Seeing the whole person: Integrating physical and mental healthcare

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We now have multiple papers and evidence concerning the risks for people with a mental health condition of having difficulties with their physical health (Zolnierek, 2009; Naylor et al, 2012; Park et al, 2013). There is strong consensus from all authorities that there is a need to have an integrated approach in this respect; however, we really need to pay particular attention to the following clear challenges for people with a mental health condition (Naylor et al, 2016):

- Rising levels of multimorbidity.
- Inequalities in life expectancy.
- Psychological aspects of physical health.
- Medically unexplained symptoms.

We are still trying to focus on the notion of "parity of esteem", which can be defined as valuing mental health equally with physical health (Bailey et al, 2013). However, this new focus has many barriers, including the challenge of measuring outcomes, cultural barriers between establishments and differences in budgets and payment systems between the varying organisations.

The NHS *Five Year Forward View for Mental Health* (Mental Health Taskforce, 2016), which is now 6 months old, makes the argument for collaboration in what has been called "triple integration", which involves the integration of health and social care, primary and specialist care, and physical and mental healthcare (Stevens, 2016).

How will this impact on diabetes services?

Although nurses still need to have extensive knowledge of diabetes and the risks associated with this condition, we also need to recognise that the fundamental purpose of our role is seeing the "whole person".

When a person arrives for a diabetes review, is diabetes the only thing we see – with the rest of the person not mattering? If we are rigid with the fixed features in our diabetes consultation, we are at risk of a diminished sense of responsibility for an individual's mental health needs, which could mean vital opportunities are missed to improve that person's health and wellbeing.

Alternatively, though, there is an awareness that we are genuinely worried that we need to have "experts in everything", and that we often only have limited skills in understanding the complexity of the mental health diagnosis. This new culture of co-operative care and collaboration can only really work if we understand the importance of proactively seeking out the entire specialist team involved with the patient whilst also recognising the value we add to them with our skills and expertise in diabetes. Only then will we have true collaboration for the best physical and mental health outcomes for all the people we care for.

Reducing stigma

Whilst understanding and embracing collaborative working, we also have to recognise the need to reduce the stigma and discrimination still being experienced by people with a mental health diagnosis when using our health services. Time to Change, the mental health anti-stigma campaign run by the charities Mind and Rethink Mental Illness, launched projects in response to research showing that one in three people still report stigma and discrimination within health services (Mental Health Today, 2016; Time to Change, 2016). As we manoeuvre towards our integrated approach, together with our mental

health colleagues, we can work together to reduce this discrimination and stigma, until we are able to manage mental health needs in conjunction with diabetes care and it becomes normal everyday practice.

We are very fortunate to have some wonderful articles in this month's mental health section which will help us to deliver on this collaborative strategy and help us focus on moving forward this year and into the future. Kavita Vedhara and colleagues demonstrate that, even after controlling for other predictive factors, illness beliefs are associated with survival time in people with diabetic foot ulceration. Such beliefs can be modified and thus should be taken into account during consultations. MaryJane Simms and Maureen Monaghan describe a significant proportion of young people and their families who find it difficult over the long term to adjust to a diagnosis of diabetes. Identifying this group early and intervening to improve their coping skills and adjustment can improve not only their quality of life but also their diabetes-related outcomes in later years. Finally, Johanna Taylor and David Shiers provide a practical framework to screen for and manage diabetes and cardiovascular disease in people with severe mental illness. Nurse practitioners are ideally placed to coordinate this, in collaboration with their colleagues in mental health. ■

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