Chapter 11: Systems Discussion

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Chapter 11 Systems Discussion

11.1. Background

The National Mental Health Outcomes Strategy, "No Health without Mental Health", has outlined the principles of good quality mental health care (See box 10.1). Despite this, mental health services remain lacking across England, with poor outcomes for users, lack of choice in terms of services and a lack of parity between physical and mental health services.

Mental health care accounts for only 13% of NHS spending while being responsible for 28% of all morbidity in England[i]. People with psychotic, affective personality or drug and alcohol related disorders die on average about 15–20 years earlier than people without mental illness[ii], [iii].

The Chief Medical Officer has identified a number of significant issues relating to the delivery of mental health Services across England[iv]:

- Mental health services are not currently achieving appropriate availability coverage, as evidenced by the treatment gap.
- There is evidence that the services that do exist are being strained further, reducing effective coverage.
- There is a lack of systematic, appropriate and mandated use of activity and outcome measures to enable evaluation of the effectiveness of services at both local and national levels. Significant variation in practice, activity and outcome is suspected, but no datasets exist to allow appropriate comparison of spending and outcomes between trusts.
- Systems are not currently embedded to collect meaningful quality and effectiveness data (meaningful to people with mental illness as well as to clinical staff).

Reflecting this national picture, there are local issues regarding provision of mental health services that cut across clinical groups, age groups and services. These issues are pervasive and may not show up in routinely collected quantitative data. The following chapter outlines concerns (and solutions) to these systems issues highlighted by service users, carers and professional in the course of interviews and workshops in Herefordshire.

The issues considered are:

- Ease of Access to care and support
- Supported self-management
- Community mental Health Services
- Liaison Psychiatry services.

Box 10.1: Principles and Objectives underpinning Mental Health Services- No Health Without Mental Health (2011)

The principles of high-quality care to apply at all stages of care and support:

- Putting the person at the centre and sharing decision-making – 'No decision about me without me' should be a governing principle in service design and delivery;
- Early recognition of and intervention in problems in workplaces, places of work and education, primary care, acute health and social care settings and the criminal justice system, as well as anywhere else care and support is taking place;
- Where appropriate, adopting a whole-family approach;
- Equal and timely access to appropriate services and evidence-based interventions;
- Proactive, assertive engagement, particularly with people at higher risk (e.g. people at risk of offending/offenders/other risky behaviour);
- Single assessments that underpin continuity of care – using the principle of 'ask once';
- Co-ordinated interventions planned around outcomes agreed by the user of the service, tailored to their individual needs, choices and preferences, with a recovery-based focus on building individual strengths and improving quality of life, including improvements in employment, accommodation and social relationships;
- Co-ordination of care and support – using tools such as the Care Programme Approach;
- Care in the least restrictive manner and setting.

11.2. The Current Picture

Service users/ carers and professionals were asked "What is most important in keeping people mentally and emotionally well?" Both groups ranked the components in the same order, with "access to care and support" and "ability to self-manage" identified as the most important components.

Figure 11.1: Professionals responses to “What is most important in keeping people mentally and emotionally well? ” (n=84)

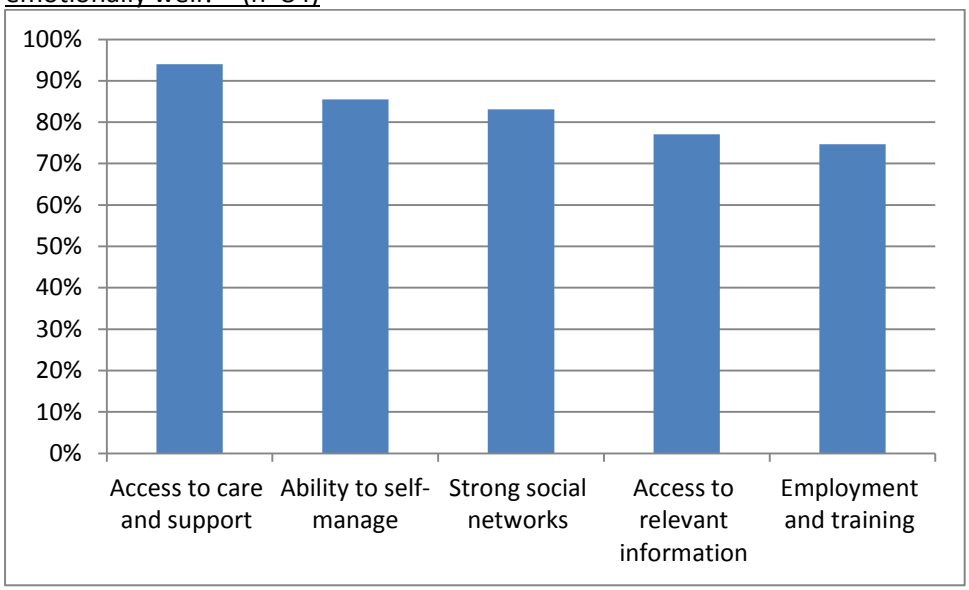
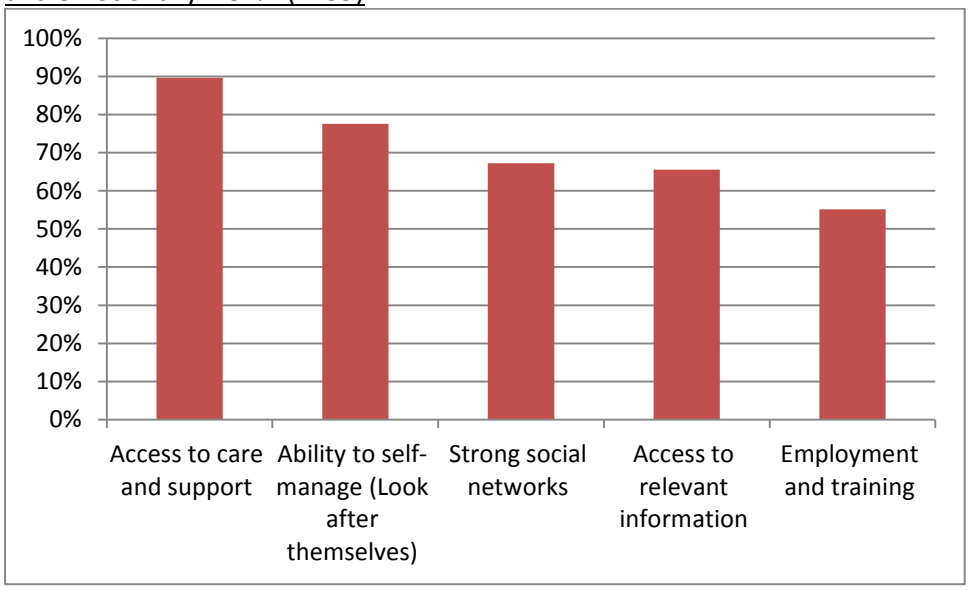


