Mental health care in England:
The Past, the present, your Future

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Nov 19th 2015
Today's talk: Action needed from rehab faculty

Thank you for all your leadership

Update on the national direction in mental health

Leadership: What’s needed from you as Rehab leaders

- **Dynamic partnerships** with service users, carers, rehab professionals
- **Information on your services** on NHS Choices & your own trusts websites, what's offered, outcomes, partnerships
- **Evidence** presented in accessible formats to persuade
- **Access standards to NICE Quality stds** beyond EIP: fight for them
- **Influence**: Come and advise the minister about carers and rehab
- **Incentives and payments for best outcomes**
- **Comms, comms, comms, & more comms**
The 5 Year Forward view Lifespan mental health approach:

based on expert narrative, scientific evidence & economic outcomes

Building Positive mental health Literacy
in individuals & communities

Prevention
of mental ill health

Improving Access
to Integrated
Timely, Effective
care outcomes
for all new patients

Transformation
of commissioning & provision
for best outcomes, quality and value

To achieve it needs Leaders, information, intelligence, incentives & Quality improvement plans
Transforming Mental health care: the big priorities to achieve parity of access, effective care, quality & value across the Lifespan: 5YFV

Communities: Building informed, collaborative resilient communities &

Maximizing Prevention as 70% of all mental illness starts before age 24 and the environments at school, work, relationships, communities play a major role in the development of positive mental health or creation of mental illness.

Right time, Right care access standards & measured outcomes for the 16 mental health pathways from primary care to specialized commissioned provision & using the power of digital.

The NICE psychosis Quality Standards apply equally to rehab services.
2015: The major growing public interest in mental health literacy:

• The busting of the 5 great myths
• Time to Change, NHS Choices, Media, Daily Mail. Whole City digital platforms
• The Incredible Crisis Concordat 22 front line community agency whole system partnerships
• The social movement 250+k committed MH leaders & @Wes
• Citizens UK: 500,000 citizens prioritize mental health
• The international evidence movement & the MH8
• Using digital apps, self management on line, Bog Data for individuals
• Focus on tackling identifying, coding & tackling causes
Prevention: The life span health determinants of mental health conditions

Genetic & biochemical

Genetic Loci Linked to Schizophrenia

Organic brain & neurodevelopmental

Schizophrenia in Monozygotic Twins

Societal

Life span high risk events
- Life Transitions
  - Unemployment
  - Adolescence
  - Pregnancy
  - Bereavement
  - Migration
  - Gang/veteran trauma
  - Carers

Biochemical ‘causes’
- Caffeine, nicotine, alcohol, street drugs
- Neurotransmitters
- Endocrine disorders

Family history
- Substance misuse
- Mental ill health/chaotic deprivation
- Abuse: physical, sexual, emotional

School difficult
- Dyslexia, Dyspraxia, ADHD
- Autistic spectrum
- Bullied

Truanting
- Drug use & dealing
- Petty crime
- In Care

Mental illness starts
- Regarded as ‘bad’ or ‘strange’

Institutions career
- Expensive placements
- Youth offenders
- Acute psychiatric wards
- Forensic units

Psychoses: the tragic story of missed opportunities for prevention, early treatment and reduction in lifelong suffering & expensive institutional care
High impact prevention programmes:
Through a new era in public health, patient self management & stratification

Zero Child abuse
- Ambition for England: sexual, physical, emotional

Schools
- Resilience embedded in the school culture & curriculum, early identification though school nurse and form tutor training, & Governors for well being & resilience

Employers
- Positive productive employment practice, jobs, Health & Safety employment standards

Parenting & relationships programmes
- The ‘statin’ of good mental health now at pregnancy clinics, primary care & adult education

Alcohol:
- Strategy needed asap to save £20 billion for the NHS, Police, Local government

High Value groups to prioritize
- Leaving care CYP
- Frequent crisis, admissions, detentions, stable accommodation, transitions
- Integrated care pathways in primary and acute services

