Defragmenting - Mental Health Services

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Fragmentation happens when a file system lays out files in non-contiguous parts, or fragments.
In one admission you meet so many teams + staff

- Crisis care team
- Liaison team
- Admitting team
- Inpatient team
- Community team
- Home treatment
- Discharge team
- Different ward
- Support workers
- Tenancy support
- Primary care
- Who will I see next?
Mental health team

- Specialist EIS
- Specialist AOT
- Specialist perinatal
- Specialist Autism & LD
- Specialist forensic
- Specialist drug & alcohol
# RehabPsych

Complex long-term psychosis

<table>
<thead>
<tr>
<th># Persistent symptoms of psychosis</th>
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<tbody>
<tr>
<td># Mental &amp; physical comorbidities</td>
</tr>
<tr>
<td># Relapses &amp; readmissions</td>
</tr>
<tr>
<td># High risks &amp; vulnerabilities</td>
</tr>
<tr>
<td># Functional impairment</td>
</tr>
<tr>
<td># Social exclusion</td>
</tr>
<tr>
<td># Often sent out of area</td>
</tr>
<tr>
<td># Ongoing high support needs</td>
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</tbody>
</table>
#RehabPsych teams work with...

Service users are often surprised at how many teams and agencies are involved in their care. It is not always a nice feeling!

<table>
<thead>
<tr>
<th>Acute wards/ intensive care/early intervention</th>
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<tbody>
<tr>
<td>Forensic services</td>
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<tr>
<td>Housing providers &amp; tenancy support</td>
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<tr>
<td>Community mental health teams</td>
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<tr>
<td>Mental Health Act &amp; legal</td>
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<tr>
<td>Police, Courts, Ministry of Justice</td>
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<tr>
<td>Immigration &amp; home office</td>
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<tr>
<td>Department of work &amp; pensions (Welfare)</td>
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<tr>
<td>Social services &amp; funding panel</td>
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<tr>
<td>Support agencies in community</td>
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<tr>
<td>Peer support services</td>
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<tr>
<td>Community employment resources</td>
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<tr>
<td>Legal and advocacy, mental capacity</td>
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<tr>
<td>Primary care teams</td>
</tr>
<tr>
<td>Physical health secondary care hospitals</td>
</tr>
<tr>
<td>And many others</td>
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</table>
Who could benefit from integrated mental health care?

People with multiple physical and mental health conditions, including older people with frailty as well as younger people with highly complex needs.

People with long-term physical health conditions who would benefit from support for the psychological aspects of adjusting to and living with their condition.

People with persistent physical symptoms such as chronic pain that can be maintained and reinforced by psychological and biological processes acting in tandem.

People with severe mental health problems who often experience poor physical health and less effective care and support for their physical health needs.

Everyone!

www.kingsfund.org.uk/publications
#RehabPsych

![Venn diagram showing the overlap between mental health and physical health.](image-url)
#RehabPsych

Physical health  Mental health  Social care
Prevalence of morbidity compared to national averages

- **Diabetes**: Heather Close 36%, UK average 4.70%
- **Smoking**: Heather Close 64%, UK average 20%
- **Hypertension**: Heather Close 32%, UK average 24%
- **Obese (BMI > 30)**: Heather Close 52%, UK average 27%
- **Multimorbidity**: Heather Close 80%, UK average 12%
10 priorities for integrating physical and mental health
Priority 1: Incorporating mental health into public health programmes
Priority 2: Promoting health among people with severe mental illnesses
Priority 3: Improving management of medically unexplained symptoms in primary care
Priority 4: Strengthening primary care for the physical health needs of people with SMI
Priority 5: Supporting the mental health of people with long-term conditions
Priority 6: Supporting the mental health and wellbeing of carers
Priority 7: Supporting mental health in acute hospitals
Priority 8: Addressing physical health in mental health inpatient facilities
Priority 9: Providing integrated support for perinatal mental health
Priority 10: Supporting the mental health needs of people in residential homes
Mental illness

Substance use

Dual
“Our home is not just a dwelling place. It should be a place of comfort, shelter, safety and warmth...it is the main setting for our health throughout our lives.”
Housing is vital for recovery, but is poorly integrated into health care.

Rehab teams work with housing & help develop skilled support.

#RehabPsych
Key recommendations for housing

- Acknowledge housing as a right
- Offer a range of supported accommodation
- Create joint commissioning strategies between local authority housing, social services and health services
- Provide long-term and permanent solutions
- Nurture a skilled and motivated workforce in the housing sector
- Enable people to live in safe neighbourhoods
- Recognise supported housing as a health intervention
- Provide a choice of holistic support

From the report *More than shelter* available from www.centreformentalhealth.org.uk/more-than-shelter
Out of Sight, Out of Mind?

Fragmentation and social dislocation caused by ‘out of area’ treatment

CQC report 2018, 2020
#InSightInMind
Recommendations

1. NHS England, providers & commissioners must commit to end out-of-area rehabilitation placements.

2. The commitment must include a whole system approach

3. Rehabilitation should be supported by local services in each CCG footprint, as part of the NHS Long Term Plan.

4. Health, housing and social care must work together locally and nationally – both strategically and operationally
Where are my health & care records?

How many sets of records do I have?

Multiple systems = multiple barriers
Health = Social care
Figure 1 Integration of health and social care, in every area of England, by 2020

Co-ordinating health and social care services around the individual, so that it feels like one service.

