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Investing in emotional and psychological wellbeing for patients with long-term conditions



A guide to service design and productivity improvement for commissioners, clinicians and managers in primary care, secondary care and mental health.

Foreword

No health without mental health, our national strategy for England, clearly calls for good, patient-centered treatment together with joined-up, personalised pathways and systems. The economic context adds to the emphasis that all interventions must be as efficient as possible at delivering outcomes that are cost effective and safe.

I welcome this up-to-date compendium. It supports the strategy by setting out some of the key roles of psychological and psychiatric interventions in the treatment of long-term physical illness and medically unexplained symptoms.

It has been sponsored and funded by strategic health authority mental health leads and by the Department of Health, in partnership with the Mental Health Network. Their common goal has been to support the actions of health and social care commissioners, clinicians and providers to meet the whole of their

patients' mental and physical health needs – which, too often, are only partially addressed – while also improving productivity and spreading learning across disease-specific local clinical networks.

The challenge of ensuring that patients' needs are met holistically, effectively and efficiently is a responsibility for all of us involved in our health and social care services. To help us do this, the authors have brought together robust clinical evidence, emerging economic analysis, and current examples of service design and delivery. With the emphasis on Quality, Innovation, Productivity and Prevention (QIPP) and the roll-out of Improving Access to Psychological Treatments (IAPT), both further service examples and additional economic evidence will inevitably emerge in the next few years. The evidence set out in this compendium will support us in the ongoing processes of investment, integration, redesign and continual quality improvement.

Dr Hugh Griffiths
National Clinical Director for Mental Health

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Executive summary

People with long-term physical health conditions will often have psychological and emotional needs resulting from the burden of illness-related symptoms, the disability associated with the physical illness, and the impact of living with more than one physical condition at any time. For some, a mental health disorder will also be present. In the face of such multi-morbidity, personalised planning of care, including a collaborative care approach, is required to facilitate meaningful management plans¹. To ensure meaningful access to effective services, and to maximise the efficiency of those services, a well coordinated and collaborative patient journey between physical, psychological and mental health components of disease specific pathways is required, as well as cross-cutting pathways where common co-morbidities exist.

Whilst each physical health disorder brings a unique set of symptoms and lifestyle challenges, there is learning to be achieved across the range of disorders. This guide provides an overview of psychological need and interventions in long-term physical health conditions in general, in some specific conditions (diabetes, chronic obstructive pulmonary disease) and in medically unexplained symptoms. This is presented alongside evidence of cost benefits to be realised by addressing emotional and psychological need. Together, these demonstrate that there is considerable potential to improve quality of life and quality of care, and to generate service efficiencies and cost savings. Considerations of physical health conditions in people with long-term mental illness are also included.

Practical implementation examples are provided. These service models are championed by practitioners in the field. They are no more important than other examples, and are not presented as templates for system design solution. They have been collated for the purpose of sharing innovation and in support of developing practice networks within and between health sectors and care pathways.

The guide compliments publications already available (see 'Useful resources' section) and supports Quality, Innovation, Productivity and Prevention (QIPP) programmes and the roll-out of Improved Access to Psychological Treatments (IAPT).

Introduction

There is a growing body of clinical and economic evidence to support investment in clinical services which address mental health conditions and physical health long-term conditions. Long-term conditions are those conditions that cannot, at present, be cured, but can be controlled by medication and other therapies. In England, 15.4 million people have a long-term condition. The life of a person with a long-term condition is forever altered – there is no return to ‘normal’.²

A large number of conditions meet the criteria of being ‘long-term’. However, only a small number of these conditions are responsible for disproportionate service usage and costs. The focus of this guide is on three long-term conditions that have an established evidence base of psychological need and care and identified service innovations to meet such need. The long-term conditions covered are:

- diabetes
- chronic obstructive pulmonary disease (COPD)
- coronary heart disease.

For similar reasons, medically unexplained symptoms (MUS) are also considered.

‘People with one long-term condition are two to three times more likely to develop depression than the rest of the population. People with three or more conditions are seven times more likely to have depression.’

People with long-term conditions use disproportionately more primary and secondary care services. This pattern will increase over time with an ageing population. Over 30 per cent of all people say that they suffer from a long-term condition. This group accounts for 52 per cent of all GP appointments, 65 per cent of all outpatient appointments and 72 per cent of all inpatient bed days.³ As summarised in the Department of Health’s mental health strategy, launched in 2011,⁴ the statistics are startling:

- people with one long-term condition are two to three times more likely to develop depression than the rest of the population. People with three or more conditions are seven times more likely to have depression
- having a mental health problem increases the risk of physical ill health. Co-morbid depression doubles the risk of coronary heart disease in adults and increases the risk of mortality by 50 per cent
- mental health problems such as depression are much more common in people with physical illness. Having co-morbid physical and mental health problems delays recovery from both
- adults with both physical and mental health problems are much less likely to be in employment
- people with mental health problems are less likely to benefit from mainstream screening and public health programmes
- people with mental health problems have higher rates of respiratory, cardiovascular and infectious disease, and of obesity, abnormal lipid levels and diabetes
- people with mental health problems such as schizophrenia or bipolar disorder die, on average, 16–25 years younger than the general population.

The links between physical and mental health are clear. There are shared risk factors for illness: illness regularly presents with both psychological and physical symptoms; and being physically ill, particularly on a chronic basis, often has an impact on mental health and psychological wellbeing. Despite these obvious connections, many individuals do not receive care that addresses both their physical and psychological needs. The reasons for this, while complex, include:

- the continued stigma of mental health problems – it may be easier to accept physical over emotional explanations for symptoms. This may result in unconscious processes that put feelings 'into' the body, hence 'somatic' or bodily symptoms
- a continued lack of expertise and training in psychological assessment, management and mindedness for many practitioners
- integrated service design and provision that is 'patchy'
- commissioning structures and provider organisations which separate physical, mental health and whole-person care and outcomes.

'Many individuals do not receive care that addresses both their physical and psychological needs.'

Policy background

“There has not been enough focus on the root causes of ill health. Mental and physical health and wellbeing interact, and are affected by a wide range of influences throughout life... A new approach is needed, which gets to the root causes of people’s circumstances and behaviour, and integrates mental and physical health.”⁵

The Government has reaffirmed the need to place quality of care at the heart of the NHS. The white paper, *Equity and excellence: liberating the NHS*, states that quality cannot be delivered through top-down targets but by focusing on outcomes.⁶ The central importance of quality and innovation delivered through integrated networks of care, engaging the health service, social care and voluntary sector, is further emphasised in the Operating Framework for the NHS in England.⁷

The NHS needs to achieve up to £20 billion of efficiency savings by 2015 through a focus on quality, innovation, productivity and prevention. Savings made can be reinvested in patient care by supporting frontline staff, funding innovative treatments and giving patients more choice. The Quality, Innovation, Productivity and Prevention (QIPP) programme is focused on ensuring that each pound spent is used to bring maximum benefit and quality of care to patients, and that the right care is delivered at the right time, in the right setting. There are clear links between investment in treating co-morbid mental health and physical health problems and potential gains in all of the QIPP elements.

‘There are clear links between investment in treating co-morbid mental health and physical health problems and potential gains in all of the QIPP elements.’

Mental health accounts for around 11 per cent of NHS expenditure, with one in four of the population having some form of common mental health problem, and up to one in 100 people living with a serious mental illness.⁸ Mental health problems present a significant economic challenge to the whole economy. The Centre for Mental Health estimated that the economic and social costs of mental health problems in England in the financial year 2002/03 were £77.4 billion.⁹ A recent update of this figure suggests that the aggregate cost of mental health problems in England was £105.2 billion in 2009/10.¹⁰

In 2004, *Organising and delivering psychological therapies* commented that the provision of psychological interventions for people with long-term co-morbid conditions was an important component of the delivery of an effective mental health service.¹¹ In 2005, the Improving Access to Psychological Therapies (IAPT) programme was developed. This led to a large investment in the provision of psychological therapies in the NHS. The focus was on the provision of evidence-based therapies for common mental health problems. It was recognised early in the programme that there was a need to look at the delivery of psychological interventions in a range of other areas. As a consequence, a number of special interest groups were established. These focused on specific areas where it was felt that further national coordination of expertise and service examples was needed. These groups reported in 2008, producing positive practice guides. Two guides specifically address long-term conditions¹² and medically unexplained symptoms,¹³ provide a brief introduction to the evidence and examine a number of practice examples.

The significance of the economic and social costs of co-morbid mental health conditions has been recognised in recent policy documents:

- the Government’s mental health strategy¹⁴
- *Talking therapies: a four year plan of action*¹⁵
- the public health white paper.¹⁶

The mental health of people with long-term physical health conditions

Over 15 million people in England – 30 per cent of the population – have one or more long-term physical health condition.¹⁷ There is a close relationship between long-term physical conditions and mental health and wellbeing.

Co-morbid mental health problems are highly common;¹⁸ an estimated 30 per cent of all people with a long-term condition also have a mental health problem.¹⁹ The prevalence of depression and anxiety is higher in people with physical illness compared to the general population. In a study of more than 245,000 people in 60 countries, an average of between 9.3 per cent and 23 per cent of participants with one or more chronic physical disease had co-morbid depression.²⁰

Overall morbidity is increased when co-morbid mental health problems are present. Moussavi found that those with depression co-morbid with one or more chronic physical disease had worse health scores than those with angina, arthritis, asthma or diabetes alone.²¹ Those with depression and diabetes were the most disabled.²² Depression in people with coronary heart disease (CHD) predicts further coronary events (odds ratio = 2.0) and greater impairment in health-related quality of life.^{23 24} Depressed individuals with CHD are more than twice as likely to die as those with CHD alone.^{25 26}

The mechanisms underlying the association between depression and either mortality or morbidity in physical illness are not fully understood,²⁷ but diminished healthcare behaviour or physiological impairment, or a combination of the two, may be important. There are shared risk factors, and the links have been well described.^{28 29}

Living with long-term physical conditions brings with it considerable emotional adjustment and burden to patients, carers and families.

Past experience, coping strategies, emotional resilience and health-related behaviours all influence the response to diagnosis and the impact of living with physical symptoms and resulting disabilities. The impact will change over time as the health condition, disability and life circumstances change.

What are the psychological needs?

The prevalence of associated psychological needs is greater in those with long-term conditions than in the general population. Adapted from NHS Diabetes and Diabetes UK's summary of psychological needs in diabetes,³⁰ the emotional and psychological needs of people with long-term conditions can be described on a continuum from healthy coping, through disease-related distress, to psychological and psychiatric conditions. The broad aim of emotional and psychological care is to support the individual with the long-term condition, their carers and family in preventing and reducing any distress that has a negative impact on the individual's general wellbeing and ability to self-manage their illness, and the impact of their illness, effectively.

Long-term physical conditions are complex and present substantial challenges for every individual living with the condition, their carers and family. Effective self-management is crucial to the achievement of a healthy and satisfying life. This may require acceptance of the illness, managing symptoms, personal motivation, adherence to treatment regimes, managing stressful medical procedures, adjustment of expectations, and changes in behaviour and routines. This process will be influenced by developmental stage, age, impact of the physical health condition itself, past experiences of illness, and pre-existing patterns of health-related behaviours. In addition, an individual, their carers and

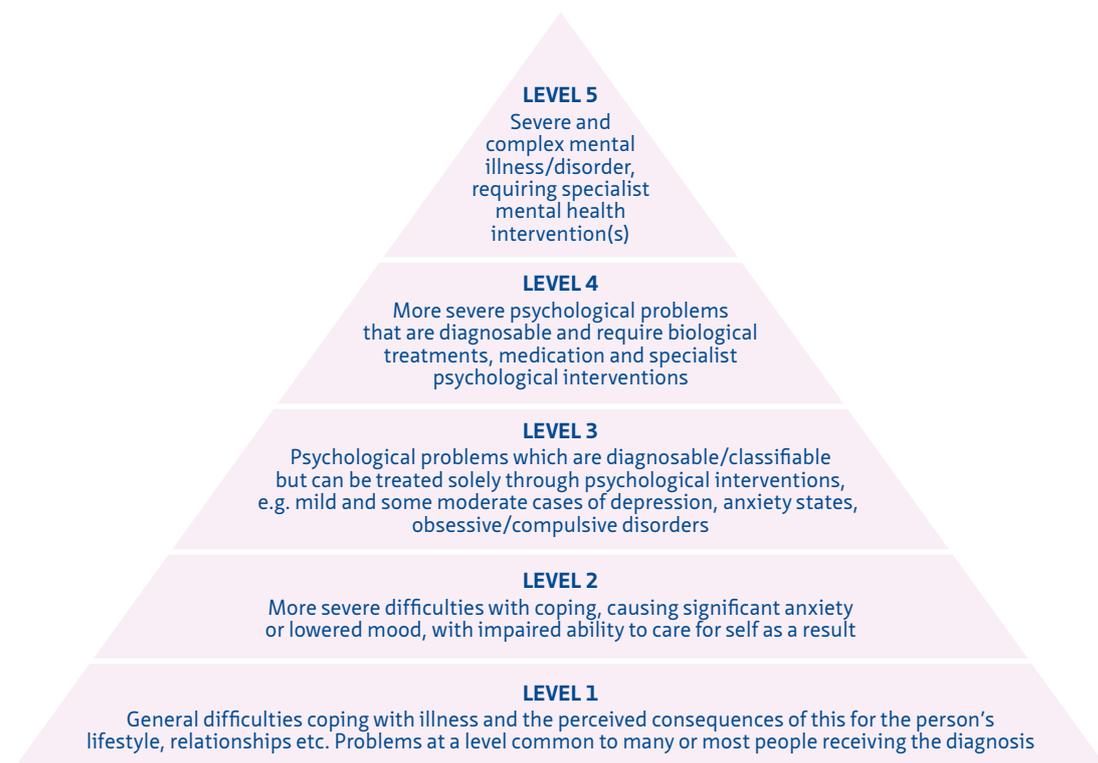
family may have emotional and psychological needs unrelated to their physical health condition that affect their wellbeing and ability to manage their physical health condition.

The spectrum of psychological need associated with diabetes was summarised into five levels and conceptualised in a 'pyramid of psychological need'.^{31 32} Following discussion with a clinical reference group, this has been adapted to represent need generically in long-term conditions (see Figure 1). This is not a 'stepped need' model; rather, an individual may have needs represented at several levels simultaneously. For example, someone with severe mental illness (Level 5) may also have anxiety (Level 1) about an aspect of their

diabetes or respiratory disorder management. An individual may also move up or down the levels of need at different points in their life, with management of the physical illness, life events or a change in circumstances. Other needs, for example co-existing severe and enduring mental illness or personality disorder, may require support and access to services (Level 4 or 5) on a longer term basis.

At the level of general difficulties in coping, it is estimated, for example, that some 60 per cent of adults with diabetes report at least one troublesome concern or emotional difficulty related to diabetes,³³ and some 40 per cent of adults with diabetes suffer from poor psychological wellbeing.³⁴

Figure 1. The pyramid of psychological need (adapted)



Adapted from *The pyramid of psychological need*.^{35 36}

Overall, it is estimated that 20 per cent of people with a long-term physical condition are likely to suffer from depression,³⁷ with depression and anxiety being two to three times more common than in the general population.³⁸

Individuals with known serious and complex mental health problems have a higher rate of physical health problems than the general population. The prevalence of diabetes in people with schizophrenia, for example, is estimated to be three times that of the general population.³⁹ At the same time, people with long-term physical conditions may develop severe and complex mental health conditions.

