Mental health's time has come

'The evidence is irrefutable: mental illheath is preventable, has scientific evidence of the benefit to people, communities, whole local economies, and government, of evidence based investment'

Transformational partnerships for value are needed with leaders equipped with information & intelligence & new financial mechanisms

Dr. Geraldine Strathdee,
Mental health intelligence and leadership programme
Jan 2016

Fundamental new insights on the economics of mental health: the user narrative, scientific evidence, HM Treasury deep dives

- In England, we spend a lot of money on mental health, but we spent it on dealing with the consequences of NOT having provided prevention and early access to highly cost effective treatments

- So a lot of lives are lived in misery, children brought up in poverty, expensive institutions are full, and our communities are less wealthy and have less social capital than a different pattern of leadership & investment would enable

- There is a wealth of evidence from people, International scientific evidence, and Intelligence examples of 'what good looks like' to work out how to reverse this poor use of taxpayers money ……..

- There is a wealth of evidence on how to make quick wins that can transform outcomes and energize

Every government's dream:

……*the answer to building a successful country*

Benefits of Good Mental Health

There is good quality evidence that improving wellbeing, including mental wellbeing, has a wide range of health, social and economic benefits. These include:

- *Reduced risk* of mental illness and suicide
- *Improved physical health* and life expectancy
- Better *educational attainment*
- *Reduced health risk* behaviours such as smoking, alcohol and drug use
- Improved employment rates and productivity
- Reduced antisocial behaviour and criminality
- *Higher levels of social interaction* and participation
- *Supporting recovery and reducing stigma and discrimination* faced by people with mental health problems

Building collaborative , resilient communities for England

Key questions: Based on the known clinical, academic and 'what good looks like in practice' intelligence & evidence

1. How much wealth and social capital can be achieved by optimizing positive mental health & resilience in individuals and communities
2. How much mental illhealth can be prevented …up to 20-30%?
3. At the onset of a mental illness, how much early intervention can be provided through rapid access to education, digital & peer support
4. How much treatment can be provided with online therapies + support

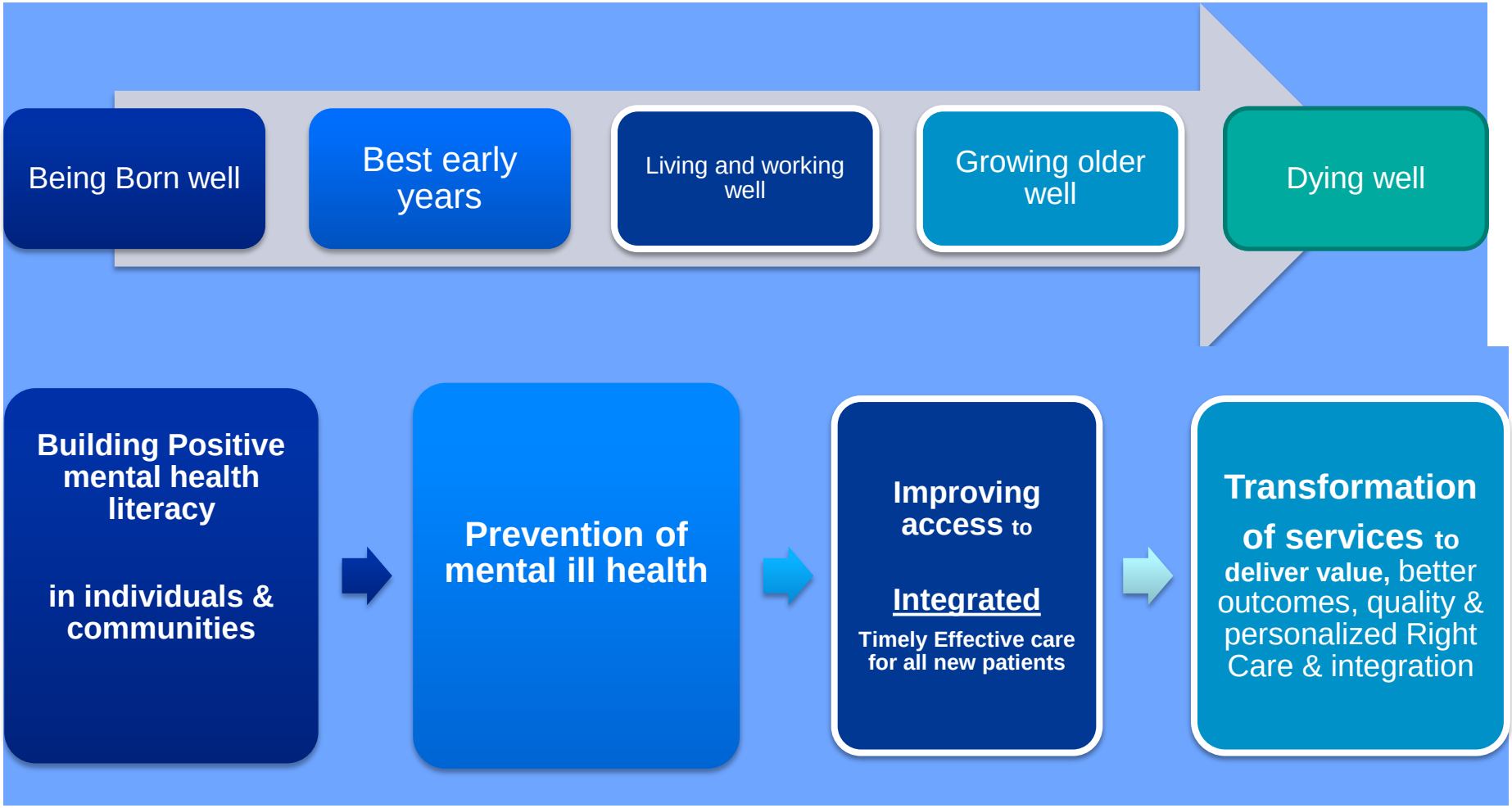
Within health care :

