Cost Effective Positive Outcomes for Children and Families

An economic analysis of The Place2Be’s integrated school-based services for children

A publication by The Place2Be

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The Place2Be Research and Evaluation Team for their diligence and;

All of the committed staff and wonderful children and families within participating schools for their optimism and ability to make changes that save society money.
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Unit costs of The Place2Be’s school services in 2008/09
We warmly welcome the publication of this report by The Place2Be. Based on careful and thorough analysis, it is a valuable addition to a small but growing body of research that evaluates mental health interventions for children from an economic perspective. Particularly when budgets are under pressure, it is essential that spending decisions in schools, as elsewhere, are based on a proper understanding of costs and prospective benefits. At the same time, collecting and analysing the information needed for this purpose is far from straightforward.

The Place2Be is therefore to be congratulated, both for recognising the importance of economic evaluation and for undertaking the work in such a professional manner. It is increasingly recognised that, in the absence of effective intervention, mental health difficulties in childhood can have profound long-term consequences, with a range of adverse outcomes for individuals, families, communities and society as a whole.

The findings of this report give powerful support to the case for investment in prevention and early intervention. Such spending not only relieves distress today; it also improves a child’s life chances, to the benefit of us all in the future.

Cost Effective Positive Outcomes for Children and Families provides a thorough assessment of the economic impact of the service provided by The Place2Be. The service intervenes early, targeting children who are at risk now to prevent deteriorating mental health outcomes in the future. A quantitative impact assessment of this kind of early intervention strategy is both challenging and essential.

The assessment is challenging because establishing the statistician’s perfect ‘control group’ – children who are at risk but who are not treated – is not an option. The authors rise to the challenge, presenting a range of convincing evidence. The service’s cost efficiency is striking, and suggests that investing in services today could generate savings tomorrow if more costly intervention is avoided. And its short term impact is clear, with close to half of the children studied moving from an ‘abnormal’ or ‘borderline’ mental health assessment to ‘normal’ status after counselling.

It is essential because future benefits can be overlooked by ‘short-termism’ in economic decision making. The report tackles this head on, clearly setting out the benefits – including in educational performance and employment outcomes – that improved mental health can bring. By combining these elements – cost efficiency, short term impact, and long term benefits – the report strongly supports The Place2Be’s work. In doing this, Cost Effective Positive Outcomes for Children and Families shows how taking the decision to intervene early can be the right thing to do for children at risk, and for the wider economy.

Dr Lynne Friedli and Michael Parsonage
Dr Lynne Friedli is a mental health promotion specialist and internationally respected author. One of her recent publications was published by the World Health Organisation’s European Office.

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Richard Davies
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Is this a ‘worthwhile’ exercise?
Benita Refson OBE, Chief Executive

Monitoring and evaluating the impact of our work has been a central premise since we were founded in 1994. In 2006, when commissioning was intended to become the most efficient and effective way of purchasing services, we were increasingly being asked to identify our unit costs and impacts. At that time we were a little uncertain as to how best to approach this in a meaningful way, but recognised the importance of not only demonstrating the effectiveness of our work but also the costs, efficiencies, impacts and outcomes of the services we deliver, not just to the lives of children, families and schools, but also to the wider community and society.

We invited Economists, Clinicians, Commissioners and leading Grant Making Trusts to a workshop to get an insight into how we could best approach this. With their help we identified that by employing a Business Impact Analyst we could uniquely, for a voluntary sector organisation, attempt to ‘crack this nut’. Thanks to a grant from Futurebuilders from 2007 -2009 we started this journey in earnest. This report is one of the outcomes of this ongoing journey.

The work in this report reflects the values of The Place2Be: perseverance, integrity and compassion. We believe it is important to continually question, evaluate, monitor, develop and adapt everything we do based on good evidence, information, instinct and experience, whilst recognising that, like medicine and other fields of human endeavour, it is as much an art as it is a science. By integrating what science through good research is able to show us with the art of practice and working with the complexities of life and human experience we believe we can further illuminate what we and others may need to do to improve the lives and opportunities of children and families.

With today’s deficit reduction agenda and need to reform public services in ways that produce better outcomes it is even more relevant to address costs, price, efficiency, savings, impact and outcomes. In this work we have made an honest (and rigorous) attempt to identify unit costs and extrapolate the costs, savings and impacts of our work to wider society. In the process of undertaking and publishing this work we have invited the views of highly respected experts, including Economists and Clinicians. Their views have been invaluable.

Whilst we recognise the limitations of some of the data and methods we have used and that longitudinal studies with control groups would be of enormous value in the future, and that there are significant costs associated with doing these forms of rigorous social, clinical and economic research, we do though believe that this study makes a worthwhile contribution, certainly to our work and values, but also to the ongoing discussions and debates on children and families overall health, wellbeing and future lives.

A report of this nature is not able to fully take into account the complexity of children’s lives. A qualitative study will help better understand the processes behind the economic figures. To this end we are committed to further work in this field.

As part of our ongoing and rigorous approach, we are continuing to adapt and develop both the data we collect and the methodologies we use to ensure that we build on this work and find ways to provide the means to compare children that are seen within The Place2Be with children in a control group. This will contribute to further economic analysis, and analysis of the impacts and outcomes of our services.

In the meantime, what this report reveals is that the unit costs of providing the services we provide in and with schools are surprisingly low and that the savings to society, both economic and social, are significant.
Children in the 21st century face considerable challenges and stresses, at home, in school, among peers and in their family and other relationships.

The Place2Be is a charity working in schools to improve the emotional wellbeing of children, their families and the whole school community.

There is consistent and strong evidence that good mental health and emotional resilience built in childhood confers lifelong benefits in terms of better health and wellbeing and a greater ability to cope with life’s stresses and strains, challenges and opportunities.

The evidence also suggests that investing in children’s mental health and wellbeing now will pay off in the future, in improved life chances and achievements, better educational attainment, greater productivity, better health, greater community involvement, and less use of health services, social care, criminal justice services and welfare benefits.

The Place2Be therefore decided to conduct an economic analysis to identify the potential long-term economic and social benefits and savings of school-based interventions that intervene early when children first show signs of emotional and behavioural distress in schools.

