

Bringing together physical and mental health

A new frontier for integrated care

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Key messages

- Integrated care initiatives in England and elsewhere have paid insufficient attention to the relationship between physical and mental health. This aspect of integration should be a major part of efforts to develop new models of care in NHS England's vanguard sites and elsewhere.
- The case for seeking to support physical and mental health in a more integrated way is compelling, and is based on four related challenges:
 - high rates of mental health conditions among people with long-term physical health problems
 - poor management of 'medically unexplained symptoms', which lack an identifiable organic cause
 - reduced life expectancy among people with the most severe forms of mental illness, largely attributable to poor physical health
 - limited support for the wider psychological aspects of physical health and illness.
- Collectively, these issues increase the cost of providing services, perpetuate inequalities in health outcomes, and mean that care is less effective than it could be. The first two issues alone cost the NHS in England more than £11 billion annually.
- The report identifies 10 areas where there is particular scope for improvement. These span the full range of health system activities, illustrating that change is needed across the system. Commissioners and providers can use these 10 areas as a guide to identify where some of the most significant opportunities for quality improvement and cost control lie.
- Examples of innovative service models described in the report demonstrate that there are opportunities to redesign care in ways that could improve outcomes and may also be highly cost effective. These include various forms of enhanced support in primary care, integrated community or neighbourhood teams, comprehensive liaison mental health services, physical health liaison within mental health services, and integrated perinatal mental health care.



- All health and care professionals have a part to play in delivering closer integration. Our research with service users and carers highlights the importance of professionals being willing and able to take a ‘whole person’ perspective, and having the necessary skills to do so. Integrated service models can support this by facilitating skills transfer and shifting notions of who is responsible for what. Equally, a great deal of improvement is possible within existing service structures.
- New approaches to training and development are needed to create a workforce able to support integration of mental and physical health. This has significant implications for professional education; all educational curricula need to have a sufficient common foundation in both physical and mental health.
- A range of barriers have prevented wider adoption of integrated approaches. These include: separate budgets and payment systems for physical and mental health; the challenge of measuring outcomes and demonstrating value; and cultural barriers between organisations or groups of professionals.
- The report describes several enabling factors and practical lessons, including the value of having a board-level champion for physical health in mental health trusts, and vice versa. New payment systems and contracting approaches offer commissioners various options for overcoming some of the financial barriers.
- In recent years there has been a welcome focus in national policy on achieving ‘parity of esteem’ for mental health. Colloquially, this phrase has often been interpreted to mean that mental health services should be ‘as good as’ services for physical health. We argue that there is a greater prize beyond this, in which mental health care is not only ‘as good as’ but is delivered ‘as part of’ an integrated approach to health.



1 Introduction

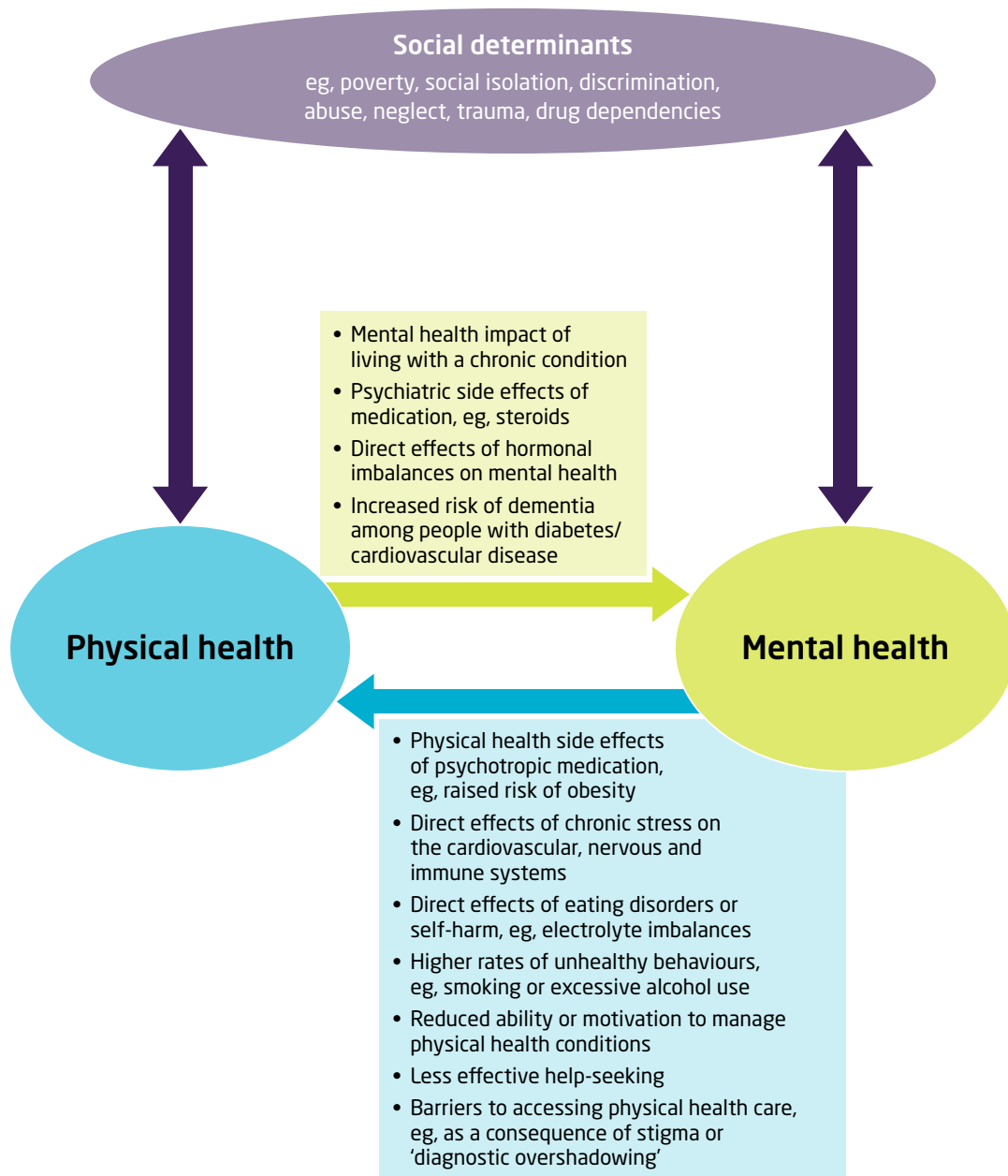
The *NHS five year forward view* makes the case for what has been called ‘triple integration’ (Stevens 2015) – integration of health and social care, primary and specialist care, and physical and mental health care. The importance of the third of these components has been further emphasised in the report of the independent Mental Health Taskforce to the NHS in England, which called for the development of integrated care spanning people’s physical, mental and social needs (Mental Health Taskforce 2016). The purpose of our report is to explore in greater detail what this should involve.

Physical and mental health are closely interconnected and affect each other through a number of pathways (see Fig 1) (Prince *et al* 2007). Throughout this report we take a biopsychosocial perspective, in which health is understood as being a product of biological, psychological and social processes. This is the conceptual framework that many health professionals are trained to work within, but often the principle is not borne out in practice. A number of factors have made it difficult to respond to physical and mental health needs in an integrated way, including institutional and cultural barriers, separate payment systems for physical and mental health care, and the trend for increasing sub-specialisation in professional education. As a result, people using services commonly find that their physical and mental health needs are addressed in a disconnected way.

A strong consensus has emerged calling for more integrated approaches in the health and care system. However, this report argues that to date, efforts to develop integrated care in England and elsewhere have too often paid insufficient attention to integration of mental and physical health. There needs to be a stronger focus on this aspect of integration, which should address four related but distinct challenges:

- rising levels of multi-morbidity
- inequalities in life expectancy
- psychological aspects of physical health
- medically unexplained symptoms.

Figure 1 Mechanisms through which physical and mental health interact





Rising levels of multi-morbidity

The increasing prevalence of multi-morbidity is a central part of the rationale for integrated care. The number of people living with two or more conditions is rising rapidly, meaning that multi-morbidity and the challenges it brings for co-ordination of care are increasingly becoming the norm (Barnett *et al* 2012). Data from analyses such as the Symphony Project in Somerset indicates that multi-morbidity is a more important driver of costs in the health and social care system than other factors such as age (Kasteridis *et al* 2015). As previous research has shown, the existence of co-morbid mental health problems alongside long-term physical health conditions is a particularly common and pernicious form of multi-morbidity (Naylor *et al* 2012). Our earlier analysis indicated that between 12 per cent and 18 per cent of all NHS expenditure on long-term conditions is linked to poor mental health – most commonly in the form of depression or anxiety disorders, which if left untreated can significantly exacerbate physical illness and drive up the costs of care (Naylor *et al* 2012). This form of multi-morbidity affects around 4.5 million people in England; they experience significantly worse health outcomes as a result.

Inequalities in life expectancy

The other side of the multi-morbidity challenge is that people with mental health problems – particularly the most severe mental illnesses – are at much higher risk of a range of physical health conditions. The clearest and most alarming illustration of this is the finding that life expectancy for people with bipolar disorder or schizophrenia is 15 to 20 years below that of the general population, largely as a result of raised rates of cardiovascular disease and other physical health conditions (Laursen *et al* 2014; Miller and Bauer 2014). Physical health issues are also highly prevalent among people with eating disorders, personality disorders, drug or alcohol use disorders, or untreated depression or anxiety. These striking and persistent inequalities serve as a powerful reminder that the case for integrated care for mental and physical health is an ethical one as much as an economic one.

Psychological aspects of physical health

The need to integrate support for mental and physical health is not limited to those people meeting formal diagnostic criteria. All physical health problems have a psychological dimension, particularly when they involve learning to live with a long-term condition, which may require a profound process of internal



adaptation and can be accompanied by significant functional impairment, economic disenfranchisement and social isolation. In this report we argue that from a patient perspective, a meaningful definition of integrated care must also include provision of integrated psychological support to help people adapt and manage their health effectively. Failure to do so can be associated with poor outcomes and faster disease progression (de Ridder *et al* 2008).

It is also important to consider the psychological aspects of *health* as opposed to illness. The case for integrated approaches applies to prevention and health promotion as much as to treatment and care; in the following sections we argue for much greater inclusion of a mental health and wellbeing perspective within public health programmes targeting risk factors for heart disease, lung disease, stroke, cancer and other preventable conditions. Similarly, integration of mental and physical health is particularly important in relation to the perinatal period. Although not an illness, this is a time when mental and physical health are very closely connected, and during which psychological needs are not always well addressed.

Medically unexplained symptoms

A large number of people experience physical symptoms for which no clear biological cause can be identified. These symptoms are often chronic in nature (for example, persistent pain, tiredness or gastric symptoms); they can cause people significant distress, and often have an important psychological component. The terminology used to describe these symptoms is a subject of debate. However, the most widely used term is ‘medically unexplained symptoms’. Symptoms of this kind illustrate that in practice, it is often not possible or helpful to draw a distinction between ‘mental’ and ‘physical’ health. For these difficult-to-define problems, applying a clear diagnostic label (mental or physical) can be inappropriate, and a biopsychosocial approach towards management is particularly important. The concept of medically unexplained symptoms can also include people who have a physical condition but experience symptoms at a level that is disproportionate to the severity of that condition.

Medically unexplained symptoms are more common than is often recognised, and people experiencing them are typically referred for multiple investigations and assessments, at considerable expense to the system and with little or no benefit for the patient. The NHS in England is estimated to spend at least £3 billion each year



attempting to diagnose and treat medically unexplained symptoms (Bermingham *et al* 2010). Much of this expenditure currently delivers limited value to patients; at worst, it can be counterproductive or even harmful.

What does this report add?

The challenges described above are all part of the rationale for integration of mental and physical health. These are well-recognised challenges that have been subject to extensive research. Our intention in this report is to add to the evidence base by providing:

- an analysis of what integrated care for mental and physical health would look like from a patient or service user perspective (Section 2)
- an overview of 10 areas where integrated care is most needed, highlighting the existing evidence available in relation to each (Section 3)
- examples of innovative service models currently being developed and deployed in England (Section 4)
- an analysis of the barriers to change and suggestions as to how these can be overcome (Section 5).

The report draws on a review of published research evidence, qualitative interviews and focus groups with service users and carers, and case studies of 10 services in England. We conclude by arguing that overcoming the longstanding barriers to integration of mental and physical health should be a central component of efforts to develop new models of care that bring together resources from across local health systems.



Terminology and scope

We use the term **integrated care** to refer to the provision of health and care services in such a way that ensures that the various needs of an individual using these services are met in a co-ordinated way, with medical, social and psychological needs being addressed together.

By **integration**, we mean any processes that support movement towards the goal of integrated care, as defined above. This often involves overcoming the breakdown in communication and collaboration that can arise between different parts of the system and different groups of professionals. Importantly, this is not limited to structural change or organisational merger, but includes processes at all levels (Curry and Ham 2010).

We focus specifically on integration in relation to physical and mental health. More broadly, an integrated approach to mental health could refer to a number of things, including integration within mental health services (for example, between services for children and adults) or integration between mental health and other public services such as housing. These other forms of integration are not the focus of this report.

Terminology around **mental health** is contested. We use the terms mental health problem to refer to any form of mental health condition (including dementia), severe mental illness to refer specifically to conditions involving psychosis or very high levels of need, and mental wellbeing as a more general term capturing emotional and psychological welfare and resilience.

We use the term **biopsychosocial** to refer to a perspective in which health is understood as being a product of biological, psychological and social processes, and is assessed and managed accordingly. An integrated approach to physical and mental health implies taking a biopsychosocial perspective.

The report does not cover the need for integration with regard to people with **learning disabilities**. The inequalities experienced by people with learning disabilities in access to care for both physical and mental health are well established – for example, see Emerson *et al* (2011) – and are an important area for improvement, but are beyond the scope of the research conducted here.



2 Getting the basics right: integrated care from a service user perspective

This section explores what an integrated approach towards mental and physical health would look like from a service user perspective, and why it is needed. As part of our research we conducted a series of focus groups and interviews with people who have experienced concurrent and overlapping problems with their mental and physical health. Through these methods, we involved around 40 people who had experienced a diverse range of conditions. Physical health conditions included cardiovascular disease, diabetes, cancer and chronic lung disease. In terms of mental health, participants' experiences included various diagnoses such as depression, anxiety disorders, bipolar disorder and psychosis, as well as significant psychological distress that may or may not have met formal diagnostic criteria. The focus groups also included women who had experienced mental health problems during the perinatal period, and people who had experience of caring for a family member with co-morbid mental and physical health problems.

This component of our research was designed in collaboration with an external steering group composed of people with lived experience of mental and physical health problems, and carers. The steering group helped the research team to identify areas to explore, contributed to draft versions of our interview schedule, and were involved in discussions regarding emerging findings.

Experiences of care and support among focus group participants and interviewees were highly variable, with some examples of excellent care in which support for mental and physical health was successfully integrated. This highlights that there is already good practice to build on. However, the balance of opinion among participants suggested that this remains the exception rather than the norm, with fragmented care being a common experience.



Although the needs and experiences of the people involved in our research were highly diverse, our analysis identified several common themes (see Table 1). We were struck by the observation that these often related to ‘getting the basics right’ rather than (or in addition to) the need for service redesign or structural solutions. The common themes also tended to have broader relevance to all forms of integrated care, but with particular features that are important in relation to integration of physical and mental health.

Table 1 Key elements of integrated care from a service user perspective

Professional attributes	<ul style="list-style-type: none"> • Taking a ‘whole person’ perspective • Communication and consultation skills
System attributes	<ul style="list-style-type: none"> • Co-ordination of care • Proactive care
Role of service users/carers	<ul style="list-style-type: none"> • Peer support and self-management • Support for family and carers

Taking a ‘whole person’ perspective

If I go to see someone about my eyes, my eyes are what I am and the rest of me doesn’t matter. It’s the same with mental health. If I go to see someone for a mental health problem, I am a mental health problem.

Focus group participant

Perhaps more than anything else, integrated working requires a mindset whereby health and care professionals see the fundamental purpose of their role as being to support improvements in both the mental and physical health of the people they work with. Participants in our research commonly described being seen as ‘a heart patient rather than a whole person’ (for example). The danger in having a rigid demarcation between ‘mental health professionals’ and ‘physical health professionals’ is that it creates a diminished sense of responsibility and means that opportunities to improve outcomes are missed. Importantly, participants stressed that this does not imply that all professionals need to become ‘experts in everything’. However, it does mean that anyone working in health and social care needs to have the following:



- a foundation of basic common competencies in mental and physical health
- an openness to explore what a person's wider needs might be beyond the boundaries of their own specialism
- an understanding of other forms of support that are available and how to make a referral to relevant services.

There are a number of barriers that could discourage clinicians from conceiving of their professional responsibilities in the way described here. The service users involved in our research were often conscious that time can be a very significant constraint – for example, limiting a clinician's scope to explore the physical and mental aspects of a person's health (professionals involved in other components of our research made this point too). It is particularly difficult to envisage how this can be done within a typical 10-minute consultation in general practice, raising the question of whether alternative approaches are needed in primary care. While these constraints need to be recognised, it should also be acknowledged that time is not the only issue; sometimes the barriers are as much about skills and confidence, habitual ways of understanding role boundaries, or stigmatising attitudes towards mental health problems. These are all factors that are amenable to change.

Communication and consultation skills

The importance of good communication and consultation skills stood out as a major priority for service users and carers. Their accounts highlighted that there are particular aspects of communication that are important in relation to integration of mental and physical health. The way information and reassurance is given, the kind of questions that are asked, and the quality of listening a professional is able to offer all have the effect of either narrowing or broadening the scope of a clinical encounter. For example, a participant with diabetes described how the first question in check-ups was generally 'how are your HbA1c levels looking?' rather than 'how are you coping?' – the latter being more likely to open up a discussion about psychosocial wellbeing.