1. What is the most clinically and cost effective model of wider primary care MH, where 80% of MH happens, and what can be achieved by community pharmacy & a focus on (Intermountain style) CYP services
2. How can we maximise value in integrated care HRGs in acute care & LTC pathways
3. How do we stratify the top 10% high cost, low volume crisis, admissions and high cost episodes which accounts for 40% spend
4. How do we maximise community care as hospital care accounts for 50% spend for 10% people

This presentation

- The new national priority for mental health
- The evidence on the economics of mental health
- World Cities new approach to mental health
  - The London Commission
  - HM Treasury review 2016
  - New York, 2016
- West Midlands & Bradford
- What is needed for strategy
- What is needed for implementation

The 5 Year Forward View Lifespan approach to mental health policy: making clinical and economic sense



To achieve it needs Leaders, information, intelligence, incentives & improvement plans

London and New York: international city leaders
6 Guiding principles

NHS England

LONDON MENTAL HEALTH

The invisible costs of mental ill health

MAYOR OF LONDON

New York City's greatness is founded on a simple promise: you can thrive here, no matter where you come from or where you want to go in life.

But for too many New Yorkers, poor mental health interrupts the realization of that great promise. As City leaders, we are obligated to use every tool and power of government to make sure there is a path to health and happiness for all New Yorkers. For that to be possible, we need a true and effective mental health system.

We take a huge step forward on that journey with the release of *ThriveNYC: A Mental Health Roadmap for All.*

The mental health crisis facing the residents of our city has been decades in the making. Mental health issues have not been treated by the public or private sectors with the same urgency as physical health issues—even as illness and other threats to mental health affect the lives of nearly every family in the five boroughs each year.

Public initiatives to support the mental health of New Yorkers have been underfunded by billions. Commercial insurers have only been required to provide comparable coverage for mental health treatment under all policies since 2010, and they have a long way to go in providing full and fair coverage.

This legacy of scarce resources, and scarcer attention, has prompted a practical and moral obligation for City government to take up this work. We are serious about getting New Yorkers the help they need to overcome the symptoms of mental illness. But we are also determined to prevent mental illness whenever we can, and that means doing everything we can to alleviate the severe stresses that are at the root of many conditions.

So while we strive to make sure every New Yorker in every community has access to a mental health professional, we simultaneously need to keep building and preserving affordable housing in those communities—so more families are freed from worrying every waking moment about whether they'll be able to make rent that month.

As we work to identify and treat new mothers who suffer from postpartum depression, we must simultaneously provide more working parents with protections like Paid Sick Leave, so no one has to choose between their child's health and their job.

And as we build toward a time when all of our schools offer mental health services to their children, we also need to make sure our kids have essential social-emotional supports in pre-kindergarten and after-school programs.

By following the path laid out in this Roadmap, we will change the trajectory of the lives of so many New Yorkers, and help them become better parents, friends, co-workers, and students.

To make this future a reality, we need your help. If your life has been touched by mental illness, please share your story with someone you trust. And if someone you know is going through a tough time, take a moment to hear them out. There are now more and better resources that are easier for New Yorkers to access. A crisis decades in the making won't be resolved overnight, but *ThriveNYC* is the first step in our mission to help our citizens fulfill their potential.

As the First Lady says, there is no health without mental health. Let's get healthy—together.

Bill de Blasio

Mayor Bill de Blasio

London calculated the costs of NOT addressing mental health in an evidence based way

The Cost to London

The wider impacts result in around **£26 billion** each year in total economic and social costs to London.

The public sector spends **£7.5 billion** a year to combat it.

Another **£2 billion** is lost through lost taxes.

MAYOR OF LONDON

Reduced workforce productivity

£920 million in sickness absences

£1.89 billion in reduced productivity

£7.20 billion in increased worklessness

A total £10.4 billion is lost to London business and industry.

The way london calculated the cost : www.london.gov.uk/mentalhealth

Creating Social Capital

- The London Commission, (2014) which was on wider health, is an exemplar of how the city leaders

Analysed

- the key impacts of mental illness
- the evidence base on effective interventions

Developed an evidence based responsive strategy which focuses on

- Early years ‘Best start in life” evidence based strategy
- “Healthiest Employer’ city
- Primary care at scale developments
- Safer transport development
- Major police forces / NHS collaboration to almost zero police cell use
- Is commissioning a £2.6 million on line digital platform to support individuals and peer communities develop resilience

Context from Geraldine Strathdee, National Clinical Director: "Access to evidence based care delivered by trained staff is less accessible in MH"

NHS England

Access to effective care by condition….	% in treatment
Anxiety and depression	24
PTSD	28
Psychosis	40-80
Eating disorders	25
Alcohol dependence	23
Drug dependence	14

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

Enhanced Primary care Diabetes services was key to better care, reducing hospital spend

Mental health conditions is the largest proportion of the disease burden in the UK (22.8%), larger than cardiovascular disease (16.2%) or cancer (15.9%)

People with psychosis die 14-20 years earlier of untreated physical illnesses due to 14/4% being excluded from basic health checks so they use x 4 A/E & acute services

7% SMI are in paid work
59% triple amputees are in paid work

England spends a large amount on institutional care by several departments, more than needed for prevention, self management, early intervention of effective treatments.
Is this Value based policy and care?

