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No Health without Mental Health

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Introduction

The aim of this report is to draw attention to the close links between physical and mental well being. The report is primarily concerned with mental health problems that are associated with, or arise from, physical illness, and the general interface between mental and physical health.

In part one of the report, the needs of elderly people and young people with physical and mental health problems are discussed. Both groups have particular age related needs that require consideration. There is an extremely high rate of mental illness in older people with physical health problems, and severe physical illness in children or young people impacts on young people themselves, their emotional development, and their families.

Part one also includes primary care, as the majority of patients with physical and mental health problems are managed in primary care, and GPs play a vital role in the detection and treatment of psychological problems in those who are physically unwell. A more detailed description of the interface between physical and mental health problems in primary care can be found in the Joint Working Report between the Royal College of Psychiatrists and the Royal College of General Practitioners.¹

Part one concludes with a discussion of medically unexplained symptoms; one of the most common physical health problems that GPs and hospital clinicians see on a regular basis. The role of psychological factors in the development and persistence of medically unexplained symptoms is described and the efficacy of psychological treatment is reviewed.

Part two of the report focuses upon the particular mental health problems that arise in the context of long term physical conditions. Instead of trying to cover every long term physical condition, four exemplar conditions have been chosen (cancer, coronary heart disease, diabetes, and chronic obstructive pulmonary disease). All four conditions carry enormous health burdens. The cost of healthcare for patients with Type 2 diabetes will rise by 25% over the next 30 years and the economic burden of the disease will rise by 40%.² The total annual cost of all coronary heart disease was £7.6 billion in 1999, the highest of all diseases in the UK for which comparable analyses have been conducted.³ Chronic obstructive pulmonary disease is the fifth leading cause of mortality worldwide and is the most costly adverse health outcome caused by tobacco smoking.⁴

For each condition, the emotional burden of the disease is described; the prevalence of mental health problems is reviewed and discussed, along with the appropriate treatment and management. Where relevant, evidence from randomised controlled trials or systematic reviews is presented. Although each condition is different and poses unique physical challenges for patients, the mental health problems discussed in relation to these conditions are similar to those encountered by patients with other long term conditions, and the information provided should be useful to clinicians involved in the management of patients with any enduring illness. A further section covers neurological disorders as these conditions are associated with particularly high rates of mental health problems.

Part three of the report focuses on the general hospital and covers specific departments or services where mental health problems may be of particular concern. This section includes obstetric services, because of the high rates of pre and post-natal mental health problems. There are also special sections on the emergency department and palliative care services.

The final sections of the report address the physical health needs of patients with mental illness and those with learning disability. Although there are problems in the detection and treatment of mental health problems in the physically ill, paradoxically, the physical well being of patients with major mental illnesses is also often poorly managed. People with severe mental illness have significant physical morbidity due to a range of factors, including the side effects of psychotropic medication (which may cause weight gain and increase the likelihood of developing diabetes), as well as lifestyle issues, such as a tendency to smoke heavily. People with severe mental illness may also have problems accessing appropriate medical care because of difficulties such as the inability to arrange and attend the necessary appointments. For individuals with learning disabilities there are also major barriers to accessing physical healthcare, such as communication difficulties and a lack of awareness in staff or carers of the need to screen for, and attend to, physical health problems. Physical health problems are much more common in people with learning difficulties than the general population.

Overall, it is hoped that this report will provide useful information about the link between physical and mental health and provide a much needed impetus for the development of better care for people with both physical and mental health needs.

Notes about the report

- This document presents key findings regarding the link between physical and mental health and does not represent an exhaustive literature review into every existing physical and mental health issue.
- The report generally refers to legal frameworks and organisational structures in healthcare services in England. However, the statement of the importance of recognising the link between physical and mental health and the call for better services is likely to resonate across all countries of the United Kingdom.
- Where relevant, we have referred to guidance provided by the National Institute of Health and Clinical Excellence (NICE) and the Scottish Intercollegiate Guidelines Network (SIGN). For a more detailed report on the mental health content of NICE and SIGN guidelines, please [click here](#) or visit www.rcpsych.ac.uk

Recommendations

Awareness

1. All national guidelines about medical conditions – including those issued by NICE and SIGN- should include specific advice about the detection and treatment of mental health problems associated with medical conditions.
2. Screening for depression in specific long term conditions in primary care should be continued and extended under the Quality and Outcomes Framework (QOF).
3. Screening for depression and other common mental health problems should be routinely introduced in the acute hospital setting.
4. People with learning disabilities and people with severe mental illness should receive relevant annual physical health checks.

Liaison Mental Health Services

5. Each general hospital should have an adequately funded liaison mental health service to provide mental health care throughout the entire hospital to all who need it, including those with learning disabilities.
6. Liaison services should include specified and appropriate provision for older people, as well as children and young people.
7. Patients in general hospitals with mental health problems should have the same level of access to a consultant psychiatrist as they would from a consultant specialising in physical health problems.

Engaging patients and carers

8. Information and education should be developed and provided in appropriate ways for patients, carers and the public to develop community awareness of the psychological aspects of physical conditions.
9. Patients should be better informed about, and involved in, decisions about their treatment, discharge and self-care.
10. Patients and carers should be involved in designing and improving mental health services to general hospitals and primary care settings, through audit, research and training. Full support should be provided.

Re-organisation, commissioning and quality standards

11. Liaison mental health services should be commissioned and reviewed against agreed specific service standards, to ensure they provide effective, evidence based interventions to treat mental health problems in the general hospital.
12. All care pathways for delivering physical healthcare should have a mental health component. There should be a counterpart pathway for commissioning practice to ensure the services are in place to deliver this.

Training

13. All health practitioners should have training in mental health.
14. The curricula of all doctors in training and the continuing professional development of qualified doctors should reflect the relationship between mental and physical health, both in general and in specific conditions.

Part 1: The Link between Physical and Mental Health

Overview

What is the psychological impact of physical illness?

Severe physical illness is stressful and frightening, but the relationship between depression and physical disorder is complex. People react to illness in many different ways, but most go through a dynamic process which changes over time. There may be an initial worry about a symptom and its possible cause, followed by the shock/reality of a diagnosis (e.g. cancer), followed by a period of adjustment as information is assimilated, and ways of coping are formulated. In many physical conditions, this process of adjustment has to be repeated as the illness progresses or enters a new phase. Families and carers are often as distressed as the person with the illness, and they too have to go through a process of adjustment. Most people, given time and appropriate help and support, can adjust to even the most serious, disabling and life threatening conditions.

How many people develop mental health problems as a consequence of their physical condition?

Approximately one quarter of people with physical illness develop mental health problems as a consequence of the stress of their physical condition. In these cases, the process of adjustment fails, and people develop depression, anxiety, panic or some other form of mental disorder. Depression is characterised by a persistent and severe low mood which is qualitatively different from 'normal distress'. Anxiety is characterised by severe agitation and apprehension which is qualitatively different from 'normal worry'. Both have major effects on the ability of the individual to function, including the ability to sleep properly, concentrate, socialise, care for others, work and carry out normal daily activities.

Box 1: What happens when depression and anxiety develop in the context of a physical illness?

- Recovery from the physical condition is impeded
- Pain can become more difficult to control
- Confidence to participate in rehabilitation programmes is reduced
- In extreme cases, the patient can come to believe that they are a burden on their family or the hospital and would be better off dead. For example, physical illness in the elderly is a major risk factor for suicide.

Does depression increase the risk of physical illness?

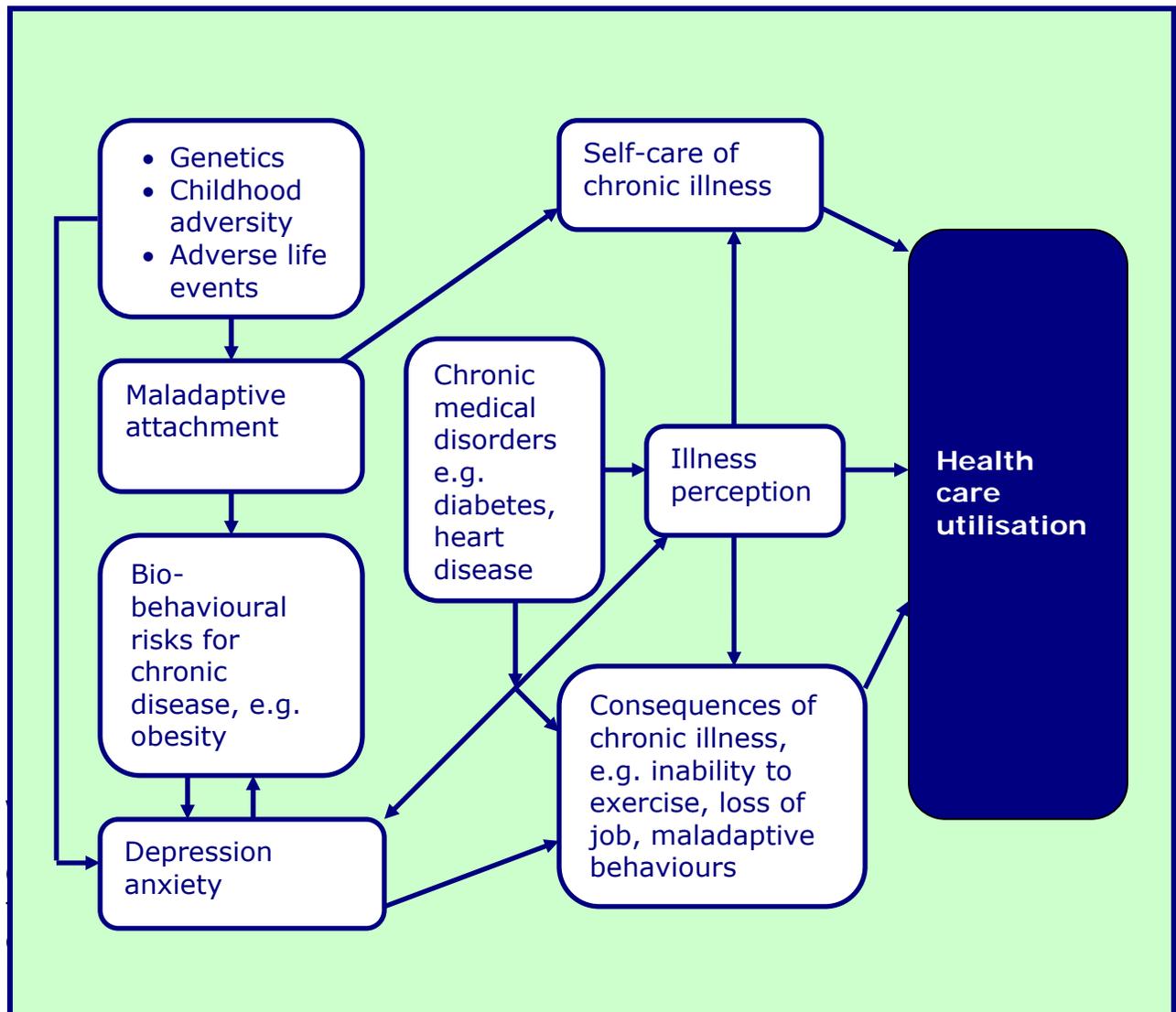
It is clear from numerous studies in many different physical conditions that patients with chronic medical illness, compared to those without, have an increased risk of depression⁵. This is so for virtually any long term condition⁶. It is also true that depression itself is a risk factor for physical illness. Major depression doubles one's

lifetime risk of developing type 2 diabetes⁷ and depression has also been proven to be a risk factor for the development of heart disease.⁸

How is the relationship between depression and physical illness best understood?

A conceptual model of the relationship between depression and physical illness has been developed⁹ and an adapted model which includes illness perception is shown in Figure 1. The model describes three known risk factors for the development of depression: genetic vulnerability, childhood adversity (abuse or neglect) and stressful life events.

Figure 1: A conceptual model of interaction between major depression, medical illness and health care utilisation (adapted from Katon, 2003)



alcohol consumption, sedentary lifestyle etc. Once chronic illness develops, it can cause deterioration in health, inability to exercise, poorer quality of life, job loss and financial insecurity, increased worry, family strain, maladaptive health behaviours (such as increased alcohol consumption) and brain changes (both early and late). Each of these factors, separately or in combination, can increase the risk of depression. Depression in turn can then adversely affect many of the factors

previously mentioned, leading to a vicious cycle of poor physical and mental health and poor function.

Why is perception of illness so important?

The way that people perceive illness is a powerful predictor of depression, with those who perceive illness as more threatening than others being at higher risk of depression. Self care and management of chronic illness can also be adversely affected by depression, while some factors which predispose a person to depression also increase the likelihood of poorer self care (for example, childhood adversity, maladaptive behaviours and maladaptive patterns of attachment).¹⁰

Even relatively mild mental health problems in patients with physical illness can have major effects on the physical condition. For example, a mild eating disorder in a patient with diabetes will have potentially serious long term consequences of a disproportionate nature to the severity of the eating disorder itself.

How well detected are mental health problems in long term conditions?

Over half of all cases of depression in the general hospital setting go unrecognised by physicians and nursing staff.¹¹ For example, a large scale study of people with diabetes found that only half the cases of depression were detected.¹²

There are similar problems with detection in primary care.^{13,14,15} Mental health problems are particularly hard to detect when there is an overlap of symptoms. For instance, people with chronic obstructive pulmonary disease may experience decreased appetite, tightness in the chest and fatigue – symptoms which are also associated with depressive or anxiety disorders. Depressed people attending general practices usually present with non-psychological symptoms, such as pain or poor sleeping.¹⁶ When a chronic physical disease is found to be present, there is the risk that attention will shift to this disease, and the depression may then be overlooked.¹⁶

Clinical barriers, such as short appointment times, a lack of knowledge about depression and treatment, or a lack of time to talk to the patient about these issues can also prevent detection of mental illness. Some healthcare professionals may not think to enquire about psychological symptoms, or may feel uncomfortable doing so. Even if these symptoms are discussed, practitioners might, quite reasonably, regard depression and anxiety as understandable reactions to being physically unwell. As such, the patient's symptoms are normalised and the practitioner might not realise the mental health problem could be treatable.

In turn, patients may be reluctant to seek help because of stigma around mental health issues, or perhaps guilt about 'bringing the disease onto themselves' through lifestyle habits.

Box 2: Questions that may be used to elicit symptoms of depression

- Have your symptoms got you down at all?
- Do you ever get the feeling that you can't be bothered to do things?
- Is there anything you look forward to (or does your illness stop you)?
- Has this illness affected your confidence?
- Do things ever get so bad you think about death?

From the Handbook of Liaison Psychiatry (Lloyd and Guthrie, 2007).