The focus of this study is on The Place2Be’s individual and group counselling as more robust outcome measures are available for these interventions.

In total, 2,344 children from 119 schools in 13 hubs (or local authority areas) received individual and group counselling through The Place2Be in the 2007/08 academic year. Of these, 1,855 children received individual counselling and 489 children received group counselling.

The Place2Be makes use of the Strengths and Difficulties Questionnaires (SDQ, Goodman) with child, parent and teacher as a brief screening tool to assess the mental health of children, pre- and post-intervention. For the purposes of this study, only those children for whom completed teacher and parent SDQ scores were obtained and who had shown clinically significant improvement were included in the analysis.

Based on outcome measures, it was found that 225 out of these 2,344 children showed clinically significant improvement in their mental health post-intervention. They included 125 cases of full improvement, 75 cases of partial improvement and 25 cases of prevention of mental health problems.

These results lead to the estimate that without The Place2Be’s intervention, 50% of these children’s mental disorders and problems would have continued throughout childhood and 50% would have persisted into adulthood and continued over the individual’s lifetime. Evidence from other studies indicates that the improvements resulting from The Place2Be’s interventions would continue into adulthood in 50% of cases.

It can therefore be inferred that The Place2Be’s individual and group counselling in the 2007/08 academic year achieved 112 cases of mental health improvement and prevention of mental disorders and mental health problems in the short and long term.

The total cost of The Place2Be’s individual and group counselling in the 2007/08 academic year was £2 million: £1.3 million in direct costs and £0.7 million in indirect costs.
By drawing on studies of the costs of mental disorder and the savings from preventing childhood conduct disorder to calculate the potential total cost savings that could be achieved by The Place2Be’s individual and group counselling, it can be estimated that the total savings over the lifetimes of this group of 112 children could be £15 million. This breaks down into £10.2 million for those children achieving full mental health improvement; £4.4 million for those achieving partial improvement; and £0.58 million for those where development of mental health problems was prevented.

Moreover, the benefits accrue not just to these individuals themselves, but to their families and to society more widely in terms of reduced use of health and welfare services and increased economic productivity.

These cost-savings exceed the costs of providing the service by £13 million – a net return on investment of 600%. Moreover, the initial costs of the intervention are repaid after five years, with net cost savings in the years thereafter.

Much of the evidence on which these calculations are based is necessarily speculative, and based on limited hard data. Nevertheless, given the benefits such interventions may bring over a child’s lifetime in terms of helping them achieve their fullest potential and avoiding the burden of mental ill health and all that goes with it, such speculation makes a valid contribution to a growing evidence base.

What can be said with confidence is that the interventions provided by The Place2Be help many vulnerable children in the short term and, if these short-term benefits are maintained, they provide a foundation for long-term improved resilience and mental wellbeing, and consequently financial and human cost savings are likely to accrue leading to cost effective positive outcomes for children and families.

What no one disputes is that we owe it to our children and, indeed, to our future social and economic prosperity, to invest in protecting and promoting the emotional and mental wellbeing of children and families.
Children in the 21st century face considerable challenges and stresses, at home, in school, among peers and in their family relationships.

- Surveys of school-age children today present a vivid picture of their concerns. In the most recent TellUs national survey (100 children in years 6, 8 and 10, aged 6–16) (Chamberlain et al, 2010), more than half (51%) said they were worried about exams; 43% worried about the future and what they were going to do after they left school; nearly a third were worried about friendships (31%), and a similar number by ‘The way I look’ (30%). Other common concerns included ‘My parents or family’ (29%), ‘Being healthy’ (26%), ‘Money’ (26%), and ‘Being bullied’ (25%). Girls were more likely than boys to worry about exams and the future, friendships and family, how they looked, and being healthy.

- While more than two thirds of the children and young people in this survey (67%) said they were happy at that particular moment, and 64% said they could talk to their parents if they had any worries, or to their friends (66%) or another adult (40%), this still leaves a significant number who were not in this position. The annual surveys also show a small but clear decline in numbers of children who do have someone in whom they can confide. The overall picture is of a generation of young people growing up under increasing pressures to achieve, yet facing an increasingly uncertain future, and under considerable social and peer pressures.

- These social and peer pressures include use of alcohol and drugs. While two thirds (68%) of these young people had never drunk alcohol, four per cent had been drunk twice in the previous four weeks, five per cent had been drunk three or more times in the last four weeks, and nine per cent had taken drugs. They are small numbers, but they reflect trends in the adult cultural environment.

- Bullying is a major stressor for a significant number of children. In the TellUs4 survey, around half (46%) of the children and young people said they had been bullied at school and 21% outside school. Overall, 29% of children and young people said they had been bullied in the last year, 18% in the past four weeks in school and 24% outside school.

- The UK is uncomfortably far from the haven of happy childhood that we might like to believe. Unicef (2007) states: ‘The true measure of a nation’s standing is how well it attends to its children – their health and safety, their material security, their education and socialisation, and their sense of being loved, valued, and included in the families and societies into which they are born.’

- Yet, according to the recent Unicef (2007) survey of children’s wellbeing in the world’s richest nations, the UK has the highest percentage of children living in poverty (households with an income of less than 50% of the median) – second only to the US.

- Moreover the UK ranks consistently low, or lowest, on a number of key measures, including the health of its children and young people, their sense of life satisfaction and wellbeing, their experience of violence and bullying, and their family cohesion. Our children and young people are least likely to describe their peers as ‘kind and helpful’. Families in the UK are least likely to sit down to a meal together regularly – although parents in the UK are more likely than parents in many other countries to spend time ‘just talking’ to their children.

The knock-on effect on children’s emotional and mental health and wellbeing should not surprise us.

- Mental health problems often start in childhood. Half of young adults with mental health problems first developed symptoms by age 15 years, and 75% had symptoms in their late teens (Kim-Cohen et al, 2003; Kessler et al, 2005).

- Early adult depression is commonly preceded by childhood anxiety; adult anxiety is preceded by both depression and anxiety (Kim-Cohen et al, 2003).
One in ten children aged 5-16 years – three per class in every school in the UK – has a clinically diagnosable mental health problem such as depression, anxiety or psychosis (Green et al, 2005).

