BRIEFING

Centre for Mental Health

57: Better together

A public health model for mentally healthier integrated care systems

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Summary

This is the second in a series of briefings from Centre for Mental Health to support the development of mentally healthier integrated care systems – it builds on the first published last year (Centre for Mental Health, 2020).

This briefing focuses on how integrated care systems can adopt a public health model to use their budgets, powers and influence to support better mental health outcomes.

Covering the whole of England, 42 integrated care systems bring together all NHS organisations and upper tier local authorities in a geographical area to plan health and care. From April 2022 these integrated care systems will become statutory organisations with duties set out in the Health and Care Bill currently progressing through parliament.

This is an opportunity for powerful local institutions to work even more closely with each other and the people they serve to improve mental health and wellbeing.

To fulfill this potential, integrated care systems should ensure ambitious one-year plans and five-year strategies to address the factors that have the most influence on health.

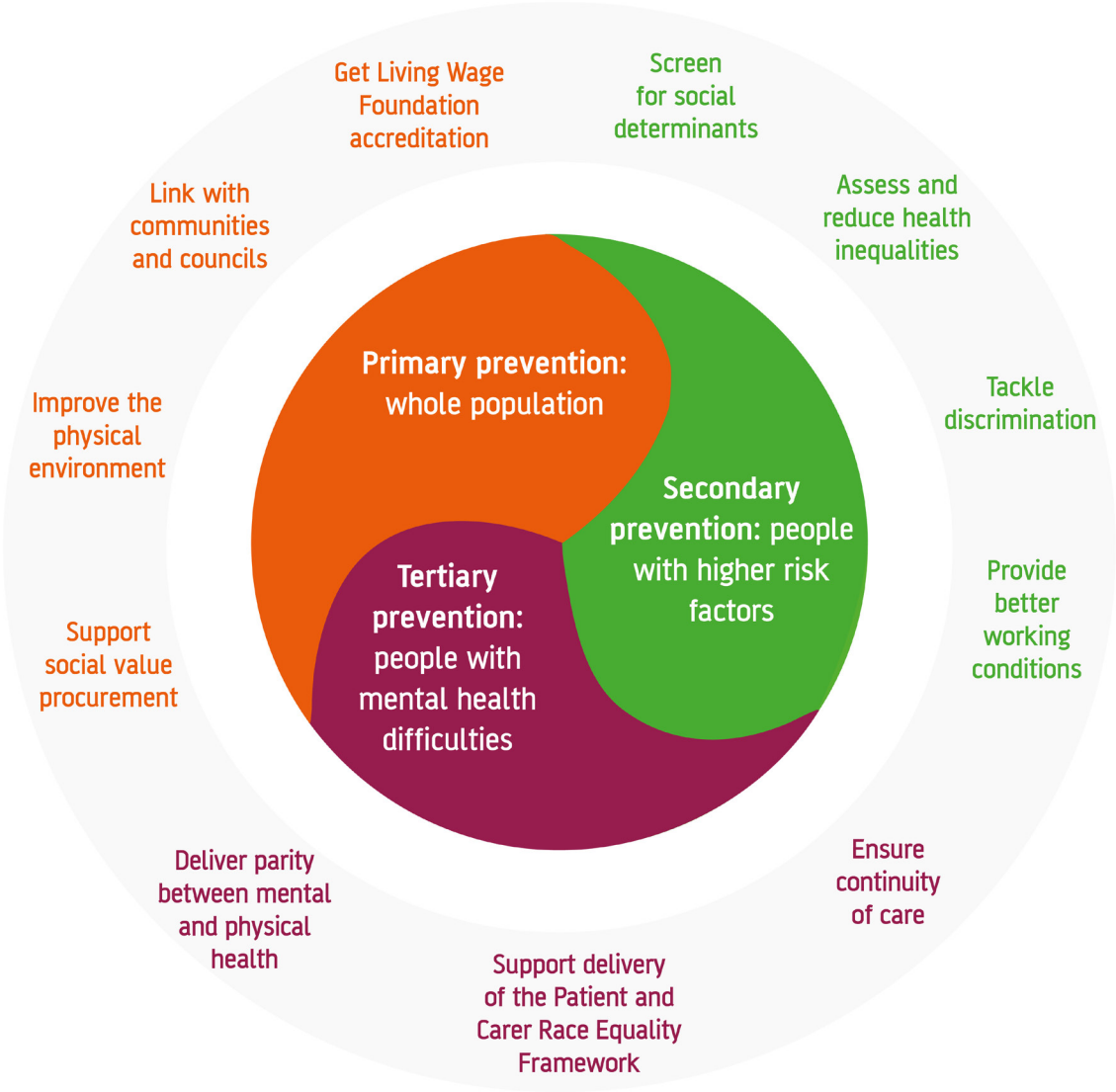
The World Health Organisation (WHO, 2017) says that, beyond genetics, these factors are:

