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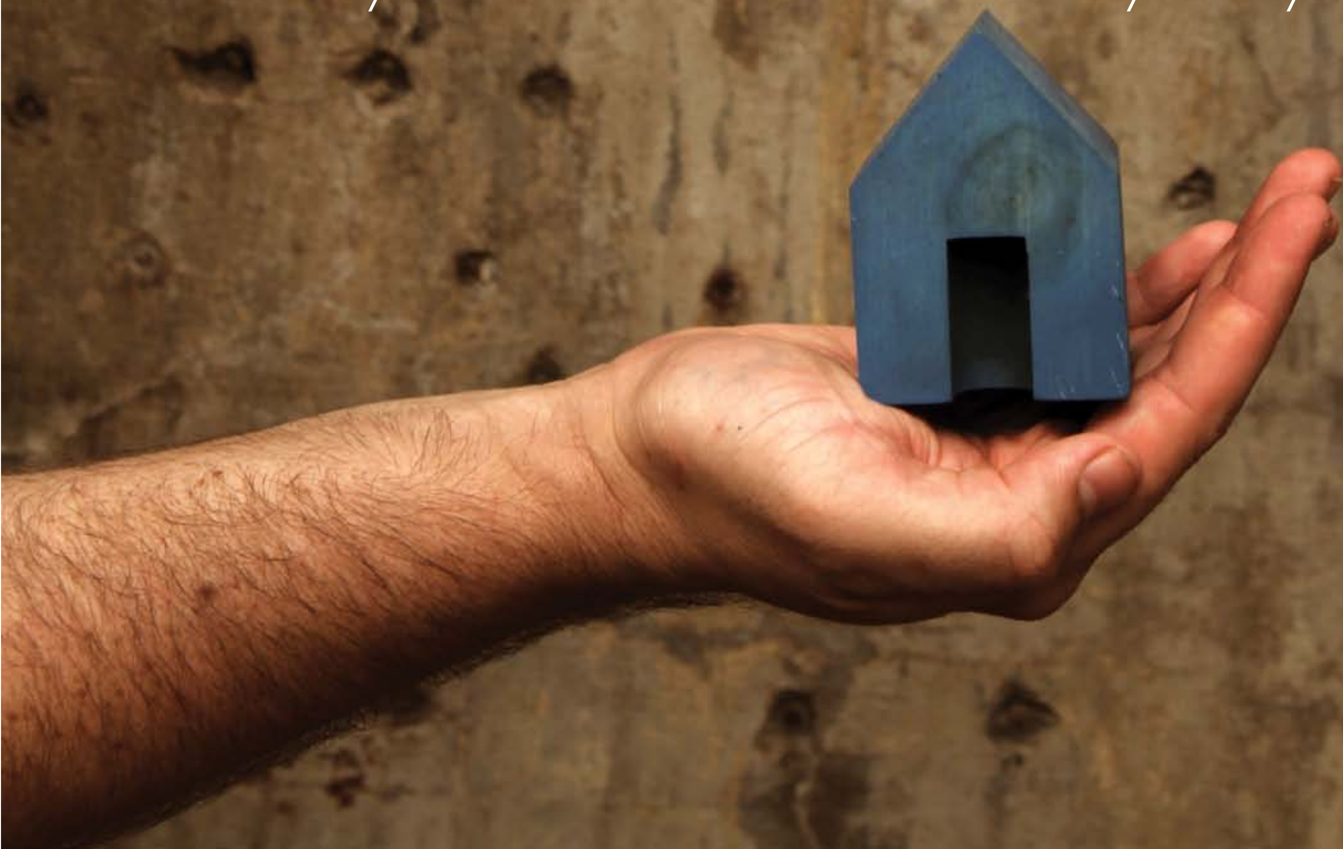
A guide to good practice in the use of out-of-area placements

Faculty Report FR/RS/06
November 2012

By Tom Edwards, Paul Wolfson and Helen Killaspy
from the Royal College of Psychiatrists'
Faculty of Rehabilitation and Social Psychiatry



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Royal College of Psychiatrists'
Faculty of Rehabilitation and Social Psychiatry
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Introduction

This faculty report offers a good practice guide to dealing with issues relating to adult service users being considered for, and those currently residing in, out-of-area placements. There is also advice on how to repatriate service users. The document is relevant to anyone who is involved with out-of-area placements, including members of placement funding panels; rehabilitation, community and forensic psychiatrists; other mental health staff such as care managers, care coordinators and out-of-area reviewing officers; commissioners and advocates; and finally, service users and their relatives.

