Improving mental health conference: How community & primary care services can support better mental health outcomes

The National System Partners Strategy

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Visiting Professor, UCLP Academic Health Science Centre

February 4th 2014
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• The world of strategy as it was….
• Strategy now
• The mental health system board & its partnership
• The Three thirds direction vision
• NHS England  focus on outcomes & tools
• New Funds: what the evidence says are best buys

Your voice & ideas are IMPORTANT

1. The London Health Commission needs to hear your views on your top 3 priorities for mental health in London
https://www.london.gov.uk/priorities/health/london-health-commission/london-health-commission-call-for-evidence

2. Can you contribute? Please contact us if you feel you can contribute or develop practical support tools for MH commissioners and providers.

   Geraldine.strathdee@nhs.net
Strategy Now........

There are no national blueprints that will apply everywhere
The focus is on
  • What people tell us they want for their care
  • The principles of the ‘where and what’ care they want
  • Providing the tools and support to help commissioners and providers for their local area

Sustainable Strategy to Improve Outcomes is to:
  • Create leaders with competencies
  • National information, informatics & intelligence programme
  • Find ‘What good looks like’ & disseminate
  • Communication myth busters & brave people....

Culture change: focus on Quality and Value
  • from monocular vision to integrated, empowering, transparent care
  • Raising the profile with the public & policy makers, funders and economists.....to show how we can achieve Parity
The Mental Health System Board Partnership
.. together we can deliver better outcomes and value and parity
Three ‘directions’

- Tackling causes, building health literacy & prevention
- Primary & community & social integrated care
- The complex specialist population
Depression: the commonest causes in communities & the greatest primary care & LTC demand but the response has to lie in partnerships to prevent as well as treatment.

- Elderly isolated & people with dementia
- Victims of domestic violence
- Key life cycle: • Divorce • Retirement • Redundancy • Menopause
- Isolated women with small children
- Dyslexia, Dyspraxia, ADHD, Autism, Asperger’s and Learning Disabilities
- People with schizophrenia and sight and hearing problems
- Victims of school and employment stress and bullying
- Long term physically ill
- Alcohol and drug addictions
- Victims of domestic violence
- Long term physically ill
First direction

Tackling causes
Building health literacy
Prevention

- Employment practice
- Schools: building resilience & training school nurses & form tutors
- College students: Physical & mental health literacy
- Transport: support for older people to prevent isolation
- Transport hub: vulnerable people initiatives
- Information on self health literacy
- Communities & leaders

Does it costs more to NOT TREAT mental ill health and the consequences of that failure, than it would cost to treat those most in need. read the London mental health report
Parity and equalities: Benchmark October 2013

There is a disparity in the number of people with mental illness in contact with services, compared to physical health, yet it is a major cause of premature death & lives lived in distress and misery

<table>
<thead>
<tr>
<th>By condition</th>
<th>% in treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety and depression</td>
<td>24</td>
</tr>
<tr>
<td>PTSD</td>
<td>28</td>
</tr>
<tr>
<td>Psychosis</td>
<td>80</td>
</tr>
<tr>
<td>ADHD</td>
<td>34</td>
</tr>
<tr>
<td>Eating disorders</td>
<td>25</td>
</tr>
<tr>
<td>Alcohol dependence</td>
<td>23</td>
</tr>
<tr>
<td>Drug dependence</td>
<td>14</td>
</tr>
</tbody>
</table>

Mental health problems are estimated to be the commonest cause of premature death

Largest proportion of the disease burden in the UK (22.8%), larger than cardiovascular disease (16.2%) or cancer (15.9%)

People with schizophrenia die 15-25 years earlier

Depression associated with 50% increased mortality from all disease

26% of adults with mental illness receive care
92% of people with diabetes receive care
Second direction

Primary & community & social integrated care

The complex specialist population
Commissioning for improved outcomes in your community

