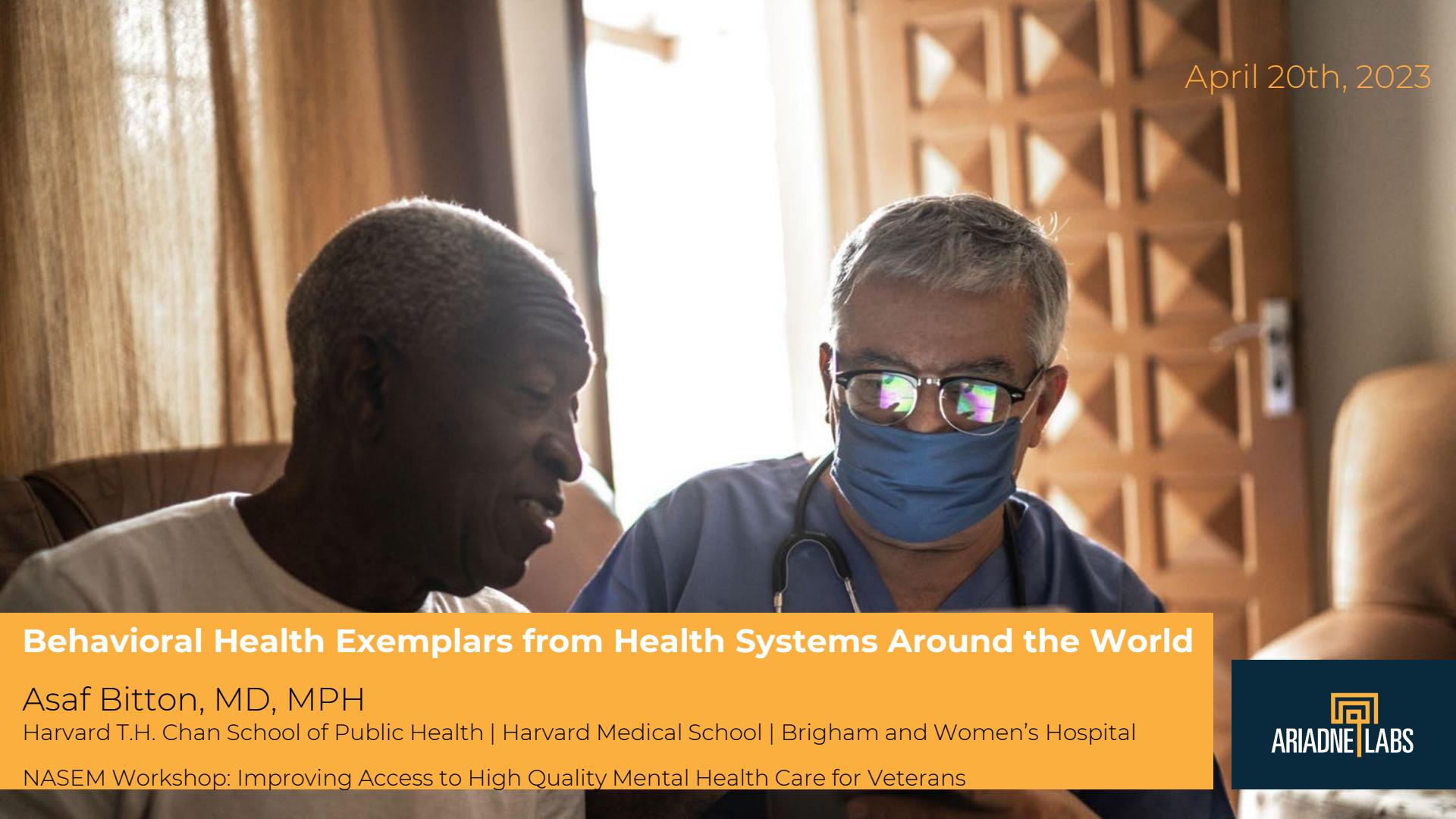

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# Behavioral Health Exemplars from Health Systems Around the World

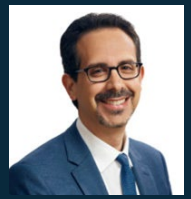
Asaf Bitton, MD, MPH
Harvard T.H. Chan School of Public Health | Harvard Medical School | Brigham and Women's Hospital

NASEM Workshop: Improving Access to High Quality Mental Health Care for Veterans

ARIADNE LABS

We are a joint center for health systems innovation at Brigham & Women's Hospital and the Harvard T.H. Chan School of Public Health

Atul Gawande, MD, MPH
*Founder*



Asaf Bitton, MD, MPH
*Executive Director*

ARIADNE LABS

Brigham and Women's Hospital
Founding Member, Mass General Brigham

HARVARD T.H. CHAN
SCHOOL OF PUBLIC HEALTH

Ariadne Labs has studied, built, and globally scaled numerous health care tools and interventions over the past decade.

phcpi
PRIMARY HEALTH CARE PERFORMANCE INITIATIVE

We have extensive experience in assessing high-performing health care systems around the world and in the U.S.