Mental health problems in childhood can seriously impact on a person’s life chances. Good mental health is associated with good educational outcomes, better employment prospects, and greater capacity to maintain emotionally satisfying interpersonal relationships. Mental ill health in childhood is also associated with poorer physical health in adulthood (Foresight Mental Capital and Wellbeing Project, 2008).

Mental health and emotional problems in childhood are associated with mental health and conduct disorders in adult life. For example, 80% of children showing behavioural problems at the age of five go on to develop more serious forms of anti-social behaviour (Meltzer et al, 2000).

Conduct and behavioural disorders in childhood are linked with later substance misuse and antisocial personality disorder and also with increased risk of adult depression, anxiety, eating disorders, psychotic disorders and bi-polar disorder (Kim-Cohen et al, 2003).

Over 90% of young offenders have had a mental health problem as a child (Lader, Singleton & Meltzer, 2000).

An estimated one in ten young people in the UK self-harm (Hawton & James, 2005), although the actual numbers may be much higher. Self harm leads to 24,000 hospital admissions among young people per year (Samaritans & Centre for Social Research, 2002). Reasons for self-harm most frequently mentioned by young people include being bullied at school, difficulties with their parents, stress and worry around academic performance and exams, parental divorce, and bereavement. Other factors include problems to do with race, culture or religion, sexuality, self-esteem and feeling rejected (Mental Health Foundation, 2006).

According to the NSPCC, 16% of children aged under 16 have been sexually abused – 5% by an adult stranger, 11% by someone known but unrelated to them, 1% by a parent or carer, and 3% by another relative (NSPCC, 2007). Three-quarters (72%) did not tell anyone about the abuse at the time; 27% told someone later, but nearly a third (31%) had not told anyone about their experience(s) by early adulthood.

At the same time, children also demonstrate considerable resilience and potential for recovery (Maughan & Kim-Cohen, 2005). For example, only half of boys with conduct disorder go on to develop antisocial personality disorder (Maughan & Rutter, 2001), and the majority of children with anxiety or depression will not have mood disorders in adult life (Wals & Verhulst, 2005).

Overall, the data suggest, if more emotional and behavioural disorders among our children and young people could be treated and prevented in childhood, the numbers of people who struggle with mental ill health and diminished opportunities throughout their adult life could be considerably reduced. This, in turn, would generate huge savings in human, social and financial costs.

Note: This report uses the term ‘mental disorder’ to describe psychological or behavioural problems that deviate from the norm, cause significant distress, and meet the threshold for a clinical diagnosis. The term ‘mental health problem’ is used to describe less severe difficulties that do not meet the threshold for a clinical diagnosis but still cause distress and need help. This is in line with the government guidance on child and adolescent mental health services (Department of Health, 2004).
The Place2Be is a charity working in schools to improve the emotional wellbeing of children, their families and the whole school community.

It was established in 1994 in response to increasing concern about the extent and depth of emotional and behavioural difficulties displayed by children in our schools.

The mission of The Place2Be is to enhance the wellbeing and prospects of children and their families by providing access to therapeutic and emotional support in schools, using a proven model backed up by research.

The Place2Be vision is a world where children have the opportunity to grow up with prospects rather than problems.

The aim is to give children the chance to explore their problems through talking, creative work and play, in order to help them cope with current stresses and distress and help prevent more serious mental health and behavioural problems in later life. When children are happier and less preoccupied with problems, they find it easier to learn, and their educational chances are improved, with potential knock-on benefits throughout their adult life.

There is consistent and strong evidence that emotional resilience built in childhood confers lifelong benefits in terms of better mental health and wellbeing and greater ability to cope with life’s stresses and strains (Foresight Mental Capital and Wellbeing Project, 2008).

The Place2Be is currently working with 58,000 children in 172 schools across the UK, often in areas of great deprivation. Services are available to children coping with a range of complex problems such as bereavement, family breakdown, alcohol and drug misuse, domestic violence, physical and emotional abuse, trauma and bullying.
The Place2Be’s school-based service comprises:

- one-to-one counselling sessions
- group sessions
- The Place2Talk – a lunchtime self-referral service, open to all pupils in a Place2Be school (both individuals and in groups)
- transition work – supporting Year 7 and 8 pupils
- A Place for Parents – a counselling service for parents and carers
- liaison and collaboration with other educational and children’s welfare organisations and agencies
- training in promoting children’s mental and emotional health for schools and community groups

This model has three distinctive characteristics:

- it offers a wide range of interventions, including universal, targeted, individual and group work, to meet children’s and families’ needs
- it engages a range of stakeholders (parents, school staff, and staff in other children’s services) in working towards the shared goal of improving children’s mental health and providing support to parents and carers
- it is embedded in the school system and integrated into the day-to-day life of the school, its staff and pupils

These are all recognised as important elements of successful school-based mental health interventions (Adi et al, 2007; Tennant et al, 2007; Rones & Hoagwood, 2000; St John, Leon & McCulloch, 2004).
Outcomes from The Place2Be’s school-based service

The Place2Be evaluates its interventions using a range of validated and widely used outcomes measures (see table 1).

Table 1: Outcomes measures used to evaluation outcomes from The Place2Be interventions in schools

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<tr>
<th>Interventions</th>
<th>Main outcome measurement tools</th>
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<td>Individual and group counselling for children</td>
<td>Goodman’s Strengths and Difficulties Questionnaire (SDQ) – a validated screening tool to assess the emotional and behavioural strengths and difficulties of children and young people (completed by parents, teachers and children) (Goodman, 2006a, 2006b)</td>
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<tr>
<td>The Place2Talk</td>
<td>In house, whole school satisfaction and impact questionnaires (administered to children and school staff)</td>
</tr>
<tr>
<td>A Place for Parents</td>
<td>Clinical Outcomes in Routine Evaluation Outcome Measure (CORE-OM) – a validated tool to assess the global distress levels of adults (administered to parents)</td>
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Counselling

In 2007/08 (the period used for this economic analysis), 2344 children received individual or group counselling and had complete parent-rated (n=946), teacher-rated (n=1655) or self-rated (n=1242) SDQ scores. Of these 71%, 60% and 64% respectively reported reduced total difficulties scores (The Place2Be, 2009a).