- Social determinants like poverty and discrimination
- The environment like air quality and housing
- Individual factors like physical health and substance misuse.

By adopting a public mental health model based on addressing these factors, integrated care systems can reduce risks and support resilience and recovery.

This should mean working collaboratively with the whole population, those at greater risk and people with diagnosed conditions.

Figure 1: Suggested actions for mentally healthier integrated care systems



Introduction

After a lag due to lockdowns, the Covid-19 pandemic is being accompanied by a sharp rise in demand for mental health services. Referrals to children's mental health services are up 134% on last year and emergency crisis care presentations are up 80% (RCPsych, 2021).

Sadly, this is not surprising as many of the risk factors for mental ill health including bereavement, physical illness, loss of income, isolation, uncertainty, abuse and neglect are also features of the pandemic and the measures taken to control it. It is also likely that demand for mental health services was artificially suppressed by the earlier stages of the pandemic, including lockdowns.

Even before the pandemic, mental ill health was one of the most prevalent forms of illness in the UK (ONS, 2017) with one in six people experiencing diagnosable symptoms at any time, and thousands dying prematurely at a cost of over £119 billion in England alone (Centre for Mental Health, 2020).

Mental ill health is often caused and worsened by preventable trauma and the circumstances in which people live. It is also closely associated with physical ill health (Ohrnberger *et al.*, 2017), as people with mental illness are more likely to suffer long-term physical health conditions and vice versa.

The NHS and social services have a vital role in providing evidence based, easily accessible, recovery focused treatment and support for people with mental health difficulties, and it is important that integrated care systems and their boards prioritise these services.

Whilst high quality clinical services are vital, research (McGinnis *et al.*, 2002) suggests that health care accounts for as little as 10% of health outcomes. The size and nature of the challenge means that treatment alone cannot manage this crisis - we also must address the factors that make up the other 90%.

Principal among these factors is poverty, which is associated with more years of lost life than smoking and obesity combined (Galea *et al.*, 2010).

Whilst a person's genetic inheritance accounts for about 30% of outcomes, genetic predisposition to certain conditions, like schizophrenia, is also heavily influenced by what happens to a person and the environment they live in (Carey, 2012) – this 'turning on' of a genetic predisposition by social or environmental factors is known as 'epigenetics'.

Behaviour, such as whether we 'choose' to smoke or drink too much (accounting for up to 40% of health outcomes), is also largely a product of our circumstances (Mullaintathan and Shafir, 2013) – the poorest fifth of the population are twice as likely to smoke as the richest (ONS, 2014), most likely due to the stress of their economic circumstances. Last year an important study (Kivamaki *et al.*, 2020) found that low socioeconomic status was associated with increased risk for 16 diseases, including psychiatric disorders, that formed a 'cascade' of interrelated health conditions including later heart disease, lung cancer and dementia. Taken together, this strongly suggests that living in poverty drives unhealthy behaviour which in turn makes it more likely people suffer mental and physical ill health.

Comprised of major local employers, buyers of goods and services, trainers, educators and custodians of public environments, integrated care systems and their partners have a lot of influence over these environmental and social determinants. If all these mechanisms are used well, integrated care systems can take significant steps to prevent ill health and support their communities more effectively.

