

**Canadian
Collaborative Mental
Health Conference**

**Interprofessionalism
to enhance
collaborative care**

**Toronto, Canada
20th June 2014**

Collaborative mental health care and co-morbidity in primary care- a global perspective

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Founding Chair, Wonca Working Party on Mental Health

Declaration of Conflict of Interest

Canadian Collaborative Mental Health Care Conference



- Nothing to declare relevant to this presentation

Acknowledgements:

Canadian Collaborative

Mental Health Care Conference



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- The Conference Chairs Professors Peter Selby and Arun V Ravindran
- The Project Co-ordinator Marina Bourlak
- Julia Lecce Assistant Manager
Centre for Addiction and Mental Health
- The conference participants
- My collaborators in Wonca, WFMH and NHS Waltham Forest

Aims

- To show that mental health is an integral and essential component of general health
- To quantify the contribution of mental health to other long term conditions
- To explore the concept of collaborative versus integrated care
- To demonstrate the need to review skill mix and redesign systems to better address the challenges of co-morbid health conditions
- To provide a range of practical examples that will enable participants to design their own protocols for establishing collaborative care models for managing co-morbidity and mental health

The case for collaborative care

- Why do we need it ?
- Is it effective?
- Can it be replicated?
- How can you do it?
- What are the key ingredients for success?

The unmet need

1. People with severe mental illnesses have a two to threefold increased risk of death compared to persons of the same age and sex in the general population. They die on average 20 years younger than the general population, cardiovascular disease being the leading cause of excess mortality.
2. People with severe mental illnesses are 2 to 3 times more likely to develop diabetes and other cardiovascular risk factors. Only one-third have normal weight.
3. Poor physical health can entail severe mental illness – the risk of developing depression doubles in people with diabetes. The majority of cancer sufferers will also get depressed, affecting both quality of life and survival.
4. Combined mental and physical health problems engender stigma for individuals and their families. Almost two-thirds of all people with mental disorders do not seek treatment, largely because of stigma.
5. Mental and physical health problems have substantial costs to society: the costs of poor mental health alone in the EU have been estimated at €436 billion each year (more than €2,000/ household). The additional costs of physical health problems in mentally ill may increase this figure by as much as 70%.
6. There are also positive interactions between mental and physical health: mental well-being supports good physical health and vice versa.

Enabling change through policy

1. The links between mental and physical health must be recognised and addressed in all health-related strategies and programmes at EU and national levels, including disease-specific and other policies such as social, employment, discrimination, research and education, nutrition, tobacco and alcohol. Policy makers should ensure that integrated mental and physical health care is the norm and not the exception.
2. Health systems need to ensure adequate structures and processes, such as training schemes and guidance to health care professionals, carers, families and service users, in order to empower them to tackle combined mental and physical health challenges in their respective environments.
3. Health promotion objectives and measures should better reflect the interplay between mental and physical health, including in health information campaigns and incentives to encourage behaviour change.
4. Decision makers should set up systematic monitoring structures, benchmarks and performance assessments to ensure the implementation of policies supporting integrated care.
5. Targets and actions for improved mental and physical health and well-being must be matched with need-based resource allocation.

SOME FACTS

More than **450 million** people suffer from mental disorder globally.

The lifetime risk for schizophrenia is 0.8% - 1.44%.

25% of all individuals develop one or more mental disorders during their life course.

DEPRESSIVE DISORDER

is the fourth leading cause of disease burden (in DALYs) globally and is projected to increase to the second leading cause in 2030.

Globally, nearly 50% of people who have schizophrenia receive

NO mental health interventions.

CANNABIS

is the most widely used illicit drug and 3.8% of the global population older than 15 years use this drug.

Treatment is often **INADEQUATE** in those people who have received treatment for schizophrenia and **2.8%** of total years lived with disability are due to schizophrenia.

Many people with mental disorder have poor access to care.

Suicide is a serious public health problem and accounts for more than **10% of deaths** in industrialised countries.

4.4% of the worldwide burden of disease is attributable to alcohol consumption.

Disorders due to use of illicit drugs are associated with an increased risk of other infectious diseases such as hepatitis B and C and HIV infections.

LIFETIME estimate of prevalence for depression and dysthymia is **4.2% - 17%**.

INTERNATIONAL COURSE IN PRIMARY CARE MENTAL HEALTH

- Challenges are great
- Science to service gap in mental health
- Service to reality gap in mental health
- We need to improve access with an appropriate skill mix

Primary care is very important

The World Health Report 2008

Primary Health Care



Now More Than Ever



Integrating
mental health
into primary care
A global perspective



Integração
da saúde mental
nos cuidados
de saúde primários
Uma perspectiva global



Examples of good practices





Mental health in Belize

Paucity of epidemiological data in international literature

Harmful use of alcohol, particularly among men, is regarded as problematic for the country.

Family violence

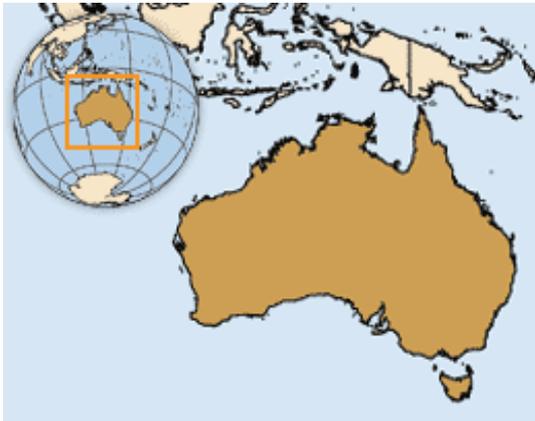
National mental health programme: creation of networks for guaranteeing care within the community

Future development planned:

- Department of Mental Health
- Acute mental health units
- Support systems at regional hospitals

Best practices: Australia

Integrated mental health care for older people in general practices in inner-city Sydney



- General practitioner physicians provide primary care for mental health to patients
- Community psychogeriatric nurses, psychologists, and geriatric psychiatrists give advice and support
- Supported, collaborative, and shared model of care

- ➔ Greater autonomy and responsibility of primary care providers for older people's mental health care
- ➔ Less 'revolving door' patients due to better continuity of care

Best practices: Argentina

Physician-led primary care for mental health in Neuquén province, Patagonia region



- Primary care physicians lead the diagnosis, treatment and rehabilitation of patients with severe mental disorders
- Specialists advise on complex cases
- Community-based rehabilitation centre provides training and complementary clinical care in close coordination with PHC: the 'Austral'

- ➔ Improved social inclusion for people with mental disorders
- ➔ Lower cost for effective community-based mental health services

Complexity and integration

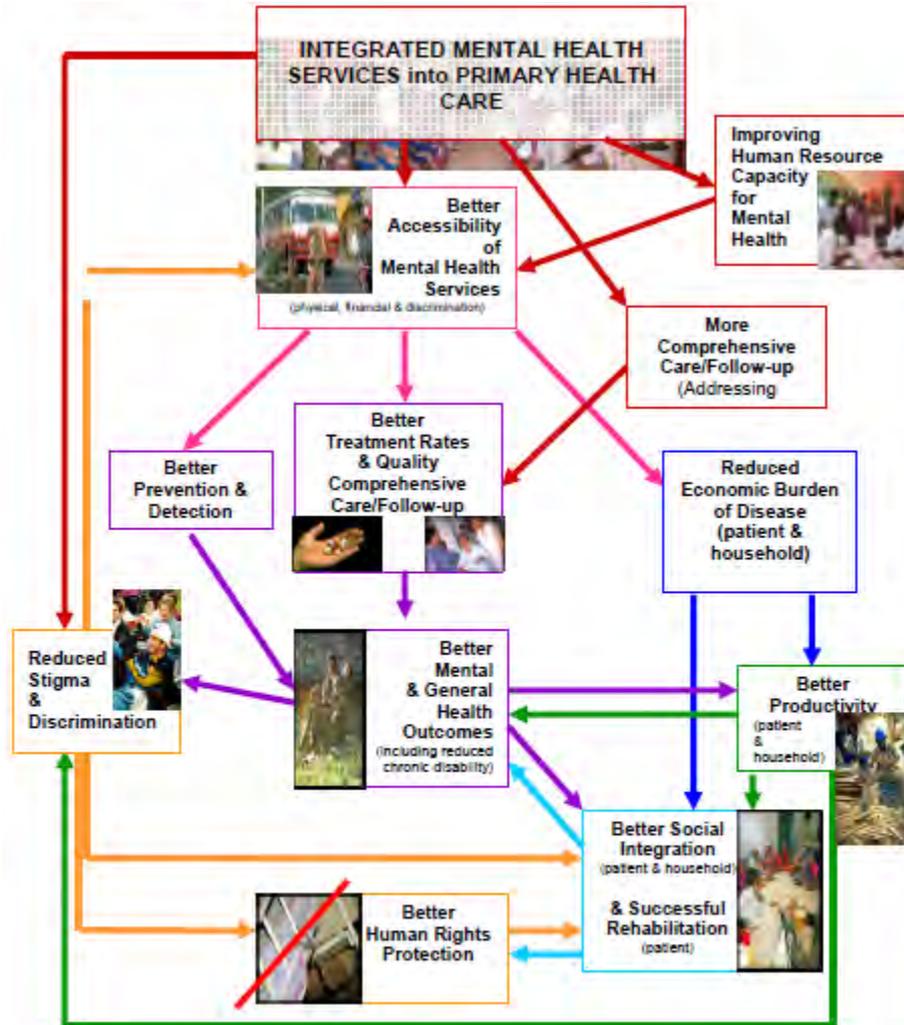


Figure 1: Rationale for Integrating Mental Health Services into Primary Health Care

The aspiration to reality gap in mental health

Maudsley Discussion Paper No. 1

THE GENERAL PRACTITIONER, THE PSYCHIATRIST AND THE BURDEN OF MENTAL HEALTH CARE

David Goldberg & Kevin Gournay
Institute of Psychiatry, London

THE MAUDSLEY
enhancing mental health care

750 YEARS
OF PSYCHIATRY IN MIND

BETHLEM
HOSPITAL
1275-1981

‘Administrative and medical logic alike suggest that the cardinal requirement for the improvement of mental health services is not a large expansion of psychiatric agencies, but rather a strengthening of the family doctor in his therapeutic role’

Michael Shepherd 1966

Has anything changed?

Alvarez et al. *BMC Research Notes* 2013, **6**:61
<http://www.biomedcentral.com/1756-0500/6/61>



RESEARCH ARTICLE

Open Access

Endocrine and inflammatory profiles in type 2 diabetic patients with and without major depressive disorder

Adriana Alvarez^{1,5*}, Jose Faccioli¹, Mónica Guinzbourg¹, María M Castex¹, Claudia Bayón¹, Walter Masson², Ignacio Bluro², Andrea Kozak¹, Patricia Sorroche¹, Lina Capurro¹, Luis Grosembacher¹, Adrián Proietti¹, Carlos Finkelsztejn¹, Lucas Costa³, Patricia Fainstein Day¹, Arturo Cagide², León E Litwak¹ and Sherita H Golden⁴

Diabetic patients with depression are more likely to experience cardiovascular events

Collaborative Care for Depression

A Cumulative Meta-analysis and Review of Longer-term Outcomes

*Simon Gilbody, MBChB, MRCPsych, DPhil; Peter Bower, PhD;
Janine Fletcher, MSc; David Richards, PhD; Alex J. Sutton, PhD*

Conclusions: Collaborative care is more effective than standard care in improving depression outcomes in the short and longer terms. Future research needs to address the implementation of collaborative care, particularly in settings other than the United States.

Arch Intern Med. 2006;166:2314-2321

Re-defining the role of primary care



Integração
da saúde mental
nos cuidados
de saúde primários
Uma perspectiva global



Integrating
mental health
into primary care
A global perspective



10 principles for integrating mental health into primary care

1. **Policy and plans** need to incorporate primary care for mental health.
2. **Advocacy** is required to shift attitudes and behaviour.
3. Adequate **training** of primary care workers is required.
4. Primary care **tasks** must be **limited and doable**.
5. Specialist mental health professionals and facilities must be available to **support** primary care.
6. Patients must have access to **essential psychotropic medications** in primary care.
7. Integration is a **process**, not an event.
8. A mental health service **coordinator** is crucial.
9. **Collaboration** with other government non-health sectors, nongovernmental organizations, village and community health workers, and volunteers is required.
10. Financial and human **resources** are needed.

Global Mental Health Action Plan

Vision

A world in which mental health is valued, mental disorders are effectively prevented and in which persons affected by these disorders are able to access evidence-based health and social care and exercise the full range of human rights to attain the highest possible level of health and functioning free from stigma and discrimination.

Cross-cutting Principles

<p>Universal access and equity</p> <p>All persons with mental disorders should have equal and equitable access to health care and opportunities to achieve or recover the highest attainable standard of health, regardless of age, gender, or social position.</p>	<p>Human rights</p> <p>Mental health strategies, actions, and interventions for treatment, prevention and promotion must be compliant with international human rights conventions and agreements.</p>	<p>Evidence-based practice</p> <p>Mental health strategies and interventions for treatment, prevention and promotion need to be based on scientific evidence and good practice.</p>	<p>Life course approach</p> <p>Mental health policies, plans, and services need to take account of health and social needs at all stages of the life course, including children, adolescents, adults, and older adults.</p>	<p>Multisectoral approach</p> <p>A comprehensive and coordinated response of multiple sectors such as health, education, employment, housing, social and other relevant sectors should be utilized to achieve objectives for mental health.</p>	<p>Empowerment of persons with mental disorders</p> <p>Persons with mental disorders should be empowered and involved in mental health policy, planning, legislation, service provision, and evaluation.</p>
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Goal

To promote mental well-being, prevent mental disorders, and reduce the mortality and disability for persons with mental disorders