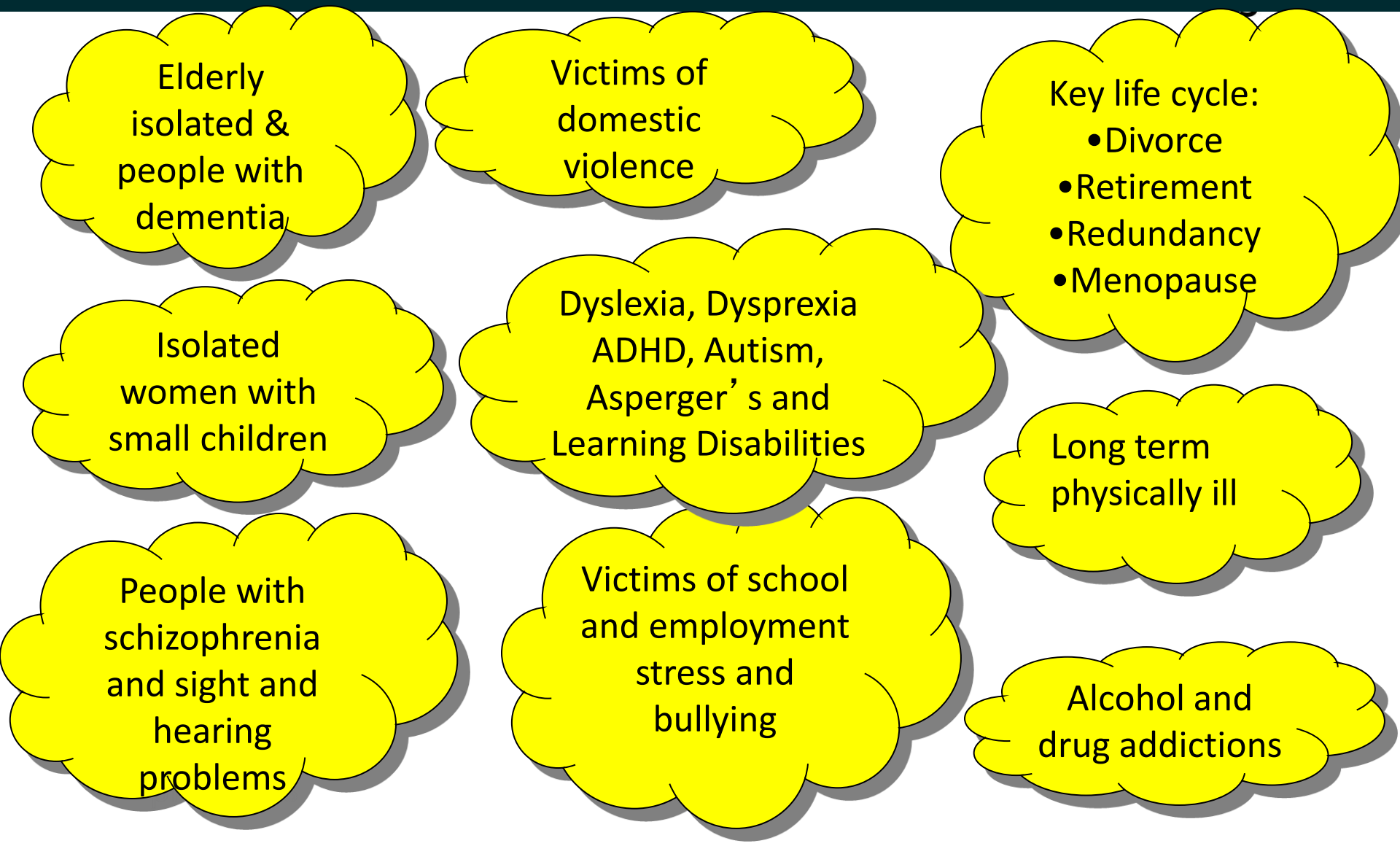
Key questions:

- **What are the levels of investment in prevention and access to effective services for people with mental ill health?**
- **Why do only under 33% access treatment?**
- **What proportion could be prevented and why is there little spend on prevention of mental ill health?**
- **For those who do access treatment how good is the quality and outcomes?**
- **Why are people with mental illness the most excluded from treatment in primary care in England?**

See LSE paper for further context and facts: http://cep.lse.ac.uk/pubs/download/special/cepsp26.pdf

Depression : think about the causes & solutions follow…….

Which part of government, local government, social care and healthcare need to act?



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?

Access standards to Right Care for psychosis, perinatal conditions , eating disorders will lead to major changes in life outcomes and value …….*aiming for world best* ..