Not only is this approach morally and economically the right thing to do but it will also help integrated care systems comply with the NHS Long Term Plan, which focuses on 'prevention' and the NHS England guidance which says the new systems exist to:

- Improve outcomes in population health and health care
- Tackle inequalities in outcomes, experience, and access
- Enhance productivity and value for money
- Help the NHS support broader social and economic development.

Centre for Mental Health is currently working with the Greater Manchester Health and Social Care Partnership and others to realise these objectives and looks forward to sharing learning and supporting other areas.

Links to local communities and councils

Integrated care systems have already begun to take a lead role in decision-making and planning of health services across the country. In almost all cases, they cover a larger area than clinical commissioning groups and are less well aligned with local government areas. We have already seen evidence that this is drawing power and decision-making further from local communities, leaving smaller voluntary and community organisations without a voice in the new arrangements, and with fewer opportunities to work alongside statutory sector partners (Allwood and Bell, 2019).

We urge integrated care systems and their boards to ensure clear lines of accountability to health and wellbeing boards at upper-tier local authority level and to provide opportunities to plan, commission and deliver services together.

Although council budgets will often be dwarfed by that of NHS trusts, it is important that local authorities are properly involved as democratically-led bodies with responsibility for many of the social determinant and environmental levers including public health, child protection, social care, housing, parks, transport, education and community spaces.

Voluntary and community organisations should also be properly involved in the planning and delivery of integrated care systems. Statutory bodies currently have a mixed record in how far they enable these organisations to develop and sustain their offer. This disadvantages many of the most marginalised communities, for whom effective support is often reliant on small organisations with limited and volatile funding.

Get Living Wage Foundation accredited

Organisations comprising integrated care systems are usually the largest employers and buyers of goods and services in their area – the NHS alone is Europe's biggest employer.

By paying workers, including staff delivering outsourced contracts like cleaning, to at least a Living Wage Foundation level, integrated care systems can make an immediate, direct reduction in poverty and ill health for large numbers of people.

It is important to note that the Living Wage Foundation is an independent body and that their Living Wage rate (calculated by experts every year, currently £10.85 per hour in London and £9.50 in the rest of the UK) is different from the Government's 'National Living Wage' which is currently as low as £4.30 per hour.

Employers who have gained Living Wage Foundation accreditation report higher productivity and better recruitment, retention, and satisfaction of staff, as well as improved health and wellbeing of their workforce. This is especially important in the NHS and supply chains where low wages are contributing to a major labour shortage and hundreds of thousands of vacancies.

In 2017 Barnet, Enfield and Haringey NHS Mental Health Trust (BEHNT) became one of the first major NHS organisations to get Living Wage Trust accreditation. The trust's chief executive commented at the time, "this is not only good for staff but also benefits society. Most importantly, the trust believes that this demonstrates a commitment to be a fair and ethical employer" (BEHNT, 2017).

Several other NHS trusts, GP surgeries and clinical commissioning groups have since signed up to pay Living Wage Foundation rates, but still fewer than 10% of NHS bodies and only about one in three local authorities are accredited. Accreditation is important as it covers contracted staff, such as cleaners, caterers and security guards, who are the lowest paid and often have the worst health outcomes.

In February 2020 both South London and Maudsley and Guy's and St Thomas's NHS trusts, covering some of the same area, got Living Wage Trust accredited. This gave hundreds of key workers (who had been on national minimum wage) a life-changing £70+ a week pay rise.

Buy more goods and services locally and from at-risk groups

From stationery to vehicles, cleaning to decorating, the 'anchor institutions', which make up an integrated care system spend billions of pounds a year buying goods and services.

By supporting local businesses and other organisations to bid for and supply more of those goods and services, an integrated care system can support more local residents into decent employment and out of poverty. In doing so, the risk of them and their families becoming mentally and physically unwell reduces, and pressure on services falls as well.

Social value procurement, where the awarding of contracts is influenced by outcomes other than just quality and price, can also be used to support specific groups of people at higher risk.

