BRIEFING NOTE

Centre for Mental Health

Parity of esteem

Centre for Mental Health is an independent mental health charity working to improve the lives of people facing or living with mental ill health. Our research and development work aims to improve the way people with mental health conditions are supported to build better lives on their own terms. Timely access to effective services is crucial in every area of mental health care and support. This note sets out the evidence we have available.

What is it?

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 2012. The government requires NHS England (the body which commissions primary care along with other key services) 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. The NHS Constitution still does not give equal access to mental health care and spending on mental health services is failing in many areas.

The impact of poor mental health on physical health

Mental illness reduces life expectancy: by 7 to 10 years in people with depression, by 10 to 15 years in those with schizophrenia, and by almost 15 years in those who misuse drugs or alcohol (Chang *et al.*, 2011). In fact, mental illness has a similar effect on life-expectancy to smoking, and a greater effect than obesity (LSE, 2012).

Mental ill health is also associated with increased physical morbidity. Depression has been associated with an increased risk of coronary heart disease (Hemingway and Marmot, 1999), and a four-fold increase in risk of myocardial infarction (MI), and of death within six months of MI (Lesperance *et al.*, 2000). There is a two-fold increase in type 2 diabetes (Fenton and Stover, 2006) and a three-fold increase in the risk of non-concordance with treatment for all illnesses (Martin *et al.*, 2005).

Schizophrenia is associated with a three-fold increased death rate from respiratory disease (Saha *et al.*, 2007), and a two-fold increased risk of obesity, diabetes, hypertension, metabolic syndrome, and smoking (De Hert *et al.*, 2009).

The impact of poor physical health on mental health

Poor physical health increases the risk of mental illness. For example, the risk of depression is doubled in people with a chronic physical condition (NICE, 2009) and is more than seven times higher in people with two or more chronic physical conditions (Moussavi *et al.*, 2007).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 (Egede, 2007). Children experiencing a serious or chronic illness are also twice as likely to develop emotional disorders (Parry-Langdon, 2008).

A recent review also found that patients with chronic obstructive airways disease (COPD) had much higher rates of generalised anxiety disorder, panic, and depression. This was explained by social and occupational withdrawal and isolation. It resulted in increased admissions, longer hospital stays, and higher relapse rates (Howard *et al.*, 2010).

Urgent care

Recent data published by the Health and Social Care Information Service (HSCIC, 2013) shows that people with mental health problems have a significantly different level of contact with physical health services compared with other patients. In 2011/12:

- **78%** of mental health service users accessed hospital services compared with 48% of non-mental health service users.
- **54%** of mental health service users arriving at A&E came by ambulance or helicopter compared to **26%** of non-mental health service users. A higher proportion of these patients were admitted and they stayed in hospital around 30% longer.
- **71%** of those admitted were classified as an emergency compared with 40% of non-mental health service users.
- They also had more outpatient appointments.

Many people who attend A&E have physical health problems relating directly to poor mental health. There are at least 200,000 self-harm presentations to general hospitals in England each year (DH, 2013) while alcohol-related admissions doubled in the 11 years up to 2007 (NAO, 2008).

Section 136 of the Mental Health Act empowers the police to remove a person who appears to be in distress from a public place to a place of safety. Government guidance stipulates that a 'place of safety' should generally be in a hospital, with police cells used only in exceptional circumstances.

A 2013 report produced by Her Majesty's Inspectorate of Constabulary (HMIC), Care Quality Commission (CQC), Health Inspectorate of Wales (HIW) and Her Majesty's Inspectorate of Prisons (HMIP) found that in some areas police cells were used frequently as a place of safety because of a lack of effective local arrangements with local health services. It also noted that 80% of those detained under section 136 are not admitted to hospital for treatment. This suggests an urgent need for better working relationships and knowledge between the police and mental health services.

The gap between health and care resources

Almost one in four British adults and one in ten children experience a diagnosable mental health problem at any given time.

This makes mental health problems the largest source of disability in the United Kingdom. However, despite the availability of effective, evidence-based interventions, most people are not receiving treatment and services are often variable and fragmented.

Mental health problems account for 28% of morbidity, but spending on mental health services is only 13% of total NHS expenditure.

The gap risks becoming a gulf, with funding for adult mental health services in England actually falling in 2011/12, despite the government's commitment to give mental health parity of esteem with physical health.

Centre for Mental Health recently estimated that a comprehensive roll out of hospital-based liaison psychiatry services could save £5 million per year in an average 500 bed general hospital or £1.2 billion per year nationally.

For more information please see *Bridging the gap: The financial case for a reasonable rebalancing of health and care resources* published in partnership with the Royal College of Psychiatrists

Access to services

Appropriate waiting times must be established so that people with mental health problems know the maximum waiting time for a treatment just as people with physical health problems know the longest they can expect to wait for treatments. The NHS constitution has no requirements on waiting times for people with mental health problems.