Setting 5-year ambitions for improving outcomes
A how-to guide for commissioners

December 2013
## Context: The 7 ambitions and the baseline measures

<table>
<thead>
<tr>
<th>The 7 ambitions</th>
<th>Do I have to submit a 5-year ‘quantifiable’ ambition figure?</th>
<th>What is the baseline measure to set the quantifiable ambition against?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Securing additional years of life for your local population with treatable conditions.</td>
<td>Yes</td>
<td>Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare (Adults, children and young people)</td>
</tr>
<tr>
<td>2. Improving the health related quality of life of people with one or more long-term conditions</td>
<td>Yes</td>
<td>Health-related quality of life for people with long-term conditions</td>
</tr>
<tr>
<td>3. Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital</td>
<td>Yes</td>
<td>Quality Premium Composite Indicator</td>
</tr>
<tr>
<td>4. Increasing the proportion of older people living independently at home following discharge from hospital</td>
<td>No indicator available at CCG level to set quantifiable level of ambition against. However CCG plans on this ambition should be in making explicit links to the related ambition as part the Better Care Fund, set for 2 years at Health &amp; Wellbeing Board level.</td>
<td></td>
</tr>
<tr>
<td>5. Increasing the number of people having a positive experience of hospital care</td>
<td>Yes</td>
<td>Patient experience of hospital care</td>
</tr>
<tr>
<td>6. Increasing the number of people having a positive experience of care outside hospital, in general practice and in the community</td>
<td>Yes</td>
<td>Patient experience of GP services and GP Out of Hours services</td>
</tr>
<tr>
<td>7. Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care</td>
<td>Baseline data not yet available at CCG level to set quantifiable level of ambition against. However ‘case note review’ data will be available to measure progress on local plans in the next few years.</td>
<td></td>
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<tr>
<td>Programme</td>
<td></td>
<td></td>
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<tr>
<td>--------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Commissioning capacity and capability &amp; support tools</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Primary care mental health</td>
<td></td>
<td></td>
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<tr>
<td>3. Mental health informatics and intelligence</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Emergency response and suicide prevention</td>
<td></td>
<td></td>
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<tr>
<td>5. Integrated care and acute care</td>
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<td></td>
</tr>
<tr>
<td>6. Industrializing improvement in psychosis care</td>
<td></td>
<td></td>
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<tr>
<td>7. Outcome measurement and care packages</td>
<td></td>
<td></td>
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<tr>
<td>8. Child and young people mental health</td>
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</tbody>
</table>
Second direction

Primary care PMH experts & CCG MH leaders are working strengthening:
- Demand management
- Whole team training re suicide & depression
- Integrated physical & mental health for LTCs
- Enhanced schemes for SMI
- Enhanced schemes for MUS
- Seattle style depression case managers or
- IAPT Plus employment & social support
- Virtual case conferences on frequent attenders
- GP Masterclasses
- Practice nurse masterclasses
- Transparent information on quality & offer
- Integrated estates programmes

For more details on these write to us and we can put you in touch with Primary care leaders doing them
Third Direction

- Services across the country are delivering great innovation
- Crisis parity: Single point of access crisis services with tele triage, tele health, 24/7 home treatment, liaison MH 24/7
- Top 10%: Multi agency, multi disciplinary home treatment teams with personalised care for the most complex
- Least restrictive care & ‘Francis’ in mental health
- Stop post code Quality Address variation & spread best practice & reduce burden
- Choice
- Tariff based on Care packages and outcomes
- Reducing premature mortality: Physical health CQUIN
Reducing avoidable admissions
Commissioning Mental Crisis Service
Tiers of Care

Primary Care

Accessible information to prevent crises and get help early

Intermediate tier

Admissions to Acute Care in acute and mental health beds & respite and crisis houses

Emergency Department Mental health liaison team Lifespan & whole person

One-stop Shop Crisis Call Centre offering Tele-triage, tele-health + 24/7 Home treatment team Co located unplanned care services

£££££
Avoidable mental health admissions: ‘best buys’
(not comprehensive)

Pre-admission Assessment
- CRHT team of capacity and capability to meet needs
- Personalised care budgets
- Crisis and respite house
- Adult placement schemes
- Nice concordant care plans