What are the implications?

This association and increased prevalence of mental health problems is important. Co-morbid health anxieties or mental health disorders are associated with:

- poorer objective health outcomes
- poorer subjective health outcomes
- higher use of healthcare resources
- wider costs of, for example, lack of employment, sickness absence, informal family care and support.

This includes: unnecessary investigation; increased presentations in primary care, emergency departments and outpatient clinics; increased use of medication; increased admissions with longer lengths of stay; and, in older people, increased risk of institutionalisation. For example, co-morbid depression is associated with a 50–75 per cent increase in health spending among diabetes patients,⁴⁰ and yet only half of the cases of depression in diabetes are detected.⁴¹ At least 28 per cent of patients admitted to hospital with physical illness also have a significant mental health problem, and a further 40 per cent have sub-clinical depression or anxiety.⁴² This rises to at least 60 per cent

'Between £8 billion and £13 billion of NHS spending in England is attributable to the consequences of co-morbid mental health problems among people with long-term conditions.'

for people over the age of 60.⁴³ Naylor *et al.*⁴⁴ have estimated that co-morbid mental health problems are a major cost driver in the care of long-term conditions, typically associated with a 45–75 per cent increase in service costs. They calculate that at least £1 in every £8 spent on long-term conditions is linked to poor mental health and wellbeing, meaning that between £8 billion and £13 billion of NHS spending in England is attributable to the consequences of co-morbid mental health problems among people with long-term conditions. It is further suggested that the majority of these costs will be associated with the most complex patients whose long-term conditions are most severe or who have multiple co-morbidities.

Do psychological needs extend across all age groups?

Living with long-term physical health conditions is relevant across the entire lifespan. Approximately 11 per cent of children experience significant chronic illness, including chronic mental health disorders,⁴⁵ while 10–13 per cent of adolescents report living with a chronic condition that substantially limits their daily life.⁴⁶ Living with a severe physical illness impacts on young people themselves, their emotional and social development, and their families.⁴⁷ Children living with long-term physical illness are twice as likely to suffer from emotional or conduct disorders.⁴⁸

There is considerable overlap between children with medically unexplained symptoms and

long-term conditions, with both being significant risk factors for chronic mental and physical ill health in adulthood.⁴⁹ In addition, approximately 10 per cent of children and young people frequently experience somatic symptoms not fully explained by medical assessments yet which cause significant impairment.⁵⁰

In all age groups, and in particular older people and those with severe and enduring mental illness, there may be more than one long-term physical condition present. For those living with three or more physical conditions, the risk of common mental health disorders increases to seven times that of the general population.⁵¹

Are service models available to address psychological needs?

The assessment of psychological needs and the provision of psychological interventions are delivered through the process of personalised care planning. Care planning, as part of case management, is an approach to addressing an individual's full range of needs. It takes into account health, personal, social, economic, educational, mental health, ethnic and cultural background and circumstances. Care planning recognises that there are other issues, including psychological wellbeing, personal interests and social contacts that, in addition to medical needs, impact on a person's total health and wellbeing.⁵²

Achieving system quality and productivity gains requires service redesign across primary/secondary/mental health services, with associated workforce development and commissioning pathway realignment. For quality and productivity gains to be achieved, pathway components need to be developed and commissioned in a planned way that ensures the right treatment is available at the right time and in the right setting for individuals.

Patients engaged in and informed about the management of their illness achieve the

'Patients engaged in the management of their illness achieve the best health.'

best health and quality of life.⁵³ Supporting and improving self-management is complex. A whole-system approach to developing self-management skills has been taken through the Health Foundation's co-creating health demonstration programme.⁵⁴ This rests on moving from a traditional relationship between clinician and patient to a collaborative relationship, of providing disease-related information, teaching self-management skills, goal setting and motivational interviewing. Supporting self-management in a complex health resource setting is also facilitated by the collaborative care approach, endorsed by the National Institute for Health and Clinical Excellence (NICE).⁵⁵

NICE's *Depression in adults with chronic physical health problems* guideline⁵⁶ describes collaborative care and when it is an appropriate way to organise care. The guideline makes clear that collaborative care is not a new care process. Instead, it is a way of organising and combining care processes that facilitates a whole-person approach to those people with co-morbid depression and a physical long-term health problem. While NICE only endorses collaborative care for this particular group of people, there is evidence, particularly from the United States, that the principles of collaborative care can be applied to those suffering from any long-term condition, such as diabetes, or from depression alone.⁵⁷

The key elements of collaborative care are:⁵⁸

- shared (between patient and health professional) understanding of health problems – what the patient wants to gain by managing the health condition better

- shared agreement of how the problems are going to be addressed – agreeing solutions to the health problems
- a shared approach from primary and secondary care services to the management of the patient. This shared approach may mean that primary care delivers the healthcare, but that secondary care provides support and supervision to primary care staff. Such supervision is critical to the success of collaborative care
- a case management approach that ensures all patients are followed up and their needs addressed. The case manager's responsibility is to ensure that patients are not 'lost' and that they receive high-quality, evidence-based care
- supervision, to help the case manager identify the needs of the patient, is an integral part of the care package.

The range of psychological care across the pathway includes:

- primary care management of active monitoring and positive diagnosis, management of common mental health problems, guided self-help strategies and programmes, motivational interviewing
- psychological interventions at the primary/secondary care interface, including integrated/stepped/collaborative care models with planned and coordinated care, interdisciplinary working and clear access points to services
- psychological care input into long-term conditions and acute hospital multidisciplinary teams
- development of liaison psychiatry services in acute hospitals to provide assessment, treatment, advice, consultation and management of complex cases.

Interventions with an evidence base, and recommended by NICE in the treatment of long-term conditions,⁵⁹ include:

- psycho-education
- group-based skills training
- individual and group cognitive behavioural therapy
- treatment of identified specific co-morbid mental health disorders, for example, anti-depressants for the treatment of depression.

What are the training needs?

The Royal College of General Practitioners and the Royal College of Psychiatry have published a strategy for training primary care staff in psychological awareness (available at www.iapt.nhs.uk). It argues that all primary care staff require psychological awareness training in order to provide whole-person care. The strategy provides a useful overview of training needs for the primary care workforce.

Professional bodies and IAPT provide guidance on the training needs of the more specialised mental health workforce. What remains unclear, with no consensus between professional organisations, is how much mental health professionals need to know about long-term physical health conditions. This remains the subject of discussion and consensus development.

The Royal College of General Practitioners and the Royal College of Psychiatrists' Mental Health in Primary Care Forum publishes factsheets on a range of clinical topics, including coronary heart disease and depression, medically unexplained symptoms, and smoking in patients with serious mental illness. The Academy of Medical Royal Colleges has also established an online resource of materials relating to long-term conditions, medically unexplained symptoms and mental health (available at www.rcpsych.ac.uk/improvingpmh).

Specific examples of long-term conditions

On the following pages, three long-term condition disease groups are examined:

- diabetes (pages 12–23)
- chronic obstructive pulmonary disease (pages 24–34)
- coronary heart disease (pages 35–40).

Examples of service innovation which integrate psychological interventions are provided, with a focus on learning, pathway development and evaluated benefits. Although it is anticipated that the learning can be applied across disease-specific innovations, this cross-fertilisation has not been tested or evaluated.

Diabetes

Diabetes is a common long-term physical health condition characterised by high blood glucose. It affects people of all ages, with increasing numbers of children under five years of age being diagnosed.⁶⁰

What do we know about the psychological need?

The prevalence of depression, anxiety and eating disorders is significantly higher among people with diabetes than among the general population. As summarised by the diabetes work group,⁶¹ depression is at least twice as common in people with diabetes, with an estimated 41 per cent of people with diabetes having poor psychological wellbeing, and many with psychological needs that do not meet the criteria for a formal diagnosis. In the United States, data indicate that 13 per cent of all new cases of Type 2 diabetes will also have clinical depression.⁶²

These patterns are important as evidence shows that co-morbid depression exacerbates the complications and adverse consequences of diabetes,⁶³ in part because patients may more poorly manage their diabetes. Not only does this increase the risk of disability and premature mortality, it also has substantial economic consequences. Healthcare costs are higher and productivity is lower due to reduced work performance, increased absenteeism and withdrawal from the labour force. In the UK, compared to people with diabetes alone, individuals with co-morbid depression and diabetes are four times more likely to have difficulties in self-managing their health and seven times more likely to have days off work.⁶⁴ In the United States, healthcare costs for those with severe depression and diabetes are almost double that of those with diabetes alone.⁶⁵

In a survey of Diabetes UK members, people with diabetes indicated a want and need for

psychological support, but are not always able to access appropriate services.⁶⁶

In addition, there is a higher prevalence of diabetes in people with severe and enduring mental illness. The detection and management of diabetes in this group, particularly in the mental health inpatient setting, is an area for further development and focus.

Psychological interventions

The psychological needs in diabetes and evidence supporting a range of psychological interventions have been robustly summarised by a joint working group⁶⁷ and mapped to the five levels of the 'adapted pyramid' model outlined on page 7. The summary was based on a review commissioned by the working group and undertaken by Dr Jackie Sturt and Kathryn Dennick at Warwick Medical School. The available evidence is mostly focused on the lower levels of the pyramid, in particular, patient education and self-management at Level 1. There is also evidence to support a range of interventions, or combination of interventions, at Levels 2 and 3, including: cognitive behavioural stress management, cognitive behavioural therapy (CBT), anti-depressant therapy, blood glucose awareness training (all at Level 2); group or individual psychotherapy, group CBT integrated inpatient therapy involving behavioural training and family therapy, blood glucose awareness training and psycho-education with attention to diabetes-related body image concerns (all at Level 3). They found little research to evaluate interventions at Levels 4 and 5.

Collaborative care developed in the United States, and described in National Institute for Health and Clinical Excellence (NICE) guideline 91,⁶⁸ has recently been shown to reduce glycosylated haemoglobin as well as co-morbid depressed mood and systolic blood pressure,⁶⁹ and a recent meta-analysis has confirmed the positive effect on diabetes outcomes.⁷⁰

Benefits to patients

Addressing psychological needs has been shown to improve glycosylated haemoglobin (HbA1c) by 0.5 to 1 per cent in adults with Type 2 diabetes.^{71 72 73} As summarised by NHS Diabetes and Diabetes UK,⁷⁴ improvements with psychological intervention include: reduced psychological distress and anxiety; improved mood and quality of life; improved relationships with health professionals and significant others; and improved eating-related behaviours such as binge eating, purging and body image symptoms.

The economic case

There is considerable scope for NHS savings and health gains for patients through improving the care pathways and delivering appropriate psychological interventions for patients with diabetes and co-morbid common mental health problems.

The Department of Health commissioned Professor Martin Knapp and colleagues from the London School of Economics and Political Science (LSE), the Centre for Mental Health and the Institute of Psychiatry to undertake economic modelling on a range of mental health interventions. One of these was collaborative care for patients with Type 2 diabetes and co-morbid depression. This work included a review of the available clinical and cost effectiveness evidence. As far as possible, the LSE made estimates of the costs and benefits of the interventions in terms of savings to the NHS and wider exchequer, benefits to health and wider economic benefits. The evaluation was published by the Department of Health in April 2011,⁷⁵ with earlier modelling summarised in the *Impact assessment to the mental health strategy*.⁷⁶

'There is considerable scope for savings through delivering psychological interventions for patients with diabetes.'

Excerpts from the diabetes section on collaborative care for patients with Type 2 diabetes and co-morbid depression published in *Mental health promotion and mental illness prevention: the economic case*,⁷⁷ are shown below.

Intervention modelled

Collaborative care can be delivered in a primary care setting to individuals with co-morbid diabetes and depression. Using a NICE analysis, it is estimated that the total cost of six months of collaborative care is £682, compared with £346 for usual care. A two-year evaluation in the United States found that, on average, collaborative care achieved an additional 115 depression-free days per individual; total medical costs were higher in year one, but there were cost savings in year two.⁷⁸

Impact

The model assessed the economic case for investing in six months of collaborative care in England for patients with newly diagnosed cases of Type 2 diabetes who screen positive for depression, compared with care as usual. The costs associated with screening are not included in the baseline model. The analysis assumed that 20 per cent of patients under collaborative care would receive CBT, compared with 15 per cent of the usual care group. Existing data on the cost effectiveness of CBT were used to estimate the impact on healthcare and productivity losses.

Figure 2 shows the estimated costs and savings for 119,150 new cases of Type 2 diabetes in England in 2009, assuming 20 per cent screen positive for co-morbid depression. Completing and successfully responding to collaborative care leads to an additional 117,850 depression-free days in Year 1 and 111,860 depression-free days in Year 2. According to the model, the intervention results in substantial additional net costs in Year 1 due to the costs of the treatment. In Year 2, however, there are net savings for the health and social care system due to lower costs associated with depression in the intervention group, plus further benefits from reduced productivity losses. Using a lower 13 per cent rate of co-morbid diabetes and depression, total net costs in Year 1 would be more than £4.5 million, while net savings in Year 2 would be more than £450,000.

Figure 2. Estimated costs and savings of collaborative care for new cases of Type 2 diabetes screened positive for depression in England

	Year 1 (£)	Year 2 (£)
Health and social care	7,298,860	-385,240
Productivity losses	-331,170	-314,330
Net cost/pay off	6,967,690	-699,570

2009 prices. Source: *Mental health promotion and mental illness prevention: the economic case*. Dept of Health, 2011

The study also estimated the incremental cost per quality adjusted life year (QALY) gained, which was £3,614 over two years. This is highly cost effective in an English context.

These estimates of the potential benefits are very conservative. The model does not factor in productivity losses due to premature mortality, nor further quality of life gains associated with avoidance of the complications of diabetes, such as amputations, heart disease and renal failure.

Nor does the analysis include long-term cost savings from reduced complications. These are potentially substantial: research in 2003 showed that for diabetes-related cases the average initial healthcare costs of an amputation were £8,500 and for a non-fatal myocardial infarction £4,000.⁷⁹ If, on average, costs of just £150 per year could be avoided for the intervention group, then investment in collaborative care would overall be cost saving from a health and social care perspective after just two years.

Key points

- The collaborative care intervention is cost-effective in an English context after two years, but has high net additional costs in the short term due to implementation costs.
- A wider-ranging analysis is merited to demonstrate the potential longer-term savings in health and social care costs due to reduced complications of diabetes.

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Commissioning

Guidance for commissioning psychological services in diabetes is available.⁸⁰ The 'pyramid of need' provides a framework for considering the range of interventions required to meet the needs of people with diabetes across the age range.

Case studies – examples of diabetes/mental health services

Further examples of innovations and psychological service models are provided in the working group document produced by NHS Diabetes and Diabetes UK.⁸¹

CASE STUDY

CBT wellbeing programme for Type 2 diabetes – a group intervention: NHS Berkshire West

.....

This service arose from a concern about the prevalence of co-morbid anxiety and depression in patients with Type 2 diabetes and the potential socio-economic consequences. It was funded by South Central Strategic Health Authority with a view to disseminating best practice. The underpinning theory is that a reduction in fear and anxiety will enhance self-management, improve quality of life and result in reduced healthcare costs.

