
Making parity a reality

Six asks for the next government to improve the nation's mental health

MANIFESTO

About the Royal College of Psychiatrists

The Royal College of Psychiatrists is the professional medical body responsible for supporting psychiatrists throughout their careers, from training through to retirement, and in setting and raising standards of psychiatry in the UK. The College aims to improve the outcomes of people with mental illness and the mental health of individuals, their families and communities. To achieve this, the College sets standards and promotes excellence in psychiatry; leads, represents and supports psychiatrists; improves the scientific understanding of mental illness; and works with and advocates for patients, carers and their organisations. Nationally and internationally, the College has a vital role in representing the expertise of the psychiatric profession to governments and other agencies.

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Summary

One in four people experience a mental health problem in any given year (McManus *et al*, 2009), at an annual cost of £105 billion to the English economy alone (Centre for Mental Health, 2010). However, treatment for people with mental health problems has long been underfunded and undervalued, and too often the stigma and discrimination they experience prevents them from seeking help.

Fortunately, this is beginning to change, and we welcome the commitments made by all three political parties on the need to achieve parity for mental health. However, to make parity a reality, these commitments need to be sustained, and delivered. The millions of people of all ages who do and will experience mental health problems deserve to be given the timely, appropriate care and support they need.

We are therefore calling on the next government to ensure that:

- 1 Everyone who requires a mental health bed should be able to access one in their local NHS trust area, unless they need specialist care and treatment. If specialist care is required, then this should be provided within a reasonable distance of where the patient lives.
- 2 No one should wait longer than 18 weeks to receive treatment for a mental health problem if the treatment has been recommended by NICE guidelines and the patient's doctor.
- 3 Everyone who is experiencing a mental health crisis, including children and young people, should have safe and speedy access to quality care, 24 hours a day, 7 days a week. The use of police cells as 'places of safety' for children should be eliminated by 2016, and by the end of the next parliament occur only in exceptional circumstances for adults.
- 4 Every acute hospital should have a liaison psychiatry service which is available 7 days a week for at least 12 hours per day. This service should be available to patients across all ages. Emergency referrals should be seen within 1 hour and urgent referrals within 5 working hours.
- 5 A minimum price for alcohol of 50p per unit should be introduced. This will reduce the physical, psychological and social harm associated with problem drinking, and will only have a negligible impact on those who drink in moderation.
- 6 There should be national investment in evidence-based parenting programmes to improve the life chances of children and the well-being of families.

Ask 1: Tackle the mental health beds crisis

Everyone who requires a mental health bed should be able to access one in their local NHS trust area, unless they need specialist care and treatment.¹ If specialist care is required, then this should be provided within a reasonable distance of where the patient lives.

Why is this needed?

A critical shortage of mental health beds is having a damaging impact on patient care

As with physical healthcare, some people have mental health needs which cannot be met in the community and therefore need hospital care.

Between 1998 and 2012, there has been a 39% decrease in the number of mental health beds available in England (Green & Griffiths, 2014). As a result, the number of mental health patients forced to seek emergency treatment outside their local area has doubled in the past 3 years alone. In 2013/2014, more than 3000 people had to be sent out of their local area for treatment, up from 1300 in 2011/2012 (Buchanan, 2014).

Patients are now being sent as far away as 300 miles from home (e.g. Devon to Yorkshire) for non-specialist care which should be available in the area covered by their local mental health trust.

A shortage of beds has also led to patients being sent home in the absence of a bed or having to be detained under the Mental Health Act 1983 in order to secure one. Over a quarter (28%) of respondents to a survey of trainee psychiatrists (Royal College of Psychiatrists, 2014) said they had been forced to send a critically unwell patient home because no bed could be found, and 24% reported that a

¹ Non-specialist care are those services which are commissioned by clinical commissioning groups. Specialist services are commissioned by NHS England; a list can be found here: <http://www.england.nhs.uk/ourwork/commissioning/spec-services/npc-crg/group-c/>

bed manager had told them that unless their patient was detained under the Mental Health Act, they would not get a bed. In practice, the inadequate number of beds means that only those most seriously unwell are prioritised and treated, leaving many to travel unreasonable distances away from home to receive care, or in some cases not being appropriately treated at all.

