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Should Mental Health Services be Integrated into General Hospitals?

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In its recent consultation the European Union stated in its Green Paper on Mental Health that a model of service which integrates mental health services into a general hospital is preferable.

Issues

There is very good evidence 1 that psychiatry services when provided within somatic care can make an impact on both survival and length of stay. This paper identified 576 studies of potential interest, of which 97 met predefined quality criteria and were examined in detail.

The study found that mental illness was much more common in general hospitals than in the general community with the prevalence of patients with mental health symptoms making up between 60% and 70% of the total. To illustrate this another way the report says “To put these findings into context we return to our typical general hospital. We already know that of its 500 beds, 330 are occupied by older people at any one time. Two hundred and twenty of these older people will have a mental disorder. 96 will have depression, 102 dementia, 66 delirium, 10 alcohol misuse and two schizophrenia. Such a general hospital will have at least four times as many older people with mental disorders on its wards than the local mental health services have on theirs.”

The report notes that length of stay is longer and mortality is worse for patients with mental health problems than those without. This evidence supports strongly the hypothesis that a high proportion of patients in district general hospitals will benefit from psychiatric interventions. It does not demonstrate the case for integration, because that service can be provided by liaison psychiatry either within the same organisation or outside the organisation.

Do Psychiatry Services Benefit from Being Within the Same Organisation as Somatic Services?

The authors’ experience is that psychiatric services provided for severely mentally ill patients have not benefited from integration. In England money set aside for a liaison psychiatrist was used instead for an A&E consultant in an integrated organisation because government targets gave greater priority to A&E waiting times than psychiatry. Similarly, medium-secure mental health services in an integrated organisation had 20% of their income diverted to support somatic services in the general hospital.As the effect of mental health services is less determinate than somatic services, there is a view that reducing financing has less consequences.

This View is Not Supported by the World Health Organisation’s understanding that depression causes the second-highest burden of disease, and bi-polar disorder is the sixth most disabling disease. If we go back to the proportion of in-patients in somatic care with intercurrent mental health problems, diverting funds from mental health services may be a false economy and may in fact be the origin of some of the inefficiencies in somatic care, causing longer lengths of stay and higher mortality.

So from Which Organisational Model do Patients Benefit Most?

It is useful to make a distinction between patients with common mental disorders like anxiety and mood disorders, and the Severely Mentally Ill (SMI). The common mental disorders typically do not need in-patient care, are less debilitating and, by definition, are more common. Typically 15-18% of the population will have a common mental health problem at any moment in time. These patients often present with physical symptoms and can be actively investigated in somatic care departments of a hospital. They are also often treated in their local community-based services or in general practice.

For patients with common mental disorders the concept of offering an integrated care model in a general hospital is self-apparent. Patients with mood disorders and anxiety report that they do not wish to be treated in a way that separates them from “normal” healthcare. They feel stigmatised by the psychiatric label and feel associated with those with more severe mental illnesses. As shown in the English study of liaison services, there is very significant co-morbidity in the average general hospital with nearly half of those patients presenting with physical health problems having intercurrent mental health problems. Meanwhile those presenting with a common mental health problem very often have intercurrent physical health problems. This very common inter-relationship between physical health problems and common mental health problems indicates a preference for the care to be inter-related.

By severe mental disorder we mean schizophrenia, manic-depressive illness, severe personality disorders and brain damage. For this group, very different considerations apply. People with severe mental illness often lead more chaotic lives and have important non-health service needs whose consideration is essential if the patient is to be able to achieve the most satisfactory mental health state possible. A high proportion of those patients with severe mental illness are regarded as chronic patients; not necessarily that they need constant care but that from time to time they will need an intensity of service that people with common mental health disorders will not. The central needs of patients with chronic psychiatric illnesses are often connected with housing, money, activities, social company, social support as well as psychological

and psychiatric treatment. Sometimes it is necessary to intensify the treatment a patient with severe mental illness receives either by making treatment compulsory or by placing the patient in a secure setting when necessary. It is accepted that when the social elements such as housing, social interaction and so on are not available, psychiatric support and treatment are not as effective.

The group who have been diagnosed as having a severe mental illness need different settings, different values, different treatment modalities than other patient groups, from those with common mental health problems right through to patients with a single, straightforward physical condition. A service to people with severe mental health problems needs to take these factors into account. In a general hospital, long-term accommodation, a therapeutic milieu, social contact, compulsory treatment, and homely and inclusive buildings are secondary considerations when compared with the technical quality of a procedure. For the patient group with severe mental illness those issues are an integral part of the care. The combination of social, psychological and medical needs is not part of the core business of general hospitals. This makes it unlikely that general hospitals will provide the best care.

Would Mental Health Services Benefit from Increased Somatic Involvement?

People labelled “mental health” experience inferior access to somatic services than the general population. People with mental health problems have increased incidence of disease such as coronary disease, diabetes and pulmonary deficiency. They are more inclined to smoke, abuse alcohol and use recreational drugs. People with mental health symptoms should get increased access to somatic services but in most European countries that is not true.2 Having patients with common mental health disorders in general hospital settings would overcome some of this stigma and help good mental health to be seen as a normal thing.

So What About Integration?

There is little doubt that integrating mental health services into a general hospital has benefits for that hospital.

We have seen that a somatic hospital’s workload is compounded by the very significant levels of mental health co-morbidity. The case is made we believe, for those with common disorders who need secondary care to receive that in a general hospital setting. They will be less stigmatised, probably more receptive to treatment, and healthier as a result of a short intervention in their local hospital.

For patients with severe and enduring psychiatric symptoms, their needs are not best served by the general hospitals except for their separable somatic care needs. Patients in this group have a much bigger spectrum of needs from housing and social interaction to systems of work and modalities of treatment which are not the staple fare of general hospitals. General hospitals try to treat psychiatry patients in the way they treat all other patients. ,Standardisation is a worthy managerial approach to service quality. However when patients sit so far outside the standard that standardised treatment can be counterproductive, we need to think again.

The question is defined by the patient and quite rightly so. The answer must reflect that too. The guiding rule should be that the less severe the need, the more a patient should receive their care at a general hospital, and the more severe the need, the more care needs to be specialised and orientated around the wider and more complex needs of the individual concerned.

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