Background

Some service users with complex and longer-term mental health needs cannot be discharged home from the acute admission ward and require a longer period of treatment and support. Others may have spent long periods in secure hospitals and no longer need secure care, but continue to have complex long-term needs. For some years, this group has been at risk of 'out-of-area placement' due to disinvestment in local longer-term rehabilitation and supported accommodation services (for a brief history of the increased use of out-of-area placements, see Appendix A).

When local services cannot meet the needs of an individual, a placement is found elsewhere. The person agrees to go for a visit. They find it preferable to the acute ward and decide to give it a try. They move to the placement, sometimes after a period of transitional leave. A few weeks later, they are visited by a member of staff from the mental health services in their area of origin to see whether they have settled in. If all is going well, this can be where the pathway stops; they are seen as 'placed' and there is little further focus on their ongoing rehabilitation.

This group of service users can sometimes remain in a high-cost placement for many years, often many miles away from where they once lived. They can be effectively forgotten by the mental health service that sent them there. The reason for this is not financial prudence – in fact, out-of-area placements cost, on average, 65% more than local placements (Killaspy & Meier, 2010). The situation represents an unacceptable 'out of sight, out of mind' approach to the care of those with longer-term and complex mental health needs. This group were among those described as the most socially excluded people in the UK by the Office of the Deputy Prime Minister in 2005.

At last, things are changing. There is now clear guidance from the Department of Health on appropriate commissioning of out-of-area placements in the form of a web-based toolkit published by the Royal College

of Psychiatrists, *In Sight and In Mind* (National Mental Health Development Unit, 2011). This provides advice and guidance for those who commission and plan health and social care services for people with longer-term mental health problems, on developing local care pathways to reduce the need for out-of-area placements. It includes helpful suggestions for the assessment, review and potential repatriation of those placed out of area. The seven steps of the approach are summarised in Appendix B.

Aims

The aims of this document are to:

- emphasise the need for clinicians, providers, managers and commissioners to minimise the use of out-of-area placements because of the associated human, social and financial costs
- clarify the clinical and social factors associated with appropriate use of out-of-area placements
- provide a clinical perspective on good practice in relation to out-of-area placements including:
  - the systems required to oversee all out-of-area placements made by an organisation
  - step-by-step guidance for practitioners making an individual placement
- present an overview of the statutory frameworks relevant to civil liberties
- offer practical advice on repatriation of service users from out-of-area placements
- demonstrate that repatriation must be linked to reinvestment in local services so that robust local care pathways are available to reduce the need for future out-of-area placements.

Problems associated with out-of-area placements

Out-of-area placements can bring social dislocation for the service user from their home area, leading to isolation from family and friends. Placements are sometimes isolated from the community local to the facility and may provide little support to facilitate service users' accessing local community resources. Reports of poor quality of care have been made about some facilities, including a lack of documentation about the person's history, a lack of rehabilitative focus and poor adherence to the review processes of the care programme approach (CPA). There can also be a lack of input from the community mental health services local to the out-of-area placement (Ryan *et al*, 2004). Cultural and language issues for migrants can be further challenges for service users in out-of-area placements. Some of these issues are illustrated by the following service user's view:

> 'When there is no provision in the local area, a service user's condition can be exacerbated by being sent out of area to unfamiliar surroundings. They can feel dislocated from all that is familiar and reassuring. The treatment goals can seem uncertain. Exile from a familiar place into a sterile, coercive environment is hardly treatment conducive to recovery. Out-of-area placements seem to hark back to the 19th-century lunatic asylums which were established in remote areas, far away from the centres of population. Mentally ill people were ousted from the general population and found themselves penned into a secure ghetto. Out-of-area treatments have the overtone of trying to sanitise the local area of the mentally ill, instead of making provision for people in their local community' (service user, 2012, personal communication).

The financial cost of out-of-area placements

Out-of-area placements represent a huge financial burden to the public sector and they are more expensive than local provision. In England, it has been estimated that around 85% of adult placements are occupied by people requiring rehabilitation or continuing care (i.e. ongoing care, not necessarily continuing healthcare) (Hatfield *et al*, 2007). In 2009–2010, just over £3 billion was spent by health and social care commissioners on longer-term adult mental health services, of which £692 million (around 23%) was spent on out-of-area services. Out-of-area facilities comprise independent hospitals, residential and nursing care homes and various forms of supported accommodation. Around half of such placements are funded by local authorities, a quarter by the National Health Service (NHS), with

roughly a quarter being jointly funded. However, placements funded by local authorities only account for around a third of the overall expenditure, since they tend to be nursing and residential care placements, whereas those funded by the NHS tend to be in-patient facilities, which are more expensive. These include specialist services, such as those for people with particular conditions (e.g. eating disorders or psychosis plus Asperger syndrome), as well as specific types of in-patient services (e.g. secure services, psychiatric intensive care, in-patient psychotherapy services, female-only services). There is also some evidence that out-of-area placements are not always reserved for those with particularly specialist needs (Killaspy *et al*, 2009).

