Integrating physical and mental health

Chris Drinkwater and Brian Fisher argue that integrating mental and physical health services and promoting mental wellbeing makes sense for people, populations and the public purse

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If the NHS is to become a patient-centred service that supports and enables people and populations to take better care of themselves then it needs to integrate physical and mental health both at the individual level and in terms of services for physical and mental health. The recent DH document No Health without Mental Health is a good starting point, as is the Marmot Review, Better Health, Fairer Health, which focuses on the causes of the causes of ill health that underpin inequalities in health with much of this attributed to low self-esteem and feelings of powerlessness.

The link between mental and physical health manifests itself in many ways. There are, for example, the people with short and long term mental illnesses who die early from physical health problems such as heart disease and diabetes. There are people with long term physical health problems whose high use of services reflects psychological and social issues rather than the objective severity of their physical condition.

Then there are the people who are shunted around healthcare services with medically unexplained symptoms or with borderline personality disorders and who fall between the cracks of rigidly defined referral criteria.

Yes, primary care needs to consider how to deal more effectively with people who present with medically unexplained symptoms, perhaps through use of cognitive behavioural therapy and re-attrition techniques. Yes, we need to see closer integration between mental health services and primary care. But we also need to build on the growing body of evidence that a sense of psychological wellbeing is positively associated with better health outcomes. The challenge for CCGs and their member practices is to translate this into a new approach to mental health that focuses on promoting positive and more preventive approaches for mental health and wellbeing across populations.

A five-step approach both to what individuals can do to improve their wellbeing and to how services can be re-designed seems to be the most favoured approach. The five steps for individual mental wellbeing are dealing with stress, anxiety and depression are:

Connect. Connect with the people around you: your family, friends, colleagues and neighbours. Spend time developing these relationships. Learn more in Connect for mental wellbeing.

Be active. You don’t have to go to the gym. Take a walk, go cycling or play a game of football. Find the activity that you enjoy, and make it a part of your life. Learn more in Get active for mental wellbeing.

Keep learning. Learning new skills can give you a sense of achievement and a new confidence. So why not sign up for that cooking course, start learning to play a musical instrument, or figure out how to fix your bike? Find out more in Learn for mental wellbeing.

Give to others. Even the smallest act can count, whether it’s a smile, a thank you or a kind word. Larger acts, such as volunteering at your local community centre, can improve your mental wellbeing and help you build new social networks. Learn more in Give for mental wellbeing.

Take notice. Be more aware of the present moment, including your feelings and thoughts, your body and the world around you. Some people call this awareness “mindfulness” and it can positively change the way you feel about life and how you approach challenges. Learn more in Awareness for mental wellbeing.

This is not just about the individual. The NHS as a whole can promote these approaches, for instance, by harnessing community development to build stronger and deeper connections between people.

The stepped approach to provision supported by the NHS Confederation and adopted by Sandwell and West Birmingham CCG starts with better provision of self-help information and education in community settings and ends with centralised specialist mental illness services. The steps in between progress from guided self-help and triage in community settings, through low intensity one-to-one support including IAPT, high intensity support and psychological interventions for people with long term conditions to integrated mental health teams and liaison psychiatry. The advantage of this framework is that it inverts the current...
focus on high dependency specialist needs for the few, with more of a focus on population wellbeing, prevention and primary care. Importantly, it also fosters an integrated whole systems approach to what needs to be available at the various steps, at the same time as it forces clarity about the flow across the interfaces.

One of the main learning points identified by the Sandwell team is the continuing difficulty of addressing the interface between primary care and specialist services. Psychiatry, like community paediatrics and care of the elderly, is one of the specialties where liaison with general practice is particularly important. It doesn’t happen on a systematic basis because of a combination of structural, managerial and cultural problems. Liaison activities are not usually built into consultant contracts and not seen as a productive use of time. This then tends to widen the cultural gulf between generalists and specialists with professionals each side feeling they are left to manage problems that should not be their responsibility without additional support. The challenge for cost-effective service re-design is to ensure that general practice is seen as part of the wider team for managing mental health issues within a defined population. This will mean that liaison, training and support as well as seeing patients should become part of the role and responsibilities of a consultant psychiatrist. We also need to make liaison psychiatry a more respected part of the profession with a better career prospects and more long-term relationship with patients.

The Sandwell team report improved access to community mental health and wellbeing services and to talking therapies producing hypothetical savings of £1.4 million. Effective liaison psychiatry between GPs and specialists might produce even more dramatic cost savings. A recent report on the Rapid Assessment and Discharge Team (RAID) operating in the A&E Department at City Hospital, Birmingham identified accrued cost savings of £3.5 million in a year through early discharge and fewer re-admissions. The rationale for this service was based on figures that showed an estimated 28% of acute hospital inpatients have diagnosable psychiatric disorders and that 72% of frequent attenders at A&E have a significant mental health problem. Interestingly these figures almost exactly parallel figures that show that mental illness accounts for around a quarter to a third of all GP appointments with this figure rising significantly for frequent attenders.

As the Sandwell team and others are starting to demonstrate the solution is about looking at the psycho-social context of mental health where a social prescription for wellbeing activities may be more important than a pharmaceutical prescription.

Weblinks: all weblinks for the fine steps to mental well being can be found at www.nhs.uk under the Moodzone tag.