Mental health care in England: dawn of a new era

Dr. Geraldine Strathdee, National Clinical Director for Mental Health

@DrG_NHS

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What are our 5 aims for lifespan mental health?

1. **Building resilient individuals and communities**: To continue to build public and political support for mental health reform through increasing awareness of the individual and societal benefits of positive mental health & awareness of the types & causes of mental illness, in order to transform attitudes to mental health & reduce stigma. The power of social media & digital enablers are key & new attitudes to universal Integrated care & adult education.

2. **Preventing mental ill-health**: To understand and maximize the opportunities for prevention of mental ill-health, and the promotion of mentally healthy and resilient individuals and communities.

3. **Introducing 24/7 access standards to timely, effective care with outcome measurement**: When a person develops mental illnesses, they have timely access to personalized, integrated, holistic, effective, high quality treatments, that optimizes the health & functional outcomes & quality of life for individuals, their families, takes place in the community or in the persons home, & reduces unnecessary use of restrictive care.

4. **Integration & Transformation of care & services**: When a person’s illness is complex and severe, and requires specialist interventions, that the care provided, is personalized, culturally appropriate, delivered in the least restrictive settings and 24/7 personalized home care services where safe by trained and supported staff.

5. **Building a compassionate coaching models of care and a sustainable future**: To develop & deliver the transformation needed, though creation of an expert ‘state of the art’ leadership development, implementation & improvement programme and promotion of a Learning Organization model throughout all our commissioned healthcare organizations.
The 5 Year Forward View Lifespan approach

...........starting to be tested out in the Devos & Vanguards & innovative sites
Why do we need a lifespan approach

The science: The scientific developments from many disciplines & powerful patient narratives are leading to a growing international consensus on the causes, triggers, the ‘science’ of mental health & the treatment of illness of the 16 conditions

- 70% of all mental ill health has started before the age of 24 years. Mobility & life course transitions are key times of vulnerability for all ages

The economics: In England, we spend a lot of money on mental health, but we spend it on dealing with the consequences of NOT investing in prevention & early access to treatment,

- a lot of lives are lived in misery, children brought up in abuse
- People are unable to stay in, or secure employment
- ‘Mind’ and ‘body’ ‘illness’ are treated in silos, so people’s outcomes are poor
- Our communities and country has less economic wealth and less social capital than an evidence based pattern of leadership & investment would enable
- The values and ambitions of the 5 year Forward View is an excellent opportunity to reverse this poor use of taxpayer spend & lack of value
The 5 Year Forward View Lifespan approach

- Being Born well
- Best early years
- Living and working well
- Growing older well
- Dying well

- Building Positive mental health in individuals & communities
- Prevention of mental ill health
- Improving access to Integrated Timely Effective care for all new patients
- Transformation of services to deliver value, better outcomes, quality & personalized Right Care & integration

To achieve it needs Leaders, information, intelligence, incentives & improvement plans
The major growing public interest in mental health literacy:

- The busting of the 5 great myths
- Time to Change, NHS Choices, Media, Daily Mail.
- The Incredible Crisis Concordat 22 front line community agency whole system partnerships
- The social movement 250+k committed MH leaders & @Wes
- The international evidence movement
- Focus on tackling identifying, coding & tackling causes
- The ‘think like a patient, behave like a taxpayer’ new public interest in the way we spend our money…..
Prevention: High impact programmes to build resilient communities & achieve 10%, 20%, 30% prevention & reduced demand

1. England as an international leader
   - On the journey to aim for Zero Child abuse: sexual, physical, emotional

2. Pregnancy:
   - Integrating physical & MH supported healthy pregnancy & relationships

3. Parenting & relationships
   - Offering programmes at pregnancy clinics, primary care & adult education

4. Schools:
   - Resilience embedded in school curriculum & early identification through school nurse and form tutor training & Governors for well-being & resilience

5. Employers
   - Incentivisation of Positive productive employment practice, occupational health services with mental health training, IPS & jobs
High impact prevention

1. **Alcohol:**
   - strategy needed asap to save £21 billion!

2. **Adult education & TC channels for today’s ‘education’ issues**
   - ‘Build your relationships adult education courses’, finance & debt management, ‘managing obesity’, understanding mood, anger, diabetes

3. **Media & Public campaigns** to build awareness, & reduce stigma

4. **Digital & NHS Choices**:
   - Access to information, peer support, Digital Platforms

5. **Highest NHS Value Prioritizing High risk groups**:
   - e.g. Leaving care CYP, Frequent comers: Frequent crisis, admission, detentions, lack of stable accommodation, transitions
Increasing access to timely, effective services for the 16 mental care pathways, and maximizing digital potential.

