



Parity of Esteem for Mental Health



Achieving parity of esteem between mental and physical health in care standards and public attitudes has been attempted for decades. This note outlines the history of these efforts, the various ways in which parity is defined and measured, the challenges of achieving this ideal and the strategies that may be employed to that end.

Defining Parity of Esteem

The Royal College of Psychiatrists (RCPsych) has proposed one of the simplest and most influential definitions of 'parity of esteem': "Valuing mental health equally with physical health".¹ 'The term itself is not well-recognised outside of the UK. Within the UK it is not universally thought useful (see Box 1) and provokes a wide spectrum of reactions. At one end of the spectrum are those who believe that mental and physical health are different in kind and that mental health has a much larger 'social' component than physical health. At the other end are those who argue that mental health problems are brain diseases. This note focuses principally on the *health* aspects of mental disorder, with only limited attention to the wider social means for combating and preventing mental problems (such as employment, housing, and peer support).

Historical Background

At the inauguration of the NHS in 1948, both mental and physical healthcare were included in the comprehensive service. Treatment for mental disorders was principally based in the remote Victorian-era asylums, and there were restrictions on treating mental problems in general hospitals. The 1959 Mental Health Act removed all these restrictions, while the Royal Commission that preceded the Act claimed in 1957 that "most people are coming to regard mental

Overview

- The relative esteem of mental and physical health can be measured in various ways.
- Stigma and discrimination are important barriers to parity.
- The relationship between mental and physical health is complex, and some question the validity of the distinction.
- Mental illness can make it more likely that patients' physical health problems are missed by health professionals.
- Healthcare is sometimes administered in ways that are considered barriers to parity.
- Key issues for addressing parity of esteem are education, tackling legal and funding barriers and liaison between specialists to achieve 'whole person' care (which includes both mental and physical health).

Box 1. A Vague, Arbitrary, Unnecessary or Impossible Concept?

Opinions about the usefulness of the term parity of esteem vary widely among health professionals. They include those who:

- consider it an unhelpfully loose and vague concept, which functions as a 'catch-all' aspiration without defining a clear course of action
- consider that it does not allow for mental health to be more important than physical health and argue that mental health should be funded and administered according to the level of disorder, rather than through comparison with physical health
- think that the problem is better discussed using existing concepts such as 'discrimination' and 'social justice'
- see mental and physical health approaches as so different that parity is impossible without radical change to mental health law.

Despite debate about the term 'parity of esteem', there is a high level of consensus that mental healthcare services have been historically underfunded in comparison with physical healthcare services.

illness and disability in much the same way as physical illness and disability". Efforts to achieve parity of esteem have been ongoing since this time.

Recent History

Use of the term 'parity' in mental and physical healthcare started in 21st century North America, with attempts to achieve equality in health insurance coverage between medical and surgical procedures on the one hand and mental health and substance abuse problems on the other. This was expressed by the shorthand 'parity'. The US

government legislated in 2006 (in the area of health insurance) for parity between mental and physical health.

The term gained a reference to 'esteem' in UK debates, and was included in the Government's 2011 mental health strategy document *No Health Without Mental Health*, which made it clear that "we expect parity of esteem between mental and physical health services".² The first clause in the Health and Social Care Act (2012) was altered during the Report Stage in the House of Lords to include explicit reference to mental health.³ This led to a commitment in the NHS constitution that states that the NHS is "designed to diagnose, treat and improve both physical and mental health".⁴ Concomitantly, the NHS Mandate for 2014/15 states unambiguously "NHS England's objective is to put mental health on a par with physical health".⁵

Measuring the Parity Gap

There is no universally accepted method for measuring parity, but there are three common concepts in this area: 'Excess mortality', which largely focuses upon severe mental illnesses (SMI which covers schizophrenia, bipolar affective disorder, and other psychoses), and the 'burden of disease' and 'treatment gap' (which cover both SMI and common mental disorders, CMD).