Objectives and Targets

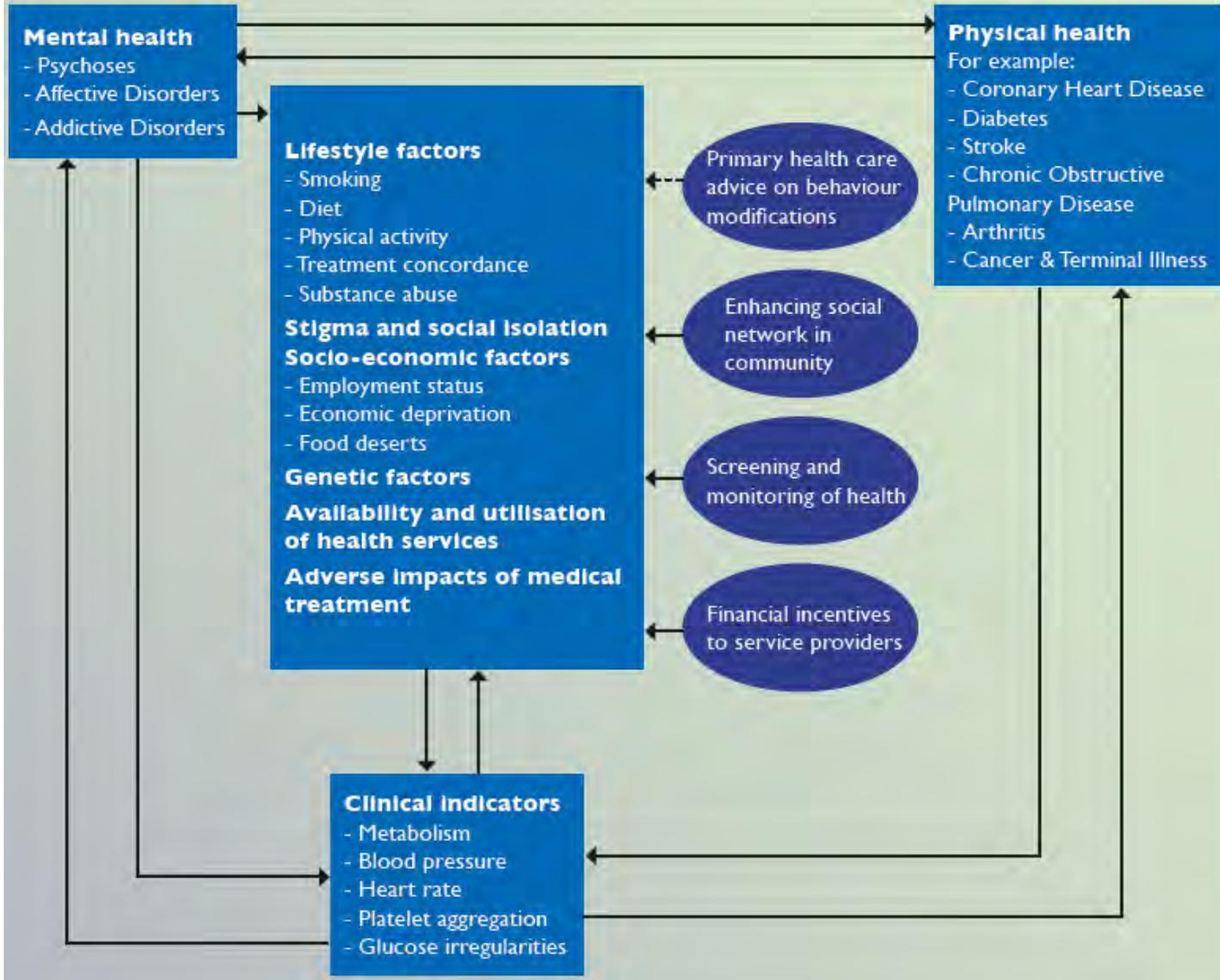
<p>1. To strengthen effective leadership and governance for mental health</p> <p><i>T 1.1: 80% of countries will have updated their mental health policies and laws (within the last 10 years) by year 2016.</i></p> <p><i>T 1.2: 80% of countries will be allocating at least 5% of government health expenditure to mental health by year 2020.</i></p>	<p>2. To provide comprehensive, integrated and responsive mental health and social care services in community-based settings</p> <p><i>T 2.1: The number of beds used for long-term stays in mental hospitals will decrease by 20% by year 2020, with a corresponding increase in the availability of places for community-based residential care and supported housing.</i></p> <p><i>T 2.2: The treatment gap for severe mental disorders will be reduced by 50% by year 2020.</i></p>	<p>3. To implement strategies for mental health promotion and protection including actions to prevent mental disorders and suicides</p> <p><i>T 3.1: 80% of countries will have at least two national, multisectoral mental health promotion and protection programmes functioning by year 2016 (one universal, one targeted on vulnerable groups).</i></p> <p><i>T 3.2: Rates of suicide in countries will be reduced by year 2020.</i></p>	<p>4. To strengthen information systems, evidence and research for mental health</p> <p><i>T 4.1: A global observatory for monitoring the mental health situation in the world will be established by year 2014.</i></p> <p><i>T 4.2: 80% of countries will be collecting and reporting at least a core set of mental health indicators annually by year 2020.</i></p>
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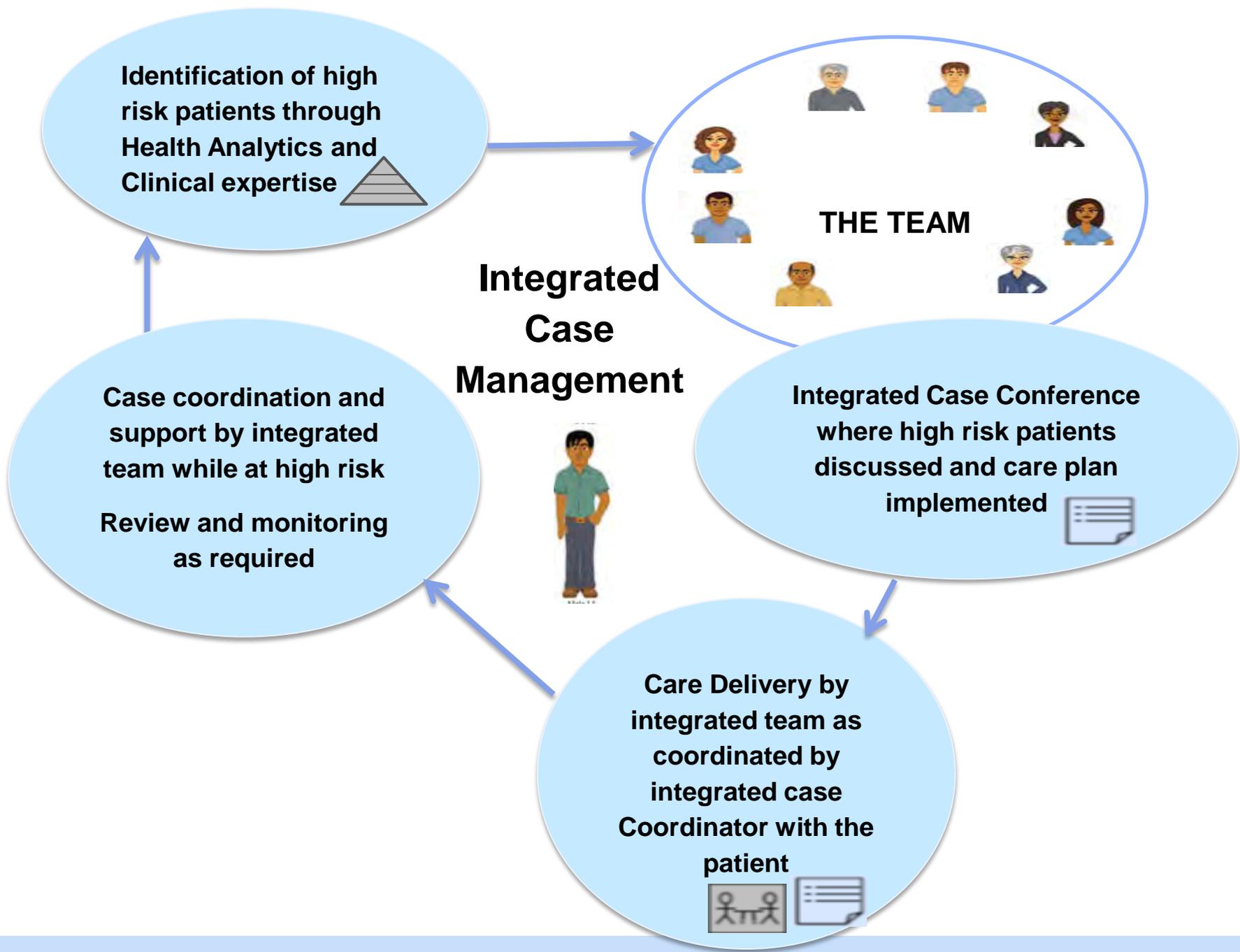
Collaboration and integration: mental health & primary care

MINIMAL	BASIC at a distance	BASIC on-site	CLOSE partly integrated	CLOSE Fully integrated
 COLLABORATION CONTINUUM				
Separate sites	Separate sites	Same facility	Same facility	Same facility
Separate systems	Separate systems	Separate systems	Some common systems	A common system
Sporadic contact	Communicate periodically about shared patients by phone or letter	↑ communication due to proximity	↑ face to face communication due to proximity	Same team
Separate cultures	Separate cultures	Separate cultures	Some shared culture	Patient experiences mental health treatment as part of regular primary care

Illustration of some links between mental health and physical health

(Source: David McDaid, October 2008)



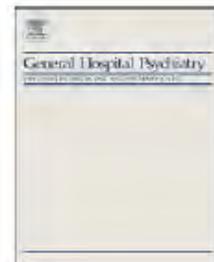


Long-term Effects of a Collaborative Care Intervention in Persistently Depressed Primary Care Patients

Wayne Katon, MD, Joan Russo, PhD, Michael Von Korff, ScD, Elizabeth Lin, MD, MPH, Greg Simon, MD, Terry Bush, PhD, Evette Ludman, PhD, Edward Walker, MD

CONCLUSIONS: A collaborative care intervention was associated with sustained improvement in depressive outcomes without additional health care costs in approximately two thirds of primary care patients with persistent depressive symptoms.

J GEN INTERN MED 2002;17:741-748.



Depression and risk of mortality in individuals with diabetes: a meta-analysis and systematic review

Mijung Park, Ph.D., M.P.H., R.N. ^{a,*}, Wayne J. Katon, M.D. ^b, Fredric M. Wolf, Ph.D., M.Ed. ^c

^a Department Health and Community Systems, University of Pittsburgh School of Nursing, Pittsburgh, PA 15261, USA

^b Department Psychiatry and Behavioral Sciences, University of Washington School of Medicine, Seattle, WA 98195, USA

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Depression significantly increases the risk of mortality in individuals with diabetes. Early detection & treatment of co-morbid depression may improve outcomes in this population

Collaborative Care for Patients with Depression and Chronic Illnesses

Wayne J. Katon, M.D., Elizabeth H.B. Lin, M.D., M.P.H., Michael Von Korff, Sc.D., Paul Ciechanowski, M.D., M.P.H., Evette J. Ludman, Ph.D., Bessie Young, M.D., M.P.H., Do Peterson, M.S., Carolyn M. Rutter, Ph.D., Mary McGregor, M.S.N., and David McCulloch, M.D.

CONCLUSIONS—As compared with usual care, an intervention involving nurses who provided guideline-based, patient-centered management of depression and chronic disease significantly improved control of medical disease and depression. (Funded by the National Institute of Mental Health; ClinicalTrials.gov number, NCT00468676.)

The Pathways Study

A Randomized Trial of Collaborative Care in Patients With Diabetes and Depression

Wayne J. Katon, MD; Michael Von Korff, ScD; Elizabeth H. B. Lin, MD, MPH; Greg Simon, MD, MPH; Evette Ludman, PhD; Joan Russo, PhD; Paul Ciechanowski, MD, MPH; Edward Walker, MD; Terry Bush, PhD

Conclusion: The Pathways collaborative care model improved depression care and outcomes in patients with comorbid major depression and/or dysthymia and diabetes mellitus, but improved depression care alone did not result in improved glycemic control.

Arch Gen Psychiatry. 2004;61:1042-1049

Prevalence of Chronic Obstructive Pulmonary Disease Among Those With Serious Mental Illness

Seth Himelhoch, M.D., M.P.H.

Anthony Lehman, M.D., M.S.P.H.

Julie Kreyenbuhl, Pharm.D., Ph.D.

Gail Daumit, M.D., M.H.S.

Clayton Brown, Ph.D.

Lisa Dixon, M.D., M.P.H.

Objective: Individuals with serious mental illness have elevated smoking rates, and smoking is a significant risk factor for chronic obstructive pulmonary disease (COPD). The goal was to determine the prevalence of COPD among those with serious mental illness.

Method: The authors surveyed a random sample of 200 adults with serious mental illness with questions from the National Health and Nutrition Examination Study III that were previously used to estimate the national prevalence of COPD. They compared the prevalence of COPD in the sample to a randomly selected matched subset of national comparison subjects.

Results: The prevalence of COPD was 22.6%. Those with serious mental illness were significantly more likely to have chronic bronchitis (19.5% versus 6.1%) and emphysema (7.9% versus 1.5%) than the comparison subjects.

Conclusions: The prevalence of COPD is significantly higher among those with serious mental illness than comparison subjects. Improved primary and secondary prevention is warranted.

(Am J Psychiatry 2004; 161:2317–2319)

COPD – The global picture

- According to the latest WHO estimates (2008), currently 210 million people have COPD worldwide ¹
- COPD is a major public health problem in subjects over 40 years of age and will remain a challenge for the future:
 - ▶ Total deaths from COPD are projected to increase by more than 30% in the next 10 years ^{1, 2}
 - ▶ WHO predicts that COPD will become the third leading cause of death worldwide by 2030 ³
 - ▶ COPD is an increasing cause of chronic disability and is predicted to become the fifth most common cause of chronic disability worldwide by 2020 ⁴

1 World Health Organization (WHO). 2008. COPD: Fact sheet No. 215. World Health Organization [Online]. <http://www.who.int/mediacentre/factsheets/fs315/en/> Accessed: August 2008

2 World Health Organization (WHO). 2008. COPD: Burden . World Health Organization [Online]. <http://www.who.int/respiratory/copd/burden/en/> Accessed: August 2008

3 World Health Statistics Report 2008. World Health Organization

4 Barnes P. Chronic Obstructive Pulmonary Disease: A growing but neglected global epidemic. PLoS Medicine. May 2007 Vol 4 Issue 5. p 112

COPD – Burden to the NHS Waltham Forest

COPD is among the most costly inpatient conditions treated by the NHS

- The total annual cost of COPD to NHS Waltham Forest has been estimated to be over £2.9 million, which equates to ~£1,250 per COPD patient ¹

Undiagnosed COPD – Waltham Forest

- The prevalence of diagnosed COPD in the Waltham Forest is approximately 0.86% (nearly 2,300 people) ¹
- It has been estimated that the actual number of patients with COPD in Waltham Forest is around 11,200. This leaves approximately 8,900 people that are unaware they have the disease which, if left untreated, could severely restrict their lives and eventually kill them ²

