An overview of research on the value for money of community mental health services: a review of reviews and bibliometric analysis

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Background and Aims

The World Health Organization's World Health Report 2001 called for a continued shift away from the use of psychiatric hospitals and long-stay institutions to the provision of community-based mental health care, arguing that such care produces better outcomes, such as quality of life, that it better respects human rights and that it is more cost–effective than institutional treatment. The report recognised that community care implies providing a comprehensive range of services and points of contact, with contributions from different professionals and sufficient links to other sectors such as housing and employment.

A review more than a decade ago looked at economic evidence on the consequences of deinstitutionalisation in Germany, Italy and the UK, countries that had already substantially rebalanced their mental health care systems away from 'asylums' towards more community-based models of care (Knapp, Beecham, McDaid, Matosevic, & Smith, 2011). The economic case for deinstitutionalisation was strong because of the improved quality of life that can be associated with community-based care. Moreover, individuals with lived experience of mental health conditions preferred living in the community.

We examined how this evidence base on the value for money for investing in community mental health services has developed further over the last decade.

Methods

Approach: Rapid scoping review of systematic reviews published from 2013 to 2023, supplemented by recently published additional studies on the economic case for investing in community mental health services for early intervention, treatment and ongoing support for people of all ages living with mental health conditions.

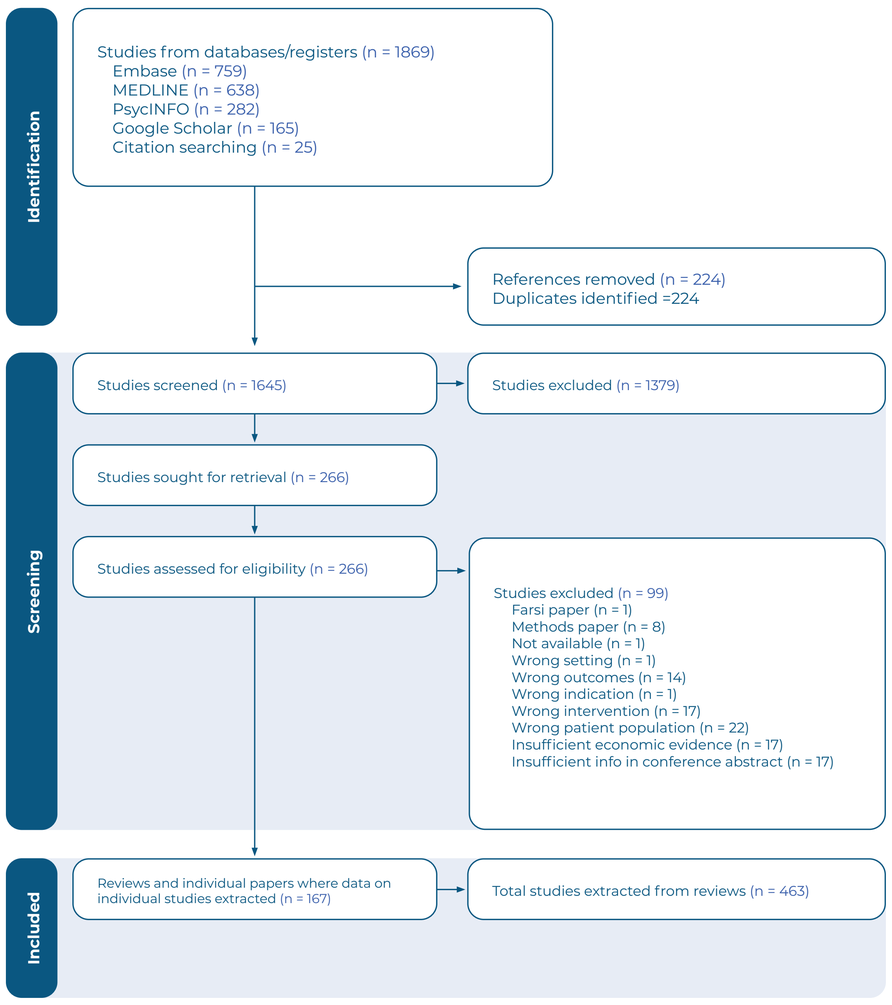
Exclusions: Pharmaceutical-only treatment or interventions delivered to hospital inpatients, as well as interventions for ADHD, learning disabilities, alcohol disorder, substance abuse, and dementia. Studies focused on mental health promotion or primary prevention of mental health conditions were also excluded. There were no language/geographical restrictions.

Screening & Extraction: Papers were doubled screened at title/abstract and full text stages. Data extracted included country of study, type of intervention, mental health conditions covered and specific settings. Type of economic evaluation, costs included and whether evaluation was positive, negative or inconclusive were documented. Positive evaluations had to report better outcomes with no change or lower costs than comparators, or a cost per Quality Adjusted Life Year (QALY) gained considered to be good value for money in the country where the study was set, or a net monetary benefit greater than 1.

Results

From 1,869 initial papers, information on 463 individual studies reported in 167 reviews/ papers was extracted. (See PRISMA flow chart).

