income tax, from equity release schemes, from private insurance

policies and the partnership system first set out in the Wanless Social Care Review, the work for which was undertaken by PSSRU staff at LSE. Early results from the survey, which were completed online, were presented on Radio 4 on 31 January when Care Services Minister Ivan Lewis joined a studio audience along with the LSE team, to discuss care services and their funding. The transcript from the programme can be found on the Radio 4 You and Your's programme website.

*A report of the findings will be produced shortly.*





## Modelling of demand for long-term care for 'working-age' adults and older people

**Funded jointly by the Strategy Unit (Cabinet Office) and the Department of Health, the PSSRU recently developed a model projecting levels of demand and associated expenditure for long-term care for the younger adult population (aged 18–64).**

The aim of the work has been to produce a simple model to produce projections for England to 2041 of:

- numbers of disabled younger adults, by broad client group;
- numbers of recipients of informal care;
- numbers of assessments of younger adults;
- numbers of users of residential and community-based social services;
- numbers of recipients of Disability Living Allowance (DLA) care component;
- public expenditure on social services for younger adults, gross and net of income from user charges, and on DLA care component;

- numbers of staff providing social care for younger adults.

The model utilises data from the 2006-based official ONS population projections for England, as well as other relevant data sources such as the 1996/7 FRS and Eric Emerson's study on learning disability.

In addition, the Strategy Unit (Cabinet Office) and Department of Health funded the PSSRU to update its projections of demand for long term care and associated expenditure for the older population (aged 65 and over) in England to 2041.

Two discussion papers are now available on the PSSRU website:

Wittenberg R, Malley J, Comas-Herrera A, Fernandez JL, King D, Snell T, Pickard L (2008) *Future Demand for Social Care, 2005 to 2041: Projections of Demand for Social Care and Disability Benefits for Younger Adults in England*, Report to the Strategy Unit (Cabinet Office) and the Department of Health, PSSRU Discussion paper 2512, Personal Social Services Research Unit, London

Wittenberg R, Pickard L, Malley J, King D, Comas-Herrera A, Darton R (2008) *Future Demand for Social Care, 2005 To 2041: Projections of Demand for Social Care for Older People in England*, Report to the Strategy Unit (Cabinet Office) and the Department of Health, PSSRU Discussion Paper 2514, Personal Social Services Research Unit, London

## Self-funded social care for older people: an analysis of eligibility, variations and future projections

**Julien Forder recently contributed a background paper: *Self-funded social care for older people: an analysis of eligibility, variations and future projections*, to the Commission for Social Care Inspection State of Social Care 2007 report.**

The report concentrates on older people's services and support (reflecting the lack of data and analysis of other client groups). It uses the PSSRU micro-simulation model – developed for the 2006 Wanless Review of Social Care.

The aims of the report were five-fold:

1. to calculate how much, overall, people in these groups contribute towards the costs of their care, looking at the overall levels of care use, public expenditure and private pay for social care used by people over 65;
2. to calculate levels of unmet need;
3. to consider the consequences of changes in the needs eligibility thresholds that councils use;
4. to make projections about the numbers of self-payers in the future;
5. to look at variations between councils in the: rates of supported older people and expenditure, and therefore, by implication, the numbers of potential self-payers.

*The background paper is available online at [http://www.csci.org.uk/pdf/20080128\\_Self-funded\\_social\\_care\\_for\\_older\\_people.pdf](http://www.csci.org.uk/pdf/20080128_Self-funded_social_care_for_older_people.pdf)*



## Deinstitutionalisation and community living – comparative perspectives and international implications

The final report on this project has recently been published and brings together evidence collated within the Deinstitutionalisation and Community Living – Outcomes and Costs (DECLOC) project. The work was funded by the European Commission and aimed to collect available information on the number of disabled people living in residential institutions in 28 European countries, and to identify successful strategies for replacing institutions with community-based services, paying particular attention to economic issues in the transition. The project was led by Jim Mansell and Julie Beadle-Brown at the University of Kent and Professor Martin Knapp at the London School of Economics and Political Science, and involved experts from Universities in Germany, Belgium, Spain and the Czech Republic, supported by the main European non-governmental organisations and professional networks and associations.

Martin Knapp and Jennifer Beecham have been involved in reviewing the economic evidence on balance of care, whether towards or away from reliance on institutional models.

The report highlights that there are at least 1.45 million people in residential care across Europe. Over 70% of those in residential care live in facilities with more than 30 places, and estimated rates per 100,000 of institutionalisation range from 0 (Sweden) to over 500 (Estonia and Latvia).

The report notes that Article 31 of the UN Convention on the Rights of Persons with Disabilities requires States to collect data 'to enable them to formulate and implement

policies to give effect to the present Convention'. Such information 'shall be disaggregated as appropriate' and used to address the barriers faced by disabled people in exercising their rights. States 'shall assume responsibility for the dissemination of these statistics and ensure their accessibility to persons with disabilities and others'. However, countries taking part in the study were found to have some way to go to meet these requirements

Findings from the study indicate that national and regional governments have a central role for vision and leadership, working in close collaboration with representatives of users and their families. There is a need for a comprehensive, long-term perspective, which considers all the costs and all the benefits of the process of transition. Results from the study underline the need for creativity in developing solutions to the wide range of implementation problems which may emerge and learning from the process as experience and knowledge are gained of how to provide good services in the community. Once comparison is made on the basis of comparable needs of residents and comparable quality of care, there is no basis for believing that services in the community will be inherently more expensive than institutions.

The DECLOC project provides recommendations for European organisations and Member States to help the transition from institutional systems of residential care for disabled people to systems based on services in the community. These recommendations include a fourfold focus on:

1. strengthening the vision of new possibilities in the community
2. sustaining public dissatisfaction with current arrangements
3. creating some practical demonstrations of how things can be better
4. reducing resistance to change by managing incentives for the different actors in the process.

The full report is available at [www.kent.ac.uk/tizard/research/DECL\\_network/Project\\_reports.html](http://www.kent.ac.uk/tizard/research/DECL_network/Project_reports.html)

## Prisoners' families: civic virtue and policies of impoverishment

**Rose Smith, Roger Grimshaw, Renee Romeo, Martin Knapp, 2008**

**Benefits: *The Journal of Poverty and Social Justice*, 16, 1, 3–17**

This article explores the poverty and disadvantage experienced by prisoners' families living at or below the level officially recognized as 'poor'. Current social policy ignores the priority given to the care needs of children by predominantly female relatives and partners of prisoners. In conjunction with criminal justice and immigration legislation, social policies have combined to impoverish, disadvantage and exclude prisoners' families. Reforms of the welfare system may improve the adequacy of state welfare benefits, but unless fundamentally reshaped, social policy could continue to penalize the 'care' offered by prisoners' families and so further entrench inequalities.



## Model to assess the economic impact of integrating CRHT and inpatient services

**Paul McCrone and Martin Knapp**

Recent years have seen the introduction of Crisis Resolution and Home Treatment (CRHT) teams into the acute mental health care pathway in most areas of England. However, to date there has been limited evidence as to the economic benefits and resource implications of offering CRHT services alongside inpatient treatment. This paper assessed the economic implications of properly integrating CRHT services within the acute care pathway, so that they offer home treatment as an alternative to inpatient admission in appropriate cases.

A decision model was developed to compare the costs where Home Treatment (HT) is considered as an alternative and supporting service alongside inpatient services with the costs where it is not. To enable a cost analysis comparing the pathways through these two models, a probability value must be attached to each branch in the model, and for each route taken through the model a cost must be estimated. Probability and cost values for the model were obtained from a National Audit Office (NAO) audit of CRHT teams and published figures. Sensitivity analyses were carried out to assess the robustness of the model.

