Suicide prevention & improving depression care: national perspective

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## Areas for action

1. Reduce the risk of suicide in key high-risk groups
2. Tailor approaches to improve mental health in specific groups
3. Reduce access to the means of suicide
4. Provide better information and support to those bereaved or affected by a suicide
5. Support the media in delivering sensible and sensitive approaches to suicide and suicidal behaviour
6. Support research, data collection and monitoring
National support for suicide prevention

- System alignment & cross government thinking
- Parity programme
- Mental health Information & Intelligence programme
- CCG leadership programme launch soon
- Acute and unplanned care review & the Crisis Concordat
- Self Harm: implementing NICE & outcomes
- Primary care review and transformation
- Workforce, workforce, workforce
- Quality improvement tools and agencies
Depression: TACKLING CAUSES

- 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
- Long term physically ill
- People with schizophrenia and sight and hearing problems
- Victims of school and employment stress and bullying
- Alcohol and drug addictions
Commissioning Upstream
mental health is society’s responsibility, not just the health services

Prevention & health promotion
Early identification & early intervention
Timely Access to services offering choice, quality outcome focus
Care at home or in the least restrictive settings,
Crisis response that is easy to access & expert

Parity for people with physical & mental health
Integrated physical & mental health & social care
Where every contact is a kind enabling, coaching experience
# Parity programme

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

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

<table>
<thead>
<tr>
<th>Broken down 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>

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 12-15 years earlier

Depression associated with 50% increased mortality from all disease
National support for suicide prevention

- Mental health Information & Intelligence programme
- CCG leadership programme launch soon..
- Acute and unplanned care review
- Crisis Concordat
- Self Harm : implementing NICE & outcomes
4. Acute care
Mental health  Model Unplanned Tiers of Care
Intermediate tier

Admissions to Acute Care in acute mental health beds

Emergency Department Mental health liaison team (dementia, alcohol, psychosis, self harm all ages)

Single Crisis number coordinating tele triage, tele health + 24/7 community Home treatment team & community alcohol detox,

Primary Care & self-care
Self-harm: Recent findings of relevance to treatment, prevention and policy guidance
Nav Kapur, Keith Hawton

• Self-harm is a major health problem in the UK
• NICE self harm care is being given in only 42%
• This is leading to repeat self harm, suicide, early death from other causes (especially alcohol-related)
• Clinical management can be effective, including preventing repetition
• Very wide variation between hospitals in service provision, in spite of official guidance
• Aim is to provide training to all staff who encounter people with self harm
National support for suicide prevention

- Primary care review and transformation
- Workforce, workforce, workforce
- Quality improvement tools and agencies

- PLEASE, PLEASE respond to the NHS England primary care consultation saying how you think we can better support primary care mental health
CCG GP Mental health leadership programme

Knowledge based leadership for high impact and improving outcomes ………..a new model of leadership

- Personal leadership development
- Mental health Informatics competency
- Expert ‘what good looks like’ immersion week
- Commissioning Information and best practice
International learning

Primary care mental health service organization: they have a ‘stratification’ care cluster approach (Kaeser, Scandanavia, US Vets)

- Demand management: reduce employment and school and community causes
- Prevention targeting of High risk groups
- Self assessment & self management
- Mild Common conditions
- Moderate primary care repeat attenders & LTCs
- Long term severe mental illness
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.
Depression in the Primary Care Setting

Estimated 6-9% of elderly patients in primary care are suffering from major depression.

17-37% suffering from mild depressive symptoms.

7% reporting some suicidal ideation (above 30% for patients with major depression).

Katon USA Depression case managers

• 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.

