mental health foundation

Crossing Boundaries

Improving integrated care for people with mental health problems

Final Inquiry report
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Summary

This report sets out the findings from the Mental Health Foundation's Inquiry into integrated health care for people with mental health problems. The Inquiry ran from April 2012 to June 2013. Its aim was to identify good practice, generate discussion, and draw up key messages on integrated healthcare for people with mental health problems.

Methodology

The work involved

- a literature search on integrated health care and mental health care
- three expert seminars attended by a total of 31 people
- a call for evidence on how better to integrate care, leading to over 1,200 responses.

Background

Since the founding of the NHS in 1948, physical care and mental health care have largely been disconnected within delivery of healthcare services across the UK, leading to accusations that services operate in silos, and that people's overall health care needs are often ignored. Throughout this time there has been an understanding of the benefits of integrating care across boundaries (eg health, social care, employment, housing), and today there is universal support in principle for better integrated health care across the UK. However good integrated care for people with mental health needs remains the exception rather than the rule.

What we found

A new way of thinking about health

The way that we support people with mental health problems is based on a flawed paradigm. It assumes that physical and mental health are fundamentally different (albeit each having some impact on the other), requiring different specialist approaches, and ignores the common factors in the global determination of health and illness, which have biological, psychological and, in particular, social components.

To achieve integrated healthcare, policy-makers, service planners and commissioners need to better understand the indivisibility and unitary nature of physical and mental health, which means that distinguishing between them is likely to lead to an incomplete response to people's needs as well as flawed thinking about mental health. In addition, they should focus on major social and structural influences such as education, unemployment, housing, poverty and discrimination, rather than just on support given to individuals based on a medical diagnosis of mental illness. Such support can clearly have a positive effect but may be limited in the extent to which it can improve health by mitigating adverse social factors.

Improving integrated care in current systems

In terms of how current care provision can be better integrated, the Inquiry identified two underpinning essentials:

- having the right people in the organisation – both leaders who will drive forward integration at a strategic level agenda and staff who understand and respect the roles and responsibilities of other professions and are willing to work with patients and across organisational and professional boundaries
- cross-boundary inter-professional training and education – there is a pressing need for more interprofessional education and training on mental health, both in terms of its genesis and indivisibility with physical health. This must be ongoing with continuing professional development.

The Inquiry found a good deal of agreement about the barriers to effective integrated care and the conditions that need to be met for effective integrated care. This suggests that failure to provide integrated care is not a failure of understanding what needs to be done, it is more a failure of actually implementing good practice in organisational strategies and the day to day business of organisations and staff.

It was also clear that while integration within and between health and social care was vital, the provision of fully integrated services to people with mental health needs goes further, into many other aspects of people's lives such as education, work, housing and leisure, and individual lifestyles. Commissioners and providers of services must ensure that there is a wide range of services available to people to help them establish and maintain healthy lifestyles. Staff across a range

organisations with which people with mental health needs have daily contact need to be offered mental health awareness training to ensure that there is an informed and integrated response to people's needs.

Factors that facilitate good integrated care

Based on the evidence it considered, the Inquiry highlighted nine factors that impacted on the provision of good integrated care for people with mental health needs.

1 Information-sharing systems

To support the effective day-to-day provision of integrated care to people with mental health problems a compatible information system within and across different organisations is essential. This system would establish individual electronic records of patients' integrated health and social care needs and interventions. It would also have the facility to record information about education, housing, welfare benefits and employment status, identifying specific occupational health needs. The information system would also require the ability to anonymise and aggregate health and social care records to inform a needs assessment of the local population, and hence local joint and multi-agency commissioning plans. In addition, further technological development and trialling in the field of IT use in health care could lead to significant improvements in integrated care for patients, and research in this area should be prioritised.

2 Shared protocols

Shared protocols between two or more organisations, or parts of an organisation, set out the responsibilities of each in delivering an agreed service and/or outcome. Although care needs to be taken to ensure staff 'buy-in' to shared protocols, where they have been established the evidence suggests they work well. We commend the development of shared protocols within and across the range of statutory, independent and voluntary organisations that support people with mental health problems.

3 Joint funding and commissioning

Separate funding streams hinder integrated care, while pooled funding, and services commissioned across boundaries, increase the likelihood of patients receive better care. Combining health, social care and other (eg education) budgets at a local commissioning level provides the opportunity to mirror the service delivery requirements of people who need a single coordinated approach to manage their mental health condition. Commissioners need to be aware that the support people with mental health needs want extends beyond traditional health and social care interventions, to help with issues related to lifestyle choices such as exercise and smoking.

4 Co-located services

The co-location of primary care and specialist mental health staff was strongly supported in the evidence submitted to the Inquiry, and could bring significant benefits to patients in terms of a better integrated response to their needs – so long as the staff understand their respective roles and responsibilities and work willingly and collaboratively together. We are not convinced that the merging of organisations involved in providing different aspects of care to people with mental health needs would in itself improve that care.

5 Multidisciplinary teams

Despite evidence that multidisciplinary care was not always effectively implemented, for example within Community Mental Health Teams (CMHTs) and through the care programme approach (CPA), we felt that there was a good reason why such models had survived for so many years as an integrated response to people's needs. We believe improvements in how these models work could be effected by the better interprofessional education and training of staff working within multidisciplinary teams, as advocated in this report.

6 Liaison services

The message from the evidence on liaison services is clear. There are significant benefits to establishing both psychiatric liaison services in physical health care settings, and physical care liaison services in mental health settings. Commissioners need to be better aware of the evidence for such services, the improvements to integrated patient care and the cost savings that can be made.

7 Navigators

Although we would not be prescriptive about the details, we strongly support the principle of a single named individual who can help people navigate their way through complex systems across health, social care, housing, employment and education (among other services) and help to pull together integrated care packages. In our view this would go a long way to ensuring that people received effective integrated care. We would suggest that the piloting and evaluation of such a role should be a research priority.

8 Research

We consider the existing evidence base on integrated care strong enough for immediate action to be taken to improve integrated care for people with mental health needs, along the lines we have suggested in this report. However we would argue for more research into how best to support people with complex, co-morbid needs, which should include economic assessments of different models and approaches to integrated care.

9 Reduction of stigma

A public and a healthcare workforce that are better informed about health and mental health issues would help to create an environment in which a truly integrated response to poor mental health could be established. On top of continuing public mental health awareness work, both primary and secondary schools need to ensure that emotional and mental health issues are fully integrated in what children are taught about health and healthy living in the widest sense. This would mean that young adults intending to move into careers in health and social care already have the basic understanding of the indivisibility of physical and mental health, so the formal professional training on holistic and integrated care that they receive from day one will come to them quite naturally. By itself, though, this is not enough. There is a small, but good, evidence base suggesting that interpersonal contact involving people with mental health problems can reduce stigmatising attitudes and behaviour. We need to undertake more research into this approach.

In addition, diagnostic overshadowing among mental health patients can be dangerously discriminatory and needs to be addressed through staff training and education. There are also occasions when stigma and discrimination need to be tackled by legislation, such as through the Equality Act 2010 and crime and disorder legislation.

Conclusion

There are a number of structural and organisational arrangements that can help to establish effective integrated care for people with mental health needs. Among the most important are having effective information-sharing systems (ideally integrated IT systems within and across different organisations involved in care, and individual electronic patient care records), the ability to pool funds from different funding streams into a single integrated care budget, and shared protocols and partnership agreements.

However while these are all helpful, the key message from our Inquiry is that it is the quality of people involved that makes or breaks integrated care – leaders with a determination to drive forward integrated care at an organisational level as a way of improving patients' experience and outcomes, and staff who understand the holistic nature of health care and have no professional defensiveness about working closely with colleagues in other disciplines, and with patients and families.

The future of effective integrated care therefore lies primarily in recruiting, maintaining and developing a workforce, both in health and social care, and in other organisations who have contact with people with mental health needs, that is passionate and committed to the principles and practice of holistic care and partnership working.

Aim of the Inquiry

The Inquiry ran from April 2012 to June 2013. Its aim was to identify good practice, generate discussion, and draw up key messages on integrated health care for people with mental health problems.

Methodology

The work involved

- a literature search on integrated health care and mental health care
- three expert seminars attended by a total of 31 people, with discussion based on a paper outlining the challenges to integrated mental health care and parity of esteem between physical health and mental health
- a call for evidence on how better to integrate care, leading to over 1,200 responses from members of the Foundation's Policy Panel and other mental health service users, carers and health professionals responding to the question posed in our Future of Mental Health Services (FOMHS) Inquiry: "How can better integration of physical and mental health be achieved in the future?" We quote extensively in this report from these two sources.

Definition of integrated healthcare

There is no single agreed definition of the term 'integrated healthcare', or 'integrated care'.

The World Health Organisation (2008) states

> Integrated service delivery is "the organization and management of health services so that people get the care they need, when they need it, in ways that are user-friendly, achieve the desired results and provide value for money".

The Department of Health in England (Department of Health, 2011) suggests integrated care is when both health and social care services work together to ensure individuals get the right treatment and care that they need, that help them to remain in control and live independent lives.

> "[Integrated care] is most commonly used to express a very practical desire to make sure separate specialist healthcare services work closely together to ensure all a patient's needs are met. This might mean providing a person with a single diagnosed disorder, such as heart disease, with both clinical cardiac care alongside smoking cessation advice and home support by social care staff. Or it could mean that a patient with co-morbid problems, such as chronic depression and asthma, gets co-ordinated specialist support for both their mental health and physical health problem. In terms of a patient's care pathway, it can mean better integrating primary care and secondary care services so that a patient has a smooth care journey that helps them recover from an illness".

Goodwin et al (2012) suggest that integrated care "can be defined as an approach that seeks to improve the quality of care for individual patients, service users and carers by ensuring that services are well co-ordinated around their needs". This involves "overcoming barriers between primary and secondary care, physical and mental health, and health and social care to provide the right care at the right time in the right place".

In a briefing paper on integration and mental health for the Integrated Care Network (ICN), which sets out the policy context for mental health and examines challenges and opportunities of integration, Appleton (2009) suggests:

> "Integration describes the coordinated commissioning and delivery of services and support to individuals in a way that enables them to maximise their independence, health and wellbeing. Coordination of this type is especially important for people with mental health problems who often require support from a variety of organisations or individual care workers. The delivery of integrated care is influenced by the practice of staff, the systems they work within, how users are engaged and the structure of organisations."

Integrated care might also be considered to simplify the delivery of "shared care", as described by Lester (2005) in a paper giving a GP's perspective on health care for people with a mental illness:

> "Shared care enables a 'best of both worlds' scenario, with the opportunity to provide good-quality holistic care. Shared care should lead to pooling of expertise and enhanced creativity in problem-solving. It should also lessen the possibility that vulnerable patients are 'left in limbo', with patients and carers feeling that they are failing to make progress through the mental health system….. Shared care also offers opportunities for addressing long-standing issues regarding the morbidity and mortality of people with serious mental illness".

Background

Since the founding of the NHS in 1948, physical care and mental health care have largely been disconnected within delivery of healthcare services across the UK, leading to accusations that services operate in silos, and that people's overall healthcare needs are often ignored. However the issue of integrated healthcare for people with mental health needs is hardly new. In its first report on the operation of the NHS nearly 65 years ago, the then Ministry of Health reported positively on developments in mental health care, including the establishment and expansion of community out-patient care (Ministry of Health, 1950). The report highlighted the environmental factors that impacted on people's mental health, making it clear that a range of services outside the newly-formed NHS had a role to play in addressing mental health needs:

> "In the Child Guidance Clinic the part played by the parents at home in causing the maladjustment of the child leads to attempts to improve the milieu in which the child lives. In the adult clinic the effect of unsuitable working conditions leads to the interest in vocational guidance and personnel selection, [and the] effect of the domestic situation leads to interest in problems of housing, divorce, delinquency and so on. That this process is proceeding rapidly is shown by contemporary legislation. The Disabled Persons Act places upon the Ministry of Labour responsibility for helping persons suffering from mental as well as physical disabilities to obtain paid employment; the Criminal Justice Act increases the facilities for recognition and treatment of mental disorders among offenders".

Fast-forward some 30 years to 1979, and the issue of the shared involvement of different services in providing support to people with mental health problems was the subject of a collection of essays looking at various aspects of what were, at that time, "new methods of mental health care" (Mental Health Foundation, 1979). The essays ranged across many areas that are familiar to us today. These included shared involvement at a personal level between members of a multidisciplinary team; various ways of sharing facilities or resources; joint care planning between health and social services to make the most effective use of resources available to the mentally ill; joint financing and formally shared responsibility.

The essays also raised some of the barriers facing integrated care - effective collaboration being undermined by a lack of clarity as to who carries prime responsibility at any time; the challenges of professions working together; the relocation of specialist services in local settings; the right organisational links between social work, multi-professional health teams and primary care services.

It is perhaps sobering that a key message about the importance of having the right staff attitudes towards integrated care - an issue also central to today's debate - was part of the debate in these essays nearly 35 years ago:

> "One of the most important changes often needed is in the personal attitudes of the staff concerned, and formal educative or re-educative programmes may have particular relevance…. Whatever the formal links or arrangements between health and social services, in a district psychiatric service personal acquaintance and contact between individuals are essential ingredients, and efforts must be made in both services to facilitate these."

Move 15 years further forward to 1995 and there are clearly still difficulties in getting the various different organisations involved in care to work effectively together. A report from the King's Fund (King's Fund Policy Institute, 1995) referred to previously stated difficulties in implementing community care:

> "In the case of mental health, the evidence and argument presented here tends to confirm that conclusion. Across community care as a whole, as with the reform of the NHS, change appears to create the need for further change, but at the same time, the long standing issue remains of how to weld together services run by different organisations and financed in different ways".