The language used by professionals can shape what kind of problems a person feels it is acceptable or legitimate to experience and discuss. A striking number of participants described how language around 'being a fighter' and remaining stoic



in the face of physical illness had made them feel guilty for suffering from a mental health problem. As a result, they did not seek help until their problems became critical, and felt judged and undermined when they did. In the case of women during the perinatal period, there was often a related fear that by disclosing any concerns around mental health, they would be deemed an unfit parent and have their child taken away from them. Professionals can counter some of these reactions by acknowledging emotional distress and anxiety in a non-judgemental way, and discussing the forms of support available.

What is the point of treating someone to a medically high standard if you destroy them as a person at the same time?

Interview participant

Other research has emphasised that careful use of language can be particularly important in relation to medically unexplained symptoms, where there is a risk that clinicians might alienate a person or invalidate their suffering by giving the impression that they are implying their symptoms are ‘all in the head’ (Gask *et al* 2011). The stigmatising attitudes that exist in relation to mental health mean that skill and sensitivity is required in discussing issues of this kind. Similarly, working with people experiencing significant mental distress to help them to improve and manage their physical health can require an ability to use advanced consultation skills and motivational techniques.

More generally, several participants felt that the psychological impact of physical illness would have been less harmful if professionals had communicated with them more effectively and given them more tailored information about their condition – not in the form of generic leaflets, but in relation to the specifics of their case, what stage they were at in the treatment process, and what they could expect to happen next. On several counts, therefore, effective communication was seen as an essential component of an integrated approach towards mental and physical health.

Co-ordination of care

By definition, the participants in our research had experienced multiple health issues and had often been in contact with a complex array of services and professionals. Their accounts frequently highlighted a lack of communication or co-ordination between different components of care. There was particular



fragmentation between support for physical and mental health – a finding that is perhaps unsurprising given the institutional separation of mental and physical health care in England. A common observation was that the only person performing any form of co-ordination role was the patient themselves.

You are your own advocate – you have to be able to navigate all the different services.

Focus group participant

Many of those we interviewed believed that having someone to help with co-ordination – someone with a good overview of both mental and physical health needs – would be a significant step towards integrated care. Some described receiving help with this from their GP, but experiences were mixed; others felt that GPs are not always best positioned to play this role, particularly in terms of their accessibility. Participants emphasised the need for care to be co-ordinated by someone who is easy to contact when difficulties arise. Some of the participants with experience of cancer had been allocated a specialist nurse key worker – a named individual who was readily accessible, and who helped co-ordinate different appointments and aspects of treatment. This kind of support was valued immensely by those who received it.

Participants suggested that a key feature of a well-co-ordinated system of care would be ‘only telling your story once’, illustrating that care co-ordination needs to be underpinned by common assessment processes and appropriate sharing of patient information across providers.

Proactive care

An integrated approach towards mental and physical health would involve professionals anticipating how and when physical health conditions might have an impact on mental health (or vice versa), and suggesting appropriate pre-emptive action. Many of the participants in our research described the system as being reactive rather than proactive. For example, although individual experiences varied, many of those who had experienced physical health conditions reported that they had only received support for their mental health after they had been very persistent in asking for it, or when their mental health deteriorated to a sufficiently poor level that it could no longer be ignored. Similarly, women who had experienced mental



health problems during the perinatal period highlighted missed opportunities to identify problems at an early stage and offer proactive support.

It is a reactive service, not a proactive service.

Focus group participant

People with conditions such as bipolar disorder or psychosis made similar observations about the lengths they had to go to in order to get help with their physical health. The difficulties people often described, such as the effect of psychotropic medications on weight gain, are well-established and entirely predictable – and therefore potentially avoidable. By explaining and monitoring these side effects, professionals can help service users know what to expect, and can support self-management behaviours that could mitigate some of the worst effects.

Encouragingly, participants also identified good practice that can be built on. For example, as part of rehabilitation programmes for long-term conditions, some had received psychological support as a routine part of their care package, and said that this had been very valuable in helping them adapt to living with their condition and prepare for what was to come. However, not all individuals had received this kind of support. There appeared to be some variation in the support available according to the type of condition; some participants observed that proactive psychological support appeared to be more embedded in cancer care than other long-term conditions such as cardiac rehabilitation. This observation was not solely related to the presence or absence of psychological therapy within rehabilitation programmes, but also extended to the general culture and levels of psychological-mindedness within different specialisms. This raises the important question of how good practice in one area can be transferred to others.

Peer support and self-management

The role of patients in quality improvement was identified as being a critical issue, in two senses. First, participants argued that they would be able to manage their physical and mental health more effectively if provided with the necessary information, self-confidence and support. Some highlighted specific improvements they felt would enable them to do so – for example, shared electronic records that patients can access, combining information from mental and physical health consultations. There is a careful balance to be struck here though; some participants



qualified their support for the idea of self-management with the observation that it is important that patient empowerment is not equated with the message that it is ‘all up to you’.

Second, peer support groups, online networks and other means through which patients can offer support to people in a similar situation to themselves were consistently emphasised as an indispensable way of bridging the gap between mental and physical health. Participants described how various forms of peer-led support were valuable in helping them deal with the psychological aspects of physical illness, or cope with mental health problems during the perinatal period. It was suggested that where this does not already happen, patients should be signposted to relevant forms of peer support as a routine part of clinical practice. Recovery colleges were mentioned as one recent innovation within the mental health sector through which peer-led support can be delivered.

The most useful person in your journey is someone who is two to three years ahead of you in your treatment.

Focus group participant

Support for family and carers

The final theme that emerged from our focus groups and interviews was the importance of emotional and practical support for family members and carers. Some of the participants who had lived with conditions such as cancer reflected that the emotional toll on their partners had, in some ways, been greater than the impact on their own mental health.

My wife suffered mentally more than I did, and that was completely overlooked.

Focus group participant

As we argue in the following section, routinely supporting the mental wellbeing of carers is an important component of integrated approaches towards mental and physical health. Several participants also suggested that people providing significant levels of care to a person with a physical or mental health problem should be considered an integral part of the care team, and that by working closely with professionals they could help support co-ordination of care for physical and mental health.



Section summary

Our research with service users and carers illustrates the ways in which physical and mental health care can often be disconnected, and underlines the need for a more integrated approach. Human and relational aspects of care emerge as a key part of this. Ultimately, any attempt to respond to mental and physical health needs in a more co-ordinated way has to be mediated through interactions between professionals and service users. This is the starting point for integrated care, and should not be forgotten when exploring alternative service models and structural solutions.

We were struck by the overlap between the themes identified in this component of our research and the work of National Voices, which in 2013 developed a patient-centred narrative for integrated care framed around a series of ‘I’ statements ([National Voices 2013](#)). The first and most central of these was that the ideal of integrated care can be captured by the following statement: ‘I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.’ Similarly, there are commonalities with work on shared decision-making. For example, Barry and Edgman-Levitan (2012) argue that clinicians need to be able to ask patients ‘What matters to you?’ as well as ‘What is the matter?’ Our research suggests that these general principles are particularly important in the context of integration of physical and mental health.

One limitation of the research presented in this section is that we have not distinguished between the needs of different groups. For example, people with medically unexplained symptoms were not targeted for recruitment into the focus groups, and may be expected to have different priorities from people with diagnosed long-term conditions. In the following section we take a more differentiated approach, examining in greater detail 10 specific service areas where integrated care is needed most.



3 The case for change: 10 areas where integration is needed most

The interaction between mental and physical health has important consequences at all levels of the health and social care system. The concept of integrated care in relation to mental and physical health therefore covers a wide territory. The objective of this section is to provide a map of that territory by describing 10 areas where there is particular scope for improvement. As illustrated by Table 2, these areas span the full range of health system activities, from public health to acute hospital care.

Table 2 Ten priority areas for improvement

Prevention/public health	<ol style="list-style-type: none"> 1. Incorporating mental health into public health programmes 2. Health promotion and prevention among people with severe mental illnesses
General practice	<ol style="list-style-type: none"> 3. Improving management of 'medically unexplained symptoms' in primary care 4. Strengthening primary care for the physical health needs of people with severe mental illnesses
Chronic disease management	<ol style="list-style-type: none"> 5. Supporting the mental health of people with long-term conditions 6. Supporting the mental health and wellbeing of carers
Hospital care	<ol style="list-style-type: none"> 7. Mental health in acute general hospitals 8. Physical health in mental health inpatient facilities
Community/social care	<ol style="list-style-type: none"> 9. Integrated support for perinatal mental health 10. Supporting the mental health needs of people in residential homes



The 10 areas were chosen on the basis of a literature review and in consultation with an expert advisory group. The areas covered are by no means exhaustive – other areas could potentially be added to this list. However, our intention is to highlight some of the areas where particularly significant opportunities exist. Note that although Table 2 categorises the 10 areas according to the parts of the system that are most relevant to each, in reality most of the changes needed span multiple settings.

For each area, we briefly describe the shortcomings of current approaches, assess the impact that these problems have on patients and the system, and outline what a more integrated approach might look like. Our intention is not to provide a comprehensive review of the (often substantial) research available in each of the 10 areas, but to give illustrative evidence.

Collectively, the evidence described in this section demonstrates why change is needed across the system. Those who do not wish to read the detail for each of the 10 areas may choose to skip to the summary on page 42.



Priority 1: Incorporating mental health into public health programmes

The problem

Poor mental health is a major risk factor implicated in the development of cardiovascular disease, diabetes, chronic lung diseases and a range of other conditions. It is also a major public health issue in its own right, accounting for 23 per cent of the burden of disease in the United Kingdom (UK) ([World Health Organization 2004](#)). There is increasing evidence that at least part of this burden is preventable (Knapp *et al* 2011). Despite this, prevention of mental health problems and promotion of positive mental wellbeing often receives limited attention in health improvement work, and is not well integrated with action on other priority public health issues such as tobacco, alcohol or obesity. Mental health prevention and promotion activities account for less than 0.03 per cent of NHS spending on mental health ([Mental Health Strategies 2012](#)), and the majority of joint strategic needs assessments (JSNAs) have little or no coverage of mental health and wellbeing (Campion, forthcoming).

Impact on people

Poor mental health is associated with higher rates of smoking, alcohol and drug abuse, lower educational outcomes, poorer employment prospects, lower resilience, decreased social participation and weaker social relationships – all of which leave people at increased risk of developing a range of physical health problems ([Health and Social Care Information Centre 2012](#); Keyes *et al* 2010; [Foresight 2008](#)). For most people, mental health problems begin in childhood or adolescence (Jones 2013). This can have lifelong effects, and is a major route through which health and social inequalities are transmitted across generations ([NICE 2013](#); Colman *et al* 2009).

Impact on the health system

Poor mental health is associated with greater resource use within the health system and adds to the burden created by smoking, alcohol and other behavioural risk factors ([Joint Commissioning Panel for Mental Health 2013e](#)). The wider impact of mental health on public services and the economy is significant; the Organisation for Economic Co-operation and Development (OECD) estimates that mental health



problems cost the UK around 4.5 per cent of gross domestic product (GDP) – £80 billion – in 2015. Most of this is in the form of lost employment and reduced productivity (OECD 2014). Within the NHS, the annual cost of staff absence and reduced productivity as a result of poor mental health is estimated to be more than £1 billion (Parsonage 2007).

What would a more integrated approach look like?

A more integrated approach to population health would tackle the determinants of poor physical and mental health in a co-ordinated way, using ‘place-based’ approaches to combine resources from different sectors. Mental health and wellbeing would form a core part of JSNAs, with health and wellbeing strategies giving particular priority to interventions capable of improving mental and physical health together. These might include: promotion of outdoor physical activity (Institute of Health Equity 2014; Rosenbaum *et al* 2014); prevention of hazardous alcohol use; and interventions that enhance social interaction, facilitate social cohesion and combat isolation (Economic and Social Research Council 2013; Jenkinson *et al* 2013).

Childhood health would be a particular priority, with a focus on intervening early to prevent the development of more significant problems later in life. This would include investment in evidence-based parenting interventions (Hutchings *et al* 2007), nurse–family partnerships or Sure Start (Melhuish *et al* 2008; Olds *et al* 2007), and schools-based programmes to promote social and emotional learning (Durlak *et al* 2011; NICE 2009b). Targeted public mental health initiatives would be developed for population groups at greatest risk, such as black and minority ethnic groups (Kirkbride *et al* 2012). Strengthening the evidence base on public mental health would be a high priority (Davies 2014).

Further guidance

- *Guidance for commissioning public mental health services* (Joint Commissioning Panel for Mental Health 2013e)
- *Annual report of the Chief Medical Officer 2013. Public mental health priorities: investing in the evidence* (Davies 2014)



Priority 2: Promoting health among people with severe mental illnesses

The problem

People with severe mental illnesses such as bipolar disorder or psychosis are at particularly high risk of physical ill health as a result of medication side effects, lifestyle-related risk factors and socioeconomic determinants ([Joint Commissioning Panel for Mental Health 2013e](#)). For example, smoking rates among people with a mental health condition are three times higher than among the general UK population ([Public Health England 2015](#)). Despite this, people with these kinds of conditions are less likely to receive health promotion interventions such as smoking cessation support, and most mental health professionals do not feel that reducing smoking is within their remit (Kulkarni *et al* 2014). People with severe mental illnesses are less likely to receive many other forms of preventive care, such as routine cancer screening (Lawrence and Kisely 2010).

Impact on people

Certain psychotropic medications are known to cause weight gain and obesity, leaving people at greater risk of developing diabetes or cardiovascular diseases, and contributing to low quality of life ([Gatineau and Dent 2011](#)). The high prevalence of smoking, alcohol abuse and other lifestyle-related risk factors also contributes to this, and is one of the main factors responsible for the dramatic 15–20-year gap in life expectancy among people with severe mental illnesses (De Hert *et al* 2009). Contrary to some assumptions, people with severe mental illnesses who smoke are just as likely to want to quit as the general population, but are more likely to be heavily addicted and to anticipate difficulty quitting ([Royal College of Physicians and the Royal College of Psychiatrists 2013](#)). Smoking cessation in this group is associated with improved mental health and reduced levels of medication, illustrating that quality of life as well as longevity is affected (Campion *et al* 2008).



Impact on the health system

The significant costs to the health system and the wider economy caused by smoking, obesity, alcohol misuse and substance abuse are well established. What is less well known is that a substantial proportion of these costs occur among people with mental health problems. For example, the estimated economic cost of smoking among people with mental health problems was £2.34 billion in 2009/10, of which £719 million was spent on treating diseases caused by smoking (Wu *et al* 2015). In the case of substance abuse, 85 per cent of people using alcohol services and 75 per cent of those using services for drug addiction also have a mental health problem (Weaver *et al* 2003).

What would a more integrated approach look like?

Local authorities would see people with mental health problems – and particularly those with severe mental illnesses – as a priority target group for public health interventions. This would include provision of tailored services to support healthy living – for example, bespoke smoking cessation services (Gilbody *et al* 2015). Voluntary and community sector organisations would play an important role in supporting lifestyle changes, and families and carers would also be actively involved in this. Screening services would be accessible for all. There would be clear agreements over who holds clinical responsibility for the physical health side effects of psychotropic drugs. Closer working between health, local government and other sectors would help to address the social determinants of health for people with severe mental illnesses. All mental health professionals would receive substance misuse training, and there would be much closer working with addiction services. More fundamentally, cultural change within the mental health workforce would mean that all professionals see promoting physical health as being an important part of their role.

Further guidance

- *Recognising the importance of physical health in mental health and intellectual disability. Achieving parity of outcomes* (British Medical Association 2014)



Priority 3: Improving management of medically unexplained symptoms in primary care

The problem

Medically unexplained symptoms are physical symptoms that lack an identifiable organic cause. They can include musculoskeletal pain, persistent headache, chronic tiredness, chest pain, heart palpitations and gastric symptoms. These symptoms are highly common and have a major impact both on the people experiencing them and on the health system. There is often no clear referral pathway for medically unexplained symptoms, and as a result patients are repeatedly investigated, which can cause significant harm and contribute to excess health care costs (Department of Health 2014c; NHS Commissioning Support for London 2011). Patients with medically unexplained symptoms are particularly common in primary care, yet most GPs receive no specific training in managing these symptoms and may lack confidence in exploring the psychological issues potentially involved (Chitnis *et al* 2014; Salmon *et al* 2007). Identifying and managing medically unexplained symptoms can be highly challenging, not least because failing to identify a condition that has a straightforward medical cause can also have serious consequences.

Impact on people

Poor management of medically unexplained symptoms can have a profound effect on quality of life. People with such symptoms often experience high levels of psychological distress as well as co-morbid mental health problems, which can further exacerbate their medical symptoms (Henningsen *et al* 2003; Kroenke *et al* 1994). More than 40 per cent of outpatients with medically unexplained symptoms also have an anxiety or depressive disorder (Nimnuan *et al* 2001). Chronic pain can worsen depressive symptoms and is a risk factor for suicide in people who are depressed.

Impact on the health system

Patients with medically unexplained symptoms account for an estimated 15 to 30 per cent of all primary care consultations (Kirmayer *et al* 2004) and GPs report that these can be among the most challenging consultations they provide. Medically unexplained symptoms also account for a significant proportion of outpatient appointments – in one study, accounting for more than 20 per cent of all outpatient activity among frequent attenders (Reid *et al* 2001). In primary care, some of the



biggest challenges are related to patients with a mixture of medically unexplained symptoms and poor adjustment to a long-term physical health condition, leading to disproportionate symptoms and medication use for the long-term condition. The annual health care costs of medically unexplained symptoms in England were estimated to be £3 billion in 2008/9, with total societal costs of around £18 billion (Bermingham *et al* 2010).

What would a more integrated approach look like?

The needs of people with medically unexplained symptoms vary enormously, and evidence suggests that biopsychosocial management delivered within a stepped care framework can be an effective approach for some people (Chambers *et al* 2015). GPs have an important role to play in this, identifying people affected, exploring relevant psychosocial factors, and doing so in a way that acknowledges physical symptoms as real (Peters *et al* 2009; Morriss *et al* 2007). Where symptoms are mild, sensitive handling and watchful waiting by the GP may be sufficient. People with moderate needs would receive appropriate psychological interventions and other support as necessary. Those with the most complex needs would be considered for referral to a dedicated service for medically unexplained symptoms with specialist mental health input using a collaborative care approach including joint case management with GPs. Where a referral for psychological intervention is made, GPs need to be able to discuss this with patients in a way that avoids implying that their symptoms are ‘all in the mind’ (Department of Health 2014c).

