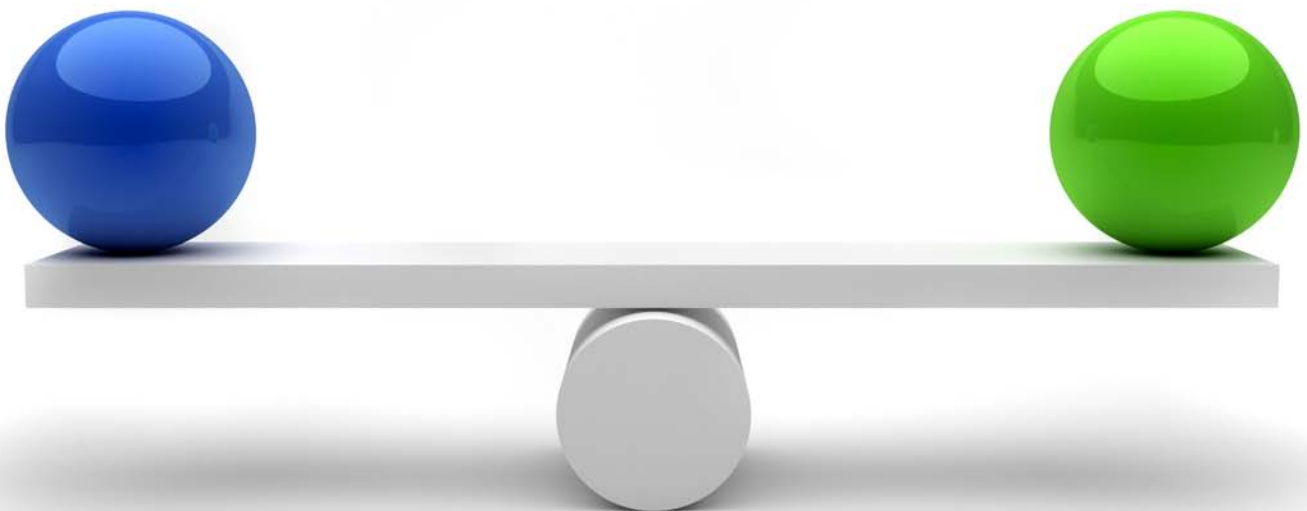


**Whole-person care:
from rhetoric to reality**
**Achieving parity
between mental
and physical health**

Summary



Background to this report

In April 2012, the Royal College of Psychiatrists was asked by the then Minister of State for Care Services, Paul Burstow, in partnership with the Department of Health and the NHS Commissioning Board Authority Medical Directorate, to advise the Ministerial Advisory Group on Mental Health Strategy ('the MAGMHS') on how to achieve parity of esteem between mental and physical health in practice, and to develop a definition and vision for 'parity of esteem'. In September 2012 the new Minister of State with responsibility for mental health, Norman Lamb, affirmed the government's continuing commitment to this work.

A core working group was established representing different population groups, mental health charities, professional bodies, service users and carers and individual professional experts. This met three times, in May, July and September 2012. Working group meetings were supplemented by individual contact and virtual working. In addition, the College had detailed individual discussions with other experts and organisations to discuss particular aspects of parity and how these might be addressed.

Authors and contributors

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Introduction

'A Man's body and his mind, with the utmost reverence to both I speak it, are exactly like a jerkin, and a jerkin's lining; – rumple the one – you rumple the other.'

(Laurence Sterne, from *The Life and Opinions of Tristram Shandy, Gentleman*, 1761)¹

'We are made by others and others are the making of us in every biopsychosocial sense.'

(DR Crossley, 2012)²

The long-standing and continuing lack of parity between mental and physical health evidenced in this report is inequitable and socially unjust. This 'mental health treatment gap', exemplified by lower treatment rates for mental health conditions, premature mortality of people with mental health problems and underfunding of mental healthcare relative to the scale and impact of mental health problems,* falls short of government commitments to international human rights conventions which recognise the rights of people with mental health problems to the highest attainable standard of health; yet it can be argued that this lack of parity is so embedded in healthcare and in society that it is tolerated and hardly remarked upon. It also affects people with physical health problems who also have mental health needs that may not be recognised in more physically healthcare-orientated settings. The poorer outcomes that result are considered by many, both within and outside mental healthcare, as all that can be expected.