The report went on to state that the implementation of the Care Programme Approach (intended to ensure good, joined-up care for people with chronic mental health problems living in the community) had been patchy, and that there was a need for better interagency work between health, social services, housing, environment, leisure, police and education authorities.

What we have, therefore, is a 65 year history of statements of intent around better integrated care for people with mental health problems, but a situation today where good integrated care appears to be the exception rather than the norm, and where there are isolated pockets of much-lauded good practice, but overall dissatisfaction with progress made across the UK.

Two responses to our Inquiry from members of the Foundation's Policy Panel illustrate this:

"I have found that within specific mental health services, such as an Early Intervention Team and my local Community Mental Health Team, physical health is addressed quite well. The EIT attempted to link in with [X] Hospital to check whether my problems were down to a physical cause as some physical symptoms corresponded. I think that in general, the physical health problems and side effects of drugs used for mental health problems really need to be addressed usually sooner by professionals and also monitored more strictly before it becomes a problem. I feel there needs to be more emphasis on maintaining physical health in hospitals - such as frequent exercise and better nutrition. Mental and physical health are intrinsically linked, so taking proactive steps towards improving and actually utilising physical health whilst in hospital might even aid recovery. I feel in a way physical health is neglected by being confined in a hospital ward (sometimes without access to fresh air)." (Policy Panel member)

"The emphasis when addressing mental health services is on mental health illnesses and disorders, physical health does not ever get addressed. I know that a good healthy diet and exercise is important to emotional wellness but from personal experience this has never been discussed at any of my CBT sessions. Also when I was a voluntary inpatient at my local psychiatric hospital healthy living was only ever addressed in a voluntary group discussion." (Policy Panel member)

Where are we today?

There is universal support in principle for better integrated healthcare across the UK. It is seen not only as important in improving clinical outcomes for patients, and helping them to recover from both physical and mental health problems, but it is also seen as a sensible economic approach, with joined-up services saving money, for example, through addressing costly Medically Unexplained Symptoms (MUS) – aches or pains or other physical symptoms that do not appear to have an obvious cause.

In England, the Coalition Government (Department of Health et al, 2013a) has issued a joint 'shared commitment' from leading health and social care organisations that sets out how local areas can bring together local authorities, the NHS, social care providers, education, housing services, public health and others to make further steps towards integration, and "end the institutional divide between physical and mental health, primary and secondary care, and health and social care".

It has also provided new funding to assist local authorities and healthcare organisations to provide integrated care - £2.7 billion to local councils to help them join up NHS and social care services, with an extra £100 million in 2013 to 2014 and an extra £200 million in 2014 to 2015.

The Labour Party, currently in opposition, has also put its weight behind a future health system that "needs to be better integrated to deliver a 'whole-person care' approach", and has gone to public consultation on "how best we can better integrate physical health, mental health and social care" (Labour Party, 2013).

The Scottish Government has also taken a strong interest in integrated care, and the better integration of care services for people with a mental illness more specifically (Scottish Government, 2008). It has set out a series of recommendations including

- raising awareness among staff, partner organisations, service users and carers of the increased rate and poorer outcomes of common physical illnesses in people with severe mental health problems; and the provision to this group of lifestyle and other health promotion interventions

- the training and education of all who provide care and treatment to people with severe mental health problems should embrace a holistic approach, with a focus on recovery, and reflect an understanding of the inherent interactions between the mind/brain and the rest of the body.

The Welsh Government (Welsh Government, 2010) has also made it clear that for people with mental health problems "Care and treatment will be holistic - holistic care and treatment addresses the medical, psychological, social, physical and spiritual needs of people accessing mental health services". And in its response to the Bamford Review of mental health and learning disability in Northern Ireland, the Northern Ireland Department of Health, Social Services and Public Safety (2009) states its ambition to "Strengthen the integration of health and social care, enhance health and wellbeing, promote evidence – informed practice, focus on safe and effective care and enhance multidisciplinary and inter-sectoral working".

This political thrust is echoed by health professionals. The Royal College of Psychiatrists' paper on achieving parity between mental health and physical health (Royal College of Psychiatrists, 2013) sees integration of mental, physical and social care as an essential feature of a health system that expects to reduce inequalities in health care and provide the best possible support to individuals:

> "Planning for integration - this requires movement away from mental health, physical health and social care 'silos'; the consideration of mental health should be integral to all health and social care, at any point where someone with a mental or physical health problem comes into contact with a service…. Generic health and social care policy, planning and services will integrate mental health from the outset."

The Royal College of Nursing (2003) includes in its defining characteristics of nursing "people's responses may be physiological, psychological, social, cultural or spiritual, and are often a combination of all these…. The focus of nursing is the whole person and the human response rather than a particular aspect of then person or a particular pathological condition".

The Royal College of General Practitioners - representing those health professionals who are the primary 'gatekeepers' to all health care in the UK and who are best placed to provide an initial assessment of any individual's physical and mental health needs – has also stated the importance and benefits of integrated care, while noting that "implementation in the NHS is at best patchy" (Royal College of General Practitioners, 2012a).

Support has also come from influential health thinktanks, such as The King's Fund, which argues that "improving integrated care should be seen as a 'must do' priority to ensure it receives the attention needed" (Goodwin et al, 2012). The argument is not just about providing better care and support to individuals with often complex needs – it is also about making the best use of limited resources within very hard-pressed public services, and reducing the use of expensive secondary care services.

The Audit Commission (2011) has pointed out that, at a time when both the NHS and local authorities need to make significant savings, "integrated working across health and social care could offer potential, both for efficiency savings and improving outcomes for people". It encourages health and local authority partnerships to use local data and benchmark themselves against others to know what makes a difference.

The NHS Confederation's Mental Health Network also makes the business case, pointing out that at least £1 in every £8 spent on long-term conditions such as diabetes and coronary heart disease is linked to poor mental health and wellbeing, and that savings far outweigh the cost of psychological interventions (NHS Confederation, 2012).

Findings 1: a new way of thinking about health

> "The promotion of positive mental health often gets overlooked in non-mental health specialist services. During a registration appointment, for example, most GP/nurses will ask, as a matter of course, whether or not a patient smokes or how much they weigh, but not whether or not they are happy. This seems strange to me as many physical health issues (arguably) stem from poor mental health. The promotion of mental health should run throughout interventions aimed at promoting/improving and treating physical health. I suspect many healthcare professionals feel it an intrusion to ask questions about mental health and/or do not feel qualified to handle mental health issues. The distinction between 'mind' and 'body' is a false one and has been widely challenged. Yet, it continues to be deeply embedded within the structure and organisation of the NHS." (Policy Panel member)

> "A better understanding of the biopsychosocial model among ALL practitioners. This includes work to reduce the myth of biomedical dualism." (FOMHS respondent)

> "Less of a dichotomy between "this is physical health" and "this is mental health" – it isn't this simple and how services are set up can reinforce this false dichotomy." (FOMHS respondent)

> "Education of junior medical staff and medical students and common stem health care workers that Descartes was wrong!" (FOMHS respondent)

A good deal of the evidence the Inquiry looked at suggested that the way that we support people with mental health problems is based on a flawed paradigm. It assumes that physical and mental health, rather than being indivisible, are fundamentally different (albeit each having some impact on the other), requiring different specialist approaches, and ignores the common factors in the global determination of health and illness, which have biological, psychological and, in particular, social components.

There is growing evidence that the distinction

between physical and mental health is misleading and artificial. Friedli (2009) suggests that a focus on social justice and social structure and context may provide a corrective to an over-emphasis on individual pathology as the cause of poor health. She points to psychobiological studies that provide evidence of how chronic low level stress 'gets under the skin' through the neuro-endocrine, cardiovascular and immune systems, influencing hormone release (such as cortisol), cholesterol levels, blood pressure and inflammation. Hence physical and mental health do not have separate, though related, production lines - the catalysts for both physical and psychological problems are in fact identical, for example debt, poor housing, violence and crime.

The Economic and Social Research Council (ESRC, 2012), in a booklet actually called Life Gets Under Your Skin, picks up on the evidence that health and wellbeing is increasingly thought to be influenced as much by society as by biology, and that social factors can be more significant than genetic factors in predicting outcomes. In particular it emphasises the importance of family, social networks and work to psychological wellbeing.

> "We need to focus resources on the social agenda more – meaningful occupation, adequate housing and benefits, social integration etc…. I worked with countless young women who were single mothers with up to 4 children who were desperately struggling mentally, financially and emotionally; the children start to drop out of school and then the mothers drop out of mental health services because they are scared their children will be removed by social services. They then become more isolated and the children get even less help and support." (FOMHS response)

This way of thinking about health has also been relevant to discussions of about medically unexplained symptoms (MUS), where aches and pains cannot be explained. Kirmayer et al (2004) point out that patients with medically unexplained symptoms comprise from 15% to 30% of all primary care consultations, leading to expensive (an estimated £3 billion annually in England) and often ineffective responses. In fact, most patients have culturally based explanations available for their symptoms, acknowledging that stress, social conditions, and emotions have an effect on their physical condition.

> "Physical health services are often happy to run test after test on a person to seek evidence of causes, rather than sit down and listen to them for any length of time to find out what might be happening in their life. This is particularly obvious with older people. I know of someone who is getting quite bewildered by all the different appointments she has with different physical health specialists, but who just needs one of them to talk with her for an hour and listen to her worries." (Policy Panel member)

The concept of 'salutogenesis', or the generation of health, (Antonovsky, 1987) aims to move debate away from thinking about physical and mental illness as separate entities with distinct pathologies, towards a focus on peoples' resilience, resources and capacity to create overall levels of health from their early years, to last them throughout their lives. Central to this is a person's feeling of confidence that the stimuli from their internal and external environments are structured, predictable, and explicable; they have the resources available to meet the demands posed by these stimuli; and these demands are challenges worthy of investment and engagement.

A study of the impact of people and systems that adopted a salutogenic way of living (Eriksson, 2007) found that people "will not only live longer but perceive they are in good health, enjoy a better quality of life and mental wellbeing. In addition, they can stand stress better than the average and have more constructive health behaviours. Even if they become ill or get a chronic disease they will do better than the average".

In a report commissioned by the National Institute for Health and Clinical Excellence (NICE), Harrop et al (2009) look at a wide range of evidence on approaches to maintaining and generating health. They highlight a number of protective factors and processes that moderate or mediate relationships between structural disadvantage and health behaviours and outcomes. These include positive identity factors such as high self-esteem and positive ethnic or racial identity; family factors and supportive environments including structured parenting and extended kinship networks; and community factors including strong community networks fostering cultural norms which contribute positively to development and health behaviours.

> "Spending should not be on pills…. Spending needs to be on social-activist activities geared at changing the way society functions, to reduce the inequalities that create and entrench what we call mental health problems." (FOMHS respondent)

In the wider societal context, we need to develop policies that support, rather that endanger, good health, in terms of the environment people grow up, live and work in - our homes, schools, hospitals, workplaces and public spaces. Fundamentally, the things that cause poor health are largely (though not exclusively) social risks – domestic violence, childhood abuse, limited education, poor housing, unemployment, loneliness. Mental health is itself a social determinant and has an impact on people's physical health, mortality rate, life expectancy and experience of chronic diseases.

This means a view of integrated health that is not limited to health and social care, but looks at people's lives in the round. This applies to the population across the UK, but is particularly important for those who experience mental health problems given the known adverse impact on their physical and mental health of poor societal and environmental factors.

The underlying message from all this evidence is that to achieve integrated health, incorporating mental health, policy-makers and service planners need to focus on major social and structural influences such as education, unemployment, housing, poverty and discrimination, rather than just on support given to individuals based on a medical diagnosis of mental illness. Such support can clearly have a positive effect but may be limited in the extent to which it can improve health by mitigating adverse social factors.

Backing up this approach, responses from people with mental health problems to this Inquiry repeatedly called for a holistic approach to their needs, and to be treated and supported as individuals, often with a range of complex issues, not as diagnoses.

> "Recognition that physical and mental health are totally integrated within any one person and cannot be divorced from each other when considering the well-being of any individual." (Policy Panel member)

> "Change the entrenched mindset. Remove the differentiation. Take the caption, "physical and mental health" (as completely separate terms as it's meant in modern medicine) change it to "mind and body" or "wellbeing" as one term, because they are linked, inseparable and wholesome." (Policy Panel member)

And as one service provider put it to us:

> "There is an issue of whether socio-economic conditions cause poor mental health, or poor mental health affects socio-economic circumstances. But actually it doesn't matter – what you need is a system that tackles both issues. You have to get your medical interventions running alongside your psychological interventions. By addressing the more social aspects of people's lives, it is much more effective. The patients come out after x number of sessions [of a talking therapy], and they are different people." (Expert seminar participant)

The key message here is that health and social care planners, commissioners, service providers and professional groups need to better understand both the theoretical basis of health and ill-health, and the innate indivisibility of physical and mental health, which in effect means that distinguishing between them is likely to lead to an incomplete response to people's needs.

Findings 2: improving integrated care in current systems

If the evidence suggests that we need a radical shift in approach to health and mental health, and how to address mental health needs, then the Inquiry also considered a wide range of more immediate pragmatic and practical approaches to making the current health system work better for people with mental health needs.

In this section, we have identified two underpinning issues that the evidence we looked at makes absolutely clear are required for integrated care, wherever it is provided and whatever services it aims to bring together. These are

- having the right people in the organisation to drive integration, and
- cross-boundary interprofessional training and education for health and social care professionals.