In 2009, a request for information about out-of-area placements and expenditure to all primary care trusts (PCTs) and local authorities in England (using the Freedom of Information Act), made by the Faculty of Rehabilitation and Social Psychiatry and the Royal College of Psychiatrists' Policy Unit found that, on average, out-of-area placements cost 65% more than local placements; NHS-funded out-of-area placements cost 100% more than local NHS placements, and out-of-area placements funded by local authorities cost 40% more than those funded locally. The average annual cost of a local placement was £21 000 and that of an out-of-area placement was £35 000 (Killaspy & Meier, 2010).

A route to an out-of-area placement

Care pathways to out-of-area placements

Out-of-area placements are considered for people whose needs cannot be met locally. This may be for a number of reasons.

- There is a lack of provision of a local care pathway incorporating rehabilitation services and supported accommodation.
- The service user has particularly complex needs and local provision is not feasible, owing to the small number of people requiring the specialist service. Less densely populated localities may struggle more to provide the full complement of rehabilitation care pathway service components. As a consequence, a lower threshold for sourcing an out-of-area placement for an individual service user may be needed in these areas, compared with those in urban areas.
- There is a lack of availability of a suitable local placement, even when a local care pathway does exist; this may be a particular problem for those with offending histories.
- The service user has expressed a desire to be placed out of area and this is considered a reasonable request by the clinical team.
- The service user cannot reside locally because of victim issues (e.g. there is an injunction preventing them from residing in a certain area) or the risk posed to the service user by local residents (e.g. from people who may exploit them or inveigle them into using substances that have a negative impact on their mental health and risk to others).
- The service user has developed links with community resources local to an out-of-area placement, such that their ongoing recovery is better supported by finding them a more independent placement in the same area, rather than repatriating them to their area of origin.

Identifying a suitable placement

There is no website or publication available to specifically assist the clinician in the process of locating particular or specialist mental health provision. In England, the website of the Care Quality Commission, which provides inspection reports, can be a useful starting point to review details of the

quality and type of care provided by different hospitals and registered care homes (www.cqc.org.uk/public). Some NHS trusts and local authorities have staff whose role is to identify suitably supported accommodation for people leaving hospital. More developed systems may include teams of staff who hold an overview of all local supported accommodation provision and liaise with providers and practitioners to match vacancies with service users' needs according to priority. This kind of expertise can be called upon when a specialist placement is needed that cannot be provided locally. If they are unable to help, getting in touch with a charity which supports the service user's particular condition may be worth trying. As a final resort, an independent social worker can be commissioned to provide advice on a suitable placement. This will cost and so will need to be authorised.

Where the clinician has no experience of a proposed placement, it is worth checking whether any colleagues may have used it in the past to gain their views. Internet searches can also be a useful source of further information, although the validity of reports found online may need to be borne in mind. The local placement funding panel administrator will also have details of all providers previously used. If there is no appropriate experience to hand, it is important that a clinician visits the service to gather information about its location, the facilities available, the needs of current service users, and to gain a sense of its culture and professionalism. The Care Quality Commission website should also be consulted. Discussions with the team from the proposed placement are important in order that they gain relevant information about the service user's needs and current care plans. In addition, the referring team can feel reassured that the staff at the proposed placement have the relevant information, confidence and skills to potentially work with the service user. Wherever practically feasible, the service user and/or a carer/supporter should visit the proposed placement to ensure their views about its suitability are included in the decision-making process.

Any extra support required should be negotiated and agreed before the service user moves to the placement. Disputes about who should pay for additional support (e.g. clozapine monitoring or extra personal care) can be very upsetting for the service user and cause unnecessary delay or disruption to the process of moving in.

The choice of placement needs to take into account service user preference wherever possible. However, where there are competing priorities, this can present a dilemma. For example, a service user may want to live locally, near their family, but a facility that can provide for their individual needs and assist their recovery more effectively is available further away. The pros and cons of all options should be discussed fully with the service user and their family. The benefits of a facility further away that can provide longer-term recovery and greater independent living skills may outweigh the local option, which can be considered again when further rehabilitative progress has taken place. Where there are possible differences of opinion between service users, family and clinicians over the choice of placement, the involvement of an advocate may be appropriate.