The use of screening tools

Since the introduction of the Quality Outcomes Framework (QOF), general practitioners (GPs) receive a financial incentive to perform regular health checks on patients with diabetes and coronary heart disease that include screening for depression.¹⁷ Generally GPs use the 2 question screen*. If the patient answers positively to either question, this is followed up with a more complete assessment using tools such as Patient Health Questionnaire (version 9) or the Hospital Anxiety and Depression Scale. This screening strategy has been successful in many well-organised practices. The challenge in primary care is to extend such screening to all long term conditions and to provide (or have access to) appropriate interventions for people when their depression is detected. Screening for psychological distress is also performed in other settings, for example as part of cardiac rehabilitation for patients with coronary heart disease, though the practice is patchy and uptake of rehabilitation remains disappointingly poor. Healthcare professionals from various settings have reported that they find the various screening tools for depression confusing and time consuming for routine practice.¹⁸

The NICE guideline for Supportive and Palliative Care recommends routine assessment of psychological needs among patients and their carers at key stages of the illness. Brief mental health assessments should also be made routinely for people admitted to acute hospital beds. This could identify those with mental disorders or those at high risk of developing them. In all settings, it is important that patients and carers are fully involved in discussions around the person's care, and provided with sufficient information and support.

Conclusion

Mental health problems are common in people with medical conditions and develop because of a complex interplay between psychological, physical and social factors. Mental health problems have an adverse effect on a variety of health outcomes in patients with medical conditions, but detection rates are low, so many people do not receive appropriate treatment for their mental health problems.

* 2 question depression screen: "During the last month have you been feeling down, depressed or hopeless?" and "During the last month have you often been bothered by having little interest or pleasure in doing things?". Yes to either question has 96% sensitivity and 57% specificity compared to research interview

The Mental Health Needs of Older aged Adults

How common are mental health problems in older aged adults?

Mental health is a major issue for people over the age of 65, and the problem is growing. In the UK, it is estimated that the number of older people with mental health problems will increase by a third over the next 15 years to 4.3 million, which is 1 in every 15 older person.¹⁹

There is a strong link between physical and mental health in this age group. Two-thirds of NHS beds are occupied by older people, and up to 60% 'have or will develop a mental disorder during their admission', with dementia, depression and delirium being most common.²⁰ In contrast, 16% of older people in the general population have mental health disorders.²¹

What impact do mental health problems have on older people with physical illness?

Mental disorder in older people is an independent predictor of poor outcome, such as 'increased mortality, greater length of stay, loss of independent function and higher rates of institutionalisation...the cost to sufferers and carers is substantial'.²² These outcomes are exacerbated by the inadequate funding of mental health services for older people, and the fact that general hospital staff often lack the specialist knowledge and support required. For example, acute staff may not recognise delirium in up to 50% of cases. At the same time, it is estimated that preventative interventions can reduce incidence of delirium by 30-40%, meaning that valuable opportunities to improve patient outcomes are frequently being missed.²⁰ Other potentially treatable conditions such as depression are also commonly overlooked. The 'Who Cares Wins' report²⁰ describes attempts of acute services to treat mental disorder as 'inconsistent' and other literature describe similar concerns, such as the fact that older people can be 'particularly susceptible to the adverse effects of drugs and be subjected to polypharmacy'.²³

Aside from causing unnecessary suffering to patients and their loved ones, poor detection and treatment of mental health problems has serious cost implications. Dementia and delirium can increase the length of stay by up to 10 days²⁴ and psychiatric liaison interventions have been shown to reduce length of stay by on average 2 days following hip surgery.²⁵

How could better detection of mental health problems improve outcome?

The introduction of routine mental health assessments of all older age admissions could identify those at high risk of dementia, delirium and depression, allowing opportunities for care plans to include strategies for preventing and managing these conditions as soon as possible. It is also important that carers are involved in early discussions around the patient's care, and provided with sufficient information and support. The National Dementia Strategy, 'Living well with dementia' recommends improving care for people with dementia in general hospital by providing leadership through a nominated senior clinician, and developing a care pathway for people with dementia that is supported by a specialist liaison service²⁶.

Conclusion

The mental health needs of older people in general hospitals urgently need to be better understood and more adequately addressed. This is most likely to be achieved via a multi-disciplinary liaison mental health team with specialist knowledge of older people.²⁰ A liaison team that is well integrated with the general hospital will be ideally placed to work with acute colleagues, providing advice, support and training, and increasing the confidence and competence of all staff working with older people who have mental health problems.

Box 3: Key recommendations from the 'Who Cares Wins' Report (Royal College of Psychiatrists 2005)

- All must ensure that older people admitted to general hospitals are not disadvantaged but have timely access to quality specialist mental health assessment and treatment.
- All must fully understand how common mental disorders among older people in general hospitals are, the adverse impact this has on outcome and the evidence that these disorders can be prevented and treated.
- Commissioners need to ensure that all acute hospital trusts have clear plans to meet the mental health needs of older people. This will require the provision of specialist liaison mental health services, attention to skill mix and improved training of general hospital staff.
- Acute hospital trusts and mental health services must retain the principle that good mental health for older people is based in multidisciplinary team working.

The Mental Health Needs of Children and Adolescents

How common are mental health problems in young people with medical conditions?

According to a national survey of child and adolescent mental health around 10% of 5–15 year olds has a mental disorder, including 4% with anxiety and depression.²⁷ Children with medical conditions have a higher incidence of mental health problems than the average population, and a higher incidence of learning disabilities, developmental disorders and autistic spectrum disorders.²⁸

Another group of young patients seen in the general hospital and paediatric wards are children and adolescents with psychosomatic presentations²⁷ and those where there is significant psychological impact of chronic physical illness. Children with developmental delay and learning disabilities have a much higher mental health morbidity than children without, and are more likely to be admitted to paediatric wards because of a higher prevalence of physical problems.²⁹

How can mental health professionals help care for children and young people with physical and mental health problems?

Paediatricians rarely have the time or expertise to address the wide spectrum of mental health needs in hospitalised children³⁰ and most paediatric departments are still without any meaningful child and adolescent mental health service (CAMHS) input,³¹ which is likely to be a major obstacle to the timely diagnosis of mental health problems.

Mental health professionals can play a key role in the care of young hospital patients. A lack of compliance to treatment plans, for example in diabetes, may be related to coping, stress, trauma and anxiety – in which case support and psychological intervention may be crucial.³²

Aside from the paediatric wards, where a CAMHS presence is essential, joint working between mental health and acute colleagues has been recommended in joint clinics such as in diabetic, asthma³³ nephrology³⁴ as well as oncology and epilepsy/neurology.³⁵ Some CAMH liaison teams also provide input to clinics in rheumatology, dermatology, gastroenterology, cystic fibrosis, haematology, and ante and postnatal clinics. This allows not only work with vulnerable children and those with mental health problems but also facilitates preventive work, liaison, joint psychosocial meetings and consultation.

Other useful input may include working into perinatal services, intervening early to prevent the effects of antenatal anxiety and postnatal depression, which have damaging developmental effects on babies and children.³⁶ Children whose parents or siblings die in the hospital may also need support.³⁷ In practice little of this is available in most hospitals and services are often ad hoc rather than planned or strategically commissioned.

Risk assessment and intervention of all urgent and complex cases, including self-harm, remain key elements of liaison work.²⁸ Patients may be any age from birth to 18th birthday and present with problems in the management of a physical disorder, self poisoning or self-injury.³⁸ Many such patients are also in need of child protection assessments.³⁹ Finally a liaison team will have important input to

paediatric staff development and training.⁴⁰ Child health staff need to know how to manage the experiences and anxieties of their patients and to identify mental disorders.

Conclusion

In order to prevent, diagnose and treat mental health problems, every hospital requires a critical mass of multidisciplinary CAMHS staff, with sufficient numbers to cover others on annual, study, maternity or sick leave. Psychiatry, psychology, nursing and social work are the core professions, but others may be co-opted.

Mental Health and Primary Care

How common are mental health problems in primary care?

Around fifteen percent of adults in the UK have been assessed as having a neurotic disorder.⁴¹ Ninety percent of people with mental health problems are cared for entirely in primary care.⁴² Many of these are patients with depression and anxiety symptoms. Good mental health is important to everybody's daily functioning and relevant to patients' ability to be involved in the care provided by GPs. It is hard to define, but is more than the absence of mental illness and includes concepts such as self-efficacy, self-worth and empowerment.

What is the GP's role in the management of people with both physical and mental health problems?

Primary care is charged with providing care for 'common mental health problems' and contributing to health promotion, but there is a lack of clarity about who should lead on the care of those with chronic, complex and disabling non-psychotic problems. GPs require a good understanding of the healthcare needs of all these groups. In addition, GPs have a responsibility for the management of physical problems of patients with severe and enduring mental health problems, sharing share care with mental health services.

Depression and anxiety frequently co-exist with long term physical conditions⁴³ and such co-morbidity is associated with physical limitation, greater functional impairment, increased use of health services, and higher mortality.⁴⁴ Major health problems can lead to worry and distress and the degree of stress caused by an illness is more closely related to the patient's perception of the illness than the severity of the illness itself. Problems with anxiety and depression in the medically ill are commonly missed,^{45, 14, 46} which results in unnecessary suffering and disability. GPs have a key role in helping people to cope with physical illness and facilitating a natural psychological adjustment. In addition, GPs need to recognise when patients with physical illness are becoming depressed and treat accordingly. They also need to feel confident in managing patients whose physical symptoms remain unexplained.⁴⁷

How can treatment help?

There is good evidence from studies conducted in primary care that collaborative treatment for depression, including appropriate use of antidepressants, is beneficial for both adults of working age and older people who are suffering from a depressive disorder.⁴⁸

Conclusion

The continued splitting of mental from physical functions perpetuates the stigma, discrimination and exclusion associated with having a mental illness. The core of the generalist's role is to help patients make sense of often paradoxical symptoms in the context of their whole life story.

Box 4: Key recommendations from the Royal College of General Practitioners position statement (Royal College of General Practitioners, 2004)

- Primary Care Practitioners become skilled at bringing into view the diverse factors that will affect a patient's mental health, including their physical health and be aware of the full range of interventions and resources available to address mental health problems (including the range of voluntary, community and specialist mental health organisations).
- Primary Care Practitioners develop skills of multi-disciplinary team working to provide adequate support for patients, mindful that patients also often value the continuity afforded by one-to-one relationships.
- Primary Care Practitioners improve the physical care of patients with mental health problems, through understanding the latest evidence and by evaluating and acting on the physical health needs of patients with severe mental health problems.
- Educators ensure that the training and educational needs of all primary care clinicians regarding mental health are identified and met, including becoming skilled at identifying symptoms of depression, anxiety, cognitive impairment, and lifestyle issues, in people with chronic physical illnesses.
- Educators provide appropriate training for reception staff.
- Primary mental health care developments include timely availability of specialist mental health advice or support for patients with complex non-psychotic conditions; systems for review of physical health needs of patients with long-term mental health problems and systems for review of the mental health needs of those patients with chronic physical problems.

Medically Unexplained Symptoms

How common are physical symptoms which do not have an apparent underlying organic cause?

Physical symptoms unexplained by an identifiable disease or organic process are extremely common. At present the preferred term to describe this phenomenon is 'medically unexplained symptoms' (MUS). An estimated 20% of new inceptions of illness in primary care - and as many as 30-40% of all new medical outpatient referrals - are accounted for by patients with medically unexplained symptoms.⁴⁹ Although a small proportion of patients with MUS are eventually found to have an underlying organic disorder, in the majority of cases no underlying reason for their symptoms is identified.

What is the link between medically unexplained symptoms and psychological factors?

There is a close association between MUS and psychological factors.⁵⁰ The more bodily complaints a person reports, the more likely they are to also report psychological distress.⁵¹ A similar relationship exists between number of bodily complaints and degree of impairment and frequency of healthcare use.⁵² Approximately 40% of outpatients with MUS will have diagnosable anxiety and depression.⁵³ However, this is not to suggest that all patients with MUS have identifiable mental health problems.

Many different 'functional syndromes' have been developed over the last 30 years with clear diagnostic criteria (such as irritable bowel syndrome or fibromyalgia). There is considerable overlap in symptoms between different functional conditions,⁵⁴ yet most of these syndromes are studied as if they are discrete conditions within particular medical specialties. In primary care there is actually little evidence to support the existence of discrete somatic syndromes.⁵⁵ Recent work by Fink and colleagues, who studied over 1000 patients with somatic symptoms, suggests that functional syndromes are not discrete entities but are manifestations of underlying phenomena of bodily distress.⁵⁶

The way symptoms are presented to doctors is shaped by four factors:

1. The social context in which the symptom is experienced (such as intolerable job, marital discord)
2. The context in which it is presented (e.g. primary care, psychiatrist)
3. The patient's beliefs and expectations
4. The diagnostic language of the physician

Initial consultations with GPs can be pivotal, yet most patients with MUS perceive the explanations of GPs as being at odds with their own thinking.¹ Patients perceive their symptoms as being caused by something malfunctioning in the body and require a causal explanation.⁵⁷ The majority also raise issues related to psychosocial stress during the consultation.⁵⁸

Box 5: How can GPs help people who have MUS during the initial consultation?

Patients come away feeling empowered:

- If they feel understood and respected, and not dismissed
- If they receive an explanation of their symptoms which makes sense to them
- If their psychosocial issues are acknowledged

What factors contribute to the development of medically unexplained symptoms in adult life?

For each individual, different combinations of factors will be of importance. The main factors are listed below:

- Childhood abuse
- Childhood neglect
- Childhood experience of physical illness
- Familial transmission of worries or concerns about illness and health seeking behaviour
- Life events and chronic stress
- Insecure relationship styles

In some cases physiological and psychological factors are equally important. Irritable bowel syndrome is more likely to develop following a gut infection in individuals who are depressed or anxious than those who are not.⁵⁹ In this scenario, both an inflammatory process within the gut and stress at the time the infection, are required for the somatic symptoms to develop.

Patients with medically unexplained symptoms show an abnormal amplifying perceptual style,⁶⁰ restrictive assumptions about health and body functions,⁶¹ and a tendency to over-interpret physical sensations as possible signs of organic disease.⁶² Causal beliefs have been found to be associated with dysfunctional abnormal illness behaviour,⁶³ and patients show a memory bias for illness-related stimuli.⁶⁴ In other words, patients with medically unexplained symptoms have a tendency to worry and focus upon their symptoms which may not be helpful and may result in an increase in the severity of symptoms.