The expected health costs when HT was considered were approximately £2,200 over a 28-day period, compared to approximately £2,900 when HT was not considered. Sensitivity analyses revealed that the model was robust to changing most of the values used; where a change in values would alter the results importantly, that threshold was unlikely to occur, according to expert opinion and

evidence. Two exceptions were: the probability of being admitted after a referral was considered for both inpatient and HT services and rejected for HT, and the probability of being admitted when the acute care pathway did not include consideration of whether HT might provide an alternative or supporting service alongside inpatient services.

Around £600 can be saved per patient if home treatment is considered in addition to inpatient treatment. If the proportion of

patients considered for both options is increased to 90% (from the current level of 50%), the total savings to the NHS could be around £53 million. If those HT services that currently gatekeep below average numbers of patients are brought up to the current average, the potential cost savings are around £12 million.

*The full report can be downloaded from the National Audit Office website at [http://www.nao.org.uk/publications/nao\\_reports/07-08/07085\\_economic\\_impact.pdf](http://www.nao.org.uk/publications/nao_reports/07-08/07085_economic_impact.pdf)*

## Inpatient treatment in child and adolescent psychiatry – an exploratory prospective study of health gain and costs

**Jonathan Green, Brian Jacobs, Jennifer Beecham, Graham Dunn, I Kroll, Catherine Tobias, Jackie Briskman, 2007**  
*Journal of Child Psychology and Psychiatry, 48, 12, 1259–67*

Inpatient treatment is a complex intervention for the most serious mental health disorders in child and adolescent psychiatry. This paper summarises findings from the first large-scale study into its effectiveness and costs. Previous studies have been criticised for methodological weaknesses.

The study undertaken was a prospective cohort study, including economic evaluation, conducted in eight UK units (total n = 150) with one-year follow-up after discharge. Patients acted as their own controls. Outcome measurement was the clinician-rated Childhood Global Assessment Scale (CGAS); researcher-rated health needs assessment; parent- and teacher-rated symptomatology.

The authors found a significant ( $p < .001$ ) and clinically meaningful 12-point improvement in CGAS following mean 16.6 week admission (effect size .92); this improvement was sustained at 1-year follow-up. Comparatively, during the mean 16.4 week pre-admission period there was a 3.7-point improvement (effect size .27). Health needs assessment showed similar gain ( $p < .001$ , effect size 1.25), as did teacher- and parent-rated symptoms. Improvement was found across all diagnoses. Longer stays, positive therapeutic alliance and better premorbid family functioning independently predicted better outcome. Mean cost of admission was £24,100; pre-admission and post-discharge support costs were similar.



## Transition pathways for disabled young people with complex needs: Exploring the economic consequences

**Martin Knapp, Margaret Perkins, Jennifer Beecham, Sujith Dhanasiri, Charlotte Rustin and Derek King, 2008**

*Child: Care, Health and Development, forthcoming*

Disabled young people with complex needs face particular challenges when they reach adulthood and seek to move from school to employment or further education. There are potentially substantial personal and social costs arising from these challenges. The costs to young disabled people and their families can therefore be high. The aim of the work described in this paper was to quantify these costs and to identify the societal economic impacts arising from these challenges.

The authors sought evidence from recent UK research, policy and related literatures; undertook

exploratory statistical analyses of birth cohort data; and analysed information provided by thirty disabled young people requiring high levels of practical and communication support.

The findings indicated that the personal, family and social costs that result from unsuccessful transition are substantial and wide-ranging. Health service and local authority expenditure are important elements, but do not allow young people to achieve the educational or employment goals to which they aspire, resulting in considerable costs for the state, whether through missed

opportunities to contribute to the economy or through dependence on welfare benefits.

The considerable sums currently spent on disabled children and young people are clearly not enough, or not deployed appropriately, to enable those who reach adulthood to fulfil their ambitions, or to meet government policy intentions for young people to achieve economic well-being. ■

## Future supply of informal care for younger adults and older people

The PSSRU was funded by the Strategy Unit (Cabinet Office) and the Department of Health to produce projections of the supply of informal care for younger adults and older people in England to 2041. For both younger adults and older people, the supply of informal care was compared to demand in future years. The analyses focus on the supply of intense care provided for 20 or more hours a week and on demand for social care from disabled people. The results show that, on the assumptions used, future informal care supply is projected to be lower than estimated demand in respect of both younger adults and older people.

Two Discussion Papers are now available on the PSSRU website:

Pickard L (2008) *Informal Care for Younger Adults in England: Current Provision and Issues in Future Supply, England 2005–2041, Report to the Strategy Unit (Cabinet Office) and the Department of Health*, PSSRU Discussion Paper 2513, London.

Pickard L (2008) *Informal Care for Older People Provided by their Adult Children: Projections of Supply and Demand to 2041 in England, Report to the Strategy Unit (Cabinet Office) and the Department of Health*, PSSRU Discussion Paper 2515, London. ■

## Domiciliary care services in England: policy evolution, current debates and market structure

**Jose-Luis Fernandez, Tom Snell, Ami Somani, Martin Knapp**

This recently completed report provides an overview of the basic structure of the English community care system (including regulation of care services), a history of current community care policies since the 1970s (including a summary of key policies and the impact of European law on English community care policies), as well as a summary of the current community care policy debate (also looking at choice), and the community care market (including financing and regulation issues).

*The report and further information can be requested from Dr Jose-Luis Fernandez (j.fernandez@lse.ac.uk).* ■



## Predictors of employment for people with severe mental illness: results of an international six-centre randomised controlled trial

Jocelyn Catty, Pascale Lissouba, Sarah White, Thomas Becker, Robert E. Drake, Angelo Fioritti, Martin Knapp, Christoph Lauber, Wulf Rössler, Toma Tomov, Joeske van Busschbach, Durk Wiersma, and Tom Burns, 2008

*British Journal of Psychiatry*, 192, 224–231

An international six-centre randomised controlled trial comparing individual placement and support (IPS) with usual vocational rehabilitation for people with serious mental illness found IPS to be more effective for all vocational outcomes.

The aim of the trial was to determine which patients with severe mental illness do well in vocational services and which process and service factors are associated with better outcomes. In order to meet this aim, patient characteristics and early process variables were tested as predictors of employment outcomes. Service characteristics were explored as predictors of IPS effectiveness.

The study found that patients with previous work history, fewer met social needs and better relationships with their vocational workers were more likely to obtain employment and work for longer. Remission and swifter service uptake were associated with working more. Having an IPS service closer to the original IPS model was the only service characteristic associated with greater effectiveness.

The IPS service was found to be more effective for all vocational outcomes. In addition, maintaining high IPS fidelity and targeting relational skills would be a valuable focus for all vocational interventions, leading to improved

employment outcomes. Motivation to find work may be decreased by satisfaction with current life circumstances. ■

## Health economic aspects of suicide prevention

Reinhold Kilian, Brendan Kennelly, David McDaid, Thomas Becker, 2007  
*Suizidprophylaxe*, 34, 4, 220–26

This research paper looked at the theoretical and methodological background of the economic evaluation of suicide prevention strategies and discussed this with regards to the implications for health care resource allocation. In addition, the results of studies on the costs of suicide and the results of studies on the health economic evaluation of suicide prevention programmes are discussed.

