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Bridging the Gap:

The financial case for a reasonable rebalancing of health and care resources

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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 been 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.Intensive case management

   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.

Introduction

Almost one in four (23%) British adults are experiencing a diagnosable mental health problem at any given time [1].

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 [1] and services are often variable and fragmented[2]. Mental health problems represent almost 17% of the total burden of disease in high income countries [3], but spending on mental health services accounts for only 13% of total NHS expenditure [4]. Bridging this gap would improve the health of the nation and improve productivity in the NHS and also reduce the considerable wider costs to society.

The long-standing and continuing disparity between mental and physical health is inequitable, socially unjust and inefficient [5]. Underinvestment in mental health services and a lack of integration with physical health services have reinforced stigma, created a bottleneck in health care improvement, constrained physical health outcomes, and impaired broader economic performance.

For example, 80% of all hospital bed days are occupied by people with co-morbid physical and mental health problems [6]. These patients cannot be seen quickly, moved to more appropriate settings, or prevented from presenting in the first place, without adequate mental health services being available. Untreated need in the community is also a significant issue, with less than a quarter of people with common mental disorders receiving treatment.

Since 2007, the UK and much of the developed world has experienced the worst economic downturn since the great depression of the 1930s. Even as tentative signs emerge of a modest recovery [7], there is no prospect of a return to the large increases in NHS funding seen under the Wanless prescription [8]. The more likely scenario is one of flat public funding for the foreseeable future [9]. The current ring-fence on health spending has led to health accounting for an increasing proportion of total public expenditure [10] and the protection is only secure for the remainder of this parliament.

Local government funding has enjoyed no such protection and deep cuts have put social care under increasing strain [11]. The NHS is struggling to meet the £20 billion "Nicholson Challenge" by 2014/15 [12] and already there is discussion of the next "Challenge" to follow it. All this comes at the same time as a rising and ageing population that will drive demand in the medium and long term [13]. This could represent a perfect storm for already underfunded mental health services.

In this climate, all areas of health and social care must meet the productivity challenge; mental health services are not, and should not, be an exception. Efforts are already under way to improve the productivity of mental health services and several promising areas have been identified including [14]:

- Reducing unnecessary bed use in acute and secure psychiatric wards;
- Establishing systems to review the use of highly expensive out-of-area treatments;
- Improving workforce productivity;
- Strengthening the interface between mental and physical health care.

Such changes can reduce costs and improve the service for patients, but it is imperative that high-performing mental health services are not subject to shortsighted salami slicing. The evidence makes it clear that this action would actually increase costs: to the NHS, local authorities, the public sector in general, and the wider economy. It would also result in unnecessary suffering for some of the most vulnerable people in society.

The commissioning of mental heath services through block contracts, rather than a payment by results system, means that it is much easier to make such cuts [15]. There is already worrying evidence that mental health services are being targeted for disproportionate cuts. The most recent figures [16] [17] show that overall cash investment in adult mental health services fell by 1% in real terms between 2010/11 and 2011/12, with individual regions experiencing cuts of up to 5.3%. In older people's mental health services, the real decrease was 3.1%. This also masked cuts of up to 10.6% in individual regions. Total expenditure per head between regions also showed large variation. While Herefordshire spent £315 per head on mental health, almost double the England average of £166, East Riding of Yorkshire spent just under £98 per head[18].

Historic under-resourcing of mental health services has already resulted in increased costs elsewhere in the system. The A&E crisis, difficulties managing flow through acute hospitals, and the increasing cost of caring for older people, are just a few topical examples. So now, more than ever, it is important to reinvest scarce resources into services that can improve care and make savings throughout health and social care.

This report defines resources in the broadest way possible. Financial resources are important, but improvements to mental health education and training for clinical staff across the NHS are also needed. This is the only way to build the capacity required to meet the mental health challenge. Less tangible resources are also needed, such as a leadership mindset, at every level in the NHS, devoted to addressing mental health issues.

This report does not propose a wholesale re-allocation of resources away from physical health care to mental health care. Instead, we are calling for a reasonable 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 – for example, to increase the focus on early intervention, to implement NICE guidance on mental health, and to improve the physical health of people with mental health problems.