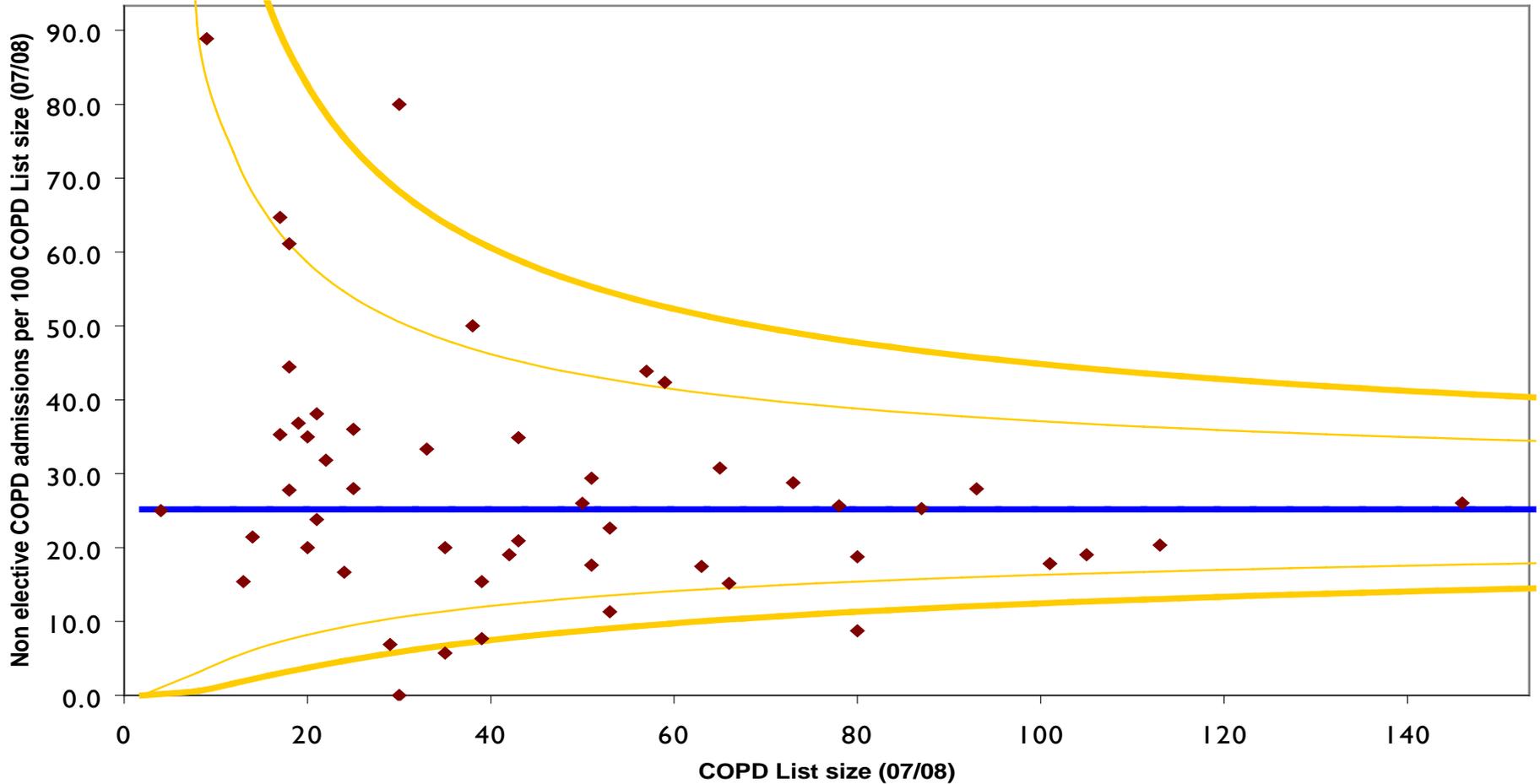
1. The Information Centre. Chronic Obstructive Pulmonary Disease. Quality and Outcomes Framework (QOF) for April 2007 -March 2008, England. [Online]. 2009 [cited 29th October]; Available from: http://www.ic.nhs.uk/webfiles/QOF/2007-08/NewFilesGS/QOF0708_PCTs_Prevalence.xls

2. Nacul L, et al(2007) Model for estimating the population prevalence of chronic obstructive pulmonary disease: cross sectional data from the Health Survey for England, *Population Health Metrics*, 5: 8

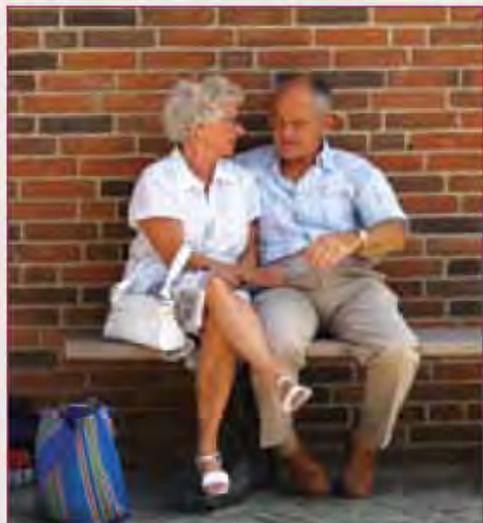
COPD admissions versus COPD list size

Waltham Forest PCT Non elective COPD admission rates

Upper 99.8% Upper 95% Overall Lower 95% Lower 99.8%



COPD and collaborative care (NICE award 2011)



Challenging existing assumptions

Led by local GP Dr Gabriel Ivbijaro, a COPD management pilot was set up. The pilot had the support of 10 GP practices and included an education programme for both healthcare professionals and patients.

- Mandatory training sessions for staff were used to tackle clinical issues and share best practice.
- A Chest Consultant, Professor Mike Roberts and Specialist Respiratory Nurse, Anne O'Malley from the local hospital provided key support for staff training and education for patients.
- Collaboration with GSK and application of their POINTS auditing tool supported GP consultation and enabled structured patient reviews.
- An intermediate care service was set up at the health centre, run by the Specialist Respiratory Nurse, to help patients manage their condition in the community, reduce acute exacerbations and avoid inappropriate referrals to secondary care.
- Project Management was provided by Frank Hamilton supporting the clinicians with data analysis and communication.

Seeing real results in local patients

The pilot scheme's progress was regularly monitored through clinical reports and at the training sessions. The 10 practices were able to input into the service redesign based on their key issues and challenges. The pilot prompted significant improvements in the following areas:

- NICE compliance
- Clinical recording (i.e. of acute exacerbations, breathlessness etc)
- Clinical data quality
- Drug therapy
- Building clinical capabilities of local workforce

Additionally, Waltham Forest saw a significant reduction of (27 per cent) in the length of hospital stays for COPD patients. Furthermore, the project team predict that cost savings of up to £500,000 related to reduced non-elective hospital admissions could be made over three years.

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Telephone: 020 84308033

www.nice.org.uk

IPCRG (International Primary Care Respiratory Group) collaboration with Wonca (World Organisation of Family Doctors)



- Position paper 2014

(in prep: Lionis C, Tsiligiannis I, Sifaki-Pistolla D, Gkatzoudi C, Ivbijaro G, Thomas DM, Galvez L)

- Collaborative care is essential and must include training

Waltham Forest a real life example: demographics



- Population 258,249
- Diverse population - 42 % Black Asian minority ethnicities
- 51% female
- Elderly population in north of borough and younger population in south. Projected older population growing
- 15th most deprived borough in England. Deprivation ranking becoming worst over time
- 1/3 households defined as income deprived and 1/5 households have no member in employment



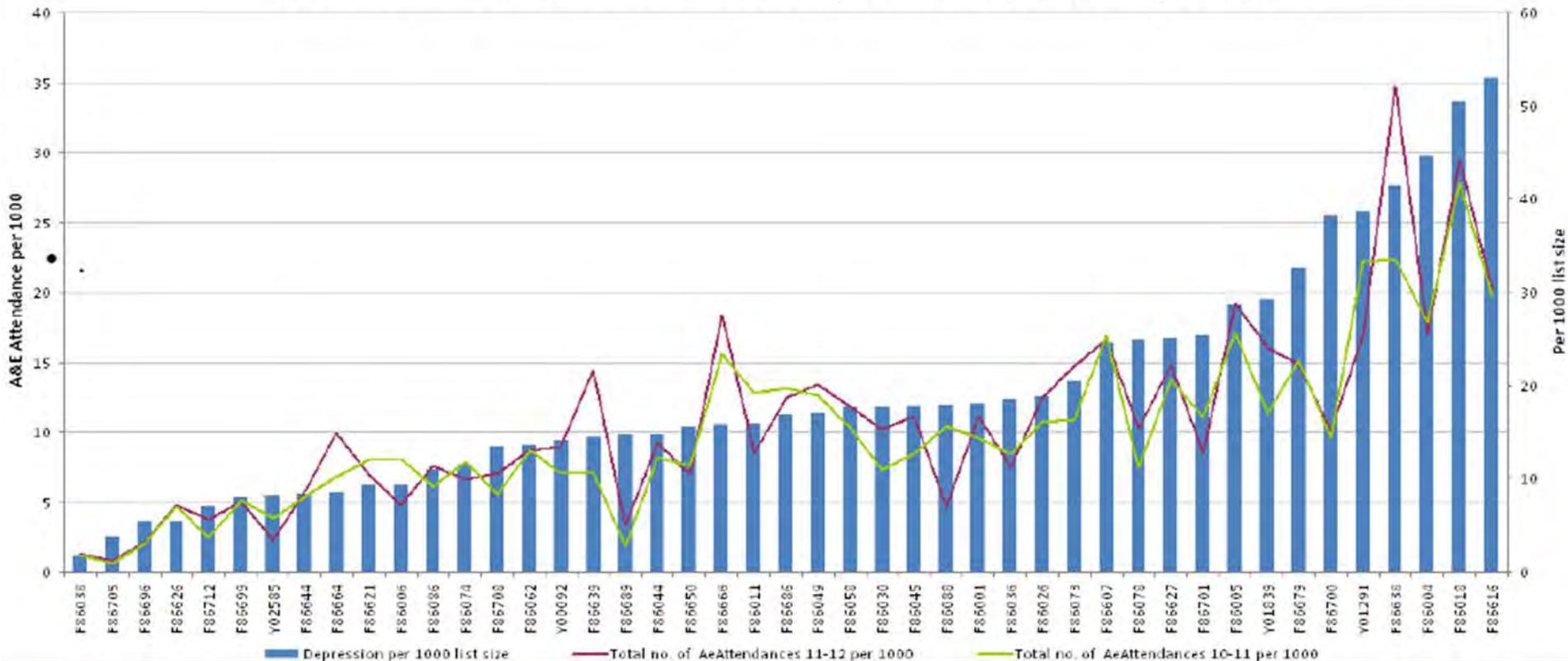
Waltham Forest: Some key challenges

- A relatively young population compared to England
- Above national average in 0-10 & 20-44 age groups
- 42% BME
- 6th most deprived London Borough with >1/3 population income deprived
- High birth rate
- High prevalence of low birth weight

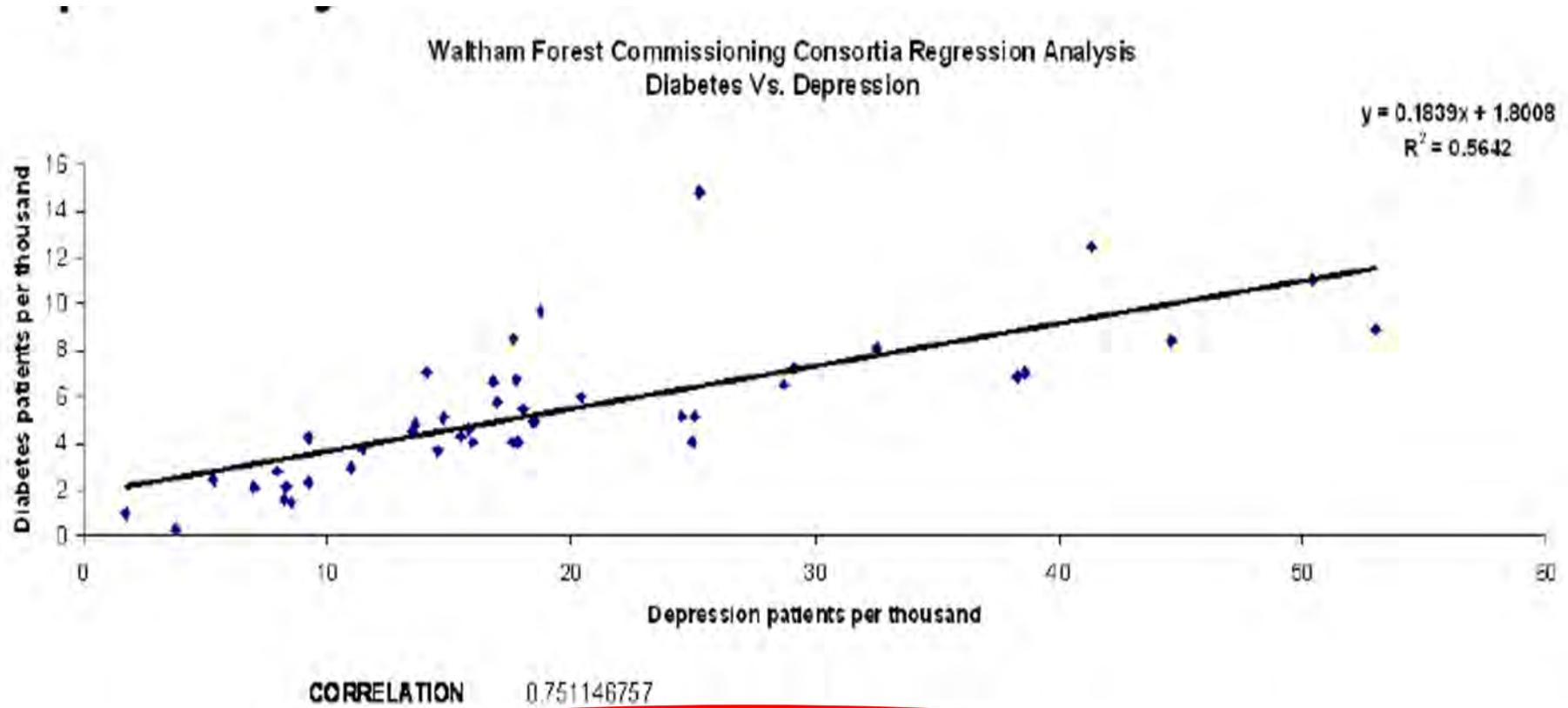


A&E attendance per practice for patients with depression & long term conditions in Waltham Forest

Total number of A&E attendance in 10/11 and 11/12 for patients with depression having 2 or more LTC