The Place2Talk

In a national sample of respondents, 90% of 1208 children who had used The Place2Talk between February 2006 and July 2008 and responded to the question said that the service had been helpful. The overwhelming majority (94%) of the 397 school staff who responded also felt that it had helped the child (The Place2Be, 2009b).

A Place for Parents

A total of 256 parents used A Place for Parents in the 2007/08 academic year. Of the 111 parents for whom complete pre- and post-intervention CORE-OM data were available, 102 (92%) showed a reduction in global distress scores (The Place2Be, 2008a).
The costs of The Place2Be’s school-based service

In 2008/09 The Place2Be’s school services cost in total £4.8 million (see Appendix A for a more detailed breakdown).

The cost per child per annum of the drop-in service, The Place2Talk, was £6.00, with each child receiving on average 0.3 hours of service over a year. Cost per child per annum of one-to-one counselling was £954, with each child receiving on average 51 hours of service over a year. Cost per child per annum of group counselling was £160, with each child receiving on average 21 hours of service over a year.

The cost per case per annum of A Place for Parents was £556, with each parent/s receiving on average 25 hours of service.

The cost per hour of CAMHS generic single and multi disciplinary services (equivalent to tier 2-3 services) in 2008/09 was £33. A clinical service from CAMHS generic single and multidisciplinary services cost £1,744 per case per annum. [do we need a footnote explaining what the tiers are or we could reference the later Figure 1 by way of explanation]

The cost per hour of The Place2Be's parent counselling service was £22 in 2008/09, 31% less than that of adult counselling services (£32) in primary care. [we need a reference here]

It cannot be argued that what The Place2Be offers is in any way equivalent to the CAMHS service. However, as many children supported may otherwise have been referred to CAMHS for counselling, and The Place2Be’s children’s service costs 42% less than the average cost of CAMHS generic single and multi-disciplinary services, there is likely to be, for at least some children, immediate cost savings due to the interventions.
All improvements in children’s mental health and wellbeing are to be welcomed. However interventions need to be able to demonstrate short and long-term cost-effectiveness as well as clinical improvements.

The evidence suggests that investing in children’s mental health and wellbeing now will pay off in the future, in improved life chances and achievements, better educational attainment, greater productivity, better health, greater community involvement, and less use of health services, social care and welfare benefits (Foresight Mental Capital and Wellbeing Project, 2008).

The Place2Be therefore decided to conduct an economic analysis to identify the long-term savings our interventions could potentially achieve by intervening early when children first show signs of emotional and behavioural distress in schools.

It was decided to focus solely on The Place2Be individual and group counselling. The analysis used SDQ outcome measures, together with evidence from other research studies of interventions and evidence-based estimates of the economic and social costs of mental disorder and mental health problems.

**The Place2Be’s school-based individual and group counselling for children**

The Place2Be’s individual and group counselling is targeted at those children who present emotional/behavioural difficulties in school. The children are referred by school staff, parents and others to The Place2Be’s school project managers. They undertake an initial assessment of the severity of the children’s problems and risk and protective factors for the children and their families. The initial assessment also includes the use of the SDQ. Following assessment, the school project managers will refer the children to short or long term individual or group counselling and sometimes to external agencies if necessary. If the children take up The Place2Be’s individual and group counselling, the SDQ scores obtained during the assessment provide a baseline for measuring progress post-intervention.

The Place2Be core model is guided by a variety of counselling approaches. It is a targeted, preventative intervention primarily aimed at achieving mental health improvement in children at risk of going on to develop lifelong mental disorders. It achieves this by building on their strengths and helping them to *make sense of the feelings and thoughts they have in coping with the difficulties in their lives*.

Figure 1 illustrates where The Place2Be’s counselling services fits within the common framework of child mental health services and the four-tier CAMHS framework.
The individual counselling is delivered by The Place2Be counsellors in a designated room on the school premises equipped with play materials for the children. The counsellors are qualified or trainee counsellors who volunteer to work with The Place2Be for at least a day a week during term time over a year. Individual counselling lasts between one academic term and one academic year. On average, 16 individual counselling sessions are provided to each participating child.

Group counselling focuses on the issues that the children bring to the sessions and on particular themes or topics that the children have in common, such as transition, relationships, bullying. Groups sessions are facilitated by The Place2Be school project managers and counsellors or other experienced school staff for an average of six to eight children, usually in another room in school that offers privacy. Group counselling usually runs for eight sessions over one school term.

**Outcome measures**

The SDQ is a brief screening tool to assess the mental health of children and young people (aged 3–16). It has three versions: one for parents, one for teachers and one for children aged 11 and over (who are deemed able to understand the questionnaire). It produces a ‘total difficulties’ score for negative emotional symptoms and behaviours, and a total ‘prosocial score’ for positive behaviours. A higher total difficulties score indicates more serious mental health problems and emotional and behavioural difficulties in children; a higher prosocial score indicates good mental and emotional health.
A longer version of the SDQ includes an impact supplement that asks the respondent (teacher, parent and child) whether overall the child (or him or herself) has any difficulty with emotions, concentration, behaviour or relationships with others and whether this has affected their daily life, learning and interaction with others. The higher the impact score, the more serious is the impact of the child’s mental health problems and emotional and behavioural problems.

The SDQ total difficulties scores are subdivided into three bandings: abnormal, borderline and normal (Table 2) (Goodman, 2006a; Goodman, 2006b). The Place2Be equivalents are high risk, moderate risk and no risk.