Excess Mortality

It has been known since the 1930s that being diagnosed with mental illness has an adverse effect on life expectancy ('excess mortality').⁶ Definitions of and diagnostic criteria for mental illnesses have changed over time, complicating historical comparisons. Those with mental illness diagnoses die an estimated 15-25 years earlier on average.¹ Diagnosis of mental illness (in general) is associated with an estimated eleven-fold increase in suicide risk, compared to the general population.⁷ However, the bulk of increased mortality in people diagnosed with SMI is largely attributed to preventable *physical* health problems such as cardiovascular disease, obesity and diabetes.⁸ These physical illnesses may be related to factors such as mentally ill people being more likely to smoke than the general population,⁹ and rapid weight gain being one of many possible side-effects of anti-psychotic medication.

Researchers suggest that tackling preventable physical illnesses is one way of moving towards parity. This might include offering interventions for obesity or smoking cessation to the mentally ill at the same rate as the general population. However, it is unclear how far this excess mortality stems from being diagnosed with mental illness. For example, one US study shows that poverty, low social status and adverse health behaviours affect life expectancy, and often coincide with diagnoses of mental disorder.¹⁰

The Burden of Disease

Another way of measuring the parity gap is to measure the 'burden of disease'. Mental ill-health is established as the single largest cause of disability in the UK. Recent estimates put mental health at around a quarter of the disease burden and 13% of the NHS budget.¹¹ Some argue that parity might

be achieved by funding according to the 'burden of disease'. However, the situation is complex because mental health service users also use physical health services.¹²

The Treatment Gap

The 'treatment gap' is a term used to describe the difference between the number of people thought to have a particular condition, and those receiving treatment for it. According to the Adult Psychiatric Morbidity Survey of the general population in 2007, only 24% of those who reported recent symptoms consistent with a CMD received treatment. In contrast, 78% of people with heart disease, and 91% of those with high blood pressure did so.⁷ The reasons for this lack of parity are unclear, but it should be noted that *half* of the people thought to have a CMD according to the 2007 survey were recorded as having "a level of neurotic symptoms that was significant, but unlikely to warrant treatment".¹³ However, even amongst those with "symptoms of a severity likely to require treatment", only 32% were in receipt of any treatment.¹³ It is not known how many people desired treatment for their symptoms.

General Barriers to Parity

Some of the barriers to achieving parity recur across the NHS because they stem from general attitudes towards mental illness or the laws pertaining to it. These are discussed in this section. Others are specific to various parts of the NHS and are discussed in the following section.

Stigma of Mental Illness

A key obstacle to parity is the stigma associated with mental illness.¹ The Oxford English Dictionary defines stigma as "a mark of disgrace or infamy". It covers problems of knowledge (ignorance), attitudes (prejudice) and behaviour (discrimination) and has been a focus of social science and mental health research for over 50 years. The stigma attached to mental illnesses was traditionally thought to be lessened by emphasising that they are biologically-based illnesses, rather than degenerative, moral or social inadequacies.¹⁴ There is broad consensus among social scientists and psychologists that while this illness model lessens ideas of *responsibility* for the condition, it does not decrease the desire for social distance that members of the public feel towards those considered to be mentally ill (due to stereotypes of unpredictability or violence attached to SMI).¹⁵ In fact, the model may increase this desire for distance. A more effective approach might include encouraging *contact* between those who may harbour stigmatising attitudes, and people diagnosed as mentally ill (when not in crisis). Evidence from small-scale studies suggests face-to-face contact is especially effective.¹⁶

Diagnosis

Research suggests that patients with SMI have the highest mortality rate for cardiovascular disease, but the lowest chance of receiving specialised interventions.⁷ These patterns of less access to effective physical healthcare have been described as a form of structural discrimination.¹⁷ This is compounded by 'diagnostic overshadowing', where the symptoms of physical ill health are mistakenly attributed to a

mental health problem, or vice versa.⁷ Mental illnesses are more likely to be undiagnosed than physical conditions, so overshadowing tends to work against parity of esteem.¹⁷ To combat this, a new incentive – Commissioning for Quality and Innovation (CQIN) – was introduced in 2014 for mental health providers carrying out checks and interventions on the physical health of mental health inpatients.

Legal Barriers to Parity

Two main types of law affect people with mental illness diagnoses: mental health law and mental capacity law.