Cost-of-illness studies reveal that on average a completed suicide causes societal costs of about 1.7 million Euros and a reduction of the German suicide rate by 10% could prevent costs of about 1.8 billion Euros to the German population. However, the few existing health economic evaluation studies do not allow evidence-based decisions about an efficient allocation of health care resources to suicide prevention programmes. Therefore, an intensification of research activities in this area is necessary. ■

## Outcomes and costs of community living: semi-independent living and fully staffed group homes

David Felce, Jonathan Perry, Renee Romeo, Janet Robertson, Andrea Meek, Eric Emerson and Martin Knapp, 2008  
*American Journal of Mental Retardation*, 113, 2, 87–101

In a matched-groups design, costs and quality of life outcomes for adults with intellectual disabilities with relatively low support needs were compared between those in fully staffed group homes (n = 35) and in semi-independent living (n = 35). Data were collected on participant characteristics, setting organization, various lifestyle outcomes, and costs. There were no differences in the majority of lifestyle outcome measures. Fully staffed participants had better

outcomes in money management and some health indicators. Semi-independent living participants had better outcomes for choice and community activities undertaken without staff support. Costs for semi-independent living were less. On balance, semi-independent living could offer certain cost-effective lifestyle advantages provided that sufficient attention is given to health, living, and financial well-being. ■



## Cost-effectiveness of cognitive behaviour therapy in addition to mebeverine for irritable bowel syndrome

**Paul McCrone, Martin Knapp, Tom Kennedy, Paul Seed, Roger Jones, Simon Darnley, Trudie Chalder, 2008**

*European Journal of Gastroenterology and Hepatology*, 12, 4, 255–63

Irritable bowel syndrome is often treated in primary-care settings, and it has a relatively large economic impact. Cognitive behaviour therapy (CBT) in addition to mebeverine has been shown to be effective in the short term, compared with treatment with mebeverine alone. This study assessed the impact that CBT in addition to mebeverine has on resource use, and its cost-effectiveness. Participants were recruited from general practices: those with ongoing symptoms were randomly allocated either to

remain just on mebeverine or to receive CBT in addition to mebeverine. Service use and lost employment were measured at baseline and at the 3-month, 6-month and 12-month follow-ups. The net-benefit approach was used for combining the data on therapy costs and symptoms.

The study found that the mean additional cost of CBT was £308. No significant impact of CBT on the use of other services or on lost employment was noted. The cost per clinically important reduction in

symptoms was £220 by the end of treatment, £171 at the 3-month follow-up, £1,027 at the 6-month follow-up and £3,080 at the 12-month follow-up, for CBT in addition to mebeverine compared with mebeverine alone.

The study concluded CBT in addition to mebeverine seems to have reasonable cost-effectiveness in the short-term treatment of irritable bowel syndrome, but not beyond three months. ■

## Public spending levels for social care of older people: why we must call in the debt

**Bleddyn Davies, 2007**

*Policy & Politics*, 35, 4, 719–26

This debate article focuses on the funding allocated to social care for older people, providing an overview of funding mechanisms and suggests that social care for older people has been underfunded in the past. The article further suggests that the rate of transfer of resources should be accelerated from the beginning of the next decade. ■

PSSRU in collaboration with LSE Health run both formal and informal seminar series during the academic year. For details of seminars scheduled for academic year 2007-08 visit the LSE Health and Social Care website at <http://www.lse.ac.uk/collections/LSEHealthAndSocialCare/eventsAndSeminars/Default.htm>



## Mental health promotion in the workplace

Martin Knapp, David McDaid, Helena Medeiros

There are profound and wide ranging personal and societal impacts of poor mental health. The economic impacts are also considerable. They are particularly associated with lost opportunities to work, engage in voluntary activities or home responsibilities, as well as with increased utilisation of health and social care services and a higher risk of contact with the criminal justice system. Family members may have to devote a considerable amount of time to supporting a loved one, while stigma, ignorance and discrimination may limit educational, employment and housing opportunities.

There are many reasons for promoting positive mental health and for seeking to prevent the emergence of problems in the first place. At the core of all of this is a desire to improve the quality of life of a population. But decision makers are also very aware of the costs of not acting appropriately or early enough. For example, the total cost of depression in Sweden in 2005 was estimated at €3.5 billion (Sobocki et al 2007) while the cost of schizophrenia in England in the same year was estimated at €10.4 billion (Mangalore and Knapp 2007). There have been studies which have pointed to the average cost of a completed suicide: €2.04 million in Ireland and €1.88 million in Scotland (McDaid et al 2007). Each of these, and many other examples could be given, is a substantial amount. While even the most optimistic of advocates would never imagine that all instances of depression could be prevented, or all psychoses avoided, or all suicides averted, it is surely possible for European societies to prevent some

of these distressing and often devastating events occurring.

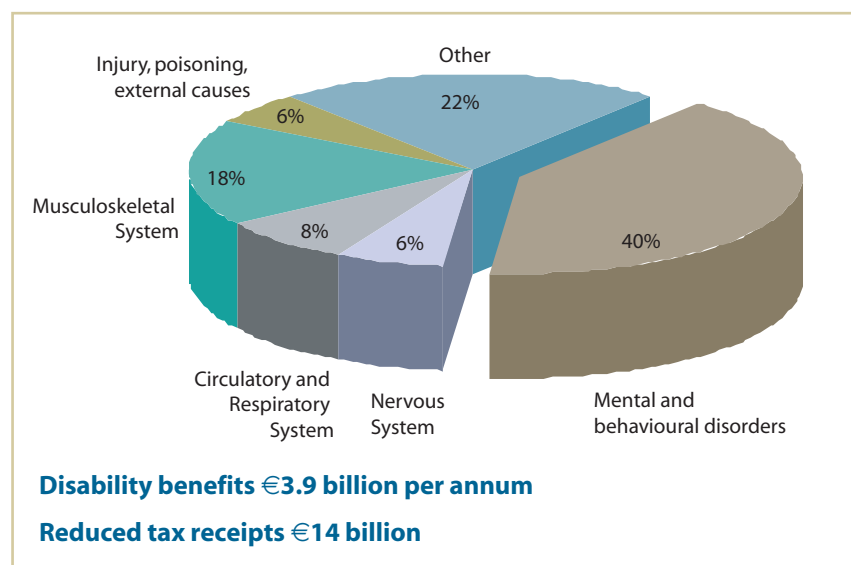
The workplace is increasingly recognised as a key area for mental health promotion. It is worth remembering the major impact of mental health problems on employment and related dimensions. For example, work by the European Brain Council on the costs of mental disorders in the EU points to the large contribution of lost productivity through absenteeism made to the overall cost. Interestingly, comparing their figures with figures for cardiovascular disease, the productivity losses from depression, for example, are considerably larger.

In fact, absenteeism may not be the major source of economic losses associated with depression or other mental health problems. American evidence suggests that the cost associated with 'presenteeism', which is a short hand term for

under-performance whilst actually at work, could be as much as five times greater than the cost of absenteeism.

The impact of economic inactivity or absenteeism on social security and related systems is also evident across many European countries. Total disability benefit payments in England, Scotland and Wales in 2007 amounted to €3.9 billion, with the largest contribution (40%) attributed to "mental and behavioural disorders" (see Figure 1). Given that these are self-reported and that many workers may prefer to not identify their health problems as psychiatric, this could well be an underestimate. In France, 25% of illness-related social security expenditure is due to stress (Bejean and Salten 2006). Between 1990 and 2003, disability benefits for mental health problems in Finland increased by 93%, and in the latter year accounted for 42% of all benefits paid (Jarvisalo 2005). The General Workers Union in Spain estimate that between 50 and 60% of sick leave and disability claims are due to stress at work. There are other examples from across Europe.

Figure 1: Disability benefits by disease in Great Britain



Employment is a fundamental component of or contributor to quality of life, the main source of income for most people, commonly a major influence on someone's social network, and also a defining feature of social status. The interconnections between mental health problems and employment are many and various.