Admission
- Stated outcomes at onset of admission
- Agreed LOS to achieve outcomes from onset
- Physical assessment and treatment
- Allocated primary nurse and CC

On ward treatment
- Can you get well if you are scared?
- All assessments done within 48 hours
- Daily senior nurse ward round
- Therapies and activities
- Learning self management and substance misuse control

Effective discharge
- Date of first follow up appointment
- Medication and GP discharge notification
- All utilities working, food in house, benefits sorted
- Self management & family involved crisis plan
Avoiding admissions
Improving patient experience
Increasing safe discharge
Increasing home treatment

a bottom up clinical service flow chart from Oxleas thanks to great SU input and process mapping ......
<table>
<thead>
<tr>
<th>1</th>
<th>Pre-admission To prevent admission</th>
<th>2</th>
<th>Within 1st week of admission</th>
<th>3</th>
<th>Preparing for discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>To prevent inappropriate admissions:</strong></td>
<td><strong>CC and ward Dr to ensure updated core and risk assessments available in RiO to enable informed ward round decisions.</strong></td>
<td><strong>Discharge planning case review or CPA</strong></td>
<td></td>
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</tr>
</tbody>
</table>
| For any service user in the red zone of a CMHT or any CC or a lead professional thinking of referring for admission; refer to Crisis Home Treatment Team asking the following:  
- Can admission be prevented with their support and home treatment?  
- If not, ask them to review the cases asap to support earliest possible discharge. | Primary nurse (or nominated deputy eg charge nurse, or ward manager) to agree weekly time(s) to talk and communicate either face to face or by phone with CC. | Primary nurse and CC to meet with the service user to develop the post discharge community care plan ensuring all community actions are recorded on the plan. These can remain closed until discharge. |
| **At the point of admission or before if possible:**  
- CC and CMHT Dr or lead professional to update contact details, core assessment and risk assessment. | **At the first ward round:**  
- primary nurse ensures the delayed discharge form is brought along  
- Factors likely to block discharge identified and planned for  
- Problems/needs identified, inpatient care plan agreed and any irrelevant community care plans in RiO closed or put on hold  
- Date of pre discharge case review to be set. Issues to discuss may include:  
  > Accommodation, benefits, complex, physical healthcare needs  
  > Equipment/adaptations required on discharge  
  > Referral to complex needs/forensic or other | | **Carers to be formally asked by ward manager/primary nurse of progress made during period of leave to inform plans.** |
| **State clearly in progress notes on RiO:**  
- Reasons for admission  
- Outcomes to be achieved from the admission  
- Accurate list of medicines the patient is prescribed/taking  
- What will need to be done for safe discharge  
- Expected length of stay | **Ward manager to notify bed manager of likely delay to discharges after ward rounds.** | Clozapine patients: ensure arrangements are in place for blood testing and collection of medication. If the patient is changing consultant, ensure ZTAS (Clozapine service) are informed. |
| Delayed Discharge Early Warning Signs form to be completed and given to the bed manager and passed to primary nurse | **Primary nurse/ward clerk to ensure benefits issues are sorted from day of admission** | |
| **CMHT zoning priority**  
Admitted SU to go on CMHT red zone if the length of stay is likely to be less than three months | **CC to attend ward round in person or if not feasible by telephone conference and notify team manager of any possible delayed discharge reason** | |
### 4 Discharge CPA

**At the discharge CPA**

Consultant, primary nurse and CC to develop the:

- Community care plan, with care needs, interventions and risk management to be recorded and names of those community staff responsible for care plan actions to be updated.
- Completed inpatient care plan items to be closed.
- CPA management and review pages on RiO to be completed to reflect CPA meeting.

