Evaluation in Primary Care Mental Health

Evaluating impact, focusing on what works

We all need to talk more about mental health. We need to understand better which approaches to mental health offer the best outcomes for people and why.

Every area is facing similar challenges in terms of primary care mental health: there is a significant cohort of people who are simply not getting better. For example,

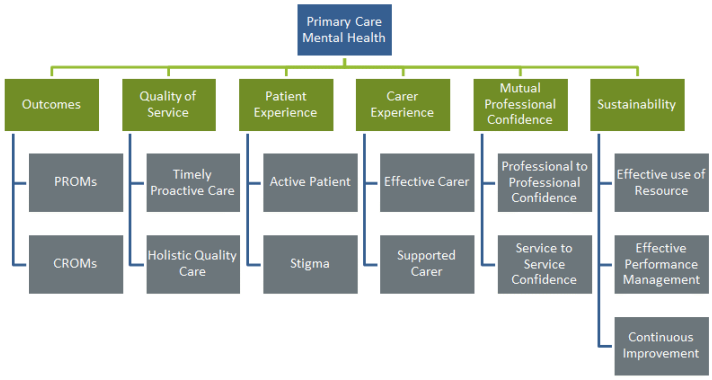
1. How to encourage "step-down" from secondary care services for people who no longer require that level of intervention and how to support them in primary care led services.
2. How to support people whose mental health challenges are beyond the expertise of primary care (in that they are not progressing) but who are not unwell enough to require secondary care support.
3. How to ensure that the actual needs of those with mental health conditions are met by the right type of services.

Healthy London Partnership commissioned Catalyze-Res to lead an economic evaluation of primary care mental health models in five different London Boroughs. The evaluation team was tasked to answer two questions:

- How do the Primary Care Mental Health models contribute value to the health system?
- How do the Primary Care Mental Health Models contribute to financial efficiencies?

What is value?

The Catalyze-Res Evaluation Team deployed techniques from decision science to address these questions. Specifically, the team used multi-criteria decision analysis to co-produce a characterisation of "value to the system" which comprised 29 components of value. The components were grouped into six main areas: outcomes, quality of service, patient experience, carer experience, mutual professional confidence and sustainability.



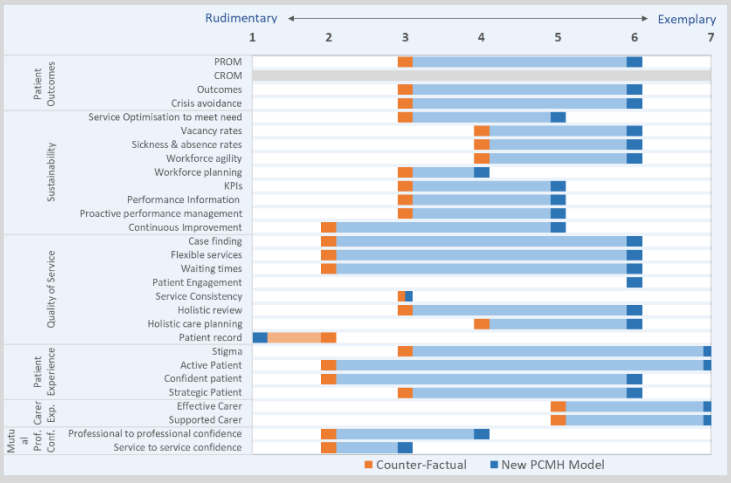
This characterisation of value formed the basis of a maturity matrix which was then used to shape the lines of enquiry with each of the five sites.

The evaluation team adopted an appreciative approach engaging with service users, with staff, with other stakeholders and reviewing data and documentation. Each site received its own report describing how well the service is doing. Where is it making a difference? How much of a difference is it making?

Each report compares the service with a "counter-factual", a parallel universe in which we considered what it would be like if this service did not exist. Answering this question is a positive way to encourage people to see the difference they are making. The individual reports also identify the areas where each service could focus to have the greatest impact on where they might increase their value to the system.