All patients with Type 2 diabetes from four GP practices were invited by GP letter to participate in a six-session cognitive behavioural therapy (CBT)-based group intervention. Groups were run by three designated and trained psychological wellbeing practitioners from the local Improving Access to Psychological Therapies service. Groups were run mostly during late afternoons and evenings to maximise access.

'The underpinning theory is that a reduction in fear and anxiety will enhance self-management, improve quality of life and result in reduced healthcare costs.'

The intervention programme was evaluated using patient feedback, diabetes measures (HbA1c), self-report measure of diabetes management and emotional wellbeing measures (PHQ-9; GAD-7; DHP-18 diabetes-specific mood questionnaire). At the last session, an open forum was held, inviting feedback via group discussion with therapists. Follow-up will be completed by GPs at six and 12 months (ongoing).

The preliminary findings are that there was an improvement in anxiety and depression following the CBT intervention. There was a trend in improvement of barriers to activity and significant improvement with respect to disinhibited eating. HbA1c sample collection will take place after three months – results are not yet available. The project and evaluation are ongoing.

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University College London Hospitals paediatric service

At University College London Hospitals NHS Foundation Trust, the paediatric and adolescent psychological services (including clinical psychologists, psychotherapists and psychiatrists) work as part of the diabetes team looking after children and young people who are either inpatients or attending an outpatient clinic.

The psychological team has developed physical healthcare skills and works as part of the diabetes multidisciplinary team. The team works within a systemic framework and offers solution-focused, narrative and motivational interviewing as well as cognitive behavioural therapy. Joint care planning and case management is undertaken in complex cases. Consultation, joint research and training is provided to the diabetes team.

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'The psychological team has developed physical healthcare skills and works as part of the diabetes multidisciplinary team.'

CASE STUDY

Leeds diabetes liaison psychiatry service

The Leeds psychiatric liaison team has close links with the diabetes service and takes referrals from the hospital teams and primary care. The range of needs addressed includes clinical depression, eating disorders and conditions not severe enough for a clinical diagnosis. Those referred tend to be having difficulty coping with their diabetes, leading to poor glycaemic control, and with some requiring repeated hospital admissions. A motivational interviewing/ motivational enhancement approach is used and found to be helpful.

The service is characterised by close and effective communication and shared care between members of the liaison psychiatry and diabetes teams. Feedback is always given regarding the results of assessments, treatments and outcomes.

Recent review of the Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM) outcome data shows that 80 per cent of those completing measures at the beginning and end of treatment show improvement in their scores on follow-up/discharge, with 41 per cent of these showing over 50 per cent reduction in their total CORE-OM scores.

'The service is characterised by effective communication between members of the liaison psychiatry and diabetes teams.'

Comments from a consultant diabetologist

"A significant number of my young diabetes patients have issues dealing with the diagnosis of diabetes, ranging from difficulties adopting a new lifestyle to depression and general withdrawal. I have been referring various patients to you over the past five years and found the service you provide to be very helpful.

"The majority of patients, and possibly all, have clearly benefited from attending your clinics and this has been associated with significant improvements in their diabetes control. In particular, your clinics have been useful at teaching patients various coping methods that made living with diabetes an easier task. I would like to take this opportunity to thank you again for all your help and input over the years."

Comments from a patient

"This has helped me realise that all this time I thought I had been dealing with my diabetes but I hadn't. I had been ignoring it. I know, now, that I need to look at managing my diabetes. Thank you for helping me with all of this."

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The diabetes and mental health service at King's College Hospital, King's Health Partners

This is an award-winning liaison mental health service embedded in the Diabetes Centre at King's College Hospital NHS Foundation Trust. Referrals are considered from within the hospital (inpatients and outpatients), GPs and any diabetes services in the South Thames region.

The main clinical criterion is that the patient may have psychological or psychiatric problems that are interfering with their ability to manage the diabetes, leading to sub-optimal control, including hyperglycaemia or recurrent hypoglycaemia. Common reasons include depression, eating disorders, anxiety, interpersonal issues and difficulties in adjustment and acceptance, coping and living with diabetes. The service often discovers that patients also have many social problems such as housing, debt or unemployment.

The service offers:

- a diagnostic and formulation assessment
- psychopharmacological and psychological treatments (cognitive behavioural therapy, motivational enhancement therapy, mindfulness-based cognitive therapy, interpersonal therapy and family work)
- neuropsychology assessments
- case management
- consultation/liaison.

'The service provides in-house training to the diabetes team, tailored and adapted to the needs of staff with demonstrated positive impact on diabetes management.'

An outreach model, 3 Dimensions of Care for Diabetes (3DFD), funded by NHS London Regional Innovation Fund, recently received three Quality in Care Diabetes Awards (see www.qualityincare.org/awards/diabetes).

The service provides in-house training to the diabetes team, tailored and adapted to the needs of staff. Modules for the MSc Diabetes in Primary Care are run, and masterclasses in diabetes provided to the local Improving Access to Psychological Therapies services. Web-based training in depression in diabetes has been developed for the King's Health Partners Health Education and Innovation Cluster.

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CASE STUDY

Bournemouth diabetes psychological service

Following a research project demonstrating significant levels of psychological distress in patients with Type 1 diabetes and clinically relevant reduction of HbA1c following psychological interventions provided by a clinical psychologist and a diabetic specialist nurse, funding was secured for a clinical psychologist within the diabetes team.

Psychological care is now embedded in all aspects of the diabetes service. The clinical psychologist has a diverse role that includes, for example:

- one-to-one therapy
- input into group interventions such as education, newly diagnosed groups and 'pump starts'
- consultation
- clinical supervision of the team.

'Psychological care is now embedded in all aspects of the diabetes service with demonstrated positive impact on diabetes management.'

The positive impact of psychological input on diabetes management has been demonstrated. In a group of 48 patients attending one-to-one therapy for a mean number of 11 sessions, there was a mean reduction in HbA1c of 0.7 per cent and a mean reduction in Problem Area in Diabetes (PAID) total of 53 per cent (18 points).

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CAMHS paediatric psychology specialty: South Staffordshire and Shropshire NHS Foundation Trust

A paediatric psychology service is integrated with the diabetes team for children, adolescents and young people in transition to adult services.⁸³ A clinical psychologist and paediatric psychology specialist nurse provide psychological interventions and support to children, young people and their families. Children are seen quickly after initial diagnosis. Consultation, case discussions, supervision and teaching help develop the psychological skills of other paediatric staff.

A multi-level care pathway has been created with different stages of psychological intervention, the diabetes team providing some of the interventions, for example, the health education groups. The service and model of work has been a creative use of limited resources with positive outcomes for young people.

'Consultation, case discussions, supervision and teaching help develop the psychological skills of other paediatric staff.'

For further details, contact:

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CASE STUDY

North West London integrated care pilot for diabetes: West London Mental Health Trust/ Imperial College Healthcare NHS Trust

The North West London integrated care pilot aims to improve the health of patients with diabetes in the region through shared financial initiatives, clinical governance, improved communication and planning of care between GPs, secondary care physicians and other community health professionals.

The aim of the project is to reduce admissions to the acute hospitals. Early evaluation shows an improvement on actual and projected admission figures.

A liaison psychiatrist from West London Mental Health Trust attends monthly complex case discussion groups in primary care to offer guidance to colleagues about mental health and psychological factors that may be affecting the motivation, adherence and engagement of patients in the treatment of their diabetes. A regular multidisciplinary meeting between the diabetologists, liaison psychiatrists and clinical health psychologists in the hospital has been established to up-skill members of all teams in the care of these patients.

'Regular multidisciplinary meetings in secondary care and complex case discussions in primary care have been established to up-skill members of all teams in the care of patients.'

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Psychological care in the diabetes clinic: Guy's and St Thomas' NHS Foundation Trust

The diabetes centre at Guy's and St Thomas' offers a 'one-stop shop' for integrated diabetes care. Alongside medicine, podiatry and dietetics, a long-established, in situ diabetes psychotherapy service provides a clinical and consultative service. Referrals for assessment come from within the secondary care diabetes team and from local primary care teams.

Following referral, clients are invited for an initial assessment to establish psychological need and to determine appropriate intervention. Clients present with a range of psychological difficulties which impact on their ability to manage their diabetes. These include: anxiety and depression; difficulty adjusting to diagnosis; post-traumatic stress disorder; eating disorders; obesity; borderline personality disorder; drug and alcohol difficulties; and needle phobia. In addition, psychological assessment and psychotherapy are part of the routine package of care offered in the quarterly diabetes transition clinic (aged 14 to 16), the monthly young person's clinic (aged 16 to 22) and the weekly pump clinic.

'Psychological assessment and psychotherapy are part of the routine package of care offered in the 'one-stop shop' integrated diabetes clinic.'

Following assessment, clients may be offered in-house cognitive analytic therapy (CAT) or referred and signposted, as appropriate, to other services within the trust, such as liaison psychiatry, clinical psychology and St Thomas' Psychotherapy Department, which offers long-term psychotherapy and group therapy. Clients may also be referred to community mental health teams and community drug and alcohol teams.

Not all clients are able, or choose, to engage with psychological services. Psychotherapy consultation is offered in-house and to primary care teams, often via virtual clinics to guide staff working with 'difficult to help' patients. Specific CAT principles, such as 'contextual reformulation', are used within the diabetes multidisciplinary team to enhance their understanding and management of complex patients, particularly those with borderline personality disorder.

To support education and training within the trust, clinical psychotherapy placements are offered to psychotherapists, psychologists and psychiatrists, with a specialist interest in applying CAT to diabetes care and chronic health conditions.

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CASE STUDY

Cognitive analytic therapy diabetes service: Royal Sussex County Hospital

A cognitive analytic therapist works as part of the multidisciplinary diabetes team. Patients referred to the service have complex interconnecting psychological problems affecting their diabetes management and control (depression, anxiety and eating disorders). They show a high level of psychological morbidity, requiring a more complex psychological approach to treatment. Cognitive analytic therapy (CAT) is employed. This is a level four intervention as defined by NHS Diabetes,⁸⁵ is recommended by NICE as a treatment for eating and personality disorder patients, and specialises in treating the more 'resistant' patient.

The psychotherapist in post has previously conducted a randomised control trial which showed improvements in HbA1c levels after psychotherapy had ended.⁸⁶ Further research highlights continued reduction in HbA1c after CAT in these complex patients.⁸⁷ Service audit currently shows improved HbA1c levels during and after treatment, reduced admission rates and reduction in the unproductive overuse of diabetes specialist nurse sessions. Patients receive a maximum of 16 sessions of CAT. This is the model used elsewhere in complex patient groups.

'Service audit shows reduced admission rates and reduction in the unproductive overuse of diabetes specialist nurse sessions.'

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Chronic obstructive pulmonary disease

Chronic obstructive pulmonary disease (COPD) is a long-term progressive disease characterised by breathlessness, cough, sputum production, wheeze, weight loss, fatigue and sleep disorders. The course of the disease can fluctuate, with changes in symptom levels on a daily basis as well as repeated episodes of exacerbation. COPD has a significant impact on quality of life.

What do we know about the psychological need?

The experience of breathlessness can be distressing and difficult to understand and control.⁸⁸ Psychological factors can create a vicious circle, with escalating breathlessness, physiological arousal and panic. There is evidence of disproportionately higher prevalence rates of generalised anxiety disorder, panic and depression. The rate of common mental health disorders is some three times greater than in the general population.⁸⁹ The presence of psychological distress and mental health disorder results in restricted mobility, loss of energy, creates greater dependence on others, decreased levels of self-efficacy, less effective self-management of respiratory symptoms, and longer hospital stays.

Psychological interventions

Cognitive behavioural techniques have been successfully used in psycho-educational breathlessness and health promotion groups delivered in primary care⁹⁰ and secondary care settings,⁹¹ with positive impact on psychological wellbeing, coping strategies and health resource use.

Pulmonary rehabilitation group programmes offer an evidence-based, multidisciplinary approach for patients with COPD. They have good short-term benefits, with National Institute for Health and Clinical Excellence (NICE) guidelines recommending access to pulmonary rehabilitation for all patients who are limited by breathlessness.⁹² The reported

benefits, however, diminish over time, particularly where there is failure to maintain adherence to a post-rehabilitation exercise plan and failure to complete the programme. Stern and Restrick have shown that the addition of psychological input to the pulmonary rehabilitation programme, an integrated approach, improves completion rate and hence experience of breathlessness.⁹³ Recently updated guidelines for COPD recommend the inclusion of psychological intervention in pulmonary rehabilitation programmes.⁹⁴

In addition, the NICE guidelines for treatment of anxiety⁹⁵ and depression in long-term conditions⁹⁶ recommend a range of interventions and treatments that are relevant to patients with COPD. Cognitive behavioural therapy (CBT) has been successfully delivered in identified cases of anxiety and depression following initial screening.^{97 98} Respiratory-focused CBT packages, delivered by a CBT-trained respiratory nurse, have delivered improvements in anxiety and depression scores and hospital admissions.

A systematic review⁹⁹ examined CBT for anxiety and depression in COPD and found three randomised control trials (n = 165) and one non-randomised controlled trial (n = 8). This limited evidence suggests that CBT, when used with exercise and education, could contribute to significant reductions in anxiety and depression in patients with clinically stable and severe COPD. However, further trials are needed to confirm this.

Benefits to patients

Addressing health anxieties, co-morbid depression and anxiety improves a patient's ability to manage their illness and shortness of breath, improve cognitive attributions, and improve independence and exercise tolerance, with less time spent in hospital, less use of medication, decreased impact on employment and social activities and improved quality of life.

The economic case

There is considerable scope for NHS savings and health gains through delivering appropriate psychological interventions for patients with COPD and co-morbid common mental health disorders. Evidence on costs and savings is limited. Based on case studies (see pages 29–36) and published evidence,¹⁰⁰ two avenues for savings have been identified:

- psychological interventions help to reduce anxiety – this helps patients avoid exacerbations, and also helps patients self-manage and avoid unnecessary admissions
- psychological interventions also improve adherence to pulmonary rehabilitation programmes, delivering further benefits to patients and savings to the health system.

Economic evaluation of the Hillingdon breathlessness clinic

This study followed end-stage COPD patients who attended a cognitive behavioural breathlessness clinic at Hillingdon Hospital¹⁰¹ in 2006/07, including six months pre- and post-intervention recording of healthcare usage. The study included a control group of end-stage COPD patients who did not have the intervention.

The intervention involved a five weekly programme of two-hour sessions involving education, addressing anxiety and panic attacks, breathing and relaxation techniques, planning, pacing and goal setting. A health psychologist and a respiratory clinical nurse specialist run the clinic, with the support of physiotherapy, occupational therapy and the respiratory consultant physicians. The costs of running the breathlessness clinic are not published, but on the basis of the costs of group clinics elsewhere, they can be estimated at £40 per person per two-hour session, i.e. £200 per person overall.

'There is considerable scope for NHS savings and health gains through delivering appropriate psychological interventions for patients with COPD and co-morbid common mental health disorders.'

The study tracked inpatient admissions and A&E presentations in 119 patients over a period of six months before and after intervention, and usage by a control group of 119 patients over the same period. The study notes that: "As COPD is a progressive disease, it would be expected to see a continued rise in A&E attendance and hospital admissions, which is apparent in the control group."

