



Releasing the hidden millions

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First a thank you

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- To Alan Cohen and Michael Parsonage
- Who helped with the work underlying this presentation

An Apology



- ❑ This is not a politically correct presentation
- ❑ Offence is not intended
- ❑ I realise that the NHS always has to square a circle
- ❑ But someone has to fight for better, more cost effective, services
- ❑ Please listen to the underlying message

Another apology

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- I've spent the last 10 years not quite implementing government policy about mental health
- And I suspect that I am not alone
- NICE Depression
- NICE Anxiety
- NICE Schizophrenia
- NICE OCD
- Bits of NSF MH to do with common mental health problems
- Etc
- Etc

But that's fine

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- Because it was not the RIGHT government policy ...such as...
- Cancer
- Heart disease
- Stroke
- And anything to do with scanners

Cinderella was out
Ugly sisters were in

But there is a problem

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- The wrong patients
- Have been having the wrong tests
- From the wrong Doctor
- In the wrong place
- Giving them the wrong diagnosis
- So they get the wrong treatment
- So they don't get better
- So they go back to the wrong Doctor
- To get some more wrong tests.....

And waste all

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HER money!



And His too



Another Danger

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- ❑ All of the above really clogs up systems
- ❑ You could spend more on the systems and make them bigger
- ❑ So there is less to spend on mental health
- ❑ That won't make my day



Another Danger

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- Or ..
- Fix the problem in the first place
- Make fewer referrals
- Need less physical capacity
- Then you might make
- this chap's day!

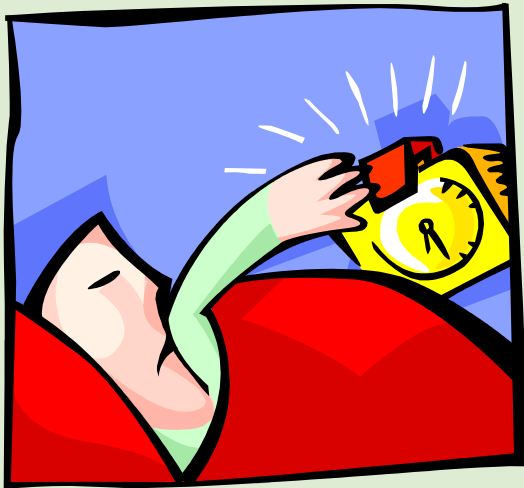


Surely He's Wrong?

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Sorry, I'm not
It's time to...



Wake up...



and smell the coffee.

(Lancet 8th Sept)

But there is a problem

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This is another 'Inconvenient Truth'
that we need to courage to face



But there is a problem

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- We must not continue pouring money away on:
 - More tests that people do not need
 - The wrong treatments
 - Services that address only the body and not the mind



How big is the Problem?



There is a lot of literature looking at medically unexplained symptoms (MUPS) in Primary Care, the table summarises 14 papers

Feder et al	24%
Mumford	5% to 10%
Pevelar	19%
Palsson	16%
Pilowsky	39%
Scicchichitano	27%
Kroenke	74%
Khan	34%
Kroenke	35%
Marple	33%
Kroenke	20%
De Waal	21.9% to 16.1%
Barsky	20.5%

How big is the Problem?

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There is a lot of literature looking at medically unexplained symptoms (MUPS) in Secondary Care, this shows prevalence in 2 London Hospitals (Nimnuan et al)

Dental	37%
Chest	41%
Rheumatology	45%
Cardiology	53%
Gastroenterology	58%
Neurology	62%
Gynaecology	66%
Total	52%

How big is the Problem?

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- Hamilton found 40% of people in a Medical Clinic in Manchester had MUPS
- Gill et al found 13.8% of all primary care consultations were 'frequent consulters'

How costly is the Problem?

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- Barsky estimates \$256 BILLION annually in the USA
- Hiller et al found 2.2 times the spend on people in this group
- Reid estimated each case cost £955 per MUPS patient, allowing for NHS inflation this is now £1657 per patient per year (in 2008-9 prices)

England 2006

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Clinic	% MUPS (estimated from evidence)	Number of annual new referrals in England 20006, age 20 - 69	Number of estimated MUPS	Cost In 2008 prices
Dental	37%	50,604	18,723	£31 million
Chest	41%	128,784	52,801	£87.5 million
Rheumatology	45%	214,157	96,371	£160 million
Cardiology	53%	374,180	198,315	£329 million
Gastroenterology	58%	150,188	87,109	£144 million
Neurology	62%	238,926	148,134	£245 million
Gynaecology	66%	1,022,844	675,077	£1,119 million
General Medicine	40.5%	563,194	228,094	£378 million
Total	52%			£2. 49 Billion

So Tell me?



- Now I can show my country probably wasted at least £2.49 Billion in 2006, sending
 - The wrong patients to
 - The wrong doctor for
 - The wrong tests, to
 - Get the wrong diagnosis , and
 - Get the wrong treatment
- Tell me it just does not matter
- And it is professional to continue ignoring it
- Or do we want to do something about it?
- Surely we have a professional duty?
- Also don't forget this is just for those specialities...so the final number is bigger

Why?



- 70% to 90% of people with depression present in primary care with somatic symptoms (Simon et al)
- Hypochondriasis
- False illness beliefs
- Safety behaviour by Doctors
- Khan et al looked at 289 patients with 433 symptoms, only finding a 0.69% chance of a symptom classified as unexplained being falsely classified
- Morriss reported about a 10% error, once MUS suspected – so we do still need to be careful, and remain vigilant

What works?

