

Why 'parity of esteem' for mental health is every hospital doctor's concern

Mental health is every doctor's business and society's business. This article illustrates current gaps which reflect the poor status of mental health within medicine, and efforts to address these by delivering 'parity of esteem' for mental health. It suggests ways in which hospital doctors can play a part in achieving parity.

Mental health is every doctor's business. Comorbid mental health conditions exacerbate long-term physical health conditions to the tune of at least £8 billion in additional costs to the English NHS every year (Naylor et al, 2012), and mental health has a significant impact on many areas of physical medicine:

- One fifth of patients with breast cancer will develop depression in the first year after their diagnosis (Kangas et al, 2005). Much of this will go untreated, and will exacerbate functional impairment and be deleterious for treatment adherence (Fann et al, 2008)
- The linkage of Hospital Episode Statistics and the Mental Health Minimum Dataset showed that 41.2% of people over the age of 18 years using secondary care mental health services in 2011/12 visited accident and emergency at least once, compared to 19.7% of the general population – over double the rate (Health and Social Care Information Centre, 2013)
- 42% of all of the tobacco in England is smoked by people with mental illness, yet despite the disproportionate harm that this causes they are less likely to be offered smoking cessation interventions than the general public (McManus et al, 2010; Szatkowski and McNeill, 2013).

Mental health is also society's business. In England, almost one in four adults and one in ten children are experiencing a diagnosable mental health problem at any given time (McManus et al, 2009). Analysis of data collected in the 2010 World Health Organization Global Burden of Disease study shows that mental health and substance misuse disorders account for the second highest proportion of 'years lost to disability' in the UK – 21.5% of the total. The same analysis looked at changes in disease burden over the 20 years between 1990 and 2010 and found that although the burden of disease in terms of disability-adjusted life years represented by, for example, cardiovascular disease had fallen by 39%, almost every mental health condition had increased its burden of disease in absolute terms (Murray et al, 2013). This represents a wealth of suffering; when the World Health Organization conducted international paired comparison surveys to 'rank' 289 conditions in terms of their severity, acute schizophrenia was judged to be the most severe, with a higher score than for even severe multiple sclerosis or quadriplegia (Salomon et al, 2012).

The mental health 'gaps'

Despite this, mental health has historically been both a distant and poor relation to physical health. This can be illustrated by the 'gaps' that exist:

The mortality gap

The life expectancy of those with severe mental illness is on average 20 years less for men and 15 years less for women than for the population as a whole (Wahlbeck et al, 2011). It is also becoming increasingly clear that common mental health problems such as anxiety and depression cause significant premature mortality (Mykletun et al, 2009; Russ et al, 2012).

The treatment gap

Only a minority of people with mental health problems in England – with the exception of those with psychosis – receive any intervention for their problem. This is true across the life course, for children and young people, working-age adults and older people. Only 24% of people with a common mental disorder (which will affect roughly one in ten people) receive treatment (McManus et al, 2009). This can be compared with data on treated prevalence in comparable high-income countries for physical health conditions which show the treatment rate for heart disease is 78%, and 91% for high blood pressure (Ormel et al, 2008).

The funding gap

Astonishingly, although mental health accounted for 21.5% of UK years lost to disability in 2010 (Murray et al, 2013) it received approximately 11.1% of the NHS budget in 2010/11 (Department of Health, 2012). This can be compared to diabetes, which accounted for 1.44% of years lost to disability in 2010 (Institute for Health Metrics and Evaluation, 2013) and received 1.5% of the

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English NHS budget (Department of Health, 2012) – virtually a 1:1 ratio. Mental illness costs the wider English economy roughly £105 billion pounds a year (Centre for Mental Health, 2010), compared to £15.8 billion for obesity (Government Office for Science, 2007) and £30.7 billion for cardiovascular disease (British Heart Foundation, 2010). Research has also revealed that despite NHS total spending being ring-fenced by the coalition government, spending on mental health services has fallen by 2% in real terms in the last 2 years (Buchanan, 2013).