Further guidance

- *Medically unexplained symptoms: a whole systems approach* (NHS Commissioning Support for London 2009)
- *Guidance for commissioners of primary mental health care services* (Joint Commissioning Panel for Mental Health 2013d)
- *A commissioner’s guide to primary care mental health* (London Strategic Clinical Networks 2014a)

Case study examples

- Integrated persistent pain pathway in Oldham (Appendix B)
- City and Hackney Primary Care Psychotherapy Consultation Service (Appendix C)



Priority 4: Strengthening primary care for the physical health needs of people with severe mental illnesses

The problem

Compared to the general population, people with severe mental illnesses are less likely to have their physical health needs identified or to receive appropriate treatment for these. Despite a policy commitment to reducing these inequalities, monitoring of physical health among people with severe mental illnesses remains inconsistent in both primary and secondary care. For example, only a minority are screened for cardiovascular disease (Hardy *et al* 2013), and other tests such as cholesterol checks and cervical smears are performed at lower rates than for the general population (RSA Open Public Service Network 2015). Part of the problem historically has been a lack of clarity over whether responsibility for providing primary health care to this group of people lies principally with GPs, mental health teams, or both (Lawrence and Kisely 2010). There are skills gaps in general practice – for example, most practice nurses do not receive training in how to perform physical health checks for people with severe mental illnesses, and there is evidence of ‘diagnostic overshadowing’ in which physical symptoms can be overlooked as a result of an existing diagnosis (Jones *et al* 2008). Barriers to accessing primary care for physical health may be further exacerbated by stigma and socioeconomic inequalities among people with severe mental illnesses (Park *et al* 2013).

Impact on people

Poor detection and treatment of physical ill health contributes to the threefold increase in mortality rates among people with schizophrenia (Brown *et al* 2010). A review of the evidence found that people with severe mental illnesses receive a poorer standard of care for a range of conditions including diabetes and heart failure, and are less likely to receive medical treatments for arthritis (Lawrence and Kisely 2010). Primary care can play an important role in ensuring that people with mental illnesses receive equitable access to care across the system.



Impact on the health system

Poor detection and treatment of physical ill health in primary care contributes to people with severe mental illnesses being among the most frequent users of unplanned care, with high associated costs. A recent analysis found that in 2013/14, people with mental health problems had three times more accident and emergency (A&E) attendances and five times more unplanned inpatient admissions than a matched control group drawn from the general population (Dorning *et al* 2015). Eighty per cent of these admissions were for physical rather than mental health problems. While this cannot be attributed to shortcomings in primary care exclusively, effective primary care will be critical in addressing these inequalities.

What would a more integrated approach look like?

Responsibility for monitoring and managing the physical health of people with severe mental illnesses would be shared between primary care and specialist mental health services, based on clear local agreements (Royal College of Psychiatrists 2009; Department of Health 2006). This would include comprehensive provision of annual physical health checks, with practice nurses receiving appropriate training to conduct such checks (Hardy *et al* 2014). General practices would systematically and proactively identify relevant individuals on their lists using disease registers and patient records. Practices would provide specific clinics for people with mental illnesses to review the services and treatments currently being received, undertake appropriate monitoring (eg, blood tests or electrocardiograms (ECGs)), provide health promotion information, and signpost people to appropriate services. All community mental health teams would have access to a physical health liaison service, providing easy access to advice and treatment from GPs and others, including for people not registered with a GP.

Further guidance

- *Recognising the importance of physical health in mental health and intellectual disability. Achieving parity of outcomes* (British Medical Association 2014)

Case study examples

- Physical health check protocol in Bradford and Airedale (Appendix G)



Priority 5: Supporting the mental health of people with long-term conditions

The problem

People with long-term physical health conditions are two to three times more likely to experience mental health problems, with depression and anxiety disorders being particularly common (Naylor *et al* 2012). Many experience psychological difficulties – for example, in relation to adjusting to their diagnosis, living with symptoms and with the impact on their social role and functioning, or managing side effects. Despite this, the detection of co-morbid mental health problems and the provision of support for the psychological aspects of physical illness are not of a consistently high standard; patients and practitioners alike tend to focus on physical symptoms during consultations (Coventry *et al* 2011).

Impact on people

Co-morbid mental health problems have a number of serious implications for people with long-term conditions, including poorer clinical outcomes and lower quality of life (Moussavi *et al* 2007; Katon *et al* 2004). For example, mortality rates after heart attack or heart bypass surgery are several times higher among people with co-morbid depression (Blumenthal *et al* 2003; Lespérance *et al* 2002), while people with diabetes have an increased risk (by more than 40 per cent) of all-cause mortality over three years if they also have depression, after adjusting for other factors (Katon *et al* 2005). These effects are mediated by a number of mechanisms, including reduced ability and motivation to manage health conditions, medication side effects and poorer health behaviours. Overall, co-morbid mental health problems have a greater effect on quality of life than physical co-morbidities (Mujica-Mota *et al* 2015).

Impact on the health system

By interacting with and exacerbating physical ill health, co-morbid mental health problems increase the costs of providing care to people with long-term conditions. For example, depression significantly increases the risk of unplanned hospitalisation for this group of people (Davydow *et al* 2013). Overall, between £8 billion and



£13 billion of NHS spending in England is linked to co-morbid mental health problems among people with long-term conditions (Naylor *et al* 2012). Co-morbid mental health problems also have wider economic costs as a result of lower employment rates and productivity (Hutter *et al* 2010).

What would a more integrated approach look like?

People with long-term physical health conditions would receive support for the psychological aspects of their condition as a standard part of their care. This would include: routinely providing psychological education and support as part of cardiac and pulmonary rehabilitation and other self-management programmes; making full use of peer support groups (locally or online); and embedding clinical psychologists within multidisciplinary teams to allow skills transfer in both directions. Active case-finding would be used to identify people at greatest risk, in line with guidelines from the National Institute for Health and Care Excellence (NICE 2010). Integrated approaches involving close working between primary care and other professionals – for example, based on the collaborative care model (*see* Section 4) – would be available for people with co-morbid depression or anxiety (Coventry *et al* 2015; Rosenberg *et al* 2014; Sharpe *et al* 2014). The most complex patients with multiple conditions would not be referred to generic psychology services, but would be supported by professionals skilled in working at the interface between physical and mental health.

Further guidance

- *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* (NHS Confederation 2012)
- *London's care pathway for diabetes: commissioning recommendations for psychological support* (London Strategic Clinical Networks 2014b)

Case study examples

- 3 Dimensions of care for Diabetes (Appendix A)
- LIFT Psychology in Swindon (Appendix F)



Priority 6: Supporting the mental health and wellbeing of carers

The problem

More than 6 million people in the UK provide informal care to someone with a health condition or disability. For many, doing so can have a significant impact on their own mental health and wellbeing. In comparison with the general population, people with substantial caring responsibilities have higher levels of stress and depression and lower levels of subjective wellbeing, as well as poorer physical health (Cormac and Tihanyi 2006). In some situations – particularly in the context of palliative care – supporting the mental health and wellbeing of carers is an explicit part of a patient’s care plan. However, this is often not the case, and in general carers are provided with limited support. For example, two-thirds of carers responding to one survey reported that staff had not directed them to relevant sources of information or advice (NHS Improving Quality 2014).

Impact on people

Survey data illustrates the toll that caring responsibilities can take on mental health and wellbeing. More than 9 out of 10 carers report that caring has a negative impact on their mental health, including stress and depression (Carers UK 2013), while 75 per cent of carers said it was hard to maintain social relationships (Carers UK 2014). This in turn can affect their ability to provide care and lead to the admission of the person they are caring for to hospital or residential care (Department of Health 2012). Health impacts are often exacerbated by carers being unable to find time for medical check-ups or treatment (Carers UK 2012).

Impact on the health system

The health and care system is highly dependent on informal care provided by family and friends. The value of this care is estimated to be around £119 billion per year – more than total spending on the NHS (Buckner and Yeandle 2011). Neglecting to look after the mental health and wellbeing of people making this significant contribution to the system risks adding to the burden of work conducted in the formal sector.



What would a more integrated approach look like?

The physical and mental health needs of carers and family members would be assessed as a routine part of the care provided to people with long-term health conditions, or people with a terminal condition. In particular, the need for support would be assessed during key transitional points in a carer's journey, such as when a person first takes on caring responsibilities and during periods of significant change. People providing substantial levels of informal care would have their own written care plan, updated on an annual basis. An evaluation of the National Carers' Strategy demonstrator sites programme suggested that it is possible to provide enhanced support to carers at a relatively modest cost and without creating a significant additional burden on health and care professionals (Yeandle and Wigfield 2011). Further research is needed to identify the most effective ways of supporting carers and reducing psychological distress (Candy *et al* 2011).

Further guidance

- Various resources available from Carers UK: www.carersuk.org/



Priority 7: Supporting mental health in acute hospitals

The problem

Mental health problems are highly prevalent in inpatient wards, outpatient clinics and emergency departments, and can profoundly affect outcomes of care for acute physical illnesses. However, they often go unidentified and unsupported ([Joint Commissioning Panel for Mental Health 2013b](#)). For example, two-thirds of NHS beds are occupied by older people, up to 60 per cent of whom have or will develop a mental health problem during their admission (Anderson *et al* 2005). Other conditions such as eating disorders can significantly complicate the management of hospitals patients. In recognition of this problem, there has been some growth in liaison mental health services in recent years, but there remains significant variation in approach across the country. Only 16 per cent of acute hospitals in England currently have access to a comprehensive liaison service ([Mental Health Taskforce 2016](#)). Acute hospital staff often lack the necessary training, knowledge and skills related to the recognition and management of common mental health problems affecting acute hospital care ([Royal College of Psychiatrists 2013a](#); [Parsonage and Fossey 2011](#)).

Impact on people

The failure to consistently support the mental health needs of people using acute hospital services has an important effect on both patient experience and care outcomes. For example, in approximately 50 per cent of cases, acute care staff fail to identify delirium in older inpatients, with significant negative consequences for the people affected ([NHS Confederation 2009](#)). Patients with dementia are still prescribed antipsychotics on some inpatient wards, despite guidance indicating that this is often inappropriate (McIlroy *et al* 2015). Under-treatment of other mental health problems such as depression leads to people spending longer in hospital than may otherwise have been necessary (*see below*).

Impact on the health system

Mental health problems have an important effect on costs in the acute sector. For example, general hospital inpatients with co-morbid depression have a longer length of hospital stay than patients who are not depressed (Prina *et al* 2015; Simon *et al* 2007; Aoki *et al* 2004). For older people, mental health problems



have been indicated as a predictive factor for longer hospital stays and higher institutionalisation rates (NHS Confederation 2009). Patients with dementia often experience delays in discharge, even when there is no substantive medical reason for delay (Parsonage and Fossey 2011; National Audit Office 2007). There is evidence linking untreated or under-treated mental health problems among general hospital inpatients to higher rates of re-attendance at A&E after discharge (Joint Commissioning Panel for Mental Health 2013b). Self-harm accounts for more than 150,000 A&E attendances per year in England (NICE 2004) and can require significant staff time to manage.

What would a more integrated approach look like?

An integrated approach would mean all acute hospital professionals having the necessary skills and confidence to manage mental health appropriately. Professionals working in emergency departments and inpatient wards would understand how to identify and respond to dementia, delirium, self-harm and acute psychosis. Outpatient teams would have the capability to help people make psychological adjustments to illness, or to manage medically unexplained symptoms. Liaison psychiatry or psychological medicine services would be instrumental in achieving these aims, performing an important educational function across the hospital. Liaison services would be age-inclusive, operate seven days a week, and would be available in every acute hospital, in line with current policy commitments (Department of Health 2014a). They would also offer outreach services to primary care.

Further guidance

- *Guidance for commissioners of liaison mental health services to acute hospitals* (Joint Commissioning Panel for Mental Health 2013b)
- *Liaison psychiatry in the modern NHS* (Parsonage et al 2012)

Case study examples

- Oxford Psychological Medicine Service (Appendix D)
- Psychological medicine services in Hull (Appendix E)



Priority 8: Addressing physical health in mental health inpatient facilities

The problem

Whereas liaison mental health services are becoming increasingly common in acute hospitals, it is rarer to find physical health liaison services in mental health inpatient facilities, despite significant levels of need and undiagnosed physical illness. People using these facilities are significantly less likely than the general population to be registered with a GP, and are more likely to present late with physical symptoms (Lawrence and Kisely 2010). Mental health professionals working in these settings may lack the confidence or skills required to identify medical conditions, and often there is a culture of giving low priority to physical health (Kulkarni *et al* 2014). Evidence suggests that at present, more than a third of patients fail to receive a physical examination within 24 hours of admission, in line with recommended practice (Vanezis and Manns 2010).

Impact on people

Chronic health problems such as heart disease and chronic obstructive pulmonary disease (COPD), as well as acute conditions such as appendicitis and stroke, are under-recognised and sub-optimally treated among people with severe mental illnesses (Lawrence and Kisely 2010; McIntyre *et al* 2007). Delays in accessing care as a result of late identification by staff working in inpatient units can lead to poorer treatment outcomes, contributing to the excess mortality rates reported in previous sections.

Impact on the health system

Reports from some mental health inpatient facilities indicate high rates of emergency transfers to general acute hospitals. More generally, there is clear evidence that for a wide range of common inpatient procedures, people with mental health problems are more likely to have an emergency rather than a planned admission, be admitted overnight, and stay longer in hospital (Dorning *et al* 2015), resulting in higher costs to the system. While this cannot be attributed solely to the quality of physical health care available in mental health facilities, it does indicate the potential for improvement through intervention in a variety of settings.



What would a more integrated approach look like?

Admission to a mental health inpatient facility would be seen as an opportunity to improve the person's mental and physical health. All people admitted to a mental health inpatient facility would receive a full physical examination on admission or within 24 hours, with investigations carried out promptly and clearly documented. Mental health nurses would perform basic tests themselves, using standardised toolkits such as the Lester tool ([Royal College of Psychiatrists 2014](#)), and would consider this an important part of their role. Liaison physician roles would be widespread, advising mental health providers on patients' physical health. Liaison roles would also exist for other professionals, such as clinical nurse specialists, practice nurses and health coaches. In secure or rehabilitation units with longer average length of stay, the more stable inpatient population would represent an opportunity to provide a comprehensive range of primary care services within the facility.

Further guidance

- *Whole-person care: from rhetoric to reality. Achieving parity between mental and physical health* ([Royal College of Psychiatrists 2013c](#))

Case study examples

- Primary care for secure inpatient units in west London (Appendix H)
- Physical health liaison service in Highgate mental health unit (Appendix I)



Priority 9: Providing integrated support for perinatal mental health

The problem

Mental health problems affect one in five women during the perinatal period (Davies 2015). Problems encountered include depression, anxiety disorders, postpartum psychosis and post-traumatic stress disorder. Despite the numbers of people affected, half of all acute trusts in the UK have no perinatal mental health services, and three-quarters of maternity services do not have access to a specialist mental health midwife (Bauer *et al* 2014; Hogg 2013). Midwives and health visitors receive variable and often limited training in identifying women who have, or are at risk of developing, perinatal mental health problems. Where perinatal mental health services are available, these are usually part of generic adult mental health services and are not always fully integrated with other maternity services (NHS Commissioning Board 2012). Access to services is particularly poor for minority ethnic groups – black Caribbean women are less likely to receive treatment for perinatal depression than their white British counterparts (Edge *et al* 2004).

Impact on people

There is considerable evidence that untreated mental health problems are associated with increased risk of obstetric complications and can adversely affect both the parent–child relationship and the child’s social and emotional development (Stein *et al* 2014; Howard *et al* 2003). There may be lasting effects on maternal self-esteem, as well as on partner and family relationships (Oates 2015; Meltzer-Brody and Stuebe 2014). Almost a quarter of maternal deaths occurring between six weeks and one year after pregnancy are due to psychiatric causes (MBRRACE-UK 2015). Women may delay seeking help due to stigmatisation and fears that their baby might be taken from them (Dolman *et al* 2013).

Impact on the health system

Perinatal depression, anxiety and psychosis carry a total long-term cost to society of about £8.1 billion for each one-year cohort of births in the UK, of which £1.2 billion falls on the NHS and social services (Bauer *et al* 2014). In comparison, estimates suggest it would cost around £280 million a year to bring perinatal mental health care pathways across the UK up to the standards recommended in national guidance (Bauer *et al* 2014).



What would a more integrated approach look like?

In an integrated service, perinatal mental health care would be delivered by specialist perinatal mental health staff embedded within local maternity services, providing training to colleagues and working closely with obstetricians, midwives, health visitors and GPs (NICE 2014). All professionals involved in pregnancy and the postnatal period would have a role to play in ensuring that women's mental health and wellbeing are supported throughout the perinatal process (Joint Commissioning Panel for Mental Health 2012). This would include important roles for midwives and health visitors in screening and providing basic support and advice (Davies 2015; Department of Health 2014b). Wherever possible, perinatal mental health problems would be identified early, during pregnancy. Specialist health visitors would be given advanced training in perinatal mental health to enable them to deliver brief psychological interventions, manage cases jointly with supervision from a psychiatrist, and provide training to other health visitors to improve awareness of mental health conditions and the different care pathways available (National Child and Maternal Health Intelligence Network 2014). The voluntary sector would play an important role – for example, in providing peer support groups – and all professionals involved in maternity care would be able to signpost to these local resources.

Further guidance

- *Guidance for commissioners of perinatal mental health services (Joint Commissioning Panel for Mental Health 2012)*

Case study examples

- Integrated perinatal mental health service in Devon (Appendix J)



Priority 10: Supporting the mental health needs of people in residential homes

The problem

Mental health problems are not a normal or inevitable part of the ageing process – the majority of older people enjoy good mental health and make valuable contributions to society ([Age UK 2006](#)). Nonetheless, depression, dementia and other conditions are common in residential homes. Two-thirds of people living in care homes have dementia and are usually at a more advanced stage of the illness ([Personal Social Services Research Unit 2007](#)). Many homes are not equipped to provide the one-to-one, person-centred care that people with dementia need, and access to support from external specialist services is variable ([Joint Commissioning Panel for Mental Health 2013a](#)). Depression occurs in 40 per cent of people in care homes and often goes undetected (Chew-Graham *et al* 2014), with many carers seeing depression as a normal phenomenon among older people (Ayalon *et al* 2008). Very few care homes cater explicitly for residents' mental health needs other than dementia, and the extent of mental health training provided to care home staff is often limited ([Levenson and Joule 2007](#)).