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

Primary Care mental health: time to get evidence based

NHS England

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, personlaised budgets, safe monitoring

To reduce 20,000 avoidable deaths a year

Depression/ anxiety

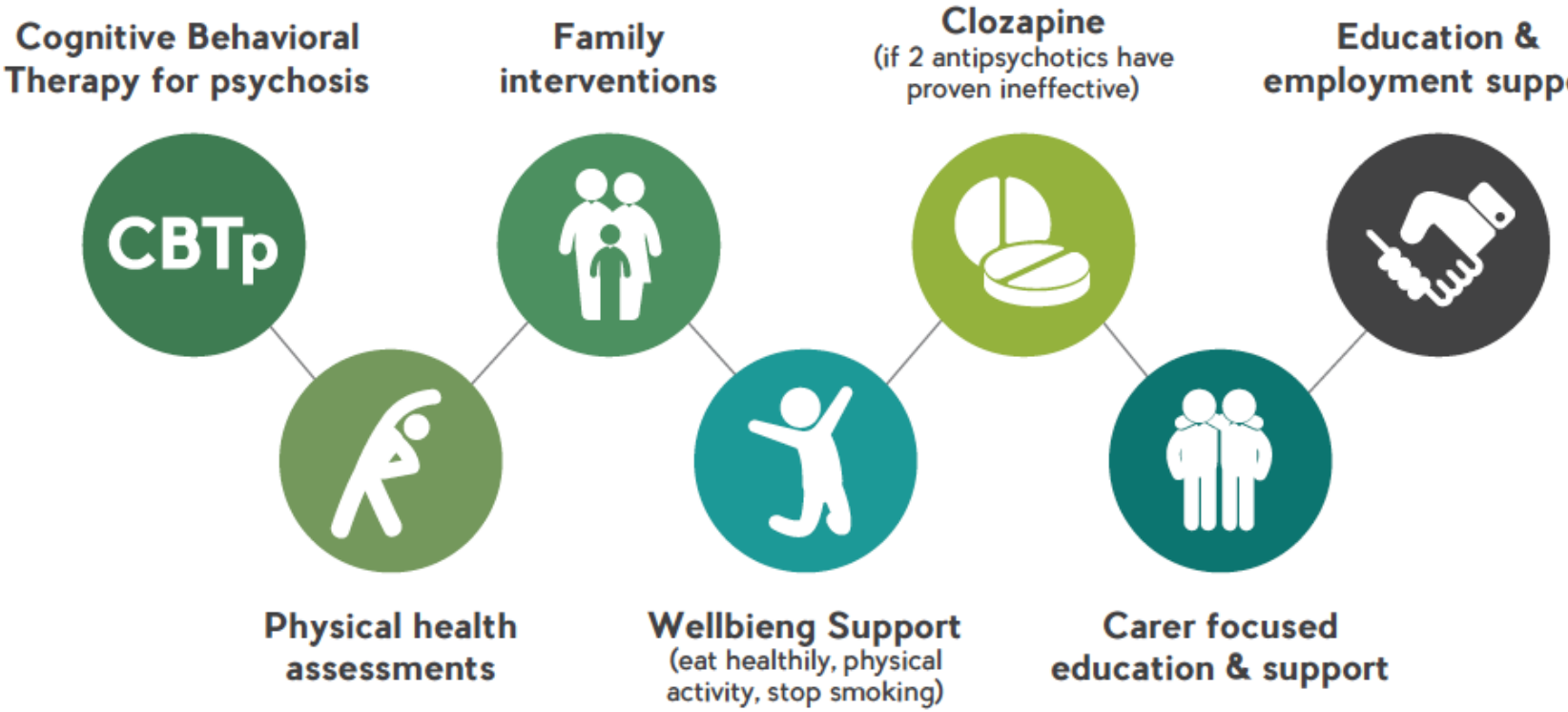
Direct access to mental health trained staff & psychological therapy

To reduce 4000+ suicides a year

Integrated physical and mental health care for MUS & LTCs care

To save 13 billion/ year

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:



time4recovery.com

TIME4 RECOVERY.
SOUTH REGION EIP PROGRAMME

Primary care: basic changes needed to fast track development

…learning from the best of international primary care in New Zealand, Canada, America, Australia, Europe, occasionally in England stratification & skillmix

1. Registration & annual checks: making every contact count

- Include 1 min self completion MH & behavioural health assessment e.g. Ipad eChat

2. Primary care team skillmix : 1/3rd to be MH workers

- Mental health is 30% of the daily work of primary care, so we need the new focus on primary care MH staff, direct access to psychological therapists, older adult depression case managers, GPwSI In alcohol, specialist practice nurses & other core MH staff