In England, section 1 of the Health and Social Care Act 2012 states that:

The Secretary of State must continue the promotion in England of a comprehensive health service designed to secure improvement –

- (a) in the physical and mental health of the people of England, and
- (b) in the prevention, diagnosis and treatment of physical and mental illness.

Section 4 of the Act states that the Secretary of State must have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service.³

The amendment to the Health and Social Care Bill which secured an explicit recognition of the Secretary of State for Health's duty towards both physical and mental health has become synonymous with the concept of parity of esteem.⁴ In conjunction with a clear legislative

**Note on terminology.* For consistency with the mental health strategy, this report predominantly uses the term 'mental health problems' as an umbrella term to denote the full range of diagnosable mental illnesses and disorders, including personality disorder. Exceptions to this are for the purposes of accurate citation of evidence. The term 'mental health problems' is defined in the mental health strategy as follows: 'Mental health problems may be more or less common and acute or longer lasting, and may vary in severity. They manifest themselves in different ways at different ages and may present as behavioural problems (for example, in children and young people). Some people object to the use of terms such as "mental health problem" on the grounds that they medicalise ways of thinking and feeling and do not acknowledge the many factors that can prevent people from reaching their potential. We recognise these concerns and the stigma attached to mental ill health; however, there is no universally acceptable terminology that we can use as an alternative.'⁵

requirement to reduce inequalities in benefits from the health service, these place an obligation on the Secretary of State to address the current disparity between physical and mental health. They also present an important opportunity to drive changes in professional training and practice, attitudes, knowledge and priorities in order to address the continuing inequities in healthcare provision experienced by those with mental health problems.

This in effect enshrines in law the commitment made in the English mental health strategy, *No Health Without Mental Health*,⁵ to 'parity of esteem between mental and physical health services'. The concept of 'parity of esteem' is relevant to all six of the mental health strategy objectives, and is of particular relevance to improving the quality of all service users' care and experience, improving the physical health of those with a mental health problem, the mental health of those with a physical health problem, and reducing the stigma and discrimination experienced by those with mental health problems.

The importance of parity of esteem for mental health has been emphasised consistently, by both government ministers and key mental health organisations. It is a principle that is as important for professionals working in social care as in health, and for those predominantly treating physical health problems as it is for those whose main focus is mental health.

Parity is ultimately, as much as anything, a mindset: government, policy-makers, commissioners, providers, professionals and the public are urged always to think in terms of the whole person – body and mind – and to apply a 'parity test' to their activities and attitudes.

This report sets out the rationale for a parity approach to mental and physical health, and makes recommendations for how parity can be achieved, largely in health and social care, although it also includes some broader recommendations.

It should be seen as the first stage of an ongoing process over the next 5–10 years that will deliver parity for mental health and make whole-person care a reality. It builds on the Implementation Framework for the mental health strategy⁶ in providing further analysis of why parity does not currently exist, and the actions required to bring it about.

A 'parity approach' should enable NHS and local authority health and social care services to provide a holistic, 'whole person' response to each individual, whatever their needs, and should ensure that all publicly funded services, including those provided by private organisations, give people's mental health equal status to their physical health needs.

Central to this approach is the fact that there is a strong relationship between mental health and physical health, and that this influence works in both directions. Poor mental health is associated with a greater risk of physical health problems, and poor physical health is associated with a greater risk of mental health problems. Mental health affects physical health and vice versa.

It is important, however, to recognise that effecting such change will be especially challenging at a time when the NHS and local authorities are operating in a climate of significant structural change, combined with requirements to make major efficiency savings. It is vitally important for people with mental health problems that relationships and trust across whole systems are maintained during this very difficult economic time.

Definition and vision for parity of esteem

Definition

The *Oxford English Dictionary* defines 'parity' as: 'the state or condition of being equal, or on a level; equality'. 'Esteem' is defined as 'to attach value (subjectively) to; to think highly of; to feel regard for, respect'.