As well as the link with individual well-being, employment is a major contributor to national and European productivity and competitiveness, and obviously also has implications for the sustainability of social welfare systems. Many national governments have turned their attention to the employment difficulties experienced by people with common mental health problems, including stress and depression, and also encouraging greater awareness among employers as to their workplace responsibilities for promoting better mental wellbeing and reducing worker stress.

Evidence on the effectiveness of various workplace based programmes, both to promote good mental well-being and deal with some of the early signs of stress and mental health problems is growing. There may well be substantial scope for economic benefits such as increased productivity and reduced need to pay disability benefits through investment in the workplace. But there are major caveats on what we know: most evidence again comes from the US and is often generated by companies, and not subject to rigorous peer-review. Nevertheless, there are some tantalisingly interesting insights.

For example, evaluation of London Underground's stress reduction programme suggests that in its first two years there was a reduction in

absenteeism costs of €705,000. This is eight times greater than the cost of the scheme. In addition, improved productivity and some positive healthy lifestyle changes were observed (Business in the Community 2005). One stress management programme in a Belgian pharmaceutical company achieved a reduction in absenteeism of just 1%, but still avoided costs of €600,000 because the economic impact of stress-related absenteeism was so substantial (Poelmans et al 1999).

Mental health promoting interventions can also be cost effective in helping those who are out of work and thus at greater risk of developing mental health problems. One US programme, designed to help individuals take more control when seeking employment and cope with difficulties and disappointments, both increased reemployment and generated a positive return on investment.<sup>14</sup> It has subsequently been implemented, with some success, elsewhere including Finland, the Netherlands and Ireland.

While the economic case is encouraging, there are a number of key challenges to meet in strengthening the evidence base on workplace health promotion. Evaluation in the workplace is clearly a sensitive issue; both employers and employees may be reluctant to participate. Caution must also be exercised over the results of evaluations: interventions reported to have significant net benefits may be produced by organizations that stand to gain commercially from their use.

Recognition of the economic impact of poor workplace mental health at national EU levels does however provide an opportunity for action. Policy makers may wish

to carefully consider providing financial support for the evaluation of workplace based mental health interventions. One pragmatic approach may be to retrospectively add an economic dimension to existing studies of the effectiveness of interventions. More partnership work between employers in the private and public sectors is also well merited; indeed the highest levels of workplace stress may well appear in public sector organisations.

Much of the work to date in this area has focused on large, often multi-national corporations. Demonstrating the economic case may also help persuade policy makers of the case for providing financial incentives to encourage small and medium sized enterprises, which otherwise might not have the resource, to invest in effective workplace mental health promoting interventions.

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This research report is based on work undertaken within the Mental Health Economics European Network (Box 1). 

### Box 1: Mental Health Economics European Network

The Mental Health Economics European Network (MHEEN I) was established in 2002 with 17 and extended in 2004 to 32 countries. The Network is coordinated by the PSSRU at the London School of Economics and Political Science and Mental Health Europe, based in Brussels, and supported with funding from the European Commission.

For further information about the Network visit the MHEEN website at [www.mheen.org](http://www.mheen.org).

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## A national survey of schemes providing support to people using direct payments

**Vanessa Davey, Tom Snell, Jose-Luis Fernández, Martin Knapp, Robin Tobin, Debbie Jolly, Margaret Perkins, Jeremy Kendall, Charlotte Pearson, Nicola Vick, Paul Swift, Geof Mercer and Mark Priestley**

### Background

Direct payments legislation was implemented in England, Scotland and Wales in April 1997, and a year later in Northern Ireland, for people between the ages of 18 and 65 assessed as requiring community care (Department of Health 1997; Northern Ireland 1996; Scottish Office 1997). Subsequent changes to the legislation have expanded the potential user population to include older people, children aged

16 and 17, parents of disabled children and carers.\*

Across the UK, direct payments must now be offered to everyone assessed as needing social care, but take-up has been slow, particularly in Wales and Northern Ireland (Riddell et al, 2005). There has been considerable growth in uptake in Scotland and England since 2003, but relative to the overall sum of people receiving community care

services, numbers remain very low. In England 27,700 people were in receipt of direct payments between April 2004 and March 2005 (Health & Social Care Information Centre 2006); in Scotland, the equivalent figure was estimated to be 1,438 people (Scottish Executive 2005).

In an effort to encourage take-up among a more diverse client base,

\* With the exception of carers in Scotland

funding was made available both to promote the use of direct payments and to develop support schemes, widely recognised as being central to their use (Hasler 2005; Pearson 2004a; Pearson 2004b; Scottish Executive 2003). The Department of Health made a £9 million Direct Payments Development Fund (DPDF) available to 90 different partnerships of local authorities and voluntary agencies in England, representing approximately three quarters of all local authorities (Department of Health 2004). Funds for the first round of successful bids were issued in September 2003, with the second round of funding a year later, at the time the survey was sent out.

Despite the policy emphasis on promoting direct payments and supporting the development of support schemes, very little is known about the degree or forms of support available, or about the accessibility of support schemes to different user groups. Two surveys were therefore designed to collect up-to-date information about the local implementation of direct payments. One questionnaire was sent to every local authority in England, Scotland, Wales and Northern Ireland. The other, described here, was sent to organisations that support people receiving direct payments, in an effort to provide the first mapping of the state of direct payments support organisations and identify their capacity to respond to the needs of different user groups.

### **Main findings**

*Origins and function of organisations providing direct payments support*  
A large proportion of organisations in England and Wales were established many years prior to their provision of direct payments support, and the supply of other services continues to form a major role in the majority of cases. The

average length of time providing direct payments support was relatively low – particularly in England where there has been a significant amount of recent market growth.

The majority of organisations in all countries identified themselves as being in either the voluntary or not-for-profit sector. However, there was considerably more diversity in the types of organisation providing direct payments support in England than elsewhere in the UK. Whereas in Scotland the majority of support was provided by local schemes, almost one quarter of direct payments support provision in England was by national voluntary providers. There was also a minor presence of local authority-led schemes.

All organisations in Scotland and Wales indicated that they provided support to all user groups, whereas a third of organisations in England did not provide support to one group or more. Overall, the number of clients covered by support schemes was found to be significantly lower than the total number of users in receipt of a direct payment.

### *Staffing*

Support organisations predominantly had small workforces: approximately one half of English and the majority of Scottish and Welsh organisations employed three workers or fewer. The average staff caseload among English organisations was at the high end of the recommended maximum level, and far greater among local providers spanning one or two neighbouring local authorities in England. Were support to be provided to the estimated 27,700 direct payment users in England without increasing the supply of support workers, this caseload would increase by more

than 60 per cent. While staffing levels tended to be highest in England, organisations in Scotland and Wales were found to have lower user-to-staff ratios owing to lower numbers of users supported.

Almost all staff members of support schemes were paid. Most individual workers supported multiple user groups: an indication that staff specialisation was not commonplace among support organisations.

### *Income*

The reported income of individual organisations ranged enormously, from under £10,000 to nearly £1 million per annum. The income of support schemes was derived almost entirely from social services, although approximately one third of income in England was obtained from the Direct Payments Development Fund, which may have become a substitute for some social services funding.

The average total income in 2004–05 reported by organisations in England was £58,635. In Wales the figure was slightly lower at £43,295, while the average for Scottish organisations was only £15,700. Among organisations in England that provided data relating to both 2003–04 and 2004–05, there was a rise in total income of approximately 19% between the two financial years. Accounting for the number of users supported, the best resourced organisations were in the North East, London, the West Midlands, the South East and Wales.

