The Challenge for Mental Health Services in a Reformed NHS

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Mental illness is the single largest cause of disability in the UK. It contributes up to 22.8% of the total burden compared to 15.9% for cancer and 16.2% for cardiovascular disease. (WHO 2008 Global Burden of Disease Report) The wider economic cost of mental illness in England has been estimated at £105.2 billion each year. (Centre for Mental Health 2010) Yet recent evidence suggests a scandal of premature mortality for people with mental illness (Wahlback 2011) and continuing public and professional ambivalence. Depression and schizophrenia routinely come bottom of the health professionals' disease prestige (Album 2008), and 25% of the general public still think that a woman who's ever been treated in a psychiatric hospital shouldn't be allowed to babysit (IC, 2011).

No Health without Mental Health, the Government's latest strategy for Mental Health, states that more people with mental health problems will recover; more people with mental health problems will have good physical health; more people will have a positive experience of care and support, and fewer people will experience stigma and discrimination. If these aims are going to be achieved, then NHS clinical commissioning groups need to understand more about mental health issues in general, and specifically how to commission better services.

The Joint Commissioning Panel for Mental Health, the implementation arm of No Health Without Mental Health, was set up in 2011 to support the commissioning groups to do just this. Half the panel members are service users or carers, so suggestions are grounded in what it means to live with mental illness on a daily basis.

The Panel has just published 4 commissioning guides (primary mental health care, dementia, services for young people and liaison psychiatry in acute hospitals) with a further 9 to follow later in 2012. Each short guide provides a description of what a 'good' service should look like, and includes the evidence base for suggestions, service user and carer experience, and case-studies of best practice.

As Professor of Primary Care at Birmingham University, I have co-led the Joint Commissioning Panel for Mental Health and led the primary care mental health commissioning guide. The essence of this guide is that mental health is primary care's business. We already know that about 1 in 4 consultations in primary care have a mental health element and that primary care is seen as the cornerstone of care for people with serious mental illness. Yet GPs still refer people into secondary care in a way they no longer do for people with diabetes for example, or a host of other long term conditions. Once referred, many patients don't turn up for their appointments; many are seen by a succession of junior staff; communication between GP and specialist can be problematic, and thousands of people get stuck on a merry go round of twice yearly appointments of dubious value.

So how can we do things differently in the future? The Panel suggests that people with mental health problems should largely be managed in a primary care setting, in a collaborative manner, with specialist expertise on hand. A patient might see a Community Psychiatric Nurse or a psychologist in their practice, or a local Improving Access to Psychological Therapies (IAPT) service, and be stepped up or down in terms of treatments depending on how well they are. Psychiatrists would increasingly be based in primary care, educating the workforce to manage people more effectively and appropriately, as well as providing critically important care where an individual is particularly unwell. Issues such as debt, employment, physical health, which are often crowded out by a focus on symptoms of depression or psychosis, become part of the conversation again. It sounds simple because it is and above all, it makes sense to patients and their families.

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