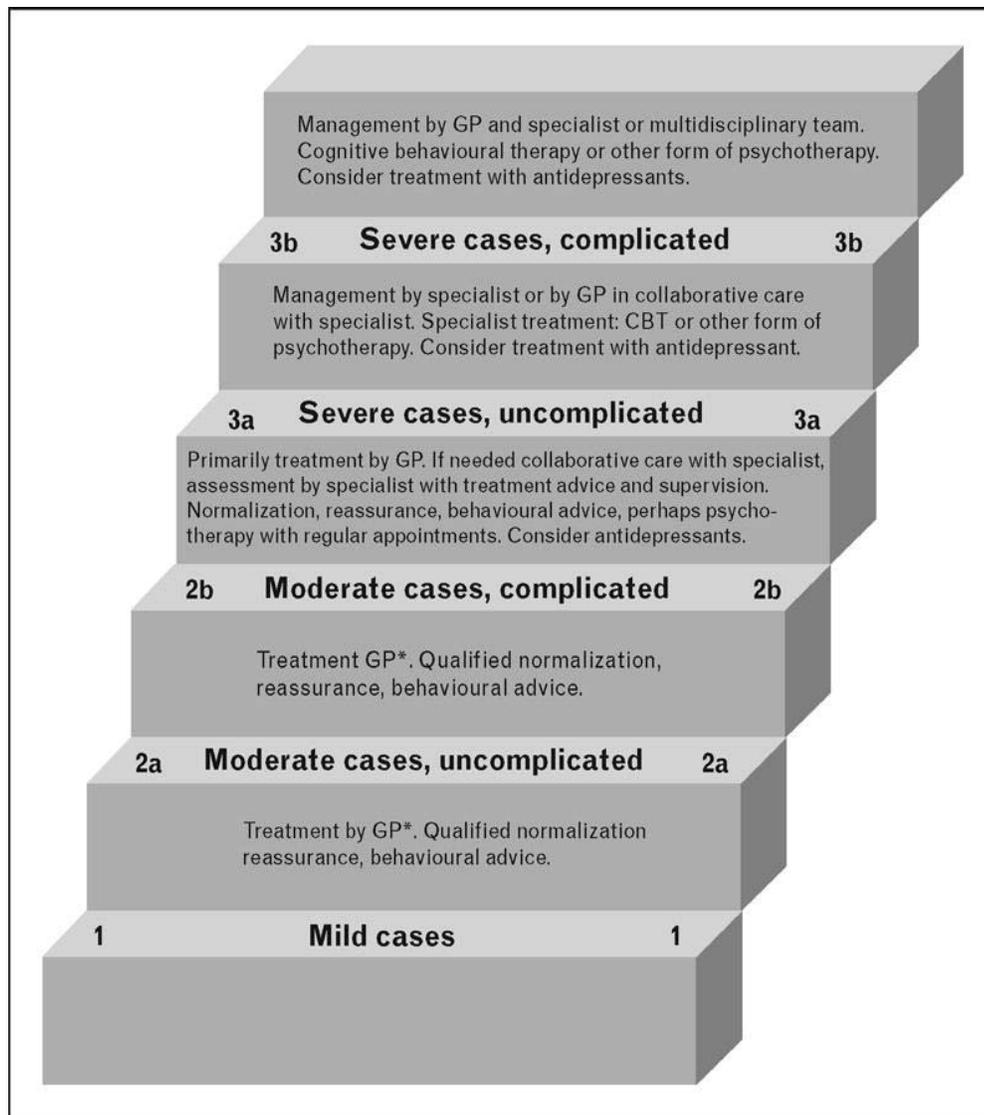
What treatments can help?

There is a substantial evidence base which supports the treatment of MUS with either brief psychological treatments or antidepressants.^{51,52} The best evidence is for cognitive behavioural therapy as most studies have used this intervention.⁵¹ There is also good evidence for the benefits of psychodynamic interpersonal therapy, and hypnosis for patients with MUS.⁶⁵ Tricyclic antidepressants used in small dosages have been shown to produce significant beneficial treatment effects in patients with chronic pain and MUS.⁶⁶ Less evidence exists for newer antidepressants; partly because fewer published studies to date used these drugs.

Certain treatment interventions (psychodynamic interpersonal therapy) have been shown to result in reduced health care costs following treatment so can be delivered at no additional cost provided the right infrastructure is in place.⁶⁷

The most sensible approach to treatment involves a staged care approach (see Figure 2). For patients with relatively mild or recent onset symptoms, low intensity treatments should be considered. If the symptoms do not improve or show evidence of becoming prolonged, more intensive treatments may be required, such as antidepressants or brief psychological treatment. Appropriate investigation of the patient's physical symptoms should occur but excessive investigation should be avoided. Patients with very severe MUS may require a shared care approach with multidisciplinary team involvement.

Figure 2: The Staged Care Approach to Medically Unexplained Symptoms (Henningsen et al, 2007)⁶⁸



*Usually the GP, but it could be another professional.

Conclusion

At present, healthcare services are generally split into providing treatment for mental health problems or physical health problems. Patients with physical and mental health problems find it difficult to access appropriate services and this is particularly the case for patients with MUS. The amount of treatment available for such patients should be proportionate to their physical and mental health needs. In other words, individuals with chronic and severe symptoms will need more intensive treatments than those with mild or moderate symptoms.

The Mental Health of People with Long Term Physical Conditions

How do long term medical conditions impact on the individual?

Long term physical conditions impose a considerable emotional burden on patients and carers, and this can change over time, as the example below illustrates:

Box 6: Example of the challenges faced by someone with diabetes

In the early stages of type I diabetes individuals are essentially physically well, however they have to comply with diet and treatment, and these restrictions on a 'normal lifestyle' in a person can be difficult. Later as complications develop, individuals with diabetes experience a range of gradual or sudden deteriorations in health, such as impaired vision, poor renal function, peripheral vascular disease and so on.

The loss of physical function can result in unemployment, financial hardship, stress within the family, loss of sexual function, loss of social activities, and threat to life. Severe physical illness is a threat to the self, and patients often lose the ability to perform a range of activities which previously maintained their 'sense of themselves' as human beings, whether this is as parent, worker, provider and so on.

How do mental health problems in chronic disease affect outcome?

The presence of mental health problems in long term physical conditions is associated with increased healthcare use and expenditure. For example, patients with depressive disorder are twice as likely to use emergency department services as those without depression.⁶⁹

In diabetes, total health expenditure is 4.5 times higher for individuals with depression than for those without depression.⁷⁰ In chronic heart disease, depressed patients have higher rates of complications and are more likely to undergo invasive procedures.^{71,72} In chronic obstructive pulmonary disease, co-morbid depressive symptoms are associated with longer hospitalisations and increased symptom burden.⁷³

Which treatments are effective?

Antidepressant treatment is often helpful in improving mood in patients who are suffering from depression. In addition, however, many people require psychological help to adjust to a particular phase of their illness and the restrictions it imposes on themselves and their families. This doesn't necessarily have to involve formal referral for specific psychological treatment, but may involve discussions with a specialist nurse or counsellor or brief discussions with a liaison psychiatrist or nurse. Referral for specific psychological treatment would be indicated if there is a continued difficulty to adjust to the illness, or persistent symptoms of depression or anxiety.

In this section of the report, the mental health problems associated with four common long term conditions are described and a further section on mental health problems in neurological disease is included.

Coronary Heart Disease (CHD)

The British Heart Foundation estimate that in the UK around 3.4 million adults are living with coronary heart disease (CHD). Approximately 150,000 individuals will suffer a myocardial infarction (heart attack) and 117,000 people are estimated to die from CHD each year in the UK.⁷⁴

Within the UK there is significant geographical variation, with prevalence of CHD being highest in Scotland and lowest in the South East of England. The prevalence of CHD is greatest in men and increases with age.⁷⁴ There are marked variations across ethnic groups, particularly in men, with the prevalence of CHD being higher in Indian and Pakistani men than men in the general population. The prevalence of all CHD in Black Caribbean and Chinese men is much lower than in the general population.

How common are mental health problems in coronary heart disease?

There is evidence from observational studies that that CHD and mental health problems are associated. Most of the published evidence concerns the co-occurrence of depression and CHD.

Conservative studies using rigorous methods indicate that approximately 20% of patients have clinically significant depression following myocardial infarction (MI) or at the time of diagnostic cardiac catheterisation.⁷⁵ A similar proportion of patients have raised symptoms of depression that do not meet criteria for major depression⁷⁵.

In approximately half of patients detected to have depression following MI, the depression will have pre-dated the MI; in the remainder depression begins after the MI.⁷⁶ Depression that pre-dates the MI is associated with the same risk factors as seen in the general population, namely, female sex, past psychiatric history, lack of social support and chronic life difficulties, and is more likely to be persistent.⁷⁷ Post MI depression is not associated with the usual risk factors seen in the general population, but is associated with negative illness beliefs at the time of the MI (anticipating a chronic disease course with little chance of cure) and with ongoing cardiac symptoms.⁷⁸

Anxiety is common among CHD patients and often co-morbid with depression. Increased symptoms are evident in about 20% of individuals admitted following MI.^{79, 80}

Post-traumatic stress disorder occurs in about 15% of individuals following an episode of acute coronary syndrome (such as after unstable angina or MI) and is associated with poorer health and quality of life outcomes, reduced adherence to treatments and increased likelihood of readmission.^{81, 82, 83}

Do mental health problems affect the heart?

There is evidence from systematic reviews that depression increases the risk of developing CHD.^{84, 85} Depression also increases the risk of adverse outcomes among those who already have CHD; mortality and morbidity are increased among those with CHD and health-related quality of life is worse.^{86, 72.} However, it should be noted that many studies do not control adequately for potential confounding factors and there is evidence of publication bias.⁸⁷

Has screening for depression in primary care helped?

Since the introduction of the Quality Outcomes Framework (QOF), general practitioners receive a financial incentive to perform regular health checks on CHD patients that include screening for depression. However, despite this screening, the majority of depressed CHD patients do not receive adequate treatment for their depression.⁸⁸ This may be due to prioritisation of physical health problems, perceived lack of expertise among GPs, or reluctance by patients to engage in mental health services.⁸⁸

Specific guidelines for the treatment of anxiety or depression in people with CHD have not been developed, though guidance is available for the treatment of anxiety and depression in primary and secondary care in the general population.⁸⁹ This guidance advocates screening for individuals at high risk of anxiety or depression, including those with physical illnesses such as CHD. Treatment follows the principle of stepped care, where the intensity of treatment varies depending on the severity of the symptoms (see Figure 2 on page 21).

Which treatments are helpful?

Available evidence, though somewhat sparse, suggests that conventional psychological and antidepressant treatments are effective at improving depression in people with CHD.⁹⁰ Specifically efficacy has been demonstrated in Citalopram, Mirtazapine, with some evidence of benefit shown for Sertraline.^{91,92}

In the absence of guidance for the treatment of depression specific to patients with CHD, it seems reasonable that conventional guidance for the treatment of depression in the general population should be followed. Whilst depression improves with psychological and psychiatric treatment, no studies have demonstrated convincingly that medical outcomes improve if depression is treated.

Conclusion

Mental health problems are common amongst people with CHD and these problems are associated with worse medical outcomes. Routine screening is in place in primary care, though many depressed CHD patients do not receive adequate treatment for depression. More opportunistic screening when CHD patients come into contact with medical services, in addition to routine screening in primary care, would increase detection of mental disorders. Conventional psychiatric and psychological treatments are effective, though specific clinical guidelines are required to direct clinicians in their use in patients with CHD.

Box 7: Recommendations from the National Institute of Health and Clinical Excellence guideline on Coronary Heart Disease (2003)

- Carers and relatives of patients who are cognitively impaired should be made aware of treatment regimes for the patients they care for and be encouraged to identify any need for clinical support.
- The diagnosis of depression should be considered in all patients with heart failure.
- Where depression is likely to have been precipitated by heart failure symptoms, reassessment of psychological status should be undertaken once the physical condition has stabilised following treatment for heart failure. If the symptoms have improved no further specific treatment for depression is required.
- Where it is apparent that depression is co-existing with heart failure, then the patient should be treated for depression following the NICE guideline.
- For patients with heart failure, the potential risks and benefits of drug therapies for depression should be considered carefully.
- Patients with heart failure should consult a healthcare professional before using over-the-counter therapies for depression such as St John's wort (*Hypericum perforatum*). Healthcare professionals should be aware of the potential interaction with prescribed medication, and always ask about self medication, including the use of herbal products.
- Issues of sudden death and living with uncertainty are pertinent to all patients with heart failure. The opportunity to discuss these issues should be available at all stages of care.

Box 8: Summary from the Scottish Intercollegiate Guideline Network on Chronic Heart Failure (2007):

- Further research recommendations: Does the identification of depression or anxiety in patients with heart failure lead to treatment interventions which improve quality of life?
- The studies which exist in this area demonstrate high rates of unmet needs in the areas of symptom management, communication, decision-making, emotional support, co-ordination of care and quality end-of-life care.

Cancer

Background

Each year, more than a quarter of a million people are diagnosed with cancer in the UK, and 1 in 3 people will develop cancer during their lifetime.⁹³

Cancer can affect people of all ages, but the risk for most types increases with age. Two-thirds of all newly diagnosed cancers occur in people aged 65 years or older. Less than 1% of cancers are diagnosed in children aged 0-14 years.⁹⁴

Recent UK statistics from the Office for National Statistics⁹⁴ show that for men the most common cancer is prostate cancer (24%), followed by lung cancer (15%), and colorectal (14%). For women the figures are breast cancer (32%), colorectal (11%), and lung cancer (11%).

How common are mental health problems in cancer?

There is strong evidence to suggest that rates of mental health problems are higher in people who develop cancer compared to the general population. Rates of specific mental health problems vary considerably between studies, reflecting different research methods and the clinical dilemma of distinguishing between adjustment disorders and depressive and anxiety disorders in patients faced with overwhelming stress.^{95,96,97} Depression is considered to be one of the most common mental health disorders affecting people with cancer.⁹⁸ Adjustment disorders, anxiety and delirium are also common syndromes. A large population-based epidemiological study reported higher suicide risk linked with cancer.⁹⁹

Which types of cancer are most closely associated with mental health problems?

Depression is most highly associated with cancers such as oropharyngeal (22%–57%), pancreatic (33%–50%), breast (1.5%–46%), and lung (11%–44%) cancers, and also prevalent in patients with cancers such as colon (13%–25%), gynaecological (12%–23%), and lymphoma (8%–19%).¹⁰⁰

Rates of distress among patients with cancer are as high as 35%.¹⁰¹ Distress is defined by the National Comprehensive Cancer Network as: 'A multifactor unpleasant emotional experience of a psychological, social, and/or spiritual nature that may interfere with the ability to cope effectively with cancer, its physical symptoms and its treatment'.