Following this, we consider the evidence on existing healthcare and mental health service models that aim to encourage integrated working, the practical difficulties faced, and how they might be overcome.

The right people

National Voices, a coalition of health and social care charities in England aiming to give a voice to patients, service users, carers and their families, has two top lines for what people want from integrated care (National Voices, 2013), namely

- People want co-ordination. Not necessarily (organisational) integration.
- People want care. Where it comes from is secondary.

The single most important element in this is the relationship that patients have with the individuals and teams they are supported by:

> "The aspects of care correlating most closely with good patient experience are relational. Patients want to be listened to, to get good explanations from professionals, to have their questions answered, to share in decisions, and to be treated with empathy and compassion. These aspects are found in individual consultations and in team working. But integrated care arrangements need to be crystal clear about the roles and contact that various professionals will have with service users."

Alongside this, the Inquiry came across a strong body of literature, and a consistent view in responses it received, suggesting that having 'the right people' was an essential factor in establishing good integrated care across different disciplines and organisational boundaries.

> "Better integration can help drive positive change. But in the end this is not about systems, it's about people. It's about inspiring local leaders, dedicated and energetic staff and individuals who deserve the most integrated, personalised and empowering care and support we can offer." (National Collaboration for Integrated Care and Support, 2013)

> "[Integrated care] is an old chestnut which never seems to get any closer to coming to fruition. Managers and workers need to lose the territorial mindset and work together not endlessly drawing boundaries about what they will and won't do." (FOMHS respondent)

> "Relationships are the way in which integration occurs, not elaborate models or new ways of working. Focusing on allowing people in teams to build relationships would go a long way to enabling integration." (FOMHS respondent)

The evidence suggests that successful integrated care depends primarily on the attitudes of those who populate healthcare and other organisations, and the personal relationships between them, rather than any structural arrangement, helpful though that may be. In particular, strong leadership is commonly cited as a necessary part of any effective system of integrated care, along with the willingness of all staff to adopt a culture of collaboration and to work willingly across professional and organisational boundaries.

From a General Practitioner's perspective, Lester (2005) points out that interprofessional education and good communication are key elements of successful integrated care, alongside patient involvement:

> "This in turn is influenced by a number of other factors, including the commitment to shared care on both sides of the interface and a mutual understanding and respect for different ways of working and approaches to care. These features can be encouraged by interprofessional education, which enables practitioners to learn about each setting's strengths and weaknesses and can encourage a culture of collaboration and mutual respect…. To be successful, it requires good systems of communication and coordination, so that patients are not left in limbo at the interface; a shared vision; clarity of roles and responsibilities; and a system of accountability. The form and function of shared care, however, must be negotiated with patients."

Lester also points, out, though, that new initiatives are often championed by 'hero innovators', who may move on and seek fresh challenges. To be truly sustainable, therefore, new approaches to shared care cannot depend on single individuals: they need to be embedded in the fabric of the service. This is a point also made by the King's Fund in a report looking at integrated healthcare in Wales (King's Fund, 2012a):

> "The impact of a leader who really 'believes' in the importance of integration, and is determined to see it through, is evident in many parts of Wales. Staff at different levels in the [Local Health Boards] report the impact this can have. Although no leaders would deny the importance of integrated care, some have clearly made it a higher priority than others. This is an inherently fragile arrangement, however, and progress on integration in parts of Wales would be jeopardised if a few key individuals were to change jobs".

The authors refer to the potential of using the 10 Essential Shared Capabilities as a learning tool for all staff who work in mental health services, the first of these capabilities being perhaps the most relevant here – 'Working in Partnership'.

The importance of strong leadership in effective integrated care has been researched specifically in relation to mental health crisis resolution teams (Alimo-Metcalfe et al, 2007). Community psychiatric nurses (CPNs) are the main professional group in teams, but teams also include support workers, recovery workers, medical staff (including psychiatrists) and social workers. The evidence from this longitudinal study is that the key to successful crisis resolution teams is how staff across various disciplines are treated. Degree of engagement with others emerges as the best predictor, not just of staff attitudes and well-being, but also of organisational performance. However external factors such as high caseloads can have a profound effect, not only on staff morale, but also on the achievement of desired outcomes. The message here is again that people and their relationships are crucial to well integrated care, rather than the structures people are working in - although clearly some structures are more helpful to integration than others.

However if leadership is crucial to effective integration of care, a word of warning is sounded in the evaluation of the Department of Health's integrated Care Pilots in England (RAND Europe, Ernst & Young LLP, 2012), which found that the scale and complexity of delivering integrated care activities can easily overwhelm even strong leadership and competent project management. Appleton (2009) points out that NHS management culture often talks about innovation yet demonstrates a fundamentally permission based and risk averse approach to service developments; and differing organisational cultures across health, social care and the third sector conspire to create boundaries to effective joint working. More positively, the King's Fund (2013a) suggests that there has been progress in some areas in Scotland and Wales, primarily based on relatively small number of people occupying senior leadership posts, which facilitates brokerage between services.

The Royal College of Psychiatrists' report on parity of esteem (Royal College of Psychiatrists, 2013) makes a range of specific recommendations aimed at more closely linking physical and mental health care. These mention the need for leaders in integrated care, and include that "all providers of specialist mental health services should have someone at board level who leads for physical health, and all providers of physical healthcare should have a board member who leads for mental health".

One suggestion made during the Inquiry seminars was for clear, accountable leadership in England through a Clinical Commissioning Group / local authority 'mental health tsar' in each area - a joint board level appointment, supported by a team including public health expertise, data analysis, research and mental health expertise including expertise in service user involvement.

This 'tsar' would be responsible for monitoring the overall quality of services commissioned and provided for people with mental health problems as well as for public mental health/mental health promotion within the area. He or she would set and monitor targets such as employment rates for people with mental health problems. He or she would also be a focus for cultural change in local service by leading initiatives such as quality improvement programmes and learning sets for staff across different disciplines. These would focus on issues such as supporting people with mental health problems to obtain and maintain employment.

Whether or not this particular model could successfully be implemented and adapted across the UK, we considered that the intent was good – to have a single named person responsible at a senior level in each organisation for promoting and integrated care systems for people with mental health needs.

Other staff

If leadership is crucial for effective integrated care, so also is the commitment of managers and staff providing frontline services to individuals.

> "I had an incident where as a patient in a NHS clinic for a physical complaint I was 'reprimanded' by the nurse treating me at the time when she saw scars on my arm from self harming. I did not feel it was appropriate for this nurse to comment on my scars or indeed order me to not do it again! I was treated like some naughty schoolgirl and it made me feel belittled and disappointed that as a trained professional this nurse did not understand the illness of self harm." (Policy Panel member)

> "We have 'beacons' and people who are interested [in integrated health], but there have always been beacons. In order to properly integrate care you have to somehow find a way for those beacons to ignite the people who have so far proved to be asbestos clad." (Expert seminar participant)

The Social Care Institute for Excellence (SCIE, 2011), in a paper looking at factors that promote and hinder joint and integrated working between health and social care services, concluded that securing the understanding and commitment of staff to the aims and desired outcomes of new partnerships is crucial to the success of joint working, particularly among health professionals.

The Inquiry noted that the National Development Team for Inclusion's guide on paths to personalisation in mental health (NDTi, 2013) calls for staff to be "clear about the need for willingness and openness to cross professional boundaries and act and collaborate beyond specialisms to solve problems together and achieve the right outcomes for people (rather than passing people around the system)".

Baguely et al (2007) look at the issue of integrated care and partnership working from the perspective of acute inpatient care, and suggest ways that cultural obstacles surrounding the traditional perceptions of the role and responsibilities of staff, and in particular psychiatrists, must be overcome, and better working with community services and staff established:

> "The delivery of effective person centred care requires support for system change from all acute inpatient staff. It is not enough for psychiatrists to embrace change in the ways in which they practice and manage their work. Role changes must also extend to other disciplines and this involves a move away from traditional models of tasks and responsibilities….. This may involve blurring of professional boundaries, which needs to be managed effectively through teamwork and clinical supervision…. This requires a substantial cultural shift in the acute hospital sector and the development of a more holistic approach towards the care of the person. The complete integration of health and social issues demands a significant shift in the guiding principles and day-to-day practice of services."

General Practitioners

There was particular concern expressed during the Inquiry about the role, expertise and attitude of GPs towards people with mental health problems. GPs are the gatekeeper to most NHS services, whether in primary or secondary care, and they are probably the single most important professional group in terms of ensuring all patient needs are identified and addressed.

> "Compared to the mental health services I have used, I feel there is a very different case with GPs. I approached a GP last year with my physical health problems (disturbed periods and severe PMT) - in a good state of mental health, and these were put down to my previous mental health condition. This irritated me greatly." (Policy Panel member)

> "Overall you get the feeling doctors just don't have the time/interest to help with this unless a real insistence is made, even then you have to deal with a doctor's own prejudices. I felt that I wasn't taken seriously most of the time. We all see examples of great doctors, but the average GP leaves a lot to be desired. I wish that my doctor had tried to reach a better understanding of where I really was at, at the time. That would have required asking the right questions. As a result I am reluctant to go to my doctor for anything now, I felt embarrassed by the way I was treated." (Policy Panel member)

> "I have found, over the years, that treatment of a physical health problems is only treated seriously when I go to a doctor who I know does not look at me as a 'mental health problem'. Then I receive excellent treatment. Otherwise I am not treated seriously, or the problem is not as bad as I think." (Policy Panel member)

> "I have also urged other clients to re-visit their GP with symptoms which have been put down to 'stress' or 'grief'. One client is now being treated for cancer – previously undiagnosed. It seems that mental health issues are 'blamed' for no end of symptoms, and possibly preclude further investigation." (Policy Panel member)

We have a good deal of sympathy with GPs, who do an often difficult job and are under a good deal of pressure, not least because of the reported rise in anxiety and depression associated with the current recession. We do not expect them all to be mental health specialists. However the strength of evidence we received suggests the failure of many GPs to make holistic assessments of patients when they first come into their surgery, or to adequately understand or address the wider needs of people with mental health problems, a lack of time to spend with such patients, and a lack of knowledge about the range of appropriate responses (such as housing or employment support, or exercise options) available to signpost patients to. Better training of GPs in mental health issues was cited numerous times in responses received from our call for evidence, indicating that many people's experience of GP care had been unsatisfactory, as was a suggested requirement for them to undertake mandatory mental health rotations.

One suggestion put to the Inquiry during its seminars was that there should be a new mental health practitioner role established – a qualified professional who could undertake basic diagnostic work around the most common mental health conditions. This role would assist hard-pressed GPs by providing greater expertise, while at the same time reducing referrals to consultant-grade doctors or psychiatrists. Alongside this, the Inquiry heard about the benefits of 'dual trained' practitioners, such as Occupational Therapists (OTs), whose basic skills and expertise straddled both physical and mental health issues.

The key message from this evidence is that both within health and social services, and other organisations that may play a part in supporting people with mental health needs, such as schools and workplaces, we need a workforce that understands the benefits of integrated working and is committed to driving it forward; and that is willing both at strategic and day-to-day working level to collaborate with colleagues across organisational and professional boundaries, and with patients and their families.

Interprofessional education and training

> "Cross training of mental health and medical personnel beginning at earliest level and continuing throughout careers." (FOMHS respondent)

> "This requires some creative thinking and real leadership from GPs, psychiatrists, secondary care consultants and policy makers. It needs to start in medical school with mental health running through all medical specialties and continued through post-graduate training." (FOHMS respondent)

The Inquiry noted concerns about the specialised, silo'd training received by the current health and social care workforce, as well as the lack of awareness and fear many staff have around dealing with mental health problems. We considered that there were training, education and development needs for all health and social care professionals if truly integrated care was to become the norm for people with mental health problems. This was particularly important given the increasing number of specialist, as against generalist, staff and teams.

> "What we've ended up with is so many different exclusions and specialities. I've got 52 different teams working across my county.... 22 teams working with young people. You can't divide a young person 22 different ways!" (Expert seminar participant)

> "I think this is now happening with general and acute services.... The drive in different specialities to super-specialise has now meant that within the specialty people can't do more than their little area." (Expert seminar participant)

A good deal of the literature on integrated care talks of the need to improve interdisciplinary understanding of mental and physical health issues and educate health care professionals on the benefits of integrated, cross-boundary working. Recognising this, the Department of Health's Mandate to Health Education England (HEE) (Department of Health, 2013b), states that

> "Mental health is a matter for all health professionals and HEE should develop training programmes that will enable employers to ensure that staff have an awareness of mental health problems and how they may affect their patients. This should include an awareness of the links between patients' mental and physical health…. and the impact of co-morbidity as well as the actions they can take to ensure that patients receive appropriate support…. Training should also raise awareness of the increased likelihood of mental health problems presenting themselves in those people with long-term conditions and the need for care to address both issues concurrently."

There are two separate but related issues – the first is about teaching mental health professionals about physical care. As the Inquiry noted from the evidence that it received from patients, set out above, specialist mental health staff can be dismissive or ignorant of the physical health care needs of people under their care. This is considered to be one factor in people with a severe mental illness dying some 20 years before people who do not have such an illness. Among the responses received to the Inquiry's call for evidence were numerous requests for mental health staff to be better trained in assessing physical health care needs.

The second issue is about teaching all health professionals about mental health. The Royal College of Psychiatrists (2013) is clear on what it believes needs to be done:

> "the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) should consider how medical and nursing study and training could give greater emphasis to mental

health. This would help to improve the care and treatment provided by non-specialists to people who present with mental health problems, and to those with physical health problems who develop mental health problems. Mental and physical health should be integrated within undergraduate medical education, with an emphasis on joint placements and on engaging with service users who have comorbid physical and mental health problems."