### *Expenditure*

There was wide variation in the total level of expenditure reported by support organisations. This was largely a reflection of the differences in workforce levels, as staff costs accounted for approximately three-quarters of total expenditure. Recruitment

difficulties, where they exist, may be partly attributed to low pay: levels of expenditure suggest that salaries were far lower than in comparative social care positions.

The average total expenditure per organisation in England in 2004–05 was £57,800. In keeping with income levels, total levels of expenditure reported by Welsh and Scottish organisations were lower (£39,222 and £13,480 respectively). Average expenditure per whole time equivalent staff member in England was £16,372 in 2004–05. A marginal rise was observed in both total expenditure and expenditure per staff member from the previous year.

#### *Services provided to direct payment users*

Two-thirds of support organisations had a contract or service-level agreement in place with their local authority, generally specifying the types of services and information to be supplied to users, although minimum levels of support were rarely stipulated. Around a half of contracts required training of care workers or care management staff. Three-quarters of support schemes were aware that funding would be available from their local authority in the next financial year.

Advocacy services were highly prevalent and usually funded by local authorities. Almost all organisations participated in raising awareness of direct payments. The supply of campaigning and support and training for undertaking self-assessments were the least frequently offered (42% and 35% of English organisations, respectively), and were often supplied without local authority funding. A wide range of accountancy services was available, although only around one half of organisations provided payroll support. Indirect payment schemes (sometimes called third-

party schemes), although a potentially vital resource for some clients, were only available in 42% of support schemes in England.

Service provision varied markedly according to organisation type: local providers provided the greatest range of advocacy services but relatively few accountancy services, particularly payroll and related services. Conversely, affiliates or branches of national organisations serving all user groups tended to focus on accountancy services, with lower levels of advocacy services available.

Less than a third of support schemes in England could be categorised as providing employment agency or employment business services which would make them liable to regulation by the Commission for Social Care Inspection but there was confusion among respondents as to how regulation might apply to them.

Charging users for support services was commonplace in Scotland but less so in England in Wales; charges in England were most commonly levied by national organisations offering direct payments to all user groups. Private payers were supported by over a third of schemes in England and Wales, and the majority of Scottish organisations.

Most organisations in England and a large proportion in Scotland and Wales held peer support meetings; the majority of attendees were users with physical disabilities, however a large proportion of carers and mental health service users would also attend.

Around 20 per cent of services users in England had to wait to receive direct payments support. The average length of wait was just

under five weeks, although this was much longer in London, the East and Wales. Large local providers in England recorded the lowest length of wait, despite having the highest ratio of users to staff. Organisations in Scotland reported no waiting lists.

#### *Service utilisation*

Support schemes appeared to be providing intensive levels of support in the initial stages of setting up a direct payment, and various levels of continuing care. Service users in England required an average of 8 weeks support to set-up their direct payments service and a further 12 weeks on average to become independent (comfortable with their required support in managing a direct payment and other services from the organisation). During these periods service users were reported to receive frequent home visits and telephone consultations: on average, services users were visited around three times per month during the set-up period, and then once or twice per month before being able to manage their direct payment. Telephone consultations were carried out at a comparable frequency. In addition, support schemes reported that they conduct frequent reviews of clients – as often as three times per year in England.

There was little apparent difference in the input required on average by clients from different user groups, although marginally more intensive input was required to support mental health service users.

Significantly more input was reported in Scotland: set-up alone took on average 20 weeks per user. Service users from support organisations situated in London boroughs and shire counties in England also took longer than the average to set up services, possibly

owing to recruitment difficulties.

The intensity of service utilisation also varied to a large extent according to the nature of the support organisation: intensity among branches of national providers of support to all user groups was particularly high, regardless of the length of time taken in setting up services or the duration of support provided.

#### *Factors aiding or hindering the implementation of direct payment*

Overall, support organisations were more likely to identify factors that positively assist the implementation of direct payments than those that hinder implementation. The factors identified as being most crucial were generally related to the local organisational infrastructure: an effective support scheme, staff training and support, local authority leadership and the provision of accessible information for potential recipients.

Responses highlighted some significant differences in attitude to national legislation, policy and guidance: over 90 per cent of English support organisations identified this as a factor that positively affected implementation, compared to less than a half of organisations in Scotland and Wales. Furthermore, Welsh organisations identified the lack of ring-fenced budgets as being a major hindering factor.

#### **Conclusions**

The early development and successes of direct payments are owed largely to the efforts of community-based Centres for Independent Living (CILs), whose commitment to promoting access to and support of direct payments ensured their widespread acceptance as a significant contribution to independent living.

A paucity of CILs in numerous authorities, coupled with the limited capacity of existing CILs to extend support to all user groups, led to a move toward alternative providers of support.

Findings from the survey of support organisations illustrate the dynamics of the direct payments support infrastructure and its development across the UK, most notably the considerable variation in the level of diversity in direct payments support. Data also demonstrate that a considerable proportion of direct payment users are not covered by a support scheme: over 50 per cent of all people using direct payments. Whether this is a reflection of the transitory nature of users' needs for support, users finding alternative sources of assistance, or users being unable to access services, is not entirely clear. A significant proportion of schemes in England did not provide support to all user groups; a factor that may only partly be attributed to the growth of user-group specific schemes, aimed at addressing the individual needs of users of mental health services, older people and people from black and ethnic minorities.

The provision of support services was clearly contingent on local authority funding, and varied considerably between different types of provider, with the result that certain services were in short supply. The focus within a sizeable proportion of local authorities appears to be on funding support services that promote uptake and setting-up of direct payments and ensuring that recipients receive the required training to meet basic statutory requirements, while responsibilities associated with the ongoing management of a direct payment are frequently left to the individual.

It should be noted that the

continued promotion of direct payments and improved guidance and information are likely to have had a significant impact on the state of direct payments support since the survey was carried out. Moreover, a number of further developments including the end of DPDF funding, the growth of In Control services for people with learning disabilities and the launch of the individual budgets pilots will all have had a bearing on service utilisation as the situation continues to evolve.

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### Acknowledgements

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### Further information

The full report Schemes Providing Support to People Using Direct Payments: A UK Survey, presents the findings of the survey of organisations providing direct payments support. This is also available to download as the full volume (1.07MB) or just the executive summary (332KB).

## After transition: health and social care needs of young adults with long-term neurological conditions

Jennifer Beecham, Tom Snell, Margaret Perkins and Martin Knapp

The Neurological Alliance (2003) has estimated that 10 million people in the UK are living with a neurological condition, over 8 million of whom require short-term support to manage their daily lives. Over 1 million need some help with daily tasks and will be out of full-time employment, and about 350,000 require help for most daily activities.

Young adults with long-term neurological conditions who are facing the transition from child to adult services often encounter particular challenges. Accessing the right support is key to achieving independence and maximising opportunities to contribute to society, and is an important policy concern.

A recently completed Department of Health-commissioned study by Beecham et al. focuses on three neurological conditions:

### Epilepsy

is an *intermittent* condition, characterised by unprovoked seizures. It is often stabilised with medication but specialist services are needed during acute episodes or to respond to changing development or age-related needs. Epilepsy is one of the more common neurological conditions, affecting around 42,000 young adults aged 18-25 years in the UK at any one time.

### Cerebral palsy (CP)

is an *early onset* condition that can have serious consequences for children that continue into adulthood. CP covers a group of

disorders that are permanent but not unchanging and most people with CP (91%) have spastic cerebral palsy in which some muscles become stiff and weak, affecting their movement.