Some NHS mental health trusts have supported service users to establish social enterprises where they provide gardening, decorating, and cleaning services commissioned by local councils and other local anchor institutions. This fosters peer support, meaningful therapeutic activity and decently paid employment for people who may otherwise struggle in the job market.

Tenders for contracts should contain social value scoring to support local providers and those employing vulnerable members of the community.

Very large tenders can often be impossible for local organisations to bid for, so it is also important to examine how contracts could be broken up into more manageable pieces and how local organisations could be supported to work together to supply them.

Case study: The Preston Model

For nearly a decade, a collaboration between the Centre for Local Economic Strategies, Preston City Council and local anchor institutions has sought to buy more goods and services locally. This has led to the following outcomes:

- Procurement from institutions rooted in Preston retained within the city was £112.3 million – a rise of £74 million from 2012/13
- Within the wider Lancashire economy (including Preston) £488.7m of spend had been retained, a rise of £200m from the baseline analysis
- Since the inception of the project, 4,000 extra employees in Preston are now receiving the Real Living Wage (2018 initial ONS outrun)
- Unemployment halved during the first few years of the scheme
- Preston was named 'Most Improved City in the United Kingdom' in 'Good Growth for Cities 2018'.

Improve the physical environment

The institutions involved with integrated care systems have a lot of influence between them over the local physical environment, which affects the health and wellbeing of residents.

Not only does the immediate environment have a strong influence on local people's health but studies (such as Charlson *et al.*, 2021) suggest that climate change is negatively impacting the mental health of populations through extreme weather events, flooding and fires.

As well as being the landowners and custodians of major public buildings, green spaces and social housing, ICSs include (via councils) planning and licensing powers that can improve – or worsen – mental and physical health, by influencing the environment in which residents live.

The ideal mentally healthy environment is one where everyone has a decent home with easy access, via tree-lined, safe, walking, cycling and public transport routes, to:

- Parks, woods, waterways and other green spaces
- High quality employment and training opportunities
- Free/affordable 'pro-social' space including libraries, community, and leisure centres
- Good childcare and schools
- Healthy affordable food.

It also limits:

- Crime and anti-social behaviour
- Air pollution
- Access to cheap alcohol
- Harmful gambling such as fixed odds betting terminals.

Housing

Homelessness and poor-quality housing are risk factors for mental health problems, whilst secure, good quality housing is a protective factor and can be a vital element of recovery from mental ill health.

Local authorities in England have various legal duties around housing and homelessness, and it is important that these are discharged effectively.

Integrated care systems can play a role in improving housing by:

- Using their land to build genuinely affordable homes and reserving some of it to provide supported housing for vulnerable people, including those living with mental ill health
- Supporting a 'housing first' model that seeks to provide people with a decent home as a fundamental step in addressing other needs (Boardman, 2016)
- Employing as many residents as possible to reduce demand on housing stock and support residents to pay their rent and mortgages.

Earlier this year, Centre for Mental Health presented evidence (O'Shea, 2021) highlighting that supported housing for people leaving acute hospital for a mental illness may help them to return to independent community living. Integrated care systems should seek to provide supported housing to people who are otherwise bounced between temporary accommodation, hospital beds and custody suites.

Safe walking, cycling and public transport access

Regular exercise is crucial to mental as well as physical health. The most effective way of supporting more people to exercise is to build it into everyday lives.

In the last 40 years, distances walked have fallen by 30% (DfT, 2013) as architects and planners designed more movement with lifts, escalators and out of town facilities that make the car a default mode of transport for many.

Increased walking and cycling have a range of benefits:

- Better mental and physical health
- Saved money on costs of cars and road maintenance
- Increased footfall to local businesses
- Reduced traffic congestion – freeing space for emergency vehicles and those who have to drive
- Reduced climate-changing gases (transport is now the biggest domestic source of carbon)
- Improved air quality (not only does vehicle emitted pollution kill about 40,000 people in the UK a year (PHE, 2019), it has also been found to directly worsen mental health difficulties such as depression).