This bed crisis is also having a significant impact on children with mental health problems. In the same survey, 37% of those trainee psychiatrists working in child and adolescent mental health services had sent a child at least 100 miles away from their local area, and 22% had been forced to send a child 200 miles away from their families to access in-patient care.

The fall in the numbers of mental health beds available has also led to a rise in bed occupancy rates. A Community Care/BBC News Freedom of Information request in 2013 found that a shortage of beds has led to adult psychiatric wards running at an average of 101% occupancy, rising to 138% in one case (achieved by 'hot-bedding'—using the beds of patients who are on leave for new admissions) (McNicoll, 2013). The Royal College of Psychiatrists' guidance states that 'optimal' bed occupancy on a psychiatric ward is 85% (Royal College of Psychiatrists, 2010).

How can the beds crisis be addressed?

Public Health England should conduct a review of all mental health services, both specialist and non-specialist, to assess how many services are required per 100 000 people and where they should be located. This review should be conducted on the basis that in-patient wards cannot, over a period of time, exceed an average figure of 85% occupancy. Moreover, eligibility for in-patient care should not be restricted, or artificially low discharge criteria introduced to move patients out of services before they are ready, to meet the 85% target.

This would mean that both clinical commissioning groups and commissioners of specialised services would have to ensure that there is adequate bed provision to meet the level of demand. The 85% figure would mean that fluctuations in demand could be safely managed, without resorting to patients being sent outside their local area for treatment. The *NHS Constitution* (National Health Service, 2013) should be amended to reflect this commitment.

Sufficient provision of in-patient beds should not, of course, be at the expense of investing in community mental health support.

During 2015–2016 the Royal College of Psychiatrists will be holding a Commission on Acute Adult Mental Health Services which will have a specific focus on the provision of in-patient beds. We hope its findings and recommendations will inform the policies of the next government.

Ask 2: Introduce maximum waiting times

No one should wait longer than 18 weeks to receive treatment for a mental health problem if the treatment has been recommended by NICE guidelines and the patient's doctor.

Why is this needed?

'Talking therapies' are currently excluded from the National Health Service (NHS) 18-week maximum waiting time

At present, the *NHS Constitution* (National Health Service, 2013) gives people the right to start treatment for most health problems within a maximum of 18 weeks from referral. However, it does not extend this right to patients receiving talking therapies.

The first barrier to patients receiving talking therapies within 18 weeks is the explicit exclusion of 'non-medical consultant-led mental health services' (i.e. the overwhelming majority of talking therapies) from the right to a maximum treatment waiting time in the *NHS Constitution* (National Health Service, 2013).

The second barrier is that the *NHS Constitution* only confers the right (if clinically appropriate) to receive drugs and treatments within a maximum of 18 weeks if they are recommended by National Institute for Health and Care Excellence (NICE) technology appraisals as opposed to those recommended by NICE clinical guidelines. This is a significant parity issue, as a far greater proportion of mental health treatments (predominantly, talking therapies) than physical health treatments will undergo the clinical guideline assessment process rather than the technology appraisal process.

Clinical guidelines are the gold standard for evidence-based care. However, despite this more robust evidence base, these approved interventions are in practice less available to patients, as there is

not the same legal imperative for mental health service providers to make them available. For example, guidelines recommend talking therapies as a first-stage treatment for mild depression and explicitly discourage the use of antidepressants. It is therefore not equitable that a recommended, effective treatment such as group cognitive-behavioural therapy (CBT) does not have to be provided within the same reasonable time frame as the majority of treatments for physical complaints simply because it has been through a clinical guideline assessment rather than a technology appraisal.

What should be done to address this?

The *NHS Constitution* should be amended to introduce maximum waiting times (which are comparable with equivalent physical health waiting times) across all mental health services. This would ensure that all patients are able to access appropriate evidence-based mental health treatment in a timely manner.

The Secretary of State should use their powers under the Health and Social Care Act 2012 to give individuals the right to receive treatments (if advised by their doctor) recommended by NICE clinical guidelines.

Ask 3: Improve crisis care

Everyone who is experiencing a mental health crisis, including children and young people, should have safe and speedy access to quality care, 24 hours a day, 7 days a week. The use of police cells as ‘places of safety’ for children should be eliminated by 2016, and by the end of the next parliament occur only in exceptional circumstances for adults.

