



Bridging the Gap:

The financial case for reinvesting in mental health

Briefing paper

Introduction

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.

Bridging this gap would improve the health of the nation and improve productivity in the NHS.

Under-investment in mental health services and a lack of integration with physical health services has created a bottleneck in health care improvement, constrained physical health outcomes and has impaired broader economic performance. The A&E crisis is just one example of the cost of the disparity and lack of integration between physical and mental health care.

We are calling for a rebalancing of health and care resources to ensure no one is denied the mental or physical health care they need. This requires action on many fronts. This paper focuses on immediate improvements that can be made to the care and support offered to millions of NHS patients by enhancing mental health support within or on the interface with physical health services. These are provided as illustrative examples, and should not be seen as the only areas of mental health care which could improve both mental and physical outcomes if they were properly resourced.

Nearly a third of people with long-term physical conditions have at least one co-morbid mental health problem. This can exacerbate the person's physical condition and increases the cost of treatment by between 45% and 75% at a cost to the NHS of an estimated £10 billion per year. Medically unexplained symptoms, meanwhile, cost the NHS some £3 billion per year. Combining these figures suggests a total increased cost to physical health budgets of at least £13 billion, in addition to the £14 billion already spent on mental health services.

Hospital liaison psychiatry services

Liaison psychiatry (sometimes called psychological medicine) services 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.

The most comprehensive economic evaluation yet undertaken of a hospital liaison psychiatry service in the UK is the Centre for Mental Health evaluation of the Rapid Assessment Interface and Discharge (RAID) service at City Hospital, Birmingham. It concluded that

the financial benefits of the service outweighed its costs by a factor of £4 for every £1 invested.

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.**

Liaison psychiatry services have developed in an *ad hoc* fashion, resulting in a postcode lottery where there is no clear relationship between the level or type of service provided and local population needs. This might be because liaison psychiatry is still seen as an 'optional extra' in the NHS. Further, because of the commissioning split between physical and mental health it is unclear both who should take responsibility for and who benefits from the savings an effective liaison psychiatry team can generate.

In 2012, 94% of hospitals reported having access to a liaison psychiatry service and 85% of these were able to provide urgent or emergency assessment. These figures should be treated with caution, however. Some services might only have one member of staff or even just access to an off-site crisis team. The same audit showed that only 45% of urgent referrals were seen within a day, with 15% of people waiting longer than four days.

Liaison psychiatry services can also identify, and train other staff to look out for, mental health difficulties in children who attend hospitals with physical complaints. This could provide opportunities for the early detection of severe behavioural problems, or conduct disorder, and for signposting their families to evidence-based parenting programmes. The long-term financial benefits of intervening early in life are very high – for individuals, families, health services and the wider economy. However, survey evidence has also identified that only half of liaison psychiatry services include support for children while only 33% offer specialist support for older adults outside working hours.

Comprehensive liaison psychiatry services also 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%.

Community liaison psychiatry services

There is an emerging consensus that liaison psychiatry services need to expand their scope to include primary and community care services.

Some hospital liaison psychiatry services already offer outpatient 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 GP and wait several weeks or months to be seen by psychological therapy services. Two groups of people would benefit especially from an extension of liaison psychiatry services into the community:

1. **People with medically unexplained symptoms** should be a key target for community-facing liaison psychiatry services. There are already examples of such services in operation.

A Primary Care Psychological Health service in Kensington provides support for patients with complex needs, including medically unexplained symptoms. It bridges the gap between GPs and specialist mental health services. The service is headed by a primary care liaison psychiatrist and includes community psychiatric nurses and the local IAPT team within a single integrated structure. The service aims to reduce secondary-care referrals by providing case management and a range of psychological and other interventions. The input provided by the consultant psychiatrist means that the service is able to support patients with more complex needs than would be seen by a typical IAPT service.

2. There is increasing evidence that integrating mental and physical care for **people with long-term conditions** can improve both physical and mental health and reduce costs. The most well evidenced model of integrated care, and the type recommended by NICE for depression in chronic illness, includes multi-professional working, case management, structured care plans, systematic follow-up, patient education and support for self-management, and a stepped-care approach to treatment which matches the intensity of intervention to gradations of severity in patient needs.

The King's College Hospital **Diabetes and Mental Health Service** caters for patients who have psychological problems that interfere with their ability to manage their diabetes. Referrals are accepted from within the hospital, from GPs, and from any diabetes service in the region. The service offers a range of interventions including diagnosis, psychological therapy and training for health service staff.