Integrated care systems can support movement by encouraging local authority planning processes that create '15 minute' environments where more facilities are within walking distance, and which privilege walking, cycling and mobility-aided movement over cars and vans. They can also support cycle to work schemes, provide secure cycle storage, and reduce parking and traffic through hospital and other estates.

Case study: hospitals invest in cycling and public transport

King's College Hospital and South London and Maudsley NHS trusts invested in improving Denmark Hill railway station which serves both of their main sites in Camberwell.

The upgrade included new cycle storage, new entrances, more comfortable waiting facilities, sheltered platforms, better lighting powered by solar energy, and public art.

By supporting this project, they aimed to improve the air quality in the local area by encouraging the move from car use to a more sustainable mode of transport (KCH, 2021).

Supporting mentally healthier at-risk populations – secondary prevention

Screen for social determinant needs

There is growing evidence (Anderman, 2018) that screening by health and care professionals for social determinant factors is an effective way of more holistically supporting people who consult services.

In the US social determinant needs are routinely screened using 'Z codes' to establish eligibility for MedicAid and to refer, via social prescribers, to community assistance programmes to help with homelessness, food poverty, domestic violence and so on.

Obviously, the NHS does not need to screen for eligibility (though social care does) but this system of identifying non-clinical needs using coding and referrals via social prescribers could be helpfully expanded in integrated care systems.

Join up care and mental health

Properly integrated care has many potential benefits for mental health. Too often, people experience mental health care as dis-integrated, especially from physical health care. Our recent report with National Voices, *Ask How I Am*, demonstrated that people with long-term physical conditions currently get little effective support for their mental health despite being twice as likely to have depression (Wilton *et al.*, 2021).

People living with a mental illness, meanwhile, get inadequate help for their physical health, and as a result have a life expectancy that is some 15-20 years too short. While this is linked to poverty, exclusion, and discrimination in the wider world (discussed below), it is also the result of neglect of physical health for this group, including by mental health services, public health, general practice, and acute health care. Mortality from Covid-19 is also very much higher, at 2.7 times that of the general population for people with schizophrenia (Nemani *et al.*, 2021) and twice the average for people with psychosis or mood disorders (Vai *et al.*, 2021).

Fragmented services are frequently cited as a concern for people of all ages with 'complex' needs that require support from more than one agency at a time. Bringing support together and encouraging collaboration rather than competition between public services may help to reduce some of the fragmentation and gaps people face. People entering and leaving prison have experienced particularly poor mental health care which integrated care systems have the potential to improve (Durcan, 2021).

Integrated care systems need to ensure mental health is given equal standing with physical health, with local government and the NHS working together and with communities, and with resolute action to tackle health inequalities.

Tackle health inequalities

Centre for Mental Health welcomes the provisions within the Health and Care Bill to ensure that NHS England, integrated care boards and NHS trusts and foundation trusts will address inequalities in both access to and outcomes from health services.

We are working to have those provisions strengthened significantly to ensure that both new and existing statutory bodies take their responsibility seriously and that it is more than a passive, tick-box exercise.

We believe this should create a specific duty to *identify* inequalities (across the full range of Equality Act protected characteristics, including socio-economic) in health, in access to care and in outcomes, and to take steps to address them within their annual plans and five-year strategies.

Our research has shown that it is often groups of people with the poorest mental health who have the greatest difficulties accessing health care that meets their needs and produces good outcomes (Commission for Equality in Mental Health, 2020). Unless an integrated care board is focused on which groups of people have the poorest health in the first place, and why this is the case, they will struggle to reduce these inequalities and will be unable to tackle the causes of unequal health and wellbeing.

Tackle discrimination

The social and economic determinants discussed so far do not fall equally across the population and nor do the health outcomes.

Case study – Kaiser Permanente's Thrive Local

Kaiser Permanente, a US not-for-profit health care provider that was developed to serve shipbuilding communities on the west coast, is increasingly doing more than just providing expensive services when people get ill.