Figure 11.2: Patient and carers responses to ““What is most important in keeping people mentally and emotionally well?” (n=59)



Patients and carers with experience of mental health services in Herefordshire were also asked to rate local mental health services in terms of their effectiveness and supportiveness. As can be seen from figures 11.3 and 11.4 below, where 1 is poor and 6 is excellent, the majority of respondents answered that services were poor or quite poor.

Figure 11.3: Responses to the question "How effective were services?" (n=50)

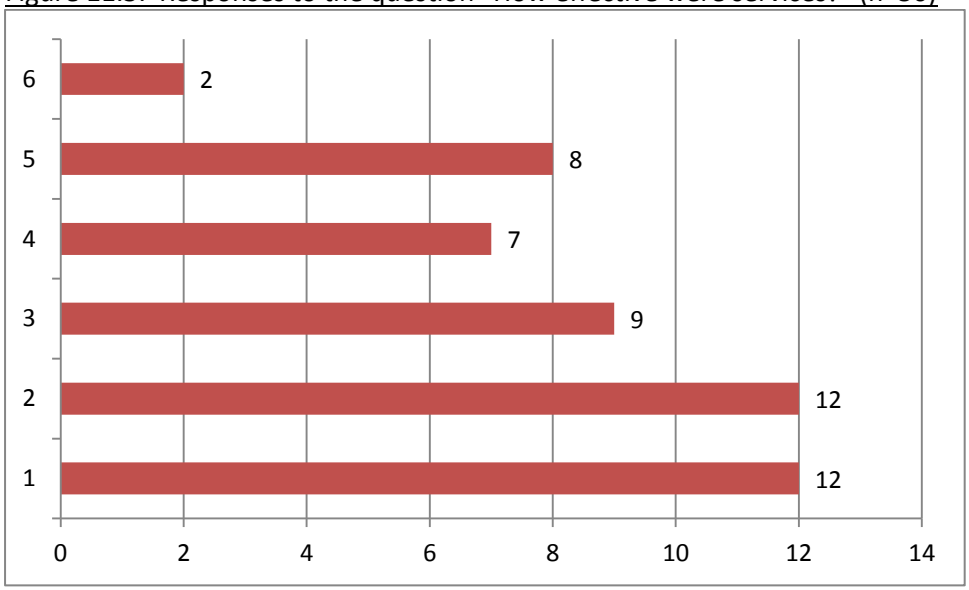
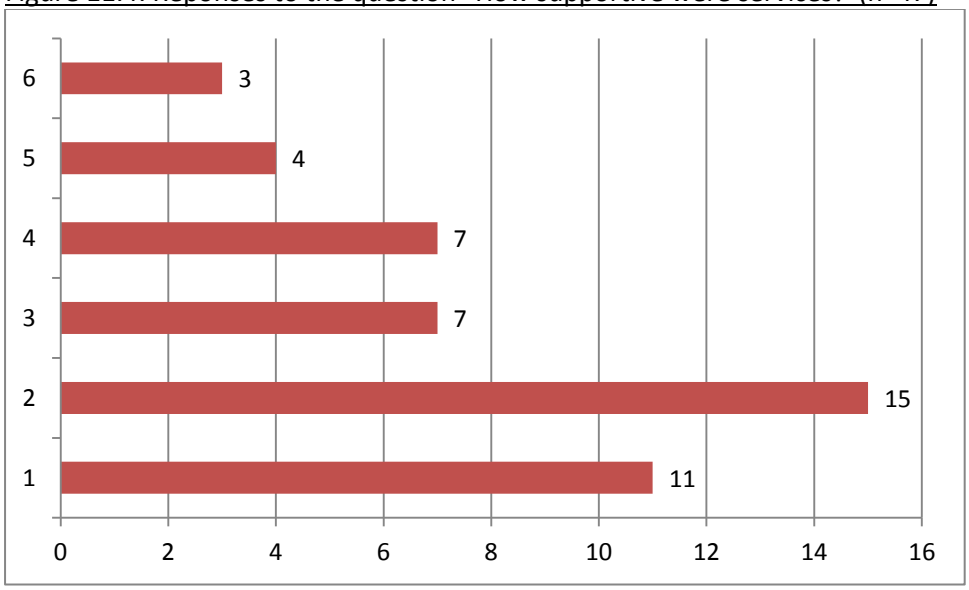