3. Primary care clinician decision support tools works well for e.g. diabetes

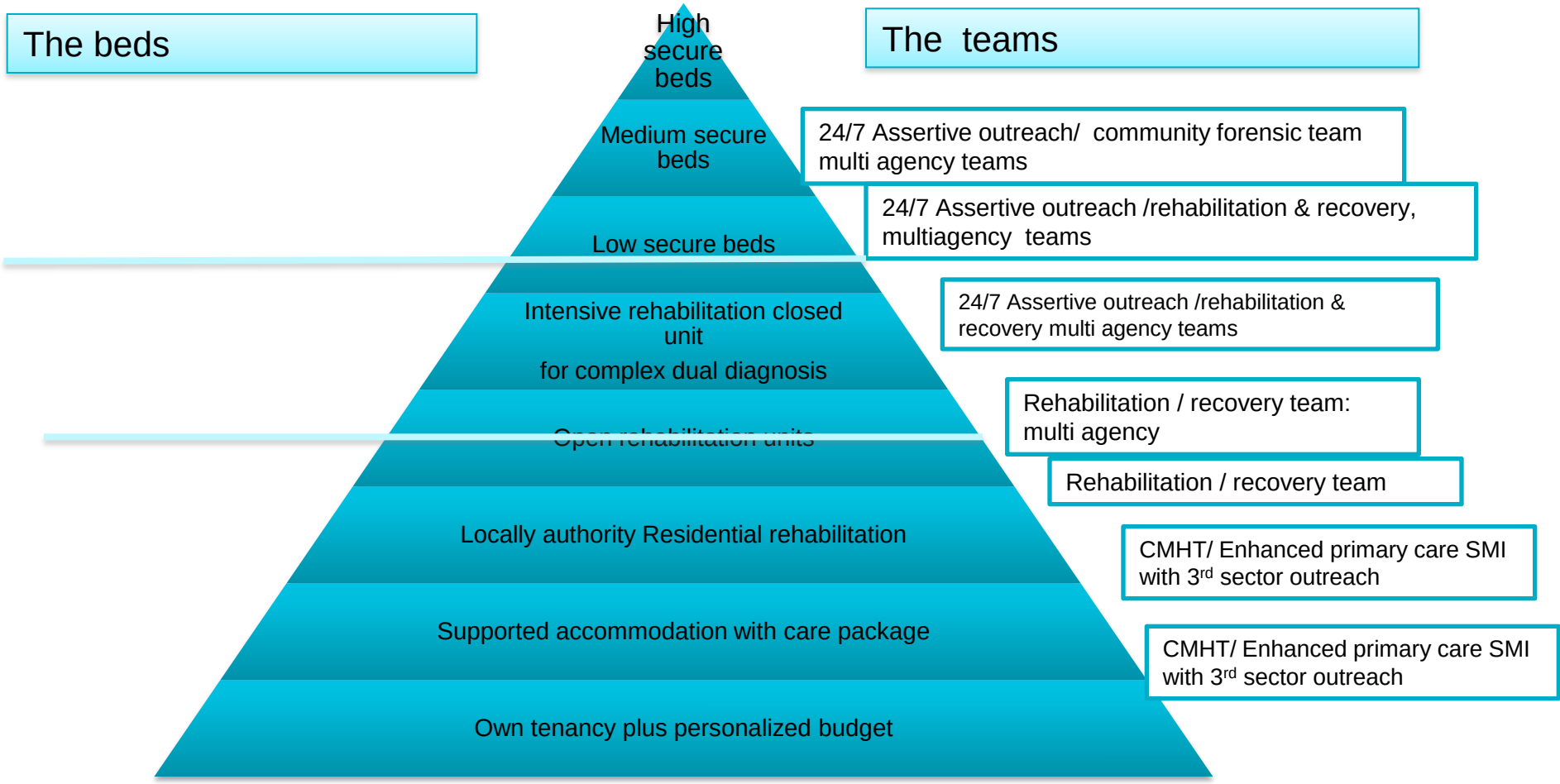
- Clinicians decision support templates, especially for annual physical QOF SMI check e.g. Bradford genius one, digital apps.
- Family and 3rd sector outreach to support people attend for health checks

4. Primary care 'at scale' value integrated care groups e.g. US,Oxford, Swindon

- Living well' with stroke, diabetes, pain, COPD, bariatric surgery,
- Enhanced SMI care, Enhanced MUS care, Alliance commissioning models

Mental health system of care:

for elective care we need a MH taskforce to build personalized, recovery orientated, high quality care & reduce suicide at every level