The stigma gap

Stigma and discrimination significantly contribute to the treatment gap (Thornicroft, 2008). Among people with a diagnosis of depression, 8 out of 10 report discrimination in at least one area of their lives (Lasalvia et al, 2013). This is not limited to the public, but is a fundamental problem for mental health services too; analysis of the Time To Change anti-stigma campaign has demonstrated that the attitudes of mental health professionals have in fact shown the least improvement (Henderson et al, 2012).

Unfortunately, there is often also a ‘belief gap’ on the part of fellow doctors (including psychiatrists) or policy colleagues when the above facts, figures and failings are quoted.

Parity of esteem: what is it?

In England, important progress is being made.

The term ‘parity of esteem’ has its roots in political discourse, but was co-opted into the topic of mental health via the Mental Health Parity and Addiction Equity Act of 2008 in the USA, and closer to home by the assertion in the coalition government’s 2011 mental health strategy that it ‘expects parity of esteem between mental and physical health services’ (Department of Health, 2012). The Health and Social Care Act 2012 explicitly recognized the Secretary of State’s duties in relation to both physical and mental health, with the relevant amendment becoming synonymous with the principle of parity. This progress is welcome, but there is a long road ahead.

In 2012, the then Care Services Minister (Paul Burstow MP) commissioned the Royal College of Psychiatrists to outline how parity can be achieved in practice. A working group was convened with a wide membership from medical Royal colleges, national clinical leaders, mental health charities, social care, service users and carers, and individual experts who advised on particular aspects of policy and research.

The following definition of parity has been used in the American literature:

‘The overarching principle of the parity movement is equality – in access to care, in improving the quality of care, and in the way resources are allocated.... If we stay true to the principle of

treating each person with dignity and respect in our health care system, then we should make no distinction between illnesses of the brain and illnesses of other body systems.’ (Fritz and Kennedy, 2012).

In essence, ‘parity of esteem’ is thus best described as: ‘valuing mental health equally with physical health’.

The working group produced a report, *Whole Person Care: From Rhetoric to Reality*, which built on the American definition and agreed that parity of esteem means that, when compared with physical health care, mental health care is characterized by:

- Equal access to the most effective and safest care and treatment
- Equal efforts to improve the quality of care
- The allocation of time, effort and resources on a basis commensurate with need
- Equal status within health-care education and practice
- Equally high aspirations for service users
- Equal status in the measurement of health outcomes (Royal College of Psychiatrists, 2013).

Four things that hospital doctors can do to help achieve parity of esteem

Watch out for ‘diagnostic overshadowing’

There is robust evidence that people with mental health problems do not always get the same level of investigations or treatment for physical health complaints as people without them. For example, people with diabetes who present to accident and emergency departments are less likely to be admitted to hospital for diabetic complications if they have a mental illness (Sullivan, 2006). Similarly, another study found that people with ischaemic heart disease who required hospitalization were less likely to have a revascularization procedure if they also had a mental illness (Lawrence et al, 2003). There is no suggestion that this is the result of malice, rather that physical symptoms are sometimes being misunderstood as manifestations of the mental health condition.

Give feedback to mental health colleagues

Psychiatrists must share some of the blame for the poor physical health of many of their patients. In the first year after being prescribed an antipsychotic, patients can put on anything from half a stone to over 2 stones in weight (depending on medication selection) (Kahn et al, 2008) and their general cardiovascular risk will unsurprisingly significantly increase (Foley and Morley, 2011). However, in a review of studies of patients taking antipsychotics, cholesterol was measured in only 47% of patients, glucose in 42% and weight in 44%. Lipids and haemoglobin A_{1c} (HbA_{1c}) were monitored in less than 20% (Mitchell et al, 2012). One UK study is particularly striking: out of 606 inpatients taking antipsychotics, only 19% had weight recorded in their clinical notes and 3.5% had their lipids monitored during

their admission (Paton et al, 2004). Even following the introduction of national guidelines, a quarter of patients on antipsychotics are not receiving the physical checks that they should (Mitchell et al, 2012). So if a doctor comes across a patient who is, for example, on antipsychotic medication but does not seem to have his/her physical health being managed then this should be taken up with his/her psychiatrist.

