THE INTEGRATION OF MENTAL AND PHYSICAL HEALTHCARE: ASPIRATION OR REALITY

A century of separation has been bad for both physical and mental healthcare. Whilst scientific and technological progress in medicine has led to huge improvements in the treatability of physical disease, these advances have arguably come at the cost of marginalising concern for the psychological needs of medical patients. Over a similar period, developments in psychiatry and psychology have led to an increased understanding of mental and behavioural health problems, and often effective methods to treat these, but the separation from medicine has led to a relative neglect of the physical health of the mentally ill [1].

Recognition of the need for collaboration in the second half of the 20th century led to the development of so-called liaison (linking) psychiatry services to hospital medical services. These pioneering initiatives focused initially, in the UK at least, on conspicuous psychiatric morbidity, particularly that associated with self-harm [2]. More recently however momentum is building for a much wider collaboration. The reasons for this include: first, a greater recognition of the frequency of co-existence of mental and physical illness [3], and second, growing evidence that such comorbid mental illness results in both a poorer outcomes for patients and greater costs of care for medical services [4]. Consequently, there has been a flurry of reports in both the UK and USA (for examples see [5], [4]) on the need to integrate mental or behavioural health into general medical care. Conversely there is also a developing recognition of the need to better integrating physical medical care into mental health services [6]. Much of this enthusiasm for integration remains aspirational however, at least in the UK. Evidence of integrated medical and psychiatric services often seems hard to find in the real world with most services still delivered by completely separate organisations.

A new report from the King's Fund entitled 'Bringing together physical and mental health' not only reviews the case for integration but, also provides real practical examples of how it has been achieved [7] . Importantly it describes both the barriers to and facilitators of its successful implementation based on interviews of those involved. The barriers are many and not all will be

overcome simply by co-location of services (co-location is not integration). They include deeply ingrained cultural factors in the workforce that reinforce division, and the separate organisational and payment systems for physical and mental health care. On the other hand key facilitators to achieving integration include strong leadership for change at both clinical and board level and a willingness to innovate in the relevant organisations.

Recent policy developments in a number of countries, including the new models of care introduced by the 'NHS five year forward view' in England [8] and the growth of accountable care organisations in the USA, have an exciting potential to facilitate integration of physical and mental healthcare. However, this will only happen if psychiatrists and other professionals now actively engage with these developments and use them as opportunities to advocate for and lead new forms of collaborative or even integrated working.

The idea of 'parity of esteem' for patients' mental and physical healthcare which has been successfully championed by the Royal College of Psychiatrists [9] has achieved enjoyed considerable influence. Indeed, in England, the Health and Social Care Act 2012 created a new legal responsibility for the National Health Service to deliver 'parity of esteem' between physical and mental health, something which the government has pledged to achieve by 2020. However interpretations of 'parity of esteem' vary. One interpretation is simply for existing mental health services to be as well funded and to provide as good care as existing physical health services. Whilst this is an important ambition, the report from the King's Fund raises our sights much higher to a vision in which mental healthcare is not only as good as physical care, but is delivered as *part of* all health and care services. That is the challenge we must address and the opportunity we must seize if we are to repair the harm caused by 100 years of separation.

References

1. Sharpe, M., *Psychological medicine and the future of psychiatry.* Br J Psychiatry, 2014. **204**: p. 91-2.
2. Mayou, R.A., *The history of general hospital psychiatry.* British Journal of Psychiatry, 1989. **155:764-76**: p. 764-776.
3. Barnett, K., et al., *Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study.* The Lancet, 2012.
4. Naylor, C., et al., *Long-term conditions and mental health*. 2012: London.
5. Collins, C., et al., *Evolving Models of Behavioral Health Integration in Primary Care*, in *Milbank reports*. 2010: New York.
6. Thornicroft, G., *Premature death among people with mental illness.* BMJ, 2013. **346**.
7. Naylor, K., et al., *Bringing together mental and physical health: A new frontier for integrated care.* . 2016, The Kings Fund: London.
8. NHS England, *Five year forward view*. 2014: London.
9. Royal College of Psychiatrists, *Whole-person care : from rhetoric to reality.* 2013.