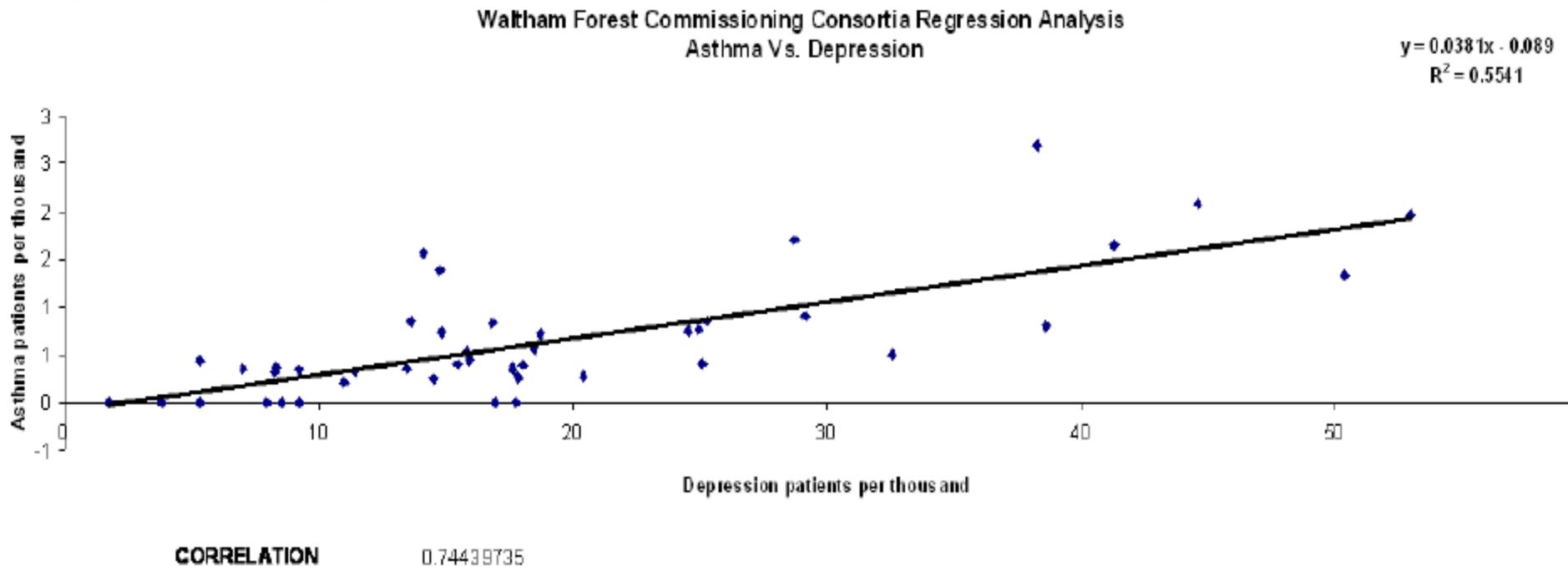


Diabetes & Depression: Regression Analysis



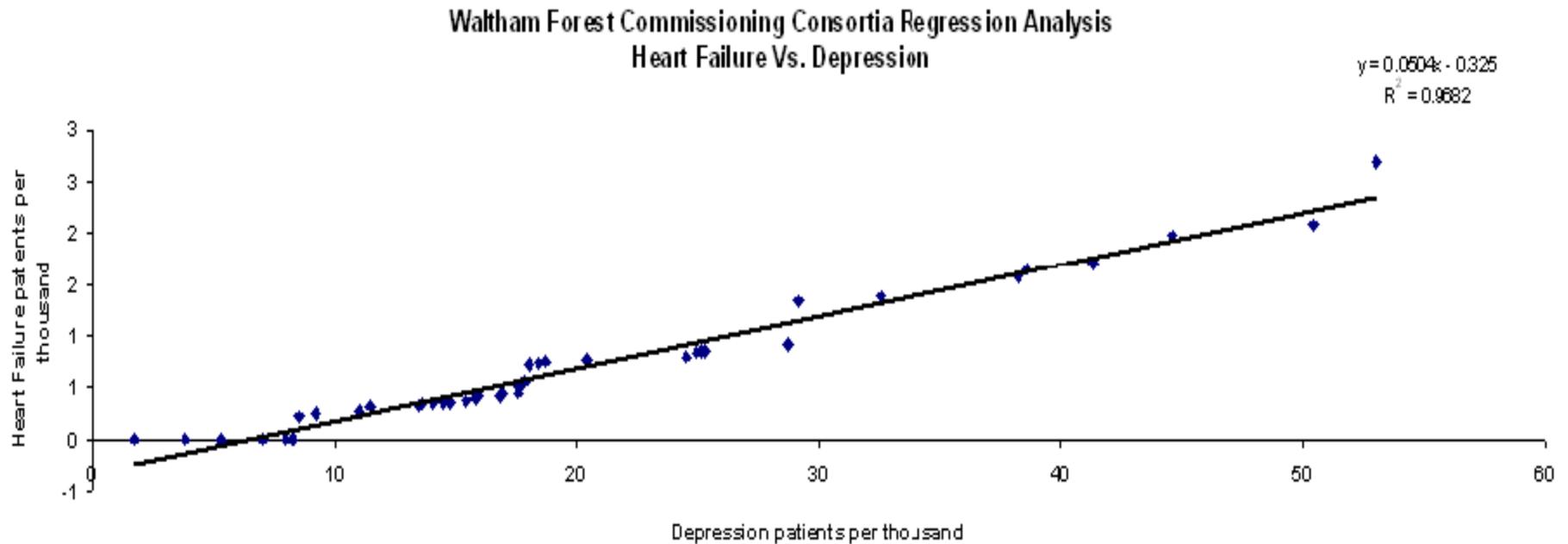
There is a direct correlation between diabetes & depression and higher use of services in the Waltham Forest GP practice population

Asthma & depression in Waltham Forest: regression analysis



There is a direct correlation between asthma & depression and higher use of services in the Waltham Forest GP practice population

Heart failure & depression: regression analysis

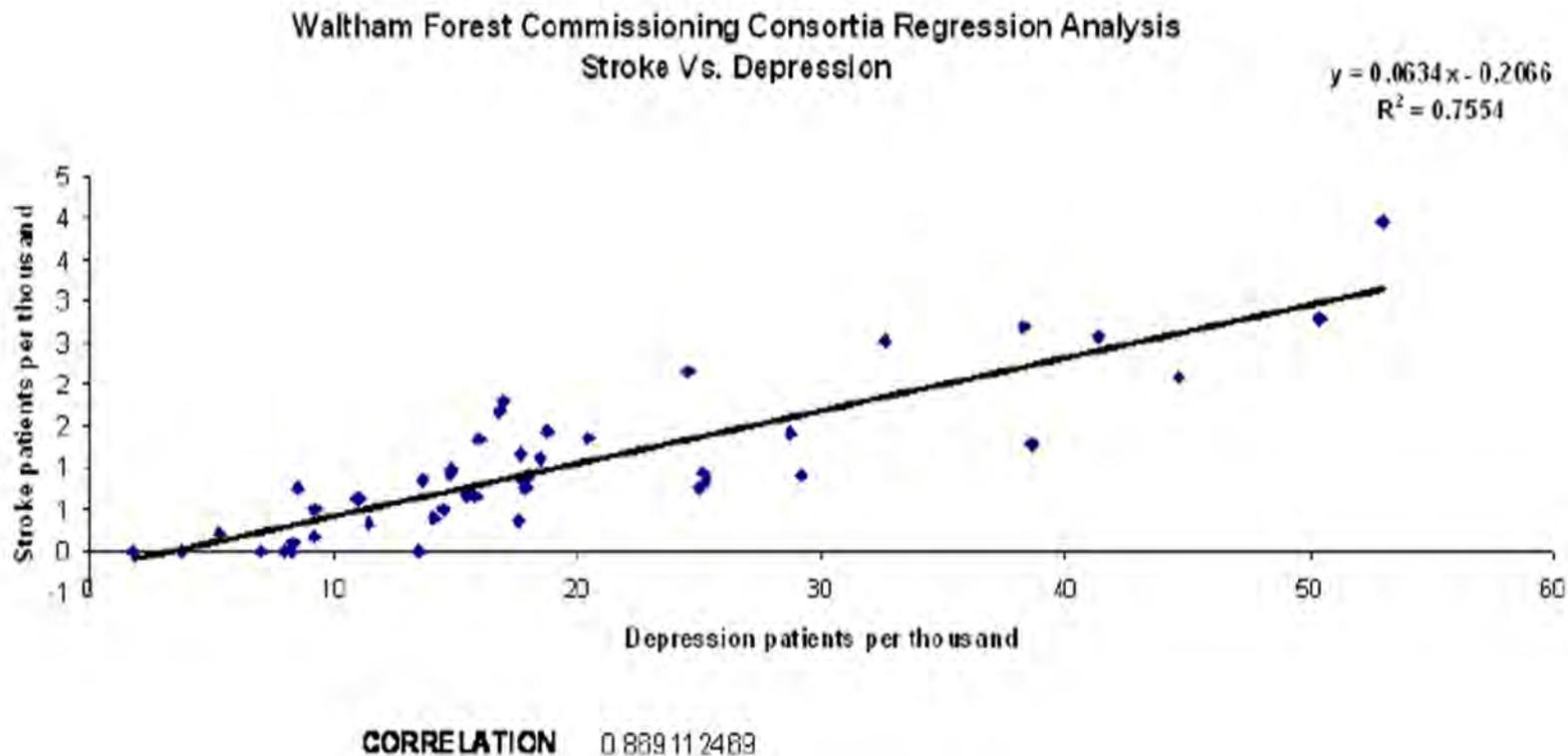


CORRELATION

0.98398617

There is a direct correlation between heart failure & depression and higher use of services in the Waltham Forest GP practice population

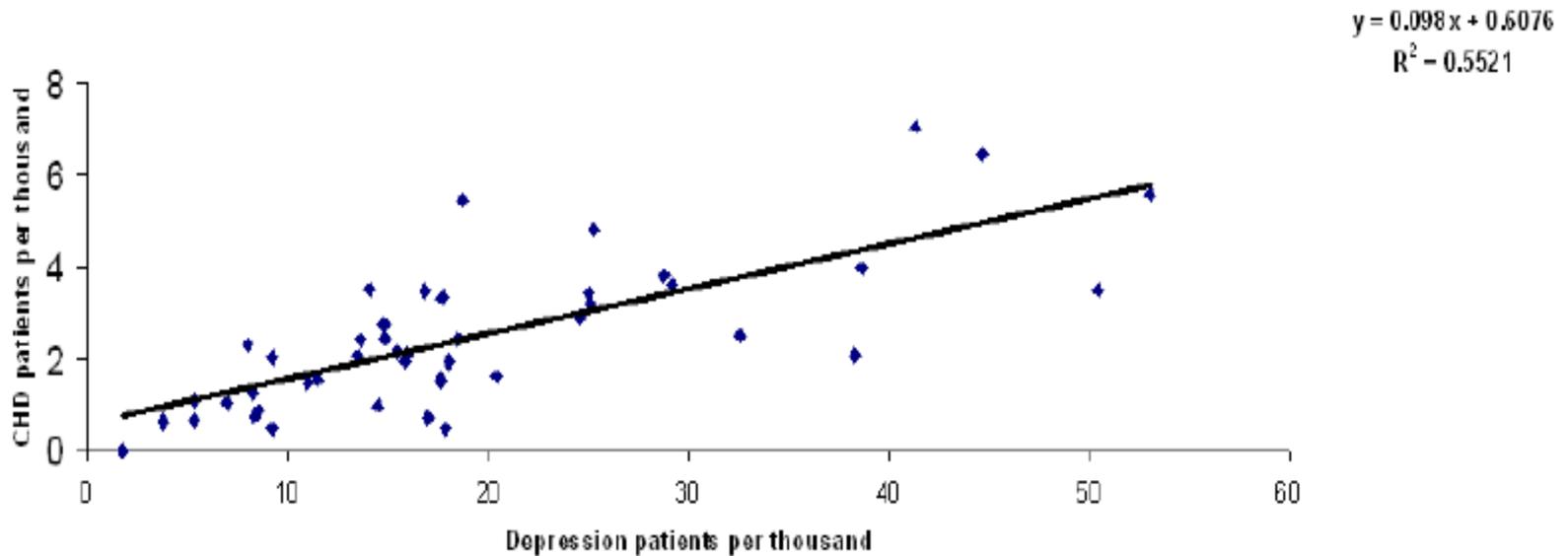
Stroke & depression : regression analysis



There is a direct correlation between stroke & depression and higher use of services in the Waltham Forest GP practice population

CHD & depression : regression analysis

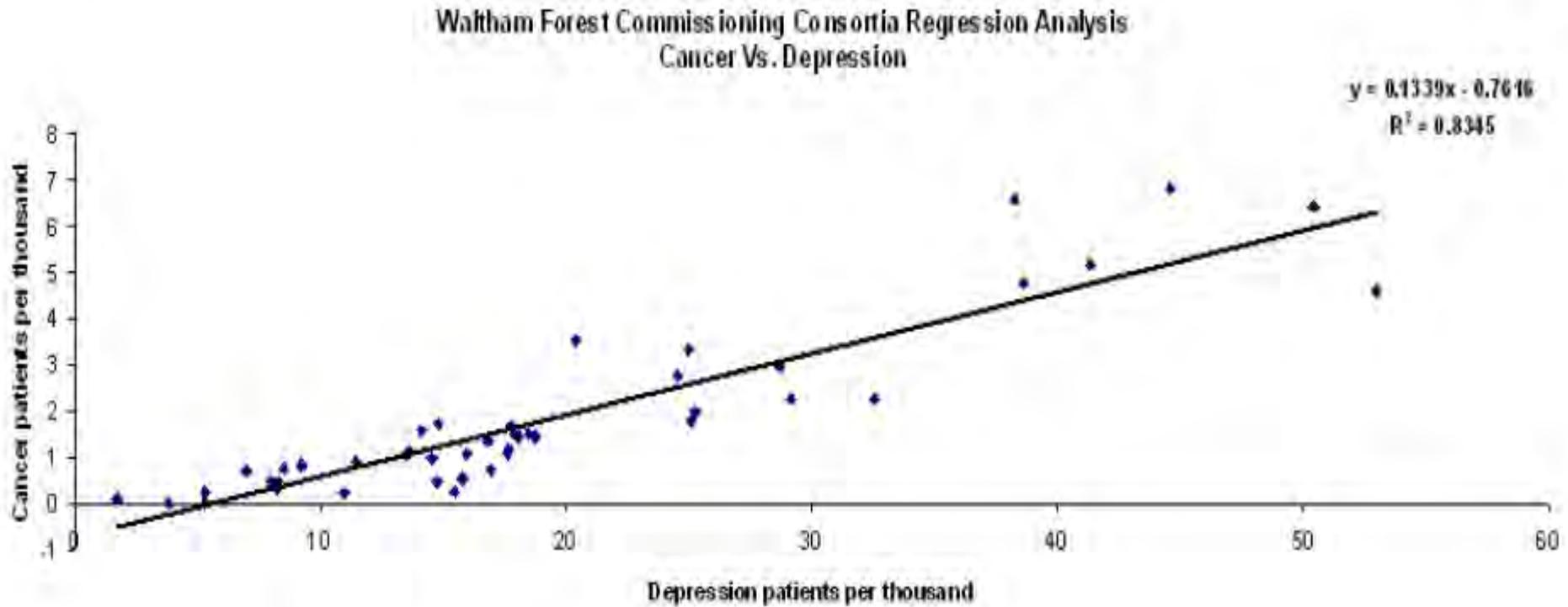
Waltham Forest Commissioning Consortia Regression Analysis
CHD Vs. Depression



CORRELATION 0.743036317

There is a direct correlation between CHD & depression and higher use of services in the Waltham Forest GP practice population