At any one time there will be about 9,400 young adults in the UK who are aged between 18 and 25 years and have CP, of which only about 7% of young adults with CP live in staffed care settings - the great majority live with their parents.

### Acquired Brain Injury (ABI)

is a *sudden onset* disorder. Road traffic accidents, assaults, fights and falls are common causes among young adults aged 18-25 years old. ABI prevalence rates are difficult to find because of the many causes, so the study's incidence-based approach started with the number of young adults injured and attending hospital and then tracks their care pathways over a notional 12-month period.

Young adults aged 18-25 comprise 10.4% of the population and this figure has been used to estimate the incidence of ABI in 18-25 year olds as a proportion of the overall A&E attendance rate for ABI (n=15,600 young adults). This approach may underestimate the number of young adults as ABI incidence rates peak during young adulthood, and diagnosis of ABI may be poorly recorded at A&E or on the ward.

As well as looking at the health and social care services currently used by young adults, the wider impacts and unmet needs for health and



social care services for young adults aged 18–25 years with neurological conditions who have started to be supported by adult services, the authors also looked at the costs of health and social care services in this context.

The findings indicate that 11,500 young adults with epilepsy in the UK live in staffed accommodation at a total cost of £715.3 million, 40% of which is borne by the NHS (2005 prices). Furthermore other community-based services that provided important support for people with epilepsy cost £8.9 million, of which hospital services account for 62% and social care services a further 28%. The authors estimate the average cost of health and social care support as being £17,200 per person per year (2005 prices).

The study shows that support costs for a typical person with CP are £7,900 per annum (2005 prices), although this excludes costs for transport help, medication, aids and equipment, or formal personal carers at home or in education. The estimate for personal assistance would almost double the costs to health and social care services, adding £6,600 per person per year. The total health and social care costs for supporting young adults with CP are estimated at £74.3 million or £136.6 million if the costs for formal (paid) personal assistance are included.

Most incidents of ABI require little more than a visit to the A&E department or a short stay for observation at the local hospital, although one in five people may continue to have residual symptoms six months later, such as dizziness or poor concentration. The total annual costs for this group are £23.8 million or around £240 per person.

Health and social care costs are much higher for those people who have ABI-related disability. This will be around 1,600 young adults, about 10% of those seen at hospital, costing health and social care budgets at least £47.2 million per year.

The study estimates there will be around 350 young adults who are likely to return to their own homes. Many will have stayed in hospital for a month or more and about a third will have had a prolonged period of rehabilitation. The average health and social care costs over the 12-month period are £16,970 per person.

A further 940 young adults will continue to require support either in their own homes or in low-support congregate settings, of whom about one in five will have stayed at a residential rehabilitation unit; average annual costs will be £32,900 per person.

Finally there will be around 310 young adults who are severely disabled as a result of their ABI. About half of this group will have stayed in a rehabilitation unit but all are resident in high dependency placements at an average cost per person of £33,900 over the 12-month period.


The overwhelming picture that emerges from the study of young adults with neurological conditions is that:

- there is widespread under-recognition of needs and poor support during the transition to adult services;
- discontinuities in service contact are common;
- social care support is frequently reported as low;

- many young adults remain heavily dependent on their parents; and
- opportunities for independence are severely restricted.

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The full summary from this research will be available shortly.



## Projecting future service use and expenditure

Adelina Comas-Herrera, Raphael Wittenberg, Linda Pickard, Derek King, Juliette Malley

The financing of long-term care for older people is a topical issue, especially in view of demographic trends. A number of key questions arise. How many older people are likely to require long-term care services in thirty or forty years' time? How much are these services likely to cost? Will the cost to public funds prove affordable? Who should pay? How should costs be divided between public expenditure and private sources of finance? Reliable projections of future demand and of future spending on long-term care are needed in order to address these issues.

The PSSRU model was constructed as part of a project on long-term care finance funded by the Department of Health to provide answers to such questions.

### The PSSRU model

The PSSRU model has provided projections for the Royal Commission on Long Term Care, the Department of Health, the Alzheimer's Research Trust, the European Commission, the National Assembly for Wales, the Joseph Rowntree Foundation and individual local authorities. The model is regularly expanded and updated to provide new projections for the Department of Health.

The model aims to make projections of four key variables:

- the future numbers of disabled older people by age, gender and household composition
- the likely level of demand for long-term care services and

disability benefits required for older people

- the costs associated with meeting this demand, by source of funding
- the social care workforce caring for older people.

The model includes unpaid informal care and a range of formal health and social services, covering residential, day care and home-based services.

The model has recently been updated to 2004 as base year and further development of the model is in progress. The model produces four types of projections: numbers of disabled older people likely to require long-term care, long-term care health and social services that will be required to meet demand, public and private expenditure on those services and on disability benefits, and social care workforce caring for older people.

The PSSRU model does not forecast future policies or future patterns of care, but makes projections based on specific assumptions about future trends in key factors influencing demand for care. A set of base case projections take account of expected changes in factors external to long-term care policy, such as demographic trends, but hold constant policy-related factors, such as patterns of care and the funding system. The base case is used as a point of comparison when the assumptions of the model are subsequently varied in scenarios.

### Examples of application in PSSRU Research

■ *Project 1: Paying for Long-Term Care for Older People in the UK: Modelling the Costs and Incidence of a Range of Options (Nuffield-funded)*

The PSSRU team has recently completed a new study on paying for long-term care for older people in the UK, funded by the Nuffield Foundation. The study makes projections of expenditure on long-term care services under a range of options for reforming the funding system. The projections include a breakdown of expenditure between public and private funding and an analysis of the projected differential impact on older people in different parts of the income distribution.

An innovative linkage was developed between two simulation models: the PSSRU macrosimulation model and the CARESIM microsimulation model developed at the University of Essex.

A base case set of projections was made on the basis of official population projections, constant disability rates, real unit costs rising by 2% per year, current patterns of care and the current English funding system. Public expenditure on long-term care is projected to rise, under these assumptions, from around 0.95% of Gross Domestic Product (GDP) in 2002 to around 1.95% of GDP in 2051. The projections are sensitive to assumptions about future mortality rates, disability rates and rises in real unit costs.

**■ Project 2: Projections of LTC use and expenditure associated with dementia**

A second recently completed study concentrated on people with dementia. The aims were (a) to make projections, for the next thirty years, of: future numbers of older people with cognitive impairment; their demand for long-term care services; and the future costs of their long-term care; and (b) to explore the factors likely to affect future long-term care associated with cognitive impairment, such as:

- future numbers of older people
- prevalence rates of CI
- trends in household composition
- provision of informal care
- patterns of care services
- unit costs of care

The study involved the development of a model to investigate the impact of cognitive impairment among older people on LTC demand and expenditure, and the exploration of the sensitivity of the model to changes in its main assumptions about the future. The assumptions relate to trends in factors that will affect future long-term care costs of cognitive impairment. These include, not only the future numbers of older people and future prevalence rates of cognitive impairment, but also trends in household composition, provision of informal care, patterns of care service use, and the unit costs of care.

The model used for the dementia study was a macro-simulation (or cell-based model), building on previous PSSRU long-term care projection models. It used a range of data, in particular from MRC-CFAS, simulating the impact on demand of specified changes in demand drivers, or specified changes in patterns of care, which makes projections on the basis of specific assumptions about future trends. Base case assumptions were made about trends in key factors expected to impact on future LTC expenditure, and variant assumptions about the key factors are introduced to test for sensitivity.

**■ Project 3: Modelling of demand for long-term care for 'working-age' adults and older people**

This third stream of work is described on page 9 of this issue.