Distress extends along a continuum, ranging from common normal feelings of vulnerability, sadness, and fears to problems that can become disabling, such as depression, anxiety, panic, social isolation, and existential and spiritual crisis".¹⁰² Prevalence of such distress varies according to the type of cancer with rates of 43% among patients with lung cancer; 33% among patients with breast cancer; and 31% in patients with colorectal cancer. Distress is associated with poorer prognosis, younger age, lower income and less social support. It is more common at key points in the cancer journey such as diagnosis, finishing treatment and at recurrence.¹⁰³

Do mental health problems affect physical outcomes?

There is reasonable evidence to suggest that people with mental health problems face a higher risk of developing cancer. Mental health problems appear to be associated with an increased death rate from cancer.¹⁰⁴ The mechanisms for this are unclear but various possibilities have been postulated.^{105, 106} These include:

- Confounding health behaviours such as smoking and drinking
- Lack of help-seeking behaviour
- Poorer adherence to cancer treatment

Should all cancer patients be screened for psychological distress?

Detection of mental health problems among oncology patients is low. Patients often do not discuss their low mood with their general practitioner and even among those who do, most receive no potentially effective therapy.¹⁰⁷ Given this low detection rate, it has been suggested that all cancer patients should be screened for psychological distress. Several brief screening tools, such as the Distress Thermometer, have been developed.¹⁰⁸ Unfortunately such instruments have poor predictive value. If 100 people were screened using the Distress Thermometer and the cutoff point currently recommended, distress would be correctly ruled out in 51 of 60 patients, but correctly confirmed in just 22 out of 40 patients.¹⁰⁹ Clinically, such instruments might be best used as a tool to help open up a dialogue with the patient about their levels of distress, rather than as a sole diagnostic tool.

Which treatments can help?

The NICE guidelines for supportive and palliative care recommend routine assessment of psychological needs among patients and their carers at key stages of the illness.¹¹⁰ They propose a four tiered model of care in proportion to the level of need, emphasising psychological approaches above pharmacological ones. Please see page 57 for more details.

There have been over 150 randomised controlled trials examining psychological interventions in patients with cancer. However, because patients with different types or at different stages of the disease will have different needs, unequivocal recommendations have not been made.¹¹¹ Two recent meta-analyses concluded that psychological interventions in cancer patients may have a moderate clinical effect on anxiety, but not depression.¹¹²

Despite the complexity of the issue, some general conclusions can be drawn.^{113, 114, 115} Interventions should be targeted at those at risk or already experiencing significant symptoms rather than at all patients. Both group and individual interventions have had positive results, with psychosocial interventions leading to improved quality of life and enhanced coping. Involving a multi-disciplinary team and the work of specialist nurses also appears to contribute positively to physical and psychological functioning. These last two interventions are now routine in most UK cancer settings but the provision of specific psychological interventions at tiers 3 and 4 remain very patchy.

There are few controlled trials of antidepressants in patients with cancer. A recent meta-analysis (of all trials which assessed four new-generation antidepressant drugs and were submitted to the US Food and Drug Administration) showed that the benefit of these drugs may have been overestimated, particularly in mild to moderate depression.¹¹⁶ Nonetheless, antidepressants are commonly prescribed in

clinical practice, though several studies suggest that patients may be slow to take them.¹⁰⁷ Several antidepressants, including tricyclics and paroxetine, may reduce the active metabolites of tamoxifen and caution needs to be exercised in this area.¹¹⁶

Conclusion

The diagnosis of cancer is frightening for the majority of people so it is not surprising that it is associated with high levels of distress. The 2004 NICE guideline for supportive and palliative care has been helpful in outlining the psychological support that should be provided to people with cancer and their families. Implementation of the guideline has however been patchy. Screening is the exception rather than the rule; services for carers are often scanty, and specific psychological and psychiatric interventions are not consistently available.

Box 9: Key recommendations from the National Institute of Health and Clinical Excellence guideline on Referral for Suspected Cancer (2005)

- [There should be] appropriate assessment for presence of anxiety or depression.
- [There should be] appropriate assessment of current life stresses and past trauma and abuse
- Persistent parental anxiety should be a sufficient reason for referral of a child or young person, even when the primary healthcare professional considers that the symptoms are most likely to have a benign cause.

Box 10: Key recommendations from the Scottish Intercollegiate Guideline Network on Lung Cancer (1998)

- All patients should undergo psychosocial assessment and have access to appropriate psychosocial and spiritual support.

Box 11: Key recommendations from the Scottish Intercollegiate Guideline Network on Head and Neck Cancer (2006)

- Head and neck cancer patients should be offered emotional support, which may be provided by clinical nurse specialists and non-clinically trained counsellors.
- Early diagnosis clinics should be provided where possible for the investigation of patients with suspected lung cancer, because they are associated with...less patient anxiety

Box 12: Key recommendations from the National Institute of Health and Clinical Excellence guideline on Familial Breast Cancer (2006)

- Care of women in secondary care should include access to psychological assessment and counselling.
- Support mechanisms (for example, risk counselling, psychological counselling and risk management advice) need to be identified and should be offered to women not being offered mammographic surveillance who have ongoing concerns.
- In services offering risk-reducing surgery, psychological assessment and counselling should be available.
- Counselling about psychosocial and sexual consequences of bilateral risk-reducing mastectomy/bilateral oophorectomy should be undertaken.
- Women considering bilateral risk-reducing mastectomy/bilateral oophorectomy should be offered access to support groups and/or women who have undergone the procedure.
- Any discussion of bilateral oophorectomy as a risk-reducing strategy should take fully into account factors such as anxiety levels on the part of the woman concerned.

Box 13: Additional recommendations from the Scottish Intercollegiate Guideline Network on the Management of Breast Cancer in Women

- Supportive expressive therapy is recommended for patients with advanced cancer and cognitive behavioural therapy for patients with localised, locoregional or advanced disease.
- Choice of psychological treatment modality in advanced breast cancer should be based on patient preference.
- All women with a potential or known diagnosis of breast cancer should have access to a breast care nurse specialist for information and support at every stage of diagnosis and treatment. Contact details and information about the role of the breast care nurse should be available to patients, families, multidisciplinary team members, including the primary care team.
- Breast cancer services should routinely screen for the presence of distress and risk factors for very high levels of distress from the point of diagnosis onwards (including during follow up review phases).
- Multidisciplinary teams should have agreed protocols for distress assessment and management.

Diabetes

Background

Diabetes is one of the most common chronic diseases worldwide. The prevalence of detected diabetes is around 3-4% in the general population. Cases of diabetes are set to double by 2030, largely due to the epidemic of obesity and to improved survival rates.¹¹⁷ The incidence of both type 1 and type 2 diabetes in childhood and adolescence is increasing. Diabetes and its complications impose significant economic consequences on individuals, families, health systems and countries.

How common are mental health problems in people with diabetes?

Depression is associated with diabetes at various stages of its natural history. There is emerging evidence that depression may be a risk factor for type 2 diabetes; in several prospective studies, depression predates the onset of type 2 diabetes by many years.¹¹⁸ The prevalence of depressive disorders is around two fold higher than in healthy controls, with a prevalence of 9%. Depression and depressive symptoms are associated with poorer glycaemic control, diabetes complications and increased risk of death.^{119, 120, 121}

Anxiety disorders often coexist with depression and diabetes.¹²² Phobic symptoms and anxieties related to self-injection of insulin and self-monitoring of blood glucose are common and associated with difficulties in adhering to diabetes self care. This can result in further distress and increased glycaemic levels.^{123, 124, 125}

Some form of disturbance of eating habits may affect up to 10-15% of adolescent and young adult females with diabetes, who are able to reduce their weight by the under use or omission of insulin to promote glycosuria. Disturbance of eating habits is a hidden problem in type 2 diabetes. Eating problems are strongly associated with poor self-care and the increased risk of complications.^{126, 127}

The prevalence of diabetes in schizophrenia is approximately 10% but rises with age, and up to 20-25% of patients over the age of 60 years may have clinically important glucose dysregulation. Antipsychotics - in particular, atypicals or second generation - are implicated in the increased risk of metabolic dysfunction, especially in people with schizophrenia. It is also important to consider the role of substance misuse, mental state, socioeconomic deprivation and social support in people with mental health problems and obesity.¹²⁸ This is described in more detail in the later section 'Physical Health Problems Associated with Mental Illness'.

How often is depression detected in diabetes?

Despite their high prevalence, mental health problems in diabetes mostly go undetected and untreated. One large study found that only half the cases of depression were detected - of which less than a half received any treatment for depression.¹²⁹

Which treatments can help?

The two main aims for offering psychiatric treatments to people with diabetes are to improve their diabetes control and to reduce their psychological distress. Generic mental health interventions are as applicable to people with diabetes as they are to others, but the evidence that they are effective in treating both the mental health problem and the diabetes control is still poorly researched. A potentially exciting approach is to consider managing the two conditions concomitantly.

Diabetes is unique in that patient education is one of the cornerstones of diabetes care. In recent years, the importance of psychological factors associated with diabetes has become increasingly understood. In recognition of this, diabetes education now incorporates psychological techniques such as social learning theory.

Recent systematic reviews have found that psychological therapies can be more effective in improving glycaemic control in type 2 diabetes and in young people, but less so in adults with type 1 diabetes. It should be noted that the interpretation of these findings are limited to a small number of studies from highly selected samples.¹³⁰ Future studies should aim to further develop diabetes-specific psychological models.

To date, there have been 11 randomized control trials comparing different treatments for depression in diabetes but the generalisability of these results is restricted by methodological limitations. The strongest evidence appears to be for psychological treatments, in particular cognitive behavioural therapy, which is effective for both diabetes and psychological outcomes. Most antidepressants treated the depression but failed to improve diabetes outcomes. Stepped care or managed care that includes combinations of psychological and psychopharmacological approaches, provides the best scientific evidence for successful treatment of depression, but not for glycaemic control. Regardless, it is of course advisable to treat the depression because doing so will improve the quality of life for the patient and reduce healthcare costs.

Conclusion

Mental health problems are common in diabetes and are associated with poor diabetes control, complications and increased mortality. They are disabling, poorly detected and inadequately treated. The emphasis on diabetes education as a solution for impaired adherence is giving way to a more psychological understanding of the person living with diabetes as a chronic disease. There is a growing awareness that diabetes services need to be provided by professionals who are skilled in providing psychological care. This involves working with the patient to manage any depression and supporting the individual to improve their self care.

Box 14: Key recommendations from the National Institute of Health and Clinical Excellence guideline on Type 1 Diabetes (2004)

- Children and young people with type 1 diabetes should be offered an ongoing integrated package of care by a multidisciplinary paediatric diabetes care team with appropriate training in mental health.
- Children and young people with type 1 diabetes and their families should be offered appropriate emotional support following diagnosis, which should be tailored to emotional, social, cultural and age-dependent needs.
- Diabetes care teams should be aware of the risk that young people with type 1 diabetes have of emotional and behavioural problems and anxiety and/or depression, and of the negative impact this can have on outcomes, including glycaemic control and self-esteem.
- Children and young people with type 1 diabetes and their families should be offered timely and ongoing access to mental health professionals because they may experience psychological disturbances (such as anxiety, depression, behavioural and conduct disorders and family conflict) that can impact on the management of diabetes and well-being.
- Diabetes care teams should have appropriate access to mental health professionals to support them in the assessment of psychological dysfunction and the delivery of psychosocial support.
- For adults with erratic and unpredictable blood glucose control (hyper- and hypoglycaemia at no consistent times), rather than a change in a previously optimised insulin regimen, psychological and psychosocial difficulties should be considered.
- Members of professional teams providing care or advice to adults with diabetes should be alert to the development or presence of clinical or sub-clinical depression and/or anxiety, in particular where someone reports or appears to be having difficulties with self-management.
- Diabetes professionals should ensure that they have appropriate skills in the detection and basic management of non-severe psychological disorders in people from different cultural backgrounds. They should be familiar with appropriate counselling techniques and appropriate drug therapy, while arranging prompt referral to specialists of those people in whom psychological difficulties continue to interfere significantly with well-being or diabetes self-management.
- Professionals should be alert to the possibility of bulimia nervosa, anorexia nervosa and insulin dose manipulation in adults with type 1 diabetes with over-concern with body shape and weight; low body mass index; poor overall blood glucose control.

Chronic Obstructive Pulmonary Disease (COPD)

Background

In 1998, the World Health Organisation estimated that COPD was the fifth most common cause of death worldwide, responsible for almost 5% of all mortality, and prevalence is rising.¹³¹ Allowing for under-diagnosis, the true number of patients with COPD in England and Wales is likely to be around 1.5 million, and up to 1 in 8 emergency hospital admissions may be due to COPD.¹³²

How common are mental health problems in people with COPD?

People with COPD are 2.5 times more likely to experience depression and anxiety than the general population, especially if they are hypoxic or severely dyspnoeic.¹³³ A recent review of the literature suggests that in stable COPD, the prevalence of depression ranges between 10% and 42%, while that of anxiety ranges between 10% and 19%.¹³⁴ The risk of depression is higher in patients with severe COPD compared to control subjects, with the highest rates found in oxygen-dependent patients. Panic attacks are also common in 8 to 37% of patients with the disease.¹³¹

Even when the severity of COPD has been adjusted for, depression has been found to predict breathlessness, fatigue and disability in patients with COPD.¹³⁴ Depressed patients with COPD are less likely to comply with treatment, which in turn can result in increased hospital visits, longer lengths of stay and poorer outcomes. People with COPD and depression have an increased rate of mortality¹³⁵ and when faced with end-of-life decisions, are more likely to opt for 'do not resuscitate'.¹³⁶

According to the British Lung Foundation, the overall quality of life for people with advanced COPD is about four times worse than that for people with severe asthma.¹³⁷ COPD symptoms such as breathlessness and coughing can cause stress, limit a person's mobility, interfere with sleeping patterns, and reduce their appetite. As symptoms get progressively worse, so might the person's ability and desire to take part in everyday activities and work, further affecting their self-esteem, independence and emotional wellbeing. For some people, the fear of hyperventilating in public can lead to phobic avoidance of certain situations, often resulting in yet more unhappiness and significant social and functional limitations.¹³⁸

What are the problems involved in detecting mental health problems in patients with COPD?