Figure 11.4: Reponses to the question "How supportive were services?"(n=47)



Service users (n=32) at a workshop run by MIND, were asked to plot their responses with reference to Herefordshire Mental Health Services against the NICE Quality Standards for Mental Health Services, where 1= strongly disagree and 6 is strongly agree. Weighted averages were calculated for responses. These responses indicate that patients using services feel they are treated well and that services received will be effective but do not feel confident that they will have an effective care plan or that they will understand the process and supported emotionally.

Box 11.2: Weighted Averages of Service User ratings for Herefordshire Mental Health Services

Statement	Weighted average
People using mental health services, and their families or carers, feel they are treated with empathy, dignity and respect	3.97
People using mental health services, and their families or carers, feel optimistic that care will be effective.	2.65
People using mental health services jointly develop a care plan with mental health and social care professionals, and are given a copy with an agreed date to review it.	2.48
People using mental health services are actively involved in shared decision-making and supported in self-management.	2.46
People using community mental health services are normally supported by staff from a single, multi-disciplinary community team, familiar to them and with whom they have a continuous relationship	2.41
People using mental health services feel confident that the views of service-users are used to monitor and improve the performance of services.	2.41
People can access mental health services when they need them.	2.27
People using mental health services who may be at risk of crisis are offered a crisis plan.	1.95
People using mental health services understand the assessment process, their diagnosis and treatment options, and receive emotional support for any sensitive issues.	1.84

Overall therefore, service users, carers and professionals were agreed that the most important things in keeping people mentally well were access to services and support for self-management. However, the service users and carers who responded to a public questionnaire felt that services in Herefordshire were lacking in most areas, with the exception of being treated with dignity and respect by staff. These issues, of access to care and services and support to self-manage will be discussed below.

11.2.1. Ease of Access to Care and Support

A number of 'system issues' were identified in the course of interviews and workshops with service users, carers and professionals. These describe a picture of decreasing or static funding, with a system attempting to deliver high quality services at the point of need.

The impact of the change of government meant that we have to make savings and that is felt on the front line.
Mental Health Practitioner

2g is providing a good quality resource for the funding it has, but the decision on what services are delivered is dependent on funding. [Commissioners] are not paying for more than they have and there is more need than is being paid for.
Mental Health Practitioner

This shortage of funding has a number of interconnected implications:

a) Staff teams are small, with limited resilience.

My psychiatrist went off ill, so my appointment was cancelled and then delayed by 3 weeks. When you are in a bad state yourself that is pretty hard to deal with. The staff with whom I had contact were caring and professional, but there is simply no resilience in the system.
Patient / Service user

There are committed, flexible staff who are willing to work in and across teams and organisational boundaries to help clients….There is a reliance on generic specialisms as there aren't many staff.
Mental Health Practitioner

People work hard and the problems are not due to inefficiencies.
Voluntary Sector Practitioner

There is limited spare capacity within services. As a result, there are knock on effects. Band 5 nurses end up doing intermediate care for example. Whilst commissioners are already paying for a band 5's time, so it is an absorbed cost, it's not a great use of resources. In turn, a lack of community nursing can lead to hospital admission, which has clear cost implications.
Mental Health Practitioner

The size of the provision means that we have single handed specialism. There is no backfill if one person is off. Apart from the very generic specialties, it is difficult to see how some services can continue autonomously.
Mental Health Practitioner

There is not enough slack in the system to allow for training and improvement- The urgent is overtaking the important.
Mental Health Practitioner

b) Services have become more defined, enabling teams to more appropriately manage their workloads. Despite this, practitioners still voice a lack of understanding regarding service criteria, which hinders referral.

Things have been improved by [The current provider] by helping to make services more uniform in terms of presentation and thresholds for entry… Client group is more defined. For crisis, this is people at the point of admission.
Mental Health Practitioner

Boundaries between services mean that it can sometimes be difficult to get patients seen.
Mental Health Practitioner

Services tend to be split and divided. Skills that are in the adult mental health and are not pushed over to DMHOP for example
Mental Health Practitioner

There is a need for clear/ robust referral criteria and a commitment to stick to them (with some flexibility).
Mental Health Practitioner

We need to provide smooth transition across services. Wherever you put a boundary or criteria in place, you can cause problems. Teams are under pressure due to thin resources and teams can default to a "no" response. Services should be open and accessible/ flexible
Mental Health Practitioner

Services have a focus on diagnosed illness rather than mental health.
Mental health Practitioner

c) A combination of defined criteria and insufficient resourcing has led to gaps developing within provision.

It appears to me, as a lay-observer, that the various threads of mental health support just aren't joined up. There needs to be far better communication between people supporting an individual; and support needs to be delivered holistically - shaped to the individual's needs, not driven by systems and process silo working.
Patient/ Service User

There will be some people who don't meet the recovery threshold but are outside IAPT. There may be a group that slip between clusters.
Mental Health Practitioner

d) A further corollary of rising demand and limited resources is the acknowledgment that thresholds to access specialist care had risen. This in turn has meant that patients are remaining outside of specialist care with significant levels of need.