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Further details about the PSSRU Long-Term Care Finance Projections Model and the team's work can be found at [www.pssru.ac.uk](http://www.pssru.ac.uk).

For further information on our current and recently completed projects please visit the PSSRU website [www.lse.ac.uk/collections/PSSRU](http://www.lse.ac.uk/collections/PSSRU). To join the PSSRU mailing list please visit <http://www.jiscmail.ac.uk/lists/pssrulist.html>.



### Professor Juan Manuel Cabasés

Public University of Navarra, Pamplona, Navarra, Spain,  
visitor at PSSRU 2007-08

I have recently been visiting PSSRU at the Kent and LSE branches (August 2007–

January 2008), and have now returned to my position as Professor of Economics and Director of the Health Economics Research Group in the Public University of Navarra (Spain).

My research interests and expertise include the following: health economics and public economics and, specifically, economic evaluation of health care technologies (schizophrenia, stroke, AIDS, hepatitis C, breast cancer screening,...), health output measurement, health care reforms, equity in health and regional health care financing. I have published more than 100 papers in journals and chapters in books, and edited several books on health economics.

I have also been President of the Spanish Health Economic Association, President of the Spanish Society of Public Health and Health Care Management (SESPAS), member of the Board of the European Public Health Association (EUPHA) (1998–2006). Currently, I am also Vice-president of the Psicost Association (mental health economics), member of the International Health Economics Association, and of the EuroQol group.

I was interested in coming to the UK and linking with PSSRU at Kent and LSE in order to further develop my current work on mental health economics on the areas of outcome measurement, costing schizophrenia and cost – effectiveness of prevention and promotion, as a member of the PSICOST Association, an active organisation in the MHEEN and other related projects.

During my stay in PSSRU at Canterbury and LSE, I have been working on my current research on mental health economics, outcome measurement (EQ-5D modelling), regional differences in health valuation, and had the opportunity to learn and comment on PSSRU research on quality and outcome measurement of social services, and contact several colleagues in both branches of PSSRU.

I have presented two seminars at LSE: “Regional Health Care Financing in Spain” (Cañada Blanch Seminars) and “Building an inconsistency-free health EQ-5D index. Application to regional health status differences between schizophrenic patients using Bayesian techniques”, that gave place to alive debates.

This has been a fruitful personal and professional experience and I hope to strengthen the links between PSSRU and Public University of Navarra in Pamplona, Spain.



### Professor Eric Latimer

McGill University, Canada, visitor at PSSRU 2007-08

I have been enjoying, since September, a year on sabbatical at the PSSRU (LSE and Kent) as

well as the Center for the Economics of Mental Health (CEMH) at the Institute of Psychiatry. Normally, I am based at the Douglas Mental Health University Institute (a smaller version of the IOP and Maudsley put together) and McGill University, in Montreal. After a couple of years as an industrial engineer in the Canadian pulp and paper industry, I trained as a health economist in the US. I joined McGill and the Douglas

Institute in 1996. My work since then, in collaboration with Canadian and US colleagues, has concerned in particular assertive community treatment and supported employment, two evidence-based practices for people with severe mental illness. More recently I have also been looking at patterns of use of antipsychotics in Québec.

There is a growing emphasis in North America on promoting involvement of health researchers with clinicians and decision-makers, and I have invested considerable time in supporting the introduction of assertive community treatment, especially, and more recently

supported employment, in the province of Québec. My central goal has been to improve the effectiveness of services to adults with severe mental illness, within limited budgets.

I have been aware of the work of the PSSRU and the CEMH since the mid-90s and have had intermittent contacts especially with Jeni Beecham and Martin Knapp. I have long wanted to get to know them and their colleagues here better and also to learn more about the UK mental health system. I have been impressed with the quantity and quality of work that are carried out here. My family and I have also felt warmly received in UK society, much more so than the Brits' reputation for aloofness led us to expect!

### **Family structure has changed dramatically over past decade finds new research**

View press release on the LSE Press and Information Office website at <http://www.lse.ac.uk/collections/pressAndInformationOffice/newsAndEvents/archives/2007/FocusonFamilies.htm#generated-subheading1>.

### **Denying work to autistic people is expensive**

The (undiscounted) lifetime cost to society of someone with autism could be as high as £4.7 million per person, according to a study today which calls for more job opportunities for those with the condition. The report, *Economic Consequences of Autism in the UK*, was led by Professor Martin Knapp, of the London School of Economics, who said: 'Lost productivity for people with autism and their families costs the UK economy almost £10 billion.'

*Daily Telegraph*,  
20 November 2007

### **Most employers fail to tackle stress at early stage...**

Article refers to a 2006 study by the London School of Economics which claimed a £750 course of cognitive behavioural therapy was both cheaper and more effective than drug-based solutions.

*Personnel Today*  
4 December 2007

### **The economics behind the new deal for carers**

Julien Forder speaks to Mark Ivory on the economics of providing more support to long-term carers

*Community Care*,  
6 December 2007

### **Do the sums**

The BBC's month-long series, *Care in the UK*, reflects concerns about the rationing of care for older people and people with disabilities. It is timely – the corporation will ask listeners for their views and forward them to the government's consultation on the future of social care. A central part of the BBC's activities is built around the 'care calculator'. Developed with the London School of Economics, the care calculator is an online tool that enables people to find out what care is available in England and how much they will have to pay for it.

*Society Guardian*,  
16 January 2008

### **Institutional care for disabled people in EU not satisfactory**

Institutional care for disabled people in the European Union (EU) continues to fall short of acceptable standards in many cases, a report released Tuesday by the European Commission says. The European Commission financed a study on the development of community-based services for people with disabilities. The study was carried out by the University of Kent and the London School of Economics.

*Xinhua, China*  
29 January 2008

### **Dementia timebomb 'will hit 1.2m'**

Forecasts by Prof Martin Knapp, from the London School of Economics, predict that the number with dementia living in care homes will rise by 88 per cent by 2031, when close to 400,000 would be living in long-stay institutions.

*Daily Telegraph*  
24 March 2008

### **England payment support schemes overstretched**

A comprehensive analysis of direct payment support services in the UK has unearthed waiting lists for users in England, low take-up and a lack of funding for ongoing support. Though based on figures for 2004-5, the report by the Personal Social Services Research Unit (PSSRU) at the London School of Economics provides one of the most detailed pictures to date of the challenges facing direct payment support schemes, most of which are under contract from councils.

*Community Care*  
9 April 2008

For further press releases and updated information visit PSSRU Press Releases.

## Mental Health Economics European Network, Phase II Symposium

13 December 2007, Brussels

This symposium, sponsored by the European Commission, Directorate General for Health and Consumer Protection, presented findings and analysis from Phase II of the Mental Health Economics European Network.

Speakers at the seminar included members from the Network on their current research findings as well as a discussion on the future directions of mental health policy in Europe.

Presentations from the event can be downloaded from the PSSRU website at <http://www.lse.ac.uk/collections/PSSRU/researchAndProjects/mheen.htm>, and included the following:

**Martin Knapp**, *Welcome, Introduction and Finances* (PDF), Mental Health Economics European Network II Symposium, Brussels, 13 December 2007.

**David McDaid**, *Making the Case for Investment in Mental Health Promotion and Mental Disorder Prevention Activities in Europe* (PDF), Mental Health Economics European Network II Symposium, Brussels, 13 December 2007.

**Helena Medeiros**, *Challenges and Opportunities in Shifting Care from Hospital to the Community in Europe* (PDF), Mental Health Economics European Network II Symposium, Brussels, 13 December 2007.