This report focuses on three areas with an emerging evidence base for cost effectiveness: hospital liaison psychiatry services, community liaison psychiatry services, and dementia services. In all these areas, immediate improvements can be made to the care and support offered to millions of NHS patients by enhancing mental health support within or at the interface with physical health services.

The interaction between physical and mental health

Unfortunately, real life does not mirror the neat distinctions found in the health service between mental and physical health. In reality, mental health problems cause physical health problems and vice versa. Recent data published by the Health and Social Care Information Service [19] shows that people with mental health problems have a significantly different level of contact with physical health services compared with other patients. In 2011/12:

- 78% of mental health service users accessed hospital services compared with 48% of non-mental health service users.
- 54% of those arriving at A&E came by ambulance or helicopter compared to 26% of non-mental health service users. A higher proportion of these patients were admitted and they stayed in hospital around 30% longer.
- 71% of those admitted were classified as an emergency compared with 40% of non-mental health service users.
- They also had more outpatient appointments.

Many people who attend A&E have physical health problems relating directly to poor mental health. There are at least 200,000 self-harm presentations to general hospitals in England each year [20] while alcohol-related admissions doubled in the 11 years up to 2007 [21].

The impact of poor mental health on physical health

Mental illness reduces life expectancy: by 7 to 10 years in people with depression, by 10 to 15 years in those with schizophrenia, and by almost 15 years in those who misuse drugs or alcohol [22]. In fact, mental illness has a similar effect on life-expectancy to smoking, and a greater effect than obesity [23].

Mental ill health is also associated with increased physical morbidity. Depression has been associated with an increased risk of coronary heart disease [24], and a four-fold increase in risk of myocardial infarction (MI), and of death within six months of MI [25]. There is a two-fold increase in type 2 diabetes [26] and a three-fold increase in the risk of non-concordance with treatment [27].

Schizophrenia is associated with a three-fold increased death rate from respiratory disease [28], and a two-fold increased risk of obesity, diabetes, hypertension, metabolic syndrome, and smoking [29].

The impact of poor physical health on mental health

Poor physical health increases the risk of mental illness. For example, the risk of depression is doubled in people with a chronic physical condition [30] and is more than seven times higher in people with two or more chronic physical conditions [31]. The risk of depression is doubled for people with diabetes, hypertension, coronary artery disease and heart failure, and tripled in those with stroke, end-stage renal failure and chronic obstructive pulmonary disease [32]. Children experiencing a serious or chronic illness are also twice as likely to develop emotional disorders [33].

A recent review also found that patients with chronic obstructive airways disease (COPD) had much higher rates of generalised anxiety disorder, panic, and depression. This was explained by social and occupational withdrawal and isolation. It resulted in increased admissions, longer hospital stays, and higher relapse rates [34].

Is it a mental health problem or a physical health problem?

Presentations that require the attention of physical health services are sometimes actually a result of mental health problems.

People with medically unexplained physical symptoms are thought to account for up to 50% of acute hospital outpatient activity [35]. Non-specific chest pain accounts for 2-5% of all admissions to A&E[35 36] and 50% of new referrals to outpatient cardiac clinics [37]. In one study, 61% of patients with non-specific chest pain had psychiatric symptoms on structured interview [38]. Another US study found that, compared to patients who had coronary artery disease, patients with non-specific chest pain were much more likely to suffer from panic disorder (43% vs 6.5%), major depression (36% vs 4%), and phobias (36% vs 15%) [39].

Another study found that over time, 75% of patients with non-specific chest pain continue to seek medical attention, 50% remain or become unemployed, and 50% regard their lives as significantly disabled. Fewer than 50% of these patients appear reassured that they do not have serious heart disease. Most continue to

report residual chest pain during follow-up [40] cited in [41].

The economic impact of mental health problems

As we have already discussed, direct spending on mental health services (£14 billion)[23] is below that which would be expected given the morbidity caused by mental health problems. Unfortunately, the costs of mental health problems are not so constrained. And while most of the costs of mental ill health fall on those living with it and their families, the NHS also carries a heavy cost for failing to respond adequately to people's needs.