Impact on people

Mental health problems significantly affect the physical, psychological and social wellbeing of people in care homes. Confusion related to dementia or delirium can be highly distressing for residents and their families. Depression among care home residents with dementia has been associated with poor nutrition and excess mortality rates (Katz and Parmelee 1994). Depression is also a risk factor for suicide in care homes (Suominen *et al* 2003). Although depression can seriously affect the quality of life of older people, many do not receive adequate treatment, with symptoms frequently being misunderstood as an inevitable part of ageing (Eisses *et al* 2005).



Impact on the health system

Poorly managed mental health problems in residential homes are associated with challenging behavioural problems, non-compliance with treatment, and increased nursing staff time (Katz and Parmelee 1994). Depression and other mental health problems in older age can reduce motivation to manage physical health, adding to health system costs – for example, in the form of emergency transfers from care homes to acute hospitals.

What would a more integrated approach look like?

Staff working in care homes would have sufficient training to be able to detect and manage dementia, delirium, depression and other conditions, with support and supervision from specialists as required. They would understand how to promote the mental wellbeing of residents – for example, by encouraging social connection, physical activity and continued learning ([National Mental Health Development Unit 2006](#)). GPs working with older people in care homes would be able to identify those in need of mental health support, and provide relevant education and advice to care home staff (Chew-Graham *et al* 2014; [Joint Commissioning Panel for Mental Health 2013c](#)). Specialist mental health in-reach services would be available and accessible in all residential settings – for example, to help staff manage residents who need intensive support or who exhibit challenging behaviours ([Joint Commissioning Panel for Mental Health 2013a](#)).

Further guidance

- *Guidance for commissioners of older people's mental health services* ([Joint Commissioning Panel for Mental Health 2013c](#))



Section summary

The evidence reviewed across the 10 areas featured in this section demonstrates why integrated approaches towards mental and physical health are needed. Symptoms of the current fragmented system include: inadequate monitoring of physical health in people with severe mental illness; a lack of attention given to the psychological dimensions of physical conditions; under-recognition of perinatal mental health problems; and the mismanagement and over-investigation of people with medically unexplained symptoms.

This section has shown how the interaction between physical and mental health is an important determinant of patient outcomes. In addition to this, the failure to respond to people's needs in a co-ordinated way adds to resource pressures at all levels in the system. In financial terms, at least £11 billion of NHS expenditure can be linked to just two aspects of the relationship between physical and mental health – namely, mental health co-morbidities among people with long-term conditions, and medically unexplained symptoms (*see box below*).

The evidence demonstrates why integrated approaches are needed across a wide range of patient groups and also at the population level – including in relation to public health and prevention as well as to care and support. In the next section, we explore in more depth the kind of service models that might be needed to implement these approaches.



The case for change: summary of key facts and figures

Patient outcomes

- People with severe mental illnesses die 15–20 years earlier on average than the general population, largely as a result of poor physical health (Brown *et al* 2010).
- Depression and anxiety disorders lead to significantly poorer outcomes among people with diabetes, cardiovascular disease and other long-term conditions (Katon *et al* 2005; Jünger *et al* 2005; Blumenthal *et al* 2003; Lespérance *et al* 2002).

System pressures

- People with mental health problems use significantly more unplanned hospital care for physical health needs than the general population, including 3.6 times the rate of potentially avoidable emergency admissions (Dorning *et al* 2015).
- Use of unplanned hospital care is particularly high when social deprivation is also present, indicating the role that social inequalities play in exacerbating barriers to access among people with mental health problems (Dorning *et al* 2015).
- Poor management of medically unexplained symptoms adds to pressures in primary care; these symptoms account for up to 30 per cent of all GP consultations (Kirmayer *et al* 2004).

Financial costs

- 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 (Naylor *et al* 2012).
- Medically unexplained symptoms are estimated to cost the NHS around £3 billion each year (Bermingham *et al* 2010); the evidence suggests these costs are separate from and additional to costs related to co-morbid mental health problems or long-term conditions (Barsky *et al* 2005).
- Perinatal mental health problems cost the NHS an estimated £1.2 billion for each annual cohort of births (Bauer *et al* 2014).



4 Integrated service models: current developments and trends

In response to the shortcomings and unmet needs described in the previous sections, a wide range of service models are being developed in England and elsewhere that attempt to build a closer connection between physical and mental health care. This section discusses some of the areas that have been a particular focus for recent innovation, and provides illustrative examples and evidence where available. Our intention is not to advocate for any specific model, but to outline some of the possibilities that exist.

As well as drawing on research evidence, this section is based on interviews with more than 50 clinicians and managers involved in various forms of integrated care across England. Most of these interviews focused on 10 case study sites selected in consultation with an expert advisory group. These case studies are referred to in the relevant sections below and described in greater detail in appendices A to J.

This section focuses on five broad themes where we identified notable innovations in our case study sites:

- enhanced support in primary care
- integrated multidisciplinary teams in the community
- liaison psychiatry and psychological medicine in acute hospitals
- medical liaison in mental health settings
- supported self-management for physical and mental health.

The service models discussed relate closely to several of the 10 priority areas described in the previous section, although we found more evidence of innovation



in some areas than others. Often, the examples identified cut across two or more of our 10 priorities, and as such we have not organised this section using the same framework as the previous section.

At the end of this section we reflect on whether the integrated service models described are capable of delivering the vision for integrated care identified by service users and carers in Section 2.

Enhanced support in primary care

Primary care is a crucial component of efforts to build a closer connection between mental and physical health. A number of innovations in the UK and elsewhere are giving primary care an enhanced role at the interface between mental and physical health, in particular for people with long-term conditions and/or medically unexplained symptoms.

Collaborative care

The collaborative care model provides an evidence-based approach for supporting people with co-morbid physical and mental health problems in primary care, and was recommended by the National Institute for Health and Care Excellence (NICE) for treatment of moderate to severe depression alongside a chronic physical health condition (NICE 2009a). However, outside of research trials, the approach has not yet become routine practice in England.

The core components of collaborative care are:

- proactive management of physical and mental health conditions by a case manager, working closely with a GP and/or other primary care staff
- regular supervision meetings involving the case manager and a mental health specialist
- use of standardised treatment protocols by the case manager (this may include monitoring medications and delivering brief psychological interventions).

As part of a recent research trial, the collaborative care model has been used by general practices in the Greater Manchester area to integrate care for people with



depression and a long-term physical condition (heart disease, diabetes or both). In this instance, case management was delivered by specially trained psychological wellbeing practitioners employed by Improving Access to Psychological Therapy (IAPT) services. The intervention was associated with reduced depression as well as improved self-management of physical health (Coventry *et al* 2015).

In Scotland, collaborative care has been used to improve the treatment of co-morbid depression among people with cancer, again as part of a research trial rather than routine practice (Sharpe *et al* 2014). Cancer nurses were trained to perform the case management role, which included providing brief psychological interventions, with supervision from a liaison psychiatrist working in close collaboration with the primary care and oncology teams. Again, that study found that people receiving collaborative care experienced better outcomes than those receiving standard care.

This evidence from the UK lends support to similar research findings from other countries, including the USA (Rosenberg *et al* 2014), Italy (Rucci *et al* 2012) and the Netherlands (Goorden *et al* 2015). In the USA, the principles of collaborative care have been used by organisations such as Intermountain Healthcare (*see* box below), the Veterans Health Administration, and Kaiser Permanente as part of major integrated care programmes seeking to integrate mental health services into primary care (Katon and Unützer 2013). More recently, the majority of the ‘accountable care organisations’ developed since the passage of the Patient Protection and Affordable Care Act hold responsibility for budgets for physical and mental health care, although as yet it appears that only a minority have used these new contractual arrangements to integrate services at the clinical level (Lewis *et al* 2014).

Economic evaluations indicate that collaborative care can be highly cost effective and potentially cost saving relative to standard care (Katon *et al* 2012, 2008; Simon *et al* 2007). For example, in a recent UK study, collaborative care for people with cancer and depression was found to cost £9,549 for each additional ‘quality adjusted life year’ (QALY) – well below the threshold used by NICE for judging whether a treatment is sufficiently cost effective for use in the NHS (Duarte *et al* 2015).



Intermountain Healthcare: integrating mental health into primary care

Intermountain Healthcare is a non-profit health system operating in Utah and Idaho, USA. It consists of 22 hospitals, a medical group with 185 primary care clinics, and an affiliated health insurance company. Intermountain is widely regarded as a high-performing health system and a leading proponent of quality improvement methodologies.

In the early 2000s, primary care practitioners in Intermountain identified a need for a more effective way of supporting the large number of people presenting with mental health needs, often alongside a mixture of physical illness, substance abuse problems and complex social circumstances. In response to this, Intermountain developed a mental health integration (MHI) programme, which has now been rolled out in the majority of primary care clinics.

The MHI programme involves primary care practitioners accepting greater responsibility for providing mental health care, with support from an enhanced multidisciplinary team embedded in primary care. Care is delivered through a stepped care approach. An assessment algorithm is used to assign people needing support to one of three groups, depending on the level of complexity of their condition and circumstances:

- mild complexity – this group is managed primarily by the primary care physician with support from a case manager
- moderate complexity – this group, which often includes people with a physical co-morbidity and those living in an isolated or chaotic social environment, receives collaborative care from the MHI team
- high complexity – people with the most complex needs are supported by mental health specialists, either working in primary care settings or with a referral to secondary care.

Overall, around 80 per cent of mental health care is delivered by non-specialists in MHI clinics.

Implementing the MHI model has been a significant change management process. It has involved making significant investments in training practice staff (including physicians, nurses, receptionists and others) in mental health awareness, empathic communication skills, and shared decision-making. This has increased the competence and confidence of primary care practitioners to manage people with mental health problems without needing to make a referral.

A key lesson from the MHI programme is that the implementation of new integrated service models needs to be supported by cultural change. This has required consistent messages

continued overleaf



Intermountain Healthcare *continued*

from senior leaders within Intermountain aimed at normalising mental health as a routine part of everyday health care.

Evaluation of the MHI model has highlighted a number of benefits. Most notably, patient satisfaction has increased significantly, and there has been an estimated fivefold financial return on investment as a result of improved physical health and reduced activity in other parts of the system. Specific findings reported by Reiss-Brennan *et al* (2010) include the following.

- Per patient medical costs in the 12 months following diagnosis of depression were 48 per cent lower in primary care clinics involved in the MHI programme.
- Patients with depression were 54 per cent less likely to attend an emergency department if their primary care clinic was part of the MHI programme.
- There was a significant reduction in hospital admissions for ambulatory care sensitive conditions among people accessing mental health care.
- There was better diabetes control among patients with diabetes and depression.

Managing the psychological aspects of medically unexplained symptoms

As outlined in Section 3, medically unexplained symptoms are often poorly managed and have a major impact, both on patient outcomes and on GP workload. A few areas in England are currently delivering and testing new ways of supporting GPs in managing these symptoms. These approaches differ from the collaborative care model described above in that their focus is less on diagnosable mental health conditions such as clinical depression, and more on the mixed and hard-to-specify problems that are commonly seen in primary care, including various difficulties which are not formal diagnoses but which nonetheless have a significant effect on how a person functions. A key role that these kinds of services can play is in helping people to reframe the issues they present with, and exploring solutions other than further medical intervention.

One example is the Primary Care Psychotherapy Consultation Service provided by The Tavistock and Portman NHS Foundation Trust to GPs in the City of London and Hackney. The service works alongside general practices to support people with complex needs, including medically unexplained symptoms, personality disorders



and other chronic mental health problems (*see* Appendix C for more details). A core objective of the service is to strengthen capabilities and build confidence in the practices they work in – for example, psychotherapists perform joint consultations with GPs and conduct developmental work with the wider primary care team. An economic evaluation found that the service was highly cost effective, with improved patient outcomes and a 25 per cent reduction in GP attendances among people using the service (Parsonage *et al* 2014).

A new integrated persistent pain pathway in Oldham means that GPs – who have often managed patients with chronic pain largely through the prescription of painkillers or referral for medical treatment – are being supported to take a biopsychosocial perspective. People with persistent pain that is hard to manage, despite treatment, are referred by GPs to an integrated assessment hub delivered by Pennine MSK Partnership. For patients at the lowest level of severity, GPs then play an important role in co-ordinating care delivered by community physiotherapists and psychological therapists (*see* Appendix B).

A further example is a primary care liaison wellbeing service currently operating on a pilot basis in three general practices in the Bradford and Airedale area (*see* Appendix G). The service supports patients identified by GPs on the basis of high levels of service use and possible mental health needs. It provides a mix of psychological and social interventions, delivered by a multidisciplinary team led by a clinical psychologist and including a psychiatrist, physiotherapist, occupational therapist and auxiliary support worker. The team is co-located with general practice and works closely with the primary care team, including through the provision of training sessions on generic skills (eg, communication, behaviour change) as well as specific symptoms (eg, chronic pain). An economic evaluation of the service is currently being conducted by the Leeds Institute of Health Sciences.

Physical health checks for people with severe mental illnesses

A further important role for general practice, as stressed in Section 3, is to help improve the physical health of people with severe mental illnesses such as schizophrenia, as part of efforts to reduce premature mortality in this group. One means of doing this is through provision of annual health checks, assessing common risk factors such as obesity, cholesterol and glucose levels, and behavioural factors such as smoking and diet. Until 2014, GPs in England were financially incentivised



to perform these checks through the Quality and Outcomes Framework. The removal of the relevant indicator from the framework was seen as a significant step backwards by many of the primary care professionals involved in our research; but despite this, some areas have continued to encourage the provision of checks in primary care and elsewhere.

One successful example is the development of an electronic template to facilitate physical health checks, which is now widely used by primary care teams in the Bradford and Airedale area. This template is loaded on to clinical information systems in primary and secondary care. Significant effort was invested in communicating the purpose of the template, and in providing GPs and practice nurses with the training needed to use it. As a result, the proportion of people with severe mental illnesses receiving an annual physical health check is among the highest in the country.

The report of the independent Mental Health Taskforce to the NHS in England has called for the development and evaluation of enhanced models of primary care where GPs and practice nurses take responsibility for delivering a range of physical health checks and related interventions such as outreach and carer training ([Mental Health Taskforce 2016](#)).

Integrated multidisciplinary teams in the community

Community-based multidisciplinary team working is a key mechanism for co-ordinating the care provided to people with multiple or complex chronic diseases. Successful integration of physical and mental health care requires the full participation of both sets of professionals within these teams.

A successful example of integration at this level is the 3 Dimensions of care for Diabetes (3DfD) service in south London, which provides integrated care for the physical, mental and social aspects of diabetes (*see* Appendix A). The service is specifically targeted at people with poor glycaemic control, and serves a highly mixed population, some of whom have multiple complex co-morbid conditions and high levels of social deprivation. While inclusion of a mental health professional in multidisciplinary team meetings is increasingly common in diabetes care, the 3DfD model goes further than most by having a wider range of mental health professionals fully integrated in the team and also including social support workers.



This allows the service to provide support to people with a wider range of mental health problems, and presents greater opportunities for skills transfer. The team provides brief psychological therapies as well as interventions targeting social problems. In addition to seeing patients directly, an important part of the role of mental health staff in the 3DfD team is to provide formal and informal training to diabetes physicians and nurses – for example, in motivational interviewing techniques, basic principles of cognitive behavioural therapy (CBT), and general training in mental health. An evaluation found significant improvements in glycaemic control among those using the service, as well as reduced psychological distress and a reduction in emergency attendances and unscheduled admissions (*see* Appendix A).

Another example of integration in the context of community-based multidisciplinary teams is the new persistent pain pathway in Oldham mentioned earlier (*see* Appendix B). The service uses biopsychosocial assessment to understand the medical, psychological and social needs of each patient, with a range of interventions then being delivered as appropriate by physiotherapists, psychological therapists, pain nurses or, for those with higher levels of need, by a liaison psychiatrist, clinical psychologist or pain consultant. As with several of the services described in this section, one reported benefit of the persistent pain pathway is that providing psychological support within the same care processes and facilities as other aspects of musculoskeletal care removes the stigma associated with seeing a mental health professional.

The 3DfD and Pennine MSK examples are both disease-specific approaches focusing on a single condition or (in the case of chronic pain) a set of related symptoms. An alternative approach to integration is to target interventions by population group rather than by condition ([Curry and Ham 2010](#)). This is the approach currently being taken in many of the NHS England vanguard sites and elsewhere, in particular those developing multispecialty community providers (MCPs) or primary and acute care system (PACS) models. Although the terminology adopted varies by site, many are establishing integrated neighbourhood teams to create a forum for multidisciplinary case management of high-cost patients, particularly frail older people and people with multiple long-term conditions. In most cases, there is mental health representation within these integrated teams. What is not yet clear is how effectively these teams will provide a platform for integration of mental and physical health, or the extent to which the mental health or psychological aspects of care will feature as a prominent part of multidisciplinary case discussions. So far, there appear to be



relatively few examples within the vanguard sites of co-morbid mental and physical health problems being identified explicitly as a priority target group, although the Fylde Coast MCP is one exception (*see* box below).

An important question in establishing integrated teams of this kind is the extent to which the target group is defined using risk stratification tools to identify those at highest risk of avoidable hospital admission, versus defining target groups a priori – for example, selecting groups known to experience poor health outcomes and health inequalities. Both approaches have merits, but if case identification is based solely on risk stratification, there is a risk that certain groups that are in clear need of integrated care may be under-represented, including people with severe mental illnesses and poor physical health.