Building Collaborative, resilient communities for 20% NHS demand reduction?
Increasing access to Right Care NICE standards

Right Time
Right Care NICE standards

- ✓ Information
- ✓ Physical health
- ✓ Medication
- ✓ Psychological therapies
- ✓ Rehabilitation & Recovery care plans for training/employment
- ✓ Right carer and social network
- ✓ Crisis & relapse prevention
- ✓ Maximizing digital potential

Right Outcomes
Right Team

- ✓ PROMs
- ✓ PREMs
- ✓ CROMs
- ✓ Employment

Right team

- Compassionate,
- Coaching,
- Coproduction
- Recovery focus
- Multi disciplinary/agency

Right implementation & Continuous Quality improvement

- ✓ Commissioning guidance
- ✓ Baseline national audit
- ✓ Workforce plans
- ✓ Data collection plans
- ✓ Accreditation networks
- ✓ 5 ALB & Regulation
- ✓ Big Data & innovation plans
A NICE concordant EIP service is able to offer and deliver the following NICE recommended treatments to >50% of people within 14 days of referral:

- Cognitive Behavioral Therapy for psychosis
- Family interventions
- Clozapine (if 2 antipsychotics have proven ineffective)
- Education & employment support

- CBTp
- Physical health assessments
- Wellbeing Support (eat healthily, physical activity, stop smoking)
- Carer focused education & support
Why set a standard?

In 2011, *No Health Without Mental Health*, highlighted the effectiveness of EIP services. When delivered in accordance with NICE standards they help people to recover from a first episode of psychosis and gain a good quality of life.

- EIP support reduces the risk of a young person taking their own life from up to 15% to 1%.
- EIP support reduces the probability of someone being 'sectioned' from 44% to 23% in the first two months of psychosis.
- If everyone who was eligible received early intervention, it would save the NHS £44 million each year.
- 35% of people under EIP care are in employment compared to 12% of people in standard mental health care.
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.

16 Mental health ‘care pathways will be developed between 2015-2020

1. Psychoses
2. Depression /Anxiety disorders, Obsessive compulsive, Phobias
3. Organic brain disorders including Dementia
4. Alcohol and drug misuse
5. Somatoform disorders
6. PTSD
7. Eating disorders
8. Perinatal disorders
9. Personality disorders (10)
10. Self harm behaviours
11. Conduct disorders in children
12. ADHD
13. Autistic spectrum disorders
Transforming Mental health care: the big priorities to achieve parity of access, effective care, quality & value across the Lifespan: 5YFV

Transforming specialist mental health services

- **Psychosis care accounts for** 60% spend
- **National audits** show that there is major variation in standards and costs of services and the costs of similar type services
- **Transparency and clarity about what's on offer**: If you look on the NHS Choices website, there is virtually no rehabilitation service described, so no one knows what's on offer or what outcomes are achieved
- **The culture**: The National Schizophrenia Commission found that services users reported that the lack of hope and optimism from staff and lack of ambition for the patients disheartening

Enablers: real partnerships with service users and their trusted supporters, peer and group support and therapy

Leadership, Workforce, Networks, digital, scientific revolution, payment systems
Mental health is the leading out of hospital specialty:

*using intensive multi disciplinary, multi agency community treatment teams*

**The beds**

- **High secure beds**
  - Medium & low secure beds
  - Mother & baby, eating disorder, other specialist units
  - Intensive rehabilitation closed unit for complex dual diagnosis
  - Open rehabilitation units
  - Locally authority Residential rehabilitation
  - Supported accommodation with care package
  - Own tenancy plus personalized budget

**The twinned community teams**

- 24/7 Assertive outreach/ community forensic team multi agency teams
- Integrated perinatal mental health & maternity teams Eating disorder & other day treatment services
- 24/7 Assertive outreach/rehabilitation & recovery multi agency teams
- Rehabilitation/recovery team: multi agency teams
- Rehabilitation/recovery team
- CMHT Community Mental health teams/ Enhanced primary care SMI with 3rd sector outreach
- CMHT/ Enhanced primary care SMI with 3rd sector outreach

**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.
What is Right Care in mental health & how often can it be found

Quote service user: I don’t care if you call me a patient, a service user, a customer. I call myself a punter because I’m taking a punt every time I go into a service as it’s completely random what standards are available to me.