The Inquiry noted that other professional bodies have also given their support to a holistic approach to health care. The Royal College of General Practitioners (2012a) has called for an "extension of GP training to at least four years, to provide new GPs with the confidence and skills to treat patients with a range of complex needs", and in its report 'Generalism: Why expertise in whole person medicine matters' (2012b) makes it clear that its job is to ensure that GPs have sufficient knowledge of mental health care, recommending that:

"[education] must include specific provision for training in disciplines particularly relevant in general practice, including paediatric care, learning disability, mental health, care of people with life-limiting conditions, and end-of-life care for patients and their families.... Our members and stakeholders all agreed that these should be mandatory components of basic medical training, and that they should be retained in the GP curriculum as part of generalist primary medical care commitments."

This expanded role for GPs is further expounded in the Royal College of General Practitioners' future vision for general practice (Royal College of General Practitioners, 2013), which talks of integrating generalists and specialists into 'teams without walls':

"The future GP must have time and opportunities to interact more closely with his or her specialist colleagues – who themselves will need to extend their role from the traditional hospital setting and provide expertise in a more flexible manner than the traditional, hospital-based 'outpatient' model. The future specialist will also need to develop more generalist skills and apply these to his or her everyday work – just as the future GP will need to develop greater specialist skills in areas of need for population groups in which a high degree of clinical expertise is frequently required for first-contact or continuing community-based care, including general medicine, geriatrics, mental health and paediatrics."

The Inquiry felt that a useful example was provided by the London Deanery (London Deanery, 2013), which has established an integrated care programme designed to develop models of integrated care in which professionals work together to improve care for patients – "to embed high quality clinical leadership, medical training, clinical supervision and role design within emerging integrated care systems in London."

The Deanery builds on the five principles from a Nuffield Trust paper on integrated care organisations (Lewis et al, 2010) in its argument for education and training for delivering care in integrated settings, namely

- integrated care must focus on those patients for whom current care provision is disjointed and fragmented, mainly complex patients with co-morbidities
- effective clinical leadership must exist, to promote changes in clinical behaviour
- the interaction between generalist and specialist clinicians must promote real clinical integration
- there must be integrated information systems that allow the patient's journey to be mapped across a care pathway at any moment in time. This must be linked to cost utilisation data
- financial and non-financial incentives must be aligned to provide the conditions to ensure that care delivery is of high quality and cost-effective.

A study looking at the development of protocols between primary care and specialist mental health care (Ricketts et al, 2003) highlighted the need for education and training, both in the use of protocols and in mental health more generally, especially at an early stage:

"It was suggested that increased education and training on mental health should begin at undergraduate level at medical school. A significant number of both primary care and specialist mental health care respondents did not feel that primary care staff have the skills to implement the protocols".

The Inquiry looked at the Living Better Project in Scotland, which addressed mental health and wellbeing in people living with long-term conditions (Scottish Government et al, 2011). The project found that nurses lacked confidence and skills in raising mental health with patients in primary care, and required training and learning

opportunities. The training was highly valued and evaluated, and produced positive knowledge-sharing among GPs and nurses. The report recommended that future training in managing long-term conditions or multiple morbidity should be multidisciplinary to encourage more day-to-day knowledge sharing and the review of practice organisational arrangements for managing long-term conditions.

Recruitment

While much of the above is about the need for interprofessional education and training, the Inquiry also listened to calls for "improved" and "better" recruitment - recruiting staff who have the right attitude towards people with mental health problems, and treating them as human beings rather than as mentally ill patients. The key elements of this were a willingness to collaborate (with staff colleagues and patients), compassion, and the ability to really listen to what patients were telling them. The more staff considered individuals as people, the more likely it would be that they would work together to design an integrated response to assessed needs. This is also important to address the issue of diagnostic overshadowing, where staff fail to address a physical health problem because they attribute it to the person's mental illness, with potentially dangerous consequences. We refer to this more fully when we discuss stigma later in the report.

> "If you don't have mental health problems, you can have a bad day. If you do have mental health problems, you can't have a bad day – you're relapsing! And you can't be justifiably angry, whatever the injustice – it's part of your personality disorder or mental health diagnosis!" (Expert seminar participant)

> "My friend had a major asthma attack on a mental health ward and was told she was acting up. She was later admitted to critical care for 4 days." (FOMHS respondent)

There is a pressing need for more interprofessional education and training on mental health, both in terms of its genesis and interconnectivity with physical health. Our message is that this training must be cemented into the early basic training of all health and social care staff as a matter of urgency; that all professional bodies should make such training a requirement of ongoing professional development for their members; that staff across different disciplines should have regular opportunities to exchange expertise and information, for example thorough action learning/learning sets and joint continuing professional development (CPD) events; and that people who use mental health services should be involved in the training process.

Integration across health and social care, and beyond

The Inquiry is calling for a sea-change in how health is viewed, and, through education and training, an end to the false assumption that physical and mental health are fundamentally separate things. However, we also recognise that current health and social care systems across the UK have very largely operated on that basis in the past and very largely continue to operate on that basis today.

The Inquiry therefore looked at the evidence of how, despite institutional and cultural barriers, integrated care might be successfully implemented both in today's health and social care system, and across other organisations that can help to support people with mental health problems, such as schools and workplaces.

> "The issue seems to be not so much about resources, as about recognition of the needs of people with mental health problems to have their physical health also attended to, and a will and commitment to do something about it. And then getting services to work together to provide integrated health care". (Policy Panel member)

The literature on integrated care the Inquiry looked at contains a number of summaries of barriers to integrated care, and factors that help establish integrated care. There is a good deal of duplication between these summaries and widespread agreement on some of the conditions that need to be met for effective integrated care. This suggests that failure to provide integrated care is not a failure of understanding what needs to be done, it is more a failure of organisational strategies and actually implementing good practice in the day to day business of organisations and staff.

Referring to some of the barriers, Naylor et al (2012) suggest that

> "Health and social care services in England are not currently organised in a way which supports an integrated response to the dual mental and physical health care needs of patients. The institutional and professional separation of mental and physical health care leads to fragmented approaches in which

> opportunities to improve quality and efficiency are often missed. Links between mental health professionals and primary care – where most people with mental health problems are supported – have been neglected in many areas. Increasing sub-specialisation and the decline of generalism in hospital settings can create a lack of co-ordination and oversight of patients' multiple needs."

The King's Fund (2013a) has set out a fuller list, which includes

- the medical profession often having the loudest voice
- a 'cluttered partnership landscape'
- tensions around joint working, with a dominant acute sector
- NHS and local authorities both wary of 'losing control' of resources allocated to them, lacking the appetite to pool budgets
- reluctance to share information and lack of integrated IT across systems
- professional tensions compounded by public perceptions of the differing role of health and social care professionals
- separate training and professional development of key professions such as nurses and social workers
- a reluctance to adopt good practice from elsewhere.

An additional impediment to the proper monitoring and measuring of effectiveness of integrated care is that NHS regulation focuses on individual organisational performance rather than performance across care pathways which is what patients, service users and carers experience (Appleton, 2009).

Turning to possible ways of overcoming these barriers, the Inquiry noted that the British Medical Association has listed a range of integrated care models that have been tried out in the past few years (British Medical Association, 2012). These include multidisciplinary care planning, case management, co-location, contractual arrangements, joined-up or integrated care pathways, managed clinical networks, multidisciplinary teams, shared guidance and protocols, virtual teams and virtual wards. However in terms of assisting integration, the BMA suggests that there is little or no evidence base on the impact of a number of these approaches and a variable evidence base for others. Confirming previous evidence that suggests it is people who make or break integrated care, doctors surveyed by the BMA identified the three most important enablers of success in integrating services were

- Good professional relationships
- Effective clinical leadership
- A collaborative culture (such as an ethos of shared values).

The King's Fund (Kings Fund, 2013b) cites evidence showing that highly integrated primary care systems that emphasise continuity and co-ordination of care are associated with better patient experience. Key components include:

- named care co-ordinators who act as navigators and who retain responsibility for patient care and experiences throughout the patient journey
- a focus on intermediate care, case management and support to home-based care
- joint care planning and co-ordinated assessments of care needs
- personalised health care plans and programmes
- clinical records that are shared across the multi-professional team
- a move to community-based multi-professional teams based around general practices that include generalists working alongside specialists.

Goodell et al (2011) point to a range of organisational approaches that have been adopted including single integrated care organisations providing both primary care and specialist mental health services; shared care between a primary care provider and a mental health provider with mental health staff physically embedded in primary care settings; and a care manager ensuring co-ordination of primary care and mental health care, but without physical co-location of staff.

In a collection of essays focusing on psychiatry's contract with society, Lelliot (2011) touches on the factors that influence quality of health care in addition to the physical environment in which care is given:

> "it includes the availability of workers from other disciplines essential for high-quality

care, integrated information systems, and good communication links between different elements of service and between secondary and primary care. The context also includes the extent to which administrative support is effective in ensuring efficient care processes and whether those who manage teams and services possess the leadership skills required to get the best from staff".

The Inquiry noted a report by RAND Europe, Ernst & Young LLP (2012) for the Department of Health in England covering 16 Integrated Care Pilots (ICP), some of which specifically included some mental health and dementia services. This concluded that where there had been perceived benefits, facilitators to ICP success included strong leadership and pre-existing relationships at a personal level across organisations; shared values; collective communicated vision; investment of effort in widespread staff engagement; and the provision of education and training specific to service change. Large-scale, complex integrations were a barrier to success, as were staff concerns about changes to their roles or even threat to their jobs and poor IT connectivity between systems and organisations.

The Social Care Institute for Excellence (2011) has argued that factors that promote joint working include

- involving staff in the development of integrated care policies, procedures and protocols
- providing introductory and ongoing training to establish a common goal between partners, and a clear understanding by all of the role and responsibilities of each partners involved
- flexibility in relation to work roles and the development of new integrated roles
- a previous history of strong and supportive local partnerships
- effective communication and co-ordinated leadership within multidisciplinary teams, and effective methods to share information, including shared documentation and shared or compatible IT systems
- adequate funding for the initiative
- co-location, which could lead to greater levels of informal contact increasing mutual respect and understanding
- strong management and appropriate professional support at an operational level and regular team building events to foster understanding about different professional roles and overcome professional differences.

The NIHR School for Social Research (2007) suggested that the most robust evidence of integrated effectiveness related to four different aspects of organising services: a multidisciplinary specialist team; intensive case management; specialist social work; and inter-professional training.

The Wales Health and Wellbeing Best Practice and Innovation Board (2013), drawing together its own evidence on the determinants of effective integration of health and social care to help inform service design, summarised the key determinants as:

- clarity of strength of purpose - having a shared vision, culture and values that deliver person centred services based on shared outcome frameworks
- collaborative leadership at all levels, with expert change management skills and the ability to drive cross-sectoral working
- a culture of learning and knowledge management, that seeks to support the sharing of best practice, improvement and service development across organisational and sectoral boundaries
- a supportive legislative/policy environment that seeks to create the environment within which integrated services can develop
- integrated management structures, incorporating the use of joint appointments, with unified leadership and joint governance arrangements and accountability
- Trust based interpersonal and interprofessional multidisciplinary relationships across sectors, building on the strengths and unique contribution of each partner
- appropriate resource environments and financial models seeking to ensure collaborative financial models, including the need for pooled budgets
- comparable IT and information sharing systems that facilitate ease of communication
- unified performance management systems and common assessment frameworks
- collaborative capabilities and capacities, with all

practitioners being skilled in integrated working and management.

The Inquiry also noted that Health Improvement Scotland (2007) has published a set of standards for integrated care pathways (ICPs) for mental health for adult and older adult services. Some of the specific standards echo the key messages from the literature on the issue. For example, named service leads in partnership with a named ICP co-ordinator; systems in place to enable the recording and sharing of information; a holistic assessment undertaken with the service user; a general physical health assessment (or at least health promotion and healthy lifestyle advice and the appropriate management of any physical side-effects of medication).

Beyond health and social care

Both the literature and the responses the Inquiry received from its call for evidence and during its expert seminars made it clear that providing fully integrated services to people with mental health needs goes beyond health and social care into many other aspects of people's lives. As Collins et al (2013) put it in their analysis of integration in health research, policy and practice,

> "System-wide collaboration must go beyond the health sector. The well-being of the most vulnerable of health system users, whose symptoms due to mental or physical disorders lead to persistent impairments, may be a sensitive indicator of a society's need for integrated care. Full social participation for vulnerable groups requires sustained access to jobs, schools, and other services; this requires cooperation among education, social services, labour, and justice sectors."

The Royal College of Psychiatrists' report (2013) on parity of esteem between physical and mental health argues that political and managerial leadership needs to understand that population mental health can be worsened or improved by policies for which a range of government departments are responsible, such as early years, children's social care, education, welfare reform and criminal justice systems.

There was very strong support from mental health service users and carers in particular for services that could help people to maintain a healthy lifestyle – information on diet and nutrition, advice on smoking cessation and reduction in alcohol consumption, opportunities to join in local group activities, and exercise referrals. These are clearly of immeasurable value in terms of helping people to recover from an episode of mental illness, often being seen as equally important as clinical and social care.