Cancer & depression: regression analysis

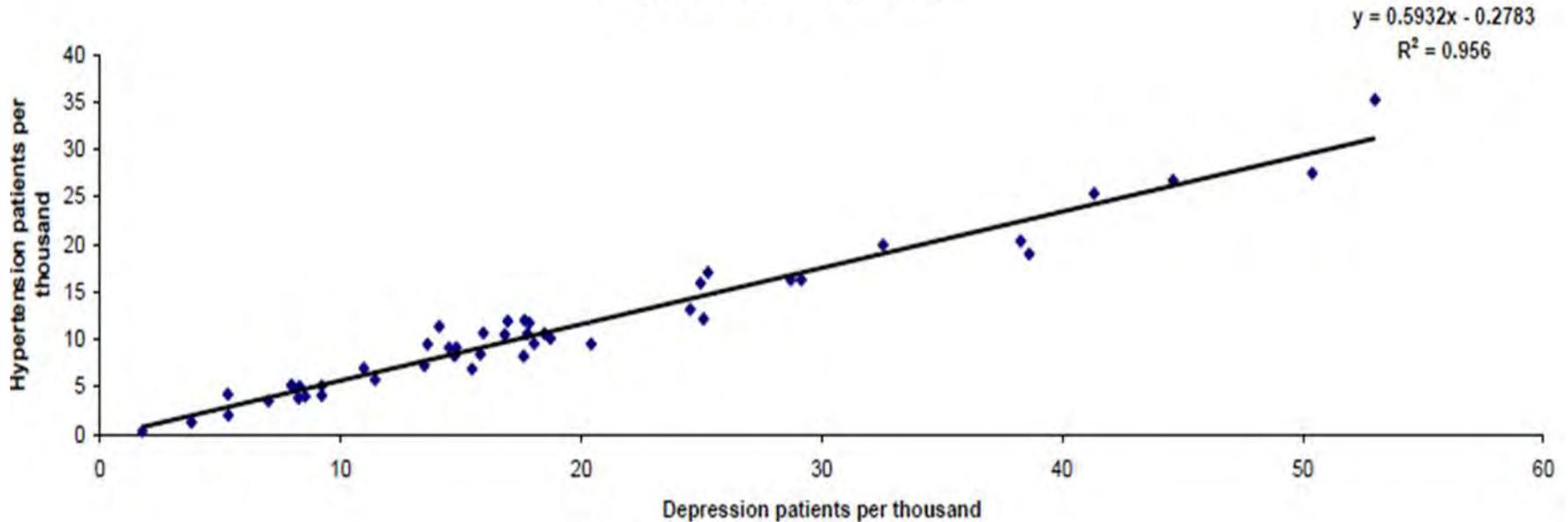


CORRELATION 0.913533955

There is a direct correlation between cancer & depression and higher use of services in the Waltham Forest GP practice population

Hypertension & Depression: Regression Analysis

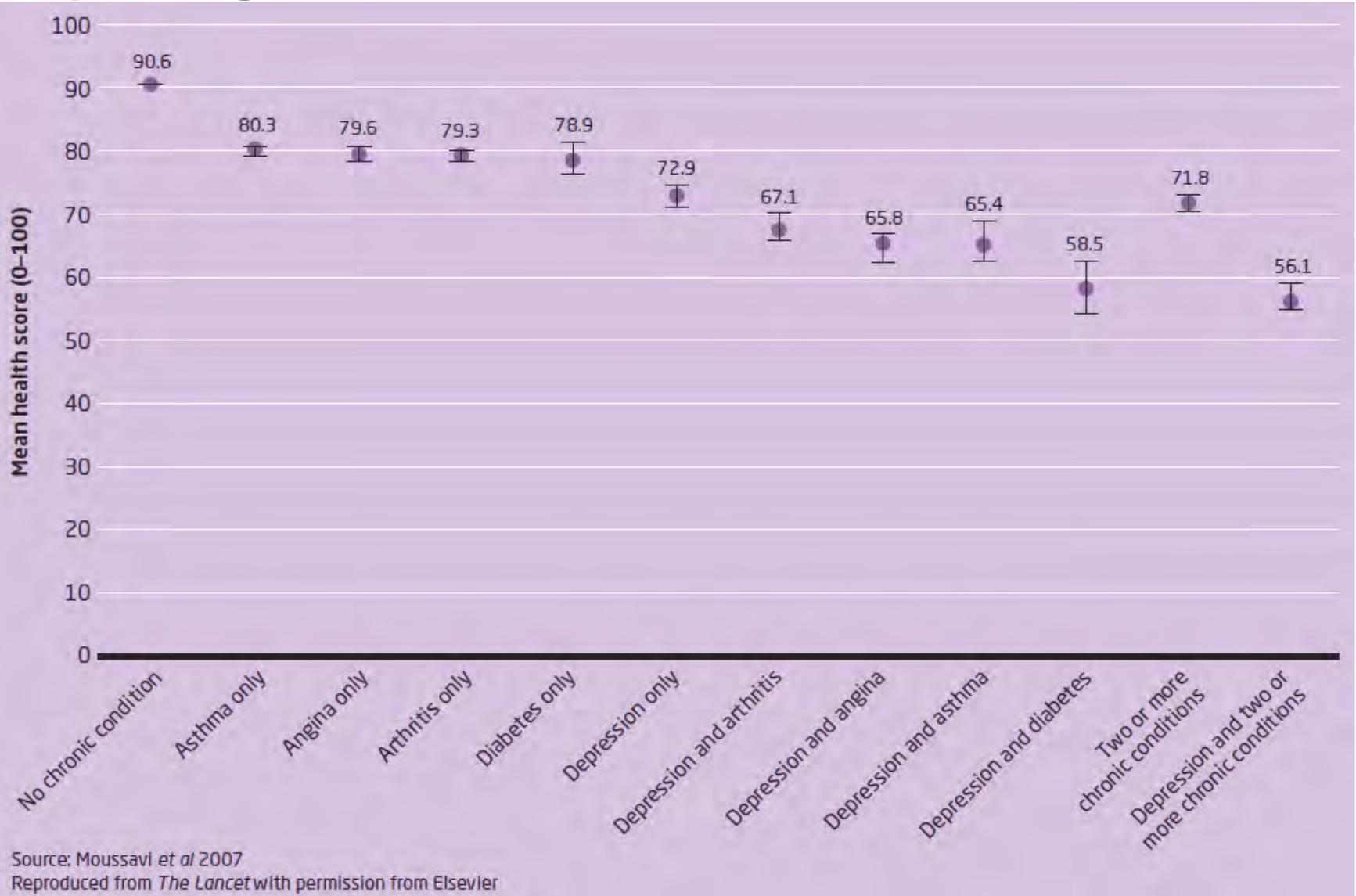
Waltham Forest Commissioning Consortia Regression Analysis
Hypertension Vs. Depression



CORRELATION 0.977735547

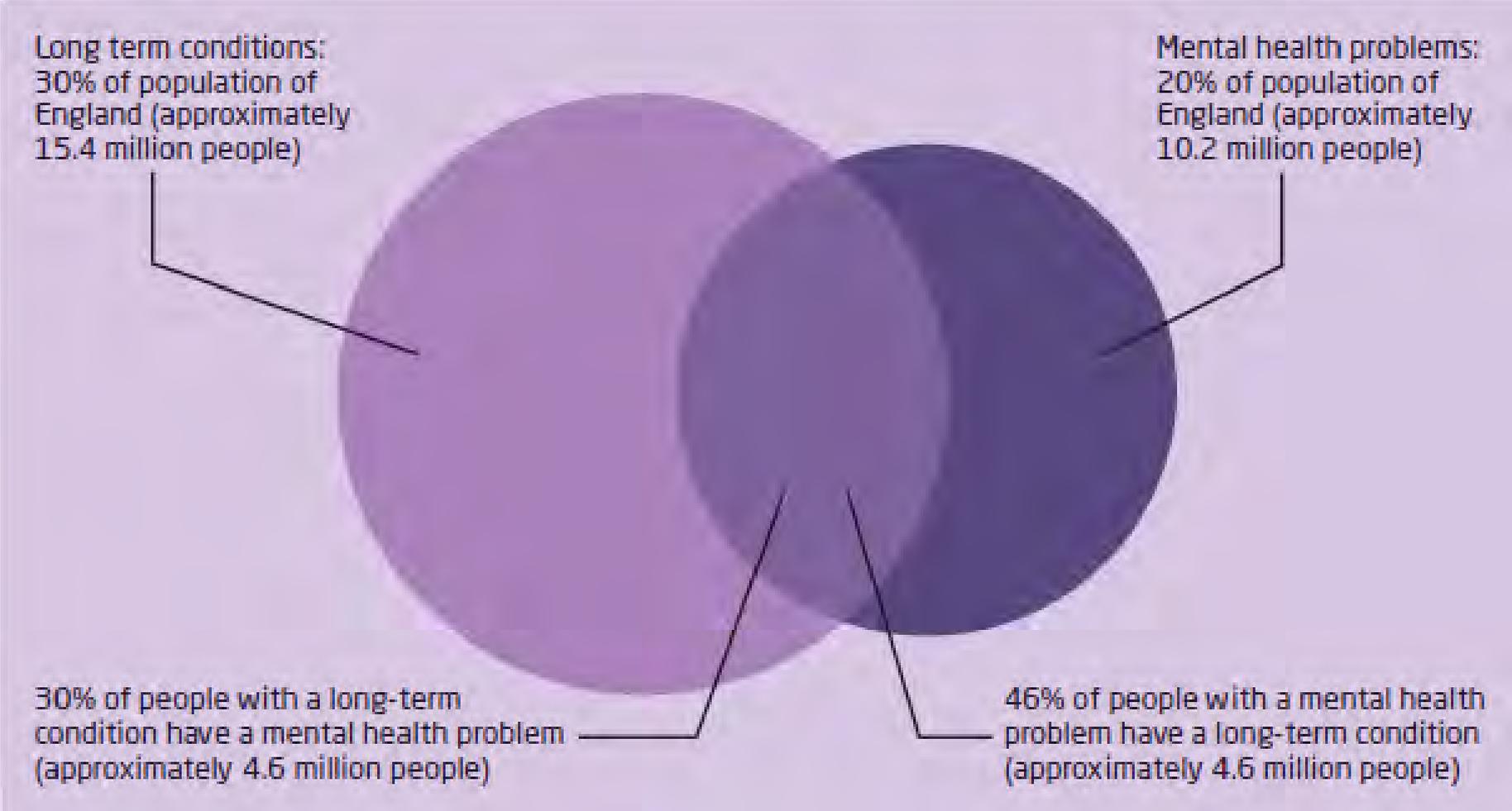
There is a direct correlation between hypertension & depression and higher use of services in the Waltham Forest GP practice population

Health related QOL scores associated with single and multiple long-term conditions

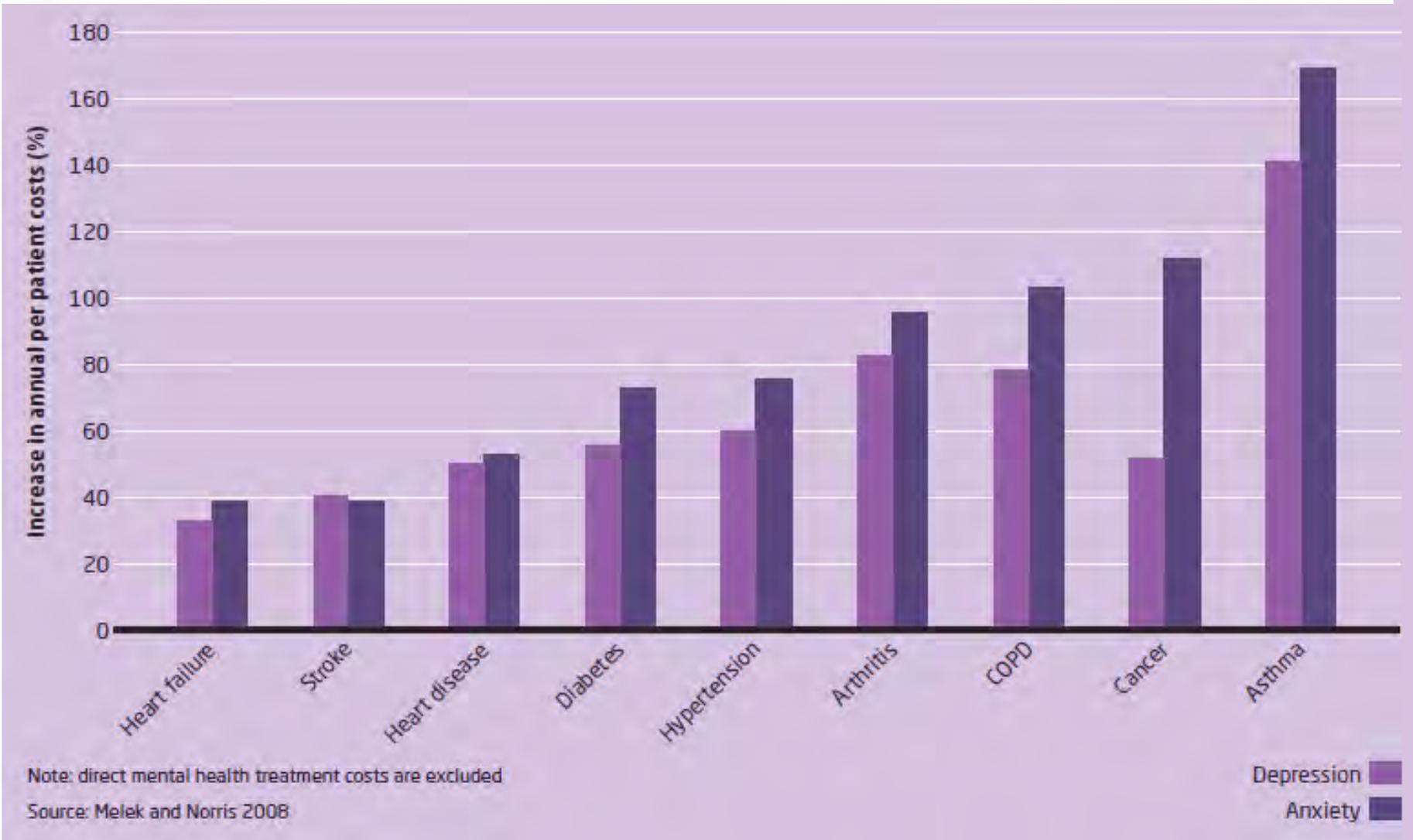


Source: Moussavi et al 2007
Reproduced from *The Lancet* with permission from Elsevier

Mental health and multimorbidity in the UK



Proportionate increase in per patient medical costs associated with depression and anxiety relative to people without a mental health problem (based on US claims data for more than 9 million people, Melek and Norris 2008)



The Mona Lisa
Brad Paisley

Now there are men who make
history, there are men who
change the world ...