There's talk of "parity of esteem"- with other conditions you would be tested and treated as soon as possible. With mental health, you pretty much have to be falling over before you get a service.
Patient/ Service User

Most of the services are when problems have got so severe, so reactionary rather than being proactive
Carer

People know when they need help, but services have become so difficult to get into that they are getting iller before they get help.
Voluntary Sector Practitioner

Threshold for crisis have been increased, leaving clinical staff at the acute to carry risk
Mental Health Practitioner

As criteria for all teams get tighter and thresholds higher, people are being managed at a lower level than before.
Mental Health Practitioner

e) This "lower level" typically includes voluntary sector organisations. However, staff within such organisations highlight that their capacity to provide support was affected by cuts in their funding.

Sadly it appears that individuals have to be very badly ill with mental health issues before they get any support from within the health community. Many people rely on assistance, but given the reduction in charitable support, they cannot get the support they need.
Voluntary Sector Practitioner

Significant amounts of third sector floating support has been removed and nothing put in its place. £1m has been removed from low level and social mental health support and changes in access to support via change in eligibility criteria; The removal of support organisations mean that we are finding people moving into crisis.
Voluntary Sector Practitioner

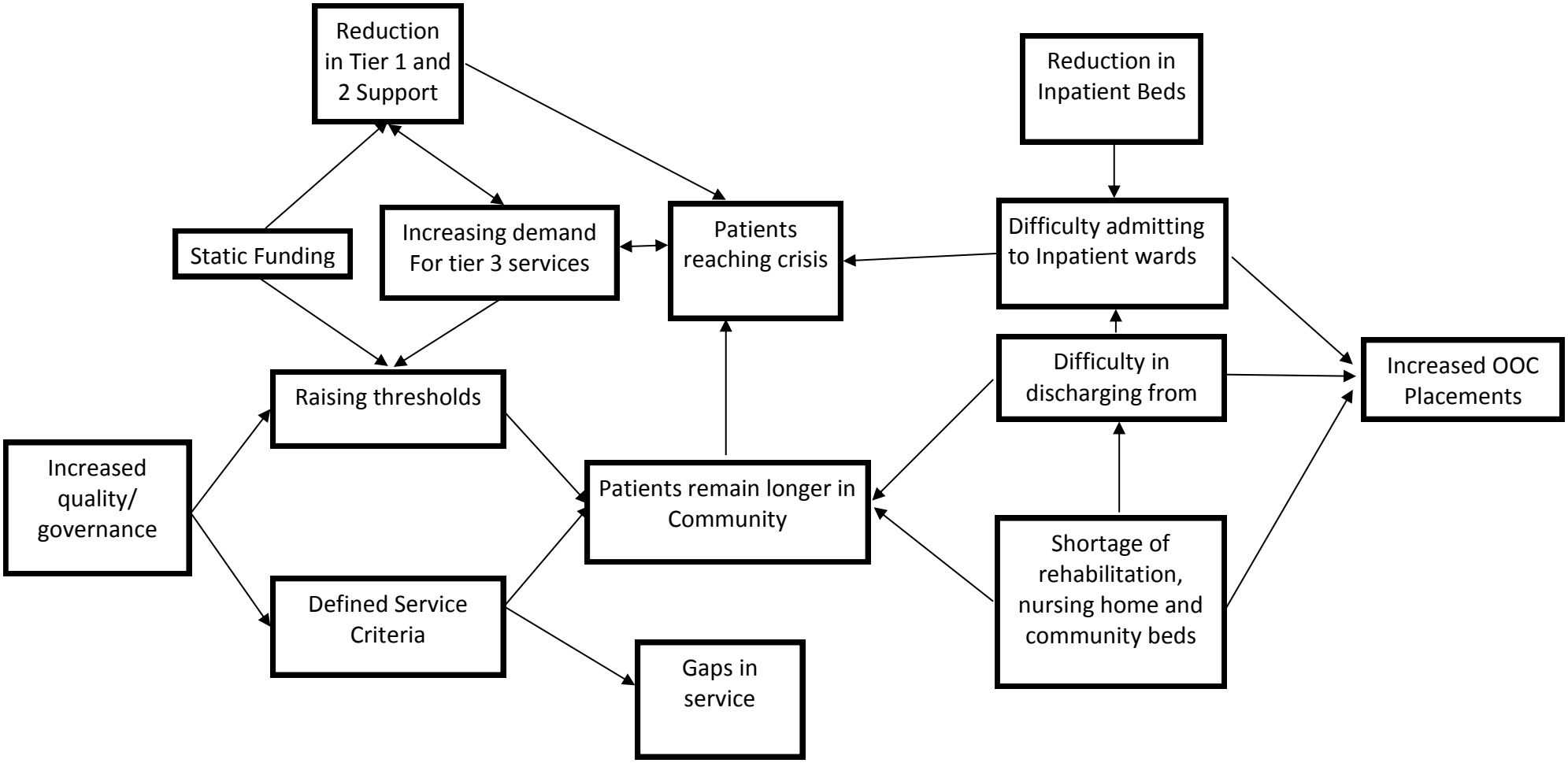
f) As a result, patients may remain without specialist support unless their GP is persistent, meaning that the service a patient receives is likely influenced by how well the GP can "work the system".