Integrating mental and physical health in NHS England vanguard sites

The 14 multispecialty community providers (MCPs) and 9 primary and acute care systems (PACSs) being established as part of NHS England's vanguard programme create an important opportunity to embed mental health within integrated community teams.

Most MCP and PACS sites are including some degree of mental health representation within local integrated neighbourhood teams. Examples include Stockport Together MCP, North East Hampshire and Farnham PACS, and Salford Together PACS – all of which have focused largely on older people initially, with plans to expand to other population groups over time. In Salford, adult and older adult mental health services will, from 2016, be brought together with other health and care services in an integrated care organisation funded through a prime provider contract, with Salford Royal NHS Foundation Trust acting as prime provider and sub-contracting with Greater Manchester West Mental Health NHS Foundation Trust.

The scale of structural change involved may vary between areas. In Southern Hampshire MCP, the current ambition is that a wide range of mental health services for older people, Improving Access to Psychological Therapy (IAPT) services, and part of the existing community mental health teams will be folded into the neighbourhood multidisciplinary teams once these have achieved a sufficient level of maturity. A different model is being developed in West Cheshire MCP, where the planned approach involves the mental health trust providing expertise for integrated care teams as a sub-contractor, without structural change that would involve providing services on this footprint.

continued opposite



Integrating mental and physical health in NHS England vanguard sites *continued*

As part of the Fylde Coast MCP, there are plans to establish an 'extensive care service' in Blackpool to provide intensive multidisciplinary case management for people with complex mental health needs, substance abuse and/or social problems. This will be targeted at people who tend not to be well served by secondary care mental health services (for example, people with complex, chronic problems rather than acute illness), and who often have poor physical health alongside mental health problems.

In West Cheshire MCP, there is an emphasis on supporting wellbeing in a broad sense, with wellbeing co-ordinators from the voluntary sector being included in local integrated care teams. The intention is that this person-centred approach will bring the relationship between mental and physical health to the forefront of multidisciplinary case discussions.

Liaison psychiatry/psychological medicine services

Liaison psychiatry (or psychological medicine) services have existed in some acute hospitals for several decades and have received renewed policy attention recently in England, partly as a result of evidence indicating that liaison services can deliver a substantial and rapid financial return on investment (Parsonage *et al* 2012). This renewed attention has included a recent commitment to invest £247 million over five years to expand the availability of liaison mental health in emergency departments (Department of Health 2016). Despite this policy interest, the provision of liaison services currently remains highly variable across the country (Joint Commissioning Panel for Mental Health 2013b).

Recent attention has focused on the rapid assessment interface and discharge (RAID) model. The components of this vary between hospitals, but as the name suggests, the emphasis is typically on rapid assessment and facilitation of discharge from A&E departments and inpatient wards. In A&E settings, the focus tends to be largely on self-harm and substance misuse, whereas for inpatients, the issues dealt with most commonly are mental health problems associated with older age, such as dementia and delirium. An economic evaluation of the RAID model in Birmingham reported that by facilitating early discharge and reducing rates of readmission (particularly among older people), the value of reduced bed use within the acute hospital exceeded the costs of the service by a factor of more than 4 to 1 (Parsonage and Fossey 2011).



While the outcomes achieved by the RAID model appear to be encouraging, it is important to state that the full scope of liaison mental health can and should go wider than this. In some acute hospitals, liaison services also perform a valuable longer-term rehabilitative function, working in outpatient clinics to help people address issues concerning the interface between mental and physical health. For example, liaison psychiatry services in Leeds are divided into several distinct services – including an ‘acute liaison psychiatry’ service resembling the RAID model for A&E, and a liaison psychiatry outpatient service that provides ongoing therapy. Clinical health psychologists often play an important part in delivering this longer-term therapeutic work, either as members of liaison teams or by being embedded in specific clinics.

From an integrated care perspective, some of the most significant opportunities for innovation lie in building community-facing liaison services that stretch beyond hospital boundaries and work in new ways with community partners (Aitken *et al* 2014). For example, both of the psychological medicine/liaison psychiatry services included in our case studies are currently exploring options to extend hospital-based liaison mental health services into primary care, to provide GPs in the local area with a service they can refer into directly (*see* appendices D and E).

The psychological medicine service in Oxford University Hospitals NHS Foundation Trust provides a distinctive model that differs in two important ways from liaison services provided in many acute trusts. First, whereas liaison psychiatrists operating in most acute hospitals are employed by the local mental health provider, the Oxford Psychological Medicine team is fully integrated with and employed by the acute trust. Second, the Oxford service is delivered largely by consultant psychiatrists and senior psychologists, with a relatively smaller role for other professionals such as liaison nurses. This is seen as being consistent with the culture of the wider organisation. Further details about the service are provided in Appendix D.

Further progress is needed to ensure that liaison mental health services are able to support people of all ages, including older people who comprise the majority of hospital inpatients (Anderson *et al* 2005). The national audit of dementia care indicated that most acute hospitals now have access to some form of liaison services for older people (Royal College of Psychiatrists 2013b), but the sophistication of these services appears to be variable. An important aspect of integration here is inclusion of mental health expertise in frailty units. The frailty unit at the



Royal Liverpool Hospital provides one such example, with liaison mental health forming an integral part of both the care provided to inpatients within the unit, and the ongoing support provided in the community after discharge.

Physical health liaison within mental health settings

As well as providing liaison psychiatry in acute settings, there is a strong case for providing primary care and other forms of medical liaison to people using specialist mental health services. This was articulated recently by the Royal College of Psychiatrists, which called for the introduction of a 'liaison physician' role in all mental health trusts ([Royal College of Psychiatrists 2013c](#)). However, to date, such arrangements are far less common than liaison psychiatry. We included two illustrative examples within our case study sites.

One example involves the primary care services developed within long-stay secure units in Broadmoor Hospital and St Bernard's Hospital, Ealing. These provide routine primary care to mental health inpatients with proactive management of long-term conditions and other physical health issues. Many of the inpatients in these facilities are not registered with a GP in the community, and have high rates of undiagnosed hypertension, cardiovascular disease and diabetes. Outcomes data suggests that provision of primary care and proactive disease management can be highly effective in this setting. For example, diabetes control is reported to exceed levels seen in the community, despite the challenges involved in working with this population (*see Appendix H*).

A second example involves the physical health checks provided in Highgate mental health unit by consultants from the neighbouring Whittington Health NHS Trust (*see Appendix I*). A weekly clinic is held that involves consultants specialising in respiratory health, diabetes, elderly care and general medicine. As with the previous example, this work has uncovered high rates of undiagnosed or inadequately treated health problems, including COPD, obstructive sleep apnoea, diabetes and heart failure (suggesting that physical health liaison in these settings may need to involve access to a team rather than a single liaison physician). As well as providing direct care to patients, another objective of the service is to improve the skills and confidence of the mental health nursing staff in performing basic physical health checks.



Supported self-management

Self-care is a core part of effective management of long-term conditions, whether mental or physical. What sometimes goes unacknowledged is the effect that mental health can have on a person's ability and motivation to manage physical conditions, and vice versa. Integrated approaches to self-management that help a person look after both their physical and mental health therefore offer an important opportunity to improve the effectiveness of self-management.

LIFT Psychology in Swindon provides a good example (*see* Appendix F). Among other things, it is a provider of IAPT services. However, LIFT is distinct from most other IAPT providers in that the guiding principle is to offer the 'least intervention first time', which in practice means that the first level of support offered to all prospective service users is participation in a group-based self-management course chosen from a range of available options. Many of these courses focus on teaching psychological self-management skills relevant to people living with long-term conditions – such as living well after a stroke; managing panic, anxiety and worry (for example in relation to respiratory conditions); or building confidence or overarching skills such as interpersonal communication. LIFT also provides psychologically informed self-management courses for people living with medically unexplained symptoms such as chronic pain, based on CBT techniques and graded exercise.

Alongside self-management groups, LIFT also provides guided self-help through one-to-one appointments with a psychological wellbeing practitioner based in the patient's GP surgery. In addition to working with service users, the team provides training sessions for teams in other parts of the health and care system – for example, on motivational interviewing or mindfulness-based techniques. This was seen as important in terms of spreading the impact of the service.

Section summary

Taking the examples described in this section collectively, several common features stand out. Although they are highly diverse, many include a focus on the following.

- **Redefining 'core business'** – As well as creating something additional, the most promising approaches also push the boundaries of existing services and attempt to shift notions of who is responsible for what.



- **Enabling skills transfer** – Many of the services seek to maximise their added value by performing an educational function alongside a clinical one.
- **Bridging the gaps** between primary and secondary care – For example, by providing new ways of accessing specialist support in general practice or strengthening skills and confidence in primary care.
- **Redesigning the workforce** – Several of the examples highlight opportunities to create new professional roles at the interface between mental and physical health.
- **Reducing stigma** – The case studies highlight how integrated service models can remove the stigma associated with using mental health services by embedding support in routine care processes.

One important question remains: are these kinds of innovation capable of bringing about integrated care as defined by service users and carers in Section 2? From a user perspective, a key metric of success is the extent to which health and care professionals are able to take a ‘whole person’ perspective and communicate with patients in a way that supports this. The focus of the innovations described in this section tends to be at a slightly different level, but nonetheless there is reason to believe they could play a role in bringing about the kind of change required. As alluded to above, part of the value of these integrated service models lies in their potential to create an enabling environment for human and relational changes in the workforce. By bringing together different groups of professionals, they can help build skills and confidence, change beliefs and attitudes, and reframe the boundaries of different professionals’ responsibilities.

The strength of the evidence behind the service models described here varies considerably. Some approaches, such as collaborative care and certain forms of liaison psychiatry, have a well-established evidence base both in the UK and internationally. For other forms of innovation, however, there is a pressing need for much greater investment in evaluation.

This section has shown that many examples of innovation exist. However, in the main, these have not yet changed the wider culture of treating mental and physical health as two separate issues, except perhaps in local areas. This raises the question of how successes so far can be scaled up, and how the barriers to change can be overcome. This is the subject of the following section.



5 Implementing change: overcoming the barriers

As we have argued throughout this report, the case for closer integration of mental and physical health care is compelling. Despite this, most attempts to do so in the UK have been piecemeal, and the progress made to date has been variable at best. This section explores the main barriers to change and how these might be overcome. In considering these barriers, we draw on the experience of leaders involved in the 10 case study sites described in appendices A to J. From our interviews with people involved in these sites, we identified a number of lessons, presented under the following themes:

- leadership
- workforce development
- finance and commissioning
- agreeing outcomes and demonstrating value
- harnessing digital technologies.

Leadership

Supporting clinical leaders

In our case study sites, innovation was often led by an individual or a small number of individuals who were committed to service improvement and who persevered in the face of a number of challenges. Dedicated individuals played a key part in designing the innovation, and influencing commissioners, board members and other colleagues. These leaders were most likely to be clinicians, and this was seen as important in gaining clinical support across different organisations. We also saw examples of highly effective partnerships between individuals who brought different skills and expertise to bear, such as a clinician working closely with a manager with influence at the strategic level.



The central role played by individual clinical leaders raises questions about sustainability and replicability. In some sites, there were concerns that changes had not yet been fully embedded and could unravel after key individuals moved to other positions. The burden placed on those involved was also clear, with one clinician remarking that ‘It all feels on my shoulders’. To sustain the momentum of innovation, it is critical to develop a strategy to identify and develop clinicians who may be able to take on leadership roles in relation to integrated care. For example, in some of our sites, this had involved making deliberate efforts to recruit leaders and team members with the passion and skill to build relationships and work across professional boundaries.

Building alliances

A common lesson across the case studies was that sufficient time needed to be invested in building alliances among local stakeholders and gathering support for innovation. In particular, those involved described the value of having senior allies at director or board level, and of getting influential senior clinicians ‘on side’. One clinical leader described her efforts to bring about integrated care as being ‘like a military campaign’. Advocates of integration had needed to be highly tactical in communicating the case for change, ensuring that they connected with the intrinsic motivations of key stakeholders – for example, by arguing for an integrated service on the basis of improving outcomes and quality.

Generally, we found there was widespread support among clinicians for the principle of closer integration of mental and physical health, although this did not necessarily translate into active involvement – ‘Everybody says it’s a great idea, but somebody else can do it’. Liaison psychiatrists described GPs as ‘natural allies’ and found they were often highly attuned to the need to take a biopsychosocial approach. These observations suggest that there may be untapped sources of support within the clinical workforce that could be drawn upon if other barriers were removed.

Levels of support from senior managers appeared to be variable, although where support was good, managerial partners had often played an instrumental role. An important lesson identified by our analysis is that having a board-level advocate for physical health care in mental health trusts (and vice versa) can be a key enabler of integration.



Willingness to experiment

Despite the growing volume of research evidence on some approaches, there is not always clear information or guidance about how exactly to design and implement an integrated service for physical and mental health. In several of our case study sites, innovation had therefore required local leaders to be willing to experiment and (importantly) to evaluate. One enabler of change was that key individuals in the local system – either on the provider or commissioner side or both – had at critical points been willing to take a risk, try something new and evaluate its impact. This did not involve implementing a new approach in the absence of any evidence at all, but it did often involve taking an iterative approach to service design, evaluating the impact of changes as they were introduced and learning from ‘practice-based evidence’.

Workforce development

A range of approaches were being used in our case study sites to develop the workforce in order to support integrated working, in particular through inter-professional training and skills transfer. An important enabler of integration was the creation of opportunities for different groups of professionals to learn from each other during the course of routine practice. All of the services and initiatives we examined saw part of their role as being to spread skills across the system. Specifically, a core objective was to improve the knowledge, skills and confidence of physical health professionals in dealing with mental health, or vice versa. This was done through a number of mechanisms, including:

- joint consultations
- multidisciplinary case discussions
- inter-professional supervision groups
- informal advice
- formal training sessions
- online training tools.

Joint consultations between mental and physical health care professionals were identified as a particularly valuable way of learning together, and can also help patients and service users to reframe their understanding of their condition using



a biopsychosocial perspective. Other forms of inter-professional training that created opportunities to discuss patient care were also viewed as highly beneficial.

The focus of training and skills transfer varied. As well as imparting new knowledge, training can be effective in changing attitudes and challenging stigmatising beliefs (Hardy 2012). Some of the areas seen as particularly beneficial are listed in Table 3.

Table 3 Areas where training and development is needed to support integration

Focus of development activity	Examples
Awareness and identification of common conditions and risk factors	<ul style="list-style-type: none"> • Prevalence and identification of common mental health problems among people with long-term physical health conditions/during the perinatal period • Biopsychosocial assessment • Physical health side effects of psychotropic medication
Communication skills/consultation techniques	<ul style="list-style-type: none"> • Motivational interviewing techniques to support behaviour change where motivation is an issue • Ways of exploring psychosocial issues during consultations • Setting more holistic goals with patients • Modelling a more sympathetic approach to managing distress (eg, on acute wards)
Understanding who to refer to, what resources are available	<ul style="list-style-type: none"> • Referral criteria for different services • Availability of peer support groups provided by local voluntary sector organisations
Teaching specific approaches or clinical skills	<ul style="list-style-type: none"> • How to conduct basic physical health tests eg, spirometry (for mental health nurses) • Mental health first aid • Basic psychotherapeutic techniques (eg, CBT) • Principles of mindfulness
Challenging expectations, assumptions and stigma	<ul style="list-style-type: none"> • Expectations regarding prognosis • Capacity of mental health service users to quit smoking • Role of mental health professionals in improving physical health, and vice versa

In a few examples, training and education went beyond the clinical team and also involved wider support staff. For example, in some practices, the Primary Care Psychotherapy Consultation Service in the City of London and Hackney (see Appendix C) has worked with all practice staff, including GPs, practice nurses and



receptionists, to improve support for people with medically unexplained symptoms and other complex needs.

More fundamentally, the workforce development needs that were highlighted by our research also point to the importance of ensuring that professional educational curricula equip trainees with the skills and attitudes needed to support integrated working. These implications are discussed further in Section 6.

Finance and commissioning

The role played by commissioners

The role played by commissioners in our case studies was mixed. In some sites, commissioners had played an enabling role, but in general, innovation had been provider-led. Several of the individuals involved in leading change emphasised how important it was to involve commissioners at the earliest possible opportunity. In cases where commissioners were seen to have played a particularly effective role, this was attributed to a high level of trust in their relationships with providers, built up over several years of partnership working.

In some cases, commissioners had developed financial incentives to help bring about changes in practice. For example, commissioners in Bradford and Airedale have encouraged the provision of physical health checks for people with mental illnesses using a locally defined Commissioning for Quality and Innovation (CQUIN) payment, and have also provided funding for a project management team that supported implementation in primary care. It is notable that similar financial incentives used by some other clinical commissioning groups (CCGs) have not always been as effective, suggesting that these need to be combined with practical support on the ground, as in Bradford and Airedale.

There was a perception among some of our interviewees that the move to clinical commissioning led by GPs could be credited with an upsurge of interest in liaison mental health and other forms of integration. The hypothesis here is that GPs see the way that mental and physical health interact in their clinical practice, and so are more likely to support the commissioning of integrated services. Clinical leads within CCGs (for example, mental health leads) might therefore be expected to play an important role in bringing about closer integration of mental and physical health.



Developing new payment and contracting approaches

A common constraint limiting the development of integrated approaches is the fact that mental and physical health services tend to be commissioned separately, with separate budgets, different payment systems, and separate commissioning teams. This was seen as a very significant barrier in several of our case study sites. New contracting models and alternative payment systems may offer some routes for overcoming this problem.

For example, in the case of Pennine MSK, a more integrated approach to commissioning had been developed through the use of a prime provider contract that devolves responsibility for service design decisions to the provider. Pennine MSK has used these freedoms to sub-contract for the mental health components of care pathways. Oldham CCG also granted Pennine MSK a high degree of autonomy in determining the outcome measures to include in this contract. While this form of contracting creates opportunities to commission more integrated services, it is dependent on high levels of trust between provider and commissioner ([Addicott 2014](#)).