### 5 48 hours before discharge

**Ward Dr** to order TTOs and advise CMHT doctor of the prescription.

**Primary nurse to complete the Preparing for discharge checklist:**

- TTOs ordered
- Carers informed of discharge date
- CC to give location, time and date of follow-up appointment
- Sick certificates signed by ward doctor
- Discharge care plan and crisis plan agreed and signed by service user
- CPA one month post discharge date set and added to RiO CPA Management
- Progress notes have been validated

Does the support of home treatment team need to be reviewed?

### 6 On the day of discharge

**Documentation and information:**

**Primary nurse to check:**

- Service user has a signed copy of their care plan
- Service user knows who to contact in a crisis – Crisis card given to service user/carer
- Service user has money for transport home
- Service user has a key to home
- Service user has food available
- Service user has TTOs
- Service user has information about their condition and medication
- Service user has the date of the 48 hour/day follow-up appointments.
- Arrangements have been made for repeat prescriptions and service user informed
- Cash and valuables returned to service user (ask user to sign property form)
- Medical certificate given to user
- Discharge entered on RiO
- Service user’s name removed from fire list, nominal list, bed list, MHA list (if applicable).

**Ward Dr** to complete the discharge notification to the GP stating:

- Medication and prescribing arrangements
- Risks
- Date of first follow-up appointment booked and given to the service user

**Primary nurse** to check that completed needs on the inpatient RiO care plan are closed.

### 7 Within 7 days of discharge

For service user with severe illness:

More than 3 month history of DSH CC to undertake a face to face contact **within 7 days** of discharge.

**Preventing suicide**

For service user who was admitted with suicide risk or attempted suicide, or suicide attempt during admission, or current risk of suicide, CC to follow up **within 48 hours**.

**Documentation and information:**

**Ward Dr to complete:**

- discharge summary
- update the RiO core and risk assessment summary of admission
- ICD formulation in the formulation screen of RiO
- send summary to GP.

**Essence of discharge summary and updated RiO is:**

- reason for admission
- key symptoms and problems at admission
- key interventions tried and response
- major risk behaviours
- care plan follow-up arrangements.
Reducing acute & care home admissions
Mental health liaison teams

Mental health hospital presentations
- Dementia
- Self harm
- Alcohol dependence
- Psychosis relapse
- Other?
What will make best use of money: Audit Commission reducing health and social care institutional based care

....... *when it is not needed*

For health and social care partnerships, this means focusing on:

- reducing unplanned hospital admissions;
- reducing admissions to residential and nursing home care from the community;
- improving hospital discharge arrangements, particularly to residential and nursing home care; and
- enabling people to be treated at home and die at home rather than in hospital if that is what they prefer.
Mental health providers lead the way to parity……..

• Reducing premature mortality
• Reducing length of stay
• Improving patient experience
• Achieving parity of physical health in MH settings

The largest international commitment to parity of esteem for physical health in mental health settings
CQUIN for 22,500 inpatients in MHTs and 3 intensive community home treatment teams ....
National Physical Health CQUIN for all mental health inpatient units and 3 intensive community treatment teams

Indicator name

Cardio-metabolic assessment and treatment for patients with schizophrenia in all inpatient & 3 intensive community teams

Description of indicator

To demonstrate, through the National Audit of Schizophrenia, full implementation of appropriate processes for assessing, documenting and acting on cardio-metabolic risk factors in patients with schizophrenia

The audit sample must cover all relevant services provided by the provider
**Indicator 1:** 65% funding for demonstrating, through the National Audit of Schizophrenia, full implementation of appropriate processes for assessing, documenting and acting on cardio metabolic risk factors in patients with psychoses, including schizophrenia.