Comparing PCMH Models

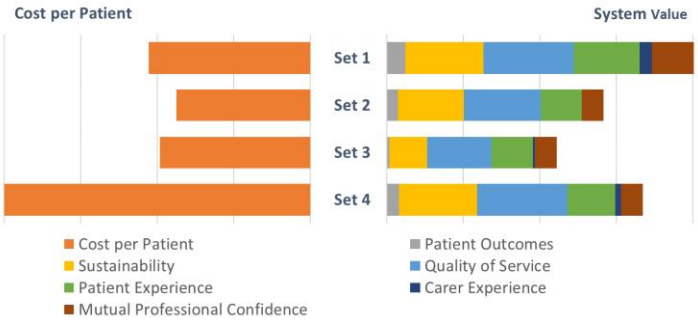
- **Dark blue squares** represent the actual performance of the PCMHS model.
- **Orange squares** represent the counterfactual (ie. the estimated performance against a criteria if the PCMHS did not exist). No orange square indicates that we have not yet determined how to rate the counterfactual.
- **Light blue bars** indicate marked difference between the PCMH model and the counterfactual.
- **Orange bars** show where the new model is worse than the counterfactual.
- **Grey bars** indicate that we have not yet determined how the service is rating against that value criteria.



Cost of Care

To establish the impact on financial efficiencies, the team considered "unit cost" – the average annual cost of care per patient within the case list of each Primary Care Mental Health Service. This revealed a significant range from £400 to £1,100 per person.

Does greater cost of care correlate to greater value? This can be difficult to answer as different service models may be managing people with different conditions. However, this evaluation found that more expensive services do not necessarily mean better outcomes or quality:



The evaluation team looked at 'cost per patient' against 'system value' and found that while more expensive services such as primary care psychotherapy may be appropriate for some patient groups, for other groups there are lower cost alternatives providing similar system value.

The service found to be offering greatest value involved strong third sector leadership with medical support provided when required. This model was also different in that it encouraged the greatest participation of volunteers to "walk alongside" people with mental health challenges and to focus on 'life plans' rather than care plans.

What makes a primary care mental health service work?

Statements suggesting that there is one model of primary care mental health services which is better than every other would be naive. However, all stakeholders for this evaluation agreed this study does reveal important features that should be considered in the development of new models of care:

- **Non-medical model vs medical model**. Ensure that the balance between 'social' and 'medical' models of care is right. A "life plan" is more effective than a "care plan". Leadership does not have to be medical, but it is essential that the primary care clinicians have confidence in the safety of the service
- **Person Centred – Recovery Centred**. Focus on enhancing the confidence and self-management skills of users. "Signposting" is rarely successful when the person needs someone to "walk alongside"
- **Local Leadership**. Encourage strong local leadership to "champion" an enhanced primary care mental health model.
- **Accountability.** Nurture accountability through good performance information and active performance management. There is a general lack of good quality data. This is not just a data issue, it is one of culture
- **Service agility.** Adapt to needs. Smaller organisations tend to be more agile and closer to the service user. This means they can be more responsive to people's individual needs and they can respond more quickly to identified strategic need.

What did this evaluation accomplish?

We have developed a robust method, grounded in decision science and appreciative inquiry, that provides genuine insight into value and value-for-money in an area where there is much need and yet where there is a real lack of quality data.

The evaluation has discovered a number of important factors that can govern better primary care mental health services, including types of care model; patient focus, making services more accountable, and adapting better to service user need. Alongside these is the importance of basic calculations of cost per patient versus the overall system value provided.

The study also revealed a number of important principles around better commissioning, including ensuring initial business case specifications are adhered to, that good quality data is provided, and that active performance management matters.

"This evaluation approach has utilised new techniques to demonstrate important features of value and value-for-money in primary care mental health. As a clinical leader, I have found it both challenging and inspiring to reflect on how value in the service models can be described and opportunities identified to increase the value we offer to service users."

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