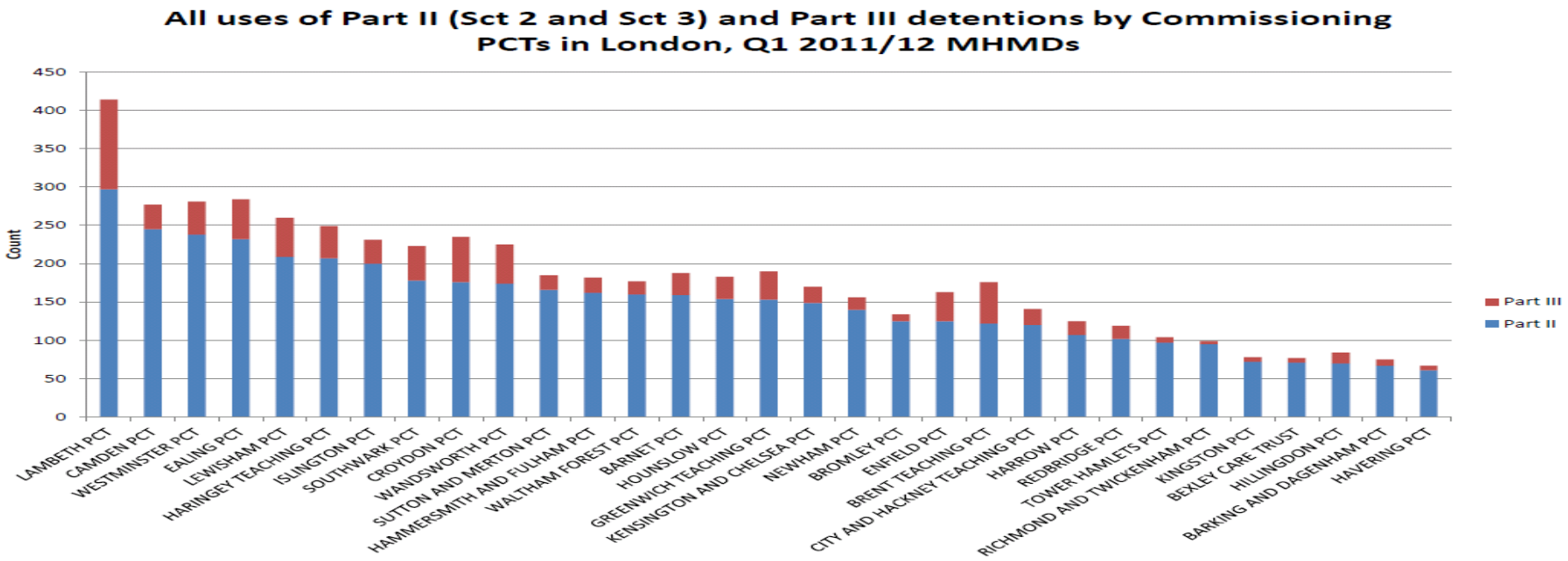


Design Principle :It is vital to understand that in mental health our 'technology' and 'care model design principle' is that in order to provide safe, NICE concordant , efficient services, we need proven effective care teams to link with beds

In mental health we are expert at using case managers to triage all admissions & work early on the discharge plans

Commissioning to address causes & reduce repeat crises that can be prevented with care plan review

the use of the mental health act part 2 and 3 by CCG area



So now, we can identify the local conditions that can lead to use of the act & address the CAUSES :

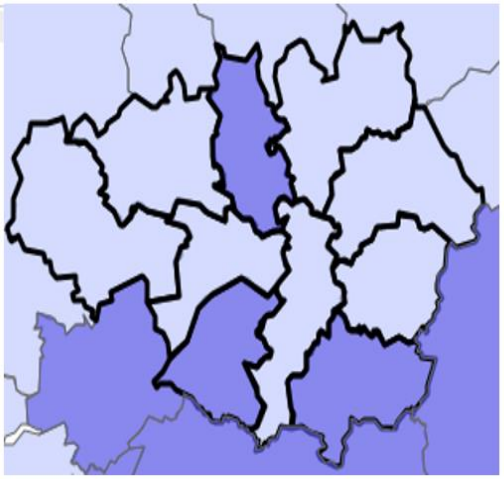
- transport hubs, homelessness, no recourse to public funds, cultural mores, link with unemployment & drug and other criminal activities, clinical management & practice variations, service configurations

What are the GM social determinants of mental ill-health the Risk factors in Greater Manchester

Socioeconomic deprivation: % of people living in 20% most deprived areas

Area	Count	Value
Manchester	334,862	65.1
Salford	112,886	47.2
Rochdale	97,249	45.8
Oldham	101,489	44.6
Bolton	116,081	41.4
Tameside	80,949	36.7
Wigan	96,965	30.3
Bury	36,753	19.7
Stockport	36,818	12.9
Trafford	25,860	11.2
England		20.4

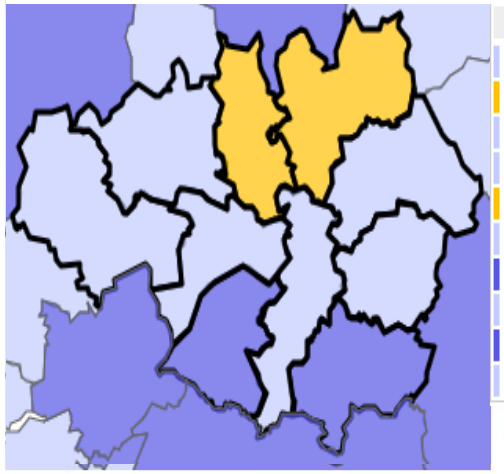
Compared to England: Lower, Similar, Higher



long-term unemployment: % of working age population

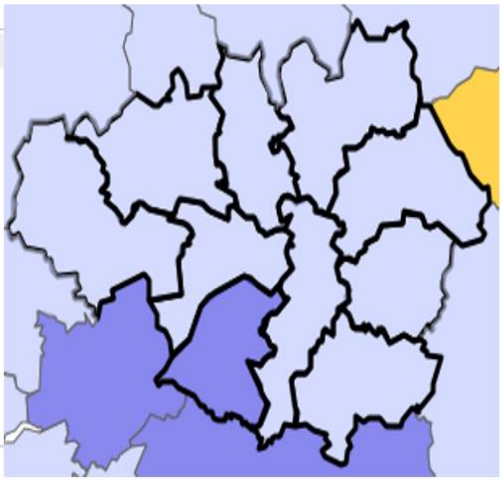
Area	Count	Value
Bolton	1,665	0.95
Bury	670	0.57
Manchester	3,220	0.89
Oldham	1,100	0.78
Rochdale	830	0.62
Salford	1,135	0.72
Stockport	915	0.52
Tameside	930	0.66
Trafford	625	0.43
Wigan	1,425	0.70
England		0.61