Challenge stigma

Liaison psychiatrists work side by side with other doctors in general hospitals and are well placed to gauge attitudes towards mental health. A survey of the former found that 72% of respondents had experienced stigmatising attitudes or behaviours from physical health colleagues at least once a month, with two-thirds saying that this had been detrimental to patient care. Examples ranged from the use of inappropriate language ('nutter' or 'fruitcake') to discharging people prematurely or arbitrarily deeming their care to be a low priority (Bolton, 2012). Mental health care has a considerable way to go itself when it comes to stigma and discrimination, so doctors should work in partnership to challenge outdated attitudes – wherever they find them.

Speak up for mental health services both within and outside the hospital

It is a common false economy to prioritize physical health services to the detriment of mental health services. In fact, better resourced mental health services can bring savings to the wider NHS and improve physical health outcomes. A well-run Early Intervention in Psychosis service can result in savings to the wider NHS of £15 862 per patient over a 3-year period (Andrews et al, 2012), a liaison team based on the Birmingham RAID model could save the average 500-bed general hospital £5 million every year (Parsonage et al, 2012), treating depression (when present) following myocardial infarction improves survival rates (Zuidersma et al, 2013) and psychological interventions can subsequently result in reduced usage of accident and emergency departments (de Lusignan et al, 2012).

Potential savings are not confined to the health system either, meaning it makes sense to speak up for mental health promotion in other contexts. For example, early diagnosis and treatment of depression at work results in

total returns of £5.03 for every £1 invested, with net savings starting by year 1, and the prevention of conduct disorder through school-based social and emotional learning programmes result in total returns of £83.73 for every £1 invested (Knapp et al, 2011).

What is the Royal College of Psychiatrists doing?

As the College President and a member of the Policy Unit, the authors can confirm that the Royal College of Psychiatrists has already disseminated the Lester UK Positive Cardiometabolic Health Resource (Lester et al, 2012) to its entire membership. They are hopeful that this plus the CPD Online modules that have been produced about the physical health of patients (Arora and Phelan, 2011; Garden, 2012) will lay the foundation for improvement on the part of the college. Looking to the longer term, the College is exploring how the MRCPsych exam can reinforce the importance of (and psychiatrists' responsibility for) high quality physical health care. The College is also looking in detail at how smoking cessation can become the norm in mental health care, in order to reduce the disproportionate mortality that stems from this cause.

Conclusions

Doctors come into medicine to make people's lives better. Gradually, the Cartesian view of the separate components of body and mind is being replaced with that of the 'whole person' whose mental and physical health are co-dependent.

Persistent under-investment in mental health services, combined with public and professional stigma, have created wide treatment and mortality gaps plus a 'bottle-neck' in health-care improvement, constrained physical health outcomes and impaired broader economic performance. The current accident and emergency crisis is just one example of the cost of the disparity between physical and mental health care (Foley, 2013). Yet the moral (let alone economic) case is overwhelming: patients should have their doctors working together as a community to improve both physical and mental outcomes. Working together to achieve parity of esteem for mental health is at the heart of this. [BJHM](#)

Conflict of interest: none.

KEY POINTS

- Mental health is both every doctor's business and society's business.
- Current 'gaps' reflect the poor status of mental health within medicine.
- Hospital doctors can play a part in achieving parity of esteem by watching out for diagnostic overshadowing, giving feedback to mental health colleagues, challenging stigma and speaking up for mental health services both within and outside the hospital.

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