Mental health law

People considered to have a mental disorder can be subject to the provisions of the Mental Health Acts of 1983 and 2007. These are based on the presence or absence of a mental disorder. They allow practices that are illegal in other medical contexts. For example, people can be detained, restrained and compulsorily treated without having broken any law (largely on the basis of risk assessments). This may reinforce different attitudes to mental and physical health and make it impossible to achieve parity.¹⁸

Mental capacity law

In contrast to mental health law, mental capacity legislation makes no distinction between mental or physical illness (or no illness at all). The Mental Capacity Act 2007 defines a number of situations in which decisions (including medical and clinical ones) can be taken on a person's behalf. Capacity law is situation- and time-specific so a person may only be said to be lacking capacity in a certain situation for a certain time. This also allows for partial capacity. Currently, mental health legislation trumps capacity legislation. Thus a person can be treated against their stated wishes, even if they are deemed to have sufficient capacity to refuse. Some argue that a healthcare system based upon universally applicable assessments of mental capacity, rather than incorporating a discrete body of mental health law, would better enable parity.

NHS-specific Barriers to Parity

As well as these general barriers, there are other ways in which parity is discouraged or actively impeded in the NHS. UK countries negotiate/administer healthcare differently, so the following barriers are not universally applicable.

Funding Cuts

The national tariff is a set of prices hospitals can charge for providing various units of care. The public enquiry into the Mid Staffordshire NHS Foundation Trust (Francis Report) recommended measures to improve safety and patient care. To pay for these changes (in the context of larger 'efficiency savings') the acute healthcare tariff was reduced by 1.5% while the community care and mental healthcare tariff was cut by 1.8%. The difference in the size of the cuts was based on the idea that the safeguards recommended by the inquiry were only required in the acute sector. However, this has since been shown as not being the case, and the tariffs will be reviewed in 2015. Meanwhile, mental and community health trusts will incur disproportionate income shortfalls.

Different Rights to Treatments

The National Institute for Health and Care Excellence (NICE) produces standards that NHS therapies must meet. Patients do not have a legal right to treatments under NICE Clinical Guidelines, but they do when treatments have undergone a NICE Technology Appraisal (and are clinically appropriate). A greater proportion of mental compared to physical therapies are assessed through Clinical Guidelines, not Technology Appraisals. This is because talking therapies such as cognitive-behavioural therapy (recommended by NICE for many mental health problems) count as a clinical interventions, not technologies. Because Clinical Guidelines are less available to service users, and there is not the same legal imperative for mental health service providers to make them available this promotes disparity in practice.¹ The RCPsych recommends that Clinical Guidelines and Technology Appraisals should both carry equal weight under the NHS Constitution.¹

Healthcare Incentives and Payments

The Quality and Outcomes Framework (QOF) is a way of paying primary care physicians across the UK for providing certain types of care. It is a series of financial incentives within the General Medical Services Contract (GP Contract) for GPs to provide services, perform checks and gather data. It has recently been reviewed, and in England, 40 indicators were removed, reducing the QOF by 38%.

Monitoring blood glucose, cholesterol and body-mass index for SMI patients is no longer financially incentivised. This is despite recommendations from NICE that these checks be retained to aid diagnosis of the physical health of people with SMI (a key parity concern, noted above). NHS Employers and the BMA – which negotiated the changes – insist that there is no expectation that GPs will stop providing physical health reviews for SMI patients.⁷ They argue that the QOF needed reduction to allow GPs to exercise more clinical judgement, and reduce micro-managing and box-ticking, and point out that the overall level of GP funding is not changing.⁷ There is debate about whether care quality will fall as a result (see Box 2).

Waiting Times and Access Standards

Most treatments in the NHS must be delivered within 18 weeks of referral. Until recently "non-medical consultant-led mental health services (such as art therapy or dietetics)" were exempt. This affects parity, as performance-based sanctions are applied in physical health, but not in some mental health areas. In October 2014 the Government announced new standards. From April 2015:

- 75% of patients referred to talking therapies will receive treatment within six weeks and all within 18 weeks
- those receiving a diagnosis of psychosis for the first time will be treated within two weeks.