**Reinhold Kilian**, *Structural Socioeconomic Characteristics and Employment of People with Severe Mental Illness* (PDF), Mental Health Economics European Network II Symposium, Brussels, 13 December 2007.

**Sonia Johnson**, *European Service Mapping Schedule* (PDF), Mental Health Economics European Network II Symposium, Brussels, 13 December 2007.

**Judit Simon**, *Mental Health and Social Care Services in Hungary* (PDF), Mental Health Economics European Network II Symposium, Brussels, 13 December 2007

A report following the symposium will be available shortly. Further details can be found on the MHEEN website <http://www.mheen.org>.

## Adult Social Care Researcher's Day

A one-day event on research methods in social care took place in November 2007 in London. The focus was on accessible methods that can inform policy and practice discussion and development. Speakers at the event were drawn from the DH-supported social care units, and included the following presentations from the LSE branch:

**Martin Knapp**, Economic evaluation: on the cheap?

**Adelina Comas-Herrera**, Projecting future service use and expenditure: a case study from dementia care

Presentations from the event can be requested from [psru@lse.ac.uk](mailto:psru@lse.ac.uk).

## Caring Choices Roadshow

**Julien Forder** took part in a panel discussion during the final Caring Choices Roadshow event at the King's Fund on 14 November 2007. The panel debated questions relating to the Green Paper on social care, supporting carers providing unpaid care and social care policy reforms.

Julien also presented at the International Foundation for

Intelligent Living Conference on 21 February Can we afford to care?. The Conference brought together academics, providers and other interested speakers to debate the costs of care.

Julien also presented at a one-day event organised by CareandHealth on The Green Paper on the Future of Adult Social Care on 30 April 2008. For further information see <http://event.conceptglobal.com/profile/web/index.cfm?PKwebID=0x54926fb0&varPage=home>.

## Deinstitutionalisation and Community Living: Comparative Perspectives and International Implications

This conference took place in Prague in November 2007 to present findings from the DECLOC project (see Research Findings section).

**Professor Martin Knapp** gave a presentation at the event on the cost and outcome analyses which formed part of the project. The presentation reviewed the economic evidence on balance of care, particularly focusing on those incentives or forces which encourage a change away from heavy reliance on institutions, as well as those that slow down that process.

**David McDaid** also presented at the conference on the implications for deinstitutionalisation and community living of the findings from the Mental Health Economics European Network. His presentation briefly described and highlighted some findings and then reflected on one key area of work: the role that economic incentives play in influencing the balance between institutional and community based living across Europe. David also co-organised a parallel workshop at the conference



on policy and funding issues.

Further information and presentations from the conference can be found at [http://www.kent.ac.uk/tizard/research/eu\\_decl\\_conference/index.html](http://www.kent.ac.uk/tizard/research/eu_decl_conference/index.html).

**David McDaid** also presented at the European Meeting on Health and Health Systems Impact Assessment (HIA/HSIA) under Portuguese Presidency, Lisbon in November 2007 on whether mental health impact in all policies should be important; as well as the German Association of Social Psychiatry meeting in Munich in November 2007 on funding for mental health.

### CCNUK Annual Conference

**Dr Jennifer Beecham** recently presented a workshop at the Care Co-ordination Network UK 2007 annual conference on 13 November 2007 in Manchester, on the cost-effectiveness of key working. Further details are available at <http://www.ccnu.org.uk/metadot/index.pl?iid=3036>

### The Early Phase of Psychosis Conference

**Martin Knapp** presented some ongoing research at the conference organised by the Institute of Psychiatry, King's College London on 29th & 30th November 2007. The conference provided a comprehensive overview of the

latest developments in research on the early phase of psychotic disorders and its clinical management. Professor Knapp presented on the economic impacts of early intervention. Further details can be found at <http://www.northernnetworking.co.uk/downloads.htm>.

Martin Knapp also presented at the Independent Living Association 2007 Conference – Individual Budgets and Beyond – in Haywards Heath. He presented on choice and control and the challenges of a choice-based care system; a summary of which featured in the ILA's Winter 2007/08 newsletter (see <http://www.ilawestsussex.org/docs/il0712w.pdf>).

### New issue of the PSSRU Bulletin

A new (December 2007) issue of the PSSRU Bulletin is now available to download at <http://www.pssru.ac.uk/b/bulletin.htm>.

The Bulletin records recent developments in the Unit, across all three branches, presents recent findings from each of our main programmes of work, and gives a concise overview of research projects and recent publications with contact information.

### Martin Knapp receives NIHR senior investigator award

Professor Martin Knapp was recently awarded one of the first 100 Senior Investigator Awards from the National Institute for Health Research (NIHR).

The Award is given to support and incentivise individuals who are making an outstanding contribution to research essential

for decision-making in health and social care.

Professor Knapp, alongside other recipients, was selected through open competition by an international panel of judges, based on the quality and volume of internationally-excellent research; the relevance of the research portfolio to the health of patients and the public; the impact of the research on improvements in healthcare and public health; and the impact of the leadership of the individual on patient and public research. Senior Investigators will be members of the NIHR College and will receive an award of £15,000 a year as a personal discretionary fund.

### Appointments: Martin Knapp

Professor Martin Knapp has recently been appointed to a visiting professorship in the Department of Pharmacology, Faculty of Medicine of Masaryk University in Brno, Czech Republic.

Professor Knapp has also just been appointed as the Chair of the Hearsay Charitable Trust. The HearSay Charitable Trust aims to provide counselling, training, education and research for and with people with impaired hearing, disabilities generally and their families and for professionals who seek to help them.

### Appointments: David McDaid

David McDaid, research fellow within PSSRU, was recently appointed to the NICE Public Health Interventions Advisory Committee.

The independent Public Health Advisory Committee (PHIAC) considers and interprets evidence on the effectiveness and the cost effectiveness of public health interventions. It produces recommendations on the use of public health interventions in England in the NHS, local government and in the broader public health arena.

### National Institute for Health Research Programme Grants for Applied Research

PSSRU at LSE has recently been successful – in partnership with other universities and groups – in the first round of the National Institute for Health Research Programme Grants for Applied Research. Programme Grants are prestigious awards of up to £2m over a period of three to five years, directed towards leading researchers who can demonstrate an impressive track-record of achievement in applied health research. Each programme comprises a series of related projects which form a coherent theme in an area of priority or need for the NHS.

PSSRU researchers at LSE will be contributing to the economic components of five programmes. Two focus on dementia (dementia services in the community; and support at home and interventions

to enhance life in dementia), another looks at supports and treatment for people with anorexia nervosa, while the fourth is on effective treatments for people with neurodevelopmental disorders. The fifth project is being led by the Manchester branch of PSSRU, and is focusing on old age mental health services.

### Services Inequalities in England

This project, funded by Age Concern, aims to look at inequities in service use by older people. The study will provide an overview of the available quantitative and qualitative evidence on inequalities in service use among older people and identify gaps in current knowledge. It will also identify potential untapped sources of evidence for filling these gaps, and methods for carrying out further analyses in a subsequent phase of the work. Dr Jose-Luis Fernandez is leading this work with assistance from a number of researchers.

### The Impact of Age Discrimination on Social Care and Mental Health Services

Members of PSSRU LSE, working alongside researchers at the Universities of Swansea and the Kent, have provided some preliminary analysis in relation to equality in service use. The work involves analysis of patterns of service use and costs to see whether there is any evidence of an explained age difference.

### eDESDE

The Electronic standard coding and mapping of services for long-term care project, led by PSICOST (Spain) aims at developing an operational system for coding, mapping and comparing services for Long-Term Care (LTC) across EU. The project is funded by the European Commission for three years. The PSSRU will be managing dissemination for this project.

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