Quality assurance in relation to out-of-area placements

Mental health services and commissioners making placements out of area should set up a system for agreeing and reviewing placements. This will include a system for overseeing all placements, as well as clear guidance for practitioners considering making an individual placement.

Systems for overseeing all placements

- A multidisciplinary steering group of senior managers, clinicians and commissioners to agree and review the appropriateness of all placements should be established and meet at least quarterly. This group may comprise or overlap with the membership of the placement funding panel.
- Appropriately experienced staff should review all individuals placed out of area regularly as clinically indicated and on a minimum annual basis. In some NHS trusts, one staff member takes on this role (an out-of-area reviewing officer), whereas in others, this function is carried out by the care manager. This is an important role in terms of care quality, service user experience and financial management; it should be undertaken by someone with appropriate skills, experience and seniority who has been allocated sufficient time and resources to fulfil the role effectively.
- Reports from the placement's clinical reviews should be regularly provided to the reviewing staff and steering group. This should be included in the contractual agreement that the commissioning body makes with the out-of-area provider.

Guidance relating to individual placements

- Ensure that multidisciplinary assessments of the current needs of the service user being considered for a move have been completed.
- Clarify that a local service that could meet the service user's needs is not available. This is likely to include a referral and assessment by local facilities which, if available, are identified as providing the closest level/type of services to what the service user requires.

- If no appropriate local provision is available, identify an appropriate out-of-area placement (see pages 10–11).
- Complete an application for the relevant panel to agree funds for the identified out-of-area placement. Discussions with the service user and carers and visits to potential placements should not start until funding has been agreed.
- Ensure that the potential out-of-area facility has access to all relevant information regarding the service user's history, current needs and risks to assist them in their assessment of the service user's suitability for their service.
- Once the move is agreed, a period of transitional leave may facilitate the service user settling into their new environment before final discharge there.
- Once the move has taken place, a care coordinator should be allocated from the local mental health service to monitor progress and review care under the statutory framework of the CPA.
- The care manager and/or out-of-area reviewing officer from the area of origin should liaise with the care coordinator and attend CPA meetings, to monitor the person's progress in the out-of-area placement and provide progress reports to the placement panel about the ongoing suitability of the placement.
- The care manager/out-of-area reviewing officer should visit individuals placed out of area as often as clinically indicated but no less frequently than annually.
- An initial review should take place within 3 months of the individual moving to the out-of-area placement, in accordance with national guidance in England (*National Framework for NHS Continuing Healthcare and NHS-Funded Nursing Care* (Department of Health, 2009*a*)).
- The out-of-area facility must maintain full records of the service user's progress and arrange CPA review meetings regularly and no less frequently than annually.
- No service user should be considered to be in an out-of-area placement that will meet their needs forever. The ongoing suitability of the placement should be reviewed regularly, with a view to a move to a more independent placement being considered when clinically feasible.
- The care manager/out-of-area reviewing officer should review the service user's support and care plans at the out-of-area facility, to ensure that the care being provided enables the service user's recovery and autonomy, rather than fostering institutionalisation and dependency.
- Those reviewing the placement should be supported by their senior colleagues and line managers to challenge institutional practices and care plans which do not have a rehabilitative or recovery focus. If problems persist, this may mean that moving the service user to an alternative placement has to be considered (see page 14).
- The service user, their carers and staff should all be aware of the point at which a repatriation plan could be considered (see page 17).

Transfer to an alternative out-of-area placement

A service user may need to move to an alternative placement for a variety of reasons, for example when:

- their needs change and can no longer be met in the current out-of-area placement
- the placement appears to be managing risk inadequately
- the placement is closing down or changing its remit
- there are concerns about abuse or exploitation of the service user by staff
- the service user's circumstances change (e.g. a close, supportive relative moves away and there is an agreed need for the service user to move to be closer to them).

A new case for an out-of-area placement will need to be made following the same process described in the previous chapter (pages 10–11). Some providers may offer an alternative placement at another facility which may be appropriate, depending on the reasons for the placement breakdown. Gaining agreement from the funding panel for an alternative in this situation can be potentially challenging, especially if the new proposed out-of-area placement is more expensive. Again, depending on the reasons for the placement breakdown, maintaining links with the original out-of-area placement provider can be useful as, although they may have to rebuild confidence in their service, they may remain an appropriate provision for future placements.

Civil liberties – the statutory considerations

Moving to an out-of-area placement care home is a major life-changing decision, whatever the age of the individual. Relevant statutory frameworks to consider when an individual moves to an out-of-area placement include the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Service users may also be subject to the Mental Health Act, guardianship, supervised community treatment orders, conditionally discharged restriction orders; or to conditions of licence from determinate, indeterminate or life sentences.