Nearly a third of people with long-term physical conditions have at least one co-morbid mental health problem. As discussed earlier, this can exacerbate the person's physical condition and increases the cost of treatment by between 45% and 75%. This costs the health service an estimated £10 billion per year [42]. In addition, medically unexplained symptoms [43], cost the NHS some £3 billion per year [44]. Combining these figures suggests a total increased cost to physical health budgets of at least £13billion, in addition to the £14 billion already spent on mental health services.

Current availability of timely and cost effective treatment

Despite the existence of effective evidence-based interventions, mental health problems continue to impose a high level of mental and physical suffering, and a total economic and social cost of over £105 billion a year. Yet many people with a range of mental health problems do not receive treatment. Only 24% of adults suffering from common mental health problems were receiving treatment. Another study found that only a slightly higher percentage of children with mental health problems received treatment. This situation is in stark contrast to most long term physical health problems [1 45]. For example, 94% of people with diabetes, 91% of those with hypertension, and 78% of those with heart disease, in comparable Western countries, were receiving treatment [46]. While some people with mental health problems may not actively seek treatment, the evidence suggests that when support is offered, it is usually accepted [4].

Waiting times for the treatment of physical illnesses have plummeted over the last 15 years and now appear to have stabilised. Across the NHS, median waits are currently around two weeks for diagnostics, four weeks for outpatient appointments and just over eight weeks for elective inpatient care [47]. Some progress has been made in tackling waiting times within mental health, for example, through the Improving Access to Psychological Therapies) IAPT programme. However, survey results indicate that around two thirds of people with depression or anxiety still wait more than six months from referral to treatment, with 1 in 5 waiting over a year and 1 in 10 waiting over two years [48]. Long waits have a significant impact both on the effectiveness of treatment and on the broader costs of mental health problems. The same survey also found that only 8% of people had a full choice of therapy and only 13% were offered a choice of location. Interventions, when they are provided, are not always in-line with the evidence base [4].

Research suggests that resource constraints, limited staff skills, and a variety of other factors can hinder the implementation of NICE guidelines for a number of mental health conditions, including depression [49], schizophrenia [50], and bipolar disorder [51].

Several mental health interventions have been shown to be particularly cost effective, but have not been uniformly implemented. Table 1 (below) shows a small selection of interventions that have a low cost per Quality-Adjusted Life Year (QALY), but there are also mental health interventions that are likely to generate net savings to the NHS per QALY. This is because, by preventing disorders from arising or deteriorating, they deliver a financial return to the NHS [4].

Table 1: Cost per Quality-Adjusted Life Year (QALY) of selected mental health interventions [4]

Intervention	Cost per QALY
Suicide awareness training (over 1 year)	£1573
CBT for depression/anxiety	£2111
CBT for medically unexplained symptoms	£3402
Collaborative care for depression in patients with diabetes	£3614
Health visiting as an intervention to reduce post-natal depression	£4500

What could we do better?

Mental health interventions have come a long way in the last seven decades. Before antidepressants and antipsychotics started to become available in the 1950s, there was little active treatment that could be offered. By the 1970s, a strong evidence base was also accumulating for various psychological therapies. There have now been hundreds of controlled trials demonstrating the efficacy, and to a lesser extent the cost effectiveness, of a range of mental health interventions. In depression and anxiety for example, the typical short-term success rate for CBT is about 50% [52]. These outcomes are at least as good as the outcomes for most acute physical treatments. This section sets out three ways in which enhanced mental health intervention can bring about major improvements in both wellbeing and productivity.

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.

Liaison psychiatry services have been associated [53] with a range of benefits including:

- Improved service user experience
- Improved care outcomes
- Ensuring patients with co-morbid long-term conditions receive better treatment while using fewer health care resources
- Treating and reducing costs for patients with medically unexplained symptoms
- Reduced emergency department waiting times
- Reduced admissions, re-admissions and lengths of stay
- Reduced risk of adverse events
- Improved compliance of acute trusts with legal requirements under the Mental Health Act (2007) and Mental Capacity Act (2005)
- Reducing psychological distress following self-harm, and reducing suicide
- Improved compliance with NHS Litigation Authority Risk Management Standards and the Clinical Negligence Scheme for Trusts (CNST)

Liaison psychiatry services can be delivered by a broad multidisciplinary team and have traditionally developed in an *ad hoc* fashion. There is currently a postcode lottery in liaison psychiatry services with no clear relationship between the resources allocated, the service models utilised, and local population needs [54]. This may be because liaison psychiatry services are still seen as an optional extra in the NHS [55] and because of the commissioning split between physical and mental health it is unclear who should take responsibility for these services. Even evidence of cost-effectiveness can fail to persuade commissioners if savings are likely to be realised in a different budget [56].