Over the period of study, the control group exhibited an increase from 124 A&E presentations in the six months before intervention to 202 A&E presentations in the six months post-intervention (1.05 to 1.70 per person), and an increase from 282 to 488 hospital bed days (2.37 to 4.10 per person). By contrast, the intervention group demonstrated a marked fall in A&E presentations after intervention (132 to 71, or 1.11 to 0.60 presentations per person), and a slight fall in hospital bed days (297 to 273, or 2.50 to 2.29). The comparison of case against control to give a true indication of the impact of the psychological intervention, **demonstrates 1.17 fewer A&E presentations and 1.93 fewer hospital bed days per person in the six months after intervention.**

These reductions in healthcare usage can be costed on a national average basis using NHS Reference Costs, to give an impression of the savings that may be achievable if the intervention was rolled out elsewhere. Using latest NHS Reference Costs and uplifting

Figure 3. Possible costs and savings associated with a breathlessness clinic rolled out nationally

	2012/13	2013/14	2014/15	2015/16	Total (4 years)	Total (10 years)
Patients having treatment	77,000	77,000	77,000	77,000	308,000	770,000
CBT programme cost	£15.4m	£15.4m	£15.4m	£15.4m	£61.6m	£154.0m
COPD-related health saving	£64.4m	£64.4m	£64.4m	£64.4m	£257.8m	£644.4m
Net NHS cost	-£49.0m	-£49.0m	-£49.0m	-£49.0m	-£196.2m	-£490.4m

to 2010/11 prices using the Hospital and Community Health Services (HCHS) Pay and Prices index, an A&E admission can be costed at £101 on average, and a pulmonary hospital bed day (with oxygen) can be costed at £372 on average. On this basis, the Hillingdon study demonstrates **savings of £837 per person** who goes through the breathlessness clinic in the six months after treatment, **around four times the upfront cost.**

Work has been done to extrapolate the findings to estimate the overall level of savings possible if the intervention was rolled out to COPD patients nationally. On the basis of treating 10 per cent of the estimated 770,000 patients with COPD per year, the possible savings are given in Figure 3.

A key limitation of the study design is that it only tracks healthcare usage in the six months pre- and post-intervention. In future research, a longer follow-up period would allow assessment of whether health improvements and savings persist, and whether longer-term savings are achievable. The initial results are, however, promising.

Case studies – examples of respiratory/mental health services

The following case studies are examples of respiratory/mental health services.

CASE STUDY

Respiratory wellbeing clinic: South West London

In the London Borough of Sutton and Merton, a psychology-led group intervention, which included cognitive behavioural therapy, psycho-education and physical health promotion for people with chronic obstructive pulmonary disease (COPD), was developed in conjunction with a practice-based commissioning group. Before implementing the group, patients had high levels of anxiety and depression, poor self-management of their condition and were making use of high levels of unnecessary and costly services, including A&E and hospital admissions. They often mistook mental health symptoms for symptoms of physical deterioration. For example, panic attacks were viewed as acute exacerbations of shortness of breath. Patients with COPD often employed 'solutions' that made matters worse, for example avoiding exercise to avoid becoming breathless, leading to a downward spiral of decreased activity and quality of life.

The group was evaluated using a range of patient reported outcomes, patient satisfaction measures, and pre- and post-intervention cost data, including A&E visits and emergency admissions. The service reports substantial health gains and reduction in depression and anxiety symptoms. Patients reported improved quality of life and better management of their condition. While the pilot did not target high-cost service users, there was a significant cost saving, with reduced A&E attendance and emergency admissions. Results from the high-cost user subgroup suggested targeting that group could, over one year, have resulted in a cost saving of approximately £290,000 – **a saving of £5 for every £1 invested** in the wellbeing clinic.

'The service reports substantial health and cost gains and reduction in depression and anxiety symptoms.'

Comments from patients

"I really enjoyed the five sessions I attended at the respiratory wellbeing clinic... I learnt how to breathe properly and to pace myself with the tasks I wanted to do, which to me was very beneficial."

"I have taken a lot from the group. I feel more confident in going out now. I used to go around on a scooter in case I got breathless, but now I walk around like everyone else."

Following the initial pilot, there is now a wider health and wellbeing service within the Improving Access to Psychological Therapies team. This is targeting a range of long-term conditions, including COPD, and provides group-based courses, guided self-help and individual cognitive behavioural therapy. The impact of the approach is being evaluated.

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Breathlessness clinic at Hillingdon Hospital

Patients with severe chronic obstructive pulmonary disease (COPD) were invited to attend a breathlessness group by a member of the hospital medical team. The intervention offered was based on a cognitive behavioural framework and used cognitive behavioural therapy and psycho-education to address anxiety, panic attacks and depression, understanding and self-management of COPD and medication, activity pacing, relaxation, breathing retraining and goal-setting. The group ran weekly for two hours over four weeks.

A feasibility study involved participants completing the St. George's Respiratory Questionnaire and Hospital Anxiety and Depression Scale before and after the intervention, and at six weeks follow-up. Retrospective data on A&E attendances and length of hospital stay were collected six months before and six months after the intervention. These data were compared with a waiting list control group. A patient satisfaction questionnaire was also completed at the end of the intervention.

There was a significant reduction in depression and a non-significant reduction in anxiety following attendance at the group. There was a significant improvement in health status as measured by Respiratory Questionnaire total scores and a significant improvement in perceived impact of COPD on daily life as measured by the Respiratory Questionnaire impacts subscale.

The breathlessness intervention is now an established service and continues to demonstrate clinical and cost effectiveness, as well as positive feedback from service users. The research study has recently been published.¹⁰² A manualised version of the breathlessness intervention will be developed and evaluated as a home-based service.

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'There was a significant reduction in depression and improvement in health status following attendance at the group.'

CASE STUDY

Chest clinic integrated pathway, CBT trained respiratory nurses: Newcastle

Chronic obstructive pulmonary disease (COPD) treatment is provided by respiratory nurses within the chest clinic in Newcastle. All nurses are trained to foundation level cognitive behavioural therapy (CBT), enabling them to identify, assess, plan care for and treat anxiety and depression co-morbid with COPD and other chronic lung disorders. Complex cases are referred to respiratory nurses who are CBT trained at postgraduate level. Monthly supervision is provided by a consultant clinical psychologist.

The CBT specialists provide individual assessments and treatments, usually of three to four sessions. Joint respiratory/CBT training and clinical experience enables careful assessment and understanding of respiratory symptoms, shortness of breath in particular, and health behaviours, ensuring appropriate physical interventions, psychological treatments and self-management advice. Useful written patient information is provided, for example on depression and panic attacks. Leaflets can be obtained from www.ntw.nhs.uk

'Evaluations have shown improvement in levels of anxiety and depression and decreased hospital admissions in COPD patients.'

Two published evaluations have shown improvement in levels of anxiety and depression and decreased hospital admissions in COPD patients.^{103 104} A CBT random controlled trial is underway.

In addition, local primary care COPD guidelines will include Quality and Outcomes Framework (QOF) depression screening questions and use of the hospital anxiety and depression screening questionnaire.

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Integrated clinical psychology in a pulmonary rehabilitation team: Whittington Hospital

Pulmonary rehabilitation group programmes offer an evidence-based multidisciplinary approach for patients with chronic obstructive pulmonary disease (COPD), and include a combination of exercise and patient education.

NICE recommends that all patients with COPD who are limited by breathlessness should have access to pulmonary rehabilitation.¹⁰⁵ Reported benefits, however, frequently diminish over time, with failure to maintain adherence to a post-rehabilitation exercise plan and failure to complete the programme. The team observed that anxiety and depression were present in the group which did not complete the pulmonary rehabilitation programme. A psychologist was recruited to join the pulmonary rehabilitation team and a trial of standard versus enhanced treatment was undertaken. The enhanced treatment included a specific, targeted cognitive behavioural therapy-based component in the rehabilitation programme.

'The inclusion of clinical psychology input improved the completion rate for pulmonary rehabilitation, with significantly reduced annual admission rates and bed day usage.'

In the pilot, the inclusion of clinical psychology input improved the completion rate for pulmonary rehabilitation, with significantly reduced annual admission rates and bed day usage. This, in turn, has been estimated to produce significant cost savings far outweighing the cost of employing the psychologist.

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CASE STUDY

Bradford and Airedale integrated respiratory team

At Bradford and Airedale, clinical psychologists provide psychological assessment, formulation and intervention to patients with long-term conditions, with the aim of optimising self-management and reducing anxiety and low mood related to their condition.

Within chronic obstructive pulmonary disease (COPD), psychology is part of a multidisciplinary team working across the acute hospital and primary care trusts (Bradford and Airedale Primary Care Trust and Bradford Teaching Hospitals NHS Trust) to deliver the Better Breathing for Better Living pulmonary rehabilitation programme. Psychology is an integral part of the team and programme, facilitating psycho-educational talks on the programme, providing one-to-one psychological assessment and intervention, as well as indirect intervention through consultation. The psychologists also work with secondary and primary care colleagues to help people with COPD optimise the management of their condition, and hence reduce unnecessary demand on healthcare resources, with associated benefits in terms of healthcare costs.

Evaluation of the integrated Better Breathing for Better Living programme in 2008 indicated there was:

- a significant reduction in anxiety and depression symptoms on the Hospital Anxiety and Depression Scale. This was the case for those people who had demonstrated clinical levels of anxiety and/or depression on the scale, as well as for those who had scored below clinical levels

- a significant improvement in perception of illness: increased perception of control over their breathing problems; and increased perception of helpfulness of exercise for breathing problems
- a decrease in concern over breathing problems; and increased understanding of their breathing problems
- a significant improvement in the number of metres that people could walk without getting breathless.

There has also been positive feedback from patients with regard the psychological input to the pulmonary rehabilitation programme and the individual work.

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'Evaluation of the integrated programme indicated there was a significant reduction in anxiety and depression symptoms.'

Wellbeing project for COPD patients: NHS Berkshire East

This project arose when a strong case was made for the role of cognitive behavioural therapy (CBT) interventions in treating depression and anxiety within the chronic obstructive pulmonary disease (COPD) treatment pathway. The project plan outlined how specific unhelpful beliefs and maladaptive behaviours are common in patients with COPD¹⁰⁶ and how these beliefs and behaviours can be addressed by CBT.

In Berkshire East, patients with moderate and severe COPD attend a pulmonary rehabilitation course incorporating exercise and education. Patients attend sessions for two hours per week for eight weeks. At two of three hospital sites, CBT therapy was integrated into the pulmonary rehabilitation therapy pathway. The third site continued with the standard rehabilitation programme (control group). The aim is to reduce anxiety and depression, to improve wellbeing and decrease unplanned service use. The specialised CBT programme is being delivered through the local Improving Access to Psychological Therapies (IAPT) service and aims to be adaptable for other IAPT services within the area.

'The aim is to reduce anxiety and depression, to improve well-being and decrease unplanned service use.'

The service is being evaluated using COPD, anxiety and patient feedback measures as well as A&E attendance and hospital admission rates in the six months preceding and six months following completion of the CBT-enhanced pulmonary rehabilitation programme. Comparisons are being made across intervention sites and with the control group.

Preliminary findings suggest a decrease in scores on the Patient Health Questionnaire (PHQ-9), Generalised Anxiety Disorder Assessment (GAD-7) and the COPD Assessment Tool within the CBT treatment group. Data is under analysis and will be available early 2012.

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CASE STUDY

Lancashire Care NHS Foundation Trust

In the Blackburn with Darwen Pulmonary Rehabilitation Team, an occupational therapist provides psychological input to individuals presenting with anxiety and depression. Interventions offered include breathing control, psycho-education and relaxation, including a home-based service. A relaxation CD has been developed and is provided, where appropriate, to patients as part of the approach to anxiety management.

The impact of the home-based service has been positive. Patients may be reluctant to attend groups due to frailty, self-esteem, anxiety and language barriers, and benefit from the home-based treatment. Observation of the impact of difficulties on daily living and of the interaction with their environment enables individualised programmes to build confidence and overcome anxieties. As a result, patients reported, for example, increased walking distance, greater ability to manage breathing, greater independence and activities, with improved overall quality of life.

'Feedback from users of the service highlighted improved self-esteem, benefits of psycho-education in helping them manage, and overall improved quality of life.'

Feedback obtained from users of the pulmonary rehabilitation service via a peer group interview highlighted improved self-esteem and the benefits of psycho-education in helping them manage their day-to-day lives. Comments included:

"It has helped me make changes. It has eased anxieties and stress. We like the relaxation techniques and the Tai Chi."

"The service has helped so much. I hope it doesn't get lost. As I said before, the pamphlets they give us are easy to understand with simple diagrams and explanations. The prevention work is important. It has kept me out of hospital and improved my quality of life. It is important to patients and to the carers as it eases anxieties. You know better when it is time to panic!"

An independent evaluation demonstrated significant improvement in anxiety and depression (measured by PHQ-9 and GAD-7) and reduction in hospital readmissions and lengths of stay.

Further evaluation is underway.

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Liaison psychiatry input into a community respiratory service: West London Mental Health Trust/Imperial College Healthcare NHS Trust/Central London Community Health

The Charing Cross and Hammersmith Hospitals liaison psychiatry team designed, implemented and evaluated a pilot project over one year, providing liaison psychiatry input to the community respiratory (COPD) service. The aim was to improve knowledge and confidence in the respiratory multidisciplinary team in psychological aspects of long-term conditions, with resulting benefits for all patients. The project also enabled those with the most complex needs to access stepped pathways of care, including liaison psychiatry assessment. The ultimate aim was to improve adherence to care plans, improve quality of life and reduce use of unscheduled care.

A liaison psychiatry senior trainee session was provided for case discussion, education and support fortnightly in the respiratory multidisciplinary meetings. Individual outpatient assessments and ward reviews were offered in the most complex cases.

After nine months, feedback from the respiratory team was that their subjective confidence and ability in relation to psychological problems had improved. Regular case discussion with psychiatric input was highly valued. Patients responded positively to being offered psychological assessment within the familiar acute hospital setting, rather than being referred to generic locality-based psychiatric services.

'Patients responded positively to being offered psychological assessment within the familiar acute hospital setting.'

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Coronary heart disease

Coronary heart disease (CHD) includes conditions such as heart attacks and angina. Stroke, which affects the brain by damaging the blood supply, is not included in this section, nor is hypertension (high blood pressure) although both are caused by similar underlying problems.

When considering CHD, there are points along the course of the disorder for which evidence of improved outcomes, or amelioration of symptoms, through the provision of psychological or psychosocial interventions, have been published.

The European guidelines on cardiovascular disease prevention, produced by the Fourth Joint Task Force of the European Society of Cardiology,¹⁰⁷ describe that: depression predicts cardiovascular events and worsens prognosis; depression is associated with at least double the risk of a major cardiac event; and, in patients with CHD, depression has effects on cardiac symptoms, overall quality of life and illness behaviour, including increased healthcare utilisation, low adherence to treatment and lowered rates of return to work.

People who have suffered a heart attack have a 30 per cent chance of developing depression.¹⁰⁸ Those with cardiac problems are approximately three times more likely to die of these causes if they also suffer from depression than if they do not.¹⁰⁹

Depression in people with CHD predicts further coronary events (odds ratio = 2.0) and greater impairment in health-related quality of life.¹¹⁰
¹¹¹ People who develop depression following acute coronary syndrome, as opposed to those with depression that pre-dates the acute coronary syndrome, may be at particularly high risk of worse cardiac outcomes.¹¹² Depressed individuals with CHD are more than twice as likely to die than those with CHD alone.¹¹³
¹¹⁴ The mechanisms behind the association between depression and either mortality or morbidity in physical illness are not fully

understood.¹¹⁵ Either diminished healthcare behaviour or physiological impairment, or a combination of the two, may be important.