Parity of treatments

Many psychological therapies are NICE approved and recommended in NICE clinical guidelines however the NHS Constitution does not entitle people to them in the same way one we are entitled to drugs that are approved by NICE Technology Appraisals. This means that commissioners are not obliged to commission psychological therapies.

Liaison psychiatry

We welcomed the June 2013 comprehensive spending review commitment that every A&E department has constant access to mental health professionals to ensure that people with mental health problems get the best possible care. We would like to see a comprehensive liaison psychiatry service in every hospital. Liaison psychiatry services have developed in an ad hoc fashion, resulting in a postcode lottery.

Comprehensive liaison psychiatry services have a key role to play in addressing the current A&E crisis, by reducing readmission rates. For example, a liaison psychiatry service working closely with an A&E department in Hull has successfully reduced the number of patients with mental health problems who frequently re-attended A&E by 60%.

Medically unexplained symptoms cost the NHS some £3 billion per year. Community liaison psychiatry services should be targeting people with medically unexplained symptoms.

Mental health – the biggest inequality

People experiencing severe and enduring mental illness die on average 15-20 years younger than those who do not. This premature mortality must be as a priority. The majority of people with schizophrenia do not receive the physical health care checks that they should even though, for example, much of the antipsychotic medication that they are on contributes to weight gain and 70% of people with schizophrenia smoke. If we are to realise parity of esteem it will become the norm for people with severe mental illnesses to get regular physical health checks and for people with chronic physical health care problems to get regular mental health checks.

Crisis care

Liaison and Diversion

The Bradley Report recommended that there should be a national roll out of liaison and diversion services to identify mental health problems among people who are arrested and taken to police custody. The government has committed to implementing this recommendation. It is vital that these services are made available in all police stations for both children and adults.

Crisis resolution and home treatment teams (CRHT)

Crisis resolution and home treatment teams were established following the NHS Plan in 2000 to offer care to people with severe mental illness in a crisis. These teams can be very effective. They can prevent a person who is experiencing a crisis from going into hospital and if the person has to be admitted into hospital they can facilitate discharge back home. 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.

Street Triage

Street triage is new initiative in which a mental health nurse accompanies police officers responding to calls about someone experiencing a crisis. They are currently being rolled out in nine areas and it will be important for these to be evaluated fully before being extended nationally. It will also be important for street triage to work alongside rather than replace liaison and diversion services and crisis resolution teams.

Collaborative care

Integrating mental health support with primary care and chronic disease management could lead to improved care for large numbers of people with long term conditions. Clinical commissioning groups should seek to integrate mental and physical health care and payment mechanisms need to be redesigned to remove barriers to integration.

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Recommendations

The Secretary of State should give a clear mandate to the NHS to bridge the resource gap between mental and physical health care, especially (but by no means exclusively) for those with long-term conditions and co-morbid mental health problems, with medically unexplained symptoms and with dementia.

NHS England should continue to work towards making parity of esteem for mental health a reality, for example by identifying opportunities to use resources differently to improve mental health support for people currently using physical health services, especially those with long-term conditions and those with or at risk of dementia.

Clinical Commissioning Groups should ensure that they are fulfilling their duty under the Health and Social Care Act 2012 to reduce health inequalities. Steps towards this will include commissioning high quality liaison psychiatry services in all their local hospitals and meeting NICE quality standards for the early diagnosis and effective treatment of dementia.

Health and wellbeing boards should consider how their membership reflects their local community and ensure parity of esteem between physical and mental health, by designating a mental health champion or by bringing in mental health expertise when required, for example from local service providers or community organisations. Boards should ensure that their Joint Strategic Needs Assessments examine the mental health needs of their communities and how far these are currently being met. And Joint Health and Wellbeing Strategies should seek to fill any gaps in provision.

Local Authority Mental Health Challenge supports and encourages local authorities to take a proactive approach to mental health. We are asking all upper tier local authorities to take up The Mental Health Challenge and nominate a member 'champion' and in return we will offer those champions support and information to help them in this important and exciting new role. There are also ten recommended actions that will enable councils to promote mental health across all of their business.
For more information see: ***www.mentalhealthchallenge.org.uk***

The Local Authority Mental Health Challenge is in partnership with Mental Health Foundation, Mind, Rethink Mental Illness, Royal College of Psychiatrists and YoungMinds.

Further reading

Available from www.centreformentalhealth.org.uk

- *Liaison Psychiatry in the modern NHS* (Centre for Mental Health)
- *Bridging the Gap (*Centre for Mental Health and The Royal College of Psychiatrists)
- *Long-term conditions and mental health: The cost of co-morbidities (*Centre for Mental Health and the King's Fund)

Available from other organisations:

- *Whole Person care: from rhetoric to reality (*The Royal College of Psychiatrists)
- *A criminal use of police cells? The use of police custody as a place of safety for people with mental health needs* (Her Majesty's Inspectorate of Constabulary, Inspectorate of Wales and Her Majesty's Inspectorate of Prisons)

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