Mental Capacity Act 2005

Attention needs to be given to the five statutory principles of the Mental Capacity Act 2005:

1. the assumption of capacity
2. taking all practical steps to enable decision-making
3. the principle that a person can make 'unwise' decisions
4. acting in the best interests of the person
5. following the least restrictive option.

If an assessment of capacity has established that someone is unable to make a decision for themselves about a move to a care home or other placement, the person's past and present wishes, feelings and values must be taken account of. The views of other people who are close to the person who lacks capacity should also be considered, as well as the views of those with a legal perspective.

An Independent Mental Capacity Advocate (IMCA) must be instructed and then consulted for people who lack capacity and have no one else to support them other than paid staff. The IMCA has specific responsibilities for deciding whether:

- serious medical treatment should be withheld or provided
- the person can be placed in accommodation for more than 8 weeks (or 28 days in a hospital) and whether to move them to different long-stay accommodation.

People with capacity should be actively encouraged to consider making an Advanced Statement and/or a Lasting Power of Attorney (LPA).

The Mental Capacity Act 2005 replaces the previous Enduring Power of Attorney with LPA. The 'donor' and 'attorney' must sign a statement that they understand the information and duties of the attorney. A third party must sign to say the donor understands the LPA and has not been coerced or misled. Personal welfare LPA can include decisions on where the person lives, day-to-day care, consent to examination, tests and treatment, assessment for social care, social and leisure activities, correspondence, access to information and complaints. An attorney cannot consent to, or refuse, treatment for a mental disorder for a patient detained under the Mental Health Act.

Deprivation of liberty

There is no simple definition of deprivation of liberty. There is a difference between deprivation of liberty and restriction of liberty, such that the cumulative effect of different restrictions may amount to a deprivation of liberty, even if individually they are not.

The following factors may indicate a deprivation of liberty that should trigger assessment of the situation according to the appropriate local deprivation of liberty protocol:

- restraint is used, including sedation, to admit a person to an institution where the person is resisting admission
- staff exercise complete and effective control over the care and movement of a person for a significant period
- staff exercise control of assessment, treatment, contact and residence
- a decision has been taken by the institution that the person will not be released into the care of others or be allowed to live elsewhere, unless staff in the institution consider it appropriate
- a request by carers for a person to be discharged to their care is refused
- a person is unable to maintain social contacts because of restrictions placed on their access to other people
- a person loses autonomy because they are under continuous supervision and control.

Human rights

Poor practice relating to the initial placement of a service user and their subsequent care and monitoring may contravene Article 8 of the European Convention on Human Rights. This states that a person has the right to respect for private and family life, home and correspondence. These rights may not apply when, for instance, the rights and safety of others are at risk.

This can be a complicated issue, particularly when a specialised placement is required and only a distant facility is available. When a service user has been detained under the Mental Health Act and requires a secure in-patient unit, this may also limit local options, which could have an adverse impact on family life.

Repatriation

Minimising the use of out-of-area placements goes hand in hand with investing in the local rehabilitative care pathway. The picture across England is variable; some areas have repatriated most of the people previously placed out of area, while others have yet to begin this process. The financial flows from repatriation can be usefully invested into the local mental health economy, to build a local care pathway.

The finance department of the local PCT and local authority can provide lists of all placements funded through the community and continuing care budgets (in the near future in England, local clinical commissioning groups are likely to hold these lists). Local representatives of the National Commissioning Board for Secure Services should hold information on patients in secure services who are nearing discharge. It makes sense to review individuals in the most expensive placements first. This includes a review of their locally held case notes before arranging a visit to discuss their views on their current placement. The views of staff at the placement on the person's current needs and progress should also be sought and the case notes and care plans held at the out-of-area facility reviewed. Further discussions should be held with the person's family regarding their views on the person's progress in the placement. Some out-of-area reviewing officers use standardised assessment tools to collate the multisource information gathered, for example the Community Placement Questionnaire (Clifford *et al*, 1991).

Establishing someone's suitability to relocate is based on their level of functioning, desire to move and the availability of an appropriately supported facility in the area of origin. When a person is ready to come back to their local area, this would generally be to a less supported setting. If there is no suitable placement available, consideration is given as to whether to find another placement out of area or wait for a suitable vacancy in the area of origin. The process is similar to the steps described earlier (guidance relating to individual placements, pages 12–13). The move should be managed at a pace that the person can cope with and include visits and transitional leave to the new placement. For those who are not ready to move, it is important to make sure that they continue to be regularly reviewed, at least annually or more frequently where indicated. Some service users, especially those who have been in a distant placement for a long time, can find moving on quite difficult and worrying. This is not a reason to jettison the idea of repatriation, but just means that the individual needs to be given more time and support with the process.