We design, test, and spread solutions for major implementation gaps in health care & public health. Examples include developing surgical and childbirth checklists, serious illness communication programs, establishing global PHC measurement standards, and new home hospital and genomics implementation protocols.

# Today We Will Review

**The IAPT Model in the UK**

Mass Training – Good Data – Large Reach at Scale

**The Trieste Model in Italy**

Community Resources – Community-Led Care of Patient

**Nuka / The Southcentral Foundation**

Integrated Primary Care / BH model, led by CHWs in a High Need Area

**CONTEXT**

*The National Health Service (NHS) is an integrated system organized into trusts that administer most healthcare, including primary care, acute care, community-based care, and mental health care. Patients are geographically empaneled to their local trust. Via a referral system, primary care is a gatekeeper to higher levels of care (including mental health care).*


# The IAPT Model in the UK

## Mass Training – Good Data – Large Reach at Scale

- Motivated by evidence reviews showing effectiveness of CBT and other “talk therapies”, as well as low population use of effective treatment
- Starting in 2008, IAPT aimed to **train new therapists** and wellness practitioners in a phased approach over 3 years.
- It operated as a **"hub and spoke" model** with a central facility for administration and telephone support.
- **Patients can self-refer** or be referred by their PCP and receive **a person-centered assessment** to create an agreed-upon treatment plan.
- All treatment should be in line with **established clinical guidelines,** proceed in stepwise approach, and be provided **by trained staff.**

# The IAPT Model in the UK

## Mass Training – Good Data – Big Reach at Scale

### Training

- Two kinds of therapists: **high-intensity CBT therapists** and **low-intensity Psychological Wellbeing Practitioners (PWPs)**.
- <u>High-intensity therapists:</u>
  1-year service contract, attended university classes for 2 days a week, and completed 200 hours of CBT with 70 hours of clinical supervision.
- <u>Low-intensity PWPs:</u>
  1-year service contract, attended university classes for 1 day a week, and learned engagement and assessment, evidence-based low-intensity treatments, values, policy, culture, and diversity.

### Measurement

- Prior to IAPT, less than 40% of patients with depression and anxiety received an evaluation of their symptoms at the beginning and end of therapy; less than 10% adequately treated overall.
- In IAPT, **patients regularly complete measures** of depression, anxiety, and mental health-related disability for every session, allowing for measuring patient outcomes regardless of how abruptly therapy ends.
- IAPT services utilized **specialized IT systems to track and report patient outcomes such** as recovery and improvement rates, while also occasionally inviting patients to evaluate their satisfaction with treatment.

# The IAPT Model in the UK

Mass Training – Good Data – Large Reach at Scale

**Success**

- IAPT training successfully scaled up CBT competence in high-intensity therapists, with positive clinical outcomes for trainees' patients, exceeding the government benchmark of 50% recovery rates.

- IAPT had a 45% full recovery rate in the first three years. More than 45,000 patients moved off government benefits, resulting in 272 million pounds saved through reduced healthcare utilization.

- As of 2015, IAPT therapists saw **960,000 people per year**, with **51%** of those with at least 2 sessions of therapy recovered, and **66% showing improvement.** However, there is variability across trusts in all measures. Therapists **reached 1.2 million people in 2021.**

- **It became the NHS Talking Therapies program in 2023.** In 2021, over **1.2 million people accessed the program, representing 1.8% of the UK population**. Since its inception, at least 6.5 million people have accessed it.

https://www.england.nhs.uk/mental-health/adults/nhs-talking-therapies/

# The Trieste Model in Italy

## Community Resources – Community-Led Care of Patient

**CONTEXT**

*After WWII, Italy's healthcare system included private insurance and sickness funds until the public healthcare system (SNS) was established in 1978. Professor Franco Basagli led the transition in 1971 from involuntary care at Trieste Mental Hospital to community-based outpatient centers. Implementation varied by region due to funding.*


- Focus is on **people with serious mental illness (SMI), with de-institutionalization through community support. Nationwide implementation with large regional variation.**
- **Catchment areas with 24-7 community mental health centers (CMHCs) staffed by a multidisciplinary team** that provides holistic walk-in services, responding to non-urgent issues within 1-2 hours.
- **CMHCs are located in non-hospital residential facilities and act as first responders** to mental-health crises in their catchment area, providing outpatient care both at the CMHC and in users' homes.
- The model **prioritizes integration, de-stigmatization, and community accountability** for vulnerable people with SMI and substance misuse. It includes Habilitation and Residential Service that manages group homes, residential facilities, and day programs, and collaborates with a large number of social services and programs, including those for caregivers.