Psychological interventions

The *Handbook for vascular risk assessment, risk reduction and risk management*, prepared for the UK National Screening Committee, recommends that exercise is effective for primary prevention and reducing cardiovascular risk, and that exercise is also of value in managing depression and anxiety.¹¹⁶ However, it does not provide any evidence that managing anxiety or depression will prevent or reduce occurrence of cardiovascular events.

The European guidelines on cardiovascular disease prevention recommend the identification of depression and psychosocial risk factors.¹¹⁷ The guidelines outline that anti-depressant medication (SSRIs) are effective in the treatment of depression in cardiovascular disease, indicating resulting improvement of cardiovascular prognosis, and recommends multimodal treatment (including behavioural, stress management and social reintegration strategies) for psychosocial risk factors, and for clinically significant depression, treatment with anti-depressant medication and psychotherapy according to established guidelines.

National Institute for Health and Clinical Excellence (NICE) guidelines recommend a range of psychological interventions for the management of depression in chronic physical conditions¹¹⁸ and for treatment of anxiety.¹¹⁹ These are relevant to the prevention and treatment of common mental health problems associated with established ischaemic heart disease. McGillon *et al.* undertook a meta-analysis of the effectiveness of psycho-educational interventions for improving symptoms, health-related quality of life, and psychological wellbeing in patients with stable angina.¹²⁰ The authors concluded that these

psycho-educational interventions significantly reduced angina frequency and medication use. NICE-approved psychological therapies have been shown to improve the psychological, symptomatic and functional status of patients newly diagnosed with angina.¹²¹ They have also been shown to reduce hospital admissions in refractory angina patients.¹²² A very recent review¹²³ found 16 trials of psychological and pharmacological interventions for depression comorbid with CHD. There was a small but clinically meaningful effect of psychological interventions and SSRIs on depression outcomes in CHD patients. There were no effects on mortality rates or cardiac events. They concluded that there are few high-quality trials and much heterogeneity of populations and interventions tested.

Offering a range of psychological therapies at different points of the pathway in a cardiac rehabilitation setting has proved both successful in reducing anxiety and depression and acceptable to patients.¹²⁴ In this stepped-care approach, psychological assessment and therapies were integral to the cardiac rehabilitation programme and team, with the available interventions including psycho-education, brief individual therapy, group workshops and individual cognitive behavioural therapy.

Collaborative care, described in more detail for management of diabetes, is applicable to the management of ischaemic heart disease.

Developments in Australia include the use of a mobile phone-based model of cardiac rehabilitation that includes mentoring, video and teleconferencing to motivate and support behaviour modifications and personal goal-setting tailored to individual lifestyles.¹²⁵

Benefits to patients

Benefits are generated both through acknowledging that cardiovascular disease can have psychological consequences and vice versa,

and by offering evidence-based interventions for identified common mental health problems.

Economic case

The key UK economic evidence about psychological interventions for people with ischaemic heart disease comes from the National Refractory Angina Centre (NRAC) in Liverpool. Moore *et al.* report the findings of a patient follow-up study of a brief cognitive behavioural intervention for patients with chronic refractory angina.¹²⁶

This study followed 433 patients who were referred to NRAC between January 1997 and October 2002, of whom 383 were diagnosed with chronic refractory angina. These patients were invited to take part in a cognitive behavioural intervention – the Cognitive Behavioural Chronic Disease Management Programme (CB-CDMP). This involved a five-item questionnaire, a two-hour systematic interview with a consultant cardiologist and a consultant in pain medicine, offering evidence-based alternative explanations for symptoms, and agreeing patient-defined objectives. All patients then received “stress management advice and relaxation training tapes and manuals, and all agreed to undertake a modest, symptom-limited, graduated exercise programme at home, at a level appropriate to achieving their personal objectives.” Patients were followed up within eight weeks at a second, hour-long, combined pain and cardiology consultation.

The study tracked general admissions, angina admissions and myocardial infarctions for the one-year periods before and after intervention for the 271 refractory angina patients for whom admission data was available. There was no control group. In the year after intervention, only eight myocardial infarctions were recorded, compared with 32 in the year before intervention. Further, Moore *et al.* note that:

“Following enrolment, total hospital admissions fell from 2.40 admissions per patient per year to 1.78 admissions per patient per year ($P < 0.001$). Total hospital bed day occupancy fell from 15.48 days per patient per year to 10.34 days per patient per year ($P < 0.001$).”¹²⁷ They observe that this reduction was primarily due to admissions for chest pain and myocardial infarction; there was no significant change in non-cardiac admissions. Based on their results, it can be concluded that in the year following the cognitive behavioural intervention, patients exhibited 5.10 fewer inpatient bed days associated with cardiac admissions on average, and 0.75 fewer inpatient bed days associated with myocardial infarction.

These reductions in healthcare usage can be costed on a national average basis using NHS Reference Costs, to give an impression of the savings that may be achievable if the intervention was rolled out. Using latest NHS Reference Costs and uplifting to 2010/11 prices, a general cardiac admission can be costed at £359 per bed day on average, and a myocardial infarction admission can be costed at £332 per bed day on average. On this basis, the study demonstrates reductions in healthcare usage of approximately £2,000 per person in the year after treatment, well in excess of the cost of psychological intervention.

While the results look promising, and certainly warrant further investigation, assumptions are needed on account of the study design to be able to attribute the observed reductions in healthcare usage as savings from the intervention itself. As with all such studies, the comparator of interest when considering possible savings is the healthcare usage of the patient with intervention (observable) against the healthcare usage of the patient if they did not have the intervention (which is unobservable). As it is impossible to observe patients in both the intervention and non-intervention states simultaneously, proxies have to be sought. A first solution is to use a randomised control trial, whereby a control

‘The study demonstrates reductions in healthcare usage of approximately £2,000 per person in the year after treatment, well in excess of the cost of psychological intervention.’

group without intervention is used as a proxy for what would have happened otherwise; depending on the study design, the random allocation between intervention and control groups should make this approach unbiased.

However, in this instance, the study design does not use a control group, but instead tracks healthcare usage in the year prior to intervention and uses this as a proxy for what would have otherwise happened. This approach brings inherent uncertainty as the extent to which healthcare usage would continue in the absence of intervention is not known. Moore *et al.* acknowledge there may be an element of mean reversion (whereby previous high healthcare usage reverts to lower usage on average by statistical chance), or there may have been “simple optimisation of antianginal medication”.¹²⁸ However, as chronic refractory angina is a progressive disease, it is reasonable to assume healthcare usage would increase over time. The reported year-on-year reductions may be underestimates of the possible savings achievable.

Case studies – examples of ischaemic heart disease/mental health services

Many primary care trusts currently provide exercise on prescription for people with cardiovascular disorders. The Mental Health Foundation has provided a useful summary (available at www.mhf.org.uk).

The following are some examples of mental health provision in ischaemic disease.

Meeting the psychological needs of cardiac patients in a cardiac rehab setting: Guy's and St Thomas' and South London and Maudsley

The cardiac rehabilitation team at Guy's and St Thomas' NHS Foundation Trust developed an integrated, stepped-care approach to assess and address the psychological needs of cardiac patients. The aim was to make psychological care more accessible and acceptable to patients and thereby improve mental health outcomes. A psychologist was embedded within the cardiac rehabilitation team to allow holistic assessment of patients' physical and psychological needs, the integration serving to normalise discussion of psychological issues and minimise stigma. The service was designed to optimise accessibility, with multiple access points to psychological care corresponding with key stages of the patient journey. A stepped-care model of service delivery provided a range of psychological interventions to match delivery with individual patient psychological needs of varying severity, complexity and duration.

The interventions offered included:

- psycho-educational sessions addressing behavioural risk factors and adjustment issues. Sessions were co-facilitated with other members of the multidisciplinary team, allowing for inter-professional learning
- group workshops consisting of eight sessions for small groups of five to eight patients

- brief individual therapy, consisting of one to six sessions on cardiac issues, risk and reducing levels of distress
- individual therapy using cognitive behavioural therapy for anxiety, depression and adjustment to adverse life events. Patients were seen for four to 26 sessions, depending on their needs.

The stepped-care model places the psychologist at the heart of the cardiac rehabilitation team, providing an integrated service that increases accessibility and acceptability and improves patients' emotional wellbeing. A significant increase was seen in the number of patients accessing mental healthcare, with 50 per cent accepting psychology referral compared with 20 per cent accepting referral to liaison psychiatry services in previous years. Audit data for 460 patients attending cardiac rehabilitation showed a 19 per cent decrease in anxiety and a 13.5 per cent decrease in depression. This is well above the national average decrease of 4 per cent. Patient satisfaction with the psychological interventions was high, ranging from 83 per cent to 93 per cent. Further details are available in a published paper.¹²⁹

'A significant increase was seen in the number of patients accessing mental healthcare.'

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CASE STUDY

Refractory angina service: Liverpool Hospital and Chesterfield PCT

Providing group-based cognitive behavioural therapy to patients with resistant angina has provided excellent outcomes, with a reduction in cardiac intervention rate, reduction in admissions, shorter admissions and reduced attendance at outpatient clinics. Savings have been made in acute hospital care, more than offsetting the cost of providing the psychological care.

'Savings have been made in acute hospital care, more than offsetting the cost of providing the psychological care.'

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Provision of CBT-group therapy and telephone follow-up: Oxford Health NHS Foundation Trust and Oxford University Hospitals NHS Trust

This initiative was designed as a pilot project in response to the South Central Cardiac Network highlighting the need to expand access to psychological services for cardiovascular rehabilitation patients. It has been observed that cardiac patients who had had surgical intervention following a heart attack had high levels of anxiety and depression, resulting in increased demand for emergency admissions. The response was to extend existing psychological services in cardiac rehabilitation to be available to all cardiac patients. All patients have now been offered cognitive behavioural therapy (CBT) in a group education session, and those whose scores on the Hospital Anxiety and Depression Scale (HADS) indicate a clinical range for anxiety and/or depression, are offered a one-to-one CBT-based assessment and treatment planning. They are then followed up with three CBT sessions via telephone.

Patients are routinely assessed using HADS at the start and following completion of a cardiac rehabilitation programme. Those patients who have HADS scores greater than ten are routinely referred for CBT. This project additionally provides a group psychological intervention to patients with a HADS score

lower than ten – a patient population who would have been excluded from psychological support in the past. A group psychological information session entitled ‘Anxiety and depression in cardiac patients’ is provided as a routine part of the cardiac rehabilitation education programme, thus reducing any stigma associated with receiving psychological support. A clinical psychologist is part of the cardiac rehabilitation education sessions.

Outcome measures used to evaluate impact are the HADS and Dartmouth Cooperative Functional Assessment Charts (COOP). Preliminary findings indicate that the CBT-based cardiac rehabilitation improves depression, quality of life and anxiety in the short term. The long-term impact is yet to be determined. The project is ongoing and entering the next phase in early 2012, involving Improving Access to Psychological Therapies (IAPT) step two and three workers.

‘CBT-based rehabilitation improves depression, quality of life and anxiety.’

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Other examples

There are many other examples across the whole age range of psychological need and service innovations in long-term conditions. This includes, for example, psychological need for the patients and carers post-stroke, neurodegenerative conditions, epilepsy, sickle cell disease, cancer and renal disorders. Evaluation of the efficacy of psychological therapies and economic arguments of actual or potential savings associated with provision of psychological care need to be developed in future.

Medically unexplained symptoms

What does this refer to?

There is ongoing debate about terminology in this area of clinical practice. The term 'medically unexplained symptoms' (MUS) is widely used and refers to physical symptoms or bodily complaints that are not fully explained by an identifiable physical cause. The symptoms can be long-lasting and can cause distress and impaired functioning. This terminology has, however, been considered unsatisfactory, mainly because of the negative definition¹³⁰ and that patients find it an inaccurate term.¹³¹

Alternative terminology is therefore sometimes used. 'Functional somatic syndromes', for example, refers to individual syndromes, such as irritable bowel syndrome, chronic fatigue and fibromyalgia, that are well recognised and diagnosed based on recognised symptoms, but as the organic aetiology is unclear they are considered 'medically unexplained' syndromes.¹³² Other terms have also been considered, including 'somatisation disorder' and 'bodily distress disorder'.¹³³ These terms, however, assume a predominantly psychological aetiology and fail to take into account the complex interplay between biological and psycho-social factors in the aetiology of these conditions. There is also some overlap between MUS, functional syndromes and somatoform disorders, the latter term used when the main feature of presentation is a high number of MUS that are persistent and lead to significant impairment.¹³⁴

There is also debate about the usefulness of collating all somatic symptoms under the one term, such as 'medically unexplained symptoms', or separating them into defined groupings, or 'functional somatic syndromes', such as chronic fatigue, irritable bowel syndrome, and chronic pain.

Even within these groups, it is possible to find subgroups of symptom patterns. There is benefit in 'lumping symptoms together' (and considering as medically unexplained symptoms), 'splitting' into separate syndromes (chronic fatigue syndrome, irritable bowel syndrome, for example), and splitting into even further sub-groupings to better understand the aetiological factors and treatment responses within specific functional syndromes.¹³⁵ The 'lumping' and 'splitting' helps identify both the similarities between syndromes and the dissimilarities.

For the purpose of this chapter, the syndromes are considered together under the term 'medically unexplained symptoms' (MUS). The limitations are, however, acknowledged, the term failing to take into account the subtle differences between key presenting symptoms and complaints and treatment approaches. MUS is the term currently used in the Improving Access to Psychological Therapies (IAPT) programme, although the terminology is under debate.

How often does MUS present?

People with MUS frequently present in both primary care and secondary care services. Most symptoms are transient. Only a small proportion of people develop persistent, potentially disabling symptoms which have high personal costs in terms of distress and loss of function, and also are expensive to healthcare and society.¹³⁶ However, up to 20 per cent of new primary care GP appointments are for people whose symptoms are eventually described as 'medically unexplained'.¹³⁷ In secondary care, a number of studies in both the UK and the United States have shown that up to 50 per cent of sequential new attenders at outpatient services have MUS. This is demonstrated in a study at King's College Hospital outpatient department (see Figure 4).

Figure 4. New attenders at the outpatient department, King's College Hospital, London¹³⁸

Specialty	% with MUS
Chest	59
Cardiology	56
Gastroenterology	60
Rheumatology	58
Neurology	55
Gynaecology	57
Dental	49

Other authors have found similarly high prevalence rates for MUS in general hospital clinic populations – for example, 53 per cent in gastroenterology, 42 per cent in neurology and 32 per cent in cardiology.¹³⁹

Analysis of 2008/9 NHS figures shows that people with somatoform disorders account for as many as one in five new consultations in primary care, 7 per cent of all prescriptions, 25 per cent of outpatient care, 8 per cent of inpatient bed days and 5 per cent of A&E attendances, with an estimated cost to the NHS associated with MUS of £3.1 billion.¹⁴⁰ However, about half the cost (£1.2 billion) was spent on the inpatient care of less than 10 per cent of people with MUS – a relatively small number of people receive very expensive and inappropriate care.

MUS occur across the lifespan. They are common in children, with estimates of one in ten children and young people frequently experiencing somatic symptoms that cause significant impairment.¹⁴¹ MUS increases as people age into adulthood. Women are three to four times more likely to experience MUS than men.¹⁴²

What interventions are beneficial?