> "As a parent of a young person with variable mental health, the role that sport has played not only in addressing his depression but in other areas such as self-esteem, identity, a sense of belonging cannot be underestimated. As much as a CAMHS team provided support and crisis intervention, as a family the support provided by his rugby club / team / coaches has been life-saving." (FOMHS respondent)

> "My daughter suffers from bipolar disorder and does try to exercise 2-3 times a week. This has a noticeable beneficial effect, however when she has a 'low' she cannot even get out of bed so exercising to help her is not going to happen." (FOMHS respondent)

> "[Integrated care] would need a huge shift in thinking – but I'd love to be handed a gym membership with my script and my appointment schedule for talking therapy. Too many of us are medicated into submission." (FOMHS respondent)

> "Mental health facilities that are similar to a local gym. Or courses being held at leisure centre, this would make it as common a place as going for a swim or sauna, and would remove the stigma from it." (FOMHS respondent)

Clearly, there needs to be good integration of this kind of support to help people with lifestyle issues such as exercise and smoking with the formal health and social care that people are receiving from the NHS and local authorities, in order to create a full package that meets patients' needs. To a great extent, as we have already noted, this relies both on agreements between the relevant organisations and the willingness of different staff in different organisations to work in partnership and across boundaries. This is more likely to be effective if there is a wider understanding of mental health issues across society and among staff working in front line services. Many respondents to the Inquiry called for better mental health awareness training for a range of staff across frontline services including the police, prison officers, teachers and lecturers in schools and colleges, community workers, leisure services staff, housing officers and employers.

> "Mental health services need to work closely with social and medical services and the police and prison authorities." (FOMHS respondent)

> "Public education should start in schools and continue throughout further education fora and

workplace." (FOMHS respondent)

"All teachers and child care workers should be trained with a modicum of mental health awareness and training." (Policy Panel member)

The Inquiry noted that the National Development Team for Inclusion's guide on paths to personalisation in mental health (NDTi, 2013) points out that staff sometimes have trouble doing what they know is right due to the constraints of the system, but "it has always been the case that determined individuals, staff and people using services, have managed to just get on and make the right things happen" – again, people, not structures, making things work. The guide goes on to highlight the importance of partnership work within local authorities (eg across library and information services and social care services, to plan for and manage people's information needs). It also emphasises the need for an integrated approach to commissioning universal services (such as housing, transport, leisure, culture, adult learning, employment services etc) and integrated local authority and health commissioning – citing the Health and Social Care Act 2012 as paving the way for the integration of health and social care professionals into integrated mental health teams within one organisation, for a more holistic approach to mental health practice.

Over and above the main factors that help to promote integrated care for people with mental health needs – which we discuss below – there are two clear messages that we take from this evidence. First, commissioners and providers of services must ensure that there is a wide range of services available to people to help them establish and maintain healthy lifestyles. Second, staff across a range organisations which people with mental health needs have daily contact with – such as schools, courts, shopping centres and workplaces – need to be offered mental health awareness training to ensure that there is an informed and integrated response to people's needs.

Nine factors that facilitate good integrated care

Taking this evidence as a whole, the Inquiry identified nine areas where good practice can play a role in facilitating integrated care for people with a mental health problem:

1. Information-sharing systems
2. Shared protocols
3. Joint funding and commissioning
4. Co-located services
5. Multidisciplinary teams
6. Liaison services
7. Navigators
8. Research
9. Reduction of stigma

1. Information-sharing systems

"IT systems need to communicate across boundaries – at present CAMHS workers, paediatric therapies, social workers, GPs and school nurses each use different systems although we may all be involved in a child's care. This is wasteful, confusing for families and works against attempts to share skills / resources to work more effectively." (FOMHS respondent)

"The NHS must move with the times regarding electronic patient information systems." (FOMHS respondent)

"The best way to integrate both is for GPs and hospital records to be shared openly and jointly reviewed by both the patient and health professional on a regular basis. That way all the issues can be worked on together setting goals/ targets/ real and meaningful health plans with the patient at the heart of it all." (Policy Panel member)

"Shared records across primary, community and secondary care would enable each to see who is looking after what – when the person was last seen by a primary care nurse or GP, or when they last had their depression assessed or had contact by a CPN." (FOMHS respondent)

"IT systems that talk to each other and allow a chronological record of interventions." (FOMHS respondent)

"Proper centralisation of records so that we can get access to parts of each others' notes and see them." (FOMHS respondent)

"A better integrated system, with well-informed GP practices able to refer straightforwardly to and share information in both directions with a coherent NHS provision, would also be very worthwhile (and hopefully a short-term investment that would actually save money in the future)." (FOMHS respondent)

The Inquiry repeatedly heard from staff across a range of organisations about the incompatibility of IT systems. Given the often complex needs of people with mental health needs, this clearly causes difficulties in implementing good, safe, integrated care, and frustration to patients and families.

The Royal College of General Practitioners (2012a) has pointed out that the lack of efficient, effective and compatible systems for the sharing of patient information is one of the biggest barriers to the integration of care, with a big gap being the lack of a comprehensive system of shared electronic care records. This leads to "clear inefficiencies and risks to patient care". The College argues that governments across the UK should bring forward proposals to facilitate the sharing of electronic patient records as a matter of urgency. The Kings Fund (2012a) has highlighted the multiplicity of IT systems between various care partners across the UK, and pinpoints this as a significant barrier to integrated care. Hotopf et al (2012), looking at how best to support whole person care, point out that IT barriers between trusts have impacts on clinical care and call for a reduction in costly and inappropriate double entry of medical records and better communication and information flows from one trust to another.

The Inquiry noted the argument for a system-wide approach in which mental health information systems, including methods for population-level data collection on mental health outcomes and individual case-level data captured in medical records, are integrated into information systems used throughout the healthcare system (Collins et al, 2013) and that innovative approaches are needed to sharing data together with a commitment to developing shared clinical records (Goodwin et al, 2012). The Nuffield Trust (2013) points to the potential of linked data sets, including greater use of GP data to develop cohort-based techniques for tracking the care of individuals that include analysis of the quality of care, as well as estimated cost and service use.

There are issues around confidentiality that rightly need to be taken into account when sharing information. However, as stated in the South Yorkshire multi-agency mental health information sharing protocol (Sheffield Mental Health Partnership Board, 2005)

> "Keeping information secure and confidential should not be confused with keeping information secret. The appropriate sharing of personal information is essential to the provision of seamless care. Having all of the relevant information to hand aids the assessment process and enables informed decisions to be made, in discussion with the individual, about the support, care and treatment required. Numerous inquiries have shown that it is both the inappropriate withholding of, and the failure to share information between organisations and/or across professional boundaries, and with carers, that has led to adverse consequences both for others and for the individual with mental health issues."

The Inquiry's key message from this evidence is that to support the day to day provision of integrated care to people with mental health problems, and for joint local needs assessments and monitoring of care, a compatible information system within and across different organisations is essential. This system would establish individual electronic records of patients' integrated health and social care needs and interventions. It would also have the facility to record information about education, housing, welfare benefits and employment status, identifying specific occupational health needs. It would specify the patient's care coordinator, with the care provided apportioned to particular named individuals and teams, with contact details, and it would be costed to enable the commissioning of appropriate services. Training will be required to ensure all staff across different agencies are aware of what information they can share while working within the constraints of data protection legislation.

The information system would also require the ability to anonymise and aggregate health and social care records to inform a needs assessment of the local population, and hence local joint and multi-agency commissioning plans.

Better use of IT to deliver integrated care

The Inquiry looked at examples of telehealth and telecare assistive technologies that aim to facilitate integrated care and improve outcomes for people with long-term health conditions or social care needs (many of whom will have mental health problems in addition to physical health conditions). In 2006, the Department of Health announced the establishment of three pilots, known as the 'Whole System Demonstrators', to test the benefits of integrated health and social care for people with long-term physical health conditions, supported by assistive technologies like telecare and telehealth. As evaluated, the project decreased bed days by 14%, emergency admissions by 20% and led to a substantial reduction in mortality rates (Nuffield Trust, 2012).

Although there is relatively little literature on the application of telehealth and telecare specifically to mental health services compared to long-term physical health conditions,

McLaren (2003) found that 'telepsychiatry' could improve communication between primary and secondary sectors and within secondary services, although service users felt more comfortable with this format than professionals. Potential benefits of telepsychiatry were given as improved access to information; provision of care not previously deliverable; improved access to services and increasing care delivery; improved professional education; reduced health care costs; and improved knowledge about clinical communication. Drawbacks included compromised relationships between health professional and patient and between health professionals; issues around the quality of clinical information; and the need for major organisational changes in the way that health care is provided to maximise its potential.

In Wales the Inquiry noted an expectation that those responsible for regional commissioning and delivery of telecare would resolve issues such as cost to service user, and integration with community equipment services and telehealth services (Welsh Assembly Government, 2011). Mental health services are firmly embedded in Scotland's National Telehealth and Telecare Delivery Plan (Scottish Government, 2012a), which commits to "a vision where everyone is able to live longer, healthier lives at home or in a homely setting [and] integrated health and adult social care as a key policy and strategic priority". The plan notes the growing numbers of adults who have multiple long-term conditions, including mental illness, and states that telehealth and telecare developments are intended to enable safer, effective and more personalised care and deliver better outcomes for the people who use a range of health, housing, care and support services. Linking up with the Mental Health Strategy for Scotland (Scottish Government, 2012b), the aim is for telehealth and telecare to improve access to psychological therapies and specialist child and adolescent mental health services, and improve public mental health as well as delivering treatment and support services.

The Inquiry believes that further technological development and trialling in the field of IT use in health care could lead to significant improvements in integrated care for patients, and research in this area should be prioritised.

2. Shared protocols

> "More dieticians and physios in mental health – at present you can't access these staff as they work for the physical trust and there are no service level agreements." (FOMHS respondent)

The development of formal or informal shared protocols or partnership agreements to help different organisations, or even just different parts of the same organisation, to work better together is commonly cited in the literature on integrated care. This might be seen as one way of addressing the increasing fragmentation and separateness of many care providers in parts of the UK, as described by the King's Fund (2013b):

> "a lack of service coordination for individual patients and, particularly, the structural and cultural isolation of generalist from specialist medicine…. which often results in patients experiencing discontinuity of care when they are transferred from home to hospital, or vice versa."

The Inquiry noted that the Integrated Care Network, looking specifically at integrating mental health services with other parts of the health and social care system, recommended the use of formal or informal partnership agreements "to provide a framework and accountability structure that can deliver more robust and effective care" (Appleton, 2009). One example of such a protocol we have already mentioned above – the South Yorkshire multi-agency mental health information sharing protocol (Sheffield Mental Health Partnership Board, 2005). Another that the Inquiry looked at was Islington's Adult Mental Health and Children's Services Joint Working Protocol (Camden and Islington NHS Foundation Trust and Islington Children's Services, 2012).

However creating an effective shared protocol is not always a straightforward process. Ricketts et al (2003) reviewed the development of protocols between primary care and specialist mental health services, covering a range of mental disorders. Their findings suggested that protocol development required a high level of management support, a single project manager and access to a range of stakeholders. Clinicians' approval was essential, but changing clinicians' behaviour required sustained effort. Inadequate dissemination of protocols was a common barrier, as was a lack of communication between primary and secondary care, with workers in each area feeling they did not understand each other, and having different perspectives – 'territorialism' was reported as common. So, as with other evidence that the Inquiry looked at, the key appears to lie in firm leadership and the willingness of staff to work collaboratively.

Despite these problems, where protocols have been established the evidence suggests they work well. The Inquiry supports the development of shared protocols within and across the range of statutory, independent and voluntary organisations that support people with mental health problems.

3. Joint funding and commissioning

> "One budget! Community / neighbourhood central budgets rather than the constant defensiveness about accountability and financial responsibility" (FOMHS respondent)

> "Many of the barriers come from different funding streams, so there is no joint working." (FOMHS respondent)

> "Too much focus is on where funding comes from in all of the separate parts and the 'we aren't funded to do that' mentality." (FOMHS respondent)

> "There are many barriers in the way but anything that involves money is a significant problem, and may be the biggest barrier of all…. Continuing to operate different payment systems across health and social care will get in the way of true integration." (Smith, 2013)

A number of people attending our seminars pointed out that the current system in England of Payment by Results (PbR) provided few incentives for integrated care, and failed to address the comorbidity that is prevalent in large numbers of people with mental health needs. They suggested that a system of payment across an integrated care pathway would improve both the service people received and save money. Experience from the USA suggested that primary care-led, collaborative stepped care for people with long term conditions and mental health problems could be both cost-effective and cost-saving. Managing common mental disorders could have a huge beneficial impact on people's physical health conditions. It was unclear, though, whether these arrangements could be replicated in UK health systems.

A number of respondents to our call for evidence argued for geographical coterminosity between health commissioners and social care teams, to facilitate shared decision-making and pooled funding. Whilst geographical coterminosity does not necessarily guarantee good delivery of integrated care, it does at least ensure that an analysis of needs (health or social care) will apply to the same population.

The Integrated Care Network (Appleton, 2009) suggest that moving away from diagnostic models of commissioning and delivery needs a shift in thinking that requires mental health to be considered as part of the wider health and social care system, losing the "special" status it has tended to rely on. This shift in thinking is related to our call for the current segmentation of physical health and mental health to be consigned to history.

The Inquiry noted that two priorities for commissioners in England suggested by the King's Fund (2013b) were developing a more integrated response to people with both mental and physical health problems, in particular supporting people with common mental health problems (such as depression or anxiety) alongside a physical long-term condition, and commissioning care that is "more co-ordinated across care settings and over time, particularly for patients with long-term chronic and medically complex conditions who may find it difficult to navigate fragmented health care systems". Specifically, they call on commissioners to

- commission services that improve the interface between primary care, mental health and other professionals, for example, based on collaborative care models recommended by NICE
- strengthen disease management and rehabilitation programmes by including psychological or mental health input
- use financial and quality incentives to encourage providers to develop innovative forms of liaison psychiatry within acute hospitals, care homes and elsewhere
- expand Improving Access to Psychological Therapy services to support people with comorbid long-term conditions, in line with government ambitions
- improve mental health skills in general practice using training programmes developed specifically for primary care professionals
- move to community-based multi-professional teams based around general practices that include generalists working alongside specialists.