The following definition of parity has been used in the US 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.⁷

In essence, 'parity of esteem' is thus best described as: 'Valuing mental health equally with physical health'.

More fully, and building on the US definition, parity of esteem means that, when compared with physical healthcare, mental healthcare is characterised 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 healthcare education and practice
- equally high aspirations for service users; and
- equal status in the measurement of health outcomes.

For simplicity, and to shift the focus from equally valuing mental health and physical health to the next stage, of taking action to achieve parity, this report refers simply to achieving 'parity' in order that mental health has equal status with physical health. Inherent in this, however, is the need to value mental and physical health equally.

The group has identified the following as key features of a parity approach:

- It should apply to people of all ages, including preconception care, and to all groups in the population, including those at increased risk of mental health problems, such as people with intellectual disabilities, asylum-seekers, people in the secure estate, lesbian, gay, bisexual and transgender people, some Black and minority ethnic populations at greater risk, children in care, care leavers and others.
- Equal access to health and social care, including: comparable waiting times; equitable treatment for all, according to their need; the provision of equivalent levels of choice and quality regardless of condition.
- Holistic care – the mind and the body should not be regarded separately but integrated: professional and public education, public health programmes, social care and treatment approaches need to reflect this; an open-minded approach to whole-person care is essential.

- Planning for integration – this requires movement away from mental health, physical health and social care 'silos'; the consideration of mental health should be integral to all health and social care, at any point where someone with a mental or physical health problem comes into contact with a service.
- Investment in the prevention of mental health problems, and the promotion of mental well-being, in proportion to need.
- Investment in mental health research, in proportion to need.
- Investment of both funding and clinical/managerial time and attention should be proportionate to the prevalence of mental health problems and scale of mental health need.
- Aspirational outcomes and an expectation that mental healthcare should continuously improve (as is the case for other areas of healthcare).
- Respect and dignity for those with mental health problems across all areas of health and social care.

Vision

A parity approach will both require and influence positive changes in attitudes to mental health, and in knowledge, priorities, professional training and practice, all of which are necessary to reduce the stigma experienced by those with mental health problems and to improve the assessment and care they receive.

Parity should pervade all aspects of mental and physical health policy, including research and development, NICE guidance and quality standards, and the planning, commissioning and delivery of mental and physical health services and public health activity. Appropriate commissioning of health and public health services should result in improved health and well-being and mean that:

- A parity approach is adopted for all health and social care provision from pre-birth and throughout the life course.
- People with mental health problems will receive timely and appropriate treatment, as is expected for those with physical health problems.
- People with mental health problems will have parity of life expectancy and no higher rates of physical illness than those without these problems.
- Mental health problems will be recognised as a risk factor in physical illness and vice versa.
- People with mental health problems will receive the same quality of physical healthcare as those without a mental health problem.
- People with mental health problems will express the same levels of satisfaction with their health and social care services as people with physical health conditions, including experiencing the same levels of dignity and respect from health and social care staff.
- People with mental health problems will receive appropriate intervention and support to address the factors affecting their much higher rates of health risk behaviour.
- People who present with a physical health problem will receive assessment to identify potential mental health problems, and appropriate intervention to prevent escalation of any existing mental health problem.
- Public mental health and well-being will be an integral part of both national and local public health services, programmes and campaigns.
- Commissioners will give the same priority to addressing and preventing mental health problems as they do to addressing and preventing physical health problems.
- Commissioners will understand that physical and mental health are inextricably linked, and that it is not possible to treat or support one without affecting the other.

- Service providers will be expected to have and to fulfil aspirations for the recovery of people with mental health problems that are the same as those for people with physical health conditions.
- Generic health and social care policy, planning and services will integrate mental health from the outset.
- Continuity of care will be a guiding principle for the commissioning and provision of both mental and physical healthcare.
- Mental health research will receive funding that reflects the prevalence of mental health problems and their cost to society.
- People with mental health problems will receive social care on the same basis as people with physical health problems – according to the impact on the quality of their day-to-day life, the risk of further deterioration in health and the need for further health or social care.
- People with mental health problems will be given the same level of choice and control over their care, including discussions about choice of treatment and access to personal budgets. Where necessary, advocacy will be provided to enable this to happen.