We make an assessment to move a patient on, but it gets batted back.
Mental Health Practitioner

GPs may 'play up' the seriousness of a patient's condition to get a more urgent referral.
Mental Health Practitioner

Collectively, such pressures result in patients being delayed access to appropriate services. Whilst the services provided are of a good standard, the size of mental health provision, in addition to system wide issues affecting admission of patients and discharge back into homes and/or community mean that people with mental health needs in Herefordshire are reaching crisis before they can access required specialist mental health services. See figure 11.5 below for a summary of the issues.

Figure 11.5: System issues within Herefordshire



11.2.2. Supported Self-Management

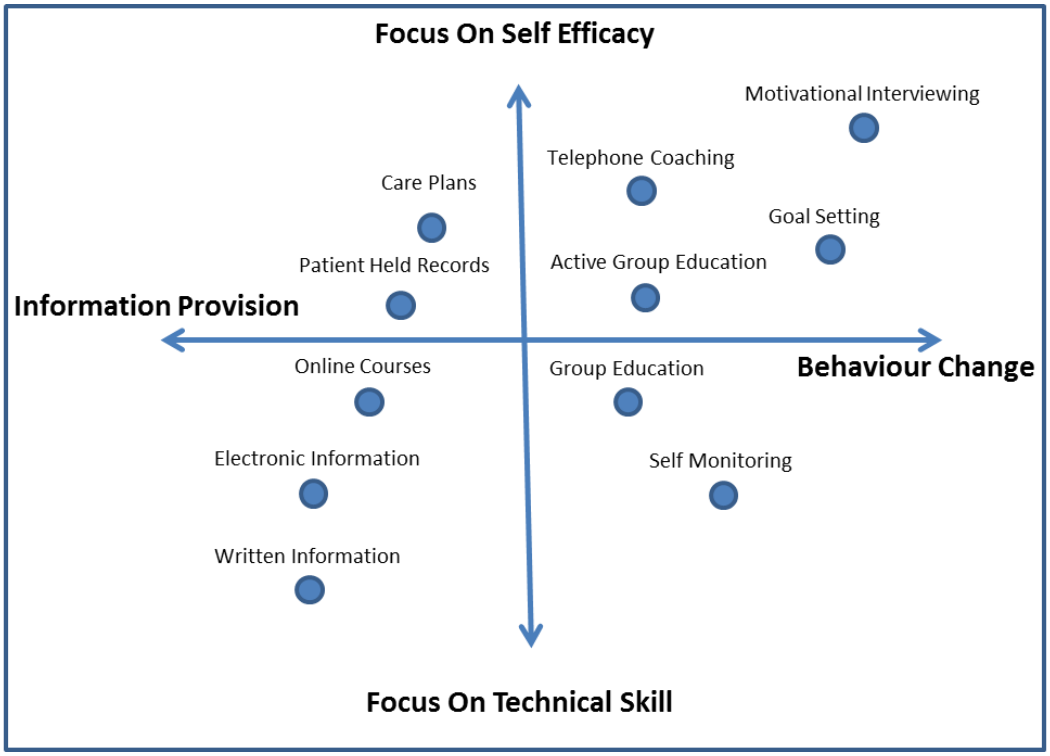
Treatment and support of people with long term conditions accounts for over two thirds of primary and acute care spend and half of all GP appointments[v]. However the vast majority of care is undertaken by people affected with long term conditions themselves, or via informal care.

Patients and service users within Herefordshire were keen to be supported to take charge of their own mental health; carers were identified as a key resource. However, it was identified that for self-care to be achieved, support and education would have to be provided to ensure it was reality.

Empowering people to take charge and take the lead in being responsible for their wellbeing is a strong force for staying well. So 'training' people to manage their illness is a good idea. Furthermore we should be assisted by the professionals and work alongside each other. We are tired of being 'done to'. Help us to take control of our own lives again.
Patient/ Service User

De Silva (2011) defined self-management as supporting a continuum of activities, from provision of a portfolio of techniques and tools to help patients choose healthy behaviours, through to fundamental transformation of the patient-caregiver relationship into a collaborative partnership (de Silva 2011).

Figure 11.6: Continuum of Strategies to Support Self-Management (after De Silva, 2011)



A review of collaborative care and self-management support for individuals with mental health diagnoses indicated the use of small group teaching, online education and support, smartphone technologies, text messages, electronic memory aids and psychosocial interventions to reduce anxiety, depression and stress[vi].

This evidence review suggests that, whilst specific conditions may benefit from individually tailored programmes, some general principles may apply, including:

- Involving people in decision making;
- Developing care plans as a partnership between service users and professionals;
- Setting goals and following up on the extent to which these are achieved over time;
- Helping people manage the social, emotional and physical impacts of their conditions;
- Motivating people to self-manage using targeted approaches and structured support;
- Helping people to monitor their symptoms and know when to take appropriate action;
- Promoting healthy lifestyles and educating people about their conditions and how to self-manage;
- Proactive follow up, including providing opportunities to share with and learn from other service users.

However, the diversity of "interventions to support self-management" poses a barrier to the development of definitive evidence statements, with small study sizes and diverse intervention types precluding reliable conclusion of clinical and cost effectiveness.