Kaiser are investing (Koh *et al.*, 2020) over $200 million in trying to meet the social needs of their members and those of the communities they serve. Since 2019 their Thrive Local network is investing in fighting homelessness and connecting people with necessities like nutritious food and support networks. By early 2022, the network will be available to all Kaiser Permanente members — and the 68 million people who live in the communities in which they serve – a considerably larger population than the one served by England's integrated care systems.

This approach led to the deployment of community health initiatives that focus on health-promoting policy, systems, and environmental changes, and an anchor strategy that uses Kaiser's major business assets to create healthy, thriving local economies. These initiatives have resulted in population-level improvements in food and physical activity behaviours and other health-promoting community changes.

To do this, Kaiser identified four steps:

1. A standardised approach to screening for social need
2. Deployment of a nationwide, locally adapted social service resource locator to connect members to community resources
3. Partnerships with select community-based social needs providers and others to address the social determinants of health
4. A strategy to evaluate and scale social interventions when those interventions prove to be effective.

Conscious and unconscious discrimination means that not everyone is equally valued and connected – this can lead to worse health and other poor outcomes.

This disproportionality came to wider attention when it was found that some Black people and people of Bangladeshi origin in the UK have suffered much higher Covid-19 infection and mortality rates than white people.

Black people are more than four times more likely to die from the virus than white people (ONS, 2020). Even when higher rates of deprivation are accounted for, the mortality rate is twice as high.

There are several reasons for this disproportionality, but we know that experiencing regular discrimination, including racism, can lead to higher levels of the stress hormone cortisol which lowers immunity to illnesses, among other effects. Discrimination also makes economic deprivation and living in poor physical environments more likely, which increases risks and reduces protective factors even further.

NHS England is piloting the Patient and Carer Race Equality Framework in four NHS mental health trusts. Integrated care systems should look at what can be applied from this framework, not least the need to ensure compliance with their equalities duties.

Similarly, because of discrimination, LGBTQ+ people have higher rates of mental ill health including self-harm and suicidal thoughts (NHS England, 2016).

When seeking to improve community health, integrated care system leaders should have equalities issues at the forefront of their minds. It is vital to be informed by local public health data about which groups of people, with characteristics protected under the Equalities Act 2010, are suffering disproportionately worse outcomes. For effective solutions these groups must be well represented in decision-making, be listened to, recognised, and included in creating solutions, commissioning, and providing support.

Support the health and care workforce

The recent *Now or Never* systematic investment review from the Centre and the NHS Confederation's Mental Health Network (O'Shea, 2021) documented that enhancing, protecting, and treating NHS staff health is crucial to providing great health care by preventing absenteeism, lower productivity, and staff shortages. Centre for Mental Health modelling suggests nearly 700,000 health and care staff may require mental health support following the pressures of dealing with the pandemic (O'Shea, 2021).

In July 2020, a third of all NHS staff absences were due to stress, anxiety, or mental health problems. This consistently represents over 25% of total absences (NHS Digital, 2021c).

Integrated care systems should provide a funded strategy for the mental health of NHS, social care, and other staff that:

- Quantifies current health needs across all staff
- Estimates mental illness that will result from the pandemic
- Offers structured investment in prevention, treatment, and recovery for both
- Is culturally aware and, in some cases, culturally specific
- Offers help to all staff
- Builds on the NHS People Plan.

Its design should reflect the framework of enhancement, prevention, management, crisis and recovery, and should link to clear goals, with an accompanying evaluation to determine impact.

Health and care staff need to be healthy to provide excellent health care. This requires an investment strategy for treatment which aims to protect, enhance, and improve the mental health and wellbeing of NHS staff. The absence of such a strategy risks high levels of staff shortages through absenteeism and resignations. A strategy should commit the cost of a 1% increase in staff absences to treating staff recovery (O'Shea, 2021).

Supporting mentally healthier people with a diagnosis – tertiary prevention

Equal regard to mental health

'Parity of esteem' is the principle by which mental health must be given equal priority to physical health. It was enshrined in law by the Health and Social Care Act 2013.

The Government requires NHS England and all NHS bodies to work for parity of esteem to mental and physical health through the NHS Mandate.