Giving mental health equal status with physical health will result in major improvements in the health and wealth of the nation, and is achievable through interventions that can save money in both the short and the longer term.

Key recommendations

The current reality is very far from this vision. The parity of esteem working group has identified a wide range of factors affecting this long-standing lack of parity between mental and physical health and this report makes recommendations for addressing these. It also presents a number of commitments that working group member organisations have made to achieving change in these areas. These commitments are set out on pp. 84–87 of the full report (available at <http://www.rcpsych.ac.uk/usefulresources/publications/collegereports/op/op88.aspx>).

We set out below the key recommendations that we believe will make the biggest contribution to achieving parity, and which should therefore be early priorities for action.

1. Leadership for parity

Political and managerial leadership, at both national and local level, is vital for achieving parity. Such leadership needs to recognise and understand not only the interrelationship between mental and physical health in the major health and adult social care policy priorities for which the Department of Health takes government responsibility, such as obesity, dementia and dignity in care. It must also recognise that population mental health can be worsened or improved by policies for which other government departments are responsible, such as early years, children's social care, education, welfare reform and criminal justice.

At national level, we recommend that mechanisms are identified for driving a parity approach to relevant policy areas across government. Options could include a cross-government committee under ministerial leadership, and the development of some kind of parity assessment process to ensure that parity can inform all policy developments – across all areas of government – which have implications for mental health.

At local level, we recommend that:

- all local councils should have a lead councillor for mental health in recognition of the need for all local authority activities and commissioning to take full account of mental and physical health and their social determinants
- all providers of specialist mental health services should have someone at board level who leads for physical health
- all providers of physical healthcare should have a board member who leads for mental health.

At the level of service delivery, clinical leadership will be essential in securing a culture change in the provision of both physical and mental health services that refuses to accept second best for service users with mental health problems.

2. Policy changes to promote parity

To help drive change, the government and the NHS Commissioning Board should work together to:

- Make it clear, including as part of the NHS Constitution, that parity is expected between mental and physical health, in all relevant aspects of the work of the NHS.
- Give people equivalent levels of access to treatment for mental health problems as for physical health problems, agreed standards for waiting times for this treatment, and agreed standards for emergency/crisis mental healthcare.
- Continue to improve access to psychological therapies so that they are provided as a timely and appropriate response to assessed need for such interventions.
- Include a right in the NHS Constitution for service users, when it is judged clinically appropriate, to receive treatments that have been recommended by the National Institute for Health and Clinical Excellence (NICE) in clinical guidelines as well as in technology appraisals.

At present, the NHS Constitution confers this right only (if clinically appropriate) to drugs and treatments recommended by NICE technology appraisals and not to those recommended by NICE clinical guidelines. This is a parity issue, as in practice a greater proportion of mental health treatments than physical health treatments have undergone a clinical guideline assessment process rather than a technology appraisal process. This means that they are in practice less available to service users, as there is not the same legal imperative for mental health service providers to make them available. NICE clinical guidelines are the gold standard for evidence-based care. To use the example of mild depression, guidelines recommend talking therapies as a first-stage treatment and explicitly discourage the use of antidepressants. It is not equitable that a recommended treatment such as group cognitive-behavioural therapy does not have to be provided within the same reasonable time frame as the majority of treatments for physical complaints because it has been through a clinical guideline assessment rather than a technology appraisal. We recognise that as a first stage this may initially need to be a pledge rather than a right.

- Include a pledge in the NHS Constitution that patients with mental health problems, including people treated under the Mental Health Act, will be given information and support in making as many collaborative decisions about their treatment as possible.

3. Parity of professional and public respect: tackling stigma and discrimination

No part of the NHS should tolerate professional attitudes, behaviour or policies that stigmatise mental illness and thus contribute to the discrimination experienced by people with mental health problems. Unless such attitudes are challenged and changed, mental health will not gain parity with physical health. An element of this is showing the same respect to mental health professionals as to professionals working in other areas of health, as the stigma associated with mental health can also affect the esteem in which they are held.