The case for local provision

Several factors are important in considering the case for developing local provision for the treatment and care for people with longer-term, complex mental health problems.

1. *Localisation* A local whole-care pathway that includes rehabilitation units, supported accommodation and other voluntary sector services (such as vocational rehabilitation services and supported employment) is required to facilitate service users' recovery and social inclusion, as close to their area of origin and existing social networks as possible. Under local management, it is far less likely that service users will be 'out of sight and out of mind'.
2. *Personalisation* A local service can be tailored to the needs of the individuals it is developed for and respond to changes in needs of the local population.
3. *Choice* A person should be able to remain living in their community of origin, if that is their wish and their needs are not so specialised that local provision is not feasible.
4. *Social inclusion* It is hard to find another example in the NHS where a patient has to leave their home area to be resettled many miles away for long periods of time, merely to access a standard treatment environment.
5. *Mental health and safety* The current culture of patients being discharged from hospital once the acute phase of their mental illness has resolved dominates in-patient care pathways and can be too optimistic for some service users with complex needs. In the absence of any local rehabilitation facility, service users are more likely to be discharged prematurely from the acute ward, at arguably greater risk.

The faculty report *Making the Case for a Rehabilitation Facility* (Edwards *et al*, 2010; also see Appendix C) provides guidance on how to develop a business case for a rehabilitation in-patient facility. Such a business plan would also need to take into account the demand from service users currently placed in similar out-of-area placements, who could then be repatriated to this locally developed equivalent facility. In addition, the projected likely demand for such a facility in the future would also need to be taken into consideration in the business plan. The principles contained in *Making the Case for a Rehabilitation Facility* can also be applied in preparing business cases for other components of a local rehabilitation and supported accommodation pathway.

Box 1 Case vignette

The NHS is a complex and constantly evolving organisation and so it can be difficult to avoid situations that produce discontinuities in care due to staff moves. The following case vignette illustrates some of the difficulties for people in out-of-area placements associated with service reorganisation.

Sarah is 25 years old. Following a head injury in her late teens, she developed a mental illness with psychotic and affective features, and this led to her long-term involvement with mental health services. She had major problems with impulse control and could be disinhibited and sometimes aggressive. She was highly vulnerable to exploitation and to invitations to use drugs and alcohol. Management of her mental illness and behaviour included oral antipsychotic and mood stabilising medication, as well as high levels of nursing supervision and support throughout a 24-hour period (as required). She was generally cooperative with this, and therefore consideration was given as to whether she could be managed in a non-hospital setting. A placement was found 150 miles from her home county, which was able to provide residential care at a cost of £2000 per week. This placement was approved and it allowed Sarah to consolidate the stabilisation of her mental health, and to enjoy a better quality of life than she had in hospital, with a high level of support from those providing care. Soon after this, there was a reorganisation of services in her home county. The consultant psychiatrist and care coordinator, who had been in regular contact with Sarah and the residential care placement, moved into different teams. The funding panel which authorised placements were made aware, 2 years later, that Sarah's care and progress had not been reviewed by any representative from the funding authority during this period, despite payment of £2000 per week continuing.

If a robust system had been in place to ensure regular reviews of Sarah's placement (Box 1), the change of staff would not have mattered. The funding panel should have had a system to facilitate regular reports on individual placements by an out-of-area reviewing officer or care manager. This person would have been aware that they had a responsibility to visit Sarah regularly and report to the funding panel on her progress, collating information from visits and attendance at CPA meetings with the local community mental health team currently responsible for her care.

Once this situation had come to the attention of the local mental health commissioner, a member of the clinical staff from the local NHS trust in the home area was asked to review Sarah and all other people placed out of area. This process identified a number of service users with similar levels of need to Sarah. A steering group was convened comprising the local mental health commissioner, senior clinicians and managers from the local NHS mental health, a representative from a local housing association and a representative from the local authority. This group carried out a strategic analysis of the needs of all those placed out of area, which identified that there was justification to propose a business plan to develop a local residential care home providing community-based rehabilitation for service users like Sarah. The business case included the financial flows identified through repatriation of service users placed out of area who could potentially move to the new facility, as well as the projections for the future need for a service of this type, and the anticipated rate of move on from the facility to more independent, supported accommodation in the local area. The local

residential care home was opened and was able to provide care at a cost 20% less than the average out-of-area placement. The facility provided service users with the opportunity to have closer contact with family and friends and local community mental health services were able to resume care coordination for them.

Further examples of how financial flows from repatriation can be reinvested into the local mental health economy are presented in the *In Sight and In Mind* document (National Mental Health Development Unit, 2011).