There are several barriers to the detection of mental health problems in COPD patients. One problem is the overlap of symptoms such as decreased appetite, tightness in the chest and fatigue. Clinical barriers, such as short appointment times, a lack of knowledge about depression and counselling, or a lack of time to talk to the patient about these issues can also prevent detection of mental illness. In turn, patients may be reluctant to seek help because of stigma around mental health issues, or guilt about 'bringing the disease onto themselves' through smoking.¹³⁴

It is advisable that people with COPD are screened for depression and anxiety, but there is a lack of consensus as to the most appropriate screening tool and it has

been estimated that as many as two-thirds of COPD patients with mental health problems may not be receiving the help they need.¹³⁹

Which treatments can help?

NICE recommends that patients found to be depressed or anxious should be treated with conventional pharmacotherapy.¹³² Cognitive-behavioural programs that focus on relaxation and changes in thinking are also thought to be effective, with one study suggesting that as little as a 2 hour session of cognitive behavioural therapy can reduce anxious and depressive symptoms.¹³⁹

A systematic review of 37 randomised control trials showed that collaborative-care models were significantly more effective than treatment in primary care alone; they increased treatment compliance and reduced depression for 2 to 5 years.¹⁴⁰ Pulmonary rehabilitation (PR) is one such approach receiving growing support. PR typically provides supervised exercise training, psychological support and education. Interviews and screening tools are used to address quality of life, adherence to treatment, adjustment to the disease and self-efficacy,¹⁴¹ and signs of major depression or anxiety that will require specialist care are sought out. PR often includes the use of medication, for both physical and psychological symptoms, and this can increase participation in exercise.¹⁴² Education about COPD can reduce anxiety about the disorder, and help individuals to develop a strategy for self-management, thus increasing their autonomy and confidence.¹⁴³ Whilst there appears to be evidence that PR can be effective, especially in improving quality of life issues, some patients, particularly those with a history of treatment for depression, will require more specific and intensive psychological interventions.¹³⁴

Conclusion

The increased prevalence, poor track record of detection, and negative impact of depression and anxiety in patients with COPD collectively substantiate the need for psychiatric screening for people with COPD. This needs to be followed by a multi-agency approach which tackles both the physical and psychological aspects of COPD, and takes into account the relationship between the two.

Box 15: Key recommendations from the National Institute of Health and Clinical Excellence guideline on Chronic Obstructive Pulmonary Disease (2004)

- Healthcare professionals should be alert to the presence of depression in patients with COPD.
- The presence of anxiety and depression should be considered in patients: who are hypoxic; who have severe dyspnoea; who have been seen at or admitted to a hospital with an exacerbation of COPD.
- Patients found to be depressed or anxious should be treated with conventional pharmacotherapy
- Patients should be managed by a multi-disciplinary team which includes mental health professionals

Neurological or Brain Disorders

Background

Neurological disorders, or brain disorders, are associated with high rates of psychiatric co-morbidity. One can look at these disorders on an individual basis but essentially the problems tend to be similar from disorder to disorder. This review will concentrate on stroke, multiple sclerosis, Parkinson's disease and epilepsy, but much of the content can be extrapolated to other neurological disease.

How common are mental health problems in neurological disorders?

It is estimated that 30% of new patients attending neurology out-patient clinics have physical symptoms not explained by organic disease, including 5% with conversion disorders.¹⁴⁴ Such symptoms cause significant physical and psychological disability and neurologists found them difficult to help.¹⁴⁵

Stroke

Stroke is linked with cognitive impairment, emotional disorder and behavioural change. Approximately half of patients who have a stroke will report some form of emotional disruption. Delirium will affect some 30-40% of patients during the first week after stroke and dementia is also common, affecting one quarter of patients within three months following a stroke. Most epidemiological studies suggest a prevalence rate of major depressive disorder of around 25-35% in stroke patients, and significant anxiety is displayed in 25-30%.¹⁴⁶ The presence of depression in stroke patients is associated with increased disability and possibly mortality.^{147, 148} However the direction of causality is unclear and is most probably circular.

Parkinson's disease

Parkinson's disease can result in significant mental health problems including cognitive impairment, psychosis, emotional symptomatology and impulse control disorders. If a patient lives long enough dementia may develop. Psychotic disorders are common in Parkinson's disease with rates of over 60% having been described.¹⁴⁹ Depression is also common in Parkinson's disease, with a prevalence of around 40-50%.¹⁵⁰ Several large-scale studies have identified depression as the major determinant of quality of life in Parkinson's disease.¹⁵¹ Over recent years, there has been increasing interest in impulse control disorder. Particular concerns are libidinous behaviour, pathological gambling and punding (an obsessive sorting behaviour). Such disorders appear to affect some 10-20% of patients with Parkinson's disease and not surprisingly, given their social nature, cause significant distress for family members. As such, it is important that clinicians are aware that they are an integral part of the disease process.

Multiple sclerosis

Multiple sclerosis is a disorder of the central nervous system and is commonly associated with mood disorders and cognitive impairment. Approximately half of MS patients will display symptoms of sub-cortical dementia during the course of the illness¹⁵² and 30-50% of patients report depressive symptoms. Fatigue and pain are both common complications of MS and contribute significant psychological morbidity in these conditions.

Epilepsy

Epilepsy is associated with a range of mental health problems most notably altered behaviour during seizures, psychosis and mood disruption. Depressive and anxiety disorders affect approximately one third of patients.¹⁵³ The relationship between depression and epilepsy is bi-directional; in other words, each is a risk factor for the other.

Which treatments can help?

With all neurological disorders the diagnosis of depression is problematic as it is often unclear which symptoms are attributable to the disorder and which are attributable to depression.¹⁵⁴ In stroke patients, most pharmacological treatment studies have suggested that the effective treatment of depression leads to overall reduction in disability.¹⁵⁵ Depression in people with Parkinson's disease responds to standard drug treatment.¹⁵⁶ There are few analysed control trials of antidepressant drug therapy in MS but those available suggest modest efficacy with these agents.¹⁵⁷ People with conversion disorder are often treated with antidepressant medications and psychotherapies.¹⁵⁸

Conclusion

The core problem in provision of healthcare is that the prevalence of mental health problems in neurological disease is so common that around 50% of patients presenting in neurological services will have some requirement for psychiatric treatment. Furthermore, the provision of such treatment spans various disciplines and few clinicians are trained to deal with disorders across the spectrum of need. In general terms it is necessary to have clinicians who can cope with both the physical and the psychological aspects of these disorders and who are comfortable in both fields. This makes specific demands on training that are not well catered for in the current system.

Box 16: Key recommendations from the National Institute of Health and Clinical Excellence guideline on Epilepsy (2004)

- Individuals should have access to counselling services...and tertiary services should include psychiatry.
- Referral to tertiary services should be considered when there is psychological and/or psychiatric co-morbidity.
- Individuals with epilepsy and their families and/or carers should be given information about psychological issues.
- In an individual with an attack, a physical examination should be carried out,including of the individual's mental state.
- Where non-epileptic attack disorder is suspected, suitable referral should be made to mental health services for further investigation and treatment.
- Referral (to tertiary services) should be considered when there is psychological and/psychiatric co-morbidity.
- The expertise of multidisciplinary teams involved in managing complex epilepsy should include psychology, psychiatry and counselling.

Mental Healthcare and the General Hospital

Overview

What is the emotional impact of being admitted to hospital?

The process of being admitted to hospital is often stressful. The environment is alien and people have to share toilet and bedroom facilities. One's identity as an individual is affected as outdoor clothes and belongings are removed. Access to relatives and loved ones is restricted and people have to interact with many different nurses, doctors and other health professionals. They may be in pain and discomfort and worried about what is the matter with them. Those people who smoke heavily, or drink alcohol to control anxiety, will find the restrictions imposed by hospital admission particularly hard. Many older people, who are orientated in their home, which is familiar to them, may become easily confused when placed in a new and strange environment. If patients are moved from one ward to another within the early days of admission, this can disorient them further.

Nursing and medical professionals on acute medical wards are very busy and may not always have time to enquire about emotional distress. Some staff also report feeling uncertain about how to manage distress when patients become upset. Some hospital wards do not have interview rooms where patients and their families can be seen in private and personal conversations might take place behind a curtain drawn around the patient's bed. Dealing with fear and worry and other strong emotions in a hospital setting may therefore be difficult for staff.

The next section of the report focuses upon four different areas within general hospital services where mental health problems are common and mental health services are frequently required: the acute medical setting, maternity services, the emergency department and palliative care settings.

The Acute Medical Setting

The length of stay of patients in the general hospital has dramatically fallen over the last 10 years with the average length for people in England admitted for specific care falling from 14 days to 6 days.¹⁵⁹ People can develop a variety of mental health problems in the acute setting and Table 1 lists some of ways in which liaison mental health services can help care for such patients.

How common are mental health problems in the general hospital?

The rates of psychological morbidity in patients in the general hospital setting are three to four times higher than in the general population. For example, the prevalence of significant mental illness in consecutive patients admitted to an acute medical setting is approximately 28%, and a further 40% have sub-clinical symptoms of anxiety/depression¹⁶⁰. For older adults in general hospital beds, the rates of depression and anxiety are even higher.

Patients with co-morbid mental health problems, compared to those without, have a much poorer outcome, after controlling for severity of disease. Even patients with sub-clinical psychological symptoms (i.e. mild symptoms of anxiety and depression) have a poorer health outcome than patients without psychological symptoms.¹⁶⁰ There is often a failure to detect and treat patients' mental health problems, both when they are in hospital and after they have been discharged to primary care.¹⁶⁰

The presence of co-morbid mental health problems in people with physical illness has an adverse impact on several key outcomes which are important for the welfare of patients, their families and the efficient management of acute trusts. These include:

- Increased length of stay^{161, 162}
- Increased healthcare costs¹⁶³
- Increased mortality^{164, 72, 135}
- Increased suicide¹⁶⁵
- Poorer quality of life¹⁶⁶

What follows is a brief description of some common problems encountered in the general hospital setting. These problems are areas in which liaison mental health teams will have expertise.

Delirium

Delirium is a complex neuropsychiatric syndrome with an acute onset and fluctuating course. It is characterised by clouding of consciousness and cognitive dysfunction. Patients can have a range of levels of alertness from somnolent to hyperalert. Hyperalert or activated patients are more likely to have hallucinations, delusions and illusions whereas somnolent patients are more likely to have agitated behaviour. Delirium in somnolent patients goes undetected.¹⁶⁷ Delirium occurs in about 15-20% of all general admissions to hospital and the rates are considerably higher in elderly patients (up to 60%).

Very little is known at present about how to identify patients at high risk of developing delirium, although those patients with three or more risk factors are nine times more likely to develop delirium during their hospital stay than patients without (see box 17 below).²⁰

Box 17: Risk factors associated with developing delirium during a hospital stay

Predisposing factors

- Vision impairment
- Severe illness
- Cognitive impairment
- Raised blood urea/creatinine

Precipitating factors

- Use of physical restraints
- Malnutrition/dehydration
- More than 3 medications added
- Use of bladder catheter
- Any iatrogenic event (harmful consequence of a procedure or intervention)

Treatment should be aimed at symptomatic relief and treatment of the underlying causes of the delirium. Supportive and environmental factors are the cornerstone of symptomatic treatment. Antipsychotics help with a range of symptoms and are effective in patients who are hyper or hypoactive.^{168,169}

Dementia

Dementia is characterised by global impairment of intellectual functioning with insidious onset and progressive course over months or years, resulting in disturbed memory, disorientation in time, place and person, language deficits, reduced judgement, altered emotional control, social behaviour and motivation and interference with personal activities of daily living such as washing, dressing, eating and personal hygiene.²⁰ Approximately 35% of elderly people admitted to an acute general ward will be suffering from dementia, and a further 20% will have mild cognitive impairment.

Patients with dementia are particularly vulnerable in general hospitals. They are highly susceptible to environmental change and may find it difficult to communicate their needs, for example regarding toileting or pain relief. Patients with dementia are at high risk of delirium and there is good evidence that better management of dementia in hospital can result in improved function and decreased length of stay.²⁵

Capacity

All doctors should be able to assess a person's capacity to consent to medical treatment. In England and Wales, the Mental Capacity Act (2005) has helped to clarify the legal framework for patients where capacity may be impaired. Under the Mental Capacity Act (2005) a person has capacity if he/she is able to:

- Comprehend information relevant to the decision
- Retain information for long enough to make the decision
- Use the information and weigh it to arrive at a choice
- Communicate his/her decision

In Scotland, the Adults with Incapacity Act applies.

In most cases in acute medical settings, the determination of capacity is straightforward, particularly in patients with delirium or severe dementia. It is not uncommon, however, for complex scenarios to arise where the determination of capacity is more difficult, particularly where it is possible that subtle mental health problems (such as depression) may be affecting a person's ability to make a choice, (for example, to end life saving treatment). In these cases the opinion of a consultant liaison psychiatrist is essential to ensure the best interests of the patient are being carefully considered.

Hospital staff on acute wards may need on some occasions to prevent patients who are confused from leaving the ward in order to protect them from harm. The Mental Capacity Act Deprivation of Liberty safeguards were introduced into the MCA (2005) through the Mental Health Act (2007). The safeguards apply to anyone aged 18 or over who suffers from a mental disorder or disability of mind and who lacks capacity to give informed consent to arrangements made for their care and for whom deprivation of liberty is in their best interests in order to protect them from harm. The safeguards apply from April 2009 and should ensure that people who lack capacity are given the care they need in the least restrictive manner.

Acute Disturbance

Medical disorder can manifest with disturbances in thinking and behaviour.

Approximately 4% of patients in the acute medical setting become acutely disturbed, i.e. show behaviour which interferes with their care or with the care of other patients, or show behaviour which places themselves or others at risk.¹⁷⁰

Males are more likely than females to become disturbed. The prevalence of disturbed behaviour is equally common in patients above and below the age of 65 years. In most cases, aggressive behaviour is directed towards staff rather than other patients. Although the prevalence of disturbed behaviour on acute wards is relatively low, it consumes a disproportionate amount of resources. Additional staff are required and expert knowledge of using sedation in physically unwell people is also important. Disturbed behaviour is often a symptom of delirium with an underlying medical cause.

Self-harm

Self-harm is covered in more detail in the section on mental health services to emergency departments. People who self-harm and are admitted to acute wards will have made serious attempts to harm themselves, some of which may have been near-fatal. All should receive a detailed psychosocial assessment as soon as they are physically well enough to participate in an assessment; the risk of further self-harm or suicide should be considered very seriously.