Why is this needed?

There is a huge variation in the quality and availability of emergency care for people experiencing a mental health crisis

Whereas patients with a physical health crisis such as chest pain will usually be rapidly assessed and receive appropriate treatment, patients experiencing a mental health crisis will not. Instead, even those people who are suicidal or experiencing a psychotic episode may have to wait for an unjustifiably long period of time, which can worsen their chances of recovery. And even then, they will frequently end up receiving inadequate assessment and treatment, often leaving families to provide care for long periods of time.

Research conducted by Mind (Mind, 2011–2014) illustrates this situation, revealing that:

- **crisis care services are understaffed:** four in ten mental health trusts surveyed (41%) had staffing levels well below established benchmarks
- **people are not getting the help they need:** only 14% of people with experience of having a mental health crisis said that, overall, they felt they had all the support they needed when in crisis
- **people are not assessed quickly enough:** only a third of respondents who came into contact with National Health Service (NHS) services when in crisis were assessed within 4 hours (as recommended by NICE)
- **services are not available all the time:** one in ten crisis teams surveyed failed to operate 24-hour, 7-day-a-week services, despite NICE recommending they do this

- **people cannot contact crisis teams directly:** only half (56%) of crisis teams accepted self-referrals from known patients and just one in five (21%) from patients that are not already known to them; this is despite NICE guidance that crisis teams should offer self-referral as an alternative to emergency services
- **there is a lack of respect and dignity:** less than a third of those surveyed (29%) said they felt that all staff treated them with respect and dignity.

Police stations are routinely being used as a 'place of safety' for people experiencing a mental health crisis

Section 136 of the Mental Health Act 1983 allows the police to take someone they believe to be experiencing a mental health crisis (and who may cause harm to themselves or another) to a safe place where a mental health assessment can be carried out. However, recent research by the Care Quality Commission (2014) has found that in some areas police stations are being used routinely as a 'place of safety'. This is in clear breach of the Mental Health Act Code of Practice which says that police cells should be used only in exceptional circumstances (Department of Health, 2008).

- Overall, 36% of those detained under Section 136 still go to police custody: 7761 cases in 2012/2013 (Health and Social Care Information Centre, 2013)
- 263 children (45% of all children and young people detained under Section 136) were detained in police cells in 2012/2013. This is largely because 35% of the 161 health-based places of safety do not accept young people under the age of 16 (Care Quality Commission, 2014).

How can we ensure that safe and speedy crisis care is available?

The next government should maintain a firm commitment to implementing the current *Mental Health Crisis Care Concordat* (HM Government, 2014), an agreement signed by over 20 national organisations in a bid to drive up standards of crisis care. Critically, the *Concordat* requires NHS England to ensure that people experiencing a mental health crisis receive an emergency service response of equivalent speed and quality to that provided for individuals in crisis because of a physical health problem. One consequence of this is that clinical commissioning groups will need to commission a sufficient number and mix of crisis services at the scale to meet the needs of the local population. This will ensure that health-based places of safety and mental health beds are available 24 hours a day, 7 days

a week for people of any age, including children and young people. These services should be staffed in accordance with existing national guidelines and local communities should be meaningfully involved in their planning and review.

Children and young people detained under Section 136 often present with complex social, medical and mental health needs. NHS England, clinical commissioning groups and Social Services should develop new models of emergency care which would reflect this breadth of need. The College would like to see the use of police cells as 'places of safety' for children eliminated by 2016 and calls for them to be used only in the most exceptional circumstances for adults by the end of the next parliament.

Ask 4: Improve liaison psychiatry services

Every acute hospital should have a liaison psychiatry service which is available 7 days a week for at least 12 hours per day. This service should be available to patients across all ages. Emergency referrals should be seen within 1 hour and urgent referrals within 5 working hours.

Why is this needed?

Failing to deal with comorbidities between physical and mental health leads to poorer health outcomes and costs the NHS £10 billion per year

Nearly one in three people with a long-term physical health condition have at least one coexisting mental health problem, such as anxiety or depression. Mental health problems can exacerbate the person's physical illness, prolonging recovery and increasing the cost of treatment to the NHS by an estimated £10 billion per year (Royal College of Psychiatrists & Centre for Mental Health, 2013). Indeed, over 40% of older people in acute hospitals have dementia, depression or delirium and these conditions both impair rehabilitation and significantly lengthen hospital stay (Department of Health, 2012). Moreover, 'medically unexplained physical symptoms' that often mask underlying mental illness cost the NHS some £3 billion per year (Royal College of Psychiatrists & Centre for Mental Health, 2013).