Supported self-management shows some promise in regulating symptoms and preventing relapse in persons with depression[vii], anxiety[viii] and OCD[ix]. Supported self-help also shows some benefit in terms of medication adherence for psychiatric patients[x].

Service users and carers in Herefordshire were vocal in their wish to be better supported to provide (self) care, but also explicit that such approach would require meaningful input from professional service providers.

There needs to be more support for Carers
Patient/ Service user

There needs to be support for people pre diagnosis of mental health problems. Signposting should be improved so families know where to go, with more self-help groups in the market towns, not just in Hereford at good times.
Patient/ Service user

We need more education with relatives to help them understand the services provided and how they can contribute. Relatives can get overwhelmed, but simple support could improve patient care and carer wellbeing.
Mental Health Practitioner

As such, when taken as a suite of tools and integrated into a wider strategic approach to improving mental health support, there is potential for interventions to support self-management to improve mental and physical outcomes for individuals with mental disorders across primary, secondary and community settings and contribute to a clinical and policy framework for care integration[xi]. The National Voices review also highlights the need for cultural change in terms of service delivery, ensuring patients themselves are willing to change (and integrating stages of change models into

programmes) and training clinicians and other practitioners to work collaboratively and proactively with service users.

11.2.3. Community Mental Health Services

In speaking with service users, carers and practitioners engaged with mental health services in Herefordshire, it becomes clear the needs of mental health service users are too extensive and complex for specialist mental health services to meet in isolation.

Just as mental health need is multi-causal (See chapter 4), multiple partners are required to respond adequately to the needs of mental health service users in Herefordshire.

The need for multiple approaches for meeting service users' needs is apparent both within and between services:

There needs to be greater understanding of the links between physical and mental health
Patient/ service user

We are treating more physical health issues as well as mental health issues. There has been an increase in physical needs.
Mental Health Practitioner

We are good at managing their mental illness, but not their other issues. Things like their family and friends, their care needs, their occupational therapy, budgeting and employment... The chaos in their lives.
Mental Health Practitioner

In particular, the interface between specialist mental health services, primary care and social services was seen as critical in supporting patients' needs over time.

GPs were seen as a crucial "first step" for patients in accessing mental health services.

I would like to go to my GP surgery to access more mental health services. It is a comfortable place that I trust. I don't want to always be passed on to 'mental health' services.
Patient/ Service user

GPs need to play a key role in liaising with their patients identified to have mental health problems when they are at home, including more regular proactive check-ups or a phone call by the GP, and when at crisis point, proactive regular contact with the patient, in addition to the crisis team.
Patient/ Service User

However, opportunities for people with low-level or stable conditions to receive support in primary care are confounded by a lack of support to meet their non-mental health needs and a failure of communication between services

I was disappointed to have to go over the same questions, because they didn't have my notes
Patient/ Service User

There are still people being managed by mental health services when they could be managed by primary care, but practices are reluctant to take them back.
Mental Health Practitioner

Patients with stable MH problems have been discharged from MH services and they are turning up very frequently instead in general practice because they have social needs & isolation. This is not an efficient use of GP time. The idea was that community services would be developed, but that hasn't happened.
Primary Care Practitioner

The crisis team and consultants should give feedback on referrals, particularly if there was a more appropriate referral route.
Primary Care Practitioner

We need a single point of access from general practice into acute mental health services. It is difficult to decide on the appropriate person to refer to.
Primary Care Practitioner

Social care was seen as a key partner whose membership of multidisciplinary teams was seen as crucial to meet patients' needs. However the current arrangements were seen as inadequate by some respondents, highlighting the need for improved communication and increased co-ordination of care and support, whilst recognising the skills that different specialists provide.

We need more of a social care presence, there is a need to address finances, housing, packages of care. The delay in organising panel papers, or due to placements falling through lead to more bed days and delays in discharge, restricting beds further.
Mental Health Practitioner

The processes needs to simplify as it takes too long to get packages of care and they are becoming more and more difficult to get, with more hoops to jump through due to the funding situation. The problem with delays in care packages is that services stop working when they don't get paid.
Mental Health Practitioner

If I have a client, we won't know if they have MH contact. We use personal contacts, but it would be enhanced if we knew each other.
Adult Social Care Practitioner

Multidisciplinary team working brings different ideas and skills. We try to work to our different strengths; we do assessment clinics and decide who would be the best person to give the best service to the patient.
Mental Health Practitioner

Separation of teams is not good. We need multidisciplinary teams. There needs to be a balance between generic workers and separate specialist teams.
Mental Health Practitioner

We are duplicating work with social care. It should be a joint assessment and then start to focus on individual skills and specialities
Mental Health Practitioner

There needs to be improved communication between health and social care services, with defined responsibilities and more "flow" between services.
Mental Health Practitioner

These complex needs, each served by multiple agencies, highlight a requirement for effective liaison between specialist mental health practitioners, other health staff, social care and voluntary and community organisations, in addition to support for self-care and informal care as outlined above. As a result, there is highly evident need for effective mental health liaison and care co-ordination that follows service users throughout their journey.

11.3. Mental Health Liaison Psychiatry Services

Reflecting the links between physical and mental health and the multiple needs of patients, there was a call from professionals for improved liaison psychiatry to work across specialities, educate practitioners and reduce demand.