# The Trieste Model in Italy

## Community Resources – Community-Led Care of Patient

### Training

- Standard training pathways for psychiatrists and psychologists
- Emphasis on **social workers along with psychosocial rehabilitation workers** who staff CMHCs – shift from *“hospitalization for patients to hospitality for guests”*
- Rehabilitation and Residential Support Service run daytime activities in **partnership with volunteer and numerous social promotion associations**.
- Social cooperatives train & employ people with mental health & substance use disorders, **creating social lattice for integration.**

### Measurement

- **Focus on social > medical measures**, as well as community accountability for population outcomes
- Proportion of people living independently or with support outside of institutions
- Measures of ”hospitality” at CMHCs – holistic person experience
- Engagement of community members and associations with community model

# The Trieste Model in Italy

## Community Resources – Community-Led Care of Patient

**Success / Challenge**

- Deinstitutionalization in Trieste decreased compulsory treatment and forensic hospitalizations, **cut psychopharmaceutical spending in half (1971-2000), and associated with 45% regional reduction in suicide rates.**
- Currently, **only 18 out of 5,000 people treated by Trieste's Mental Health Department are still housed involuntarily,** with most of the budget spent on community services and direct payments to promote social integration.
- **Large regional variation and uptake across Italy**. Northern Italy has adopted and spread the model more successfully than Southern Italy. **Major political and funding challenges** right now with current government.
- **Attempts at spreading model to US have had only variable success.** San Francisco failed in collaborating with Trieste due to structural differences. However, LA has implemented a pilot program using Trieste's model, which has shown to be effective in managing mental health crises and promoting long-term outcomes through social inclusion and community services.

**CONTEXT**

*Existing health systems failed to provide adequate care to Alaskan natives. The Southcentral Foundation introduced the Nuka system in the late 20th century, treating patients as customer-owners. The system serves 60k+ Alaskan natives with quality, patient-centered care, including remote villages, and the word "Nuka" means strong giant structures and living things.*

# Nuka / Southcentral Foundation

## Integrated Primary Care / BH model, led by CHWs in a High Need Area

- The Nuka model of healthcare relies on **empanelment to primary care, high patient access, and team-based care** to improve care outcomes.
- Patients are empaneled to an **integrated and comprehensive care team, which includes a behavioral health consultant, trained CHWs, and uses open scheduling, expanded office hours**, and increased electronic communication to increase patient access.
- **Behavioral health consultants** focus on a broad range of clinical situations and are available by scheduled appointment, patient walk-in, or referral from another provider. Primary care uses annual screenings for mood and substance abuse and other targeted methods alongside more spontaneous forms of behavioral health integration.

# Nuka / The Southcentral Foundation

## Integrated Primary Care / BH model, led by CHWs in a High Need Area

### Training

- Behavioral health consultants require a master's degree, but no single university program prepares individuals for the unique job requirements.
- Southcentral Foundation has adopted the practice of growing their own behavioral health consultants and CHWs through **standard training, continuous learning, and collaboration with local universities**.
- Behavioral health consultants and CHWs are chosen via recruitment interviews that focus on **personal style and commitment to community/customer focus**.
- **Family Wellness Warriors (FWW)** have particular training in **trauma-informed care**. **Learning Circles** utilize **group therapy** based on Alaska Native storytelling and sharing.

### Measurement

- Southcentral foundation collects extensive, iterative, and sequential measures of patient experience, HEDIS process & outcomes.
- Strong use of PDSA cycles and iterative QI technique to orient data for improvement
- Routinely report ED visits and hospital discharges, as well as customer / employee satisfaction

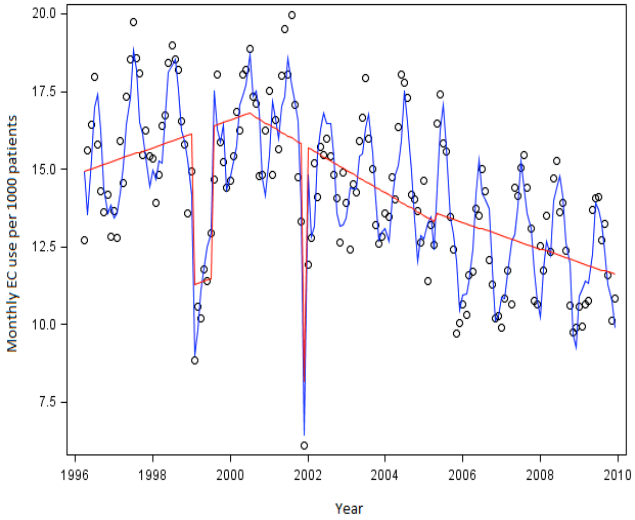
# Nuka / The Southcentral Foundation

## Integrated Primary Care / BH model, led by CHWs in a High Need Area

**Success**

- Nuka care has been successful, twice winning the Malcolm Baldrige Award and reporting significant decreases in ED visits and hospital admissions.
- A propensity-matched comparison study of the FWW program demonstrated **55% system-wide ED visits, 80% decrease in substance-use visits, and 71% reduction in untreated depression**.
- Major social outcome changes: **20% reduction in unintentional injury visits to the ED, suggesting widespread downstream effects**

Rates of ER Visits/Month
for Unintentional Injuries




http://www.annfammed.org/content/11/Suppl_1/S41

# Closing Thoughts / Observations / Themes

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# Thank you!

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# Questions?

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