Hospital liaison psychiatry services

Liaison psychiatry services are usually based in acute or general hospitals. There is no one-size-fits-all service model. The Royal College of Psychiatrists has established the Psychiatric Liaison Accreditation

Network (PLAN) to assess and improve the quality of liaison psychiatry services. So far, the network has 45 members of which 24 have been accredited, with the other teams being supported to work towards accreditation. Due to a lack of investment, many liaison psychiatry teams are not able to provide a full liaison psychiatry service to the whole of the general hospital [56].

The *National Audit of Dementia Services in General Hospitals* [57] includes questions on general liaison psychiatry services. 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. 82% of services had a named consultant psychiatrist lead. 78% of hospitals with access to a liaison psychiatry service had the service onsite. While superficially reassuring, these figures should be treated with caution as they give no indication of the extent of the liaison psychiatry service. Some services might only have one member of staff or even just access to a crisis team. Some named consultants may only have very limited input. These concerns are fuelled by figures in the same audit showing that only 45% of urgent referrals were seen within a day, with 15% waiting longer than four days.

A more comprehensive, but geographically limited, mapping exercise has recently been completed in the South West of England [58]. This showed wide variation in the composition of teams among the eight services that replied, from a solely nurse-based service to multidisciplinary teams. Only one team had an occupational therapist, two had a social worker, and none had a psychologist within the team. One trust was found to be delivering different services to four different Clinical Commissioning Groups (CCGs), without any basis for this in local need. The only team that appeared to offer 24/7 cover was not a discrete liaison psychiatry team, but turned out simply to be access to the local crisis team, which had variable liaison psychiatry experience.

Working-age adult liaison psychiatry services

Traditionally, working-age adult liaison psychiatry services have formed the core of the general hospital liaison psychiatry service. This group accounts for 43% of all inpatient admissions, but because of short stays, they only account for 30% of occupied bed-days. [55] There is therefore less scope for savings overall but these services can be effective by focusing on the most complex issues, for example self-harm, eating disorders, alcohol and substance misuse, neuropsychiatric problems, medically unexplained symptoms and severe mental illness [55].

Later life liaison psychiatry services

Older people make up only 45% of inpatient admissions, but longer lengths of stay mean that they account for 65% of total bed days [55]. This is the fastest growing group in society. It is also the group that has the strongest relationship between physical ill-health and mental health problems, such that they account for 80% of hospital bed days occupied by people with comorbid mental and physical problems. The “three Ds”, Dementia, Depression, and Delirium, account for most of the cases [55].

Despite representing the greatest area of need within liaison psychiatry, only 68% of liaison psychiatry services report having a consultant psychiatrist who specialises in old age, with at least some time dedicated to the service. Only 33% of hospitals had access to a liaison psychiatry service for older adults in the evenings and at weekends [57]. This may represent a missed opportunity to prevent admissions and reduce lengths of stay.

Child and adolescent liaison psychiatry services

Children and young people account for 11% of hospital admissions, but short lengths of stay mean that they make up only 4% of all occupied bed days [55]. A survey of liaison psychiatry services in 2012 [59], found

that just over 50% provided a children's liaison psychiatry service. Of those, the majority offered a team within Child and Adolescent Mental Health Services (CAMHS) and about half as many offered a separate paediatric liaison psychiatry service. This is in keeping with the tradition that liaison psychiatry services have been provided on an *ad hoc* basis by CAMHS [60]. Some covered the entire range of wards, while others were only funded to cover particular services. Separate commissioning arrangements have also stifled the development of joint liaison psychiatry services [60].