There are, however, many areas where parity of esteem has not yet been realised. Mental health problems account for more than one quarter of the burden of disease but less than one tenth of NHS spending (Centre for Mental Health, 2021).

Apart from the obvious point that any illness should be alleviated where possible, mental illness reduces life expectancy – it has a similar effect on life expectancy to smoking, and a greater effect than obesity.

Mental ill health is also associated with increased chances of physical illness, increasing the risks of the person having conditions such as coronary heart disease, type two diabetes, or respiratory disease.

Poor physical health also increases the risk of mental illness. The risk of depression is doubled for people with diabetes, hypertension, coronary artery disease and heart failure, and tripled in those with stroke, end-stage renal failure and chronic obstructive pulmonary disease. Children experiencing a serious or chronic physical illness are also twice as likely to develop emotional disorders.

Priorities for achieving parity

- Integrated care systems should ensure that appropriate waiting times are established for a wider range of mental health services so that people with mental health problems know the maximum time they can expect to wait for treatment.
- National Institute for Health and Care Excellence (NICE)-approved and recommended mental health therapies should entitle people to access them in the same way we are entitled to NICE-approved drugs.
- The premature mortality experienced by people with severe mental illness must be a priority – integrated care systems should join Equally Well UK which works to achieve this.
- It is vital that people using mental health services have 24/7 access to a crisis team and that these teams are not scaled back to cut costs.

Continuity of care: criminal justice system

Currently, too many people leave prison with serious and complex mental health difficulties yet receive no support in their community (Durcan, 2021). Locally commissioned community mental health services frequently refuse to treat people leaving prison, even if they have been receiving specialist treatment while in custody.

Integrated care systems will take responsibility for commissioning some of the specialist services currently managed by NHS England, potentially including health care in prisons and immigration removal centres. This is an opportunity to realign services for people who have multiple and complex needs, providing care 'through the gate' and ensuring that a period in custody is not followed by a gap in care and support.

It will be vital that integrated care systems must be required to secure continuity of care when people go into prison in or from their areas, and to do the same when they are released.

Conclusion

As the health secretary Sajid Javid acknowledged in a recent speech (Javid, 2021), the elective care backlog is mirrored by social and mental health 'backlogs', with the pandemic and other factors increasing the poverty and distress that make people more likely to become unwell.

Integrated care systems, involving the biggest employers and budget holders in every area of England, have huge potential to address these backlogs by tackling social and environmental determinants, as well as ensuring excellent clinical support for those with diagnosable mental health conditions.

Whilst there are real opportunities here there are also risks that already-powerful acute hospitals dominate further, and that the understandable urge to tackle the elective care backlog leads to neglect of what drives ill health in the first place.

To avoid this, NHS bodies in integrated care systems must work meaningfully with local communities through councils, the voluntary and community sector, Healthwatch and other means.

All institutions involved should ensure they are employing, training and buying goods and services locally, especially from organisations that support vulnerable people. Those people should be paid at least at Living Wage Foundation levels and able to access genuinely affordable housing, active travel, and green spaces like parks.

In service terms, health care providers should deliver parity between mental and physical health services, screen for social needs, support delivery of the Patient and Carer Race Equality Framework, and ensure continuity of care for those leaving the criminal justice system.

Whilst this will appear daunting to services struggling under continuing high demand with exhausted staff, it is vital that this opportunity is taken to address the 'causes of causes' (Marmot, 2017) of ill health, both mental and physical.

Final recommendations

Sign up to **Equally Well**: Centre for Mental Health and Rethink Mental Illness lead the Equally Well coalition dedicated to prioritising physical health for people with mental health problems, as well as pledging to play their part in reducing the inequalities. Email **helen.butlin@centreformentalhealth.org.uk** for more information.

Make sure local authorities in your integrated care system have a local government mental health champion – Centre for Mental Health also leads this scheme, supporting councillors to champion mental health in their area. Email **ed.davie@centreformentalhealth.org.uk** for more information.

Contact us

To discuss any element of this briefing paper, please contact Ed Davie on 07805 942 095 or **ed.davie@centreformentalhealth.org.uk**

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