The following cardio metabolic parameters (as per the 'Lester tool' and the cardiovascular outcome framework) are assessed;

- Smoking status
- Lifestyle (including exercise, diet, alcohol and drugs)
- Body Mass Index
- Blood pressure
- Glucose regulation (HbA1c or fasting glucose or random glucose as appropriate)
- Blood lipids
- Hepatitis C

The results recorded in the patient's notes/care plan/discharge documentation as appropriate,

together with a record of associated interventions according to NICE guidelines or onward referral to another clinician for assessment, diagnosis, and treatment e.g. smoking cessation programme, lifestyle advice and medication review.
**Indicator 2:** 35% funding for completion of a programme of local audit of communication with patients’ GPs, focusing on patients on the CPA, demonstrating by Quarter 4 that, for 90 per cent of patients, an up-to-date care plan has been shared with the GP, including the holistic components set out in the CPA guidance:

- ICD codes for all primary and secondary mental and physical health diagnoses.
- Medications prescribed and monitoring and adherence support plans.
- Physical health condition(s) and ongoing monitoring and treatment needs.
- Recovery interventions including lifestyle, social, employment and accommodation plans where necessary for physical health improvement.

- The local audit will cover a sample of patients in contact with all specified services for more than 100 days and who are on the CPA.
New ideas to test out and evaluate
Commissioning to deliver the Physical health
inpatient CQUIN & reduce premature mortality

Commissioning support of the options to support delivery

1. **GP practice contracted for wards with practice nurse sessions** in diabetes, COPD, CVS for ward staff
2. **CPD** for MHT medics and nurses and all MDTs with
3. **SLAs with acute trusts and community specialists & path labs** for sessional provision when needed
4. **Physical health liaison team** to emulate a Liaison MH team in acutes
5. **Enhanced practice schemes** : e.g. east London
6. **Integrated community and MH trusts** : is there another model
7. **3rd sector outreach and healthy lifestyle, social inclusion and support for safe medicines** community teams that need outreach to bring to appointments
8. **SLAs** with diagnostics, pathology & medical equipment & training
<table>
<thead>
<tr>
<th>What outcomes do you want to improve for your community</th>
<th>Best buy’ strategy in MH</th>
<th>Specialist MH</th>
</tr>
</thead>
</table>
| Securing additional years of life for your population  | • Primary care DES or enhanced practice for SMI  
• IAPT Plus employment plus social care  
• International model of depression case managers | Psychological therapies  
Recovery focus  
Individual & employment IPS  
Physical health CQUIN commissioning |
| Improving the health related quality of life for people with LTCs | Health Centre based integrated physical and mental health teams | Special needs housing workers in MDTs |
| Reducing avoidable hospital admissions through integrated community services | 7 day home care services with recovery workers | Liaison MH services (Raid) in acute  
Early intervention teams  
Crisis Home treatment teams  
Tele health + tele triage  
Self management programmes |
| Increasing the proportion of people living independently at home after discharge from hospital | | Assertive outreach services  
Increase MDTs  
Personal budgets with 7 day recovery |
| Increase No. people who have a positive experience of hospital care | | Buy psychological therapies for SMI  
Buy IPS for employment |
| Increase No. people who have a positive experience of care in general practice & the community | | |
What does every clinical team need to do & what support do they need to do it

Template Letter to GP to get the summary record with Reed/ICD codes, medications, physical blood etc results

Mental health & Lester plus cardiometabolic physical assessments

Coproduced formulation with service user

ICD physical & MH codes recorded on ECR

Co produced Care Plan with core components of NICE/SCIE effective care
Co produced Care Plan with the 7 core components of NICE/SCIE effective care:

1. Information
2. Healthy lifestyle & physical health rx,
3. Psychological therapies
4. Safe medicines and routine GASS
5. Recovery social, training & employment plans,
6. Carer education & support;
7. What to do in crisis
Stratification: target the top 10% of patients who used 50% of spend

The top 10% are expensive because:

- Hospital Capital costs
- Repeated admissions
- Mental health Act detentions
- Comorbidities
  - Psychosis
  - Substance misuse
  - Personality development
  - Organic brain problems
  - Physical LTCs
  - Stigma and social exclusion
  - Offender patterns
Early identification of high need and high risk cases
Established effective systems of local multi-agency services
Expert senior team reassessed all expensive placements
Needs led Beds AND EXIT TEAMS appointed to reduce LOS
Now progressed to home treatment with personalised care packages
We use Kaeser principles of 40% activities in groups
Economic crisis ....... what will deliver value