It is understandable, and appropriate, that people with physical symptoms attend their doctor for advice and, in some circumstances, symptoms warrant further investigation or specialist opinion. If no obvious physical cause can be found, appropriate assessment of physical health experiences, social factors and psychological response is needed.

There is some evidence that 'symptom reattribution' is a successful form of intervention for people with MUS, this being a structured consultation delivered by GPs which aims to provide a psychological explanation to patients with somatised disorder.¹⁴³ However, a recent study suggested that, while it does improve doctor-patient communication, it does not improve patient outcomes.¹⁴⁴

The recent MUS guidelines for health professionals published by the Forum for Mental Health in Primary Care,¹⁴⁵ summarise that "just being there" to listen, reassure and provide explanation is helpful. Management of symptoms, and treatment of any associated symptoms of depression or anxiety, in accordance with the relevant National Institute for Health and Clinical Excellence (NICE) guidelines, is beneficial. Primary care interventions focus on the consultation style adopted by professionals rather than defined psychological interventions. This has been summarised in Improving Access to Psychological Therapies (IAPT) guidance¹⁴⁶ and the recent Forum guidelines.

In secondary care, specialist services such as pain or fatigue clinics and liaison teams provide specialist multidisciplinary care for patients presenting with more complex MUS, including associated high levels of disability and high levels of distress.¹⁴⁷ The services provide assessment, care and treatment for people with more severe or complex disorders than those found commonly in primary care. The approach is multidisciplinary and biopsychosocial, using approaches that are evidence-based.

Some general elements of care are similar to those suggested for use in primary care, including eliciting the physical symptoms, finding out the meaning of them to the patient, carrying out any necessary physical examination and appropriate investigations, giving a clear diagnostic statement (i.e. what is occurring and what is not occurring) and, wherever possible, providing an explanation for the symptoms in biopsychosocial terms. While it is always important to remember that people with MUS may develop new physical pathology which would require appropriate diagnosis and treatment, it is essential to reduce and avoid unnecessary and unwarranted investigations.

In view of ongoing concerns that something 'physical' is being missed, patients presenting with MUS may at first be reluctant to see someone identified as a mental health professional. It is, therefore, essential to carefully engage the patient, introducing them to what will be a different approach to helping their symptoms. The new approach can be described as 'problem-based' – developing a problem list with the patient in order to expand the focus from exclusively somatic (physical) to include psychological/emotional and social/relationship aspects of their difficulties, using psychotherapeutic, cognitive-behavioural and social/interpersonal interventions alongside pharmacological treatments, as required.

Cognitive behavioural techniques are often used, including:

- graded activity and/or graded exercise
- developing a consistent daily routine which incorporates good sleep hygiene
- identifying unhelpful thoughts and how these may later affect behaviour and emotions
- challenging unhelpful thoughts or accepting these as thoughts rather than facts
- problem solving and stress management
- reducing symptom focusing.

Treatment may also involve reducing consulting, investigations and prescribing.

Cognitive behavioural therapy (CBT) has been found to be both "feasible and effective" for MUS.¹⁴⁸ A meta-analysis of treatment for chronic fatigue syndrome suggests that both CBT and graded exercise therapy are promising treatments, with CBT possibly the more effective treatment in patients who have co-morbid anxiety and depressive symptoms.¹⁴⁹ There is evidence for the efficacy of psychological treatments for irritable bowel syndrome (including CBT and psychotherapy, either alone or in conjunction with antidepressant medications¹⁵⁰), fibromyalgia (CBT¹⁵¹), and multisomatoform disorder (brief psychodynamic psychotherapy¹⁵²).

For severe and complex MUS, the specialist biopsychosocial approach provided by liaison mental health teams or teams specialising in functional syndromes can allow a clear understanding of the nature and causes of the condition to be developed, the physical, psychological, social and risk aspects to be addressed, and any co-existing organic pathology to be treated.

The economic case

Alongside benefits to patients, there is scope to make significant healthcare savings by improving care pathways and the delivery of appropriate psychological interventions for people with MUS.

The Department of Health commissioned Professor Martin Knapp and colleagues from the London School of Economics and Political Science (LSE), the Centre for Mental Health and the Institute of Psychiatry to undertake economic modelling on a range of mental health interventions. One of these was CBT in patients with MUS. Excerpts from the published modelling¹⁵³ are presented opposite.

Further summary is published in the *Impact assessment to the mental health strategy*.¹⁵⁴

Intervention modelled

CBT has been found to be an effective intervention for tackling somatoform conditions and their underlying psychological causes.¹⁵⁵ Studies report a positive impact on symptoms and lower healthcare resource utilisation due to reduced primary care consultations and the avoidance of unnecessary diagnostic tests and invasive procedures.^{156 157} The limited data indicates that 40 per cent of individuals receiving CBT continue to report much improved, or very much improved, somatisation (physical symptoms caused by mental or emotional factors) 15 months after treatment, compared with just 5 per cent of those who receive treatment as usual.¹⁵⁸

A course of CBT may last for ten sessions at £40 per session. Costs associated with the need to raise the awareness of GPs to the potential role of CBT treatment for somatoform conditions, either through e-learning or (much more expensively) face-to-face training, are also included. These include costs associated with encouraging GPs to attend regional workshops prior to e-learning, and the cost of locums while GPs are attending face-to-face courses.

Impact

The model looks at the impact on costs in England, over three years, of the CBT intervention for working age individuals who present to GPs with somatoform conditions. Based on existing studies, it assumed that 50 per cent of those offered CBT (after six months' observation) take up the treatment, and that patients who improve will avoid the additional utilisation of healthcare resources commonly associated with somatoform conditions. While no data are available on clinical effectiveness beyond

21 months, the model assumes that the benefits are maintained until the end of year three. The economic analysis looks at the costs to the healthcare system and the impact on productivity as a result of somatoform related sickness absence from work.

The results (see Figure 5) show the impact on net costs and the cost per quality-adjusted life year (QALY) gained. When all patients with somatoform conditions (sub-threshold and full disorders) receive CBT, and e-learning is used to increase GP awareness, the model shows an overall saving of £639 million over three years, nearly all because of reduced sickness absence. The impact on the NHS is broadly cost neutral. If the more costly option of face-to-face GP training is used, net NHS costs increase by £143 million, but the cost per QALY gained is only £3,402, which would be considered highly cost effective. Also taking into account reduced sickness absence, the model shows that CBT for all somatoform conditions with face-to-face GP learning would start to be cost saving in year three. A variety of sensitivity analyses were conducted. For instance, if we assume that all individuals treated for MUS received 15 sessions of therapy at £50 per session, then total costs of the CBT treatment would rise to £1.59 billion, with net costs to the NHS of £737 million at a cost per QALY gained of £17,527.

The analysis also demonstrates the higher returns available when the intervention is targeted solely at patients with full somatoform disorders. In this scenario, the model shows that the net impact of the intervention is cost saving to the NHS after two years if face-to-face GP training is used, and after just one year (saving around £60 million in year one) if e-learning is used. In both cases, net cost savings are improved when the analysis includes reduced sickness absence of around £40 million a year.

Figure 5. Annual costs/pay-offs impact in CBT for sub-threshold and full somatoform disorders (with e-learning for GPs) (2009 prices)¹⁵⁹

	Year 1 (£ million)	Year 2 (£ million)	Year 3 (£ million)	Total (£ million)
CBT awareness training for GPs	0.6	0	0	0.6
CBT cost	847.6	0	0	847.6
GP consultations	-45.8	-45.1	-44.5	-135.3
Prescriptions	-13.3	-13.1	-12.9	-39.2
Outpatient consultations	-5.8	-19.7	-19.5	-45.0
Inpatient stays	-82.2	-181.7	-179.0	-442.9
A&E attendances	-64.3	-63.3	-62.4	-190.0
Net NHS costs	636.9	-322.9	-318.2	-4.2
Productivity losses	-214.7	-211.6	-208.5	-634.8
Net NHS and productivity costs	422.2	-534.5	-526.7	-639.1

Key points

- While the economic case for CBT is most compelling if resources are targeted at those with full somatoform disorders, the case for also tackling sub-threshold conditions is strong. All models are likely to be cost saving in the long-term.
- The model relies on evidence of effectiveness from studies in the United States, which may not be easily generalisable to an English context. However, sensitivity and threshold analyses indicate that, even assuming very limited improvements in health outcomes, investing in actions to tackle somatoform disorders remains cost-effective from a societal perspective under most scenarios.
- More information is required on the relative effectiveness of e-learning compared to face-to-face learning as a way of raising GP awareness, because costs are substantially lower.

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CASE STUDY

Primary care in London: City and Hackney project with the Tavistock Clinic

The City and Hackney Primary Care Psychotherapy Consultation Service (PCPCS) was commissioned by the City and Hackney PCT from the Tavistock and Portman NHS Foundation Trust. It became operational in October 2009. The service bridges the gap between provision at primary care level and secondary/tertiary care for those patients with complex needs who, for various reasons, either do not meet the thresholds or find it difficult to engage with these services. Patients with medically unexplained symptoms (MUS) are one of the groups catered for. Many such patients do not realise the contribution that psychological concerns can make to physical symptoms and so are often unwilling to access help in a mental health setting or traditional psychological therapies service.

An innovative feature of the PCPCS is that it not only provides a clinical service to patients through assessment (with experienced clinicians) and interventions from a range of therapeutic approaches (including cognitive behavioural therapy, dynamic interpersonal therapy, mentalisation-based treatments, groups and couple/family work), but also provides close collaboration with GPs to support and develop their work with their patients. This is provided through professional consultation, joint consultation (with the patient), case-based discussions (with primary care teams) and training.

'The service was very distinctive and clearly targeted a client group that other services were either unable or unwilling to address.'

Working alongside the local Improving Access to Psychological Therapies service, the PCPCS is designed to bring secondary care experience into primary care. The service helps to narrow the gap in the stepped-care model in a way that ensures patients have access to the support they need, when and where they need it.

The service was externally evaluated in a Capita report.¹⁶⁰ Extracts from the report:

"There was near universal acknowledgement that the PCPCS provided a different and much valued additional service to that which already existed. There was a general view that the service was very distinctive and clearly targeted a client group that other services were either unable or unwilling to address."

"Many GPs expressed positive experiences of the PCPCS' understanding and willingness to work with people holistically and support them to address a wider range of issues other than just therapy-based intervention."

"Many GPs had observed an improvement in more appropriate attendance patterns at the practice and been impressed by the ability of the service to successfully engage the patient where previous services had failed. There was a real sense that the PCPCS went much further than any other service to address poor engagement issues and help the patient reflect on their previous inappropriate use of service in a constructive way."

Continued overleaf

“Most services reported an ongoing and positive relationship and that the PCPCS supported effective communication regarding potential cross-referrals and/or future input into after-care arrangements. Some examples were quoted whereby an initial assessment or proactive engagement had resulted in an appropriate and very effective transfer of care from the PCPCS to other services better placed to undertake further interventions.”

“The evidence suggests that this is a highly valued service and one that stakeholders would like to see continued. There was a clear view that the need was of sufficient scale to warrant the continuation of the service.”

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‘The evidence suggests that this is a highly valued service and one that stakeholders would like to see continued.’

CASE STUDY

London Health Programmes – managing persistent symptoms project

London Health Programmes is an NHS organisation leading the development of proposals to improve health and healthcare services for Londoners. London Health Programmes works with London's commissioners to transform frontline services and drive up standards in care quality. In consultation with patients, clinicians and GPs, London Health Programmes proposes service changes which are expected to save lives, improve Londoners' health and deliver efficient healthcare services.

The mental health team, part of London Health Programmes, has been successfully running a project since 2010 to improve the care of people with medically unexplained symptoms (MUS) (otherwise referred to as persistent symptoms) in the capital. The team has already delivered the first part of the project. This focused on primary care and was completed in March 2011.

A number of key documents have been published as a result:

- the MUS whole-systems approach
- an executive summary for GPs
- practical tips for MUS
- an MUS project implementation report.

These are available at www.londonhp.nhs.uk/services/medically-unexplained-symptoms

An MUS education and training package has been developed and delivered in pilot sites, and is now more widely available via the London Deanery Integrated Care Programme. The project now extends the learning from primary care into the secondary care sector, with emphasis on people who frequently present in acute hospital emergency departments.

Primary care

The MUS whole-systems approach was at the core of the project and provided examples of a range of effective approaches across the whole system to manage MUS. A wide range of stakeholders contributed to the project, including patients, commissioners and clinicians from a range of primary and secondary care service providers.

In 2010/11 a pilot was undertaken to establish the prevalence and cost of MUS within the GP-registered population of a small number of pilot sites and to test the effects of GP practices implementing a targeted approach to the management of patients with MUS. The aims were:

- to use the information to estimate the potential direct cost to the NHS of MUS in London
- to explore the impact of GP practices utilising the care model set out in the MUS whole-systems approach document.¹⁶¹

Key elements of this model at the primary care level are: the practice identifying patients with MUS and providing consistency to their care through identifying a 'usual GP' to see the patient; and a system for 'flagging up' the patient in the practice to reduce consultations by numerous GPs.

Continued overleaf

The key findings of the pilot include:

- MUS in primary care is very difficult to define as there is no agreed diagnostic process. This was particularly evident in debates around people with co-morbid conditions
- MUS is expensive – a retrospective search of NHS utilisation (primary and secondary care) over 24 months revealed an average cost of £42,000 per month per patient
- patients with MUS consult frequently – the group of 227 patients accounted for 8,990 GP contacts, equating to a cost of £13,000 per month
- patients with MUS are frequently investigated – the number of investigations equated to 74 per month – an average of eight per patient.

Emergent learning from the project included:

- the role of the GP is significant in the management of patients with MUS as patients seek reassurance and need a consistent approach and personal contact
- coding helps practices provide a consistent approach. The project used the READ code I6H (unexplained symptoms continue)
- continuity and management reduces costs over time (both investigations and GP utilisation were reduced during the pilot).

‘The role of the GP is significant in the management of patients with MUS as patients seek reassurance and need a consistent approach and personal contact.’

Following the pilot project, all participating GPs stated that they recognised the need to improve continuity of patient management for patients with MUS. Over 81 per cent had already taken steps to implement this in their practices.

Secondary care

The secondary care project has an emphasis on people who frequently present in acute hospital emergency departments. A workshop, with an expert audience focused on understanding the clinical issues and on establishing a pilot project, was held in August 2011. Education sessions for staff have taken place at two pilot sites, based on workshops run during the primary care project and providing an overview of concepts and issues around MUS.

The project has its roots in QIPP and will go on to test and evaluate interventions for reducing attendance in emergency departments and appropriate models of care. Project delivery should result in a more skilled and capable workforce, improved quality within a defined pathway, greater system-wide cohesion and, ultimately, reduced reattendance rates in the department and beyond.

Improvements in relation to repeat attenders with MUS in the emergency department, often currently with onward processing throughout hospital pathways, should lead to realised benefits in clinical and support staff time and other costs, not only in the emergency department but also in inpatient, outpatient and diagnostics departments.

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CASE STUDY

Specialist care – mental health assessment and treatment unit within an acute hospital setting: Yorkshire Centre for Psychological Medicine

The Yorkshire Centre for Psychological Medicine (YCPM) delivers biopsychosocial inpatient assessment and treatment for people with severe and complex medically unexplained symptoms (MUS) and physical/psychological co-morbidities (often long-term conditions). The YCPM is a specialist unit in a general hospital, originally established at Leeds General Infirmary in 1980. It is a unique service which offers access to patients not only from Leeds and Yorkshire but across the UK.