We know that there are huge numbers of patients with physical manifestations of mental health issues and vice versa. Psych liaison needs to be much wider, encompassing community hospitals and out patients. It would pay for itself
General Practitioner

We are missing a proper psychiatric liaison within WVT. A proper multidisciplinary team could deal with delayed discharge, medically unexplained symptoms and primary care issues.
Mental Health Practitioner

A lot of what Psych liaison is about is education. Currently minor self-harm and OD is sent to crisis. Psych liaison would enable clinical staff operate improved clinical judgment.
General Practitioner

We have an RMN but not on duty at all times. Ideally we would have one on every shift. Additional RMNs in the A&E team would reduce the demand on crisis.
Acute Hospital Consultant

There are still situation where individuals are discharged from ED to wait for MH assessment- risk of potential massive patient harm- This is a Francis report issue. There is a situation where the A&E

have the choice of either not meeting the 4hour wait target or discharging the Patient to wait for mental health support. That is how breaches are being kept down for mental health.
Mental Health Practitioner

Enhancing management in mental health improves outcomes in physical health and vice versa[xii]. There is evidence that liaison services are both clinically and cost effective[xiii].

A liaison service should be an integral part of the services provided by acute hospital trusts. In addition, there is a clear role for liaison to support primary mental health care to manage people with LTCs and MUS, in order to avoid unnecessary admissions to secondary care.

An acute liaison service is designed to provide services for:

- People in acute settings (inpatient or outpatient) who have, or are at risk of, mental disorder
- People presenting at A&E with urgent mental health care needs
- People being treated in acute settings with co-morbid physical disorders such as long-term conditions (LTCs) and mental disorder
- People being treated in acute hospital settings for physical disorders caused by alcohol or substance misuse
- People whose physical health care is causing mental health problems
- People in acute settings with medically unexplained symptoms (MUS).

The service aims to increase the detection, recognition and early treatment of impaired mental wellbeing and mental disorder to:

- Reduce excess morbidity and mortality associated with co-morbid mental and physical disorder
- Reduce excess lengths of stay in acute settings associated with co-morbid mental and physical disorder
- Reduce risk of harm to the individual and others in the acute hospital by adequate risk assessment and management
- Reduce overall costs of care by reducing time spent in A&E departments and general hospital beds, and minimising medical investigations and use of medical and surgical outpatient facilities
- Ensure that care is delivered in the least restrictive and disruptive manner possible.

Effective mental health liaison requires a full spectrum of activity, from prevention and treatment of mental illness in patients with long term conditions (e.g. coronary heart disease[xiv]; diabetes[xv]; cancer[xvi] ; chronic pain[xvii]and COPD[xviii]) through to improving the physical health of people with mental illness, via such interventions as smoking cessation[xix].

There is a need within Herefordshire for clear, well understood pathways between primary care teams (including IAPT practitioners and primary care mental health nurses) and specialist mental health services.

There is an equally pressing need for acute liaison services to provide specialist mental health input to acute hospitals and oversee acute inpatient and community-based interventions for comorbid long-term conditions and medically unexplained symptoms. Appropriate management of medically unexplained symptoms should lead to a significant reduction in the inappropriate use of acute inpatient resources as these patients often have many assessments and outpatient appointments.

There is currently no single, uniform model for liaison services across the country. However there is a body of evidence, reflected in JCPMH guidance[xx] indicating what liaison services should look like.

Principles

- Staff members sole (or main) responsibility is to the liaison team
- The team includes adequate skill mix
- The team has strong links with specialist mental health services and good general knowledge of local resources
- There is one set of integrated multi-professional healthcare notes
- Consultant medical staff are fully integrated.

11.4. Recommendations

Parity of Esteem

Mental health must achieve parity of esteem with physical health. This will have a number of implications:

- The system will treat people as a whole, appreciating the links between mental and physical health, housing, employment and training, deprivation and social isolation.
- The mental health impacts of long term conditions and the physical impacts of mental health conditions will be explicitly recognised.
- The functions of psychiatric liaison will be reinforced and extended to cover primary care and community hospitals, with a strong presence within the acute hospital.

All agencies have a role in promoting mental health and supporting people with mental health conditions. Identification of people's mental health needs should occur across the NHS system, reinforced by extension of psychiatric liaison services across acute and community hospitals, with communication and training links to primary care.

Supported Self-Management

Meeting people's care needs will require support to informal carers and to individuals to manage their own conditions. Supporting people to identify risk or trigger factors, and agreeing steps that they can undertake, can enable more people to take in charge of their mental health. There is a need for an active market place with choice for the person in terms of where and how they choose to access assistance. This will include support to voluntary sector, service user and carer groups.

Employers and other organisations can also encourage people to consider these personal care plans as a resource to increase resilience. Raising awareness of mental health with family, friends, employers and communities can help foster an environment for good mental health to develop.

Ease of Access to Care and Support

There remains significant unmet need for common mental health conditions. Insufficient numbers of people are being diagnosed and people appear to be receiving support too late. Many recognised that some of their experiences could have been avoided if early intervention had been available. Part of this issue is that the current system is complex for patients and professionals to navigate. People do not understand where to go and how to ask for help, with the exception of seeing a GP. This is further complicated by the need of carers and families requiring a route to ask for assistance with a concern of a loved one.

For this reason, the mental health "front door" needs to be within primary care, specifically within GP practices. This would tackle stigma and encourage more people to treat their mental health in line with their physical health. People will be able to access assessment, treatment and appropriate triage to further mental health support if and when required.