Table 2: The clinical categories of the SDQ total difficulties scores

<table>
<thead>
<tr>
<th></th>
<th>Parent-rated SDQ total difficulties scores</th>
<th>Teacher-rated SDQ total difficulties scores</th>
<th>Self-rated SDQ total difficulties scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abnormal (High risk)</td>
<td>17 40</td>
<td>16 40</td>
<td>20 40</td>
</tr>
<tr>
<td>Borderline (Moderate risk)</td>
<td>14–16</td>
<td>12–15</td>
<td>16–19</td>
</tr>
<tr>
<td>Normal (No risk)</td>
<td>0 13</td>
<td>0 11</td>
<td>0 15</td>
</tr>
</tbody>
</table>

The Department of Health’s best practice guidance on child and adolescent mental health services (2004) recognises a difference between childhood mental disorders that meet the threshold for a clinical diagnosis and childhood mental health problems that fall short of this threshold. The two most recent national surveys of child mental health in 1999 (Meltzer et al, 2000) and in 2004 (Green et al, 2005) both found a prevalence rate of mental disorders of almost 10% among children aged 5–15 (ie. high risk). Goodman (2006a, 2006b) found that 10% of children fall within the borderline category (ie. moderate risk).

The aims of The Place2Be’s individual and group counselling are to help relieve existing mental health problems in children and to prevent the children in the high risk and moderate risk categories from developing full mental disorders or mental health problems later on. The indicator of success is an improvement in SDQ scores post-intervention that moves them out of these categories and, ideally, into the no risk group.
5. Our findings

A word of caution

Before reporting the process and findings of our economic analysis, we want to be completely upfront about the strength and validity of the evidence on which our calculations are made.

Some of this evidence is necessarily speculative. There are also some gaps in the data, learning and research (not just our own but those from external sources and in the published literature) available to us, which imposes limitations on what we can say with total confidence and credibility.

We did not have access to randomised controlled trial data. Nor did we have data that would allow us to track the outcomes of our individual and group counselling over time. We had no control group with which to compare the outcomes of our study group. We cannot rule out conclusively the influence of other factors on the mental health improvements noted in the children receiving our counselling services.

There is also a lack of accurate research data on the full costs of mental disorders and mental health problems that would allow us to estimate more confidently the costs that would be saved from the prevention of mental disorders and mental health problems.

We have therefore had to make a number of measured and conservative assumptions to arrive at our estimate of the benefits of our intervention. To argue that improvement following a year of individual or group counselling in childhood will persist and prevent future mental health problems and related costs over a person’s lifetime is itself a bold deduction from the research and statistical data available to us.

We make no attempt to hide these critical unknowns, not least of which is the impossibility of pinpointing with total confidence which factors contributed to the improvement seen in the children with whom we worked, and how much influence can be attributed solely to The Place2Be’s intervention.

What we do have is robust evidence that a significant number of children receiving our counselling services do show improvements in the short term at least. We also now have a detailed map that shows not only the journey that needs to be undertaken if such an economic analysis is to be produced but also those precise points where more research needs to be undertaken and where data from external sources is either too vague or inadequate to allow us to proceed to our end point with confidence.

Moreover, we have consulted widely on this analysis. The experts to whom we sent this report have highlighted the limitations outlined above, but have also in many cases strongly endorsed our conclusions. Some have argued that we have been too conservative in our assumptions. We have not, for example, costed in possible reductions in criminal behaviour in adult life of those children receiving our intervention – an area for further exploration, as there is robust and increasing evidence that crime is linked with childhood conduct disorder, and also imposes very high costs on society.

We have been advised that we have been too anxious not to overstate our case: that there will always be uncertainties over the value added by ‘pay now, save later’ early intervention schemes. We have also been told that we have been overly cautious in our estimate of the degree of improvement achieved by our intervention with these children.
As explained below, we have included only those children whose parents and teachers agreed on their rating of their mental health and emotional well-being. There were a further 153 children where the parents and teachers agreed there were mental and emotional health problems but disagreed as to their severity. Their positive outcomes might have been added to the total numbers of improved cases. Moreover, we have not included in our analysis the immediate (as well as long-term) savings incurred by intervention with those children with the greatest mental and emotional health needs.

This breadth of commentary from experts in child mental health and economics arguably balances out at the point where we can say with confidence that the limitations in our analysis can be accommodated comfortably within the margin of our final estimate of savings.

The analysis

In total, 2344 children from 119 schools in 13 hubs (or local authority areas) received individual and group counselling through The Place2Be in the 2007/08 academic year. Of these, 1855 children received individual counselling and 489 children received group counselling.

We included in our analysis only those children for whom we had complete pre- and post-intervention teacher and parent SDQ scores. This combination has been shown to provide a more accurate picture of risk than either teacher/child or parent/child combined information. The information given by teachers and parents also complements each other: the former are better at picking up externalised mental disorders and the latter better at picking up internalised mental disorders (Goodman et al, 2000).

We had complete parent and teacher pre- and post-intervention SDQ scores for 936 (40%) of the 2344 children. Pre-intervention, 322 (34%) had SDQ total difficulties scores within the high risk range, and 34 (4%) had scores within the moderate risk range (see Table 3 and Figure 2).

Table 3: SDQ total difficulties scores pre intervention – teacher and parent ratings (cross tabulated)

<table>
<thead>
<tr>
<th>Number of children in the SDQ clinical categories before intervention</th>
<th>Teacher-rating</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Abnormal</td>
</tr>
<tr>
<td>Parent-rating</td>
<td></td>
</tr>
<tr>
<td>Abnormal</td>
<td>322</td>
</tr>
<tr>
<td>Borderline</td>
<td>69</td>
</tr>
<tr>
<td>Normal</td>
<td>110</td>
</tr>
</tbody>
</table>
Post-intervention, 90 children showed improved SDQ scores: 80 (25%) of the 322 children who were high risk pre-intervention had moved into the moderate or no risk categories and 10 (29%) of the 34 children who were at moderate risk pre-intervention had moved into the no risk category (see Figure 3).

The improvements in these 90 children could be further categorised in three groups:

- 30 children in the high risk group had moved one level up to the moderate risk group. We defined this as partial improvement – they were now at reduced risk of mental disorder, but they were still at risk of mental health problems
- 50 children in the high risk group had moved two levels up, directly into the no-risk group. We defined this as full improvement
- 10 children in the moderate risk group had moved one level up to the no-risk group. We defined this as the prevention of mental health problems (see Table 4).
It was also important to calculate the likely outcomes for the 1408 children who received The Place2Be individual and group counselling but for whom there were no completed parent and teacher-rated SDQs. Of these, 480 (34%) could be considered at low risk of mental disorders, as they participated in thematic group work, for which only teacher-rated SDQs are required. The others could be considered as having significant and perhaps greater problems than the children and families with complete outcome data. This is because the main reasons for the incomplete parent or teacher SDQ data were either that the parent(s) could not be contacted, or the child continued to receive counselling support into the next academic year.