Stroke did a 7 year, year on year improvement plan to improve clinical care: leading edge areas are doing the same for psychosis see http://wessexahsn.org.uk/img/news/Pathway-to-Recovery-Web.pdf

Are you willing to do the same?

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*
What standards does your rehab service show

| Table 1: Key comparisons between NAS2 and NAS1 for each of the standards set for this audit (standards 1 to 7) |
|-------------------------------------------------|----------------------------------|----------------------------------|
| Standard / Indicator                            | NAS2 (%) | NAS1 (%)            |
| Standards 1 & 2 – service users’ experience & report of positive outcomes | Direct comparison not possible as the service user survey was modified |
| Carers report being ‘somewhat’ or ‘very’ satisfied with the information and support received | 80% | 81% |
| Range across Trusts                             | 56 – 100% | 55 – 100% |
| Standards 4 – monitoring of physical health risk factors | Monitoring of five risk factors (family history excluded) | 33% | 29% |
| Monitoring of smoking                           | 89% | 88% |
| Monitoring of BMI                               | 52% | 51% |
| Monitoring of glucose control                   | 57% | 50% |
| Range across Trusts for monitoring of BMI       | 5 – 92% | 27 – 87% |
| Monitoring of glucose control                   | 57% | 50% |
| Range across Trusts for monitoring of glucose control | 16 – 99% | 25 – 83% |
| Monitoring of lipids                            | 57% | 47% |
| Monitoring of blood pressure                    | 61% | 56% |
| Monitoring of five risk factors in those with established cardiovascular disease | 37% | 37% |
| Monitoring of alcohol consumption               | 70% | 69% |
| Standards 5 – intervention offered for identified physical health risks | Intervention for smoking | 59% | 57% |
| Intervention for BMI > or = 25kg/m²             | 71% | 76% |
| Intervention for abnormal glucose control       | 36% | 53% |
| Intervention for elevated blood pressure        | 25% | 25% |
| Intervention for alcohol misuse                 | 74% | 72% |
| Standards 6 – provision of information about medication | Service users said they received information | 46% | 52% |
| Trusts said they provided information           | 37% | 42% |
| Standards 7 – involvement in prescribing decision | Service users felt involved | 71% | 74% |
| Trusts said they involved the service user      | 54% | 62% |
Human Rights: why are people detained under the MH act in your area: is it illness or unidentified and unaddressed public health needs

With analysis of the use of the Act by LA and CCG, we can now identify the local conditions that can lead to use of the act & high impact & spend transport hubs, homelessness, no recourse to public funds, cultural mores, link with unemployment & drug and other criminal activities, clinical management & practice variations, service configurations
1.1. Secure services represent a major area of spend

**NHS spend on MH**
- 25% on specialised services

**Spend on NHS-funded MH services (excl. dementia/LD)**
- £6,786m
  - £3,656m
  - £1,669m (25%)
  - £1,288m
  - £174m

**Specialised MH spend**
- 69% on secure mental health

**Spend on specialised services**
- £1,700 m
  - £1,200m (70%)
  - £315 m
  - £70 m

**Secure MH spend**
- 83% on Low & Med secure

**Spend on secure services**
- £1,200 m
  - £200 m (~15%)
  - £525 m (~45%)
  - £475 m (~40%)

- High secure
- Medium secure
- Low secure

Note: All figures 2014/15

Source: Baseline model for MH costing pilot; NHS England specialised services finance teams
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

~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

*Source: Southdown Housing Association*
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.