Liaison psychiatry services (sometimes called psychological medicine) address the mental health needs of people who are under the care of acute physical health services such as general hospitals and, increasingly, community services. Although approximately 94% of hospitals currently have a liaison psychiatry service, only 45% of urgent referrals are seen within a day, with 15% of referrals waiting longer than 4 days (Royal College of Psychiatrists, 2013a). Survey evidence has also identified that only half of liaison psychiatry

services include support for children, while only one third offer specialist support outside working hours for older adults (Royal College of Psychiatrists, 2013a).

What can be done to address this?

The next government should ensure that all hospitals have high-quality liaison psychiatry services on hand 7 days a week for at least 12 hours each day. This would mean that liaison psychiatry services can attend emergency referrals within 1 hour and urgent referrals within 5 working hours across all patient age groups (Royal College of Psychiatrists, 2013b).

Liaison psychiatry services would also go a huge way towards addressing the current crisis in accident and emergency (A&E) services by reducing readmission rates. For example, a liaison psychiatry service working closely with an A&E department in Hull has reduced the number of patients with mental health problems who frequently re-attended A&E by as much as 60% (Royal College of Psychiatrists & Centre for Mental Health, 2013).

The presence of a liaison psychiatry service would also ensure that mental health difficulties experienced by children who attend hospitals with physical complaints would also be more readily identified. This would provide the opportunity for early detection of emotional disorders and the provision of evidence-based interventions for anxiety and depression. The long-term financial benefits of intervening early in life are significant for individuals, families, health services and the wider economy alike.

Through investing widely in liaison psychiatry services, savings of £5 million per year would be generated in an average 500-bed general hospital, or £1.2 billion per year nationally (Parsonage *et al*, 2012). The majority of these savings would accrue from reducing length of stay among older in-patients, who account for about 80% of all hospital bed-days occupied by people with comorbid physical and mental health problems (Parsonage *et al*, 2012).

There is also an emerging consensus that liaison psychiatry services need to expand their scope to include primary and community care services, particularly given the growing importance of chronic rather than acute physical illness.

Some hospital liaison psychiatry services already offer out-patient clinics to follow up patients in the community. However, many have not been funded to provide this service and patients often have to speak to their general practitioner (GP) and wait several weeks or even months to be seen by psychological therapy services.

We would therefore like to see liaison psychiatry services becoming more integrated into community health provision, working in collaboration with other providers including GPs, community nurses and the Improving Access to Psychological Therapies (IAPT) programme.

Ask 5: Introduce a minimum unit price for alcohol

A minimum price for alcohol of 50 p per unit should be introduced. This will reduce the physical, psychological and social harm associated with problem drinking, and will only have a negligible impact on those who drink in moderation.

Why is this needed?

Of all alcohol sold, very cheap alcohol products play the biggest part in driving alcohol-related harm

The cost of alcohol to consumers has more than halved in the past 30 years (Health and Social Care Information Centre, 2012), and consumption has unsurprisingly doubled as a result. It is cheaper alcohol, often with a high alcohol content, that tends to be purchased by problem drinkers – those who regularly exceed the recommended drinking doses.

Problem drinking has serious consequences. Alcohol misuse costs England alone approximately £21 billion per year in healthcare, crime and lost productivity (House of Commons Health Committee, 2012):

- in 2012 there were 6495 deaths in England directly related to alcohol (Office for National Statistics, 2011)
- there were 1.2 million alcohol-related hospital admissions in England in the year 2011/2012 (www.lape.org.uk)
- alcohol-related harm is estimated to cost the NHS in England £3.5 billion a year (Public Health England, 2013).

What would be the impact of minimum unit alcohol pricing?

The University of Sheffield (Sheffield Alcohol Research Group, 2013) has estimated that the introduction of a minimum unit price of 50p in England would lead to:

- 960 lives saved every year
- 35 100 fewer hospital admissions per year
- an annual saving of £600 million to the NHS.

