

## EDITORIAL

# The case for inclusion: mental health and the NSF for long-term conditions

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The 'long-term conditions' model of care was originally conceived by the Kaiser Permanente healthcare organisation in the USA. It involves stratification of the level of risk of populations in the community who have chronic conditions. Teams are formed with both primary and secondary care staff to provide personalised outreach services to identified vulnerable individuals before a crisis-driven hospital admission becomes necessary. These teams, led by community matrons, work across organisational boundaries. The primary objective, and the major criterion of success, is reduction of admissions to acute hospital beds. Patients are empowered and helped to better manage independent living in the community. This involves redesign of existing care pathways and outcome measures. Case management models such as the UK Evercare pilots for care of the elderly (Boaden *et al*, 2005) are being introduced and evaluated in a number of localities.

Early work by Chris Dowse (e.g. Dowse, 2003) and a report from the King's Fund reviewing lessons from chronic disease management in the USA (King's Fund, 2003) were followed by the formation and launch in 2004 of 'long-term conditions learning collaboratives', under the aegis of strategic health authorities.

## The NSF for Long-Term Conditions

The National Service Framework (NSF) for Long-Term Conditions (Department of Health, 2005a) is a 10-year programme for change. Its focus is on long-term neurological conditions such as multiple sclerosis, although the Minister of State for Health

### Box 1 The quality requirements of the NSF for Long-Term Conditions

- 1 A person-centred service
- 2 Early recognition, prompt diagnosis and treatment
- 3 Emergency and acute management
- 4 Early and specialist rehabilitation
- 5 Community rehabilitation and support
- 6 Vocational rehabilitation
- 7 Providing equipment and accommodation
- 8 Providing personal care and support
- 9 Palliative care
- 10 Supporting family and carers
- 11 Caring for people with neurological conditions in hospital or other health and social care settings

(Department of Health, 2005a)

notes that many of its 11 quality requirements (Box 1) apply equally to people with other long-term conditions, disabilities or persistent pain (Department of Health, 2005a: p. 1).

In line with the long-term conditions model of care, the purpose of this NSF is to transform health and social care services to improve the quality of life of people with chronic conditions and support their independent living.

## Relevance for mental health

Practising clinicians know that many mental health disorders are as lifelong and enduring as diabetes and asthma. Each year eight billion pounds are spent by the National Health Service (NHS) and social

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services on mental illness (Layard, 2004). According to the Psychiatric Morbidity Survey (Singleton *et al.*, 2001), 16% of adults of working age have a mental illness, and up to a half of these people are seriously ill. Suicide is the second most common cause of death among young people in England (Dowse, 2003).

There is obviously a clear case for inclusion, and prioritisation, of mental health in the government's programme of reform of health services provision. However, mental health is omitted from the next step in NHS reforms, the Long-term conditions agenda (Department of Health 2005*b*), as has been pointed out by the NHS Confederation in its briefing paper on long-term conditions (NHS Confederation, 2005). What are the relevance and implications of this policy for mental health services in the UK? Chronic physical conditions are clearly its focus, and long-term mental illness is barely mentioned.

Although the major psychoses more obviously fit the long-term conditions paradigm, other mental health disorders, for example, obsessive-compulsive disorder, chronic depression and a number of comorbid conditions such as personality disorder with substance misuse, can be as crippling, causing long-term disability and affecting quality of life. Better management across the primary and secondary services divide can contribute significantly to suicide prevention and risk management. In the UK, secondary services in adult mental health concentrate almost exclusively on serious mental illness, often because of reduced resources and increasing demand together with problems caused by rising comorbid substance misuse. As a result, primary care practitioners struggle with 'heart-sink' patients, many with chronic depression or personality disorder, both of which contribute significantly to suicide risk in the community.

## Links between mental health and physical conditions

### Chronic illness

Mental health also plays an important part in the management of treatment adherence in many long-term physical conditions. Furthermore, in mental illness unwanted side-effects of psychotropic medication contribute to physical morbidity. The metabolic syndrome of weight gain, glucose intolerance, insulin resistance and hypertension associated with anti-psychotics, for example, is highly predictive of type 2 diabetes and cardiovascular disease. Obesity is common in patients in long-stay psychiatric environments, including high secure units, where they are exposed to high-calorie diets with insufficient opportunity to exercise. We know that schizophrenia is an independent risk factor for heart disease.

## Liaison services

The experience of psychiatric liaison services in acute hospitals also informs us that effective management of treatment adherence for many long-term physical conditions involves joint care plans with both physical and mental health input. With elderly people, prevention of falls is an important part of the management of long-term physical conditions in acute old age wards; but it is important also to realise that many of these individuals also have depression or early dementia, which may not be recognised and given proper treatment.

This is also an opportunity to remind ourselves that a key recommendation of the inquiry into the death of Daksha Emson, a doctor who killed herself and her child, was that joint care plans be organised with both mental health and obstetric services for mothers at risk of severe postnatal depression (North East London Strategic Health Authority, 2003). What would be the findings of a nationwide survey of compliance with this important directive?

A renewed focus on the links between mental health and physical conditions across the age range, through modifications of the principles of the long-term conditions model of care, would enable more holistic services to be developed and better health and social care to be offered to patients. It also is an opportunity to tackle stigma and the common avoidance of issues surrounding mental illness by policy-makers.

## Development of competencies in primary care

The long-term conditions agenda is also about better services led by primary care, with the support and expertise of secondary care professionals. The aim is to enable primary care services to meet more of the needs of individuals with mental health disorders and to offer them better recovery programmes in the community with engaged primary care practitioners. To achieve this we must review the transitions between primary and secondary services, and re-design care pathways, building outcome evaluations into care programmes. It also requires more outreach activities by secondary services and a breaking down of training barriers, with secondment of primary care practice staff to secondary services.

There is increasing evidence that colleagues in general practice are now ready for new thinking and initiatives involving mental health issues. Mental health registers have been introduced and general practitioners with special interests (GPSIs) are being trained. Recent articles in the *BMJ* have also highlighted patient preference for more mental health

care to be located with GPs (e.g. Bower & Gilbody, 2005; Lester *et al*, 2005). Depression has been cited as a prime target for development of primary care competencies.

## Involvement in sector-wide 'long-term conditions collaboratives'

So what can psychiatrists do? Over the past year, each strategic health authority has set up 'long-term conditions collaboratives' led by primary care trusts to share learning and best practice on the development of pilot projects in the management of long-term conditions. Psychiatrists can get involved with willing GP partners in initiatives that allow more seamless ways of working to be developed – perhaps a modification of the care programme approach, but with more primary care input. This means a challenge to the way services are currently delivered, in terms of organisational structure and type of staff deployed. The results can be a return to a way of working in which the patient experiences a more integrated care pathway and continuity in their journey along it; a new concordat between psychiatrists, primary care practitioners and social services; and much better job satisfaction, and higher morale for psychiatrists and their teams.

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