It was assumed that the same pattern of improvement in mental health would occur in these 1408 children as found in the group for which full data sets were available. It was calculated that, as 1408 is 1.5 times greater than 935, proportionately this group would therefore include 75 cases of full improvement, 45 cases of partial improvement and 15 cases of prevention of mental health problems.
This brought the total for the year 2007/08 to 225 out of the 2344 children receiving The Place2Be counselling who showed clinically significant improvement in their mental health post-intervention. They included 125 cases of full improvement, 75 cases of partial improvement and 25 cases of prevention of mental health problems following intervention.

**Long term benefits**

It was now necessary to estimate how many of these children would, without The Place2Be’s intervention, have continued to experience mental disorders and problems into adulthood and over their lifetime.

Research shows that:

- between 20% and 45% of childhood conduct disorders persist into adulthood (Earls & Mezzacappa, 2004; Maughan & Rutter, 2001; Stewart-Brown, 2004)
- 14%–18% of boys and 15%–31% of girls continue to have severe emotional problems and 39%–58% of boys and 46%–58% of girls continue to have mild/moderate emotional problems in adulthood (Richards et al, 2009)
- half or more cases of hyperactivity in early childhood persist into adolescence, and half or more cases in adolescence persist into adulthood (Schachar & Tannock, 2002)

There is also good evidence that childhood mental disorders can develop into other types of mental disorder in adulthood:

- childhood conduct and behavioural disorder is associated with anxiety, depression, substance dependence, schizophrenia, and mania in adulthood (Kim-Cohen et al, 2003; Maughan & Rutter, 2001)
- depression in childhood increases the risk of developing anxiety disorders in adulthood (Kim-Cohen et al, 2003)
- anxiety disorders in childhood increase the risk of developing depressive disorders in adulthood (Kim Cohen et al, 2003; Klein & Pine, 2002)

Moreover, conduct disorders combined with hyperactivity/attention disorders in childhood increase the risk of conduct disorders in adulthood and result in still worse antisocial outcomes (Hill, 2003; Scott, 1998).

Drawing on these studies, it was estimated that, without The Place2Be’s intervention, 50% of these children’s mental disorders and problems would have continued throughout childhood and 50% would have persisted into adulthood and continued over the individual’s lifetime.
Long term follow up data

As mentioned earlier in the report, there is an absence of comparative, randomised controlled trial (RCT) and long-term follow-up data that would have shown whether the effectiveness of The Place2Be’s individual and group counselling persisted over time and any confounding factors and subsequent deterioration.

Based on the latest and emerging research knowledge on the life course of mental disorders a crude and very conservative assumption was made that the improvements seen following The Place2Be’s individual and group counselling would continue into adulthood in only 50% of the cases.

Thus, it was estimated that The Place2Be’s individual and group counselling in the 2007/08 academic year achieved short and long term mental health improvement in 112 children: 62 cases of full improvement, 38 cases of partial improvement and 12 cases where mental health problems were prevented (Table 5).

Usefully, the same figure appeared when calculating the proportionate long-term outcomes in comparison with other studies of interventions with children that used different approaches over longer periods of time.

Table 5: Prevention of mental disorders and mental health problems due to The Place2Be’s individual and group counselling in the 2007/08 academic year

<table>
<thead>
<tr>
<th>Due to the intervention</th>
<th>Among all participants of the individual and group counselling in the 2007/08 academic year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mental disorders/problems that otherwise last during childhood</td>
</tr>
<tr>
<td>Prevention of mental disorder (full improvement)</td>
<td>Number of children $-125/2/2 = 31$</td>
</tr>
<tr>
<td>Prevention of mental disorder (partial improvement)</td>
<td>Number of children $-75/2/2 = 19$</td>
</tr>
<tr>
<td>Prevention of mental health problem</td>
<td>Number of children $-25/2/2 = 6$</td>
</tr>
</tbody>
</table>
To calculate the full costs of mental ill health, it is necessary to include not just the health care and other service and capital costs but also associated human costs above and beyond those incurred by people who do not have a mental disorder or mental health problem, including the impact on carers (Knapp, 2003).

Table 6 lists these extra costs of a single case of mental disorder over a lifetime, from age nine to age 64. This is likely to be a conservative estimate, but reliable data to support links with other costs – for example, criminal activity in adult life – are not available. The total cost is £247,612 (in 2007/08 prices): that is, £32,346 over childhood (age 9–15), and £215,266 over adulthood (16–64).

### Table 6: Extra costs of a case of mental disorder over a lifetime from age 9 to age 64 (2007/08 prices)

<table>
<thead>
<tr>
<th>Costs</th>
<th>Costs from age 9 to age 64 (2007/08 prices)</th>
<th>% of total cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human costs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mort morbidity of mental disorder</td>
<td>£13,052</td>
<td>55%</td>
</tr>
<tr>
<td>Mort morality of mental disorder</td>
<td>£80</td>
<td>0%</td>
</tr>
<tr>
<td>Health and social service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health and social service</td>
<td>£25,017</td>
<td>10%</td>
</tr>
<tr>
<td>Education service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education service</td>
<td>£3,449</td>
<td>1%</td>
</tr>
<tr>
<td>Impact on carers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health and social service used by carers</td>
<td>£973</td>
<td>0%</td>
</tr>
<tr>
<td>Time off work due to caring responsibility</td>
<td>£1,708</td>
<td>1%</td>
</tr>
<tr>
<td>Output loss</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unemployment</td>
<td>£47,004</td>
<td>19%</td>
</tr>
<tr>
<td>Sick leave</td>
<td>£18,370</td>
<td>7%</td>
</tr>
<tr>
<td>Mortality of mental disorder</td>
<td>£69</td>
<td>0%</td>
</tr>
<tr>
<td>Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefits payment</td>
<td>£13,552</td>
<td>5%</td>
</tr>
<tr>
<td>Cost of administering benefits</td>
<td>£339</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>£247,612</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Note:** These costs are reported in 2007/08 prices. Future values are discounted by 3.5%, in line with HM Treasury approved methodology (HM Treasury, 2003). The calculation also assumes that costs grow in line with real GDP – an approach taken by other cost-of-illness studies (McCrone et al, 2008; Sainsbury Centre for Mental Health, 2003).