Recent guidance from Monitor encourages commissioners to develop new payment approaches for mental health services, including using capitated and year-of-care models ([Monitor and NHS England 2015a](#), [2015b](#)). These approaches could be used to support integrated commissioning of physical and mental health services. For example, under capitated approaches, a group of providers can be paid to provide an integrated package of care for a defined population, including physical and mental health and potentially also social care and other relevant services. To create financial incentives for integration, it is important that payment systems of all kinds routinely include the costs of both mental and physical health care.

Identifying a sustainable funding source

In most of the examples we examined, it had been highly challenging for innovators both to obtain initial funding to cover the costs of change, and then to secure a sustainable source of funding for the longer term. Throughout critical stages in their development, many of the services had relied on goodwill and unfunded time put in by clinicians. They had often survived by drawing together relatively small amounts of funding from multiple sources, creating a complicated web of financial flows.



The funding arrangements for liaison psychiatry services are highly variable across England, and often complex. Psychological medicine services in Oxford University Hospitals NHS Foundation Trust are unusual in that they are provided by the acute trust itself rather than a mental health trust (*see* Appendix D). The costs are largely absorbed by the acute trust as the service is only partially funded by income from commissioned outpatient attendances. These costs have to be covered through general income from tariff payments for acute care.

Several of the services had been set up as pilots with non-recurrent funding. Where pilot funding is used for the initial phase of development, ideally there should be clarity over the outcomes that new services are expected to deliver, and a plan for how they will be rolled out more widely and financed on an ongoing basis should the agreed outcomes be achieved. As the financial benefits of integrated services often accrue to several different budgets and multiple organisations, thought should be given to how the full economic impact of a new service model can be assessed, and how any financial risks and gains will be shared.

Agreeing outcomes and demonstrating value

Service leaders in our case study sites were highly conscious of the need to demonstrate value to commissioners. Most had agreed an outcome or set of outcomes with commissioners, which they would be accountable for achieving. These outcomes informed how the services were designed and what would be measured as indices of 'success'. Examples of outcomes measured by some of the services included:

- parity of outcomes across different population groups
- improved clinical outcomes in people with co-morbid physical and mental health conditions
- improved psychological outcomes in people with long-term physical health conditions
- reduced emergency hospital admissions
- reduced use of bed days in acute hospitals.

In some cases, the nature of integrated approaches made it methodologically difficult to attribute improved outcomes with any certainty to the service in question. For



example, in liaison psychiatry, the relevant outcomes are predominantly the outcomes of the teams or units in which the service works. This means it is difficult to attribute improvements in outcomes specifically to the input of mental health professionals. The Royal College of Psychiatrists has published a framework of outcome measures for liaison psychiatry designed to help with this (Trigwell *et al* 2015). In addition, the LP-MAESTRO project currently being conducted at Leeds Institute of Health Sciences is evaluating other ways of measuring the effectiveness and cost-effectiveness of liaison services through the use of routine NHS data.

Collection of ‘softer’ outcomes had helped some services to understand and demonstrate the value of their work. For example, the Oxford Psychological Medicine Service collects the views of other trust staff on the value of the service provided. Staff feedback was reported to be particularly helpful in confirming the added value of the service to the work of the organisation.

Harnessing digital technologies

Digital technologies have been used in a number of ways to facilitate integration of physical and mental health. One example is the use of digital screening tools to identify hospital patients who may be in need of mental health support. The IMPARTS trial being conducted across King’s Health Partners Academic Health Sciences Centre uses a tablet-based tool and wider professional development package to support closer integration of mental and physical health care. Patients attending outpatient clinics are asked to complete a screening questionnaire on a tablet while waiting for their appointment. The results are appended instantly to their electronic patient record via a Wi-Fi connection, so that during their consultation the clinician can see if they are flagged as being at risk for depression or anxiety. Several pathways are then available, including referral to liaison psychiatry or psychological therapy.

A common stumbling block for integrated care is the existence of barriers to the sharing of information about patients as a result of incompatible IT systems in different parts of the health and social care system. In many parts of the country, mental health providers, acute trusts, general practices and other providers use mutually incompatible systems. As expected, these difficulties had emerged as significant impediments in our case study sites; several of them reported ongoing work with IT providers to improve interoperability between clinical information systems. In general, this remained an area where further progress was needed.



Section summary

Many of the barriers discussed in this section are generic issues that have impeded the development of all forms of integrated care. However, overcoming these barriers may be particularly challenging in relation to integration of physical and mental health care because of the extent of structural divisions between the two. Services are typically provided by different organisations, involving different staff groups, in different physical locations, with different financial and contracting arrangements, and are held to account using different forms of performance monitoring and system oversight. This does not mean that the barriers are insurmountable, but it does illustrate why overcoming them requires particular thought and attention from policy-makers and system leaders.

Our analysis identified a number of practical lessons for local leaders, with the following being seen as particularly important:

- supporting clinical leaders to ensure that innovation is embedded and not dependent on the commitment of individual leaders
- recruiting board-level advocates for physical health within mental health trusts, and vice versa
- creating opportunities for inter-professional learning and skills transfer between physical and mental health professionals as a part of routine practice
- developing new payment and contracting models that support integrated approaches to commissioning across physical and mental health.

There are also a number of bigger issues that require further work at the national and local levels, including the development of interoperable electronic care records and consideration of the implications for professional education. The latter of these is discussed further in the following section.



6 Discussion

A new frontier for integrated care

Integrated care has traditionally focused on bridging the gaps between health and social care, or between primary and secondary care. Bringing together mental and physical health is an important third dimension of integration that needs to take its place alongside the other two.

This new dimension also comes with a change in emphasis in terms of the beneficiaries of integrated care. Integrated care programmes have often targeted patients at greatest risk of acute hospital admission, identified through the use of risk stratification tools, with a particular focus on frail older people. While they remain an important target group, other population groups are known to experience poor health outcomes, and these also stand to benefit significantly from integrated care. This includes people with co-morbid mental and physical health problems, and people with chronic medically unexplained symptoms, who experience many of the features of frailty but from a younger age.

This line of argument has parallels with the work of Alderwick and colleagues (2015), which makes the case for building closer connections between integrated care and public health. If, as the authors suggest, those leading integrated care initiatives are to move from an emphasis on the *care of patients* to the *health of populations*, this will involve adopting a health inequalities perspective, and broadening the focus to consider the role of social determinants of health. Integration of mental and physical health must be central to this, for two reasons. First, the premature mortality of people with mental illnesses is one of the starkest health inequalities in the UK today. Second, the relationship between mental and physical ill health is intimately connected with social deprivation, as shown by the work of Barnett and colleagues (2012), and represents an important mechanism through which inequalities are perpetuated. In short, taking a population health perspective on integrated care puts integration of mental and physical health centre stage.



A key test for any attempt to develop integrated approaches towards mental and physical health is the extent to which it succeeds in bringing about the vision for integrated care articulated by service users in Section 2 of this report. It could be argued that there is a disconnect between this vision and the service-level innovations described in Section 4. In the former, the emphasis is significantly on the human and relational aspects of care rather than on structural solutions. Efforts to integrate physical and mental health care will need to include change at this more fundamental level to ensure that all health and care professionals are equipped to take a ‘whole person’ or biopsychosocial approach in their work.

While structural change may not be necessary to ‘get the basics right’, substantial workforce development certainly is needed. Integrated service models that bring physical and mental health professionals together in new ways could be an important mechanism for achieving this workforce development. The creation of new opportunities for inter-professional learning and skills transfer could encourage those involved to reframe their professional responsibilities – with physical health professionals feeling more confident and more skilled to consider the mental health and wellbeing of the people using their services, and vice versa. What is needed is a way of scaling up the local successes already seen so that mental and physical health are brought into closer relation across the country. One way this might be done is through the changes set in motion by the Forward View.

Achieving the Forward View

The new models of care introduced by the Forward View create a potentially important opportunity for the wider introduction of integrated approaches towards physical and mental health. Some of the most promising vehicles for implementing these integrated approaches will be those that deconstruct traditional boundaries in the system. For example, significant progress could be made on several of the 10 priorities described in Section 3 if work on these is pursued within multispecialty community providers (MCPs) and primary and acute care systems (PACS). Similarly, vanguard sites focusing on enhanced health in care homes could support improvements in mental health care in residential homes, and the urgent and emergency care vanguard sites could strengthen the management of mental health in acute hospital emergency departments (as indeed some are aiming to do).



Although most of the sites implementing new models of care are incorporating mental health to some extent in their programmes of work, our overall assessment is that there does not yet appear to be the kind of resolute focus on integration of physical and mental health that would be needed to meet the challenges described in this report, or to seize the opportunities that exist. Without this, the goal of ‘triple integration’ envisaged by the Forward View is unlikely to be achieved.

Implications for professional education and development

Integrated approaches to physical and mental health cannot be delivered solely by specialists such as liaison psychiatrists or clinical health psychologists. The agenda described in this report is one for the whole health and care workforce. To reiterate the findings of our research with service users and carers, the need for closer integration does not imply that professionals should become ‘experts in everything’, but it does require that they are equipped with the following:

- a foundation of basic common competencies in physical and mental health
- an openness to explore what a person’s wider physical or mental health needs might be, beyond the boundaries of a professional’s own specialism
- an understanding of what other forms of support are available and how to make a referral to the relevant services.

One important question is whether it is necessary to change educational curricula for medics, nurses and others in order to ensure that new trainees have these competencies. Our research certainly lends support to ongoing efforts to examine the implications of integrated working for professional education. It is encouraging, for example, that several of the Royal Colleges and others are exploring adding new components to curricula to overcome the historic separation between mental and physical health; there are proposals to expand education on mental health for physicians, and reciprocal proposals in relation to psychiatrists’ knowledge of physical health.

However, it would be a mistake to assume that progress cannot be made without fundamental changes to professional education. In relation to primary care, England (2014) argues that many GPs already have the right skills to support physical and mental health in an integrated way, but often lack the confidence, support or time to



use these skills to their full potential. According to this view, changes to professional educational curricula for new trainees should be complemented by efforts aimed at ‘reviving, refreshing and reinvigorating’ the skills and knowledge already present in the health and care workforce. Importantly, what is needed is not simply increased awareness of physical health among mental health professions (or vice versa) but greater understanding specifically of the interdependency between the two and the need for an integrated biopsychosocial perspective.

Beyond parity of esteem

The Health and Social Care Act 2012 created a new legal responsibility for the NHS to deliver ‘parity of esteem’ between mental and physical health, and the government has pledged to achieve this by 2020. The meaning of this phrase has been debated, but it is generally interpreted as implying that mental health services should be ‘as good as’ services for physical health – that people with mental health problems should receive an equivalent standard of care. This is an important ambition. However, the opportunities described in this report indicate that there is a greater prize beyond this in which mental health care is not only ‘as good as’ but is delivered ‘as part of’ wider health and care services.

It is therefore welcome that the report of the independent Mental Health Taskforce to the NHS in England places significant emphasis on the need to develop integrated care spanning physical, mental and social needs, as part of a five-year national strategy for improving mental health ([Mental Health Taskforce 2016](#)). Specific recommendations made by the taskforce in relation to integration include the following:

- NHS England should define a quantified national reduction in premature mortality among people with severe mental illness, and an operational plan to begin achieving it from 2017/18
- all acute hospitals should have all-age mental health liaison services in emergency departments and inpatient wards by 2020/21
- at least 30,000 more women each year should have access to specialist perinatal mental health care by 2020/21
- at least 280,000 people living with severe mental health problems should have their physical health needs met by 2020/21, through being offered screening, preventive interventions and treatment



- at least 600,000 more adults each year with depression or anxiety should be able to access evidence-based psychological therapies by 2020/21, with a particular focus on helping people who are living with long-term physical health conditions.

These are important goals and pursuing them should help to take the system in the right direction, as part of the wider changes described in this report. A further example of integration of physical and mental health beginning to gain momentum at the policy level is provided by the recent national service specification for diabetes transition services, which includes recommendations on mental health support for people with diabetes (NHS England 2016).

These and other developments show the important role that national policy-makers and clinical leaders can play in enabling the development of integrated approaches to physical and mental health. What is needed now is for leadership and ownership of this agenda to move beyond the confines of ‘mental health strategy’ and become part of wider strategic thinking for the system as a whole.

Conclusion

There is a compelling case for seeking to support mental and physical health in a more integrated way. The scale of the problem has been clear for some time, manifested in the elevated mortality levels among people with mental illnesses, the scant regard often paid to the psychological dimensions of physical illness, and the costly and harmful mismanagement of medically unexplained symptoms. These issues cost the NHS in excess of £11 billion annually, and result in poor care for people and their families.

What is starting to become clearer is that these are often solvable problems. In many cases, there are evidence-based interventions available that offer cost-effective ways of improving outcomes for people using the health and care system. The challenge lies in scaling up these approaches and embedding them in routine practice. The new models of care introduced by the Forward View have breathed new life into integrated care programmes in many parts of the country. These must be used to accelerate progress in the 10 priority areas outlined in this report. If integration of mental and physical health does not form a major component of these programmes, it would be a significant missed opportunity.



7 Recommendations

- Commissioners, service providers and public health professionals should work together to develop integrated approaches to mental and physical health. Some of the most significant opportunities for quality improvement and cost control lie in the 10 priority areas outlined in this report.
- Place-based approaches and the new models of care introduced by the Forward View create an important opportunity to implement integrated service models at greater scale, and to evaluate their impact. Integration of physical and mental health should be high on the agenda in local systems involved in these initiatives, and NHS England should support and encourage vanguard sites in particular to make this a priority.
- Local system leaders should see people with co-morbid physical and mental health problems and/or medically unexplained symptoms as priority target groups for more intensive forms of integrated support. A focus on groups known to experience poor outcomes should complement the use of risk prediction algorithms based on likelihood of hospital admission when identifying target groups for integrated care.
- Local authorities should assess population mental health needs as part of joint strategic needs assessments (JSNAs). They should understand how these interact with other priority public health issues, and ensure that people with mental health problems benefit from equitable access to health improvement resources. The Faculty of Public Health and Royal Society for Public Health can support this by continuing to advocate for inclusion of mental health within general health improvement activities.
- Separate budgets and commissioning teams for physical and mental health should be replaced with integrated approaches to commissioning. Commissioners should explore how to use new payment approaches (such as capitated or year-of-care payments) or new contracting models (such as prime provider or alliance contracts) to support integrated commissioning of physical and mental health services.



- Commissioners should use contracting and financial tools to hold mental health providers to account for improving physical health outcomes, and vice versa. This could include contractual requirements for mental health providers to take action on key risk factors such as smoking and weight gain.
- Educators and professional bodies should examine implications for the training needs of all health and social care professionals. As part of this, Royal Colleges and other bodies should continue working together to redesign professional educational curricula so that all health professionals have a sufficient common foundation in both mental and physical health.
- To support skills development in the existing workforce, service planners and clinical leaders should seek to create opportunities for inter-professional learning and skills transfer, including through service models that enable physical and mental health professionals to work together more closely as part of routine practice.
- Further improvement is needed to strengthen mental health provision in acute hospitals and medical liaison services within mental health inpatient settings. Commissioners should also seek to expand the scope of liaison mental health services from acute hospital settings to primary and community care. Developing services that support GPs in managing people with medically unexplained symptoms and other complex needs should be a priority.
- As an enabler of change at the organisational level, acute trusts are encouraged to appoint a board-level champion for mental health, and mental health trusts should consider appointing a board-level champion for physical health.
- Commissioners should recognise and support the important role that voluntary and community sector organisations can play in helping people to deal with the psychological challenges of living with a long-term condition.
- Further evaluation and sharing of existing best practice is needed. For example, learning should be encouraged from specialties where support for the psychological aspects of physical illness is increasingly seen as a routine part of care.



Appendices: case study site profiles

Appendix A: 3 Dimensions of care for Diabetes (3DfD)

Overview

Commissioned by Lambeth and Southwark Clinical Commissioning Groups, 3 Dimensions of care for Diabetes (3DfD) integrates medical, psychological and social care for individuals with persistent sub-optimal glycaemic control. It is delivered by a multidisciplinary team comprising a consultant diabetologist, a consultant liaison psychiatrist, a clinical psychologist and two community support workers. The team works across King's College Hospital NHS Foundation Trust, Guy's and St Thomas' NHS Foundation Trust and Thames Reach. 3DfD gives equal attention to individuals' biopsychosocial needs. Members of the integrated team can address them simultaneously, which means there is no need for multiple referrals to separate services.

Service description

3DfD works with residents of Lambeth and Southwark under the care of the diabetes teams in hospitals and in intermediate care. Individuals with HbA1c levels above an agreed threshold for at least six months and who could benefit from psychological or social support can be referred to 3DfD by GPs, the community team or hospital teams. 3DfD can support individuals with depression, anxiety, psychosis, dementia or eating disorders.

Individuals remain under the care of the 3DfD team for as long as they require this particular type of support. 3DfD can provide brief, focused interventions that are guided by intensive case management and patient-led case meetings. The aims of the biopsychosocial model are:

- biomedical:
 - improving glycaemic control
 - improving access to preventive health care



- psychological:
 - improving psychological functioning
- social:
 - providing practical assistance to address social problems.

Psychological treatment typically involves CBT to treat a range of problems. These can be motivational issues, depression, anxiety, family conflict or unhelpful health beliefs. Diabetes-specific issues include difficulty in accepting the diagnosis, needle phobia, fear of insulin, and eating disorders (among other things). Examples of social issues that can prevent successful self-management of diabetes include problems with housing or debt. The support workers can provide direct support for these issues or signpost to other services.

Patient-led case meetings are held regularly with members of the multidisciplinary team. The purpose of these meetings is to plan and co-ordinate care. By encouraging the patient to lead the meeting, the team can obtain in-depth knowledge of the problems faced by each individual and tailor the support and treatment accordingly. Meetings allow patients to maintain relationships with routine care teams, which helps them to re-engage with them during recovery. Upon discharge, individuals return to routine diabetes care in the hospital, community or in primary care.