We recommend that organisations providing NHS-funded care review their diversity and equality policies to ensure they include clear statements about non-discrimination in relation to mental health, and that a 'zero tolerance' approach is adopted in all health settings in relation to stigmatising and discriminating attitudes and behaviour towards people with mental health problems and their carers.

In every trust and hospital, non-discrimination policies should be supported, first by an encouragement to report episodes of discrimination and secondly by provision of reparative training.

The Department of Health should consider how for the next 2 years the work of the Time to Change initiative could improve the attitudes of mental health and other health professionals towards people with mental health problems and their carers.

The British Medical Association (BMA) and medical Royal Colleges should consider how doctors can adopt a more aspirational approach to the care of people with mental health problems, such as is found within physical healthcare, in relation, for example, to recovery. This would also have significant benefits for the employment prospects of people with mental health problems, given the established link between employment and mental health.

The General Medical Council (GMC) and Nursing and Midwifery Council (NMC) should consider how medical and nursing study and training could give greater emphasis to mental health. This would help to improve the care and treatment provided by non-specialists to people who present with mental health problems, and to those with physical health problems who develop mental health problems. Mental and physical health should be integrated within undergraduate medical education, with an emphasis on joint placements and on engaging with service users who have comorbid physical and mental health problems.

The working group strongly supports the proposed extra year for general practitioner (GP) training, which presents an important opportunity to teach more about child development and mental health, and the relationship between physical and mental health.

4. Parity of outcomes: preventing premature mortality

The NHS Outcomes Framework should complement the indicator of 'excess under-75 mortality in people with severe mental illness' with an additional indicator that measures excess mortality in people with mild or moderate mental illness. Without this, the picture of premature mortality is incomplete. There should be an expectation that the mortality differential will reduce year on year.

Efforts to reduce premature mortality must include a major focus on reducing smoking among people with mental health problems. Commissioners should require smoking cessation services to include a focus on smokers with mental health problems. They should also ensure that younger smokers receive early intervention, since most smoking has started by adulthood. In particular, smokers with emotional or conduct disorder require targeted intervention since they represent 43% of smokers under the age of 17.⁸

As a key primary prevention approach for reducing the increased mortality and morbidity experienced by those with severe mental illness, the NHS Commissioning Board and clinical commissioning groups (CCGs) should promote widespread adoption of the recently developed Lester UK Adaptation: Positive Cardiometabolic Health Resource. This is designed to help reduce the high rates of type 2 diabetes and cardiovascular disease in psychiatric patients treated with antipsychotic medication.

The Lester UK Adaptation resource is available at <http://www.rcpsych.ac.uk/quality/nationalclinicalaudits/schizophrenia/nationalschizophreniaaudit/nasresources.aspx#cmhresource>.

5. Parity of care and treatment

We welcome the requirement in the NHS Mandate for the NHS Commissioning Board to work with CCGs to quantify waiting times for mental health services, including for when people are in crisis, and to address unacceptable delays in access to such services. The subsequent development of access standards should result in the introduction of waiting-time standards for secondary care mental health assessment, diagnosis and treatment.

People with mental health problems who are in crisis should have an emergency service response of equivalent speed and quality to that provided for individuals in crisis because of physical health problems.

Clinical commissioning groups should ensure that they commission a sufficient mix of crisis services at the scale required by the needs and composition of the local population. These services should be staffed in accordance with national guidelines. Local communities should be meaningfully involved in the planning and review of such services.^{9,10}

The NHS Commissioning Board should as an early priority extend the NHS staff 'family and friends' test, of whether they would recommend a health setting as a place for their family to be treated, to mental health in-patient wards.

6. Parity and integrated care: addressing co- and multi-morbidity of mental and physical health conditions

Commissioners need to regard liaison services as an absolute necessity rather than as an optional luxury.¹¹ NHS and social care commissioners should commission liaison psychiatry and liaison physician services to drive a whole-person, integrated approach to healthcare in acute, secure, primary care and community settings, for all ages, including multidisciplinary paediatric liaison services for children both in and out of hospital. This will not only improve patient outcomes but also save money.