Unlike tax increases – which, if passed on to the consumer, significantly affect all purchasers of alcohol – a minimum price has very little impact on moderate drinkers as it targets price increases at the strongest alcohol products that are sold at the cheapest prices, such as own-brand spirits, very-high-strength beers and cheap white cider.

Cheaper alcohol tends to be bought more by people who drink at a harmful level, in all income groups (Jackson *et al*, 2010). Evidence has shown that these drinkers respond to price changes, switching between products to drink the maximum quantity at the lowest possible price. Understanding this ‘trading down’ behaviour is essential in understanding the specific effects of minimum unit pricing.

Although the UK government has taken a step to tackle cheap alcohol through the introduction of a ban on below-cost selling (where alcohol is sold cheaper than the cost of the tax payable on the product), this affects very few products and the health benefits are likely to be limited. The University of Sheffield estimated the below-cost ban would prevent 15 deaths per year, compared with over 960 per year at the proposed 50p minimum unit price (Sheffield Alcohol Research Group, 2013).

Minimum unit pricing targets those who are causing the most harm both to themselves and to society. In 2009 it was estimated that those who drink in moderation would only spend 28p a week (or less than £1 a month) more as a result of this policy, while bringing significant health and social benefits (Purshouse *et al*, 2009). The substantial effect would be on the heaviest drinkers, many of whom do recognise the harm alcohol is causing and wish to change.

Ask 6: Invest in parenting programmes

There should be national investment in evidence-based parenting programmes to improve the life chances of children and the well-being of families.

Why is this needed?

A lack of early intervention support for children with mental illness leads to poor lifetime outcomes at a substantial cost to the taxpayer

Research shows that half of all lifetime cases of diagnosable mental illness, excluding dementia, begin by the age of 14 (Kim-Cohen *et al*, 2003). Focusing resources on tackling mental health problems in children will not only improve their lives but will also reduce demands on adult mental health services.

About 5% of children aged 5–10 show behavioural problems which are sufficiently severe, frequent and persistent to justify diagnosis as a mental health condition (conduct disorder); a further 15–20% have problems which fall below this threshold but are still serious enough to merit concern (Green *et al*, 2005). For about half of the children affected, these serious problems will persist into adolescence and beyond (Parsonage *et al*, 2014) and as a result these young people are:

- four times more likely to be dependent on drugs
- six times more likely to die before the age of 30
- eight times more likely to have a child protection plan
- two times more likely to leave school with no qualifications
- twenty times more likely to end up in prison.

Not only does this cause a huge amount of suffering to those children and their families, but there is a significant cost to the taxpayer. The lifetime cost to society is around £260 000 per child with severe behaviour disorder (Friedli & Parsonage, 2007). Costs relating to crime are the biggest single component, accounting for more than two-thirds of the total.

How will parenting programmes help tackle mental health problems in children?

The quality of parenting is a critical determinant of children's health and outcomes, and can protect children from developing severe behavioural problems. There is a large body of evidence which shows that, if well implemented, evidence-based parenting programmes can be very effective in helping parents to respond to children in ways that will improve their behaviour, including the behaviour of siblings and the mental health and well-being of participating parents (Hutchings *et al*, 2007).

Rather than simply prescribing techniques, effective parenting programmes emphasise the principles of good parenting, such as the importance of parent-child interaction, consistency in setting boundaries and reinforcement of positive behaviour. This encourages parents to use active problem-solving to apply these principles to their own situation and to focus on behaviour change.

Studies suggest that the average cost of addressing a child's conduct disorder through a parenting programme is around £1750 per case, whereas analysis of costs and benefits suggests that up to 60% of the cost of parenting programmes is recovered within 2 years through savings in public expenditure, and all costs are recovered within about 5 years (Furlong *et al*, 2012). Parenting programmes are therefore an extremely cost-effective intervention given that the lifetime cost to society per child with severe behaviour disorder is around £260 000.

These savings in public expenditure will be accrued not only by the NHS, but also by other public services, including, for example, the criminal justice system. The Royal College of Psychiatrists would like the next government to take a broad, cross-departmental approach to funding parenting programmes given the wide-ranging benefits they bring.

Where does this manifesto apply to?

As UK health systems are devolved, this manifesto relates only to England. For more info on the work of the College in the rest of the UK, please contact:

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