From...
“...I have to tell my story multiple times to different people”
“...I’m left waiting for services whilst commissioners argue over who pays”
“...I don’t get a say in my treatment”
“...When I’m discharged from a service, I’m not sure where to go next”

To...
“I completed an integrated care plan, setting out who will provide care and support to me and when”
“I receive more care in or near to my home, and haven’t been to hospital for ages”
“I feel fully supported to manage my own conditions and live independently”
1. Digital interoperability

- I have access to a digital integrated care record that moves with me throughout the health and care system. All professionals involved in my care have access to this record (with the appropriate safeguards in place to protect my personal data).
2. Resources aimed to prevent crisis and maintain wellbeing

- If I am at risk of emergency hospital admission, I will receive the right care at the right time to help me to manage my condition and to keep me out of hospital.

- If it would benefit me, I will be able to access a personal budget, giving me greater control over the money spent on my care.
3. Value for money

• I receive the best possible level of care from the NHS and my local authority.
4. Single assessment and care plans

- If I have complex health and care needs, the NHS and social care work together to assess my care needs and agree a single plan to cover all aspects of my care.
5. Integrated community care

• *I receive more care in or near my home.*

• *My GP and my social worker or carer, works with me to decide what level of care I need, and work with all of the appropriate professionals to make sure I receive it.*
6. Timely and safe discharges

• If I go into hospital, health and social care professionals work together to make sure I’m not here for any longer than I need.
7. Social care embedded in urgent and emergency care

- If I have to make use of any part of the urgent and emergency care system, there are both health and social care professionals on hand when I need them.
Continuity of care and clinical outcomes in the community for people with severe mental illness

Alastair Macdonald, Dimitrios Adams, Tom Craig and Robin Murray

Background
High continuity of care is prized by users of mental health services and lauded in health policy. It is especially important in long-term conditions like schizophrenia. However, it is not routinely measured, and therefore not often evaluated when service reorganisations take place. In addition, the impact of continuity of care on clinical outcomes is unclear.

Aims
We set out to examine continuity of care in people with schizophrenia, and to relate this to demographic variables and clinical outcomes.

Method
Pseudoanonymised community data from 5552 individuals with schizophrenia presenting over 11 years were examined for changes in continuity of care using the numbers of community teams caring for them and the Modified Modified Continuity Index (MMCI). These and demographic variables were related to clinical outcomes measured with the Health of the Nation Outcome Scales (HoNOS). Data were analysed using generalised estimating equations and multivariate marginal models.

Results
There was a significant decline in MMCI and significant worsening of HoNOS total scores over 11 years. Higher (worse) HoNOS scores were significantly and independently related to older age, later years and both lower MMCI and more teams caring for the individual in each year. Most HoNOS scales contributed to the higher total scores.

Conclusions
There is evidence of declining continuity of care in this 11-year study of people with schizophrenia, and of an independent effect of this on worse clinical outcomes. We suggest that this is related to reorganisation of services.

Declaration of interest
None.

Keywords
Schizophrenia; outcomes; continuity, reorganisation; cohort.

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Feeling safe in an ongoing therapeutic relationship

Both professionals and service users take initiatives

Getting the right help when needed

Having a range of support options available

Being informed about what is going on

Continuity of care

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Care pathways that integrate needs & choices

Early referral
- My needs
- Near my networks
- Right place
- Easy access

Collaborative Assessment
- MDT care plans
- Risks and needs
- Focused on me
- My strengths

Coproduced Interventions
- Holistic MDT
- Shared decisions
- Least restriction
- Enhance autonomy

Supported Transitions
- Right housing
- Tailored support
- Enablement
- Choice

Least restrictive, coproduced, guided by “my needs”
Joint working

Integrated rehabilitation pathway

1.3.10 The lead commissioner should work together with service providers to deliver an integrated rehabilitation pathway, by ensuring that:

- regular communication is supported between senior service managers and senior clinicians across providers of different services within the pathway

- budgets and other resources are shared between local authorities and health services, so that local and regional rehabilitation services meet the local population’s needs

- funding mechanisms support collaboration between service providers and do not create unhelpful or perverse funding incentives that undermine people’s progression through the rehabilitation pathway

- clinical records and care plans are shared between providers

- service level agreements are developed so that relevant services and agencies can work together in a timely and flexible way, including for transitions between services (see recommendation 1.3.7)

- services within the pathway are staffed by appropriately skilled staff

- the remit for each of the services making up the pathway (see recommendation 1.3.1) is clearly specified, including the population they cover.
Universal Personalised Care: Empowering 2.5M people to have more choice and control over their own health and care by 2024.

#NHSLongTermPlan

www.england.nhs.uk/personalisedcare
If service users had control over their health and social care budgets, how would they choose to organise their care around their needs?
A person centred, whole system approach to SMI

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<tbody>
<tr>
<td>1</td>
<td>Whole system is person centred &amp; co-designed with service users</td>
</tr>
<tr>
<td>2</td>
<td>Joined up care pathways that ensure continuity &amp; with few barriers</td>
</tr>
<tr>
<td>3</td>
<td>Reducing system complexity and bureaucracy (and form filling)</td>
</tr>
<tr>
<td>4</td>
<td>Integrated data systems, reducing duplication and care is safer</td>
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<tr>
<td>5</td>
<td>Services are less territorial and designed to be not competitive</td>
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<tr>
<td>6</td>
<td>Intelligent commissioning which also uses a person centred model</td>
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<tr>
<td>7</td>
<td>Streamline the primary care + physical + mental health interface</td>
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THANK YOU