Achieving Parity

Several recent reports have focused on the education of health professionals (including doctors, psychologists, nurses and others) and provision of funding, as well as

Box 2. Physical health check incentives and care quality

Two US studies have shown decreases in care quality when health-care incentives were removed, sometimes to below pre-incentive levels.^{19 20} No UK-based studies have yet shown that clear harm results from the removal of incentives. However a study of GPs' opinions found that removal of indicators (in general) would lead to those areas being ignored. Such indicators are normally retired when they have become part of routine practice. However, only 29% of SMI patients received a full check in the previous year with the incentive in place, so standards may fall in practice.²¹ A study of earlier QOF changes shows that standards have remained stable after the removal of certain incentives. However, all indicators in that study remained indirectly incentivized by other QOF measures. SMI physical health incentives will not be monitored post incentive removal.

highlighting the above barriers to parity. These include the RCPsych's *Whole-person care*¹, the RCPsych's and the Centre for Mental Health's *Bridging the Gap* (October 2013), the Department of Health's *Closing the Gap* (February 2014) and the BMA's Science Board's *Parity in Outcomes*⁷. The reports outlined a number of ways (in theory and in practice) in which parity might be attempted. All stress the importance of 'joined-up' care alongside a number of specific interventions.

Educating Medical Professionals

One way to create conditions for parity is to provide further education for healthcare and other professionals in the area of mental health. The RCPsych supports an extra year of training in general practice, to encourage more teaching about child mental health and development and the relationship between mental and physical health.¹ Other reports focus on undergraduate medical education, emphasising a need for more holistic and varied training. For example, Health Education England's *Broadening the Foundation* report mandates that by 2017, all doctors do a community healthcare placement (including psychiatry).

Educating Healthcare Commissioners

The commissioning process is also considered vital for parity.²² All GP practices are now members of one of 221 clinical commissioning groups (CCGs) which spend 60% of the NHS budget. NHS England has produced guidance on commissioning for parity of esteem,²³ and there is additional guidance from the Joint Commissioning Panel for Mental Health and the Mental Health Intelligence Network. The Centre for Mental Health recommends that local authorities designate a mental health 'champion', who will be offered support and information to enhance advocacy of mental health issues in commissioning negotiations.²⁴ Health and Wellbeing Boards offer support to commissioners by providing a forum for integration of local authority provision.

Liaison Specialists

Parity of esteem can be attempted through liaison services – professionals who liaise across the mental/physical medicine boundary (see Box 3). This involves psychiatrists advising in physical health settings, and physical health specialists in mental health environments, to lessen the separateness of the approaches.¹ It has also been reported

Box 3. Rapid Assessment Interface Discharge (RAID)

The RAID liaison team in Birmingham offers mental health support to all people (aged over 16) within a hospital at all times. The Centre for Mental Health estimated that cost savings are in the range of £3.4-£9.5 million a year, mostly from reduced bed use among older adults. Extrapolating from this, it is estimated that similar models could annually save the NHS up to £1.2 billion.

that liaison psychiatrists have an educational function, helping to foster more positive attitudes towards mental illness, and are vital for crisis care in A&E Departments.²⁵ There is evidence that nurse-led psychiatric liaison services improve care for older adults.

Funding for parity

It is argued that mental health is underfunded relative to its impact. There is also a disparity in research spending on mental health. One review of UK health research funding showed that mental health research received 6.5% of total funding, compared with 25% for cancer, and 9% for cardiovascular conditions.¹ There is evidence that investment in certain areas of mental health eventually saves more money than it costs, especially for peer support programmes, early intervention in psychosis and smoking cessation. Rethink Mental Illness estimates that over 10 years £15 of costs are avoided for every £1 spent.¹²

Lack of Crisis Care

Health services, social services and the police sometimes need to cooperate when mental health crises occur. A review of the use of police cells as temporary 'places of safety' found that in some areas cells were used routinely for this purpose. This goes against advice in the Mental Health Act (1983) Code of Practice, which recommends exceptional use only. A Crisis Care Concordat, signed by health, policing, service user and social care groups, argued that it was necessary for people experiencing mental health crisis to get "as responsive an emergency service as people needing emergency care for physical health conditions."²⁵

Endnotes

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