Outcomes

An evaluation of phase 1 (August 2010 to March 2012) and phase 2 (September 2012 to March 2014) found very promising results in relation to improved outcomes (Doherty *et al* 2016). For example, the average reduction in HbA1c from referral to six months later was greater than the improvements seen with the introduction of new medication and greater than improvements achieved by local community diabetes clinics. Reduction in HbA1c levels can reduce the likelihood of developing complications such as retinopathy and cardiovascular disease. A 1 per cent reduction can decrease rates of diabetes-related complications by up to 40 per cent (UKPDS Group 1998). In addition, statistically significant improvements were achieved in psychological scores relating to depression (PHQ-9 scale), anxiety (GAD7 scale) and diabetes-specific distress (Diabetes Distress Scale). Improvements in social functioning were measured on the 'Outcomes Star' scale across multiple domains, including accommodation, personal responsibility and social networks.



The 3DfD team has received positive feedback from professionals and is credited with having increased the skillset of the various diabetes teams – for example, in relation to the types of mental health issues that people with diabetes can experience, and the psychological interventions that can help.

The 3DfD model has been adapted for implementation elsewhere at the Hillingdon Hospitals NHS Foundation Trust and Central and North West London NHS Foundation Trust.

Key enablers

- Strong leadership and advocacy from the clinical lead for diabetes and the consultant liaison psychiatrists was key to embedding the service and overcoming initial doubts that a bespoke service for diabetes and mental health was needed.
- The 3DfD service has followed an explicit improvement methodology, namely the Plan-Do-Study-Act (PDSA) cycle.
- Close working relationships between 3DfD team members and the hospital and community diabetes teams were helped by consistent multidisciplinary team meeting attendance, an easy referral process and swift responses to referrals.
- Team members have offered and delivered various forms of training to health care professionals in Lambeth and Southwark.
- Advance planning for continuation funding was crucial. The team has engaged with six different commissioning bodies during piloting, which was very challenging; advance communication and negotiation with commissioners was vital.

Further information

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Appendix B: Integrated persistent pain pathway in Oldham

Overview

The integrated persistent pain pathway in Oldham is provided jointly by Pennine MSK Partnership, Pennine Care NHS Foundation Trust and The Pennine Acute Hospitals NHS Trust, and commissioned by Oldham CCG.

The Pennine MSK Partnership Ltd provides comprehensive services in Oldham for rheumatology, orthopaedics and chronic musculoskeletal pain. Led by a team of clinicians, the partnership operates as an integrated pathway hub across all musculoskeletal conditions. The partnership has its own outcomes-based programme budget and can sub-contract various services to provide more holistic care. Recognising that psychological support is a key component of its work, the partnership sub-contracts mental health services from Pennine Care NHS Foundation Trust and works with The Pennine Acute Hospitals NHS Trust to deliver an integrated service for persistent pain.

The new integrated persistent pain pathway went live in June 2015 and bases the assessment and treatment of pain on the biopsychosocial model. Pennine MSK Partnership takes the lead role for 'tier 2' of the pathway and the acute trust takes the lead role for 'tier 3' (see below). The community-based pathway supports people to make informed decisions to manage their care and have an improved quality of life.

Service description

People who are suffering with persistent pain that is hard to manage, despite treatment, are referred by GPs to the hub. They are assessed by members of a multidisciplinary team, including pain specialist nurses, pain specialist physiotherapists, cognitive behaviour therapists and clinical psychologists, supported by pain consultants and liaison psychiatrists where necessary. The assessment determines which of the following tiers of service each patient will receive.

- Tier 1 is co-ordinated by general practice. Patients can access help from community physiotherapists and psychological therapists, the latter being based in Improving Access to Psychological Therapy (IAPT) services.



- Tier 2 comprises pain specialist physiotherapists, pain specialist nurses, psychological therapists and a GP with special interest in pain. The team is integrated with the community rheumatology service and the community orthopaedic service within Pennine MSK Partnership. Tier 2 is delivered by the Pennine MSK Partnership with Pennine Care NHS Foundation Trust at the Integrated Care Centre in Oldham and at community leisure gyms. Patients are assessed by a pain specialist clinician and a self-help plan is developed in partnership with the patient, with ongoing referral as needed. Interventions can include one-to-one appointments and group work.
- Tier 3 is for patients with the most complex needs. It is delivered by The Pennine Acute Hospitals NHS Trust in partnership with Pennine Care NHS Foundation Trust. Patients stepped up from tier 2 are discussed in a multidisciplinary meeting and assessed individually or jointly by a clinical psychologist, liaison psychiatrist, pain consultant and pain specialist nurse.

Staff from the three providers reported that this model allows for a more holistic approach to treating chronic pain, and reduces the prescription of strong pain-killing medications, such as opiate-based drugs or epidural injections, as the default. They argued that there was no strong evidence base for such medication having a significant impact in many cases of persistent pain and that in some cases, medication can have harmful side effects.

Staff reported that before the pathway came into being, patients with medically unexplained symptoms, fibromyalgia and chronic pain were often managed inappropriately and services were not following evidence-based care. Patients were often prescribed inappropriate medication and were described as being on a 'merry-go-round' between the pain clinic, rheumatology and orthopaedic services, and primary care. They were accumulating unnecessary treatments and experiencing variable quality of care. There was also limited access to input from the Psychological Medicine Service and talking therapies. The Pennine MSK Partnership had previously attempted to increase access to psychological support for patients with chronic pain, but this was on a relatively small scale. The Pennine Acute Hospitals NHS Trust previously had very limited access to psychological or liaison psychiatry input for patients with pain.



The new care pathway represents a significant shift for the entire local health care system; patients with chronic pain can now access a wider range of support for their psychological and social needs. In addition, staff were proud of the fact that there were short waiting lists for expert assessment and talking therapies, including CBT, as timely treatment can be vital in helping to manage chronic pain effectively.

Key enablers

A number of key ingredients helped make the partnership between physical health services, mental health services and commissioners work.

- The outcomes-based contract gives the partnership a degree of freedom to design, commission and manage the pathway, and allows them to sub-contract for other services. It creates alignment of clinical and financial responsibility.
- Strong clinical leadership from the Pennine MSK Partnership, the Psychological Medicine Service and The Pennine Acute Hospitals NHS Trust helped to make this partnership an effective one.
- There was a high level of mutual trust between the partnership and the CCG.
- There was high-quality multidisciplinary working and good communication between different groups of professionals.
- There was a strong focus on quality, including peer review of patients' care cases carried out every two months.
- Pennine MSK Partnership endeavoured to visit every general practice in Oldham to provide training in the biopsychosocial model of pain and to raise awareness of patients' mental health and social needs.

Further information

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Appendix C: City and Hackney Primary Care Psychotherapy Consultation Service

Overview

The Primary Care Psychotherapy Consultation Service (PCPCS) is an outreach service provided by The Tavistock and Portman NHS Foundation Trust to GPs throughout City and Hackney CCG. A multidisciplinary team of mental health professionals attend GP practices to help GPs manage patients with complex needs, typically characterised by a mix of physical symptoms, long-term mental health problems and challenging social circumstances. One of the service's successes is the co-location of the GP and the psychotherapists, which is seen to deliver benefits for both the medical staff and patients. GPs were reported to appreciate the assistance they receive with patients they see regularly, and patients appreciate not having to be referred to another service.

Service description

The patients the service was set up to support are those who often fall through the gaps within standard services. This includes patients with medically unexplained symptoms, personality disorders and people whose chronic mental health problems are not being managed by secondary mental health services. Historically, these patients have been managed within primary care. GPs often see these patients regularly and find themselves managing a delicate relationship whereby there may not be an appropriate service that can cater for these patients' needs.

The PCPCS team comprises professionals from psychology, psychiatry, nursing and social work. Each GP surgery has a named clinician attached to their practice, but they are able to call on the full range of expertise from the team. GPs refer patients to the team, which works in a flexible manner so that they can meet patients' needs rather than working to a defined client group. This allows them to accept around 95 per cent of referrals made to them.

The team provides three different types of consultation:

- direct one-to-one consultations with patients
- joint consultations with a patient and their GP



- consultations with GPs or other practice staff to provide advice on how best to support specific patients.

In terms of direct work with patients, this is limited to a maximum of 16 sessions and can involve psychodynamic therapy, CBT, group therapy or photography/horticultural groups as appropriate. A patient's initial assessment is conducted by a highly skilled professional within the team; this is regarded as critical for this client group.

The PCPCS team supports GPs and other practice staff to understand what might be going on for a patient, beneath the surface presentation. There is an implicit focus in this on increasing resilience and satisfaction within the primary care team. Training can be tailored for particular topics and is delivered in a variety of ways:

- informally, through support and advice
- case-based discussions in surgeries
- helping GPs to take a psychologically minded approach to consultations
- more formal training of primary care staff to enhance their capacity to help
- e-learning training programmes for GPs.

More recently, the trust has also been commissioned to provide a similar service to GPs in Camden, known as the Team Around the Practice service.

Outcomes

An internal evaluation showed that GPs reported feeling more confident in managing patients with complex needs, and greater satisfaction in holding consultations. Other GPs have reported high satisfaction from what they see as a changed relationship with their patients; they can hold conversations with them now which they would have struggled to hold before – for example, in relation to the psychological aspects of chronic pain.

An economic evaluation of this service showed that, for certain measures (depression, anxiety and individuals' ability to carry out day-to-day tasks), around 75 per cent of patients showed improvements in their mental health, wellbeing and



functioning as a result of treatment. More than half (55 per cent) had recovered in the sense that there had been an improvement in mental health to below clinical thresholds (Parsonage *et al* 2014). These results compare well to the outcomes achieved by other mental health services, particularly considering that the PCPCS works with people with highly complex needs.

There is evidence that the service has also led to a reduction in service use among patients referred to it. The above evaluation found that over a follow-up period of 22 months, around a third of the costs of providing the service were offset by savings associated with reduced service use in both primary and secondary care.

Key enablers

- Initial assessments are conducted by a highly skilled professional.
- The joint consultation model has facilitated greater trust and better working relationships between professionals.
- There was a concerted effort in the recruitment of the PCPCS team to find staff who wanted to be embedded in primary care, working closely with GPs. The team see themselves as part of primary care.
- Commissioners played an active role in the development of the service, identifying the need for it, and making funding available.
- The dual function of the service was seen as being critical to its success – combining direct clinical work with patients with a support and educational function for primary care.

Further information

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Appendix D: Oxford Psychological Medicine Service

Overview

The Oxford Psychological Medicine Service aims to transform patients' experiences in Oxford University Hospitals NHS Foundation Trust by integrating psychiatric and psychological support with medical care. The service is distinct from counterparts in other acute hospitals in that the team is employed directly by the acute trust, rather than being delivered by a mental health provider. The service is led by a consultant psychiatrist and a consultant clinical psychologist and largely delivered by consultant psychiatrists and senior clinical psychologists, within a unified team.

Service description

The team is reported to be considered as much a part of the acute trust's workforce as the medical and nursing staff. Psychiatrists and psychologists are directly employed by the acute trust and embedded in clinical teams. Working across the hospitals that make up the acute trust, the Psychological Medicine Service is available to inpatients and outpatients receiving care from a number of clinical areas, including:

- acute general medicine and gerontology
- cancer
- children's services
- chronic pain
- diabetes
- enablement services
- infectious diseases
- neurosciences
- palliative care
- respiratory medicine
- women's services.



Psychiatrists in the multidisciplinary team work alongside medical consultants, junior doctors, ward nurses and others to offer rapid, senior psychiatric opinions. They can assess suspected mental health, confusion or memory problems, or general risk. They can give advice about managing behavioural disturbance or on medico-legal issues regarding capacity and use of the Mental Health Act. They assist with discharge planning and can facilitate dialogue with mental health services outside of the acute trust for onward management. In palliative medicine, the service's consultant psychiatrists provide assessment and treatment for patients, as well as training and supervision for palliative care team members.

Psychologists in the team work as members of medical teams, adding a psychological dimension to patient management. In respiratory medicine, for example, a clinical health psychologist works with the respiratory team to assess and provide evidence-based treatment to patients with psychological issues that have a negative impact on their physical and mental health.

One of the benefits of the service is that it provides an opportunity for team members to teach and train their physical health care counterparts as they work closely together. At the time of writing, this mental health training was a trust-wide requirement for staff in cancer and women's services.

In addition to the Psychological Medicine Service, a separate Emergency Department Psychiatric Service assesses patients presenting with psychiatric issues to the emergency departments at the John Radcliffe and Horton General hospitals. This service is provided by Oxford Health NHS Foundation Trust.

Outcomes

The Oxford Psychological Medicine Service has been in place for two years and in that time has received highly positive feedback from physicians, surgeons and nursing staff. Acute care staff greatly appreciate a quick response and diagnosis of patients' mental health issues. The value that acute care staff place in the service is evidenced in the growing number of clinical departments that have commissioned its input over the past two years. One of its most important perceived impacts is that it has challenged pervasive stereotypes about mental illness within the acute care setting, and has helped to change how patients with challenging behaviours



are managed. In the view of those involved, the service has given staff on wards ‘the confidence to do the right thing in an increasingly litigious environment’.

The service is developing a set of outcome assessments, closely aligned with the performance targets for the individual medical units they work in.

Key enablers

- Key decision-makers in the acute trust were willing to take a risk and develop a different kind of service model, for which no template existed.
- There was strong and influential clinical leadership within the trust, in terms of both mental health and physical health care.
- The seniority and experience of the team members means consultant psychiatrists in particular can take ‘positive clinical risks’ and resist the inclination to admit patients to hospital unnecessarily, or prolong their stay when discharge would be more appropriate.
- There was careful selection of senior clinical team members who were very supportive of the vision driving the service.
- There was a motivated and cohesive team that quickly established good working relationships with physicians and nurses.

Further information

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Appendix E: Psychological medicine services in Hull

Overview

Liaison psychiatry services in Hull Royal Infirmary and Castle Hill Hospital are commissioned by Hull and East Riding of Yorkshire CCGs and provided by Humber NHS Foundation Trust. The service is delivered by multidisciplinary teams working throughout the hospital and accepting referrals from the emergency department, inpatient wards and outpatient clinics. One of its important features is the focus on treatment and therapeutic work, in the short term and long term. This distinguishes the service from some other models of liaison psychiatry, which focus more on rapid identification and supporting discharge.

Service description

The current service began in 1997 with three team members and since then has grown to 50–60 professionals from a range of disciplines. It covers Hull Royal Infirmary (the main emergency department for the area) and Castle Hill Hospital (the main elective procedure hospital), which combine to just under 1,400 inpatient beds. The trust also provides regional services for renal, oncology, neurosciences and trauma care to a population of 1.5 million people.

The psychological medicine department now consists of several teams:

1. Hospital Mental Health Team – A multidisciplinary team comprising working age and older adult liaison psychiatrists, nursing staff and support workers who respond to emergencies and urgent referrals in the emergency department and inpatient wards. The team has a 24-hour, 7-day presence in the emergency department, and works with people of any age presenting with suicidal ideation and/or self-harm.
2. General Liaison Team – A multidisciplinary team comprising consultant psychiatrists, psychologists, therapists and support workers who assess ward referrals (non-urgent) and referrals from outpatient clinics. They also provide additional bespoke services for specialties that commission them to do so, currently including renal, diabetes, cystic fibrosis and bariatrics. The benefits of the bespoke services include a named practitioner who works closely with staff (providing them with advice and support), attendance at designated clinics, and



patient management. The team also offers: joint clinics with the pain service and neurology; a supervisory service to stoma nurses; and an assessment and treatment service for patients with medically unexplained symptoms.

3. Chronic Fatigue Syndrome Service – A multidisciplinary team including a consultant psychiatrist and physician, occupational therapist and psychological therapists, which provides an assessment and treatment service for patients with chronic fatigue syndrome.
4. Specialist Perinatal Service – A multidisciplinary team which provides assessment and management of women with moderate-to-severe mental health problems in the antenatal and postnatal periods.
5. Huntington’s Disease Team – A specialised team assessing and managing patients with Huntington’s disease, working closely with neurologists and geneticists.
6. Learning Disability Service – A designated learning disability nurse who provides a prompt service for patients with a learning disability admitted to an inpatient bed in the acute trust. The service includes support, close work with family and carers, and tailored individual care plans.

While all these teams have their own separate functions, they also work collaboratively, with clear referral pathways between each team and the provision of shared care where necessary.

Members of the psychological medicine department also provide some training for the acute trust workforce. Mental health awareness training is to be delivered to all student nurses at Hull University, and the team is working towards making it mandatory for all staff within the acute trust to receive training around mental health awareness and suicide.

The department is currently exploring opportunities to build on close working relationships with local GPs. A feasibility study is being funded by Hull CCG to evaluate an intervention in primary care for patients with medically unexplained symptoms. This will include a training package for GPs, provision of liaison psychiatry and specialist therapy within the primary care setting, and regular joint



psychiatry-GP meetings to discuss referrals, formulations and further management of patients. This study begins in April 2016 for 12 months, with the hope that if clinical and economic effectiveness can be demonstrated, the intervention will be extended further.

Outcomes

An early evaluation of one aspect of the service showed that between 2009/10 and 2011/12, the average length of stay for older patients referred to the older people's liaison service (now embedded within the Hospital Mental Health Team) decreased by more than eight days compared to those who were not referred. Another evaluation found a decrease of 60 per cent in the number of patients with mental health problems attending A&E five or more times a year.

Key enablers

- Joint consultations involving mental and physical health physicians have allowed each to learn how complex the other condition is before working together to provide a tailored, individual care plan.
- Having the right people has been key, particularly in terms of strong and consistent clinical and managerial leadership.
- Identifying mental health champions within the acute trust workforce (clinical and managerial) has helped.
- There have been good relationships with commissioners, particularly GP commissioners who understand the need for the service.
- The liaison psychiatrists have invested significant time in building relationships across the trust.

Further information

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Appendix F: LIFT Psychology in Swindon

Overview

LIFT Psychology applies a ‘least intervention first time’ principle to psychological support. Over two decades, LIFT services have been established in a number of areas, aimed at providing psychological support in primary care, including lower intensity support. The key difference between Swindon’s LIFT service and psychological therapy providers in other areas is that patients are able to book straight onto a self-management course or a one-to-one appointment without being assessed first. The lowest tier of support (participation in a range of psycho-educational and self-management courses) is available to anyone in the area, and although GPs and other health professionals signpost to the service, a referral letter from them is not required. The service also offers guided self-help through one-to-one appointments with psychological wellbeing practitioners based in primary care.