• The intervention was that Patients were randomly assigned to the IMPACT intervention (n = 906) or to usual primary care (n = 895).
WORKFORCE

• New methods developed in AHSNs and leading providers of
  • Assessing baseline knowledge and learning
  • Master classes for practice nurses and establishing nurse network communities of practice
  • GP and MHTs Masterclasses, CPD Updates, elearning, ‘best’ Trust websites with Information
  • Learning organization culture
MH workforce model: can staff deliver effective care

<table>
<thead>
<tr>
<th>Type of Basic Training</th>
<th>CQC Commission staff survey</th>
<th>Yes, in the last month</th>
<th>Yes &gt; 12 months ago</th>
</tr>
</thead>
<tbody>
<tr>
<td>How to undertake the care programme approach (CPA)</td>
<td></td>
<td>26%</td>
<td>30%</td>
</tr>
<tr>
<td>How to give information on medications &amp; side effects to people with mental health disorders</td>
<td></td>
<td>21%</td>
<td>26%</td>
</tr>
<tr>
<td>How to conduct a mental health risk assessment</td>
<td></td>
<td>32%</td>
<td>30%</td>
</tr>
<tr>
<td><strong>How to identify patients/service users at risk of committing suicide</strong></td>
<td></td>
<td><strong>26%</strong></td>
<td><strong>29%</strong></td>
</tr>
<tr>
<td>How to assess and support carers patients with a mental health disorder</td>
<td></td>
<td>21%</td>
<td>24%</td>
</tr>
<tr>
<td><strong>How to assess &amp; treat service users with dual diagnosis (mental health &amp; substance misuse)</strong></td>
<td></td>
<td>16%</td>
<td>23%</td>
</tr>
<tr>
<td>How to undertake medicines management including non-medical prescribing</td>
<td></td>
<td>21%</td>
<td>19%</td>
</tr>
<tr>
<td>Psychological therapies</td>
<td></td>
<td>24%</td>
<td>21%</td>
</tr>
</tbody>
</table>
UCLP practice nurse master classes

- 2.5 hour Masterclass for practice nurses
- Masterclass developed by a practice nurse mental health expert with RMNs
- Train the trainer model: 1 specialist MH nurse trainer per CCG
- 2.5 hour master classes in each CCG area for 20 PNs
- 800/1400 London practice nurses trained in 6 months
- New modules in depression, suicide prevention, planned
GP Masterclass series

Oxleas NHS Foundation Trust runs a series of free evening masterclasses on mental health and learning disability issues for primary care professionals.

The aim of the series is to:
• Provide GPs with updates on the current evidence-based treatments for common mental health conditions
• Share information on new assessment tools
• Share best practice care pathways
• Topics have included depression, dementia and child and adolescent mental health issues.

How to...

Develop a successful GP masterclass programme

Sharing mental health knowledge and best practice to improve outcomes for patients

Created by Oxleas NHS Foundation Trust
A guide to the assessment and management of risk
October 2009
Edited by Francis Thompson, Simon Sherring and Phil Garnham
Oxleas NHS Foundation Trust

Oxleas stepped care model of assessment and management of risk:
Step 1: Team and organisational culture of support and openness;
Step 2: Engagement and building a trusting relationship with the service user;
Step 3: All service users have a comprehensive current and historical core and risk assessment on RIO;
Step 4: Standardised assessment tools are used to gain more information when appropriate;
Step 5: Caseload zoning with red zone for high risk clients is regularly reviewed;
Step 6: Care plans aim to develop a lifestyle and a career plan that is personalised and recovery orientated;
Step 7: Risk assessments and risk management plans are formally updated before each CPA;
Step 8: Multi-disciplinary case conference are held to pull in Trust expertise;
Step 9: Care plan second opinions from housing, ASBO team, forensic experts;
Step 10: Local High risk multi-agency panels work in partnership to provide risk sharing plans;
Thank you for listening and can you help me to help you more

- PLEASE respond to the NHS England primary care consultation saying how you think we can better support primary care mental health http://www.england.nhs.uk/ourwork/com-dev/igp-cta/

- Acute care review: do you have literature reviews on
  - Self care and self management in MH
  - Tele triage and tele health
  - Primary care MH crisis response
  - Single access crisis home treatment, S 136, transport hub response
Suicide prevention & depression treatment

SUMMARY

What's happening at national level & across the country

• The culture of whole system thinking, partnerships, improvement, shared learning
• The new Parity of esteem thinking and programme
• The 5 national programmes that will support suicide prevention
• Interesting new developments
  • Self harm plans to increase NICE evidence based care
  • Transport hub related

• How do you think we can support suicide prevention & what can we learn from you
• Thank you for all the hard work that your are doing, and the leadership you are showing

PLEASE, PLEASE REPLY TO THE NHS England CONSULTATION ON PRIMARY CARE