There was very strong support from mental health service users for the commissioning of services which would help people with mental health problems learn about issues like diet and nutrition and reduce levels of smoking and drinking, and give them free or subsidised access to exercise opportunities, such as gym membership.

The Inquiry heard about the benefits that could follow when health and social care funding was pooled under section 75 of the NHS Act 2006, alongside integrated commissioning and joint working across organisations. There was support for single health and social care budgets both at organisational and individual patient level, without which it was thought that other initiatives such as co-located services and integrated information on care pathways could not be fully effective.

The Inquiry also noted the personalisation agenda in England which includes offering people not only their own individual budget for social care, which they can (within reason) spend on the services they prefer to support them, but also, in certain circumstances, personal budgets for health care. In the fullness of time, any moves to integrate these two budgets into a single budget for someone to buy in their own health and social care should, at least in theory, lead to better integrated services. However this will depend on each person's own ability to negotiate integrated care – a good deal of support might be required to ensure the optimum service package was reached in each case. It will be important to ensure that disadvantaged individuals are able to benefit equally from personal budgets, or the very inequality that they currently experience may be increased rather than reduced.

The evidence the Inquiry heard makes it clear that separate funding streams hinder integrated care, while pooled funding, and services commissioned across boundaries, increases the likelihood of patients receiving better care. Combining health, social care and other (eg education) budgets at a local commissioning level provides the opportunity to mirror the service delivery requirements of people who need a single coordinated approach to manage their mental health condition. Commissioners need to be aware that the support people with mental health problems want extends beyond just traditional health and social care interventions, to help with lifestyle issues.

4. Co-located services

> "The 'one size fits all' approach being rolled out by the mental health commissioners [in England] has resulted in physical care and mental care being separated even further. I have spoken to GPs who have lost access to mental health workers that were dedicated to their actual practice, and who do not fully understand what IAPT and CBT is! Staff need to be in the same building together, regularly to start sharing information and for professionals to learn from each other." (FOMHS respondent)

> "We need to look at a model where there is a free flow of patients, which basically means that what we as psychiatrists are creating is primary care psychiatry. Rather than sitting in CMHTs we should be seeing patients together so that GPs have the confidence that if things go awry, I'm not going to have to wait for six weeks for this patient to be seen." (Expert seminar participant)

The Inquiry heard from a number of people that it was necessary to "take psychiatry out of the hospital and into the community". It was felt that this would in particular help provide an integrated community-based response to patients who moved between primary and secondary care, often on a regular basis, and would also help to change the perception of mental health services as a 'bolt-on' to other mainstream health services.

The call for more mental health professionals to be located in GP surgeries was overwhelming, in particular from people who use mental health services. This included psychiatrists, talking therapists, Occupational Therapists, Community Psychiatric Nurses, counsellors, community support workers, liaison officers and even whole community mental health teams (CMHTs). To our minds, primary care teams working closely with co-located specialist mental health staff makes a great deal of sense, given that the majority of mental health care takes place in the community at primary care level.

There are challenges to this, though. First, much of the evidence suggests that if you do not have staff with the right attitude towards collaborative working, then co-location does not actually guarantee better integrated care. Second, there is a lack of understanding of how collaborative care works, the roles and responsibilities of specialists in primary care settings and the importance of the interface between psychiatrists and GPs (Joint Commissioning Panel for Mental Health, 2012). Third, it may simply be impractical to locate more staff into existing primary care facilities. The first

two of these challenges could, we believe, be overcome through the revised education and training arrangements that we have proposed earlier.

Single healthcare trusts / bodies

> "We have recently merged with a mental health trust based 20 miles away. Our local hospital based next door will not now provide simple physical care to our patients who have to travel 20 miles away to see a dietician or a diabetic nurse. This is crazy." (FOMHS respondent)

> "Occupational Therapists on both physical and mental health used to meet at regular meetings in our trust. Due to mental health services becoming [a] separate trust this has fractured many communication and support networks that were previously there." (FOMHS respondent)

A number of responses to the Inquiry suggested that there would always be a problem if there were health systems that included separate specialist mental health trusts, and that all such trusts should be merged with general acute trusts, to overcome the perceived separateness of mental health within the NHS, tackle some of the stigma attached to using mental health services, and assist joint working and better integrated mental and physical health care. Others suggested that there should be merged health (including mental health) and social care trusts.

While we understand and sympathise with the idea of merging provider organisations in this way, we noted that such a system did not necessarily lead to universally effective integrated care for patients, as was suggested by one respondent to our call for evidence:

> "It may be that physical and mental health services can be combined relatively quickly into bigger integrated trusts but that won't mean that the different groups of staff will automatically work together – the split will still exists under the surface of the Trust logo." (FOMHS respondent)

For example, Northern Ireland, uniquely in the UK, has a Department (DHSSPS) that links health and social services, local trusts that provide health and social care services, and common funding of health and social care. However this organisational unity does not guarantee integrated care. Timmins (2013) states

> "… there is little systematic evidence of measurable improvements for the population as a whole from what, purely on the face of it, is the most integrated funding system in the United Kingdom. Paradoxically, it may have made social care more subservient to health care. Even where differences are longstanding – such as Northern Ireland's approach to combining the management of health and social care – there is a shortage of studies to demonstrate whether managing the two together has produced better or worse results."

The King's Fund (2013a) suggests that in Northern Ireland community mental health services may have benefitted from this formal health and social care organisational integration, and that it has brought advantages in a single employing body, a single budget and agreed strategies and plans on, for example, dementia care and mental health. Despite this,

> "Disadvantages include the continuing dominance of health care over social care, cultural differences between these areas, separate training systems, and GPs not being fully engaged in a whole system approach. The Northern Ireland story demonstrates that structural integration can facilitate effective integrated working, but ultimately achieving a seamless service requires strong leadership underpinned by a clear vision, endorsed by the key stakeholders…. innovative local solutions can be found if senior staff share aspirations and space is given for innovative, creative ways of working".

The message appears to be that while organisational stability, integrated management structures and pooled funding, for example, are helpful in order to integrate care, having single bodies responsible for integrating health and social care does not guarantee a better integrated service to individual patients. As Goodwin et al put it (2012),

> "It is important to re-iterate here that effective integrated care can be achieved without the need for formal ('real') integration of organisations. What matters most is the clinical and service integration that improves care co-ordination around the needs of individual patients and service users…. care can be delivered without further legislative change or structural upheaval."

The Inquiry did note some promising examples of integration between health and social services. In Kingston, Surrey, the clinical commissioning group (CCG) and local authority (LA) are coterminous.

The CCG Chief Officer is also the Director of health and adult services for the LA, creating single management accountability across the two bodies. As reported (Smith, 2013), in his view

> "Certainly the relationships between the council and the CCG are strong and there is a shared vision that we must fully integrate our commissioning. My vision is of a system where we have one governance structure; one budget; one team of staff who commission across health and social care."

A separate review of UK policy and practice developments in respect of integrated health and social care over the last two decades (Petch, 2012) found that "structural change will not guarantee integrated care and diverts from the detail of local implementation that needs to be achieved".

We conclude from this evidence that the co-location of primary care and specialist mental health staff could bring significant benefits to patients in terms of a better integrated response to their needs – so long as the staff understand their respective roles and responsibilities and work willingly and collaboratively together. This message, already noted in literature cited earlier in this report, once again suggests that ultimately it is people who make integrated care work, not organisational systems or structures. We are not convinced that the merging of organisations that are involved in providing different aspects of care to people with mental health needs would in itself improve that care.

5. Multidisciplinary teams

> "A primary care team of GPs, specialist diabetes nurses and lifestyle interventionists should be attached to every mental health community care team and inpatient services." (FOMHS respondent)

> "In an ideal world each patient should have a team (doctor, nurse, mental health worker, physio) that regularly meets to discuss their care and integrate services like this." (FOMHS respondent)

> "Multiagency working is essential with the families I see – ie social workers, doctors (paediatrics and psychiatrists), psychologists, OTs and speech and language therapists working closely with families and children across all settings – school, home and short break facilities." (FOMHS respondent)

The evidence we looked at strongly supported multi-disciplinary care for people with mental health needs. Goodell et al (2011) considered people with co-occurring physical and mental conditions and found that comorbidity is the rule rather than the exception, with more than 68 percent of adults with a mental disorder having at least one medical condition. They concluded that

> "Collaborative care models that use a multidisciplinary team have been shown to provide effective treatment for persons with comorbid physical and mental conditions. The most effective treatment models, however, are not in widespread use."

Of course community mental health teams (CMHTs) and the Care Programme Approach (CPA) already embed both the principles and practice of multidisciplinary care within mental health services. CMHTs will commonly include a psychiatrist, community psychiatric nurse (CPN), social worker, occupational therapist (OT) and psychologist, and CPA care plans should look beyond health care to social care and other needs, such as housing and employment. The necessity for these staff to collaborate is emphasised by the CPA Association (2013):

"Although all the patients concerned will be patients of a consultant psychiatrist, modern psychiatric practice calls for effective inter-professional collaboration between psychiatrists, nurses, psychologists, occupational therapists and other health service professional staff; social workers employed by social services authorities, and general practitioners and the primary care team, and proper consultation with patients and their carers…. It is essential to obtain the agreement of all professional staff and carers expected to contribute to a patient's care programme that they are able to participate as planned."

The Inquiry heard that not all CMHTs worked together as well as they might and that CPA plans were not always implemented as well as they could be. Despite this, we felt that there was a good reason why the CMHT and CPA models have survived for so many years – the multidisciplinary and multiagency approach that they encapsulate is both welcomed by patients as well as understood by staff to be an effective model for providing an integrated response to people's needs. We believe improvements in how these models work could be effected by the education and training messages set out in this report.

6. Liaison services

There has been increasing support in recent years for liaison psychiatry – the provision of mental health expertise in physical health settings such as A&E units and general wards. Despite a gradual expansion of liaison psychiatry services across the UK, the evidence suggests that such provision is variable. In Wales it has been described as "fragmented, under-resourced and unlikely to meet patients' needs" (Sakhuja and Bisson, 2008), and a survey in the south of England (Gordon and Wolf, 2010) found that

> "the provision of liaison services in the south of England is patchy. We found no relationship between hospital bed numbers and the presence of a dedicated liaison psychiatry service. No service met the staffing recommendations of the 2003 Royal College of Physicians and Royal College of Psychiatrists guidelines for a 600-bed hospital, despite the fact that 48% of hospitals in the area surveyed exceeded this size."

This lack of mental health support was noted in responses submitted to the Inquiry.

> "Another situation - brought frequently to our carers group - is around mental health care when someone is admitted to a general medical ward. The unfamiliar surroundings can trigger or increase distress to the extent that a crisis team intervention would be necessary. But it can be very difficult to receive this sort of support on a ward. Care coordinators stay away assuming the person is being cared for by staff. But the ward staff cannot cope with the crisis and do not know what to do. Staff may not be able to access any psychiatric support (this has happened to our members). So the person is left in physical pain, but in more serious emotional distress, with no support. If the person lashes out in their distress, they risk being barred from the ward because of their unacceptable behaviour." (Policy Panel member)

However the issue is not just about mental health expertise in physical care environments or teams, but also physical care expertise in mental health environments or teams.

> "On the whole, physical health is not addressed by mental health services. Even to the extent of mental health services ignoring the impact of psychiatric medication on weight. We have heard from someone with severe physical health problems (including incontinence) who did not get the usual support because of their severe mental health problems and communication difficulties. People don't know what support they are entitled to and do not ask - they expect services to inform them and support them. Mental health services do not necessarily know about physical health support so don't offer it. Physical health services assume the person is supported in mental health services." (Policy Panel member)

> "... physical and mental health teams having access to each others' knowledge and experiences to work closer together, ie physical health nurses working on mental health units to support patients with physical conditions such as diabetes, healthy lifestyles and to empower mental health nurses with up-to-date physical nursing practice. Also mental health nurses to work on physical health wards to support patients with mental health disorders who are undergoing treatment for physical illnesses." (FOMHS respondent)

Many participants at the Inquiry's seminars felt that liaison psychiatry was a good model for integrated healthcare. The Inquiry noted an economic evaluation of the Rapid Assessment Interface and Discharge (RAID) psychiatric liaison service operating in City Hospital, Birmingham (Centre for Mental Health, 2011). The analysis focused on the ability of the service to promote quicker discharge from hospital and fewer re-admissions, resulting in reduced numbers of inpatient beddays. It concluded that the services saved money as well as improving the health and wellbeing of its patients. Another evaluation described the development of a liaison psychiatry service in hospitals in North London, to address the mental health needs of patients both on acute wards and in Accident and Emergency (A&E) units (Plumridge and Reid, 2012). This found benefits including the sharing of expertise between mental health and acute care staff; increasing the recognition of psychological distress among patients; quicker care for people within A&E units; a reduction in the length of stay of patients with a mental health diagnosis; and fewer re-attendances by certain patients.

In hospitals where liaison psychiatry services have been established, the Inquiry heard that many staff change their views on how important mental health is to achieving physical health outcomes – bearing in mind that patients with the most difficult physical conditions often have psychiatric problems as well. The same principle applied to having practitioners with physical health skills in psychiatric facilities. Support was also expressed for liaison services in primary care, with GPs and psychiatrists sitting down together with patients with complex needs to provide a holistic response.