There is little evidence of the clinical or cost-effectiveness of child and adolescent liaison psychiatry. However, psychosomatic and adjustment disorders, as well as anxiety and depression, are common among children and young people with chronic illnesses. Half of all lifetime mental illness (excluding dementia) presents before the age of 14 [61] and mental health problems that develop in childhood also often persist into adult life, so even modest efficacy could indicate significant financial savings, let alone the reduction in suffering.

Training hospital staff

There is consensus that training acute colleagues is a key role of a liaison psychiatry service. [53-55 62] A US review found that educating physicians in recognising and treating depression reduced suicide rates [63]. In the UK, many general hospital staff report that they lack the confidence to recognise and support patients with mental health problems, including those presenting at A&E following self-harm or suicide attempts, and patients with dementia on the general medical wards [56]. In some cases, this can lead to poor quality treatment, distressed patients and staff, and negative staff attitudes and behaviour. This can also lead to patients discharging themselves before they have received an assessment or offer of treatment [64].

The scale of need in acute hospitals means that rationing by the liaison psychiatry team is inevitable. Training can help to mitigate this by building capacity in other hospital staff [55]. Many liaison psychiatry teams currently have too few staff to offer a regular training programme and this hinders the quality of care received throughout the hospital. Scandals such as Mid Staffs suggest that better training is needed and acute staff have reported to the Royal College of Psychiatrists Psychiatric Liaison Accreditation Network (PLAN) that they think liaison psychiatry teams would be best placed to provide this. Of the 36 services for which PLAN have data, only 19 receive any funding to provide training [56]. However, training is potentially the most cost-effective function of a liaison psychiatry service. A failure to fund this function is likely to result in greater costs elsewhere in the hospital.

Can a better system really improve care and save money?

The most comprehensive economic evaluation yet undertaken on a hospital liaison psychiatry service in the UK is that by Centre for Mental Health [65] 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.

Community liaison psychiatry services

To date, liaison psychiatry services have been largely based in hospitals. The high burden of mental health problems in the hospital population and the scarcity of resources have made this inevitable. However, there is currently a trend to move the management of long-term conditions out of hospitals and into the community., which is resulting in shorter lengths of stay.

These long-term conditions are still associated with significant mental health comorbidity and resulting increased costs even when managed in the community [55]. There is an emerging consensus that liaison psychiatry services need to expand their scope to include GPs and other physical community treatment services. [53 55 62]

Some liaison psychiatry services already offer outpatient clinics to follow up patients in the community. However, many liaison psychiatry teams 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 [56].

The next step would be to open those clinics to proactive referrals to from GPs and other community clinicians so that admissions can be avoided in the first place. Two of the key areas for expansion in community-focused liaison work, identified by Centre for Mental Health, [55] are Medically Unexplained Symptoms and Long-term Conditions.

Medically Unexplained Symptoms

Medically unexplained symptoms are persistent physical symptoms, such as headache, chest pain, back pain, dizziness, and fatigue, that do not have a readily recognisable physical cause [66]. Some of these are likely to have an unrecognised organic cause and they feel very real to the patient, but in a significant proportion of cases, they can be masking an underlying mental health problem.

GPs currently have little support to deal with people whose needs may be characterised by such complexity [55]. Cognitive Behavioural Therapy (CBT) has been shown to be effective in relieving medically unexplained symptoms [41 67]. This treatment has also been shown to be cost effective by reducing GP and hospital consultations, reducing attendance at A&E, reducing prescriptions, and reducing absence from work. Total savings of £1.75 for every £1 invested were calculated for a comprehensive programme, and £7.82 for every £1 invested for a targeted programme, with most of the pay-offs accruing to the NHS [68].

Medically unexplained symptoms are therefore 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, London, provides a continuum of support for patients with complex needs including medically unexplained symptoms, bridging 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 [55].

This service and others like it are relatively new and while they appear to address the cost and quality challenge, they still need to be subjected to robust economic evaluation. One model, produced by the Mental Health Network [69], estimated that treating patients with medically unexplained symptoms with CBT and using e-learning to increase awareness among GPs could produce a national saving of £639 million. This would be achieved mostly through reduced sickness absence, with a broadly cost-neutral impact on the NHS.