Quality

Value spend

Game changers
- Information
- Choice
- Estates
- Digital technology
These slides are a small sample of the international best practice in primary care mental health
Primary care mental health: Oxleas style, we support

1. Working with Communities to reduce primary care demand
   - Employers, schools, safer community initiatives
   - Enhanced roles for pharmacists e.g. smoking cessation
   - Library & education centres to provide information
   - Creating work and volunteering opportunities

2. Re-engineering spend to create money for increased capacity
   - Decrease referral for medically unexplained symptoms
   - Increase IAPT

3. Increase capacity through affordable skill-mix workforce initiatives
   - Prescribing benzos, antidepressants, painkillers
   - Telecare nurses/ workers, IAPT, counsellors,
   - Enhanced practice nurses, health visitors, district nurses, GPwSI
   - Depression case managers, user experts

4. Increase capacity by treating causes, not just symptoms through protocols, creation of expert patients for long term care
   - Self help manuals

5. Information & green prescriptions, new intranet design
   - Use of more standardised assessment & outcome tools
   - Improve the interfaces through agreed NICE stepped care & SLAs
Primary care mental health service organization stratification

(Kaeser, Scandanavia, US Vets)

- Prevention in High risk groups
- Self assessment and self management
- Common conditions
- Moderate primary care repeat attenders
- Long term severe mental illness
<table>
<thead>
<tr>
<th>Primary care multidisciplinary team and new (and old) models from international best evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Receptionists approach to vulnerable people</td>
</tr>
<tr>
<td>• Health visitors trained in identification of mental ill health in young mothers and families</td>
</tr>
<tr>
<td>• District nurses trained to identify depression in elderly, isolated people they visit for physical long term conditions</td>
</tr>
<tr>
<td>• Practice nurses working with people with severe mental illness and long term conditions</td>
</tr>
<tr>
<td>• School nurses trained in Psychological health and building resilience</td>
</tr>
<tr>
<td>• Innovative primary care based depression case managers in Seattle, Hungary,</td>
</tr>
<tr>
<td>• Outreach, especially for the vulnerable elderly</td>
</tr>
<tr>
<td>• Tele care and e-Care</td>
</tr>
<tr>
<td>• Intermediate care to support Long term conditions</td>
</tr>
</tbody>
</table>
Scandinavian ‘CCG ‘ depression & suicide prevention programmes GP as individual clinician support

• Understanding of local rates of suicide and high risk groups
• Empathic and skilled communication and interview style
• Use of patient self assessment for mental illness & substance misuse
• Understanding of high risk groups for early identification
• Medication and psychological therapy e.g. CBT and depression care guidelines
• Alert & comms re Media portrayal / events likely to have impact
• Knowledge of local referral and care pathway arrangements
• Knowledge of range of local support services in all sectors
## Hungary Depression & Suicide Reduction
(Szanto et al, 2007)

- Training for 28 GPs serving 73,000 people.
- 5 year depression-management educational program for GPs.
- In addition to training individuals, *services were reorganised and expertise commissioned to support primary care in a sustainable way*.
- Practice nurses were also trained.
- A Depression Treatment Clinic and psychiatrist telephone consultation service was established.

**Conclusion:** GP-based intervention produced a greater decline in suicide rates cf with the county & national rates.

**Key conclusion was that additional service reorganisation such as depression case managers should be tried.**

*The importance of alcoholism in local suicide was unanticipated and not addressed.*
USA Depression case managers (Katon)

- Depression case managers in primary care in the way that care coordinators have been introduced into specialist mental health services.

- The premise is that depression is a leading cause of functional impairment in elderly individuals and is associated with high medical costs, but there are large gaps in quality of treatment in primary care.

- RCT aimed at determining the incremental cost-effectiveness of the Improving Mood Promoting Access to Collaborative Treatment (IMPACT) collaborative care management program for late-life depression.

- 18 primary care clinics from 8 health care organizations in 5 USA states: patients were randomly assigned to the IMPACT intervention (n = 906) or to usual primary care (n = 895).