The message from the evidence on liaison services is clear. There are significant benefits to establishing both psychiatric liaison services in physical health care settings, and physical care liaison services in mental health settings. Commissioners need to be better aware of the evidence for such services, the improvements to integrated patient care and the cost savings that can be made.

7. Navigators

As pointed out by the National Collaboration for Integrated Care and Support (2013)

> "Many people with mental and physical disabilities, complex needs, long-term conditions and terminal illness also need to access different health care, social care, housing and other services, such as education, and often simultaneously. The evidence is clear, however, that these services can be fragmented, and those who need to rely on them often find that they are hard to access and that there are inadequate links between them."

The Inquiry heard about the importance of people with mental health problems having good access to information about the range of support they could get from a variety of service providers. For example, Wales has a commitment to promote integrated information and advice services, and is looking to develop an 'information hub' for social care, linked to similar plans for primary care (Welsh Government, 2011). However despite this, there was a very strong call from people who use mental health services for help to navigate the complex array of support that might be available to them (this appeared a greater problem in England, where the recent NHS reforms and drive towards "any qualified provider" was felt to be leading to a more fragmented care and support system, but the issue was relevant across the UK). This generally took the form of having a single named and trusted individual who would guide them through the maze.

> "People know they may need a variety of professionals and support services, but within this they want a single trusted point of liaison, to which they can have recourse as necessary, where the above knowledge is held. They expect this person/service to advise them on how to take next steps and, ideally, to co-ordinate their care or to help the patient/carer to co-ordinate it." (National Voices, 2011)

> "At present services are becoming more and more fragmented. We need good continuity of care. The old-fashioned GP was good for this, but now care is so complex that it's impossible for one person to keep up with everything.... maybe everyone needs a care co-ordinator that is suitable to them personally, maybe a peer-type person who has 'recovered' or is further on in their recovery to help co-ordinate their care when not well and not on top of things." (FOMHS respondent)

> "Named care co-ordinators who act as navigators and who retain responsibility for patient care and experiences throughout the patient journey." (King's Fund, 2013b)

The Inquiry noted that such a role could be particularly important at times of transition for patients, between different parts of local health services and between health and other services. There is an issue about the exact duties and responsibilities of such a co-ordinating role, given that such roles do already exist in some form or other. It could be a formal part of a paid member of staff's responsibilities, along the same lines as a CPA care co-ordinator. An alternative is to establish navigators as people whose role is simply to identify and clarify the options available for patients, and support them in accessing care, but without any formal authority – a number of respondents felt this role could be an opportunity for peer support workers.

The case for a worker of this type has been boosted through work done by the National Institute for Health Research (NIHR) School for Social Care Research (NIHR, 2012), looking at what good care looks like for people with complex needs. This found that people want a key worker who understands complex systems and can liaise with housing, employment and education, pulling packages together across boundaries and funding streams.

A note of caution needs to be sounded about the crucial role of the key worker, though. A study of the CPA used in England and Wales for people in secondary mental health services identified that failings were often associated with the care co-ordinator not being a senior enough figure within the team to be able to pull together effectively the contributions of all the different members (Goodwin and Lawton-Smith, 2010). The authors noted that

> "Investment and professional support to the role of the care co-ordinator is particularly crucial. Care co-ordinators require the requisite skills and competencies to act as a care professional to the patient as well as to have the power to exert authority among other care professionals to ensure multidisciplinary care plans are implemented successfully."

Although we would not be prescriptive about the details, we strongly support the principle of a single named individual who can help people navigate their way through complex systems across health, social care, housing, employment and education (among other services) and help to pull together integrated care packages. In our view this would go a long way to ensuring that people received effective integrated care. We would suggest that the piloting and evaluation of such a role should be a research priority.

8. Research

> "People working in mental health need to do a lot more to demonstrate the non-mental health related outcomes, for example trying to prove that better mental health in early life has direct impact on educational performance. That area of research will open doors." (Expert seminar participant)

There were a number of calls from respondents to the Inquiry for more research into the association between physical and mental health, for more studies of how integrated care can be established in practice, and in particular, to show the economic benefits of integrated care – this being considered a crucial data area to persuade commissioners to commission integrated care.

Despite the large amount of published evidence on integrated care, much of which the Inquiry looked at and is cited above, the Social Care Institute for Excellence (SCIE, 2011) thought the evidence base underpinning joint and integrated working remains less than compelling:

> "It largely consists of small-scale evaluations of local initiatives which are often of poor quality and poorly reported. No evaluation studied for the purpose of this briefing included an analysis of cost-effectiveness. There is an urgent need to develop high-quality, large-scale research studies that can test the underpinning assumptions of joint and integrated working in a more robust manner and assess the process from the perspective of service users and carers as well as from an economic perspective."

The Royal College of Psychiatrists (2013) has called for a refocusing of research on to areas of co- or multimorbidity, involving mental health and physical health problems, rather than single diseases/disorders. It believes this would help to demonstrate the interconnectivity of mental and physical health, and to underpin the developments of evidence-based treatments that address all an individual's health needs, not just their primary diagnosis.

We consider the existing evidence base on integrated care strong enough for immediate action to be taken to improve integrated care for people with mental health needs, along the lines we have suggested in this report. However, we would agree that more research into how best to support people with complex, co-morbid needs is required, which should include economic assessments of different models and approaches to integrated care.

9. Reduction of stigma

> "Fundamentally this is about stigma through society and services, target a change of attitudes and [integrated care] will follow." (FOMHS respondent)

> "As the family member of someone with dementia and the close friend of someone with bipolar disorder, I see every day how differently these two categories of person are treated from people with physical disorders and from each other." (FOMHS respondent)

> "Overcome stigma / discrimination of those who work in physical health services towards people with mental health problems – it's not all in your head!!" (FOMHS respondent)

> "Colleagues still appear to remain uncertain and unconfident in addressing mental health issues and I experienced that my client's still receive a lot of stigma from colleagues in that any report of symptoms [is] often related to mental health issues. Eg cancer was missed! "It's a mental health issue". Slipped disc was missed, "It's a mental health issue". I am sure you get the picture." (FOMHS respondent)

> "Mental health services should be part of physical health so that the stigma is hopefully reduced as they aren't seen so separately." (FOMHS respondent)

> "I work closely with community mental health teams. Having a mother with a severe mental illness I can see how her GP disregards her concerns, and her opinions over treatment are ignored by mental health professionals." (FOMHS respondent)

The general social stigma surrounding mental illness not only deters many people from accessing support for their mental health, but also creates discrimination and inequalities in mental health care. Service users gave the Inquiry examples of discrimination from healthcare staff, including mental health staff. It was suggested that acute care staff may be negative about

patients' potential for recovery if they only see acute and 'revolving door' patients, and should therefore be given the opportunity to follow up with service users who are doing well in the community. It was also argued that service users could play a role in educating staff about stigma and discrimination, and that staff needed to be given more time to build long-term relationships with patients.

An important issue here is diagnostic overshadowing, as indicated in the above FOMHS responses. According to Thornicroft (2007), diagnostic overshadowing "appears to be common in general healthcare settings, meaning the misattribution of physical illness signs and symptoms to concurrent mental disorders, leading to underdiagnosis and mistreatment of the physical conditions." Given we know that people with a mental illness often have high rates of comorbidity with physical health problems, and that having a severe mental illness, such as schizophrenia, can mean people die up to 20 years earlier than people without such a diagnosis, diagnostic overshadowing among mental health patients can be dangerously discriminatory and needs to be addressed through staff training and education.

At the same time, staff themselves can be stigmatised for working in the field of mental health.

> "Sadly stigma is alive and well! This is particularly so in my specialist field of addiction psychiatry, yet there are huge possibilities for co-working, especially with alcohol." (FOMHS respondent)

We have referred earlier in this report to the training needs for all health and social care staff in respect of the indivisibility of health, and a holistic approach to both physical and mental health, which should help to address the problem of mental health care being seen as somehow 'different' to the rest of health care. We have also noted the benefits of interprofessional training to allow staff to gain a better understanding of the roles and responsibilities of others with whom they work in partnership, and to increase respect between professions.

In terms of the public perception of mental health and mental illness, which can hinder efforts to implement integrated care, the Inquiry noted a good deal of support for the wider education of the public in this area, and in particular the need to teach children at school about the connections between physical and mental health, and not to see the two as separate issues, the former to be discussed openly, the latter to be played down as shameful and stigmatised.

> "Teach school-age children about both mental health and physical health care, this will help to destigmatise and normalise mental health problems." (FOMHS respondent)

> "By valuing mental health as much as physical health in our society we can begin to integrate the importance of both in individuals. From a young age mental health needs to be evaluated and cared for in the same way as our physical bodies. Making it relevant in education for young people is one way to start the change in attitudes." (FOMHS respondent)

We looked at, and commend, the work of public anti-stigma campaigns at present working across the UK, such as See Me in Scotland and Time to Change in England.

We noted research findings which show that both educational interventions and interpersonal contact with people with mental health problems can reduce stigmatising views (for example, Couture and Penn, 2003; Pinfold et al, 2003). Corbière et al (2012) found that people with mental disorders often preferred interpersonal contact and person-centred strategies to reduce stigma, while mental health professionals preferred education and working on recovery and social inclusion strategies. We also noted evidence from the Anti-Stigma Programme European Network (ASPEN) that, with respect to the stigma attached to depression, the key active ingredient most often identified is direct social contact with people with mental health problems, yet such contact is not at present a central feature of most depression programmes. Educational interventions, by contrast, are more common.

We agree with the argument that both a public and a health care workforce that are better informed about health and mental health issues would help to create an environment in which a truly integrated response to poor mental health could be established. On top of continuing public mental health awareness work, both primary and secondary schools need to ensure that emotional and mental health issues are fully integrated in what children are taught about health and healthy living in the widest sense. This would mean that young adults intending to move into careers in health and social care already have the basic understanding of the indivisibility of physical and mental health, so the formal professional training on holistic and integrated care that they receive from day one will come to them quite naturally.

By itself, though, this is not enough. There is a small, but good, evidence base suggesting that interpersonal contact involving people with mental health problems can reduce stigmatising attitudes and behaviour. We need to undertake more research into this approach.

In addition, diagnostic overshadowing among mental health patients can be dangerously discriminatory and needs to be addressed through staff training and education. There are also occasions when stigma and discrimination need to be tackled by legislation, such as through the Equality Act 2010 and crime and disorder legislation.

ANNEX

Seminar attendance across the three sessions

Sue Baker	Director	Time to Change
Prof Dinesh Bhugra	Chair	Mental Health Foundation
Christine Burke	Senior Development Manager	Foundation for People with Learning Disabilities
Dr Matthew Capehorn	Clinical Manager	Rotherham Institute for Obesity
Dr Mel Conway	Consultant in Public Health	South Essex Partnership NHS FT
David Crepaz-Keay	Head of Empowerment and Social Inclusion	Mental Health Foundation
Sean Duggan	Chief Executive	Centre for Mental Health
Polly Falconer	Mental Health and Training Lead	Afiya Trust
Dr Lynne Friedli	Freelance Researcher	
Dr Domenico Giacco	Psychiatrist and Research Fellow	Queen Mary University of London
Dr Patil Jawaharlal	Consultant Psychiatrist	South Essex Partnership NHS FT
Prof David Kingdon	Professor of Mental Health Care Delivery	University of Southampton
David Keown	Senior Communications Manager	Janssen
Hameed Khan		NSUN
Simon Lawton-Smith	Head of Policy	Mental Health Foundation
Ann Leitch	Chief Executive Officer, The Insight Network	Spire Healthcare
Valentina Lemmi	Research Officer	LSE
Dr Llewellyn Lewis	Deputy Medical Director Essex	South Essex Partnership NHS FT
Dr Andrew McCulloch	Chief Executive	Mental Health Foundation
David McDaid	Research Fellow in Health Policy and Health Economics	LSE
Carole Murray		NSUN
Carol-Ann Murray	Mental Health Improvement Specialist	NHS South East London
Chris Naylor	Fellow, Health Policy	King's Fund
Dr Jean O'Hara	Clinical Director and Consultant Psychiatrist	Guy's Hospital
Chris O'Sullivan	Senior Project Manager	Mental Health Foundation
A-La Park	Research Officer	LSE
Michael Parsonage	Chief Economist	Centre for Mental Health
Dr Catherine Rowlands	Specialist Registrar in Pyschiatry	South Essex Partnership NHS FT
Ron Shields	Chief Executive	Northamptonshire Healthcare NHS FT
Genevieve Smyth	Professional Affairs Office, Mental Health and Learning Disabilities	COT/BAOT
Ian Smyth	Head of Janssen Health Care	Janssen

References

Alimo-Metcalfe B, Alban-Metcalfe J, Samele C (2007).The impact of leadership factors in implementing change in complex health and social care environments: NHS Plan clinical priority for mental health crises resolution teams. Real World Group; Sainsbury Centre for Mental Health http://www.netscc.ac.uk/hsdr/files/project/SDO_FR_08-1201-022_V01.pdf

Antonovsky A (1987) Unravelling the mystery of health. How people manage stress and stay well. San Francisco: Jossey-Bass, 1987

Appleton, S. (2009) Integration and Mental health: A briefing paper for the Integrated Care Network. DH Integrated Care Network. Available online at: http://www.dhcarenetworks.org.uk/_library/Resources/ICN/ICN_advice/ICN_FINAL_Integration_and_Mental_Health2.pdf

Audit Commission (2011) Joining Up Health and Social Care: improving value for money across the interface http://archive.audit-commission.gov.uk/auditcommission/sitecollectiondocuments/Downloads/vfmhscinterface.pdf