PRISMA flowchart: Scoping review process



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Full study and additional details available here ➔

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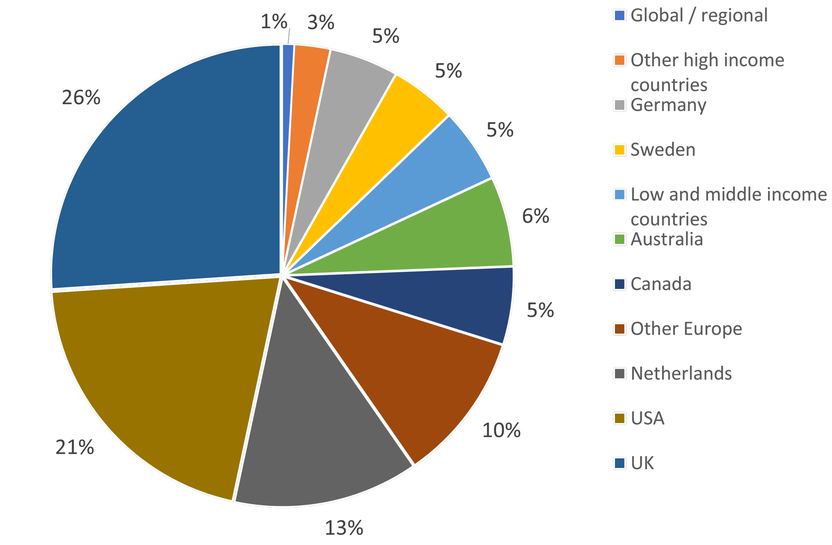
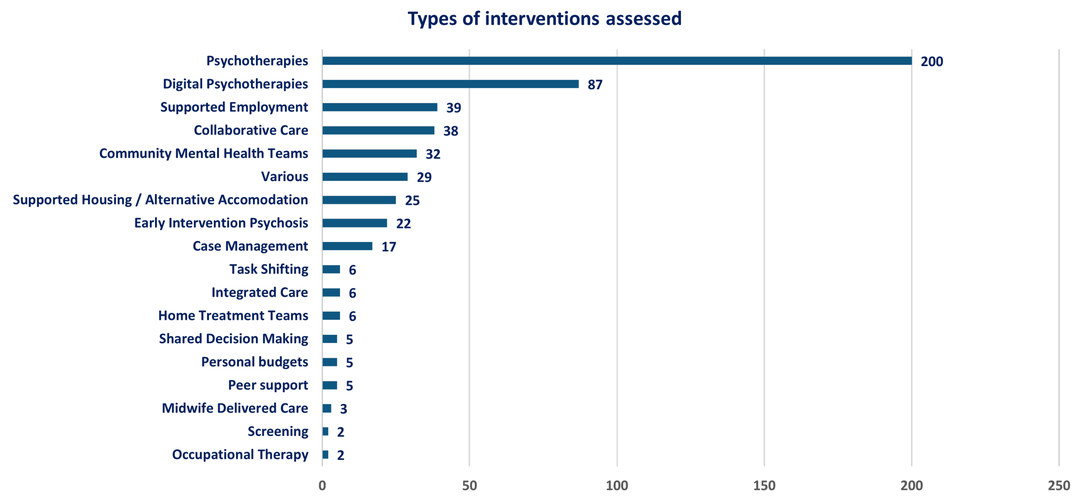
60% of included studies were from 3 countries: UK 124 (26%), United States 98 (21%) and Netherlands 62 (13%). Very few studies were found in central and eastern Europe where in some countries there is still a reliance on traditional hospital-based models of health care. A small number of studies were found in low and middle income countries.



61% of studies identified looked at interventions to support people with unipolar depression and/or anxiety disorders, while 20% focused on helping people with psychosis and 7% on bipolar disorder.

Only 4% of studies were focused on the mental health of older people, while 12% were focused on children and adolescents. Most studies looked at the economic case for specific interventions for specific conditions, especially remote or face to face psychological therapy. Less than 5% looked at system wide community mental health systems as an alternative to institutionalisation.



How strong are value for money arguments?

286 (62%) report a positive economic case; 132 (29%) are inconclusive; 45 (10%) report a negative economic case.

The table shows that for all intervention categories where more than 10 studies were identified the majority of studies are positive and very few are negative. The area of most uncertainty appears to be the digital delivery of psychotherapies, but even here only 15% of studies were not value for money. The economic case is probably conservative. Only 141 (30%) looked at impacts beyond health care systems, even though this is where two-thirds of all costs are found.

Intervention	Total Studies	Positive		Inconclusive		Negative	
Occupational Therapy	2	2	100%	0	0%	0	0%
Screening	2	1	50%	0	0%	1	50%
Midwife Delivered Care	3	0	0%	2	67%	1	33%
Peer support	5	2	40%	1	20%	2	40%
Personal budgets	5	4	80%	1	20%	0	0%
Shared Decision Making	5	2	40%	2	40%	1	20%
Home Treatment Teams	6	6	100%	0	0%	0	0%
Integrated Care	6	3	50%	3	50%	0	0%
Task Shifting	6	5	83%	1	17%	0	0%
Case Management	17	11	65%	5	29%	1	6%
Early Intervention Psychosis	22	20	91%	2	9%	0	0%
Supported Housing / Alternative Accommodation	25	17	68%	8	32%	0	0%
Various	29	17	59%	8	28%	4	14%
Community Mental Health Teams	32	22	69%	8	25%	2	6%
Collaborative Care	38	25	66%	10	26%	3	8%
Supported Employment	39	26	67%	10	26%	3	8%
Digital Psychotherapies	87	49	56%	25	29%	13	15%
Psychotherapies	200	123	62%	59	30%	18	9%

Conclusions: The economic case for a wide range of community mental health interventions is strong, but still focused on a small number of countries. Interventions implemented in Europe with a positive economic case include: specialist community mental health teams, including early intervention and crisis teams, as well as many psychological therapies, active case management, housing and supported employment. Few recent papers look at the case for deinstitutionalisation, but this evidence is still needed in many countries, including in central and eastern Europe, where the reliance on inpatient-care dominated mental health systems remains strong.