Where every contact is a kind, compassionate, coaching experience.

Robust systematic implementation methods over 5-10 years:

- Commissioning guidance
- Baseline audit
- Workforce plans
- Data collection plans
- Accreditation networks
- Build into 5 ALB plans & regulation
- Integral to new science & Big Data plans
The 15/16 Access & Waiting Time Standards

Access to psychological therapies: 75% of people referred to the Improved Access to Psychological Therapies programme will be treated within 6 weeks of referral, and 95% will be treated within 18 weeks of referral.

Access to early intervention for psychosis: More than 50% of people experiencing a first episode of psychosis will be treated with a NICE approved care package within two weeks of referral. The outcomes will be as described:

http://www.england.nhs.uk/2015/02/13/geraldine-strathdee-8/

Access to eating disorder services for CYP

Access to perinatal care

£30m targeted investment on effective models of liaison psychiatry in a greater number of acute hospitals. Availability of liaison psychiatry will inform CQC inspection and therefore contribute to ratings.

<table>
<thead>
<tr>
<th>16 Mental health ‘care pathways</th>
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<tbody>
<tr>
<td>1. Psychoses</td>
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<tr>
<td>2. Depression /Anxiety disorders, Obsessive compulsive, Phobias</td>
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<tr>
<td>3. Organic brain disorders including Dementia</td>
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<tr>
<td>4. Alcohol and drug misuse</td>
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<tr>
<td>5. Somatoform disorders</td>
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<tr>
<td>6. PTSD</td>
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<tr>
<td>7. Eating disorders</td>
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<tr>
<td>8. Perinatal disorders</td>
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<tr>
<td>9. Personality disorders (10)</td>
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<tr>
<td>10. Self harm behaviours</td>
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<tr>
<td>11. Conduct disorders in children</td>
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<tr>
<td>12. ADHD</td>
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<td>13. Autistic spectrum disorders</td>
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What is Right Care in mental health:
Its not just about access times AND the 7 Right Care NICE/SCIE effective care interventions

1. Right information that empowers & enables choice & self management
2. Right Physical health care in primary care & specialist MH providers
3. Right Medication education, Choice, monitoring, support for adherence
4. Right Psychological therapies for individuals, couples, families
5. Right Rehabilitation/ training/ employment
6. Right Care plan for housing, healthy lifestyles, self management
7. Right crisis relapse prevention care plan

In the Right least restrictive setting by the Right trained & supervised team
where every contact is a kind, compassionate, coaching experience

This applies to wider primary care, inpatient & community care specialist mental health and social care providers
Primary Care mental health

Registration:
Introduce patient self completion 1 min ipad integrated assessment at registration

Enhanced SMI care for psychoses
GpwSI
Practice nurse for physical health
3rd sector navigator outreach for healthy lifestyle, personalised budgets, safe monitoring
To reduce 20,000 avoidable deaths a year

Depression/ anxiety
Direct access to mental health trained staff & psychological therapy
To reduce 4000+ suicides a year

Integrated physical and mental health care for MUS & LTCs care
To save 13 billion/ year
**Acute care: transforming urgent and emergency care & achieving integration through liaison mental health teams & care pathways**

**Liaison mental health teams: 4 components of productive care**

<table>
<thead>
<tr>
<th>Component</th>
<th>Description</th>
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<tr>
<td><strong>in A/E 24/7:</strong></td>
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<tr>
<td><strong>Acute delirium assessment ward for people with dementia</strong></td>
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<td><strong>Acute wards where 40% patients have Mental illness</strong></td>
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<tr>
<td><strong>LTC clinics where 40-70% have untreated depression &amp; anxiety</strong></td>
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- **Productivity gains**
  - Reductions in 4 hour wait breaches
  - Admissions by 40% into acute hospital wards & care homes:
  - Repeated Attendances for self harm and other conditions

- **Productivity gains**
  - Acute wards where 40% patients have Mental illness:
  - Increases the discharge rates
  - Reduces LOS
  - Reduces expensive unnecessary investigations and operations

- **Productivity gains**
  - LTC clinics where 40-70% have untreated depression & anxiety:
  - 70% people with liver disease, 40% people with cardiac disease, 40% with long disease, 60% with irritable bowel syndrome, 80% in pain clinics
  - Patients get treatment and Repeat OPCs are reduced
  - Unnecessary diagnostics are avoided
The 5 mandatory indicators are:

1. Ensuring **MH representation on SRGs**, and links to local crisis care **concordat** action plans;

2. On site **24/7 A&E liaison mental health** service, working across full age range;

3. **24/7 access to crisis resolution** and home treatment services with fidelity to the model;

4. Sufficient access to **s.136 health based places of safety** to ensure people (esp. young people) are not detained in police cells;

5. Local **DOS must include complete, up to date** information on mental health, including CYP MH
5. Primary care MH: learning from the best of international as England is far behind & the country is disadvantaged, especially CYP, MH, employers and HMT

- In England, we are arguably, the least advanced in the OECD countries in our primary care mental health services development, potentially one cause of our poor employment ……….
- Mental ill health accounts for 1/3rd of the daily work of GPs: BUT 2/3rds GPs & <1% practice nurses do not get post grad training
- Brilliant innovations are developing across England, but we need to be more systematic in evaluating
- The new Models of Care offer opportunities to adapt some of the proven international best primary care integrated MH models
- A national primary care mental health strategy & taskforce would be timely

The SOS introducing a major new expansion of primary care.

Mental ill health accounts for 30% of primary care, but has been almost the most neglected area of focus

Integrate the Change the culture
Introduce 1 min self assessment MH checklist at Registration & annual checks: e.g. eChat

Change the skillmix Increase direct access to trained mental health professionals into every large practice & MCP

GPs with special MH interest (GPwSI) practice nurses with MH training, psychological therapists culturally trained, alcohol workers, MH pharmacy help + peer support

3rd sector outreach workers to go to homes, help with healthy lifestyle, social interactions and take medications and come for blood checks & do rehab activities/ training/ employment support

Copy USA Intermountain services where all large practices have Integration at heart of services “all staff trained in CYP & family therapies, integrated LTC & perinatal care

Run Integrated physical & mental health groups for long term conditions e.g. rehabilitation after stroke, cancer, chronic back pain, obesity etc.

Oxford, Swindon LIFT gets 7/8 people come off the bariatric surgery waiting list


70+ case studies of primary care mental health integrated physical and MH recovery care, integrated public health approaches
What services do we provide & how is most of it out of hospital?

Mental health is the leading out of hospital specialty:
*using intensive multi disciplinary, multi agency community treatment teams*

**Design Principle**: In mental health our ‘technology’ and ‘care model design principle’ is that in order to provide safe, NICE concordant, efficient services, we provide the majority of care at home with 24/7 outreach intensive, multi disciplinary multi agency teams for both urgent and emergency care services and for elective care. These teams triage admission and expedite discharge with multi dimensional care planning.
Mental health priorities

Lifespan approach to the 5YFV: outcomes, economics & value

• Health literacy: Bringing new knowledge to the public about the science of the brain & mental health, resilience & reducing stigma

• Prevention top 10 & bending the demand curve

• Increasing access to timely, effective Integrated 7 day care for the 16 conditions in
  • Primary care transformation & MCP designs
  • Acute care, wards and clinical pathways
  • Crisis care out of hospital & transformations

• Specialist mental health major QI drive to understand and reduce variation, record outcomes, increasing compassion, recovery and employment

• Maximize the 5YFV opportunities for new models & Integration in MCPs, UECs, care Homes, PACS, new housing, Devo Manc, Innovation, etc

• Data, workforce, supply chain management & economic modeling QI
Prevention & early Intervention: saves lives & money:

- Mental health has robust, well researched Economic cases for its conditions, interventions & service models: it’s not the lack of evidence that’s the issue, It’s the lack of evidence based policy, commissioning, & implementation

- The London School of Economics report show that investment in mental health promotion & prevention, and early intervention for mental disorder is highly cost effective with net savings realised even in the short term (DH, 2011).

- As examples: For each £1 spent, net returns are

  - £18 for early intervention in psychosis,
  - £5 for early detection and treatment of depression at work
  - £8 for parent training interventions for parents with conduct disorder.
  - £10 for work based mental health promotion interventions a
  - £84 for prevention of conduct disorder through school based social and emotional learning programmes.
The lack of access in the acute phases of illhealth has serious consequences on lives and the economy: One of the biggest consequences of not investing in primary care mental health is the cost in relation to employment.

Mental illness costs the UK economy £70 - £100bn per year – 4.5% of GDP (OECD estimate).