a. Cost of morbidity is the cost of the negative impact of mental disorders on the full quality of life of people with disorders and the cost of mortality is the cost of human life from premature death caused by mental disorders.

b. The cost of output loss due to mortality of mental disorders is the cost of lost earnings and productivity from premature death caused by mental disorders.
The next phase of the analysis calculated the cost-savings of preventing mental ill health by drawing on two studies of conduct disorders and conduct problems (see Figure 4).

Figure 4: Extra costs of mental disorders and problems and cost-savings of prevention

One study (Scott et al, 2001) followed up a group of children sub-divided into those with conduct disorders, those with conduct problems and those with no conduct problems, from age eight to 28. The other study (Friedli & Parsonage, 2007) used the primary data from a New Zealand longitudinal study of adolescent and adult psychosocial functioning to estimate lifetime costs of conduct disorders. Childhood conduct problems were assessed when the participants were seven to nine years old and the participants were followed up to age 25. (This analysis included costs that were not covered by the Scott et al study, which explains their higher totals. (Table 7))

Table 7: Extra costs of conduct disorder and conduct problem (Scott et al, 2001; Friedli & Parsonage, 2007)

<table>
<thead>
<tr>
<th>Conduct disorder</th>
<th>Costs to society per case (1998 prices)</th>
<th>Number of cases</th>
<th>Costs to society per case (2006 prices)</th>
<th>Number of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£70,019</td>
<td>16</td>
<td>£225,000</td>
<td>5% of the whole cohort</td>
</tr>
<tr>
<td>Conduct problem</td>
<td>£24,324</td>
<td>61</td>
<td>£75,000</td>
<td>45% of the whole cohort</td>
</tr>
<tr>
<td>No problem</td>
<td>£7,423</td>
<td>65</td>
<td>£0</td>
<td>50% of the whole cohort</td>
</tr>
</tbody>
</table>
From these studies, we calculated that, if the extra cost of a case of conduct disorder is $A$, the cost-savings of moving a case of conduct disorder to no problem are on average 117% of $A$; the cost savings of moving a case of conduct disorder to conduct problem are on average 82% of $A$, and the cost savings of moving a case of conduct problems to no problem are on average 35% of $A$.

### Total cost savings

The total cost of The Place2Be’s individual and group counselling in the 2007/08 academic year was £2 million: £1.3 million in direct costs and £0.7 million in indirect costs.

From this it can be deduced that the potential total cost savings that could be achieved by The Place2Be’s individual and group counselling with this group of 112 children could be £15 million over their lifetime. This breaks down into £10.2 million for those children achieving full mental health improvement; £4.4 million for those achieving partial improvement, and £0.58 million for those where development of mental health problems was prevented (Table 8).

<table>
<thead>
<tr>
<th>Due to the Intervention</th>
<th>Mental disorders/problems that otherwise last during childhood Saving per child</th>
<th>Mental disorders/problems that otherwise last over lifetime</th>
<th>Adjusted saving per child</th>
<th>Total Cost Saving</th>
<th>Adjusted saving per child</th>
<th>Total Cost Saving</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention of mental disorders (full improvement)</td>
<td>£10,154,077</td>
<td>£1,743,509</td>
<td>£35,872,912</td>
<td>£13,358,667</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevention of mental disorders (partial improvement)</td>
<td>£4,360,188</td>
<td>£252,303</td>
<td>£203,942</td>
<td>£3,857,795</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prevention of mental health problems</td>
<td>£58,912</td>
<td>£6,892</td>
<td>£86,664</td>
<td>£3,199,985</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>£15,102,176</td>
<td>£75,608</td>
<td>£579,412</td>
<td>£13,358,667</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Moreover, the benefits accrue not just to these individuals themselves, but to their families and to society more widely (Figure 5). The savings in human costs (58%) are by far the greatest, but significant savings also accrue to health and social care services, alongside a major contribution to the national economy in terms of increased productivity and reduced benefits payments.

**Figure 5: Who are the beneficiaries of The Place2Be’s individual and group counselling?**

These cost-savings exceed the costs of providing the service by £13 million – a net return on investment of 600%. So, every pound invested in The Place2Be’s school-based individual and group counselling produces £6.00 net return. This is much higher than the net returns on investment in many public and private businesses (Lynch, 2004).

Moreover, the initial costs of the intervention are repaid after five years, with net cost savings in the years thereafter (Figure 6).
Break-even point: 5th year after the intervention

Figure 6: Annual net cost-savings of The Place2Be’s individual and group counselling over the lifetime of the participating children.
Based on very cautious estimates, this economic analysis shows that, of 2344 children receiving individual and group counselling from The Place2Be in one year at a cost of £2 million, 112 will avoid long-term mental disorders and mental health problems over their lifetime, with a consequent saving of some £15 million in health and welfare spending, lost productivity and other costs to the national economy.

The findings support a strong, if speculative, case that The Place2Be’s mental health interventions in schools could produce considerable cost-savings in the short and long term that would repay the initial investment after five years and produce net gains thereafter.

We fully and freely acknowledge that much of the evidence on which we made our calculations is based on limited hard data. We have had to make several assumptions to arrive at our estimate of the outcomes achieved by our intervention. We have made no attempt to hide the number of critical unknowns, not least of which is the impossibility of pinpointing with total confidence which factors contributed to the improvement, and how much influence can be attributed solely to The Place2Be’s intervention.

However, given the benefits such interventions may bring over a child’s lifetime in terms of helping them achieve their fullest potential and avoid the burden of mental ill health and all that goes with it, we consider such speculation makes a valid contribution to a growing evidence base.