Long-term conditions

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 [42]. 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 [30 55].

The idea of liaison psychiatry providing integrated care is already well established in hospitals, so it would make sense for the same teams to be involved in delivering this in the community. Such a role might involve [55]:

- Diagnosis of complex psychiatric morbidity
- Case management of complex cases
- Supervision and support for others, including GPs and IAPT practitioners
- Training staff involved with integrated care
- Developing educational materials for patients.

A US study [70] has found this approach to be cost-effective in treating depression in older adults with diabetes, with a cost per QALY of less than £250.

A similar model has been implemented by The King's College Hospital Diabetes and Mental Health Service [69]. This 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:

- Diagnosis and formulation
- Psychopharmacological and psychological treatments
- Neuropsychology assessment
- Case management
- Consultation/liaison
- Training to the diabetes clinical team, IAPT and primary care staff.

Early indication of clinical and cost effectiveness are positive and a robust economic evaluation of this service is awaited.

A Chest Clinic Integrated Pathway operates for patients at the Royal Victoria Infirmary in Newcastle [69]. All nurses working in the chest clinic have been trained to at least foundation level in CBT and are able to identify, assess and treat co-morbid anxiety and depression in people suffering from COPD. 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 [71] has shown improvement in levels of anxiety and depression, and a reduction in admissions.

Similar models for other chronic physical conditions are showing promising results but require robust economic evaluation.

Modelling the impact of hospital and community liaison psychiatry services

Given the costs of co-morbidities and medically unexplained symptoms, it has been 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 [55]. A lack of evidence means that it has not been possible to estimate a potential saving from community-based liaison psychiatry services.

Significant further work is required to establish, more precisely, what services are currently being delivered and how cost effective they are. Work is also required to determine the workforce implications of such developments. The recent call from the NIHR [72] for research proposals investigating the organisation, quality and cost-effectiveness of liaison psychiatry services in acute settings is welcome, but it is unfortunate that it excludes proposals related to community liaison psychiatry.

Dementia services

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 [73]. In this section we focus on dementia, but it is important to point out that older people are also vulnerable to a wide range of other mental health problems.

The issues facing dementia services are, in some ways, closely related to those of liaison psychiatry services. However, there are unprecedented demographic changes taking place throughout the developed world and older people have the highest levels of physical and psychiatric morbidity [74]. This has unique social and economic implications.

The burden of dementia now and in the future

In 2004, dementia contributed 11.2% of all years lived with disability among people aged 60 and over. This was more than stroke (9.5%), musculoskeletal disorders (8.9%), cardiovascular disease (5.0%) and all forms of cancer (2.4%) [75]. The same report noted that on a personal level, dementia accorded a higher level of disability than any other condition with the exception of spinal cord injury and terminal cancer [75].

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 [76]. 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% [75].

Among patients with late-onset dementia (98% of the total), 55% have mild dementia, 32% have moderate dementia, and 13% have severe dementia [75].

Total annual costs varied accordingly: £16,689 for those with mild dementia living in the community, £25,877 for those with moderate dementia, £37,473 for those with severe dementia, and £31,296 for those living in supported accommodation [75].

These figures are likely to be a significant underestimate of the true cost of dementia. For example, the 8% (£1.84 billion) that is accounted for by the NHS only includes direct old age mental health spending. We also know that almost two thirds of acute hospital beds are occupied by people over 65 [77], and that 30% of

these patients will be suffering from dementia and 20% from delirium [78]. Cognitive impairment is often not recognised or assessed systematically in general hospitals. This is a major reason for delayed discharge and is often not reported to primary or secondary care on discharge [78]. Patients with dementia have longer lengths of stay and greater mortality than other patients [79].

What are dementia services and what do good dementia services look like?

Dementia services include a wide range of community, mental health and social care services designed to meet the needs of both the heterogeneous group of individuals who suffer from dementia and their carers. Since the National Dementia Strategy was published in 2009 [79], NICE has added Quality Standards [80 81] and a Dementia Pathway [82] to its clinical guideline on dementia [83]. These documents describe what good dementia services look like.