Recognising primary care's role as the front door of mental health services, there is a need to enhance and strengthen primary care mental health capacity and function.

The assessment of mental health within a primary within primary care will negate the "passing" of patients and duplication of assessment, meaning that service users do not have to repeat their story. Waiting times should reduce as people can receive early support closer to home. This is in line with the recovery model and the evidence base round early intervention.

Group therapies represent a cost effective model of delivering low level psychological support. There is a need to extend provision and make it more accessible and accepted. Other agencies have a role in promoting its availability and supporting people to attend.

Community Mental Health Services

The model of secondary mental health services must reflect the demography, geography and the financial resources available within Herefordshire, as well as issues of workforce recruitment and retention. Given its context, Herefordshire would most benefit from a model that is flexible and risk based, removing the gulfs between the existing teams with specialist workers for some specific functions. This is not removing specialisations, but gaps between teams. Multidisciplinary team working remains a critical way of managing people, with continuity of care critical.

A key consideration is whether a service configuration of separate teams for working age and older people is sustainable Removal of older people care in favour of all age team. Other areas have moved to a separation of all-age organic and functional teams.

All patients engaged with secondary mental health services should receive a care/ crisis plan.

Within this model, day care; crisis and home treatment form part of the acute care pathway, alongside inpatients. No service model changes are recommended here however, criteria for access to support must be explicit and made available to practitioners and the public. Equally, when people are discharged, they should be equipped with strategies to maintain their health at home, to include signposting to appropriate community support.

The recommendations for elements of the service model requires financial modelling and clinical consideration as part of Herefordshire Clinical Commissioning Group commissioning for outcomes. This should be reflected in the next steps arising from this Needs Assessment.

References

[i] Centre for Economic Performance's Mental Health Policy Group (2012) *How mental illness loses out in the NHS.* London: Centre for Economic Performance, London School of Economics and Political Science;

[ii] Wahlbeck K, Westman J, Nordentoft M, Gissler M, Laursen TM. Outcomes of Nordic mental health systems: life expectancy of patients with mental disorders. Br J Psychiatry. [bjp.bp.110.085100 pii;10.1192/bjp.bp.110.085100 doi]. 2011;199(6):453-8.

[iii] Thornicroft G. Physical health disparities and mental illness: the scandal of premature mortality. British Journal of Psychiatry. 2011 Dec; 199(6):441-2.

[iv] P208

[v] Department of Health (2011c). 'Ten things you need to know about long term conditions'. Department of Health website. Available at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Healthcare/Longtermconditions/tenthingsyouneedtoknow/index.htm (accessed on 19/09/14)

[vi] National Voices (2014): Supporting Self Management
Url: http://www.nationalvoices.org.uk/sites/www.nationalvoices.org.uk/files/supporting_self-management.pdf Last accessed 16/09/14

[vii] Houle J, Gascon-Depatie M, Bélanger-Dumontier G, Cardinal C. (2013) Depression self-management support: a systematic review. *Patient Educ Couns* ;91(3):271-279.

[viii] Hirai M, Clum GA.(2006) A meta-analytic study of self-help interventions for anxiety problems. *Behav Ther*;37(2):99-111.

[ix] Mataix D, Marks I. (2006) Self-help with minimal therapist contact for obsessive-compulsive disorder: a review. *Eur Psychiatry*;21(2):75-80.

[x] Desplenter FAM, Simoens S, Laekeman G. (2006) The impact of informing psychiatric patients about their medication: a systematic review. *Pharm World Sci*;28(6):329-341.

[xi] Woltmann E, Grogan-Kaylor A, Perron B, Georges H, Kilbourne AM, Bauer MS (2012). Comparative effectiveness of collaborative chronic care models for mental health conditions across primary, specialty, and behavioral health care settings: systematic review and meta-analysis. *Am J Psychiatry*;169(8):790-804

[xii] Katon, W.J., et al., (2010) Collaborative Care for Patients with Depression and Chronic Illnesses. New England Journal of Medicine, 2010. 363(27): p. 2611-2620.

[xiii] Parsonage, M. and M. Fossey (2009), Economic evaluation of a liaison psychiatry service, Centre for Mental Health. p. 1-20

[xiv] Reid J, S.C., Thompson DR. (2013) Psychological interventions for patients with coronary heart disease and their partners: a systematic review. PLoS ONE 2013:e73459., DOI: Doi:10.1371/journal.pone.0073459

[xv] Balhara YP, V.R.,n (2013) Management of depression in diabetes: a review of psychosocial interventions. Journal of Social Health and Diabetes

[xvi] Strong, V., et al., (2008) Management of depression for people with cancer (SMaRT oncology 1): a randomised trial. Lancet,. 372(9632): p. 40-48

[xvii] Williams ACDC, E.C., Morley S,(2011) Psychological therapies for the management of chronic pain (excluding headache) in adults (Review). Cochrane Database of Systematic Reviews,. 11.

[xviii] Coventry PA, H.D.(2007), Comprehensive pulmonary rehabilitation for anxiety and depression in adults with chronic obstructive pulmonary disease: Systematic review and meta-analysis. Journal of Psychosomatic Research,. 63: p. 551-565.

[xix] National Institute for Health and Care Excellence (2012*)* Smoking cessation in secondary care: acute, maternity and mental health services,. NICE public health guidance 48. Nice: London

[xx] JCPMH (2013) Liaison Mental Health Services. JCPMH: London