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- ❑ CBT
- ❑ Antidepressants
- ❑ Collaborative care
- ❑ Keeping the person in primary care and not referring



<http://www.mhchoice.csip.org.uk/silo/files/mus-review-for-pathfinders.pdf>

CBT



- Hiller et al looked at cost effectiveness of CBT in a group of people at a tertiary care centre.
- At a 2 year follow up they found a treatment related offset of €382 (-24.5%) for outpatient care and €1098 (-36.7%) for inpatient care.
- In a subgroup of somatising high users per patient savings of €32,174 were achieved.

CBT



- ❑ Arnold (Psychosomatics 24 (6): 498 (2006))
- ❑ 16 % attending primary care have MUS
- ❑ By 6 months this had reduced to 12.3%
- ❑ 4.8% demonstrated a need for treatment
- ❑ This takes into account those already being treated, and excludes those not interested in treatment, or otherwise ineligible

Drugs

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A meta analysis of antidepressant treatment showed benefit in 69% of studies.



Collaborative care

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- ❑ Collaborative care is a combination of training and psychiatric consultation / support for primary care.
- ❑ Van der Felz-Cornelius showed that collaborative care was more effective than training alone, with highly significant reductions
- ❑ 43% of care as usual for primary care service use
11.6% of the care as usual group for 'care in all health care settings'

Primary Care

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- ❑ The key is to introduce stepped, collaborative, care
- ❑ Ask PC to do more work (see flowchart on your seats)
- ❑ Screening out undiagnosed depression and anxiety, and somatisation
- ❑ Providing a logical pathway for these patients
- ❑ Pay them for it as a QOF like LES
- ❑ Provide a collaborative care support offering CBT
- ❑ Support PC when it goes wrong
- ❑ Watch referrals fall to secondary care
- ❑ Bank the change

Now some other ideas

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Perhaps not?



Drugs



- ❑ In Suffolk we spend £1.5 million annually on SSRI antidepressants
- ❑ NICE recommends using 2 inexpensive generics first line. One costs £18.00 annually, one costs £42.00 annually
- ❑ Others cost up to £250 annually

- ❑ Use PBC to get GPs to agree to only initially prescribe the 2 inexpensive drugs
- ❑ This will only work if you agree in advance to use any cost offset on psychological therapy
- ❑ Behaviour change needs a reward
- ❑ I believe that this is sufficient

Collaborative Care

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- ❑ Shown in USA to increase 2y remission from depression from:
- ❑ 41 % to 74%
- ❑ Cost neutral by 2 years, just looking at primary care
- ❑ No extra secondary care spend

- ❑ This could be introduced into primary care as a LES
- ❑ Or be part of an IAPT service, with follow up by case managers on phone
- ❑ Imagine the effect of so many fewer depressed people (Rost et al)

Diabetes

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- Depressed Diabetics cost 2.5 x more for their diabetic care, and 4x more for 'all care'



Hillingdon COPD project

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- ❑ 5 X 2hr group sessions using CBT
- ❑ Education, anxiety management, relaxation, pacing, goal setting
- ❑ Control group
- ❑ Post intervention A & E attendances and hospital admissions reduced
- ❑ Cost of service £25,000 per annum
- ❑ Savings over 6 months £69,645

Chest Pain



- ❑ Lots of admissions involving NHSD and 999
- ❑ Very fast pathway for chest pain
- ❑ Rapid, frightening, tests
- ❑ There is usually no pathway after 'you do not have heart disease'
- ❑ We need an integrated pathway that catches panic disorder and somatisation and depression
- ❑ Otherwise people can be caught for years having pointless tests

Depression

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- 25% of sufferers are in treatment
(ONS, 2000, official)
- 10% on treatment that should work
(ONS study's chief author, unofficial)
- 56% of most severe cases in treatment
(ONS, 2003)
- <10% of the long-term off work group in treatment
(Layard, 2005)

(Slide from Dr Tim Webb)

Cost-offset?



- Meta-analysis in USA of 91 studies providing psychological care in LTCs
- Average savings in health care costs = 20%
- Even when cost of new service subtracted

(Chiles & Lambert, 1999)

Cost offset mini business plan

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- ❑ Screen for MUS and anxiety / depression at the point of physical referral
- ❑ Offer treatment to those who accept it
- ❑ Remain watchful for physical disease
- ❑ Value containment in primary care

Cost offset mini business plan

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- ❑ Nationally, just using my estimates (based on Nimnuan, Reid, and Arnold) this will cost £141 million
- ❑ Just the savings on those who accept treatment and respond will be, at best, £578 million in secondary care, and £17.7million in primary care
- ❑ The net saving is £455 million
- ❑ Or £166 million assuming only half of the savings are recoverable

But there is a solution

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The RIGHT patients

But there is a solution

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Have been having the RIGHT tests

- PHQ-9
- GAD-7
- PHQ-15

But there is a solution

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From the RIGHT Doctor

But there is a solution

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In the RIGHT place



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Giving them the
RIGHT diagnosis

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So they get the RIGHT treatment

But there is a solution

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So they get better

I'm sure you all
get the idea?

That's how you release the millions

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- Do ~~we~~ you have the courage to do it?



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Thank you

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