Compared to England: Lower, Similar, Higher



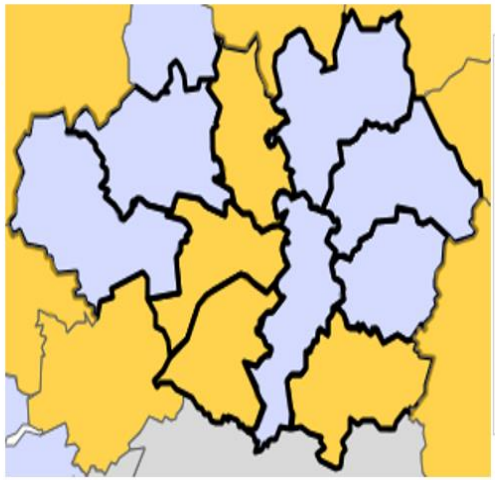
Long-term health problems or disability: % of people whose day-to-day activities are limited

Area	Count	Value
Wigan	68,321	21.5
Rochdale	44,359	21.0
Tameside	45,931	20.9
Salford	48,417	20.7
Bolton	54,913	19.8
Oldham	44,326	19.7
Bury	34,821	18.8
Stockport	52,259	18.4
Manchester	89,364	17.8
Trafford	38,603	17.0
England		17.6



Self-reported well-being: % of people with a low satisfaction score

Area	Count	Value
Rochdale	-	12.7
Oldham	-	11.2
Manchester	-	9.2
Bolton	-	8.3
Tameside	-	7.7
Wigan	-	7.5
Bury	-	5.9
Trafford	-	5.8
Salford	-	5.5
Stockport	-	5.2
England		5.6



Summary: GM is an area of high mental health morbidity due to the presence of high levels of the social determinants of mental illnesses

- 7/12 GM LAs have significantly high numbers among the 20% most deprived in the country, in 5 boroughs this is more than 40% of people
- 6/12 GM LAs have notably high rates of Long term unemployment
- All GM LAs (bar Trafford) have high rates of long term health problems. In Wigan, Rochdale, Tameside & Salford this is more than 20% of the population
- 6 GM LAs have low self-reported satisfaction scores - in Rochdale and Oldham this more than 10% of the population

What is the transformational MH crisis care model

Crisis Concordat & the Urgent & Emergency Care review

1. Identify Causes & Prevent by all agencies :

- *Identify the causes of MH crises & prevent*

•Public health, Health & Wellbeing Boards, CCGs, transport systems, police, housing, social care, primary care

2. Single coordinated access number & system

- *single access number to ring ? 111*
- *all agency response, GPs, social care, NHS*

3. Tele triage and tele health well trained staff

- *which reduced face to face need by 40%*
- *Which can reduce suicide risk*
- *Which respond to police & other referrers*

4. S 136 places of safety/ street triage. Crisis home treatment team response

5. Crisis Home treatment teams with fidelity

- *reduce admissions and LOS by 50%*
- *? Could coordinate street triage etc*

6. Liaison mental health teams

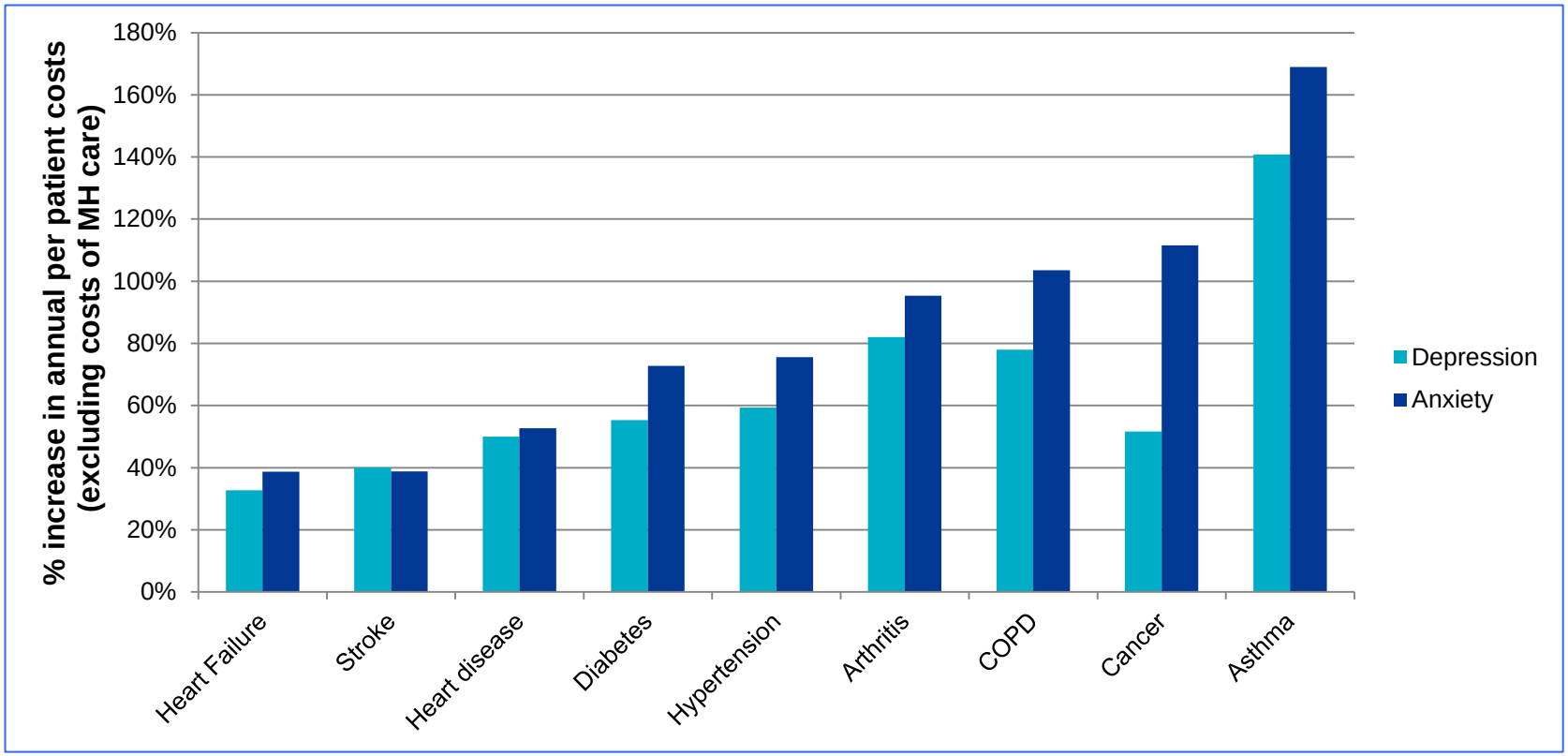
•in A/E & acute trusts reduce admissions to acute beds and care homes by 50% & reduced LOS