Conclusions

We hope that this faculty report has illustrated the need for clear, local systems to be in place for the assessment and review of service users placed out of area. The overall aim of practitioners working with people placed out of area should be for their repatriation closer to home to an appropriately supported facility at the earliest opportunity, except where local provision for the small number of service users with particularly complex and specialist needs is not feasible. A local care pathway comprising in-patient and community rehabilitation services, supported accommodation and vocational rehabilitation services is essential. Rehabilitation practitioners have a key role in the assessment, review and repatriation of service users placed out of area which needs to be recognised in job planning.

Appendix A. A timeline of key events and publications relating to out-of-area placements

1997–2002: The TAPS studies

The Team for the Assessment of Psychiatric Services carried out longitudinal studies of outcomes for patients after the closure of the asylums in north London. Very few were lost to follow-up and the majority were successfully discharged from hospital. Five years after the closure of the asylums, a large proportion of those considered most difficult to place in the community had not only been able to remain in the community without requiring readmission to hospital, but had also been able to move on to a more independent setting (Leff, 1997; Leff & Trieman, 2000; Trieman & Leff, 2002).

1999: *The National Health Service Framework for Mental Health*

The framework (Department of Health, 1999) led to major investment in community mental health services, but this was associated with disinvestment in rehabilitation services. By 2009, around a quarter of community rehabilitation teams were rebadged as assertive outreach teams (Mountain *et al*, 2009).

2002: The 'virtual asylum'

'The lack of NHS facilities for patients whose behaviours are intractably difficult to manage or require specialist placements has been exploited as a market opportunity', reported this *BMJ* editorial (Poole *et al*, 2002), describing how patients in out-of-area placements were socially dislocated and receiving inadequate rehabilitation.

2005: *Out of Area Treatments for Working Age Adults with Complex and Severe Psychiatric Disorders*

In this report, the Royal College of Psychiatrists' Faculty of Rehabilitation and Social Psychiatry reviewed the current situation regarding out-of-area placements and put forward recommendations for good practice in their delivery (Davies *et al*, 2005). These recommendations concerned promoting the case management of service users in out-of-area placements, the monitoring/management of this process and collaborative commissioning arrangements for this service user population.

2005: *The Forgotten Need for Rehabilitation in Contemporary Mental Health Services*

A further report from the Faculty of Rehabilitation and Social Psychiatry (Holloway, 2005) highlighted the inverse relationship between rehabilitation service provision and spending on out-of-area placements. The collective amnesia was the result of many factors, 'not least the desire to ignore the uncomfortable fact that severe mental illnesses […] may still lead to considerable distress and disability for the sufferer' (p. 1), and although the traditional mental hospitals had mostly closed, '[they] have been replaced bed for bed by a "virtual mental hospital"' (p. 1). Those placed out of area 'often receive scant attention from statutory mental health services – out of sight, out of mind. There is little incentive to encourage individuals to move into less restrictive settings' (p. 1). In 2004–2005, when investment was being withheld from many rehabilitation services to provide assertive outreach teams, the cost of out-of-area placements to the NHS was £222 million (Holloway, 2005).

2009: *A Template for Rehabilitation Services*

Enabling Recovery for People with Complex Mental Health Needs: A Template for Rehabilitation Services (Wolfson *et al*, 2009) was another attempt by the Faculty of Rehabilitation and Social Psychiatry to describe the components of a comprehensive rehabilitation care pathway. It made the case that although out-of-area services may sometimes be necessary for very specialist treatments, local rehabilitation services (including local supported accommodation) should be available to meet the vast majority of local need.

2009: Financial cost of out-of-area placements

Together with the Royal College of Psychiatrist's Policy Unit, the Rehabilitation and Social Psychiatry Faculty made a Freedom of Information enquiry to all mental health and social care commissioners across England regarding their expenditure on out-of-area placements. This revealed that in 2008–2009,

29 130 placements were funded by PCTs and local authorities for adults with mental health problems at a total cost of £710 million; of these, 22% were out of area. This confirmed a far higher use of such placements than could be explained by the small number of individuals with very complex needs who require very specialist care. The cost of out-of-area placements was, on average, two-thirds higher than local placements.

2009: *New Horizons*

The Department of Health's precursor to its mental health strategy, *No Health Without Mental Health* (HM Government, 2011), *New Horizons* made specific reference to 'reducing the use of out-of-area placements by ensuring sufficient high-quality local services' (Department of Health, 2009*b*: p. 35).