The Dementia UK report noted that "*historically, a lack of attention from policy makers and service commissioners to the needs of people with dementia has led to dementia care being delivered piecemeal and in an inefficient fashion*" [75]. While dementia has recently received attention as a national priority, this has not always resulted in action at the regional or local level [74]. The result has been large variations in the level of provision, expenditure and in unit costs across all services and in all UK countries [75].

This paper examines some of the key areas of dementia care that have been identified in a currently unpublished report from the Faculty of the Psychiatry of Old Age at the Royal College of Psychiatrists [84]. Some of the case studies derived from this work are reproduced here. Some will require investment to improve outcomes, but many will also cut costs. Some of these case studies have been piloted, changed, discontinued or integrated with other services without robust economic evaluation. An opportunity to identify the most cost effective service models has therefore been missed.

Raising awareness

In many cases, dementia is diagnosed too late in the course of the illness [73 85]. More partnership working between public and voluntary sector organisations is required to reduce the stigma surrounding dementia and to ensure that members of the public, and all clinical and social care staff, are equipped to recognise the early stages of the syndrome and to seek appropriate help.

Progress has been made within general hospitals, where two thirds now offer dementia awareness training to doctors and allied healthcare professionals, almost 90% offer it to nurses and healthcare assistants, and 60% offer it to support staff [57]. While early recognition is a key aim of this training, evidence also suggests that it can have a significant impact on length of stay [65]. Work remains to push these figures towards 100% and to ensure that the offer of training is taken up. Even more work will be required to extend such training beyond general hospitals and into the community.

Norfolk & Waveney Mental Health NHS Foundation Trust (now called Norfolk and Suffolk NHS Foundation Trust) established a Clinical Academy for Dementia to train and educate carers in non-dementia services. This aims to expand capacity and to improve care and quality of life for patients and their carers. So far, they have delivered Dementia Awareness Training to 1,200 care staff.

Early identification and intervention for people with dementia

Diagnosis rates have improved slightly in recent years, but in England in 2012, only 44% of people with dementia had a diagnosis. There are also considerable geographical variations in diagnosis rates. In Wales,

the figure was 39% while in Northern Ireland, it was 63%, with Belfast managing 75% [86]. In contrast, the proportion of people wanting to know their diagnosis of dementia is the same as that for cancer [87].

Early diagnosis matters for patients and carers. For example, people who take cholinesterase inhibitors have a significant delay in institutionalisation compared to a matched population who do not take these drugs [88].

The Health Improvement, Efficiency, Access to services and Treatment (HEAT) target in Scotland supports a commitment to achieve improvements in the early diagnosis and management of people with dementia. This achieved an increase in the number of people on the Quality and Outcomes Framework (QOF) dementia register from 32,000 in 2008/09 to 41,525 in 2011/12 [89].

Post-diagnostic support

Patients and carers can have a variety of responses to a diagnosis of dementia. When patients adjust poorly, it can be hard to engage them in services and carer stress can become a major problem. A review of the literature [90] found carer stress to be the best predictor of entry to institutional care. A separate review found a lack of specialist support, particularly post-diagnosis. [91] A randomised-controlled trial showed that carer support could benefit the carer's health and delay institutionalisation. [92]

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 health care savings due to the reduction in strokes and falls alone. It would avoid over 1,300 strokes and almost 120 falls per year compared to using antipsychotics. [93]

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

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 point of contact. Comprehensive risk assessment aims to ensure that only those at high risk are placed in institutional settings.

Evidence from Scandinavia and from Manchester shows that intensive case management of people with moderate dementia delays institutionalisation. [94] Another study has shown intensive management to improve wellbeing among those with dementia and their carers.[95]

Norfolk & Waveney Mental Health NHS Foundation Trust developed an intensive support team of 20 experienced qualified nurses and support workers, operational 7 days a week, from 8am till 10pm. The team visited up to twice per day for up to 6 weeks to stabilise challenging situations, avoid unnecessary admissions, and facilitate discharge from acute general hospitals or from the specialist in-patient assessment unit. In the first year, in-patient occupancy rates for the specialist dementia assessment unit dropped from 110% to 65%. The in-reach service to the acute general hospital is yet to be evaluated.