A **Chest Clinic Integrated Pathway** operates for patients at the Royal Victoria Infirmary in Newcastle. All nurses working in the chest clinic have been trained to at least foundation level in cognitive behavioural therapy (CBT) and are able to identify, assess and treat co-morbid anxiety and depression in people suffering from chronic obstructive airways disease. Complex cases are transferred to nurses who have been trained to postgraduate level and regular supervision is provided by a Consultant Clinical Psychologist. Initial evaluation has shown improvement in levels of anxiety and depression, and a reduction in admissions.

Comprehensive dementia care

Dementia is a syndrome caused by a number of illnesses in which there is a progressive functional decline in memory, reasoning, communication skills and the ability to carry out daily activities. Alongside this decline, individuals may also develop behavioural and psychological symptoms such as depression, psychosis, aggression and wandering.

There are around 800,000 people living with dementia in the UK, and the disease costs the economy £23 billion a year. By 2040, the number of people affected is expected to double - and the costs are likely to treble.

The NHS has been estimated to account for only 8% of these costs, with social services accounting for 15%, informal care for 36%, and accommodation for 41%.

Almost two thirds of acute hospital beds are occupied by people aged over 65. 30% of these patients will be suffering from dementia and 20% from delirium. Cognitive impairment is often not recognised or assessed systematically in general hospitals and

this is a major reason for delayed discharge. Key improvements that are needed in dementia care and support are:

1. Improved awareness and early diagnosis

Early diagnosis matters for both patients and carers. For example, people who take cholinesterase inhibitors have a significant delay in institutionalisation compared to a matched population which do not take these drugs.

Progress has been made in improving dementia awareness in general hospitals, where two thirds now offer such training to doctors and allied healthcare professionals, almost 90% offer it to nurses and healthcare assistants, and 60% offer it to support staff. While early recognition is a key aim of this training, evidence also suggests that it can have a significant impact on length of stay.

2. Greater use of behavioural interventions

In 2011, it was estimated that behavioural interventions cost £27.6 million more per year than antipsychotic drugs for dementia patients in England. However, the expenditure was associated with £70 million of health care savings due to the reduction in strokes and falls alone.

In 2011, Norfolk and Waveney Mental Health NHS Foundation Trust established a Primary Care Dementia Service, with 15 qualified nurses. They take referrals from primary care and community matrons and offer initial assessments, support, and advice. They specialise in helping patients with long-term physical conditions where cognitive decline is a significant co-morbidity. This aims to reduce admissions and delay institutionalisation. These are brief interventions and patients who require on-going support are referred to the Community Mental Health Team (CMHT) or the Intensive Support Team.

3. Better hospital care

A recent survey has found that while most hospitals have a liaison psychiatry service, only one third have access to the service out of hours, only 16% of patients with recognised dementia were referred and only 42% of referrals were seen within two days. Improved access to liaison psychiatry services for this group would help staff to identify and respond to cognitive impairment more quickly.

4. Intensive case management

Intensive case management involves early multidisciplinary input to draw up a comprehensive management plan with the patient and their carers. Teams have smaller caseloads and can increase resources as required by the patient. A care navigator acts as the point of contact. Comprehensive risk assessment aims to ensure that only those at high risk are placed in institutional settings.

Evidence from Scandinavia and Manchester shows that intensive case management of people with moderate dementia delays institutionalisation. There is also evidence that intensive management improves wellbeing among those with dementia and their carers.

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 comprehensively assess the mental health needs in their local area. This should include assessing the numbers and needs of people with co-occurring physical and mental health conditions, those with medically unexplained symptoms and those with dementia. Gaps in treatment and support for these groups should be addressed through joint health and wellbeing strategies.

Local Healthwatch, Overview and Scrutiny

Committees and local authority mental health champions should ask their clinical commissioning groups -1. what they are doing to make parity of esteem for mental health a reality, in line with the NHS Mandate's clear expectation for them to do so; 2. whether they offer a 24/7 all-age hospital liaison psychiatry service and comprehensive dementia services, and 3. what plans they have to improve mental health support for people with long-term conditions and medically unexplained symptoms.

This is an extract of a report by Dr Tom Foley for the Royal College of Psychiatrists and Centre for Mental Health. Full references are given in the report, which will be available in October from www.rcpsych.ac.uk/bridgingthegap and www.centreformentalhealth.org.uk.

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