- The IMPACT intervention – 1 year, stepped, collaborative care approach that included either a nurse or psychologist care manager working to support GP.
Seattle Depression Case Managers

- Care manager completed an initial bio-psychosocial history and provided education about antidepressant medication and psychotherapy approaches.
- All patients were encouraged to engage in behavioural activation and choice of antidepressant medication or problem-solving treatment (PST-PC).
- The PST-PC was a 6 to 8 session psychotherapy program which was as effective as antidepressant medication for major depression.
- The CM received weekly supervision by a primary care physician with geriatric expertise and a psychiatrist according to a stepped-care treatment algorithm which guided short-term and continuation therapy and relapse-prevention over a 12-month period.
- The CM followed up with patients in person or by telephone approximately every 2 weeks during short-term treatment and approximately monthly during the continuation phase.
- The CM received training on pharmacotherapy and PST-PC during a 2-day workshop that included didactic training with a treatment manual and role-plays, and completed at least 5 videotaped training cases of PST-PC supervised by a psychologist.

**Outcome - lower costs and greater effectiveness.**
Leadership and organization of the practice

- Establishment of care registers of high risk groups e.g. SMI, alcohol and drug dependence, Long term conditions
- Practice protocol for suicide care pathway
- Helpline numbers publicized in practice
- Education on mental illness and how to seek help for depression information easily available
- Practice based, or access to CBT therapists and counsellors
- Alcohol and drug sessional experts available to do motivational interviewing approaches & publicizing peer support
- Directory of available local services for mental health and substance misuse conditions
Scandinavian ‘CCG ‘ depression & suicide prevention programmes GP as individual clinician support

- Understanding of local rates of suicide and high risk groups
- Empathic and skilled communication and interview style
- Use of patient self assessment for mental illness & substance misuse
- Understanding of high risk groups for early identification
- Medication and psychological therapy e.g. CBT and depression care guidelines
- Alert & comms re Media portrayal / events likely to have impact
- Knowledge of local referral and care pathway arrangements
- Knowledge of range of local support services in all sectors
Primary care physicians as commissioners of services (Kaeser)

- Data literacy with understanding of suicide rates
- Local hot spots identified with reduction strategies
- Contracted timely access to crisis referral and support from local specialist
- Commissioning of crisis home treatment team
- Commissioning Liaison services & follow up for those presenting with deliberate self harm at A/E
- Commission outreach to high risk groups
Prevention

Primary, secondary and tertiary prevention all have potential to have big pay-offs – in terms of well-being and cost-effectiveness.

Current work – economic arguments for:

- Maternal depression
- Parenting interventions
- School-based programmes
- Psychosis – early detection
- Psychosis – early intervention
- Alcohol misuse
- Workplace screening (CMDs)
- Workplace wellbeing programmes
- Debt; financial capability

- Deliberate self-harm
- Suicide – general strategies
- Co-morbidity – diabetes/depression
- Medically unexplained symptoms
- Older people – social engagement
- Dementia
- Carer support
Primary care mental health leadership building

Commissioning programme leadership

Scholarships for manager & clinical leadership learning set

Development of expert GP MH clinicians e.g. GPsys, clinical nurse specialists, graduate worker leadership programme, tele-nurses

Workforce curricular development training for GPs

Intranet and information technology development programme

Training programme for Practice Nurses
Tele-assessment and Tele-triage

(Kaeser and McKesson)

Now...assessment depends on:
- Which team or Professional
- Their training or Attitude
- Monday blues...........
- IT system helpful?

We need to move to:
- Tele-triage
- All staff trained
- Lever to improve IT clinician decision support
- Develop ‘Tier 4’ IAPT
- Integrate into PbR care clusters

Tele triage impact proven internationally and in Bexley with Prof Paul Lelliott:
- Decrease need for face to face by 40%
- Faster triage
- Decrease referral to assessment by 8 wks to 2
- Increase SU and GP satisfaction
- Use of technology
- Estates reduction