All NICE guideline development groups for physical conditions should consider including representation from co-opted mental health experts to ensure that the mental health aspects of conditions are comprehensively considered. This will ensure that NICE quality standards have a sufficient focus on mental health.

7. A parity approach to public health

Public Health England and local authorities should take a parity approach to their work and support the development of local public health strategies and interventions that recognise and fully consider the mental health dimension of issues commonly conceptualised as physical health concerns, such as smoking, obesity and substance misuse. Public health programmes should also involve appropriately integrated work across health and social care in order to consider and address the wider determinants of mental health and mental illness, such as social isolation, parenting, violence and abuse.

This 'whole person' approach should apply across the life course.

Health Education England should as a priority support the development of core skills and competencies in public mental health for health and public health professionals.

8. Parity across the life course

All our recommendations apply to the whole population. In addition, action is required in the following areas affecting people of non-working age:

Children and young people

All bodies with responsibility for training professionals working with children and families should review their curricula to ensure inclusion of the ability to understand and identify mental health problems, and factors that adversely affect mental well-being, at an early stage, including signs of abuse and neglect, and to respond to them effectively. This training should include child development, the importance of emotional resilience, the relationship between a child's physical and mental development, and the determinants and risk factors for poor emotional and mental health. This is a vital underpinning for an early-intervention approach both to children's mental health problems and to population mental health as a whole. The Children and Young People's Health Outcomes Forum has also highlighted such training as a priority for action.¹²

Commissioners should require that antenatal and postnatal education for parents includes a focus on the emotional well-being of both the infant and the parents. They should also invest in perinatal, or parent–infant, mental health services to work with families where there are parenting difficulties or with particularly vulnerable parents or babies. The provision and function of such specialist services are currently variable and inequitable, and there is significant unmet need in this area.¹³

Schools should implement the NICE public health guidance on mental health promotion in schools.^{14,15} This aims to develop psychological, emotional and social skills to support resilience and coping mechanisms and will help to develop better mental health 'literacy' in children and young people. In the longer term, this has the potential also to contribute to reducing the prevalence of stigmatising attitudes to mental ill health in the wider population, as well as to earlier identification of and response to mental health problems throughout life, through educational and therapeutic means.

Older people

Clinical commissioning groups should make flexibility of access a cornerstone of service contracts, so that someone being treated within adult mental health services (AMHS) does not become automatically ineligible to be treated by a service once they pass 65 years of age, and someone under the age of 65, with for example early-onset dementia, can access the expertise of comprehensive older adult mental health services (OAMHS). This is important for fulfilling public sector duties under the Equality Act 2010. CCGs should ensure they provide specialist age-appropriate services that have porosity with adult services to ensure the mental health of this disadvantaged population is appropriately addressed.

9. Parity and funding

Parity is about equal value being placed on mental health and mental healthcare, and responses being proportionate to need. Funding for mental health must be commensurate with its impact on children and young people, working-age adults, older adults and society as a whole.

The NHS Commissioning Board and CCGs should allocate funding in a way which supports and promotes parity. This should include ensuring that any person with mental health problems (including comorbid mental and physical health problems) can expect the same access to services and the same quality of care and treatment as people who have only physical health problems.

Consideration should be given to the percentage improvement in overall health outcomes that could be achieved if investment were to be reallocated into mental health, community and dementia services from the acute physical healthcare sector.

10. Parity and research

The Department of Health should continue the adult psychiatric morbidity survey to underpin its commitment to achieving parity. Without it, we lose the most comprehensive, and therefore important, information we have about the prevalence of mental health problems and our efforts to treat them. This information will be vital for measuring the impact of actions to achieve parity for mental health.

The Department of Health should also consider reinstating the child and adolescent national psychiatric morbidity survey and should repeat its survey of psychiatric morbidity among prisoners in England and Wales (the latest available data are from 2005 and 1998 respectively).

The Department of Health should consider a refocusing of research on to areas of co- or multi-morbidity, involving mental health and physical health problems, rather than single diseases/disorders. This would help to demonstrate the interconnectivity of mental and physical health, and to underpin the developments of evidence-based treatments that address all an individual's health needs, not just their primary diagnosis.