I feel like the frame that gets to
hold the Mona Lisa
And I don't care if that's all I ever
do



- Mental health is the frame that holds medical care
- Co-morbidity is the norm and not the exception

Collaborative care is necessary to manage
the complexity

The London story



1. Mental health services case for change for London



Dr Muhammed Ali

Harrow GP; Primary Care Clinical Lead – London Health Programmes Mental Health Models of Care Project

Dr Martin Baggaley

Medical Director – South London and Maudsley NHS Foundation Trust; Secondary Care Clinical Lead and Chair of the People Experiencing a Crisis Expert Panel – London Health Programmes Mental Health Models of Care Project

(from March 2011)

Caroline Taylor (Chair)

Chief Executive – NHS North Central London; Senior Responsible Officer – London Health Programmes Mental Health Models of Care Project

Alastair Finney

Deputy Director of Strategy and Commissioning Development – NHS London

Rebecca Harrington

Assistant Director: Strategic Planning and Joint Commissioning – Camden Council and Camden PCT

Sarah Haspel

Mental Health Lead – NHS London (until March 2011)

Fiona Hill

Director – Brent Mental Health User Group; Chair of the Service User Panel – London Health Programmes Mental Health Models of Care Project

Dr Gabby Ivbijaro

Waltham Forest GP; Chair of the People Experiencing Long Term Mental Health Conditions Expert Panel – London Health Programmes Mental Health Models of Care Project

David Jobbins

Associate Director: Mental Health – London Health Programmes; Project Director – London Health Programmes Mental Health Models of Care Project

Christine Lewis

Carer, Friends and Families Representative – London Health Programmes Mental Health Models of Care Project

Dr Jahan Mahamoodi

Brent GP; GP advisor, Central North West London NHS Foundation Trust and chair of the Chair of the People Experiencing a Crisis Expert Panel – London Health Programmes Mental Health Models of Care Project (until March 2011)

Dr Geraldine Strathdee

Associate Medical Director, Mental Health – NHS London

London: the Statistics

- London has a population of approximately 7.6 million (2006) which is 12.5% of the UK population⁵.
- Over half of London's boroughs are in the top 30% most deprived districts in England, and 10 boroughs in the 10% most deprived.⁶ Of the 28 local authority areas in the UK identified as 'highly diverse' by the government, 24 are in London⁷.
- London is the most multi-cultural city in the UK. It is home to a population that speaks over 300 languages and has over 40% of the UK Black, Asian and Minority Ethnic (BAME) population⁸.
- Annual population survey (APS) estimates for 2006 suggest that almost one third (32%) of Londoners were born outside the UK. The proportion of migrants rises to 39% in inner London whereas outside the capital, migrants make up around 7% of the total population⁹.
- London has a higher proportion of mental health admissions of people detained under the Mental Health Act 1983, compared to the rest of the country. In 2008/9 – 37% of the inpatient population in London compared with 31.8% nationally¹⁰.

- 16.2% of the adult population have a neurotic disorder
- The most common is mixed anxiety and depression (9% of the population)
- 4.4% have generalised anxiety disorder; and
- 2.3% pure depression
- Other disorders (phobias, obsessive compulsive disorder and panic) affect less than 1.5%
- Generally neurotic disorders affect women more than men (19.7% v 12.5%)

NHS Information Centre¹⁶

- In contrast to the average employment rate of 74% for the UK working age population³⁷, the 2008 Healthcare Commission survey of people using specialist mental health services showed that only 22% of respondents reported being in paid work or full-time education³⁸.
- Lost output and missed employment opportunities associated with mental ill health cost £23.1bn, per year, in England³⁹.
- In the UK in 2008/09, 11.4million working days were lost to stress, depression or anxiety⁴⁰.
- As London represents approximately 12% of the total population⁴¹, London alone is expected to have lost in excess of 1.5million working days due to stress, depression or anxiety in 2008/09.
- Each year over 200,000 people with a mental illness move onto incapacity benefits⁴².
- 46% of those claiming incapacity benefit in London (122,000 people) do so for a mental illness, largely anxiety disorders and depression⁴³.
- Recent research by Carers UK found that 72% of carers (across all care groups) were financially worse off as a result of caring⁴⁴.

2. Mental health models of care for London



- Improved competence of primary care teams
 - Working with partners
 - Good communication
 - Patient at the centre
 - Value family and carers
 - Recognise and harness wider determinants of health
- Case co-ordination through role of Navigators
 - Recovery orientated practice essential

Setting up the Waltham Forest Long Term Mental Health Conditions Plan

- Employed project manager
- Developed protocol to support discharge from secondary mental health to primary care
- Reviewed primary care reimbursement (LES)
- Employed 4 generic primary care navigators
- Provided GP practices with standardised computer template for data collection
- Provided mental health training to GP practices

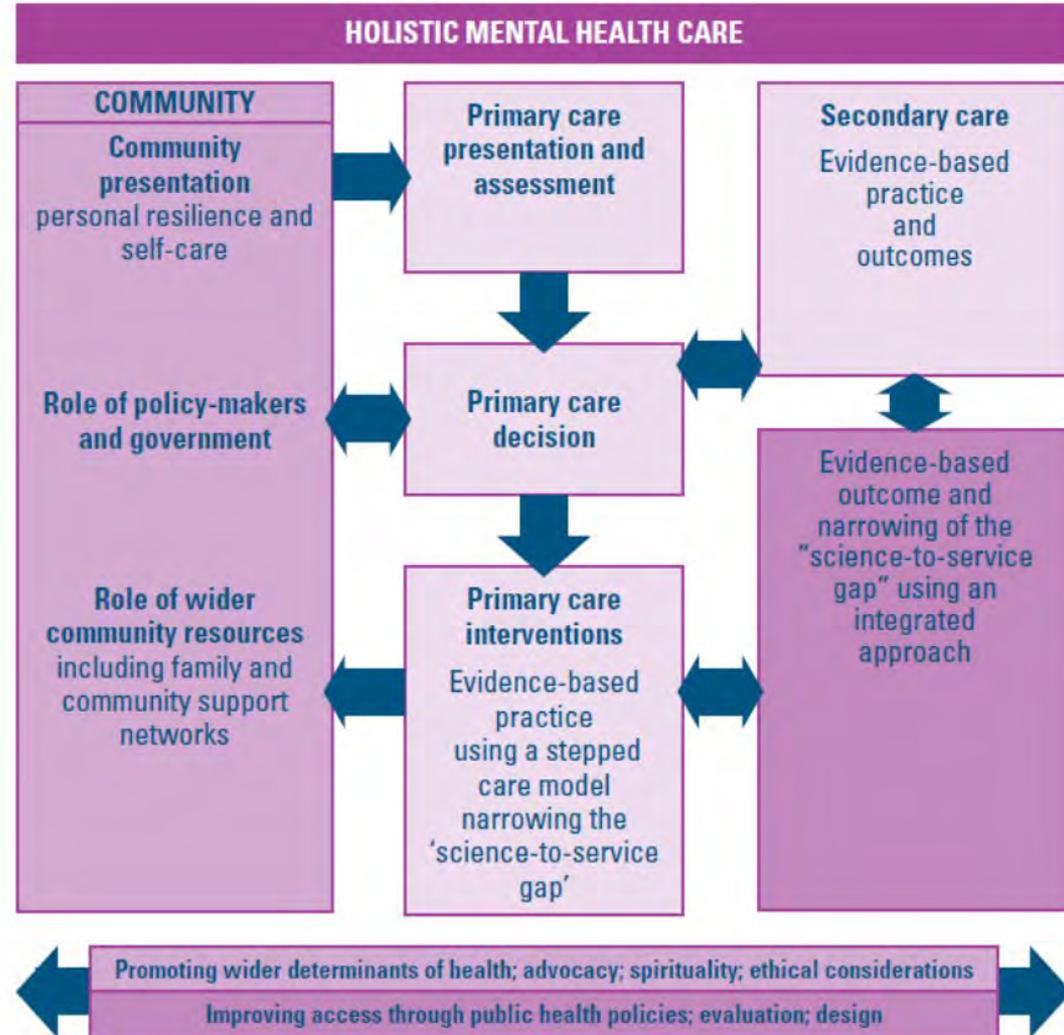


Figure 1.1 The interrelationships between elements of holistic mental health care

Case Study – 4 months of primary care management

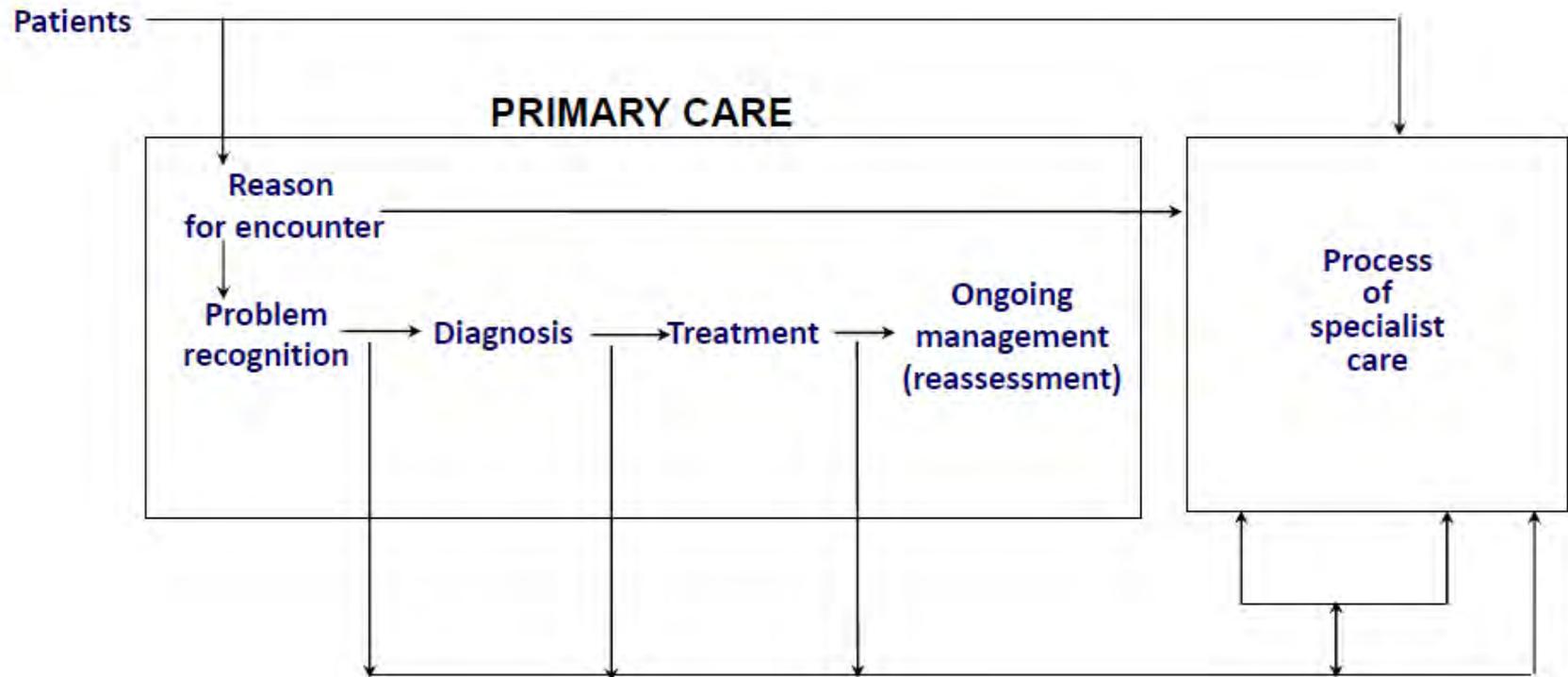
Patient Background

- 64 yr old white European male
- Mental health problems since 15 yrs
 - childhood neglect & abuse
 - history of aggression
 - paranoid schizophrenia
- In contact with secondary mental health care services 7/8 yrs
- Active lifestyle – cycling, volunteering x 2 weekly at recycling project, cultural centre x 2 weekly
- Olanzapine and Citalopram
- Lived alone in own house
- No immediate family in UK

Navigator interventions

- Physical health review: pre-diabetic and provided information on lifestyle changes and diet
- GP monitoring
- Regular meetings to discuss social inclusion and mental health monitoring
- On waiting list for basic cookery course & basic IT course
- Had to leave volunteering placement at Charity Shop after 2 months due to misunderstanding and argument with another volunteer because he ran out of medication. Navigator has worked with client to put system of remembering medication in place

Patient Journey



Source: R. Reid Adapted from Starfield. Primary Care: Balancing Health Needs, Services, and Technology. Oxford U. Press, 1998.



Generic Long Term Care Pathway

- At each stage of the pathway you should consider:
 - What needs to be done?
 - By whom?
 - Where?
 - What resources are required?
- For each activity consider:
 - What's the cost?
 - What's the quantity / volume / activity?
 - What are the quality metrics?