7. Crisis houses & day care for as alternatives

8. **Adequate acute beds when needed**

Acute & community provider long term conditions & integrated care Comorbidities- common, costly in current silo models of care and commissioning and tariff system incentives inappropriate

Comorbidities & mental ill health becoming the norm



Co-morbid MH problems are associated with a 45-75% increase in service costs per patient (*after controlling for severity of physical illness)*

Between 12% and 18% of all expenditure on long-term conditions is linked to poor mental health and wellbeing – at least **£1 in every £8** spent on long-term conditions.

Compelling Value examples : Compendium of examples of cost effective programmes for people with physical illnesses in acute trusts, primary care

Mental Health Network
NHS CONFEDERATION

briefing
November 2011 Issue 228

With money in mind

The benefits of liaison psychiatry

Key points

- Liaison psychiatry services can save money as well as improve the health and well-being of patients.
- Liaison psychiatry services are increasingly seen as an essential component of effective care in acute hospitals.
- The RAID service in Birmingham is an approach which has the potential to save very significant amounts of money for the local health economy.

"Improving the quality of treatment and care in health services is a difficult and continuous challenge in itself, but with co-morbidities and complexity increasing at a time of economic austerity, it can appear daunting to say the least. There have been some significant successes in a range of QIPP (Quality, Innovation, Productivity and Prevention) initiatives but more needs to be (and can be) done.

"Liaison psychiatry services are increasingly seen as an essential component of effective care in acute hospitals. Their clinical effectiveness has been well documented, but little has been known up to now about their potential economic impact.

"The RAID service in Birmingham represents an evolution of the liaison model and an approach which undoubtedly improves the quality of care for people with mental ill health in an acute hospital. An independent economic analysis shows that at the same time the approach has the potential to save very significant amounts of money for the local health economy.

"This *Briefing* outlines the benefits that the RAID service has brought in terms of cost savings and improved health and well-being for patients. It will be of particular interest to all those who commission and provide acute hospital and mental health services."

Hugh Griffiths, National Director for Mental Health
Lawrence Moulin, Chair of the National Mental Health SHA Mental Health Leads

Produced in association with:

Centre for Mental Health
Realising a better future

LSE The London School of Economics and Political Science

Mental Health Network
NHS CONFEDERATION

Investing in emotional and psychological wellbeing for patients with long-term conditions

A guide to service design and productivity improvement for commissioners, clinicians and managers in primary care, secondary care and mental health.

The King's Fund

Centre for Mental Health

Authors
Chris Naylor
Michael Parsonage
David McDaid
Martin Knapp
Matt Fossey
Amy Galea

Long-term conditions and mental health

The cost of co-morbidities

February 2012

Key messages

- Many people with long-term physical health conditions also have mental health problems. These can lead to significantly poorer health outcomes and reduced quality of life.
- Costs to the health care system are also significant – by interacting with and exacerbating physical illness, co-morbid mental health problems raise total health care costs by at least 45 per cent for each person with a long-term condition and co-morbid mental health problem.
- This suggests that between 12 per cent and 18 per cent of all NHS expenditure on long-term conditions is linked to poor mental health and wellbeing – between £8 billion and £13 billion in England each year. The more conservative of these figures equates to around £1 in every £8 spent on long-term conditions.
- People with long-term conditions and co-morbid mental health problems disproportionately live in deprived areas and have access to fewer resources of all kinds. The interaction between co-morbidities and deprivation makes a significant contribution to generating and maintaining inequalities.
- Care for large numbers of people with long-term conditions could be improved by better integrating mental health support with primary care and chronic disease management programmes, with closer working between mental health specialists and other professionals.
- Collaborative care arrangements between primary care and mental health specialists can improve outcomes with no or limited additional net costs.
- Innovative forms of liaison psychiatry demonstrate that providing better support for co-morbid mental health needs can reduce physical health care costs in acute hospitals.
- Clinical commissioning groups should prioritise integrating mental and physical health care more closely as a key part of their strategies to improve quality and productivity in health care.
- Improved support for the emotional, behavioural and mental health aspects of physical illness could play an important role in helping the NHS to meet the Quality, Innovation, Productivity and Prevention (QIPP) challenge. This will require removal of policy barriers to integration, for example, through redesign of payment mechanisms.