- Since 2009, the number of working days lost to ‘stress, depression and anxiety’ has increased by 23%
- Since 2009, the number of working days lost to ‘severe mental illness’ has doubled
- 60-70% of people with common mental disorders (such as depression and anxiety) are in work but this can be seen as a risk factor for future employment difficulties
- Co-morbidity of mental disorder and physical disorder is common; of the 15 million people in England with a long-term (physical) condition, 30% also have mental illness.
- In 2013, almost 41% of Employment and Support Allowance recipients had a ‘mental or behavioural disorder’ as their primary condition:

<table>
<thead>
<tr>
<th>Health Condition</th>
<th>Percentage of Caseload Distribution</th>
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<tbody>
<tr>
<td>Mental disorders*</td>
<td>40.9</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>15.3</td>
</tr>
<tr>
<td>Circulatory system</td>
<td>6.2</td>
</tr>
<tr>
<td>Nervous system</td>
<td>6.6</td>
</tr>
<tr>
<td>Injury and poisoning</td>
<td>5.3</td>
</tr>
<tr>
<td>Other</td>
<td>26.4</td>
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Executive summary

1.0m people are unemployed with mental health (MH) issues in England, and HMG spends £5.2bn\(^1\) per year

- 80% (£4.2bn) of this is through ESA payments, with only £170m (3%) spent on employment support programmes

DWP employment schemes are not tailored to MH, and have limited impact

- Those with mental ill-health represent 42% of unemployed people, but only 19% expenditure on employment support programmes
- For those with MH needs, only 8% will be in paid employment after Work Programme (29% for non-MH)

Some small scale interventions (IPS\(^2\)) demonstrate better outcomes in severe MH

- Success is due to integration of clinical and employment support, and specific focus on mental health needs

Scaling these schemes up nationally would result in net recurrent savings of £20-70m per year to HMG by year 3

- Higher spend of service more than off-set by reduction in ESA payments following initial roll out
- ~30% return to work within 6 months at an avg. cost of £2,200 per person\(^3\) (vs. £530 for Work Programme)\(^4\)

Focus should be on national implementation of IPS, with expectation to extend to other groups

- Prioritise expansion in 14 recognised centres of excellence, continuing to focus on severe mental illness
- Look to expand to common mental illness in primary care once Trailblazers pilot outcomes available
- Alternative funding mechanisms may be useful to promote innovation and reduce risk to HMG

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1. Includes out of work benefits (employment support allowance (ESA) and jobseeker's allowance (JSA)) and DWP employment programmes
2. Individual and Placement Support
3. Mature IPS schemes have demonstrated ability to reduce costs to £890 per person
4. Cost for a full course of average length (41 weeks for IPS, 104 weeks for Work Programme)
### Case study: Individual Placement and Support, Sussex (I of II)

#### Context
- **IPS is a standardised supported employment intervention targeted at SEMI**
  - Co-location and integrated clinical and employment support
  - Time-unlimited support, based on individual preferences
  - Rapid job search as core part of recovery path

**Commissioned by NHS trust**
- Provision by Southdown Housing (non-profit)
- Provided for 6/7 years
- Largest IPS service provider in UK

#### Overview of service
- Approximately 30 FTE across Sussex, East Sussex and Brighton and Hove, providing 2 services
  - IPS services to support individuals in to work
  - Retention support to help at risk individuals stay in work

**Caseload/employment specialist (over 6m)**
- 20 IPS service users
- 5 employment retention service users

**Referrals by clinical team**
- Engagement is voluntary
- Based on individual preferences

**Support continues once in work for service users and employers**

#### Employment outcomes
- 30% of IPS service users gained paid employment in 2014/15
  - Cost of £890 per service user
  - 110 days to first paid employment outcome, on average
  - High level of sustained employment for successful service users
    - 70% of jobs sustained for 3m
    - 49% of jobs sustained for 6m
    - 32% of jobs sustained for 12m

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*Source: Southdown Housing Association*
Crisis & acute care pathway: streamlining access, improving quality, increasing productivity

8. Adequate acute beds when needed
7. Crisis houses & day care for as alternatives
6. Liaison mental health teams
   • in A/E & acute trusts reduce admissions to acute beds and care homes by 50% & reduced LOS
5. Crisis Home treatment teams with fidelity
   Work well if they are big enough and well enough trained & have right cultural mix of staff
4. S 136 places of safety/ street triage: aim to stop all police cell assessment CYP in one year
3. Tele triage and tele health well trained staff
   • If you introduce trained tele triage you resolve 40% of the problems on the phone, reduce suicide
2. Single coordinated access number & system
   • Single access number to ring 111 with a good Directory of Services of all 3rd sector plus stat sector
1. Identify Causes & Prevent by all agencies:
   JSNA Identify the causes of MH crises & prevent by 10% /year: Public health, Health & Wellbeing Boards, CCGs, transport systems, police, housing, social care, primary care
Integration of care is essential for step change in mental health access: why do we need it and where do we need it