The unit aims to help people with complex difficulties make significant improvements with regard to their health and quality of life. Clinical outcomes, even in a range of very chronic and complex cases, are often very good, and patient feedback is positive. This is possible because of the nature of the YCPM unit and its function within the general hospital setting, but also due to the depth of experience and breadth of expertise within the multidisciplinary team. The team includes liaison psychiatry, nursing, occupational therapy, physiotherapy, dietetics, pharmacy, social work and administration.

The unit benefits from staff with dual (general/physical and mental health) training, and others trained in cognitive behavioural therapy and psychodynamic psychotherapy. In addition, there is direct and easy access to all medical and surgical teams in the general hospitals.

'Treatment programmes will often include physical and occupational rehabilitation in parallel with psychotherapeutic interventions.'

Assessment, formulation and treatment approaches are multidisciplinary and genuinely biopsychosocial, with an organised approach to understanding and addressing physical, psychological, social and risk aspects in every case. Treatment programmes will often include physical and occupational rehabilitation in parallel with psychotherapeutic interventions and pharmacological treatments. Detailed reports are provided as part of a careful approach to the discharge of patients to the referring team, whether in primary or secondary care.

The YCPM exists within the broader liaison psychiatry service provided by Leeds and York Partnership NHS Foundation Trust.

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The Department of Liaison Psychiatry at St Mary's Hospital (Imperial College Healthcare NHS Trust)

The Department of Liaison Psychiatry at St Mary's Hospital, London, provides a specialist outpatient service for people presenting with medically unexplained symptoms (MUS).

The team comprises a consultant psychiatrist, specialty doctor and cognitive behavioural therapist. Referrals are accepted from the acute trust clinicians and local primary care services. Extra-contractual referrals are also accepted for second opinions and advice on management.

Referrals to the service include non-epileptic attack disorder (pseudoseizures), conversion disorders, irritable bowel syndrome, chronic fatigue syndrome, functional abdominal pain, and chronic multiple medically unexplained symptoms (somatisation disorder). The team adopts a biopsychosocial (holistic) approach and undertakes a comprehensive assessment and diagnosis, with advice to the referrer on management, or direct provision of ongoing case management.

'The team adopts a holistic approach and undertakes a comprehensive assessment and diagnosis.'

Case management involves:

- establishing a clinical network, involving a minimum number of health professionals, and providing regular outpatient consultation
- communication with involved clinicians, and provision of a care plan, avoiding diagnostic tests and interventions, unless indicated
- a cognitive behavioural approach for anxiety, depression and symptom management
- a 'living with illness' approach to improving social and physical functioning, and facilitating social networks.

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CASE STUDY

Chronic fatigue syndrome service: St Bartholomew's (Barts) Hospital, London

The chronic fatigue syndrome service at St Bartholomew's (Barts) Hospital, jointly provided by Barts & The London NHS Trust and East London NHS Foundation Trust, and managed by the latter, is unique in that it is clinically led by a consultant physician (infectious diseases) and a consultant liaison psychiatrist (see <http://bartscfs.eastlondon.nhs.uk>). This allows it to properly assess patients, referred mainly by GPs, since three service audits from different NHS services have shown that around 40 per cent of such patients are found not to have chronic fatigue syndrome, with half of these having an alternative medical diagnosis (for example, sleep apnoea) and the other half having an alternative psychiatric diagnosis (for example, depressive illness). Assessment is therefore crucial to a good outcome.

Once a diagnosis of chronic fatigue syndrome is made, patients are referred to one of the multidisciplinary team for further assessment, with a view to rehabilitative therapy. The NICE guidelines¹⁶² suggest that the two therapies with the best research evidence of effectiveness are individually delivered cognitive behaviour therapy (CBT) and graded exercise therapy. The recently published PACE trial (see www.pacetrial.org) showed that these therapies were both moderately effective and safe, when added to specialist medical care, and when individually delivered by appropriately qualified therapists who had received appropriate training and supervision. Receipt of specialist medical care alone and specialist medical care supplemented by pacing therapy (staying within limits imposed by the illness) were less effective at helping both symptoms and disability. The aims of therapy are to provide amelioration of maintaining factors that are keeping a patient unwell. These are known to be illness beliefs, inactivity (or extremes of activity) as well as deconditioning, sleep and mood problems.

The Barts service provides patient choice, in that both individually delivered CBT and graded exercise therapy are available, as well

as individually delivered occupational therapy (providing graded activity therapy and occupational support). A recent audit of group-delivered rehabilitation therapy (combining all the above) showed high levels of patient satisfaction, but limited effectiveness. This is now being reviewed. Complementary to this, all patients receive specialist medical care, which consists of generic advice about managing the illness as well as prescribed medicines to treat associated symptoms (such as insomnia) and co-morbid illnesses (such as depressive illness). An information session has recently been introduced for all newly diagnosed patients to educate about the illness and treatment options. The session is available to patients, their families and carers.

The PACE trial showed outcomes of approximately 60 per cent of patients making a clinically useful improvement in both symptoms and disability with either CBT or graded exercise therapy. In clinical practice, slightly less impressive results would be expected, as demonstrated by the National Outcome Database of 26 NHS services (see www.bacme.info/document_uploads/NOD/NODpres.pdf). These services are equally effective at reducing symptoms, but less effective at improving disability. In the Barts service, an outcome of improvement in 75 per cent of patients is expected, with a third of those (25 per cent) expected to recover if given sufficient treatment. A normal course of treatment is composed of 30 sessions, including medical care. In the PACE trial, participants received up to 15 sessions of therapy and about four medical consultations in a year.

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Medically unexplained neurological symptoms: West London Mental Health NHS Trust/ Imperial College Healthcare NHS Trust

Charing Cross Hospital is a tertiary centre for patients with complex neurological problems. The liaison psychiatry service and neurologists run a joint outpatient clinic, facilitating assessment and brief psychotherapeutic intervention for patients with medically unexplained neurological disorders, including non-epileptic seizures. Patients admitted electively to the Planned Investigation Unit also access specialist liaison psychiatric review as part of the comprehensive assessment.

'This joint approach allows patients to be referred expediently by the physicians while ongoing neurological work-up continues.'

This joint approach allows patients to be referred expediently by the physicians while ongoing neurological work-up continues, enables psychiatrists and medical colleagues to work collaboratively in the exclusion of organic disorders, and provides access to liaison psychiatry expertise to broach psychological factors relevant to presentations. The service is acceptable to patients and avoids the perceived stigma and delays in referral to generic, locality-based mental health services.

Patients' feedback is generally positive:

"The doctor talked to me... helped me to understand what was happening... explained what I could do to help myself."

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CASE STUDY

Specialist rehabilitation for disabling pain conditions: Bath Centre for Pain Services

The Bath Centre for Pain Services is a centre of excellence for the treatment of, and research into, chronic non-malignant pain.

The Pain Management Unit offers intensive residential treatment for highly disabled, complex chronic pain sufferers who are inappropriate for, or have failed to benefit from, other pain management interventions. The services are residential. The treatment approach is group-based contextual cognitive behavioural therapy delivered by an interdisciplinary team of physicians, physiotherapists, occupational therapists, psychologists and nurses. The treatment aim is to return people to valued life activities.

There are courses of a variety of intensity and support, from a three-week intensive course, to a high dependency course for people unable to self-care independently, to a course for young adults aged 18 to 30 experiencing difficulty with transition to independent adulthood as a result of their pain problem. Patient outcomes show: an average increase of 30 per cent in general ability to function with the current level of pain; a reduction in psychosocial disability; a 50 per cent reduction in visits to GP; and a three-fold increase in work involvement.

'Patient outcomes show an average increase of 30 per cent in general ability to function with the current level of pain.'

The unit also runs three-week programmes for young people aged 11 to 18, accompanied by a responsible adult, usually a parent. The treatment aims to help young people return to age appropriate activities, including school/education, social and leisure activities. The young person and adult work together during the first and last weeks of the programme and have separate sessions during the second week. Outcomes show: a 68 per cent increase in full-time school attendance; a 58 per cent decrease in adolescents attending no school at all; improved physical fitness; and a reduction in parental anxiety and depression.

The residential treatment unit is a tertiary service. It is anticipated that the treatment approach may also be effective when used in a primary care setting, which could enable greater and earlier access. Initial input has been gathered from GPs, nurses, commissioners and chronic pain patients on the issues they think are important in translating the treatment from tertiary to primary care. A treatment service is being designed and will be explored in further studies.

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Mental health liaison services – improving the efficiency of acute care pathways

Working mainly in acute hospitals, liaison mental health teams provide advice to physical healthcare teams as well as providing psychological and psychiatric assessment and treatment of individual patients, linking when appropriate with community services, including community mental health teams and GPs.

Among other conditions and problems, these services provide assessment and treatment to help people with physical illness (often long-term conditions) and co-existent mental health disorder, and/or psychologically-based physical syndromes. The role and diversity of focus of liaison mental psychiatric services has been summarised in the Academy of Royal Colleges publication, *No health without mental health: the supporting evidence*.¹⁶³

The integration of liaison services in an acute setting reflects the high rate of mental health problems in patients presenting with physical health problems. Patients with a physical illness are three to four times more likely to develop a mental illness than the average population; 25 per cent of patients with a physical illness admitted to hospital also have a diagnosable mental health condition; a further 41 per cent have sub-clinical symptoms of anxiety or depression, with rates rising to 60 per cent for the over-60s.¹⁶⁴ A recent study of frequent attenders at emergency departments in Cambridge identified at least three subgroups with mental health-related presentations: moderate frequent attenders (defined as six–20 presentations per year) with unattributed medically unexplained symptoms (presenting with abdominal complaints in particular), moderate frequent attenders with undiagnosed mental health and long-term physical health co-morbidities, and extreme frequent attenders (more than 20 presentations per year) with repeated self-harm and substance misuse problems.¹⁶⁵

In addition to the benefits to patients of identifying and managing psychological problems, liaison psychiatry services can transform quality and productivity in acute settings. The potential impact, with case study examples, has been summarised in an NHS Confederation briefing.¹⁶⁶ More recently, a service and economic evaluation has been carried out on a liaison service in Birmingham – the Rapid Assessment Interface and Discharge (RAID) service (see below) – demonstrating improvements in health and wellbeing and in cost savings.^{167 168} In outline, liaison mental health services can:

- improve physical and mental health outcomes
- reduce length of stay¹⁶⁹
- improve the return to independent living for the elderly¹⁷⁰
- reduce readmissions
- reduce subsequent healthcare utilisation, including emergency care and clinic visits¹⁷¹
- improve clinical outcomes of depression,^{172 173} this being an independent predictor of readmission at six months in the elderly¹⁷⁴
- assess, formulate and treat, with reduced healthcare costs, patients with unexplained symptoms
- reduce psychological distress.

‘In addition to the benefits to patients of identifying and managing psychological problems, liaison mental health services can transform quality and productivity in acute settings.’

Liaison services can also support and assist physical healthcare services in the management of mental illness when patients with severe mental health conditions are admitted for the care of physical health problems. Liaison services can assist physical healthcare teams in assessing issues relating to consent, mental capacity and appropriate use of the Mental Health Act, and provide training and skill sharing in the psychological care of patients with physical illness.

The economic case

There is little published or documented analysis of the cost-benefits of liaison mental health services, even though the clinical benefits and apparent efficiencies are discussed. Following an internal service evaluation of the Birmingham RAID service, an independent economic evaluation was undertaken and has been recently published.¹⁷⁵ The service, delivered in a large acute trust, claims to promote improved health outcomes while at the same time reducing overall use of resources in the local health economy.

The independent economic evaluation undertaken, and detailed by Parsonage and Fossey, demonstrated total incremental savings from RAID to be in the order of £3.55 million a year, that is 14,500 bed days saved at £245 per bed day. This is in comparison with the incremental cost of RAID at £0.8 million a year. The benefit:cost ratio is therefore in excess of 4:1, or a saving of £4 for every £1 invested in the service.

This may well be an underestimate of potential cost savings. Additional benefits may be derived from decreased health resource usage as a result of improvements in the health and quality of life of patients, improvement in the identification of mental health problems, and the signposting of patients to more appropriate mental health pathways; impact on elective admissions (evaluation only considered emergency admissions); and increased discharge of older people to their homes, with decreased discharge to residential or nursing homes, and hence potential savings in the social care sector.¹⁷⁶

'The benefit:cost ratio is in excess of 4:1, or a saving of £4 for every £1 invested in the service.'

'Frequent attenders at A&E with long-term conditions and co-morbid mental health problems are offered CBT through the IAPT programme.'

Birmingham Rapid Assessment Interface and Discharge (RAID) service

The RAID service, established in 2009, is provided by the Birmingham and Solihull Mental Health NHS Foundation Trust, commissioned jointly by the Birmingham and Sandwell PCTs, and delivered within the large acute Birmingham City Hospital.

The key features of the model are:

- the service provides a comprehensive range of mental health specialties within one multidisciplinary team such that all patients over the age of 16 can be assessed, treated, signposted or referred appropriately regardless of age, presenting complaint or severity
- the service operates 24 hours a day, seven days a week. There is emphasis on rapid response, with a target time of one hour within which to assess patients referred from A&E and 24 hours for patients referred from the wards
- teaching and training on mental health difficulties are provided to staff throughout the acute hospital
- there is an emphasis on diversion and discharge from A&E and on facilitation of early but effective discharge from general admission wards
- follow-up clinics for patients discharged from the hospital are provided as well as signposting to other services in the community.

The service receives an average of 250 referrals a month. The most frequent reasons for referral are: self-harm, suicidal ideation, depression, cognitive impairment/confusion/dementia, alcohol misuse, and psychosis.

'The service provides a comprehensive range of mental health specialties within one multidisciplinary team.'

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CASE STUDY

NHS East Lancashire long-term conditions pilot

NHS East Lancashire has undertaken a diagnostic review of very high intensity users (VHIUs) of local A&E services.¹⁷⁷ The findings demonstrated that after 'accident', psychiatric issues were the second highest reason for attending A&E, and 66 per cent of these presentations were also identified as having a long-term condition.

In East Lancashire a pilot is now underway to develop collaborative care working for VHIUs of local A&E services who have long-term physical conditions and present with co-morbid common mental health problems. While patients are identified and referred by nominated GPs, the project works closely with the local hospital, providing an Improving Access to Psychological Therapies (IAPT) based 'inreach' model of liaison mental health.

The project aims to include service users with long-term conditions, namely diabetes, chronic obstructive pulmonary disease (COPD) and heart conditions. IAPT clinicians who are cognitive behaviour therapists will liaise closely with nominated GPs to receive and discuss appropriateness of referrals, attend service user collaborative care programme meetings and provide progress feedback.

'The project works closely with the local hospital, providing an IAPT-based 'inreach' model of liaison mental health.'

What is different from before?

The IAPT cognitive behavioural therapy (CBT) clinicians have improved links to community nurse specialists who work with diabetes, cardiovascular disease and COPD. This enhances collaborative work between physical and mental health clinicians and provides a smooth referral pathway. The CBT therapists have received specialist awareness training in the physical conditions, take into account the impact of the medical condition on mental wellbeing, and have spent time developing collaborative care practice.