Our assumptions, where we have made them, are extremely conservative. If we make still more conservative estimates (that, say, only 30% of childhood mental health problems persist into adulthood), the margin of savings is still so great that we are still left with a comfortable surplus. And even these most conservative estimates demonstrate the huge value of our interventions. We intend over time to update these data as more robust data become available.

We can say with confidence that the interventions provided by ThePlace2Be help many vulnerable children in the short-term at least and, if these short-term benefits are maintained and provide a foundation for long-term improved resilience and mental wellbeing, then financial and human cost savings are likely to accrue.

We have consulted widely on this economic analysis, and received detailed and constructive comment on the limitations of our evidence. All the responses underline the need for more, and more detailed research data before we can argue with total confidence for the cost-effectiveness of the services in terms of their long-term preventative impact. Indeed, this is one of the most powerful messages emerging from this work: that if the government and health commissioners are keen to have access to high quality analyses of this kind to inform policy-making, commissioning priorities and future development, then the necessary research needs also to be commissioned and funded.

What no one disputes is that we owe it to our children and, indeed, to our future economic prosperity, to invest in protecting and promoting children’s and families’ emotional and mental wellbeing.
References


References...


Appendix A

Unit costs of The Place2Be’s school services in 2008/09

1 Total cost of school service

In 2008/09, the total cost of The Place2Be’s school services was £4.8 million, comprising £3.1 million hubs costs and £1.7 million Core Hub costs. The Core Hub costs covered support for the school service in the hubs, including recruitment and training of volunteers and staff, research and evaluation for the service, fundraising, commissioning support and reporting and general administration.

Of the total £4.8 million costs, £4.5 million derived from The Place2Be children’s service and £0.3 million from the parents’ service.

This represents an 18% increase from the previous year, on a 10% increase in the number of schools served (an additional 12 schools).

2 Average unit cost for children’s service and parents’ service

In 2008/09, the Place2Be’s children’s service reached 132 schools and 42,370 children in 14 fully operational hubs. The average cost per school per annum for The Place2Be’s children’s service was £33,767. The average cost per child per annum for The Place2Be’s children’s service was £105.

In total, 237,144 hours of children’s service were provided in the 2008/09 financial year at an average cost of £19 per hour.

In total, 13,849 hours of parents’ service were provided in the 2008/09 financial year at an average cost of £22 per hour.

3 Service-specific unit costs for The Place2Be’s children’s service and parents’ service

In 2008/09 the cost per child per annum of The Place2Talk was £6, with each child receiving on average 0.3 hours of service over a year. Cost per child per annum of one-to-one counselling was £954, with each child receiving on average 51 hours of service over a year. Cost per child per annum of group counselling was £160, with each child receiving on average 21 hours of service over a year.

In 2008/09 the cost per case per annum of A Place for Parents was £556, with each case receiving on average 25 hours of service.
4 The Place2Be’s children’s service compared with CAMHS tier 2-3 services on unit cost and cost-effectiveness

In 2008/09, the cost per hour of CAMHS generic single and multi disciplinary services (equivalent to tier 2-3 services) was £33. A clinical service from CAMHS generic single and multidisciplinary services cost £1,744 per case per annum.

The comparable cost per hour of The Place2Be’s children’s service is 42% less than the average cost of CAMHS generic single and multidisciplinary services [42% = (£33-£19)/£33].

The comparable cost per case per annum of The Place2Be’s one-to-one work is 45% less than that of CAMHS generic single and multi disciplinary services in 2008/09 [45% = (£1,744-£954)/£1,744].

Based on 2007/08 output and outcome data, The Place2Be’s one-to-one work was dealing with children with similar levels of difficulties prior to intervention as were CAMHS tier 2-3 services, and achieved similar positive outcomes after the interventions, as demonstrated by the parent and child rated SDQs, while operating at lower cost. To some extent, this supports the hypothesis that The Place2Be’s one-to-one work is more cost-effective than CAMHS tier 2-3 services.

5 Unit costs of The Place2Be’s parents’ service compared with adult mental health services in primary care

Cost per hour of The Place2Be’s parent counselling service, A Place for Parents, was £22 in 2008/09, 31% less than that of adult counselling services (£32) in primary care in the same year.
Notes

1 All the costs are at 2008/09 prices.

2 The Place2Be’s parents’ service includes A Place for Parents, Parent Partnership and other support for parents.

3 The Research and Evaluation team collect output data by academic year, on an end of term basis. The 2008/09 financial year output data comprises output data from summer term 2008, autumn term 2008 and spring term 2009 (i.e. April 2008 through to April 2009). This allows us to ‘match’ the output data to the conventional 2008/09 financial year time frame (i.e. from April 1st 2008 to March 31st 2009). Two hubs (Cardiff and Leeds) are in development and their costs are counted as development costs, instead of school service cost.

4 The average hours of service received by a case over a year include referral and assessment time, sessions, and preparation for the sessions. The average hours of service received by a case in group counselling over a year consist of six hours of referral and assessment and 15 hours of session time shared with on average five other group members.

5 CAMHS teams are usually described with the tier 1-4 framework. A new set of CAMHS team types – generic single disciplinary team, generic multi disciplinary team, targeted team, and dedicated team – were developed during the CAMHS mapping exercise to better describe the function of the different CAMHS teams in operation. The first two team types are at tiers 2/3 level. The Place2Be offers a service similar to CAMHS generic single and multidisciplinary teams at tiers 2/3 level (see Curtis, 2009, pp140-143).

6 CAMHS unit cost figures are quoted from Curtis L (2009). Unit costs of health and social care. London/Kent/Manchester: Personal Social Services Research Unit and have been further adjusted to be directly comparable with The Place2Be unit cost.

7 The outcome of the CAMHS service is from a small but fairly representative sample of CAMHS teams that submitted their outcome data to CAMHS Outcomes Research Consortium (CORC).

8 Cost per hour of counselling service at primary medical care is taken from Curtis (2009).

Curtis L (2009). Unit costs of health and social care. London/Kent/Manchester: Personal Social Services Research Unit. WHERE TO REFERENCE THIS TO SAYS CATHERINE??