Some opportunities

Top 10 specialities by size of financial opportunity (to 50th Percentile)

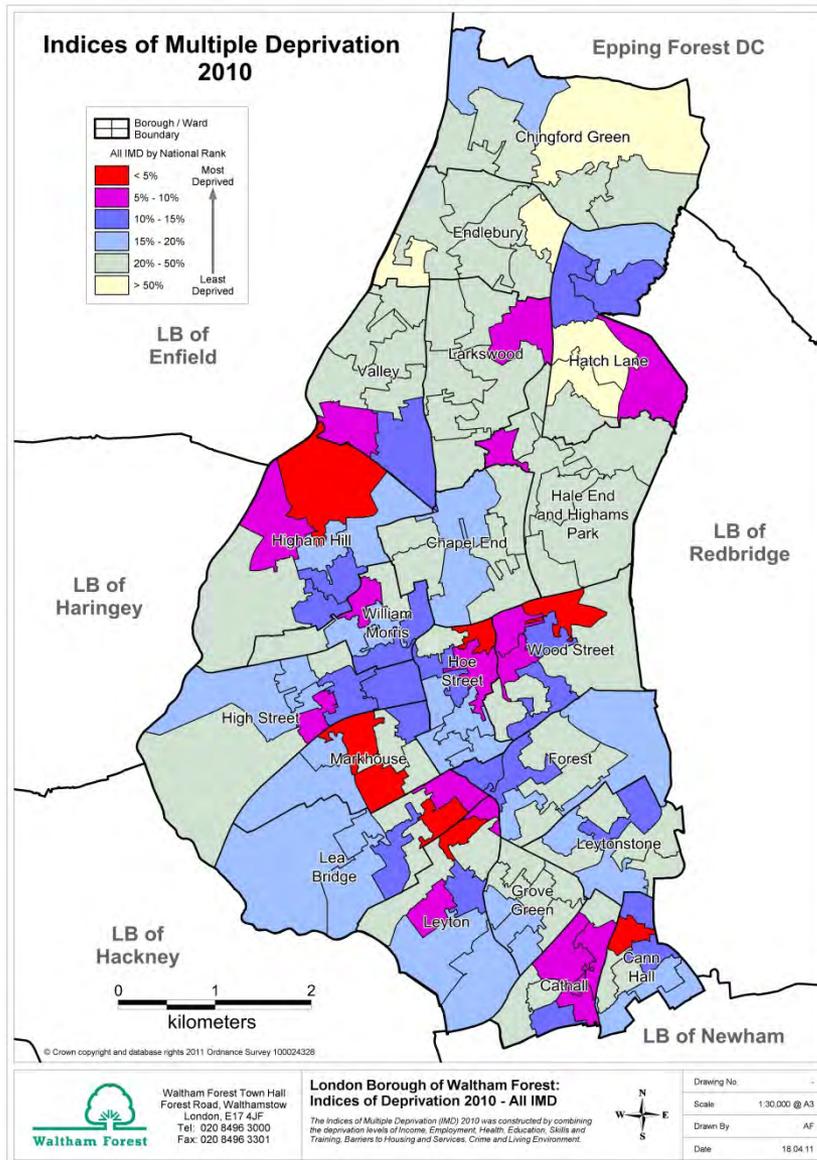
Emergency Admissions	50 th Percentile	25 th Percentile	Recognised problem?	Your current year Contract Savings
Diabetes complications	£358,698	£552,684	tbc	tbc
Cellulitis	£342,648	£441,699	tbc	tbc
Congestive heart failure	£280,491	£440,676	tbc	tbc
Chronic obstructive pulmonary disease	£253,324	£478,419	tbc	tbc
Dehydration and gastroenteritis	£176,260	£292,148	tbc	tbc
Convulsions and epilepsy	£166,124	£260,168	tbc	tbc
Gangrene	£127,441	£170,048	tbc	tbc
Asthma	£116,649	£198,175	tbc	tbc
Influenza and pneumonia	£97,252	£232,743	tbc	tbc
Perforated / bleeding ulcer	£63,613	£83,076	tbc	tbc
Total	£1,982,501	£3,149,836		£3,200,000

Indicate frail elderly

*Current year EA savings are identified as £3.2m, however unavailable by category at time of review, however next step is to identify which areas remain opportunities

*2011 figures
See referrals information

Scaling up integrated care in Waltham Forest



- Coordinated care for patients and carers in the community
- Quality patient experience and clinical outcomes
- Optimal utilisation of resources

Experience from successful integrated systems shows that three building blocks are required for Integrated care, that put together can generate significant savings

Success in integrated care

Address specific patient needs in a pathway ...

Pathways	Patient segments					
	Low risk		Medium risk		High risk	
Diabetes						
COPD						
Dementia						

... by working in a multi-disciplinary system ...

- 1 Patient registry 
- 2 Risk stratification 
- 3 Clinical protocols & care packages 
- 4 Care plans 
- 5 Care delivery 
- 6 Case conference 
- 7 Performance review 

... supported by key enablers



Accountability and joint decision-making



Clinical leadership and culture development



Information sharing



Aligned incentives



Patient engagement

Introducing the case-for-change:

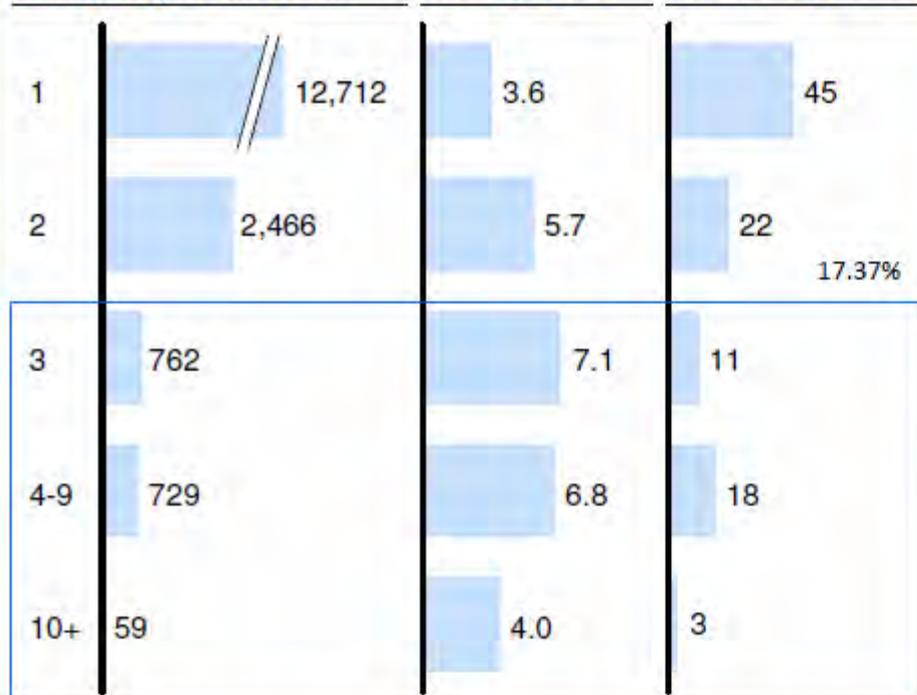
~1,500 people accounting for ~30% of acute spend, with half being over 65

2010/2011

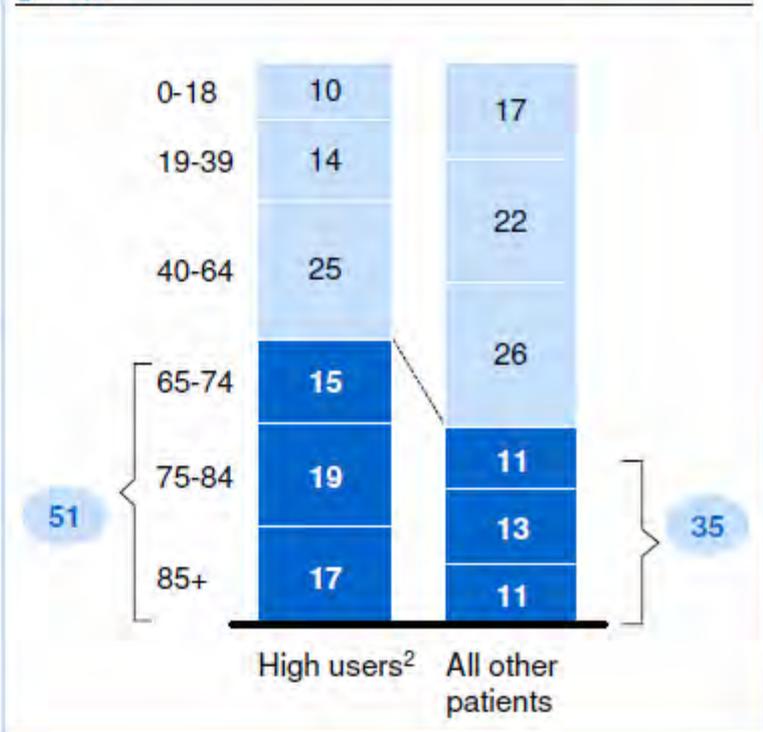
9% patients account for 32% of emergency spend, due to their frequent admissions...

Elderly patients (>65) account for 50% of high users (3+ admissions)

No. of patients by no. of emergency admissions Average LOS¹ Spend, % of total



Percentage of emergency admissions by age group



1 Length of stay

2 Defined as having 3 or more emergency admissions in 1 year

Estimated commissioning savings from Integrated Care

PRELIMINARY

	Pathway	No. of patients	Potential reduction in current spend			
			Current spend in acute care ¹ £k	Reduction through IC ² %	Total savings £k	Saving per capita £
Elderly (75+)	Elderly no LTC	9,070	14,741	24-34	4,275-5,644	471-622
	Diabetes only	1,836	4,015	42-56	1,686-2,257	918-1,229
	CHD only	842	4,597	21-30	944-1,379	1,121-1,638
	COPD only	403	1,985	31-37	618-721	1,534-1,788
	Multimorbid	2,160	6,343	23-36	1,588-2,414	735-1,118
Aged 19-75	Diabetes only	6,868	7,238	39-54	3,009-4,042	438-589
	CHD only	2,283	5,275	22-30	1,098-1,582	481-693
	COPD only	1,141	2,417	28-36	643-851	563-746
	Multimorbid	3,599	7,240	28-43	1,749-2,660	486-739

Note: There may be additional savings and investments in social care - not included here

1 Average cost over all patients in the population (including MFF)

2 See evidence base for details of assumptions on reductions and investment required

3 Not including programme costs

SOURCE: HES 2010/11; Waltham Forest IC impact model

NHS Waltham Forest | 32

Waltham Forest has begun putting enablers in place



Organisation and Accountability

- Already in place in Waltham Forest**
- Project boards, in place for ICM, are accountable to the CCGs, including all stakeholders providing transparent decision making mechanisms

- Key developments required**
- Strengthen long term governance arrangements to bind in acute care and CHS and social care
 - Ability to commit CHS and LA to packages of care
 - A performance framework needs to be established to manage all stakeholders



Clinical leadership and culture development

- ICM has improved working between primary care and community matrons
- ICM clinically led: Dr Mayank Shah as ICM project board chair in Waltham Forest

- Develop better working between health and social care, and between acute and primary care
- ICM launched in Chingford; 2 out of 3 launched in Walthamstow
- Leadership from BLT needs to come on-board



Information sharing

- Health analytics system in place allowing risk stratification of patients
- Clear metrics identified to be reported monthly to integrated care project boards
- Patient consent for information sharing obtained by GP
- Plans to give GPs access to social care data and social care to view statistical but not patient level information

- Create consolidated patient registry viewable by primary care, acute, CHS and social care
- Ensure metrics identified help drive performance and reimbursement and are effectively tracked



Aligned incentives

- Implicit incentives based on a underlying "win-win principle"

- Direct alignment required between the benefits of savings for the whole system vs potential negative impact on one provider eg. acute
- Incentives needed to ensure stakeholder participation in the care delivery model



Patient engagement

- Care plans co-developed by integrated care MDT and patient

- Stronger engagement required with a bigger role for patients in planning and managing their own health

Outcomes since April 2012

Quality

- > 1000 patients with integrated care plans since April 2012
- All 46 GP practices, Local Authority, Acute Hospital Trusts and 1 community provider delivering the model of care
- Improved co-ordinated care by multi-disciplinary teams and reduced duplication
- Every patient has a nominated and dedicated coordinator to coordinate personalised care
- Rapid access to social care as needed through direct referral to social care

Experience

- **Patients say...** “ I have a plan of my care on my fridge that the girls gave me. I just call up Joanna (my coordinator) if I am unsure of when the Julia (matron) is next coming to see me. Makes me feel less worried knowing that there is someone who I can contact”
- **GPs tell us** “having the staff attend our practice on a regular basis has helped us establish great relationships. I know now more about my patients than before as I hear the perspectives the social worker and nurses and this helps provide the best care my patients”

Comments- service user engagement event

“This type of provision is well overdue”

“I have been waiting for this for a very long time”

“When will the service start as I’m really positive you can help me”

“When can I get a Navigator to help me?”

Impact analysis – first 3 month locality pilot

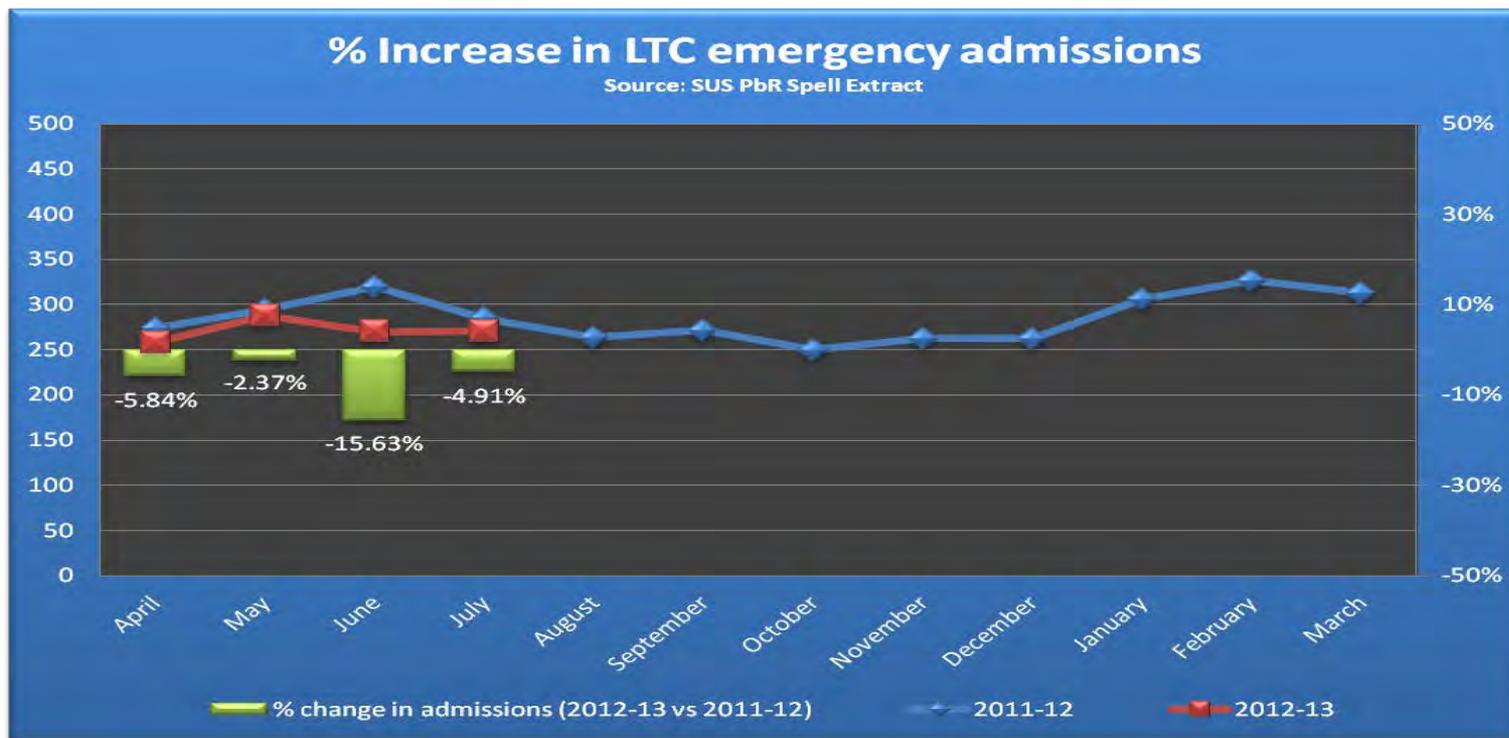
‘- in your first 3 months of implementing integrated care your A and E admissions have fallen by 11%.

This is comparing the actual number of admissions in 10/11 compared with 11/12 for the top 6 conditions which we thought we would impact on using integrated care.

This equates to a fall of 103 admissions in WF and equates to 350k worth of savings in 3 months.’