Baguely, I, Alexander, J, Middleton, H and Hope, R. (2007) New Ways of working in acute inpatient care: a case for change. Journal of Mental Health Training, Education and Practice, Available online at: http://eprints.nottingham.ac.uk/794/1/JMHT.pdf

British Medical Association (2012) Models of integrated care http://bma.org.uk/working-for-change/the-changing-nhs/reconfiguration-and-integration/integration/integration-without-structure-change

Camden and Islington NHS Foundation Trust and Islington Children's Services (2012) Adult Mental Health and Children's Services Joint Working Protocol http://www.islington.gov.uk/publicrecords/library/Children-and-families-services/Information/Guidance/2012-2013/(2012-09-25)-Think-Family-Joint-Working-Protocol.pdf

Centre for Mental Health (2011) Economic evaluation of a liaison psychiatry service http://www.centreformentalhealth.org.uk/pdfs/economic_evaluation.pdf

Collins P, Insel T, Chockalingam A, Daar A, Maddox Y (2013) Grand Challenges in Global Mental Health: Integration in Research, Policy, and Practice. PLoS Med 10(4): e1001434. doi:10.1371/journal.pmed.1001434 http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001434

Corbière M, Samson E, Villotti P, Pelletier J-F (2012) Strategies to Fight Stigma toward People with Mental Disorders: Perspectives from Different Stakeholders http://www.hindawi.com/journals/tswj/2012/516358/

Couture S, Penn D (2003) Interpersonal contact and the stigma of mental illness: A review of the literature. http://informahealthcare.com/doi/abs/10.1080/09638231000118276

CPA Association (2013) www.cpaa.org.uk/uploads/1/2/1/3/12136843/hc9023_.doc Accessed 18 August 2013

The Department of Health (2011), Integrated care, webpage http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Aboutus/HowDHworks/DH_074666

Department of Health and 13 partners (01a) Integrated Care and Support: Our Shared Commitment https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198748/DEFINITIVE_FINAL_VERSION_Integrated_Care_and_Support_-_Our_Shared_Commitment_2013-05-13.pdf

Department of Health (2013b) Delivering high quality, effective, compassionate care: Developing the right people with the right skills and the right values. A mandate from the Government to Health Education England: April 2013 to March 2015 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/203332/29257_2900971_Delivering_Accessible.pdf

Eriksson M (2007) Unravelling the mystery of salutogenesis: the evidence base of the Salutogenic research as measured by Antonovsky's Sense of Coherence Scale. http://www.salutogenesis.hv.se/files/monica_eriksson_flyer_4sid_a41_2010.pdf

ESRC (2012) Life Gets Under Your Skin http://www.ucl.ac.uk/icls/publications/booklets/lguys.pdf

Friedli (2009) Mental health, resilience and inequalities http://www.euro.who.int/__data/assets/pdf_file/0012/100821/E92227.pdf

Goodell S, Druss B.G, Walker E.R. (2011) Mental Disorders and Medical Comorbidity. Research Synthesis Report No. 21. Princeton, New Jersey: Robert Wood Johnson Foundation http://www.rwjf.org/en/research-publications/find-rwjf-research/2011/02/mental-disorders-and-medical-comorbidity.html

Goodwin N and Lawton-Smith S (2010) Integrating care for people with mental illness: the Care Programme Approach in England and its implications for long-term conditions management. http://www.ijic.org/index.php/ijic/article/view/URN%3ANBN%3ANL%3AUI%3A10-1-100855/0

Goodwin N, Smith J, Davies A, Perry C, Rosen R, Dixon A, Dixon J and Ham C (2012) Integrated care for patients and populations: Improving outcomes by working together. http://www.kingsfund.org.uk/sites/files/kf/integrated-care-patients-populations-paper-nuffield-trust-kings-fund-january-2012.pdf

Gordon J and Wolf S (2010) Liaison psychiatry services in south England http://pb.rcpsych.org/content/34/7/270.full

Harrop E, Addis S, Elliott E, Williams G (2009) Resilience, coping and salutogenic approaches to maintaining and generating health: a review http://www.nice.org.uk/nicemedia/live/11868/44523/44523.pdf

Health improvement Scotland (2007) Standards for integrated care pathways for mental health - adult and older adult services http://www.healthcareimprovementscotland.org/programmes/mental_health/icps_for_mental_health/standards_for_integrated_care.aspx

Hotopf, M, Rayner, L and Valsraj, K. (2012) Improving whole person care: report on mental health related services offered by King's Health Partners' acute trusts. King's Health Partners http://www.kcl.ac.uk/iop/depts/pm/research/imparts/K-quick-links/Mapping-Report.pdf

Joint Commissioning Panel for Mental Health (2012) Guidance for commissioners of primary mental health care services. http://www.rcpsych.ac.uk/PDF/JCP-MH%20primary%20care%20(March%202012).pdf

King's Fund (1995) Health Care UK 1994/95. London: King's Fund Policy Institute, 1995

King's Fund (2013a) Integrated care in Northern Ireland, Scotland and Wales: Lessons for England. http://www.kingsfund.org.uk/publications/integrated-care-northern-ireland-scotland-and-wales

King's Fund (2013b) Transforming our healthcare system: ten priorities for commissioners http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/10PrioritiesFinal2.pdf

Kirmayer L, Groleau D, Looper K, Dominicé Dao M (2004) Explaining Medically Unexplained Symptoms http://ww1.cpa-apc.org:8080/Publications/Archives/CJP/2004/october/kirmayer.asp

Labour Party (2013) Independent Commission on Whole Person Care http://www.sochealth.co.uk/2013/04/27/independent-commission-on-whole-person-care/

Lelliot P (2011) The role of psychiatrists and their professional associations in the regulation and performance management of mental health services. Chapter 11, pp147-162, in Psychiatry's Contract with Society, ed Bhugra A, Malik A, Ikkos G, Oxford University Press, 2011

Lester H (2005) Shared care for people with mental illness: a GP's perspective. Advances in Psychiatric Treatment (2005), vol. 11, 133–141

Lewis R, Rosen R, Goodwin N, Dixon J (2010) Where next for integrated care organisations in the NHS? http://www.integratedcare.londondeanery.ac.uk/files/Nuffield%20paper-Where%20next%20for%20integrated%20care%20organisations%20in%20the%20English%20NHS.pdf/at_download/file

London Deanery (2013) Integrated care website http://www.integratedcare.londondeanery.ac.uk/

McLaren P (2003) Telemedicine and telecare: what can it offer mental health services? http://apt.rcpsych.org/content/9/1/54.full.pdf

Mental Health Foundation (1979) New Methods of Mental Health Care. Pergamon Press ISBN 0-08-022264-1

Ministry of Health (1950) Report of the Ministry of Health for the year ended 31st March 1949. London HMSO Cmd.7910

National Collaboration for Integrated Care and Support (2013) Integrated Care and Support: Our Shared Commitment https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/198748/DEFINITIVE_FINAL_VERSION_Integrated_Care_and_Support_-_Our_Shared_Commitment_2013-05-13.pdf

National Voices (2013) Integrated care: what do patients, service users and carers want? http://www.nationalvoices.org.uk/sites/www.nationalvoices.org.uk/files/what_patients_want_from_integration_national_voices_paper.pdf

Naylor C, Parsonage M, McDaid D, Knapp M, Fossey M, Galea A. (2012) Long-term conditions and mental health: The Cost of Co-Morbidities. http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/long-term-conditions-mental-health-cost-comorbidities-naylor-feb12.pdf

NDTi (2013) Paths to personalisation in mental health: a whole system, whole life framework. http://www.thinklocalactpersonal.org.uk/_library/New_Paths_to_Personalisation_NDTi_April_2013_final.pdf

NHS Confederation (2012) Long-term health gains: investing in emotional and psychological wellbeing for patients with long-term conditions and medically unexplained symptoms. http://www.nhsconfed.org/Publications/Documents/Long_Term_Health_Gains_Briefing.pdf

NIHR School for Social Research (2012) Identifying what good care and support looks like for people with complex needs http://www.lse.ac.uk/LSEHealthAndSocialCare/pdf/Findings_1_complex-and-severe_web.pdf

Northern Ireland Department of Health, Social Services and Public Safety (2009) Delivering the Bamford Vision: The response of Northern Ireland Executive to the Bamford Review of mental health and learning disability: action plan 2009-2011n http://www.dhsspsni.gov.uk/bamford_action_plan_2009-2011.pdf

Nuffield Trust (2012) The impact of telehealth and telecare: the Whole System Demonstrator project. http://www.nuffieldtrust.org.uk/our-work/projects/impact-telehealth-and-telecare-evaluation-whole-system-demonstrator-project?gclid=CJPcrNe8lbgCFQTMtAod9m4AGg

Nuffield Trust (2013) Evaluating integrated and community-based care http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/evaluation_summary_final.pdf

Petch A (2012) Tectonic plates: aligning evidence, policy and practice in health and social care integration http://www.emeraldinsight.com/journals.htm?articleid=17015465

Pinfold V, Toulmin H, Thornicroft G, Huxley P, Farmer P, Graham T (2003) Reducing psychiatric stigma and discrimination: evaluation of educational interventions in UK secondary schools. http://bjp.rcpsych.org/content/182/4/342.long

Plumridge N and Reid S (2012) Bridging the divide using liaison psychiatry. Health Service Journal, 6 December 2012, pp24-26

RAND Europe, Ernst & Young LLP (2012) Integrated Care Pilots: Final Report, Summary Version https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/146776/dh_133126.pdf.pdf

Ricketts T, Saul C, Newton P, Brooker C (2003) Evaluating the development, implementation and impact of protocols between primary care and specialist mental health services. Journal of Mental Health (August 2003) 12, 4, 369-383

Royal College of General Practitioners (2012a) General Practice and the Integration of Care: An RCGP policy report http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z%20policy/General_Practice_and-the_Integration_of_Care%20_An_RCGP_Report.ashx

Royal College of General Practitioners (2012b) Generalism: Why expertise in whole person medicine matters http://www.rcgp.org.uk/~/media/Files/Policy/A-Z%20policy/Medical-Generalism Why_expertise_in_whole_person_medicine_matters.ashx

Royal College of General Practitioners (2013) A Vision for General Practice in the future NHS http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z%20policy/The-2022-GP-A-Vision-for-General-Practice-in-the-Future-NHS.ashx

Royal College of Nursing (2003) Defining Nursing http://www.rcn.org.uk/__data/assets/pdf_file/0003/78564/001983.pdf

Royal College of Psychiatrists (2013) Whole-person care: from rhetoric to reality Achieving parity between mental and physical health https://www.rcpsych.ac.uk/pdf/OP88summary.pdf

Sakhuja D and Bisson J (2008) Liaison psychiatry services in Wales http://pb.rcpsych.org/content/32/4/134.full

Scottish Government, Royal College of General Practitioners, Mental Health Foundation, University of Stirling, University of Glasgow (2011) The Living Better project: Addressing mental Health and Wellbeing in People living with Long-Term Conditions http://www.google.co.uk/search?q=Scottish+Government%2C+Royal+College+of+General+Practitioners%2C+Mental+Health+Foundation%2C+University+of+Stirling%2C+University+of+Glasgow+(2011)+The+Living+Better+project%3A+Addressing+mental+Health+and+Wellbeing+in+People+living+with+Long-Term+Conditions&sourceid=ie7&rls=com.microsoft:en-gb:IE- Address&ie=&oe=&redir_esc=&ei=fKrVUbS9NMmxhAeF9IHABg

Sheffield Mental Health Partnership Board (2005) South Yorkshire multi-agency information sharing protocol (mental health issues) http://www.shsc.nhs.uk/_documentbank/InformationSharingProtocolMentalHealthIssues_SouthYorkshireMultiAgency.pdf

Scottish Government (2008) Mental Health in Scotland: Improving the physical health and wellbeing of those experiencing mental illness http://www.scotland.gov.uk/Resource/Doc/251663/0073699.pdf

Scottish Government (2012a) National Telehealth and Telecare Delivery Plan for Scotland to 2015 http://www.scotland.gov.uk/Resource/0041/00411586.pdf

Scottish Government (2012b) Mental Health Strategy for Scotland: 2012-2015 http://www.scotland.gov.uk/Resource/0039/00398762.pdf

Smith D (2013) Joined up thinking. Health Service Journal, 26 July 2013, p.30

Social Care Institute for Excellence (2011) Factors that promote and hinder joint and integrated working between health and social services. Research Briefing 41. http://www.scie.org.uk/publications/briefings/briefing41/

Thornicroft G, Rose D, Kassam A (2007) Discrimination in health care against people with mental illness. http://www.ncbi.nlm.nih.gov/pubmed/17464789

Timmins N (2013) The Four UK Health Systems: learning from each other http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_summary/four-uk-health-systems-jun13.pdf

Wales Health and Wellbeing Best Practice and Innovation Board (2013) The Determinants of Effective Integration of Health and Social Care http://www2.nphs.wales.nhs.uk:8080/externaldocs.nsf/85c50756737f79ac80256f2700534ea3/714d0d6339a19c1180257b180058a29d/$FILE/The%20Determinants%20of%20Effective%20Integration%20of%20Health%20and%20Social%20Care%20FINAL.pdf

Welsh Government (2010) Delivering the Care Programme Approach in Wales http://www.rcpsych.ac.uk/pdf/Delivering%20the%20Care%20Programme%20Approach%20Wales%20July%202010.pdf

Welsh Government (2011) Sustainable Social Services for Wales: A Framework for Action
http://wales.gov.uk/docs/dhss/publications/110216frameworken.pdf

WHO (2008) Technical Brief No.1, May 2008, Integrated Health Services – What and Why?
http://www.who.int/healthsystems/technical_brief_final.pdf

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