2010: *'A Fair Deal for mental health includes local rehabilitation services'*

This editorial in *The Psychiatrist* detailed 'a compelling case for all individuals with complex mental health problems to have access to local rehabilitation services in order to expedite their recovery and social inclusion', and further strengthened the case for the regulation of out-of-area placements by linking it with the Royal College of Psychiatrists' Fair Deal campaign (Killaspy & Meier, 2010).

2010: *'Non-local mental health treatment wasting millions'*

For the first time the media took up the story. David Brindle, in *The Guardian*, investigated the financial implications and the plight of individuals living far away from their roots, relatives and friends (Brindle, 2010). The article described how the more progressive services had begun to repatriate people into appropriately supported local housing accommodation through local investment of the associated financial flows.

2010: *Making the Case for a Rehabilitation Facility: Helping Psychiatrists to Work Together with Commissioners and Senior Service Managers*

Another report from the Faculty of Rehabilitation and Social Psychiatry, this was a practical guide for psychiatrists on how to make a persuasive business case for commissioners to invest in local rehabilitation services (Edwards *et al*, 2010).

2011: *In Sight and In Mind*

This web-based toolkit (National Mental Health Development Unit, 2011) was designed to guide commissioners in the appropriate use and review of out-of-area placements. It includes practical tools to assist commissioners in assessing the use of and spending on out-of-area placements, as well as developing and commissioning rehabilitation and supported accommodation services locally to minimise the need for out-of-area placements. The toolkit was commissioned by the Department of Health and produced by a collaboration led by the National Mental Health Development Unit that included the Royal College of Psychiatrists, the NHS Confederation, the Association of Directors of Adult Social Services, the Audit Commission and providers with good track records in managing out-of-area placements.

Appendix B. The seven steps to developing a system for reviewing out-of-area placements

From *In Sight and In Mind* (National Mental Health Development Unit, 2011).

1. *'Stocktake'* – map existing local provider services (location, cost, effectiveness, outcomes); analyse options to expand the range and choice of local services.
2. *Needs assessment* – What are the needs of people in the commissioner's area? How do current services meet/not meet need?
3. *Establish a planning structure* – to address the issues and outcomes to be achieved in a systematic, managed way, involving local leaders (clinical and political), frontline clinicians/practitioners, managers, people using the services, their families and carers.
4. *Agree and communicate a whole-system strategy* – agree goals and timescales in a coherent development plan.
5. *Implementation* – starting with identifying options to develop:
   - clinical and commissioning systems (e.g. assessment, review), leadership and care pathways
   - data and information systems
   - service choice for people using the services and their clinicians/practitioners (i.e. through market development including procurement frameworks)
   - integrate service specifications and outcome measures across care pathways to build resilience and a 'whole system' focused on providing best outcomes for people (i.e. recovery and maximum independence from services).
6. *Set up and monitor key processes* – e.g. quality assurance, case management and feedback, contracting systems, involvement of people who use the services and their carers.
7. *Review and refine* – establish annual reviews of strategy, processes and services.

Appendix C. Making a case for a local rehabilitation unit

How to build a strong case – the key questions you need to answer

1. Have senior managers and commissioners been included at the start of the process in order to enhance the likelihood of success?
2. Is your commissioner aware of the template for rehabilitation services (Wolfson *et al*, 2009)?
3. Can your proposal improve the wider pathway – will it reduce the number of patients waiting in acute wards?
4. Does it enhance the current rehabilitation pathway (where it exists)?
5. Does it include a consideration of the exit strategy e.g. supported accommodation?

Has the following information been provided?

6. Factual information to enhance your case – e.g. data on the number of patients placed out of area, clinical profile, length of stay, comparative data from other areas (this could be obtained from commissioners who hold it for benchmarking purposes).
7. Identifying how many patients could be repatriated to the local area.
8. The type of rehabilitation service proposed and how it will reduce the need for future out-of-area placements.

Who is in the best position to provide the service?

9. Potential partnerships between third-sector, independent and statutory providers should be considered.
10. The strength of competitor providers must be properly assessed.

Have you utilised the full strength of the clinical case?

11 Clinical considerations are paramount and clinicians can use their local knowledge of equity issues, access to high-quality clinical care and population needs.

12 Local facilities have the advantages of geographical proximity for family and friends, continuity of care, the likelihood of local 'move-on' facilities as needed and give no financial disincentives to move on. They are also likely to give the service user more autonomy, as they are able to access treatment more locally.

A more detailed consideration of these points is found in *Making the Case for a Rehabilitation Facility: Helping Psychiatrists to Work Together with Commissioners and Senior Service Managers* (Edwards *et al*, 2010). This also includes a detailed account on how to construct a successful business case, pages 11–14.

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