Alcohol and substance misuse

Alcohol and drug misuse is also covered in more detail in the section on mental health services to emergency departments. Approximately 20% of all male patients admitted to acute medical wards will have alcohol-related problems. The prevalence is currently much lower for women (approximately 5%). There is good evidence that detection followed by a brief alcohol intervention results in significant reductions in alcohol consumption post discharge.¹⁷¹

Concerns about kindling effects suggest that not all patients who are in alcohol withdrawal or who are at risk of withdrawing from alcohol should undergo a detoxification. There is evidence that repeated detoxifications may increase craving¹⁷² and increase the risk of alcohol related seizures.¹⁷³ Staff responsible for acute medical wards should work closely with liaison psychiatry services to develop coherent policies regarding alcohol detoxification so that people are given the most suitable treatment for their particular alcohol history.

The Role of the Liaison Psychiatry Team

Treatment of mental health problems in the acute hospital setting can be provided by liaison psychiatry teams; Table 2 summarises the ways in which liaison services can help manage some of the common mental health problems that present in an acute medical setting. It is recommended that all general hospitals have liaison mental health services which are flexible and responsive to the needs of the acute hospital.²¹⁷ Health psychology and clinical psychology also provide specific psychological treatment for people with depression and anxiety, but do not cover the whole aspect of mental health work and are less involved in urgent work.

The table overleaf describes the make up of a basic team operating limited hours. The staffing levels listed represent **the absolute minimum**, and additional cover would almost certainly be required, depending on the population served. To provide a comprehensive liaison service which specifically caters for the special needs of adults with complex needs and dementia, greater numbers of the staff listed below are required. In addition, the team would also require at least one full time occupational therapist, 1.5 WTE social worker, sessions from a support worker and additional administrative support. The staffing levels required to provide a liaison service to older-aged patients are available at <http://www.rcpsych.ac.uk/PDF/RaisingtheStandardOAPwebsite.pdf>.

Additional staffing would also be required if the team's remit included the management of patients with alcohol problems in the general hospital. Doctors in training gain valuable experience from working within a liaison mental health team.

If liaison professionals are to provide teaching, training and support to colleagues within their team and throughout the general hospital; the staffing ratios above would need to be increased to allow for this.

Finally, the table above does not include child and adolescent mental health services (CAMHS) to general hospitals. This ought to be provided by specialist multidisciplinary CAMHS liaison teams, but current provision is currently patchy and further investment is required.

Please note: to provide a comprehensive liaison service which caters for the needs of adults with complex needs and dementia, greater numbers of the staff listed below are required.

Table 1: Example of levels and skill mix for a team serving a general hospital with 650 beds and 750 new self-harm patients per year (Mental Health Policy Implementation Guide, 2008).

Role	Grade	Time	Comment
Medical	Consultant	Whole time	Consultant involvement is essential, including managing risk, providing supervision and training and offering expertise on psychopharmacological treatment, complex patients, capacity and the Mental Health Act.
Nursing	Band 8	Whole time	One of the nursing roles should be as team leader.
Nursing	Band 7	3 X Whole time	The nurses operate as autonomous practitioners, undertaking assessments, and brief treatment interventions, and liaising with mental health teams in primary care. Those working with older adults will become involved in detailed discharge planning.
Clinical Psychology	Band 8	1	May be provided from health psychology team, but should be an integral part of a liaison team to provide supervision, training and delivery of brief psychological treatments.
Team PA	Band 4	1.5 X Whole time	Core to referral management, information gathering and communication.

Table 2: Common problems managed by liaison psychiatry services

Condition or problem	Difficulties faced in the hospital	What can liaison services do?	What is the evidence base?
Psychological reaction to physical illness	Some patients will develop major depression or anxiety as a consequence of their physical disorder.	The liaison service can treat depression, leading to reduced health care costs (e.g. in diabetes).	A systematic review concluded that, compared with consultation, the liaison approach for older people in general hospitals results in: more specialist assessments, more referrals with depression, better diagnostic accuracy, more mental health reviews and increased adherence to recommendations for managing the mental disorder. ¹⁷⁴ Depression in the elderly physically ill can be treated with a liaison psychiatry intervention ¹⁷⁵ and treatment of depression in older adults improves physical functioning. ¹⁷⁶ A randomised trial found that medical patients with various mental disorders were twice as likely to return to independent living if they received specialist mental health multidisciplinary liaison than those receiving usual care ¹⁷⁷ . Depression can be successfully treated in patients with diabetes using collaborative care. ¹⁷⁸ In type 2 diabetes psychological treatments improve long term glycaemic control. ¹⁷⁹ A systematic review has concluded that antidepressants are of benefit in the physically ill with depression. ¹⁸⁰

Condition or problem	Difficulties faced in the hospital	What can liaison services do?	What is the evidence base?
Delirium	Failure to detect and manage properly.	The liaison service can improve patient outcome and decrease length of stay.	A randomised trial of older people with hip fracture receiving daily proactive geriatric consultation found that this reduced episodes of delirium by one third and severe delirium by 40%. ¹⁸¹ Quasi controlled trials of perioperative care ¹⁸² and interpersonal and environmental nursing interventions ¹⁸³ in hip fracture have been associated with a reduction of delirium and length of stay. There is good evidence that both typical and atypical antidepressants are effective in treating delirium. ¹⁸⁴
Dementia	Failure to detect and manage properly.	The liaison service can improve patient outcome and reduce length of stay.	In a controlled trial, routine mental health liaison for older people with hip fracture was associated with a reduced length of stay. The intervention group had a mean length of stay of two days less than the usual care group. The cost of the service was offset by the shorter duration of admission. A randomised controlled trial of intensive specialist multidisciplinary rehabilitation of older people with hip fracture achieved a reduced length of stay for patients with mild or moderate dementia and those with mild dementia were as successful returning to independent living as patients without dementia. Furthermore, patients with mild and moderate dementia from the intervention group were more likely to be living independently three months after fracture than the usual care control group. ¹⁸⁵

Condition or problem	Difficulties faced in the hospital	What can liaison services do?	What is the evidence base?
Disturbed behaviour	Places the patient and others at risk and is difficult to manage in the acute setting.	Liaison services have the expertise and skills to help hospital staff manage patients with very difficult and disturbed behaviour.	There are proven and recommended techniques for the de-escalation of violence and disturbed behaviour, which mental health teams are trained to deliver. Mental Health legislation may be needed as part of the management of confused, aggressive patients in the general hospital. Liaison psychiatrists have expertise in mental health law and can provide appropriate advice.
Self-harm	One of the most common reasons for admission to an acute medical bed. Those patients who are admitted are those who have made the most serious attempts to kill themselves. Some professionals in the general hospital find working with people who self-harm to be stressful.	Liaison services can effectively assess and treat self-harm, resulting in decreased psychological symptoms and decreased repetition of self-harm. They can also provide support and training to acute colleagues.	Participants randomised to brief psychodynamic interpersonal therapy had a significantly greater reduction in suicidal ideation at six month follow up compared with those in the control group. They were more satisfied with their treatment and were less likely to report repeated attempts to harm themselves at follow up. ¹⁸⁶ Psychosocial treatment following self-harm results in reduced depression, hopelessness and improvement in problems. ¹⁸⁷ Specialist self-harm teams significantly improve the quality of psychosocial assessment. ¹⁸⁸ Emergency department and ambulance staff who receive support and expertise from liaison mental health colleagues are less likely to report low morale when working with people who self-harm. ¹⁸⁹

Condition or problem	Difficulties faced in the hospital	What can liaison services do?	What is the evidence base?
Alcohol abuse	There is poor management of alcohol withdrawal states resulting in increased length of stay or unnecessary admissions.	Brief liaison interventions can be effective in the reduction of alcohol use by patients identified as having alcohol problems in the general medical setting.	Heavy drinkers who receive a brief alcohol intervention are twice as likely to moderate their drinking 6 to 12 months after an intervention when compared with heavy drinkers who receive no intervention. ¹⁹⁰ In the general hospital setting, heavy drinkers who are counselled about their drinking have a significantly better outcome than controls when followed-up 12 months later. ¹⁹¹
Medically Unexplained Symptoms	These patients are high users of health resources.	Liaison psychiatry interventions can improve patient outcomes and reduce costs.	Liaison psychiatry interventions can improve patient outcomes and reduce the costs associated with medically unexplained symptoms. ¹⁹² Systematic reviews of the efficacy of antidepressants and psychological treatment for treating patients with medically unexplained symptoms, suggest both approaches are beneficial. ^{193,194}
People who attend the ED regularly ('frequent attenders')	These patients are high users of health resources and more likely to experience poorer mental health.	Liaison psychiatry can help ED staff manage patients appropriately and ensure patients are offered appropriate community based services. Case reviews can also be undertaken where appropriate.	50% of patients who frequently attend the ED have mental health problems. ¹⁸³ Liaison mental health staff can help ED staff to understand the needs of this group and the reasons why they use services frequently. ¹⁹⁵ There are very few controlled studies of psychiatric intervention in this group of patients. A recent study suggests that multidisciplinary case management has a positive effect on psychosocial factors for frequent attenders but increases ED utilisation. ¹⁹⁶

Condition or problem	Difficulties faced in the hospital	What can liaison services do?	What is the evidence base?
Lack of mental capacity	<p>The Mental Capacity Act and the Adults with Incapacity (Scotland) Act highlight the need for rapid assessments of capacity to consent to medical treatment in the general hospital setting. Failure to implement these Acts appropriately may disadvantage the patient. It can also result in legal action.</p> <p>Assessment of capacity to consent to medical treatment can be extremely complex, particularly in the presence of mental disorder.</p>	<p>An experienced Consultant Liaison Psychiatrist might be best equipped to make an informed judgement about capacity for patients with complex physical and mental health problems. Failure to implement incapacity legislation appropriately may result in expensive legal action.</p>	<p>40% of acute medical patients do not have mental capacity to make informed decisions about medical treatment, and clinical teams rarely identify patients who do not have capacity.¹⁹⁷ Liaison psychiatrists receive mandatory training in the assessment of capacity in relation to the Mental Capacity Act in England and Wales. Some liaison psychiatrists will also be trained to provide assessments under the Deprivation of Liberty Safeguards (DOLS): the new legal framework to safeguard the rights of people who lack capacity and need to be detained in a safe environment.</p> <p>The overview of Mental Capacity Act 2005 (England and Wales) has highlighted the need for rapid assessments of capacity to consent to medical treatment in the general hospital setting.</p> <p>In Scotland the Adults With Incapacity (Scotland) Act 2000 sets out the legal framework required for the provision of medical treatment to patients who lack capacity to consent.</p>
Severe mental illness	<p>A small proportion of medical in-patients have severe mental illness (e.g. schizophrenia). These patients cause great anxiety in general hospital staff and there are often major risk issues which need to be managed.</p>	<p>Liaison Services can respond rapidly and provide a continuity of service between community and hospital whilst the patient's physical needs are being attended to.</p>	<p>NICE has published clinical guidelines on the treatment and management of schizophrenia¹⁹⁸ and bipolar disorder.¹⁹⁹</p>

Condition or problem	Difficulties faced in the hospital	What can liaison services do?	What is the evidence base?
All mental health problems	General lack of knowledge and skills amongst general hospital staff in the detection and management of any mental health problem.	Education and training delivered by liaison services improve knowledge, skills and attitudes amongst general hospital staff.	NICE has published guidance on the treatment and management of most mental health and behavioural conditions (www.nice.org.uk). Psychiatric treatment has shown to be effective in treating patients with complex physical and mental health problems. ²⁰⁰

Maternity Services and Mental Health

Background

Since the implementation of the Department of Health's Changing Childbirth initiative²⁰¹ there has been a radical change in the way maternity care is delivered. GPs are no longer central to maternity care; a woman's first point of contact during pregnancy is with the midwife who frequently no longer operates from a general practitioner's surgery.

The majority of women in the United Kingdom will be deemed to be low risk pregnancies and will not see an obstetrician during their pregnancy. Whilst the overwhelming majority of women still deliver in hospital, their care too will be midwifery-led and few will stay for longer than 24 hours. Most mental health problems associated with childbirth present in the community, not in hospital, although maternity hospital services still see many women with significant mental health problems.

Traditionally, psychiatric services have been provided to maternity hospitals by liaison psychiatrists. Fewer than half of the mental health trusts in the UK provide specialised perinatal psychiatric liaison as recommended by the Maternal Deaths Enquiries²⁰² and the maternity services national service framework.²⁸

How common are mental health problems in the perinatal period?

Childbirth has long been known to be associated with an increased risk of serious affective disorder, particularly affective psychosis, often known as puerperal psychosis. Despite the increased risk, the latter is still a relatively rare condition occurring in approximately 2 per thousand deliveries. It is also well established that women with a previous history of severe affective disorder, particularly bipolar disorder, are at an estimated elevated risk (of at least 50%) of becoming ill in the days and weeks following delivery. Women with current serious mental illness may suffer from a relapse or recurrence of their condition during pregnancy, particularly if they stop their medication. On the other hand, continuing their medication raises different issues about physical safety during pregnancy. For all of these reasons, NICE,²⁰² The Maternal Deaths Enquiries and the Department of Health²⁸ all recommend that women should be asked in pregnancy about their previous and current mental health and that proactive plans be put into place for the management of their risk in the peripartum period.

There is also a widespread awareness amongst the general public and maternity professions of non-psychotic illness during pregnancy and the postpartum period, particularly depression - so-called "postnatal depression". Pregnancy and the postpartum period is a time of great emotional and psychological change and first-time motherhood represents a major life event. For some women, their pregnancies may be associated with considerable anxiety, adverse life events or difficult social circumstances. Other women may have a previous history of self-harm or problems with managing anger, and maternity services find it particularly difficult to manage women who self-harm whilst on a perinatal ward, although this scenario is not uncommon.

The prevalence of pregnant women misusing substances will vary from one area to another. It is known that substance misuse in pregnancy is associated with significant mortality and morbidity in both mother and infant. This has been highlighted in the most recent Maternal Deaths Enquiry where 11% of maternal deaths overall and 57% of the psychiatric causes of maternal death were substance misusers²⁰³. The care of the pregnant woman who misuses substances is complex and requires specific knowledge and skills both on the part of maternity professionals and substance misusing teams. It is recommended that specialised addiction services should be provided within the maternity services ensuring a “one-stop shop approach” that involves close working between a specialist obstetrician, midwife and other relevant agencies. This approach would help to ensure optimal uptake of antenatal care and the best management following delivery.

What is the role of liaison psychiatry services or perinatal services?

Whilst there is no evidence that the incidence of mild to moderate depressive illness and anxiety states is any higher at this time than in non-childbearing women, there is undoubtedly an increased awareness of these problems at a time of increased surveillance by health services. Maternity professionals will therefore often seek help from mental health services about the management of these conditions.

Mental health services need, in conjunction with their maternity colleagues, to setup a screening instrument for use at the booking clinic, guidelines on who and how to refer (an integrated care pathway) and the necessary education and training to enable non-psychiatric professionals to identify those at highest risk.