The Department of Health and NHS Commissioning Board should examine how existing and future data registers can be utilised to learn more about comorbidity of physical and mental health problems.

To improve the evidence relating to models of support for individuals' recovery, it would be beneficial to promote more social care research in mental health, to include not only clinical resolution, but also social recovery and self-management when problems persist. Social recovery often enables people to maintain themselves in communities, thus reducing demand on formal services (and acute services in particular).

To help understand why mental health does not enjoy parity of esteem at present, there should also be a greater research focus on health and social care staff culture, attitudes and behaviour towards service users with mental health problems; and further research to investigate why people with more serious mental health problems are at higher risk of dying earlier from treatable diseases.

Conclusion

If these recommendations and others in the report are adopted, if action in these areas is sustained at national and local level, and a parity test is consistently applied to policy, commissioning and practice, then, over time, parity between mental and physical health should be realised. Ultimately, the mark of success in achieving this objective will be when the term 'parity' becomes redundant, a term of historical interest rather than one of immediate, everyday concern.

Until then, much work remains to be done by leaders, policy-makers and professionals at all levels, working in partnership to common purpose across all communities.

References

- 1 Sterne L. *The Life and Opinions of Tristram Shandy, Gentleman* (1761), vol. 3, ch. 4 (eds M New, J New). University of Florida Press, 1978.
- 2 Crossley DR. Holistic psychiatry without the whole self. *The Psychiatrist* 2012; **36**: 97–100.
- 3 Health and Social Care Act 2012. Available at <http://www.legislation.gov.uk/ukpga/2012/7/section/1/enacted>
- 4 *Hansard* (House of Lords), 8 February 2012, vol. 735, cols 26–274.
- 5 HM Government. *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages*. Department of Health, 2011, p. 88. Available at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124058.pdf
- 6 HM Government. *No Health Without Mental Health: Implementation Framework*. Department of Health, July 2012. Available at <http://www.dh.gov.uk/health/files/2012/07/No-Health-Without-Mental-Health-Implementation-Framework-Report-accessible-version.pdf>
- 7 Fritz GK, Kennedy PJ. The long road ahead to mental health parity. *J Am Acad Child Adolesc Psychiatry* 2012; **51**: 458–60.
- 8 Green H, McGinnity A, Meltzer H, Ford T, Goodman R. *Mental Health of Children and Young People in Great Britain 2004*. Office for National Statistics, 2005.
- 9 Mind. *Mental Health Crisis Care: Commissioning Excellence*. Mind, 2012, p. 5. Available at http://www.mind.org.uk/assets/0002/2011/CommissioningExcellence_WEB_VERSION_2.pdf
- 10 Department of Health. *Mental Health Policy Implementation Guide*. Department of Health, 2001. Available at http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4058960.pdf
- 11 Parsonage M, Fossey M, Tutty C. *Liaison Psychiatry in the Modern NHS*. Centre for Mental Health, 2012, p. 6.
- 12 Children and Young People's Health Outcomes Forum. *Report*. Children and Young People's Health Outcomes Forum, July 2012. Available at <http://www.dh.gov.uk/health/files/2012/07/CYP-report.pdf>
- 13 Joint Commissioning Panel for Mental Health. *Guidance for Commissioners of Perinatal Mental Health Services*. Royal College of Psychiatrists, 2012. Available at <http://www.rcpsych.ac.uk/policy/projects/live/commissioning.aspx>
- 14 National Institute for Health and Clinical Excellence. *Promoting Children's Social and Emotional Wellbeing in Primary Education* (Public Health Guidance 12). NICE, March 2008. Available at <http://www.nice.org.uk/nicemedia/pdf/PH012Guidance.pdf>
- 15 National Institute for Health and Clinical Excellence. *Promoting Young People's Social and Emotional Wellbeing in Secondary School* (Public Health Guidance 20). NICE, September 2009. Available at <http://www.nice.org.uk/nicemedia/live/11991/45484/45484.pdf>



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The full report, containing the complete set of recommendations and the commitments organisations
have made to actions to help achieve parity, is available at
<http://www.rcpsych.ac.uk/usefulresources/publications/collegereports/op/op88.aspx>