For this locality of 62,000 population full year effect £1.4m
Total population of our three localities is 290,000

Financial performance



- Demonstrated savings of 337 K over first 5 months 2012/13 through reduction in unplanned admissions and associated attendances in comparison to last year
- 114 less admissions for target population in comparison to last year
- This demonstrates consistent reduction in unplanned hospital admissions for the target LTC group for integrated care in comparison to last year

Why is delivery & integration of primary care mental health so patchy?

- Skills shortages in the primary care workforce
- A lack of meaningful engagement with self-care and non-medical workforce (e.g. traditional healers)

Multidisciplinary Collaborative Maternity Care in Canada: Easier Said Than Done

Wendy E. Peterson, RN, PhD,¹ Jennifer M. Medves, RN, PhD,² Barbara L. Davies, RN, PhD,¹ Ian D. Graham, PhD¹

¹School of Nursing, Faculty of Health Sciences, University of Ottawa, Ottawa ON

²School of Nursing, Queen's University, Kingston ON

Conclusion: Representatives of professional associations of care providers believe that multidisciplinary collaborative maternity care is needed to sustain the availability of care providers and to improve access and women's choices for maternity care in Canada. However, they perceive that strong leadership and education are needed to address significant structural and relational barriers to collaborative practice.

J Obstet Gynaecol Can 2007;29(11):880–886

Integrating pharmacists into family practice teams

Physicians' perspectives on collaborative care

Kevin Pottie MD MCISc CCFP FCFP Barbara Farrell PharmD FCSHP Susan Haydt MA Lisa Dolovich PharmD MSc
Connie Sellors Natalie Kennie PharmD William Hogg MD MSc MCISc FCFP Carmel M. Martin MBBS MSc PhD MRCGP

CONCLUSION Physicians' perspectives on collaborative practice 12 months after pharmacists were integrated into their family practices were positive overall. Some ongoing operational challenges remained. Several of the early concerns about collaborative practice had been resolved as physicians discovered the benefits of working with pharmacists, such as increased security in prescribing.

Canadian Family Physician • Le Médecin de famille canadien VOL 54: DECEMBER • DÉCEMBRE 2008

Educating the workforce



Companion to Primary Care Mental Health

Edited by
Gabriel Ivbijaro MBE

Forewords by

Richard Roberts, John M Oldham, Mirta Roses Periago,
Pedro Ruiz and Paola Testori Coggi

- Primary Care Mental Health International Diploma Course
NOVA University, Lisbon
- www.fcm.unl.pt



Authors
Angela Coulter
Sue Roberts
Anna Dixon

October 2013

Delivering better services for people with long-term conditions

Building the house of care



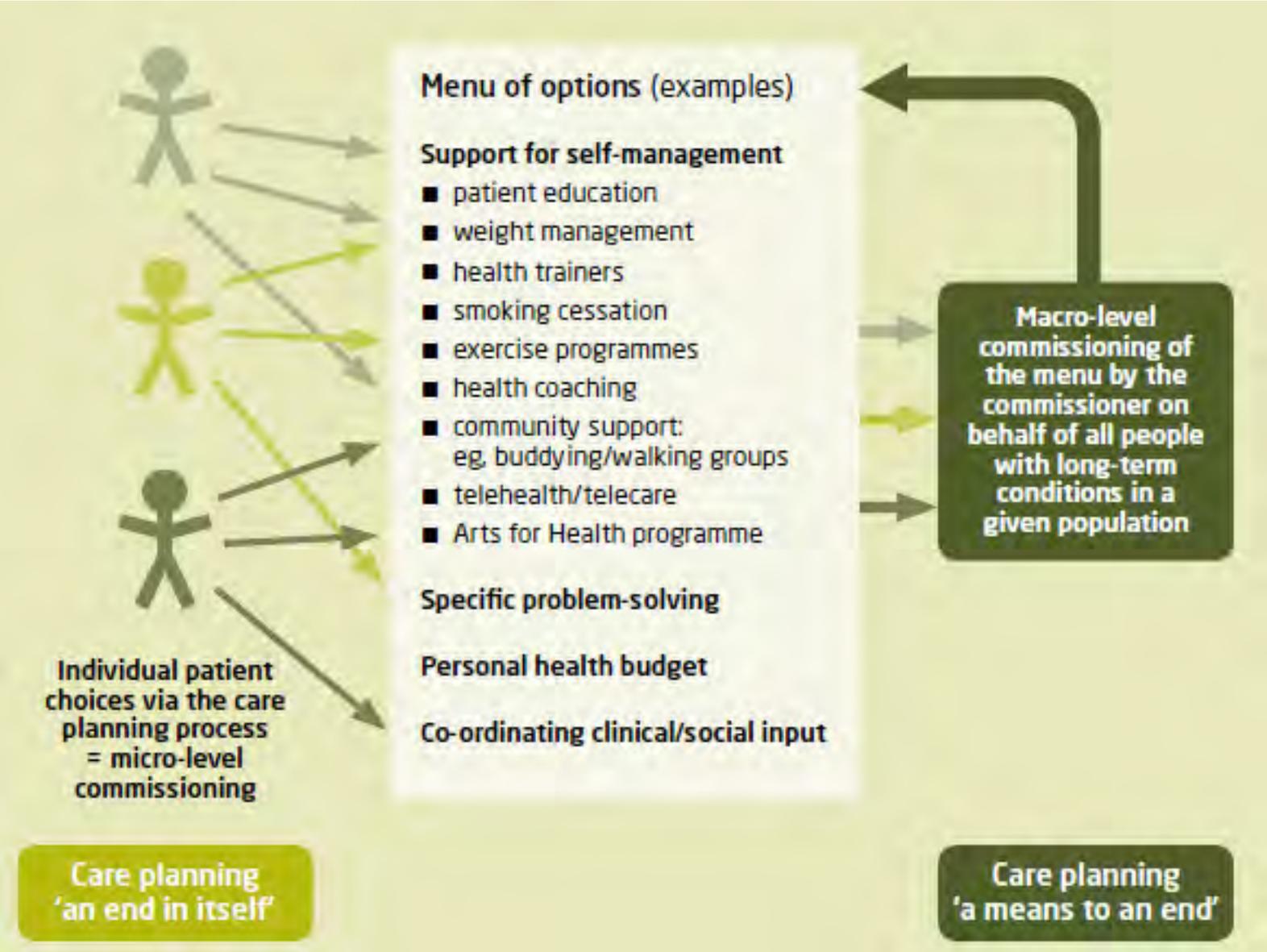
The House of Care – key elements

- People with long-term conditions are central to the process. They are supported by health and social care professionals to express their own needs and decide on their own priorities through a process of information-sharing, shared decision-making and action planning.
- Self-management support and the development of collaborative relationships between patients and professionals are at the heart of service delivery. This shifts the focus onto the roles and responsibilities of patients as well as professionals, and the systems that are needed to support them to fulfil these roles. The ultimate aim is that people should have the knowledge, skills and confidence to manage their condition effectively in the context of their everyday life.
- Tackling health inequalities is a central aim of the house of care. The number of long-term conditions and their burden falls disproportionately on people with poor health literacy and those in lower socio-economic groups. Tools, skills training and ongoing support must be available to identify those who find it harder to engage with health issues and may need extra support to do so.
- The house of care delivery system aims to ensure that each individual is involved in a unified, holistic care planning process with a single care plan. A common set of relevant skills and processes reduces the burden of training.
- Quality assurance of the philosophy, core approach and skills required is essential to ensure that implementation builds on relevant evidence and experiential knowledge, which is consistently applied.
- Care planning is the gateway to personalisation and/or personal health budgets.

Collaboration between the patient and the team



Needs may be different



Conclusions

Collaborative care for depression and anxiety problems (Review)

Archer J, Bower P, Gilbody S, Lovell K, Richards D, Gask L, Dickens C, Coventry P



Authors' conclusions

Collaborative care is associated with significant improvement in depression and anxiety outcomes compared with usual care, and represents a useful addition to clinical pathways for adult patients with depression and anxiety.

Collaboration between local health and local government agencies for health improvement (Review)

Hayes SL, Mann MK, Morgan FM, Kelly MJ, Weightman AL



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COLLABORATION®**

Authors' conclusions

Collaboration between local health and local government is commonly considered best practice. However, the review did not identify any reliable evidence that interagency collaboration, compared to standard services, necessarily leads to health improvement. A few studies identified component benefits but these were not reflected in overall outcome scores and could have resulted from the use of significant additional resources. Although agencies appear enthusiastic about collaboration, difficulties in the primary studies and incomplete implementation of initiatives have prevented the development of a strong evidence base. If these weaknesses are addressed in future studies (for example by providing greater detail on the implementation of programmes; using more robust designs, integrated process evaluations to show how well the partners of the collaboration worked together, and measurement of health outcomes) it could provide a better understanding of what might work and why. It is possible that local collaborative partnerships delivering environmental Interventions may result in health gain but the evidence base for this is very limited.

Evaluations of interagency collaborative arrangements face many challenges. The results demonstrate that collaborative community partnerships can be established to deliver interventions but it is important to agree goals, methods of working, monitoring and evaluation before implementation to protect programme fidelity and increase the potential for effectiveness.

Collaborative care approaches for people with severe mental illness (Review)

Reilly S, Planner C, Gask L, Hann M, Knowles S, Druss B, Lester H



Authors' conclusions

The review did not identify any studies relevant to care of people with schizophrenia and hence there is no evidence available to determine if collaborative care is effective for people suffering from schizophrenia or schizophreniform disorders. There was however one trial at high risk of bias that suggests that collaborative care for US veterans with bipolar disorder may reduce psychiatric admissions at two years and improves quality of life (mental health component) at three years, however, on its own it is not sufficient for us to make any recommendations regarding its effectiveness. More large, well designed, conducted and reported trials are required before any clinical or policy making decisions can be made.

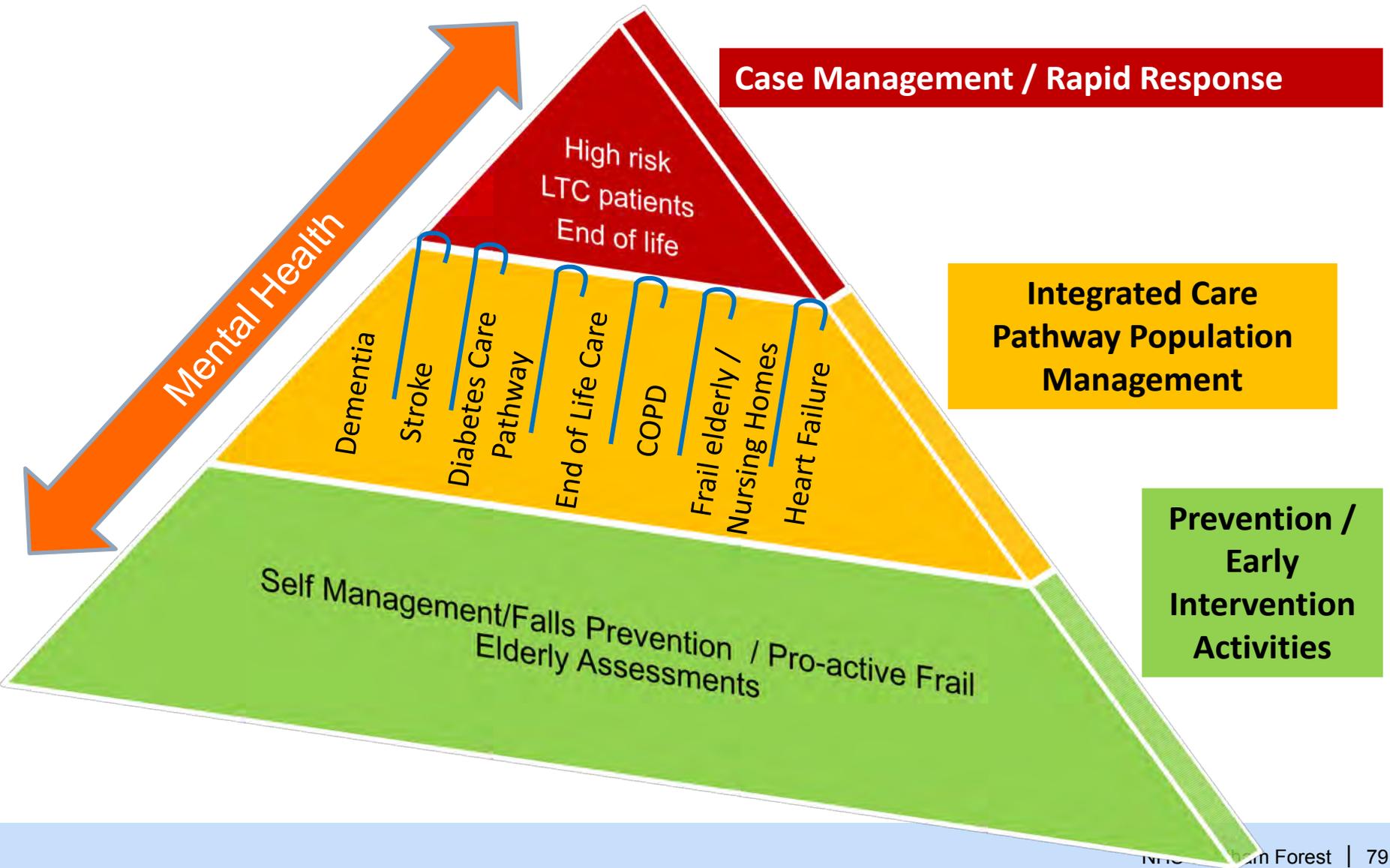
Doing nothing is not an option

Changes in rankings for 15 leading causes of DALYs, 2002 and 2030 (baseline scenario)

Category	Disease or Injury	2002 Rank	2030 Rank	Change in Rank
Within top 15	Perinatal conditions	1	5	-4
	Lower respiratory infections	2	8	-6
	HIV/AIDS	3	1	+2
	Unipolar depressive disorder	4	2	+2
	Diarrhoeal diseases	5	12	-7
	Ischaemic heart disease	6	3	+3
	Cerebrovascular diseases	7	6	+1
	Road traffic accidents	8	4	+4
	Malaria	9	15	-6
	Tuberculosis	10	25	-15
	COPD	11	7	+4
	Congenital anomalies	12	20	+4
	Hearing loss, adult onset	13	9	+4
	Cataracts	14	10	+4
	Violence	15	13	+2
Outside top 15	Self-inflicted injuries	17	14	+3
	Diabetes mellitus	20	11	+9

Source: Mathers and Loncar, 2006.

Integrated care a whole systems approach: scaling up in Waltham Forest



[London Resources](#)

<http://www.londonhp.nhs.uk/healthcare-for-london/>

<http://www.londonhp.nhs.uk/publications/mental-health/>

<http://www.londonhp.nhs.uk/publications/copy/>

<http://www.londonhp.nhs.uk/publications/policies/>

<http://www.londonhp.nhs.uk/publications/mental-health/models-of-care/>



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Thank you

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