The distinctive nature of the maternity context, the systems and procedures of maternity care, the presentation and clinical course of postpartum psychiatric conditions and issues of prescribing during pregnancy and breastfeeding all require a perinatal maternity liaison service to provide advice and support. This needs to be offered on a frequent basis to maternity professionals. The liaison clinicians are also required to see individual patients in crisis and for assessment. Mental health professionals involved in the maternity liaison service should have specialised knowledge and skills in perinatal psychiatry and be able to give informed advice on the individual risk and benefits of psychiatric treatment particularly during pregnancy. Psychiatric services to maternity services should be provided on the basis of a hub-and-spoke within a network which includes an inpatient mother and baby unit. This model enables the most seriously ill women to quickly access the appropriate level of care without unnecessarily being separated from their babies. The Mental Health (Care and Treatment) (Scotland) Act 2003 requires Scottish Health Boards to make provision for women with mental disorder in the postnatal period to be admitted to hospital with their babies.

Conclusion

The provision of appropriate and high quality mental health care for women during pregnancy and the post-natal period should be provided by perinatal maternity liaison services which span the primary secondary care interface and link closely with other established maternity networks.

Mental Healthcare in the Emergency Department (ED)

In recent years there has been increasing recognition that the mental health needs of people who use emergency departments are often not as well met as the physical needs of ED patients²⁰⁴.

What are the most common types of mental health problems in the ED?

The patient groups commonly attending EDs with mental health problems or learning disabilities at any age include:

- People who have self-harmed or are feeling suicidal
- People under the influence of alcohol or drugs
- People who have delirium or dementia
- People with co-existing physical and mental health problems
- People who attend because of a mental health problem (e.g. depression)
- People who attend because of the chaotic nature of their relationship to health services
- Acutely disturbed people who may be psychotic

Under section 136 of the Mental Health Act (1983) people were often brought to the emergency department for assessment, if it had been deemed a place of safety. Under the new Mental Health Act (2007) it is recommended that a mental health unit will be the preferred place of safety, unless there is evidence of medical illness (when the ED is preferred) or if there is serious aggressive behaviour (when the police station is preferred). This will mean that there will be fewer presentations to EDs under section 136. It is essential however that skilled and experienced staff are available in EDs to care for and assess people's physical and mental health needs, should they be brought to the ED under section 136.

Self-harm

Self-harm is one of the top five reasons for emergency department attendance in the UK²⁰⁴. Around 80% of people who self-harm and attend the ED will have taken an overdose, whilst 20% arrive following self-injuries such as cutting, burning or jumping from a height.²⁰⁵

A recent Royal College of Psychiatrists' project surveyed 682 adults about their treatment in emergency departments following self-harm, and found that the most important aspect affecting their experience of care was the attitude and behaviour of staff²⁰⁶. Being treated in a non-judgmental way by healthcare professionals can help people who self-harm cope more effectively when they leave the ED, whilst negative interactions (experienced by a quarter of respondents) can have the opposite effect:

"I was told I was a time-waster, an attention seeker and a drain on resources. This just compounded how I was already feeling...I left the A&E fully ready to crash my car at high speed. I didn't arrive feeling like that."

The NICE recommendation²⁰⁴ that all people who self-harm are offered a psychosocial assessment is often unmet by services, and even when it is, many services find it

difficult to provide assessments within the response times recommended by professional bodies.²⁰⁷

There is good evidence from systematic reviews that brief psychological and psychotropic treatments following self-harm can lead to an improvement in mood symptoms and anxiety.²⁰⁸ The evidence is less clear in relation to the prevention of further episodes of self-harm or suicide although some randomised controlled trials have shown a reduction in subsequent self-harm episodes.²⁰⁹

Alcohol problems in the emergency department

Globally, alcohol represents a major health and social issue, accounting for 3% of all deaths and 4% of disease burden, whilst up to 18% of injuries seen in emergency departments are likely to be alcohol related.²¹⁰

Alcohol is responsible for about 10% of unselected attendances at EDs, and a higher percentage of attendances with trauma.²¹¹ Whilst many patients attend the ED as a direct and obvious result of alcohol (for example after a drinking binge, or in a state of alcohol withdrawal), approximately 20% of patients admitted to hospital for illnesses unrelated to alcohol are regularly consuming unsafe levels of alcohol. These patients represent 'the future burden of alcohol misuse on hospital services'.²¹¹

The Royal College of Physicians' report goes on to recommend that detailed alcohol histories should be sought from patients who present with conditions often associated with alcohol misuse, and argues further, that 'a strong case can be made for incorporating screening for alcohol misuse into the routine healthcare provided in the general hospital setting'.

Of the available screening methods to identify harmful levels of drinking and alcohol dependency, questionnaires are more sensitive and reliable than laboratory markers. Popular questionnaires such as the Alcohol Use Disorders Identification Test (AUDIT), and shorter derivatives including the Paddington Alcohol Test (PAT) and the Fast Alcohol Screening Test (FAST), have been used successfully in a variety of healthcare settings for some time. The use of these simple instruments can lead to increases of up to 80% in the numbers of patients identified as having alcohol problems in general practice.^{212, 213}

Brief interventions consisting of a 20 minute non-confrontational and patient-centred discussion of current and previous drinking have been associated with lower levels of alcohol consumption at 6 months, as well as reduced re-attendance at the ED.²¹⁴ These kinds of treatments, however, are not widely available.

Severe alcohol withdrawal and Wernicke's encephalopathy are both medical emergencies, and should be managed accordingly. There should be local policies regarding the management of intoxication in every ED.²¹⁵

Substance misuse in the emergency department

People who misuse substances, especially those who inject drugs, have a high level of medical morbidity and mortality and as such are seen regularly in the ED department. There is also a high risk of traumatic injury which results in hospitalisation among users and those who have sustained one traumatic injury are at greatly increased risk of re-injury. Cocaine, amphetamines and marijuana, especially in combination with alcohol, play a significant role in all types of injuries, especially in motor vehicle accidents. Between 10-30% of drivers involved in road traffic accidents attending EDs have tested positive for cannabinoids when screening has been carried out, with smaller percentages reported for cocaine and other illicit drugs.²¹⁶

Other reasons for attendance have been summarised in the joint report between British Association of Emergency Medicine and the Royal College of Psychiatrists, (2004)²¹⁵ include:

- Complications arising from the direct action of the drug itself (e.g. accidental overdose).
- Hazards related to the method and administration of the drug (arterial occlusion).
- The patient's general lifestyle (e.g. poor diet etc).
- A needle exchange scheme, which is operated by some EDs.

Some people with substance misuse will attend the ED seeking opiates, or prescriptions for other drugs such as benzodiazepines or dihydrocodeine. For many individuals with drug misuse, the ED may be their only point of contact with health services. It is important, whenever possible, to engage the substance misuser, assess and treat medical problems and refer to appropriate substance misuse services. All EDs should have clear policies concerning the prescribing of opiates to drug misusing patients, with specific guidance as to when it may be indicated (e.g. for appropriate analgesia, or opiate withdrawal in pregnancy).

Liaison psychiatry teams and the emergency department

In many areas input to the ED is provided by Crisis Resolution and Home Treatment Team (CRHTs). These teams have the advantage of providing 24 hour cover but are primarily community based and focus on home treatment. As 90% of people seen in EDs for mental health problems are not offered home treatment, there can be many problems in service provision to EDs by CRHTs.²¹⁷ Liaison psychiatry services to EDs offer an alternative way of providing mental health services. These teams are either entirely ED based or manage mental health needs throughout the general hospital. Liaison services are able to provide rapid responsive and flexible services which are tailored to the needs of the general hospital or the ED department. Reports from user groups and ED departments indicate that, where liaison teams provide input to the emergency department, the service is generally appreciated. However, the provision of liaison services on a nationwide basis is patchy.

Conclusion

People with mental health and alcohol problems make up a significant proportion of attendances in the emergency department, yet a high proportion of emergency department staff have consistently highlighted the need for better training, support and supervision in this area. A lack of mental health professionals available to the ED to provide assessments and care to patients and to offer support and advice to acute staff can significantly compromise the quality of patient care. This is an issue that needs to be urgently addressed.

The Royal College of Psychiatrists has recently established an [accreditation network for liaison psychiatry services](#).

Box 18: General recommendations about patients in the ED, from 'Managing Urgent Mental Health Needs in the Acute Trust'. Academy of Medical Royal Colleges (2008)

- Patients in the acute hospital should have the same level of access to the opinion of a consultant psychiatrist as they would have from a consultant specialising in physical health problems. Ideally, liaison services across the country should be developed, so that a consultant liaison psychiatrist is available.
- Acute trusts should be commissioned to ensure provision of mental health liaison services.
- Mental health liaison services should co-ordinate the front-line response for psychiatric support to the emergency department and acute wards. This may mean working with other mental health services to provide a 24/7 service.
- These services should be subject to the quality standards expected of other medical specialities supporting the ED, including response times to EDs and medical and surgical wards; level of expertise of the clinicians involved; assessment, referral and aftercare; service organisation and joint working; quality of the environment for people with mental health problems and mechanisms for obtaining feedback from service users.
- Overall clinical responsibility for patients in the ED and in acute hospital beds lies with the responsible consultant. Specialities providing input to the ED also hold responsibility and hence the responsibilities of mental health staff should be analogous to those of other specialities.

Palliative Care Services

Palliative care is 'an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual'.²¹⁸

Palliative care takes place in a number of settings including primary care, the general hospital and more specialist palliative care units such as hospices which serve inpatients, day patients and community patients. In the UK there are 220 adult inpatient palliative care units. Approximately 58,000 adults are admitted to palliative care inpatient beds per year and 18% of cancer deaths occur in palliative care units. 155,000 patients are seen annually in the community by palliative care specialist nurses, and 38,000 deaths per year occur at home under the care of palliative community services.²¹⁹

At present, the majority of patients receiving palliative care have cancer, but palliative care services are increasingly recognising the palliative care needs of patients with non-cancer diagnoses e.g. motor neurone disease, multiple sclerosis and chronic cardiac and respiratory diseases. The proportion of patients with non-cancer diagnoses is expected to grow.

How common are mental health problems in palliative care?

Psychological distress is a common problem in patients with life threatening illnesses²³⁸. Palliative care services are usually experienced at assessing and managing this. Some problems, however, may require specialist psychiatric or psychological intervention and include the following:

Depression is commonly co-morbid with advanced disease. A systematic review in 2002 identified a prevalence of 5-35%.²²⁰ Depression may complicate the clinical picture with patients appearing to be at a more advanced stage of illness than their pathology would indicate, and can lead to an amplification of physical symptoms.²²¹ Nonetheless sadness and loss are part of life and death and care is required to not medicalise normal distress – a broader understanding of the role of meaning in understanding the illness experience is required. For example, 'demoralisation' has been used to describe the loss of meaning experienced by some patients with terminal illness.²²²

Uncertainty, physical deterioration and distressing symptoms such as pain and breathlessness can be risk factors for anxiety in this population. Anxiety may also occur as a result of prescribed medications for control of other symptoms. Anxiety states can heighten the perception of physical symptoms and lead to avoidance and reduced functioning.²²³ Anxiety and depression commonly occur together.

Palliative care patients are at high risk of delirium²²⁰ due to increasing age, advancing disease and, often, polypharmacy. There are many possible precipitants of delirium in this group including infection, cerebral disease and drugs e.g. opiate analgesia. Delirium can cause behavioural disturbance, communication impairment, reduction in mental capacity and can impede the optimal management of the patient.

It is also a marker of poor outcome.

There is a growing recognition of the interface between palliative care and dementia.²²⁴ This is not just the need for management of dementia in patients with co-morbid life threatening illness, but for a palliative approach for patients with a primary dementia diagnosis.

Although psychosis can rarely present initially in advanced disease (for example secondary to steroid treatment), most palliative care patients with a history of psychotic disorders are well known to services and do not have active psychotic illness.

Some patients with a terminal illness express a desire for hastened death and may actually seek to hasten their death.²²⁵ In the UK, euthanasia and assisted suicide remain illegal, although the Assisted Dying Bill was defeated by a narrow margin in 2006 and is likely to be represented to parliament in future. Desire for hastened death in this population is significantly associated with a clinical diagnosis of depression and hopelessness is a strong independent predictor.²²⁶ Desire for death often resolves with adequate treatment of depression.²²⁷

Detecting mental health problems in palliative populations

Several barriers to detecting mental health problems, especially depression, exist. Patient factors include non-disclosure for fear of wasting the doctor's time and underestimation of distress levels. Clinician factors include the mistaken belief that depression is an inevitable consequence of terminal illness,²²⁸ misattribution of depression symptoms to the underlying disease²²⁹ and under-confidence in eliciting psychiatric morbidity.²³⁰ As a result, depression is under-diagnosed in palliative populations. Tools used to screen for depression include the Hospital Anxiety and Depression Scale (HADS)²³¹, the Beck Depression Inventory²³² and the Edinburgh Postnatal Depression scale (EPDS)²³³. The EPDS has been found to have sensitivity of 70% and specificity of 80% in this population²³⁴ and is now widely used in the UK and US.²³⁵ For detecting cognitive impairment, the clock drawing test²³⁶ has been validated for use in palliative populations²³⁷ and is a quick and easily administered tool.

The NICE guideline on improving supportive and palliative care for adults with cancer (2004)²³⁸ has identified insufficient recognition of psychological distress in this population and a lack of available psychological support services. NICE recommend a four level model of psychological assessment and intervention by cancer networks, with specialist psychological/mental health services at level four. A survey of psychological services in hospices in the UK and Republic of Ireland in 2006 showed that only 30% of hospices have access to a psychiatrist, whilst 41% have access to a clinical psychologist and 45% have neither.²³⁹ This has implications for delivery of this model.

Providing liaison mental health care to palliative populations

One of the difficulties in providing mental health care to this population is the ongoing conceptual separation between mental health and physical health. In the palliative care setting, clinicians have little formal training in detecting and managing mental health problems, whereas in the mental health sector, nursing staff in particular receive minimal physical health training. Patients suffering with both advanced disease and mental health problems are therefore at a disadvantage. In addition, hospices have identified areas in which confidence is lacking in managing mental health problems. These include dementia, psychosis, personality disorders and suicidal patients.²³⁹

Conclusion

Although mental health problems are common in palliative populations, the majority of palliative care services lack sufficient resources to manage these problems. Liaison psychiatry is well placed to provide level four of the NICE model and training within services as there is expertise in managing mental health problems in the context of physical illness. Some larger palliative care units already have dedicated liaison psychiatry services and this model is gaining interest on a more national level.