The service is being evaluated using Patient Health Questionnaire (PHQ9) and Generalised Anxiety Disorder Assessment (GAD7) for mental health outcomes, and a brief illness perception questionnaire to measure outcomes with regard to physical health. Details will be recorded of approximate healthcare used before referral, and during/after intervention.

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Long-term mental illness and long-term physical health conditions

Long-term severe mental illness is associated with high levels of physical illness, significantly reduced life span and poor access to health promotion and intervention services, resulting in overall health inequality. The life expectancy for a male with schizophrenia is, for example, 15–20 years less than average, with more than 60 per cent of premature deaths not directly related to suicide.¹⁷⁸

The incidence of long-term physical health conditions is high, with increased prevalence of risk factors such as obesity, poor nutrition, low levels of exercise and high levels of smoking, as well as lifestyle factors and adverse effects of medication. There is increased incidence of diabetes (prevalence of 15 per cent in people with schizophrenia, 5 per cent in the general population), cardiovascular disease, hyperlipidaemia, chronic obstructive pulmonary disease (COPD), as well as bowel cancer, venous thrombosis and emboli. 50 per cent of psychiatric patients have a co-morbid physical illness.¹⁷⁹ Cardiovascular risk increases after first exposure to any antipsychotic drug,¹⁸⁰ and in a study of young people (85 young people aged 16 to 27 years) treated for first episode psychosis, a third had metabolic syndrome or showed metabolic abnormalities.¹⁸¹ Increased smoking is responsible for most of the excess mortality of people with severe mental health problems.¹⁸²

Summarised in an Academy of Royal Colleges publication,¹⁸³ types of physical health problems associated with mental ill health include:

- major depression doubles the lifetime risk of developing Type 2 diabetes
- standardised mortality rates for older people with depression is two to three times higher if untreated or unresolved
- people with schizophrenia are three to four times more likely to develop bowel cancer

- people with schizophrenia have a 52 per cent increased risk of developing breast cancer.

The majority of people living with a long-term mental illness receive physical healthcare from primary care services. A smaller number will receive physical health screening and healthcare while inpatients in either physical health or mental health settings. With recognition of physical healthcare needs, NICE clinical guidelines for schizophrenia and bipolar disorders^{184 185} include recommendations for physical healthcare, and within regular case reviews, community mental health services are expected to ensure access to regular physical health checks and healthcare. Maintaining a focus on physical health and physical healthcare is important because the presence of a mental disorder may 'overshadow' the recognition and treatment of physical health problems, reducing the quality of physical care provided.¹⁸⁶

Case studies

In view of the high prevalence of physical health problems and difficulty experienced by people with mental health problems in accessing physical healthcare and preventative services, mental healthcare providers are developing innovative service models, often in conjunction with primary care and secondary care services. This brings benefits to patients as well as productivity and cost benefits to the healthcare system as a whole. Some of these case studies are shown below.

'Health providers are developing innovative service models to benefit patients and productivity.'

CASE STUDY

Improving diabetes care in a secure mental health setting: Rampton Hospital, Nottinghamshire Healthcare NHS Trust

Diabetes is occurring at ever younger ages. Five per cent of men in their 20s have Type 2 diabetes, rising to 35 per cent of men in their 40s. Analysis of the causative factors suggests that the usual lifestyle issues, such as obesity, poor diet and sedentary lifestyle, remain the principal cause. These are significant risk factors for patients in a secure mental health setting living with severe illness. There are also a number of patients with severe mental illness who develop diabetes secondary to atypical antipsychotic medication, often with very rapid onset.

In Rampton Hospital – one of the three high-secure hospitals in England for people with severe mental health problems – the screening, detection, diagnosis and care of diabetes has been enhanced following the appointment of a GP. The number of people known to be diabetic has increased from 5 per cent to 20 per cent of the hospital population. Diagnostic accuracy has improved, with some patients previously incorrectly diagnosed as Type 1 diabetes. In others, follow-up has shown the diabetes resolves with significant weight loss or change in antipsychotic medication.

Having systematic primary care based within the hospital has ensured a high level of engagement with patients and minimised default from follow-up. Even when a patient is too mentally unwell to attend clinic appointments, consistent advice can be

given to staff and regular reviews provided by the primary care team. The introduction of a GP computer system has allowed auditing of diabetes and long-term conditions care. Access to the full range of diabetes medication is provided, including oral hypoglycaemics, newer agents such as GLP 1 agonists and good insulin management. Some patients require consideration for gastric banding.

Despite the difficulties and challenges many patients face, they remain keen to try to increase exercise, reduce weight and eat a better diet. This is supported by diabetes education delivered to both patients and other staff by the primary care team.

Diabetes care has been improved by both the organisational structures provided by primary care and clinicians with a special interest in the diagnosis and management of the most complex patients. Patients with such a restricted lifestyle and complex medication regimes present some of the greatest challenges for the management of diabetes.

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‘Diabetes care has been improved by providing specialist primary care input to the management of the most complex patients.’

Effective partnerships to improve physical healthcare for people with mental illness

In Derbyshire, the mental health trust, primary care trust and public health have worked closely together to develop a programme of initiatives to improve the physical healthcare of people with mental illness. This is led by a steering group formed in 2007.

The focus has been on building local partnerships between primary care, with responsibility for physical healthcare and secondary mental healthcare, charged with ensuring physical healthcare happens and facilitating access where appropriate. While the main agenda is good communication and coordination between the health services, the importance of jointly addressing the wider lifestyle and social factors that influence the poor physical health commonly associated with mental illness is recognised.

The objectives the group are working towards are considered from a service user perspective. They are:

- I will have an annual physical health check
- I am confident my physical health check is of good quality and worthwhile
- I have been offered follow-on support or services for my physical health needs
- my health professionals and supporting services have raised my awareness of a healthier lifestyle to support my wellbeing.

A mental health professional was appointed by the primary care trust to enable contact with individual GP practices and to improve the quality and consistency of severe mental illness (SMI) registers. Work was undertaken on the content, format and communication of annual physical health checks, making the information available to mental health staff and integrated into the care programme approach (CPA) care review process. The CPA review invitation to GPs included a request for summary of health, medication and any other issues. This led to a large increase in health information being available within the CPA discussion. A series of workshops on the theme of physical health and severe mental illness was organised, bringing together GPs and mental health clinicians.

In addition, a number of initiatives have been developed to promote healthier lifestyle choices for people affected by serious mental illness. These include walking groups, smoking cessation programmes and football groups, the latter with links to local professional football clubs. Bolsover Healthy Hearts promotes health promotion options; and a health trainer service, provided by service users trained to support and advise other people with mental health problems, assists with smoking cessation, weight management, healthy eating and access to the Citizens Advice Bureau.

'The importance of jointly addressing the wider lifestyle and social factors that influence the poor physical health commonly associated with mental illness is recognised.'

CASE STUDY

A primary care toolkit has been developed to guide effective regular physical health checks and improve communication of physical healthcare needs between primary care and mental health services. Following initial distribution at the primary care/mental health workshops, the document will be circulated to all medical practices in the county.

'Following initial distribution at the primary care/mental health workshops, the document will be circulated to all medical practices in the county.'

Further information is available at:

[www.derbyshirecounty.nhs.uk/
services_we_buy/your_health/
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Improving physical healthcare: high dose antipsychotic monitoring clinic

A service to provide safe, effective and efficient patient-centred care for the use of high dose antipsychotic treatment (HDAT) was established following an audit that identified:

- clients were not receiving appropriate monitoring when prescribed HDAT
- teams were unable to quantify how many patients were on HDAT at any point in time
- there was no robust method for determining current medication or recording medications prescribed
- there was inconsistent documentation of HDAT
- there was inconsistent practice in the monitoring of HDAT.

In February 2009, a rapid process improvement workshop approach was used to quickly improve the way in which the organisation identified and monitored clients on HDAT. All patients on HDAT are now identified and, in addition to improved monitoring and patient information, the profile of physical wellbeing has been raised for all clients. All patients open to the team now receive routine baseline

appointments for bloods, electrocardiogram (ECG) and physical examination in the physical wellbeing clinic, as well as additional appointments as clinically required. This has proved popular with service users, particularly as these appointments can be conducted in the patient's home should they prefer.

The approach has improved the accessibility to physical health services for those individuals who have previously declined such interventions. Repeat audits have shown sustained improvements and, in particular, there has been 100 per cent compliance with baseline investigations for those commenced on HDAT.

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'In addition to improved monitoring and patient information, the profile of physical wellbeing has been raised for all clients.'

CASE STUDY

Improving physical healthcare through CQUINs

As part of the Commissioning for Quality and Innovation (CQUIN) process, NHS London proposed physical healthcare improvement targets for nine out of the ten London mental health trusts. NHS London coordinated a partnership approach between commissioners, clinical experts and mental health trust quality improvement leads to develop the CQUINs.

The physical health CQUIN had six broad aims, with a focus on delivering outcomes set out in the Outcomes Framework:

1. Increase access to physical healthcare in primary and specialist mental health services for people with long-term mental health conditions.
2. Reduce the 15–25 year premature mortality from physical causes in people with severe mental illness.
3. Deliver safer care and improved experience of care for those with severe mental illness.
4. Facilitate GPs in obtaining the information they need to have optimal Quality and Outcomes Framework (QOF) severe mental illness registers as the basis for annual physical health checks, in order to detect and treat long-term physical health conditions earlier.
5. Facilitate more integrated primary and secondary care working with a timely and standard discharge and care programme approach (CPA) communication report.
6. Improve the completion of the mental health minimum data set to enable London to benchmark within the region and against other regions.

These aims were to be achieved by better identifying physical health problems in people with severe mental illness, improving their physical healthcare both in the community and during inpatient admissions, and supporting their access to GP services.

Started in 2009, the first-year improvement targets focused on establishing the necessary prerequisites for good care: ensuring all patients were registered with a GP; shared patient formulation and International Classification of Diseases (ICD) coding were increased to improve awareness of physical ill health; communication of the mental health ICD codes to the GP to enable population of the serious mental illness (SMI) QOF registers, and hence triggers for an annual health check; completion of the mental health minimum data set. Outcomes focused on ensuring that patient information was recorded in mental health settings regarding physical healthcare, and that those with SMI were supported to access physical health needs at an equitable level to the general population.

In the second year, the CQUIN developed to address treatment of physical health needs, a focus on medication reconciliation, and improvement in the quality of discharge letters back to primary care.

Continued overleaf

The mental health physical healthcare CQUIN has led to the following improvements:

- improved interface working between primary and secondary care
- increased local medical committee and primary care focus in the physical healthcare of individuals with severe mental illnesses
- improved access to physical health checks for individuals with severe mental illness, both in primary care as part of the QOF and in secondary mental health services.

In addition, local commissioners have been encouraged to develop additional physical healthcare quality measures with mental health trusts. These have included:

- screening for nutritional status on admission to an inpatient mental health facility
- screening for alcohol use on admission to an inpatient mental health facility
- a comprehensive smoking cessation strategy, including staff training, recording of smoking status and referral to smoking cessation clinics
- improvements in medication monitoring for patients on lithium.

Emergent learning includes:

- a SHA-wide collaboratively developed physical health CQUIN strategy, enabling the pooling of knowledge, resources and expertise, and a shared capacity to scope and identify effective major quality indicators
- benchmarking of best practice indicators and high impact approaches would be well served by a set of common outcome measures and collection of comparable data. Current analysis is hampered by differences in CQUIN outcomes and data.

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Appendix 1. Useful resources

Managing long-term conditions

Department of Health (2005), *Supporting people with long-term conditions: an NHS and social care model to support local innovation and integration*.

Department of Health (2010), *Improving care for people with long-term conditions. Information sheet 1. Personalised care planning*.

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Emotional and psychological wellbeing needs and services overview

Academy of Medical Royal Colleges and Royal College of Psychiatrists (2010), *No health without mental health: the supporting evidence*. www.rcpsych.ac.uk/pdf/No%20Health%20without%20mental%20health%20the%20Evidence.pdf

NICE (2009), *Depression in adults with chronic physical health problems: treatment and management*. <http://guidance.nice.org.uk/CG/WaveR/23>

Department of Health (2011), *No health without mental health: a cross-government mental health outcomes strategy for people of all ages*. www.dh.gov.uk/en/Healthcare/Mentalhealth/MentalHealthStrategy/index.htm

Royal College of Psychiatrists and Royal College of General Practitioners (2009), *The management of patients with physical and psychological problems in primary care: a practical guide*.

National Institute for Mental Health & Care Services Improvement Partnership (2006), *Long-term conditions and depression: considerations for best practice in practice based commissioning*.

Department of Health (2010), *Psychological management of long-term conditions, including medically unexplained symptoms*. www.evidence.nhs.uk/qualityandproductivity

NHS Confederation (2009), *Healthy mind, healthy body: how liaison psychiatry services can transform quality and productivity in acute settings*. www.nhsconfed.org/Publications

Department of Health (2008), *IAPT: long-term conditions positive practice guide*. www.iapt.nhs.uk/wp-content/uploads/2008/11/long-term-conditions-positive-practice1.pdf

NHS Confederation (2011), *With money in mind: the benefits of liaison psychiatry*. www.nhsconfed.org/Publications

A range of leaflets published by the Forum for Mental Health in Primary Care. Available at: www.rcgp.org.uk/mental_health/resources.aspx

A range of online resources to improve physical and mental healthcare, published via the Royal College of Psychiatrists. Available at: www.rcpsych.ac.uk/improvingpmh

Economic evidence

Naylor C, Parsonage M, McDaid D, Knapp M, Fossey M, Galea A (2012), *Long-term conditions and mental health: the cost of co-morbidities*. The Kings Fund. www.kingsfund.org.uk/publications/mental_health_ltcs.html

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www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_123984

Parsonage M, Fossey M (2011), *Economic evaluation of a liaison psychiatry service*. Centre for Mental Health.
www.centreformentalhealth.org.uk

Diabetes

NHS Diabetes and Diabetes UK (2010), *Emotional and psychological care and treatment in diabetes*.

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NHS Improvement website:
www.improvement.nhs.uk/diabetes

Chronic obstructive pulmonary disease

NHS Improvement website:
www.improvement.nhs.uk/lung

Ischaemic heart disease

RCGP (2010), *Primary care guidance: coronary heart disease (CHD) and depression – a body and mind approach*.
www.rcgp.org.uk/mental_health.aspx

Medically unexplained symptoms

Commissioning Support for London (2010), *Medically unexplained symptoms. A whole systems approach*. www.londonhp.nhs.uk

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The Forum for Mental Health in Primary Care (2011), *Guidance for professionals on medically unexplained symptoms*.
www.rcgp.org.uk/mental_health.aspx

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The Mental Health Network

The NHS Confederation's Mental Health Network (MHN) is the voice for mental health and learning disability service providers to the NHS in England. It represents providers from across the statutory, for-profit and voluntary sectors.

The MHN works with government, NHS bodies, parliamentarians, opinion formers and the media to promote the views and interests of its members and to influence policy on their behalf.

Investing in emotional and psychological wellbeing

For many patients, several physical illnesses will coexist at any one time, and for some a mental health disorder will also be present. In the face of such multi-morbidity and need, focus on the patient journey across the lifespan and across the care system will maximise effective service design and delivery.

The collation of evidence and emerging economic analysis, together with examples of service design and delivery in this guide, will assist commissioners, clinicians and managers in primary care, secondary care and mental health in designing services, improving productivity and learning across disease-specific groups.

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