People come with integrated Minds and bodies

- They interact & the environments that create a ‘healthy body’ create ‘healthy minds’
- If assessment and treatment are not integrated, the person is less able to engage and take control of their illhealth, follow an agreed care plan and rehabilitate
- They therefore use more crisis services, have more hospital admissions, die earlier, escalate to high cost provision & society loses out on wealth & talent

Integrated care is not just about co-location, it needs to mean:

- Integrated history taking & assessment at registration & in consultations
- Integrated treatments and care pathways
- Integrated teams: sessions of ‘physical’ or ‘mental’ staff or ‘alliance pathways’
- Integrated case conferencing for frequent attenders, admissions,
- Integrated Workforce training at undergrad, post grad and CPD
- Integrated National clinical audits & Inquiries, NICE guidelines, research, tariffs
- Integrated payment tariffs, incentive systems for primary, acute, MH
Increasing access for CYP: we need to be radical about NHS CYP: Intermountain Healthcare Mental Health Integration programme

Cost effective primary care CYP model
US example:
Non-profit system 22 hospitals, 185 primary care clinics, an affiliated health insurance company.

Since 2000, MH Integration programme rolled out across primary care clinics

Key components
- Team-based care with MH professionals embedded in the primary care team – psychiatry, psychology, psychiatric nursing & social work
- Care manager to coordinate health and social support
- Shared electronic medical records
- Proactive screening for MH problems among high-risk groups
- Using disease registries and evidence-based guidelines
- Exploiting new technologies e.g. telehealth and telecare
- Supported self-management of physical and mental health
- Making use of extended community resources and peer support

The process of change
- **Significant investment in training all staff (GPs, nurses, receptionists) in MH awareness, communication skills & shared-decision making**
  - CYP and families
  - Consistent messages from senior leaders: normalising MH as a routine part of everyday health care

Stepped care model
- Mild complexity – managed by GP + case manager
- Moderate – collaborative MH Integration team
- High – specialist mental health team
- 80% of MH care delivered by non-specialists

Outcomes: clinical & economic
- Significant reduction in ACS admissions among people accessing MH care
- Patients with depression 54% less likely to attend ED if part of MH Integration programme
- Per patient medical costs 48% lower
- 5-fold return on investment – savings $115 per patient per year; cost $22 per patient per yr
- Better diabetes control among patients with diabetes + depression
- Increased patient satisfaction
Quality improvement is not rocket science
but getting the tools to do it & reducing clinical time taken
away from patient care entering data into black holes is ley

- Board to floor commitment
- Clinical data dashboards for continuous improvement
- Routine transparent outcomes publication
- Workforce development
- Programme management & pathway efficiencies improvements
Where has radical transformation happened in mental health crisis care & the acute care pathway

• Check out the Crisis Concordat website for 211 CCG action plans on crisis from local agencies
• See North east and NTW single access, teletriage & tele care, increased crisis home Treatment, using digital to free u time to care & reduce admissions
• See Bradford whole city crisis transformation
• See Manc Devo + Stockport MCP + Pennine care transformation: street triage, Raid +, Delirium admission prevention
• See Gloucestershire frequent attender CQUIN at work
• See Leeds expert by experience crisis house

Read Geraldine’s Crisis blogs for examples of the way forward at

http://www.england.nhs.uk/2015/06/15/geraldine-strathdee-12/ and
http://www.england.nhs.uk/2015/06/22/geraldine-strathdee-13/
Specialist MH services Major QI drive in existing services to:

- Understand and reduce variation, improve productivity, increase compassion, recovery, employment outcomes

- Get real expertise into national data programmes, Supply chain analysis of our care pathways, QI programme management, free clinical time to care

- The major issues in specialist mental health is that
  
  - we have inspirational excellence and innovation in every service type BUT the level of variation across England is huge and unacceptable & we don’t yet have the tools to understand and change it

  - A core challenge is that although clinicians spend 50% of their time entering data into clunky ECRs and national data sets. These don’t provide the key patient safety, interoperabilities, modern functionalities & data feeds back to clinical front line teams needed to achieve continuous improvement

- Key priorities are to embed a system of routine JSNAs, clinical team transparent dashboards, transparent commissioning for value packs, Model Board to floor QI tools……….