Service description

LIFT Psychology in Swindon has a long history of providing services designed to meet the needs of people with long-term physical health conditions and/or medically unexplained symptoms. It offers a set of self-management courses designed to provide people with the skills to manage common aspects of long-term conditions alongside a suite of courses designed for specific conditions. Courses targeted at long-term conditions and medically unexplained symptoms were introduced in 2010, pre-dating the Department of Health pathfinder programme that encouraged other IAPT providers to work in this area.

The service is embedded in local GP surgeries and is organised using a stepped care model. The LIFT team provide support in tiers 2 and 3 of the model described below:

- tier 1: consultation in GP surgery/watchful waiting
- tier 2: psycho-educational courses; one-to-one supported self-help; brief CBT-based therapy; signposting to self-help resources
- tier 3: higher-intensity therapies, eg, CBT, dynamic interpersonal therapy, interpersonal psychotherapy, couple counselling for depression
- tier 4: referral to secondary mental health services.



The lowest tier of the LIFT service offers group-based psycho-educational courses for people who have self-referred into the service. It seeks to provide participants with self-help and coping skills to manage psychological problems, including psychological aspects of physical conditions. These services are run by a mixture of psychological wellbeing practitioners (trained in CBT) and assistant psychologists. They take place across the local area in public facilities including GP surgeries, colleges and libraries.

The courses that the LIFT team runs are numerous and diverse. Several are designed to help patients with specific medically unexplained symptoms or long-term conditions, including chronic pain, multiple sclerosis, cardiovascular diseases, and the effects of stroke and other neurological problems. Other courses are targeted at more general features of self-management, like how to cope with stress or low mood.

With all of the courses, the team reported that it was important to communicate the purpose of the course accurately when introducing it to people; at this stage, colleagues who signpost people to the service can help or hinder their chances of successfully helping a person. The courses are focused on helping patients get on with life through self-management, starting from a position of accepting the condition or diagnosis.

Users choose from among the various courses when they seek support from the service for the first time. They can also choose to book in for a one-to-one appointment. If patients require further psychological support, the professionals running the courses are able to refer them for the next tier of LIFT services, which involves more intense psychological support from a team of counselling psychologists and clinical psychologists. If necessary, they can also be referred into secondary mental health services.

The LIFT team provides training sessions for other organisations upon request. These include sessions on motivational interviewing, how to run group classes, and sessions on mindfulness. These training sessions are purchased by other NHS and private sector organisations.



Outcomes

The LIFT team reports that the ‘least intervention first time’ model, which offers people direct access, effectively eliminates the waiting lists that occur using the traditional ‘referral and assessment’ model. Offering an intervention so quickly removes the risk of ‘downward spirals’ while people wait for assessment or triage-based treatment. The LIFT team believes that this reduces the need for referrals into secondary care.

The team also argues that even when the lower-intensity support offered in group sessions is not sufficient to meet a person’s needs, it can help to speed up escalation when more severe needs are identified. In response to concerns about providing a service before conducting an assessment, the team argues that the content of courses (focused on relaxing, asking for help, managing worrying thoughts) does not carry any risk of causing harm.

Key enablers

- The LIFT service has a long history and a relatively stable workforce; it was reported that this created high levels of trust so that new services or courses developed within LIFT would be supported by commissioners and referred into by local primary care providers.
- Positive outcomes from initial piloting of courses for people with long-term conditions and/or medically unexplained symptoms meant that commissioners sought to continue providing these courses within the LIFT block contract.
- The team has built good working relationships with secondary care mental health teams.
- The lead for long-term conditions spends three days per week working with patients in the local acute general hospital, giving the LIFT team a direct link with hospital services as well as general practice.

Further information

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Appendix G: Physical health check protocol for patients with mental health problems in Bradford and Airedale

Overview

In the Bradford and Airedale area, a recent initiative seeks to ensure that anyone with a serious mental illness is offered a regular physical health check. The checks follow a protocol using a digital template and are designed to pick up any emerging health problems and help the patient respond to them. The first phase of the project started in primary care, in approximately 80 GP practices in the area. The second phase involved rolling the checks out into the community mental health teams and hospitals run by Bradford District Care NHS Foundation Trust.

The physical health checks are designed to reduce diagnostic overshadowing and ensure that a person's serious mental illness does not prevent them receiving the same kind of advice and support other patients would receive about how to look after their physical health.

Service description

There are more than 5,000 people with a severe mental illness diagnosis among Bradford and Airedale's patient population. This group goes through annual physical health checks in their GP practice if the GP remains their lead clinician. Patients receiving care from the community mental health team are provided with the checks in one of five community physical health clinics. There are also around 200 beds for patients who need inpatient mental health care locally; patients in those settings have the health check provided in situ.

The physical health check runs through key indicators, measuring body mass index (BMI), blood pressure, pulse and respiration, with an ECG and relevant blood tests. Care professionals also discuss lifestyle with patients, covering smoking, dietary and exercise habits, and sexual function. Data entry is made easy through the template, and GPs respond to any adverse results. In primary care, the measurements and data recording are usually done by practice nurses or health care assistants and used to inform a consultation with the GP thereafter.

Nearly all the follow-up care is carried out by the same teams leading care for the patient. However, management of high levels of prolactin (a frequent side effect



of some anti-psychotic medications) is deemed to be the responsibility of the prescribing psychiatrist.

Implementation of the physical health check protocol was facilitated by the creation of a digital template, alongside a training and engagement programme with nearly all the practices involved in delivering the checks. The digital template is the first of its kind and has been adapted to all of the major health care IT systems used in the local area. It provides a structure for consultation, prompts the care professional when an adverse result is recorded, and enables them to capture all key information very simply in one location. While there have been some delays communicating results between the systems used by different providers, the template has been well received and its usage has been consistently high. The digital template has been made available to the rest of the NHS and has been promoted by NHS England.

Key enablers

- The project team in Bradford visited 65 out of 80 practices before the health checks went live in primary care, offering half-hour sessions in practices to cover the case for change, how to use the template, and how to embed it into workflows.
- In inpatient and community mental health care settings, the team provided training on how to carry out the specific tests required (blood tests, blood pressure, height, weight and temperature measurements) alongside a scenario-based training programme to improve mental health professionals' understanding of how to respond to an emergency medical problem in psychiatric settings.
- Commissioners supported implementation of the protocol by making available some project funding for the core team, and incentivising local providers to complete checks through a locally agreed Commissioning for Quality and Innovation (CQUIN) payment.

Further information

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Appendix H: Primary care for secure inpatient units in west London

Overview

West London Mental Health NHS Trust provides forensic inpatient mental health services alongside specialist mental health services. It focuses on the primary care services that are provided to inpatients in two secure hospitals, Ealing Hospital and Broadmoor Hospital. The primary care service provided in these hospitals is similar, in many ways, to standard primary care in the community, but specific approaches, skills and tools are needed to offer good primary health care to a mental health inpatient population. The team providing the service challenge themselves to meet the same outcomes achieved by primary care in the community.

Service description

Many patients in Broadmoor and Ealing hospitals have long-term conditions such as diabetes and cardiovascular disease. The primary care team delivers care from health centres located on each hospital site. The multidisciplinary teams consist of:

- general practitioners
- band 8 and band 6 nurse practitioners
- dieticians
- physiotherapists
- health care assistants.

When patients enter the hospitals they are provided with a full physical health check, including an ECG, as part of the Care Programme Approach (CPA). CPAs are full assessments of a person's health needs and the plan for their care. A patient's CPA is reviewed every six months and the physical health check offered at the same time as the review. The checks involve consultations, blood tests and physical examinations and are normally carried out by practice nurses. Patients are then referred to doctors if particular health issues arise, such as development of diabetes or significant weight gain. Patients with complex mental health problems generally require much longer consultations and a very different set of skills to those required by primary care physicians in the community (*see* 'Key enablers' below).



Outside the regular health checks associated with the CPAs, the primary care teams see patients when they become ill or to support management of a long-term condition. Physical health review and treatment is provided through a number of routes:

- on admission and during CPA reviews (this ensures that all patients are included)
- referral to dedicated clinics for long-term condition (eg, diabetes, asthma, COPD, podiatry)
- referral for GP medication reviews for long-term conditions
- referral from ward team for acute conditions
- self-referral (by patients).

The ethos of the service is that access to care should be equivalent to or better than that available to the wider community. This includes ensuring access to a dietician, physiotherapy, podiatry, dental and diabetic services.

A multidisciplinary team meets weekly at both sites. During these meetings, team members discuss the patients they are concerned about and reach a shared decision about how best to support those patients. Interventions can include changes in diet, exercise regimes or medications, or referral to healthy eating groups run in the hospital. In addition to this, a 'Red Team meeting' is held every six weeks to review the needs of patients with raised risk for cardiovascular disease (this team comprises a GP, practice nurses, occupational therapists, the sports and exercise team, and a dietician).

Outcomes

The teams are held to the same quality standards as other GPs would be under the Quality and Outcomes Framework (QOF). (They are not, however, provided with financial incentives like other practices because they are employed by the trust and the primary care service is funded through the trust's block contract.) The team reported that the outcomes achieved on several measures are comparable or better than those achieved by patients in the community. For example, forthcoming research based on results from Ealing and Broadmoor will show significantly better control of blood glucose levels among this population than among patients with diabetes in the community. The incidence of COPD has also fallen compared with levels in the community, facilitated by the move to become a smoke-free trust in 2008.



Key enablers

- The trust agreed a single overall outcome that the primary care service is trying to achieve: that physical health outcomes would be the same in Broadmoor and Ealing as would be expected in the community. The design of the service and the clinical governance structures flow from this single outcome, with the primary care team reporting on the same outcomes as measured in the QOF, as compared to the results achieved in local communities.
- Well-managed multidisciplinary team meetings are key to making this model of care effective. This meant having a clear agenda, clear and effective chairing practices, a patient focus, constant review and implementation of best practice guidelines, and thorough investigation of all options for care.
- The stability of the patient population was also reported to be important. Patients stay in Broadmoor and Ealing for five to six years on average. The model of care would be less appropriate for facilities with a higher turnover.
- Experts skilled in motivational interviewing were brought in to train the GPs and nurses working in the primary care teams to understand how to encourage behavioural change more effectively.
- The trust installed a clinical information system similar to those usually found in general practice. Specific technical features have enabled more proactive care and management of long-term conditions – particularly being able to recall and display previous results, providing the right prompts and reminders for action, and offering appropriate clinical decision-support. On top of this, the systems are configured so that data capture and tracking of key physical health indicators is simple, enabling the team to develop better insight into the links between mental and physical health.
- Inclusion of a CQUIN incentive payment for improving the physical health of people with severe mental illness in the NHS standard contract for 2015/16 has meant that the trust is better remunerated for work in this area, and has helped to raise awareness within the trust of the physical health needs of their service users.

Further information

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Appendix I: Physical health liaison service in Highgate mental health unit

Overview

Whereas mental health liaison services in physical health settings are increasingly widespread, it is rarer to have physical health liaison services in mental health settings. In Highgate, north London, a physical health liaison service has been established whereby consultants from a range of specialties from Whittington Health NHS Trust provide weekly physical health clinics within the secure mental health unit at Highgate hospital, which is part of Camden and Islington NHS Foundation Trust. This service allows patients to receive regular, specialist care for physical health conditions within the boundaries of the mental health hospital, saving time and distress that can occur in a formal transfer from one provider to the other.

Service description

Patients at the secure mental health site in Highgate have a range of severe mental illnesses and 70 per cent of them are detained under the Mental Health Act. Data from the service suggests that many patients have long-term physical conditions affecting their health and wellbeing; for some, the specialist treatment they receive through the physical liaison clinic is the first specialist treatment they will have received for their physical condition(s).

Because a large number of patients at the Highgate site are there for extended periods, they can receive regular check-ups for their physical conditions through a weekly physical health clinic held on-site. The clinics rotate by specialty each week (specialties include diabetes, respiratory, cardiology and general old age) and are delivered by five consultants (one each week) from the Whittington Hospital. At the clinics, the consultant meets with the patient and there is a request that junior mental health doctors and specialist mental health nurses also attend. This enables the physical and mental health practitioners to educate and learn from one another.

Another service that Camden and Islington commissions from the Whittington is a telephone advice line. The junior mental health doctors at Highgate have a telephone number with direct access to the hospital's consultant general physicians. This allows staff to call to get advice on physical health conditions from a specialist instead of calling for an ambulance or immediately referring the patients to an outpatient



clinic. This service enables conversations between specialists in separate areas to help manage patients that have multiple health needs.

Outcomes

The service was relatively new at the time of writing and further evaluation is needed. Survey data collected pre- and post-implementation indicates that in the view of mental health staff at the facility, there has been a significant improvement in the standard of care for physical health since the introduction of the service. The physical health consultants from the Whittington Hospital reported high satisfaction with the joint consultations with service users and mental health staff. This collaboration and up-skilling was seen as one of the main benefits of the service from their perspective.

Key enablers

- The enthusiasm and influence of senior physical health consultants helped to embed and implement the service.
- Staff from both sites felt that the current set-up of services – where they were each in their own ‘silo’ – was not conducive to integrated, co-ordinated care, and as a result there has been an appetite to challenge these barriers.
- Joint consultations are reported to have been highly beneficial and provide two-way learning, from mental health to physical health and vice versa. They help to share different consultation methods, information about prescriptions and medications, and what to look for when monitoring physical and mental health.

Further information

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Appendix J: Integrated perinatal mental health service in Devon

Overview

The Devon and Torbay Perinatal Health Team provides mental health care and advice to women using maternity services at the Royal Devon and Exeter Hospital, Torbay Hospital and North Devon District Hospital. The team is provided by Devon Partnership NHS Trust and is fully integrated with maternity services at the three hospitals, allowing pregnant women to access mental health care in the same clinic, to the same standards and with the same methodical pathways as physical health care. It also provides community perinatal mental health services, ensuring that women who need the service (and their families) are supported throughout pregnancy and the first postnatal year, in their homes where possible.

Service description

The team is led by a consultant perinatal psychiatrist and clinical team leader, and comprises clinical nurse specialists, occupational therapists, social workers and administrative support.

All midwives in the area complete mandatory training delivered by members of the perinatal team. The training is tailored to midwifery practice and covers identification and treatment of common mental health problems, mental health emergencies, principles of the recovery model, and addressing stigma and negative attitudes. A mixture of academic content, lived experience, quizzes, films, and question and answer (Q&A) sessions are used. It is now routine for midwives to ask all women about mental health during pregnancy. Women who are at risk or who indicate they have concerns about their mental health are referred to the team. The team aims to be proactive and offer preventive care, providing a service to anyone with concerns about their mental health – wherever possible intervening early before problems escalate.

The team offers a wide range of interventions, including pharmacological interventions and psychological techniques such as compassionate mind, mindfulness, CBT and dialectical behavioural therapy, and interventions around parent-infant issues. Some of these are provided ‘in house’, others are available



from connected teams such as psychological therapy, IAPT and the Parent-Infant Psychotherapy team, with whom the Perinatal Health Team work closely.

The first tier of support, offered to all women in touch with the service, includes evidence-based advice, reassurance, information, and signposting to sources of support in the local area. People with higher levels of need are offered a full assessment and a range of psychological and drug treatments as appropriate. The most serious cases are held within specialist care. Over three years, a quarter of all the women who gave birth in the area were identified as having a mental health concern or history and received information, assessment and/or support from the team.

Women can see the team in their normal antenatal clinic or at home, avoiding the need to visit a mental health unit. This makes the service more accessible and reduces stigma.

Outcomes

Local commissioners report that the service has helped to reduce costs, and has led to better outcomes for women and their families. Fewer women have escalated to more expensive forms of care such as admission to mental health inpatient facilities.

Key enablers

- The team has built strong relationships with colleagues from primary care, health visiting, children's centres, midwifery, paediatrics and obstetrics, and has delivered training to clinicians from all of these disciplines. Interest and awareness of maternal mental health has improved and women report receiving greater support and advice as a result.
- Commissioners at South Devon and Torbay CCG and Northern, Eastern and Western Devon CCG are highly engaged with the service, and it is supported by key clinical leaders in local provider organisations.
- Women and families who have used the service work closely with the team to provide training, and can become involved in the service in numerous ways:



eg, interviewing for new staff, writing business cases, sitting on national bodies (such as the Clinical Reference Group (CRG) for Perinatal Mental Health and the Maternal Mental Health Alliance), and engaging in arts projects that address perinatal mental health issues (they have put together a short film, Head Up Heart Strong, and a play, Friction).

Further information

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The King's Fund is an independent charity working to improve health and care in England. We help to shape policy and practice through research and analysis; develop individuals, teams and organisations; promote understanding of the health and social care system; and bring people together to learn, share knowledge and debate. Our vision is that the best possible care is available to all.

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People's physical and mental health needs have traditionally been treated as two separate issues. Services are typically provided by different organisations and staff groups, in different locations, with different financial and contracting arrangements, and different forms of performance monitoring and system oversight.

Efforts to promote integrated care have so far focused on bridging the gaps between health and social care, or between primary and secondary care. But the *NHS five year forward view* has emphasised the importance of a third dimension for integration.

Bringing together physical and mental health presents a compelling case for that third dimension. Based on focus groups and interviews with service users, clinicians and managers, it explores what a 'whole- person' approach towards physical and mental health would look like from a service user's perspective. Reviewing existing service innovations, it explores 10 areas where most progress could be made.

The report highlights four major challenges:

- high rates of mental health conditions among people with long-term physical health problems
- poor management of medically unexplained symptoms
- reduced life expectancy among people with the most severe forms of mental illness, largely attributable to poor physical health
- limited support for the wider psychological aspects of physical health and illness.

Together, these issues increase the cost of providing services, perpetuate inequalities in health outcomes and mean that care is less effective than it could be.

There is much that commissioners, providers and health professionals can do within existing structures to ensure that integrated care for physical and mental health becomes a reality. The report argues that parity of esteem should mean more than mental health care being 'as good as' physical health care – it should also involve delivering services 'as part of' an integrated approach to health.

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