GUEST EDITORIAL

Liaison psychiatry and the interface between mental and physical health – perspectives from England

Hugh Griffiths

Consultant Psychiatrist, Northumberland, Tyne and Wear NHS Foundation Trust; and National Clinical Director for Mental Health, Department of Health, email Hugh.Griffiths@dh.gsi.gov.uk

The views of Dr Griffiths expressed here are given in a clinical capacity and as a national expert in the field. They do not impose any mandatory requirements on NHS organisations.

There has been increasing policy interest in the interface between mental and physical health in recent years. One of the key objectives of the current Cross-Government Mental Health Strategy (for England) is to improve the physical health of those who suffer from mental illness. In parallel, people who suffer from long-term physical conditions have very high rates of comorbid mental ill-health, which are associated with worse outcomes, can delay recovery and can lead to longer hospital stays. Therefore there are opportunities for liaison psychiatry to do its part in helping our healthcare systems to deliver better outcomes in an economically challenging environment.

In England, there has been increasing policy interest in the interface between mental and physical health in recent years, exemplified by the clear priority given to it in the current Cross-Government Mental Health Outcomes Strategy, 'No Health Without Mental Health' (HM Government, 2011). One of the key objectives of this strategy is to improve the physical health of those who suffer from mental illness, who have a high rate of comorbid health problems and who also have shortened life expectancy. For example, having conditions such as schizophrenia or bipolar disorder can lead to mortality somewhere between 16 and 25 years too early (Parks *et al*, 2006) and recent evidence suggests that those who suffer from more common mental health problems also suffer poor physical health and premature mortality (Lewis, 2012). Clearly, it is unacceptable that such significant health inequalities persist and so it follows that any mental health policy should seek to address them.

But there are other important dimensions to this interface. People who suffer from long-term physical conditions have very high rates of comorbid mental ill-health, which is associated with worse outcomes, can delay recovery and can lead to longer hospital stays. Furthermore, in acute hospitals up to 50% of sequential new out-patients are reported to have 'medically unexplained symptoms' (Nimnuan *et al*, 2001). For many of these patients, psychological interventions can be effective (Speckens *et al*, 1995).

So there are very good reasons for the current interest in this area and there are opportunities for liaison psychiatry (providing mental health services to patients in general hospital settings) to do its part in helping healthcare systems to deliver better outcomes in an economically challenging environment. For example, people with conditions such as diabetes, heart disease and chronic obstructive pulmonary disease have high rates of mental health problems (estimated at about 30%), which increase risk and delay recovery (Cimpean & Drake, 2011). The risk of mortality for those with myocardial infarction is increased threefold if they suffer from comorbid depression (Frasure-Smith *et al*, 1999). Those who have a long-term physical condition are two to three times more likely to have depression, and people with three or more long-term conditions are seven times more likely to have depression (National Institute for Health and Clinical Excellence, 2009). Furthermore, the prevalence of comorbid conditions is increasing, and adults with both mental and physical health problems are much less likely to be in employment.

Mental ill-health is common among acute hospital in-patients, occurring in around 60% of those over 65 years of age, and they have higher levels of physical morbidity and longer lengths of stay. In addition, self-harm is among the five most prominent reasons for emergency admission to hospital for medical treatment, with around 170 000 admissions per year in the UK, of which some 80% are for self-poisoning through overdose (Royal College of Psychiatrists, 2005).

The point is that this is an area which is crucial, both clinically and economically, and it has arguably received too little attention thus far. Liaison psychiatry has evolved in response to these problems and to the organisational separation between mental and physical health services. With their work predominantly in acute hospitals, liaison teams provide advice (and often training) to healthcare staff, undertake assessments for people with a very broad range of mental and physical health problems, prescribe and recommend treatment and act as a key link to other specialist mental health services. However, as highlighted in the report from the Academy of Medical Royal Colleges in 2008, the provision of liaison teams across the country is 'extremely variable'. The document goes further, describing the position as 'unacceptable' and, in describing the consensus on what good services should look like, it says 'the situation must be addressed as it is not in the best interests of an NHS [National Health Service] ambitious to be more effective and efficient'. Its recommen-

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dations include a plea that 'patients with mental health problems should receive the same priority as patients with physical problems', a statement which clearly resonates with the current government's determination to achieve 'parity of esteem' for mental health (HM Government, 2011).

But despite all this, provision remains patchy and the question has to be asked, could the NHS, with its need to achieve £20 billion efficiency savings by 2015 (by focusing on quality, innovation, productivity and prevention) achieve some of its key objectives by investing in liaison services? There is little doubt that such services, properly constructed, offer significant clinical benefits and are also generally well appreciated by acute hospital staff. However, until recently there has been scant evidence with regard to their cost–benefit profile.

In 2009, a new liaison service (developed from an existing one) was established within Birmingham City Hospital, with the aim of making comprehensive mental health assessment, treatment and care available 24 hours a day, 7 days a week to all patients over the age of 16 (including older adults), regardless of presenting complaint or severity. Rapid response is central to what the service does, with a target time of assessing all people referred from the accident and emergency department (A&E) within a maximum of 1 hour, whatever the time of day or night. An internal evaluation after a year appeared to show significant economic (as well as clinical) benefits, so an independent economic evaluation was undertaken by the Centre for Mental Health together with a team from the London School of Economics (Parsonage & Fossey, 2011).

The resulting report states that the service, in its first year of operation, demonstrated incremental savings in the order of £3.55 million (as a result of a reduction in occupied-bed-days of 14 500) for an incremental cost of £0.8 million. The benefit:cost ratio was therefore in excess of 4:1 – in other words, it saved £4 for every £1 invested. The point is that, even if it were cost neutral, it would be worth it. The fact that it has the potential to save such large amounts of money begs another question – can the NHS afford not to commission similarly enhanced liaison services everywhere?

The answer, in my view, is no. Given everything we know about comorbidities, self-harm, the need for rapid access to proper mental health expertise (wherever patients may present) and the clear economic need for the NHS to rely less on acute hospital beds in the future, this is just the sort of development which should be adopted to improve quality and save money at the same time. That is why it is mentioned in the NHS Operating Framework for 2012 (Department of Health, 2011) and why there is increasing interest in investing in similar services around the country. So, can liaison psychiatry save the NHS? Well, maybe not on its own, but it can make a major contribution and help improve quality and outcomes, especially at a time of economic hardship.

There is one final note of caution though. Working in acute hospital settings can be difficult and challenging, particularly for those professionals who may not have worked in them before. There are differences in language and culture, and understanding the fascinating but complex interface between mental and physical health requires training, time and experience. Not everyone is suited to it and, for teams to be successful they need to be staffed by people who have the aptitude, interest and knowledge. For many, this may take quite some time to build. So we need to be wary of a frantic hurry to develop new services and deliver savings. For it to work, it needs to be done properly. To rush it may be to plan for failure; thoughtful planning based on assessed local need and careful development could deliver much for patients and the wider health and social care system.

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