The Physical Health of People with Mental Illness

What impact does mental illness have on life expectancy?

On average, people with mental illness die five to ten years younger than the general population.²⁴⁰ The table below shows the standardised mortality ratios for different types of mental disorder.²⁴¹

Table 3: Standardised Mortality Ratios relating to Common Mental Health Disorders

Mental disorder	SMR	Comments
All forms of mental disorder	1.5	
Schizophrenia	1.6	Unnatural causes: 9 x more common
Bipolar disorder	1.7	
Depression	1.4	
Panic disorder	1.7	
Eating disorders	5.4	Self-starvation caused 65% of deaths
Alcohol abuse/ dependence	1.9	
Substance misuse	4.9	
Personality disorders	1.8	Unnatural causes: in 52% of deaths

Standardised mortality rates for older people

Standardised mortality rates for older people with depression is 2-3 times higher if left untreated or unresolved.²⁴²

What type of physical problems are associated with mental ill health?

The physical health problems associated with mental illness include serious conditions such as respiratory and cardiovascular diseases, diabetes, cancer and epilepsy. For example:

- People with bipolar disorder have higher levels of physical morbidity and mortality than the general population.²⁴³
- Major depression doubles the lifetime risk of developing type II diabetes.²⁴⁴
- Depression is a risk factor for developing heart disease.²⁴⁵
- People with schizophrenia are 3 to 4 times more likely to develop bowel cancer.²⁴⁶
- People with schizophrenia have a 52% increased risk of developing breast cancer.⁴²

The increased morbidity is due to factors that often occur in combination...

Social deprivation

People with mental disorders are more likely to live in poverty, be unemployed, have poor housing, to be homeless or to live in an institution such as nursing home, penal establishment, or secure psychiatric facilities. They are more likely to depend on state benefits for income, and social isolation compounds their difficulties.

Lifestyle factors

Compared with the general population, people with a mental illness are more than twice as likely to smoke tobacco²⁴⁷, eat less fruit, are less likely to exercise regularly²⁴⁸ have higher rates of obesity (70%) and more often develop the metabolic syndrome.²⁴⁹ Some also argue that people with mental health problems are more likely to become physically disabled as a result of accidents or attempted suicide.²⁵⁰

Adverse effects of medication

In particular, the long term use of antipsychotic drugs increases the risk of developing metabolic syndrome which is characterised by weight gain, high blood lipid levels, high blood pressure and glucose intolerance which can lead to diabetes.²⁵¹ The risk of sudden death in schizophrenia increases incrementally with each additional psychotropic medication taken.²⁵²

Box 19: Patient viewpoint on taking medication for both physical and mental health problems:

Receiving psychotropic medication for mental health as well as medication for physical health can be problematic because of the contraindications, but neither group of specialists cared about (or explained to me) the effects these medications have on each other. I had to borrow a BNF [British National Formulary] and look it up myself".

(Female service user, London, 2008).

Poor access to services

People with mental health problems - compared to those without - receive poorer quality healthcare.²⁵³ They are less likely to seek medical help and do not receive the same standard of physical healthcare in either primary or secondary health services as the general population.³⁶ They may not register with a GP or dentist (or may lose their registration), and can experience difficulty making and keeping appointments. People with severe mental health problems are less likely to take part in health screening such as mammography and cervical cytology.³⁶ The presence of a mental disorder may 'overshadow' the recognition and treatment of physical health problems. This overshadowing can result in a reduction in the quality of physical health care provided by health professionals.³⁶

The Disability Rights Commission has called for urgent action to improve the health inequalities experienced by people with mental disorders and disabilities and have issued new recommendations for commissioners and for those who plan and deliver health services.

Government initiatives

NICE public health guidance on premature death²⁵⁴ seeks to 'identify and support people most at risk from dying prematurely'. This guidance recommends that commissioners, providers, and NHS professionals should improve the physical health of disadvantaged people, who have a higher risk of premature death from cardiovascular diseases and smoking related diseases. This involves tackling smoking and providing treatments such as statins.

The list of disadvantaged persons to whom the above guidance is applicable includes people with mental health problems, people with learning disabilities; people living in public or social housing, some members of black and minority ethnic groups, people receiving state benefits, people who are homeless and those living in institutions (including prisoners).

Key recommendations are to:

- Develop registers of those at risk
- Encourage patients to register with a general practice
- Provide flexible, coordinated services that are easily accessible
- Encourage compliance with treatment
- Provide support to attend appointments and to collect prescriptions

NICE has produced clinical guidance and technology appraisal documents on the treatment of several mental disorders, including schizophrenia and bipolar disorders. This includes recommendations for the physical health care of people with mental disorder. Government and NHS initiatives such as smoking cessation services, disease prevention and health promotion are directly applicable to people with mental disorders.

Carers

Carers provide care for those with mental disorders and disabilities. They play a key role in providing care and support with the physical healthcare of people with mental disorders. The government in England has given carers the right to have an assessment of their own needs as set out in the 'Carers and Disabled Children Act 2000' and the 'Carers (Equal Opportunities) Act 2004'.²⁵⁵

Voluntary sector

There are a number of organisations in the voluntary sector which lobby on behalf of patients and carers and provide information and support for patients and carers²⁵⁶ on topics relating to both mental and physical health. For instance, Rethink has recently produced a Physical Health Check list to help to identify physical health needs of service users.²⁵⁷

Conclusion

There are many opportunities to improve the health and wellbeing of people with mental health conditions. This has been reflected in recent national guidelines which have set out clear recommendations for those who plan and provide care for people with mental health problems. Implementation of the guidelines will have a significant effect in reducing the morbidity and mortality associated with mental ill health.

Box 20: Key recommendations from NICE primary care guidance

- NICE recommends that people with mental disorders should be encouraged to register with, and attend a primary care service. An annual physical health check should be provided, normally in primary care. NICE guidance for physical disorders should be used to manage the physical health of people with mental disorders, when appropriate.
- Health promotion and preventative services should be provided for people with mental disorders. Those in need should receive a comprehensive health care service, for example, dental care, podiatry, optometry, audiology, physiotherapy, dietetics, speech and language therapy.
- Health care facilities should be sensitive to the needs of people with mental disorders; including people from ethnic minorities, people with communication difficulties, as well as those with cognitive or sensory impairments.

Box 21: Key recommendations from the updated NICE guidance on schizophrenia, which recommends that annual physical health checks should include:

- Monitoring of the following: weight gain and obesity (waist hip ratio or waist circumference); blood pressure; dietary intake; activity levels and exercise; use of tobacco and alcohol or other substances; blood levels of glucose; lipids (including cholesterol, HDL, LDL and triglycerides); prolactin levels (if indicated).
- The primary care clinician should document the results of the investigations.
- The results should be communicated to the care co-ordinator and/or psychiatrist, and should be recorded in the secondary care notes.
- People who are identified to be at risk of developing cardiovascular disease and/or diabetes (for example, if they have elevated blood pressure, raised lipid levels, are smokers, and have an increased waist measurement), should be managed using the appropriate NICE guidance for prevention of these conditions. People with schizophrenia who have diabetes and/or cardiovascular diseases should be treated in primary care, in accordance with the appropriate NICE guidance on the management of diabetes and cardiovascular disease.

The Physical Health of People with Learning Disabilities

The conventional definition of learning disability stipulates a significantly reduced ability to understand new or complex information and to learn new skills (impaired intelligence) together with a reduced ability to cope independently (impaired social functioning) which started before adulthood and has a lasting effect upon development.²⁵⁸ It is estimated that up to 2.5% of the UK population will have a learning disability of whom about a third or one percent will have severe and profound disabilities.²⁵⁸

What health problems are people with learning disabilities susceptible to?

Learning disabilities arise from a range of genetic conditions as well as adverse events in the pre-natal, perinatal and post-natal periods and can predispose the person to a range of concurrent physical health problems. For example:

- People with Down's Syndrome have high rates of congenital heart disease, thyroid disorder, sensory impairments and dementia^{259, 260}. As a result, they have a life expectancy which is shorter than that of the general population.⁵²
- The food seeking behaviour of people with Prader-Willi Syndrome means that they are at a greater risk of obesity and Type II Diabetes.²⁶¹
- People with cerebral palsy experience a range of musculoskeletal deformities and high rates of dysphagia and associated respiratory problems.²⁶²
- The rate of epilepsy is 20% in the learning disability population, rising to 50% in those with more profound learning disability.²⁶⁶
- People with learning disability have lower bone density than the average population.²⁶³
- Respiratory disease is the most common cause of death (46%-52%) for people with learning disabilities.²⁶⁴
- Unmet physical disorders are implicated in the aetiology of self-injury and other challenging behaviours, especially in individuals with more severe learning disability.²⁶⁵
- People with learning disabilities are also more likely than the general population to experience mental health problems and the associated risks.²⁶⁶

A useful matrix of genetic disorders and the potential physical and psychological disorders linked to each disorder is available [here](#) or by visiting www.rcpsych.ac.uk/nohealth

How difficult is it to detect health problems in people with learning disabilities?

The Disability Rights Commission investigation of equal treatment³⁶ confirmed major deficits in the physical health care of people with learning disability and the Mencap report "Death by Indifference"²⁶⁷ highlighted the tragic issue of unnecessary and avoidable deaths resulting from unacceptable care.

Health checks for people with learning disability involving systematic questioning and structured physical examination have been shown to discover high levels of unmet need^{268,269} and that the benefits of such interventions are sustained.²⁷⁰ The recent introduction of primary health care checks for people with a learning disability, as a directly enhanced service (DES) in the United Kingdom is, therefore, a welcome development. Specialist learning disability services can play an important role in facilitating this process, including the provision of relevant education, guidance and, where necessary, practical support.

At present however, there are many barriers to meeting the health needs of people with learning disabilities, including:

Difficulties in communication

The delivery of healthcare in the UK largely depends on the patient seeking help. People with little or no means of verbal communication often cannot do this. Even those with more mild or hidden learning disabilities may struggle to negotiate a system which assumes competence in areas such as literacy. Information is rarely presented in a form that is tailored to individual needs, and individuals may be unable to provide information in the form that healthcare professionals require.

Some people with learning disabilities may also have sensory impairments such as deafness, and should not be denied access to good quality mental health care simply because the health service is ill equipped to communicate with them. When seeking or receiving healthcare in any setting, deaf people have the right to be assessed by a trained worker who has deaf/deafblind awareness and skills in working with people with the whole range of hearing related communication needs.²⁷¹

Side effects of medication

People with learning disabilities are particularly susceptible to the physical and psychological side effects of medication. This can be further compounded by a tendency to acquiesce and a reduced capacity to recognise and communicate problems related to side effects.

Diagnostic overshadowing

Clinicians may dismiss behaviours that are manifestations of pain or delirium as being intrinsic to the person's learning disability. Similarly, hearing or vision problems may go undetected because healthcare professionals wrongly attribute low levels of functioning to the learning disability itself.²⁷²

Carers may be unaware of the significance of health deficits or may view them as an intrinsic aspect of the individual's condition. They may also assume that the health problem is not amenable to treatment.

Recognition of disease in people with learning disability requires training, well developed communication skills and, not least, time. Unfortunately, relevant training at both undergraduate and postgraduate level is currently inadequate with many general practitioners apparently lacking confidence in treating people with learning disability and unsure over legal issues such as capacity to consent. Specialist learning disability services have skills in facilitation, but even though these teams are greatly valued by other healthcare professionals, they are often unaware of referral pathways or perhaps reluctant to use them.

Challenging behaviour

This may result from the fact that many people with learning disability find clinical environments frightening and threatening. It is important to look beyond the presenting problem to identify potential physical, psychological and environmental causes. These difficulties can then be minimised through careful planning and preparation.^{273, 274}

Attitudes among professionals

Professionals who are unfamiliar with the needs of people with learning disability can be unduly pessimistic, with inappropriate decisions being made based upon ill-founded opinions about their quality of life and values as citizens.²⁷⁵

Poorly developed links

People with learning disability have equal rights to access generic healthcare services. This may require additional input from specialist learning disability services to facilitate this process. However, the links between these specialist services and general hospital services are often poorly developed. Some recently developed networks in the form of liaison learning disability services have shown promising results.²⁷⁶

The importance of making reasonable adjustments

It is important to allow the time required to speak to the individual. An effective consultation depends on a number of factors including:

- Providing accessible information in a style that suits the individual (this may include the use of communication aids)
- Checking for understanding
- Offering appropriate support
- Seeking background information from someone who knows the patient well
- Assessing the person in an optimum environment
- Preparing the individual for any associated physical examination
- Establishing an effective therapeutic alliance

For further advice, please see the 'Top Ten Tips on Effective Consultation', at http://www.intellectualdisability.info/values/top_ten_tips.htm This checklist has been written primarily for GPs but can be usefully applied to a general hospital setting.²⁷⁷

What kind of health care should be provided to people with learning disabilities?

Various models have been suggested to address health deficits experienced by people with learning disability. Systematic health checks appear to be the most effective. Recent studies have confirmed that systematic questioning followed by physical examination by an appropriately trained primary care clinician will discover high levels of unmet need and that the benefits of such interventions are sustained over time. However, the lack of statutory obligation and financial remuneration has, until recently, proven a major obstacle to comprehensive implementation.

Similar major practical barriers exist to accessing effective secondary health care services and unless these difficulties are anticipated and addressed, the current gaps in health provision will widen. A full list of recommendations for the treatment of physical disorders in people with learning disabilities can be found at www.rcpsych.ac.uk/nohealth.

Conclusion

Despite a legal obligation and the Disability Discrimination Act 1999 to make "reasonable judgements" to aid accessibility to premises and services, there are often significant practical barriers of a physical and logistical nature. It would appear that some form of care co-ordination is essential for people with learning disability to effectively access both primary and secondary health care services. Specialist learning disability services will have a vital role in facilitating this process, including the provision of relevant education, guidance and, if necessary, practical support. This may also involve assistance in the development of relevant health pathways and in the completion of any statutory health care initiatives. However, the temptation for specialist learning disability services to take over responsibility for the physical health care needs of people with learning disability should be resisted.

Box 22: Key recommendations from the Royal College of Psychiatrists Standards for Physical Healthcare in Psychiatric Settings

- On admission to inpatient LD facilities, all patients should receive a physical health check and appropriate investigations, when possible.
- A physical health review examination and investigations should be repeated at least annually, and at care planning meetings
- People with learning disabilities should have continued access to appropriate Primary and Secondary Health Care Services including Dental Care, Chiropody, Dietetics, Physiotherapy, Speech and Language Therapy, Ophthalmology etc.

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