People with dementia in care homes

Dementia carries a five-fold increase in the risk of nursing home placement [96]. A survey by the Alzheimer's Society found that while some homes provided excellent care, too many were not providing the patient-centred care that was required. [97] For example, the study found that the typical person in a home spent only two minutes interacting with staff or other residents, excluding care tasks, during a six-hour observation period. High levels of antipsychotics, with potentially harmful side-effects, have been found to be used in care homes [98]. Care homes also account for a large proportion of the total cost of dementia care[75].

A service in Canterbury has managed to reduce or stop antipsychotic medication in 75% of cases through a consultant-led service working with local GPs in residential homes in a specific geographical area.

A service in Camden and Islington has run clinics in care homes in association with GPs over the last five to six years, attended by 8-10 nursing home staff of various backgrounds, four times yearly over a morning. This has resulted in a reduction in emergency referrals, improved staff morale and improved accessibility to advice for patients not attending the home clinics.

Dementia in general hospitals

Despite its high prevalence, cognitive impairment is often not recognised or assessed systematically in general hospitals. This is a major reason for delayed discharge and is often not reported to primary or secondary care on discharge [57 78]. The National Audit Office found evidence that hospital staff avoided making the diagnosis as it would then make placement more difficult and delay discharge [99]. Patients with dementia have longer lengths of stay, greater mortality, and increased risk of institutionalisation [79]. There are often marked deficits in the knowledge and skills of general hospital staff who care for people with dementia [79]. While most hospitals had access to a liaison psychiatry service, only one third had 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 [57].

More needs to be done to proactively prevent admissions that result from both physical and psychiatric causes. When this is not possible, systems must be in place to identify those patients who are suffering from undiagnosed cognitive impairment or who may be at risk of developing delirium. There should also be a better interface with community services to aid discharge and prevent unnecessary readmission. There are pockets of good care, but no service has yet implemented a fully integrated, proactive system.

Late-stage dementia

The palliative care needs of people with dementia are different from patients with other conditions. The declining condition of the patient can occur over a much longer period than with cancer and the patient's distress can be more difficult to address. This care is often poorly planned and co-ordinated [100].

Good multidisciplinary palliative interventions can avoid unnecessary admissions and treatments, provide symptomatic relief and improve spiritual care [101]. Proactive planning is helpful to set up palliative care that meets the needs of the individual.

The Greenwich Advanced Dementia Service has looked after about 130 people with advanced dementia at home and has enabled about 75% to die well at home with appropriate support. Key needs include management of distress and adjustment of anti-psychotic medicines. The service saved around £2.5 million for an investment of about £200,000 [84].

Modelling the impact

We have illustrated the burden of dementia, outlined deficiencies in current service provision, and highlighted ways in which they could be addressed.

Ideally, we would like to bring this work together by mapping current service provision across the country and estimating what resources would be required to provide a good service everywhere. We would then like to be able to model the impact that this would have on patient and carer outcomes, and on costs to the NHS and beyond. The fragmented and limited data available mean that further work is required to make this possible:

- Mapping provision: The national audit of dementia care in general hospitals [57], produced by The Royal College of Psychiatrists, provides a limited picture within the hospital setting and other areas of dementia care remain completely unmapped. A national survey for each of the key aspects of dementia care outlined in this section would be the starting point for a more robust model.
- Costs and benefits: We have outlined several examples of potentially good practice. These projects have demonstrated how they could improve outcomes while decreasing costs within mental health services, the broader NHS, and beyond, but most have not been subject to robust economic evaluation.

Case study: The benefits of a comprehensive dementia service

Almost a year after Fred began experiencing symptoms, a nurse at his local GP surgery noticed his cognitive impairment when he came for his flu jab on the wrong day. She had received recent dementia awareness training and referred him to the memory service, which organised a timely assessment and investigations, made the diagnosis of Alzheimer's disease, and organised a basic care package to maintain his independence.

Fred was commenced on Donepezil that seemed to achieve a modest delay in his progression. The memory service also discussed long-term plans and give Fred a chance to decide how he would be treated if his condition deteriorated. On the advice of the memory service, Fred stopped driving, but the team ensured that he could still get to social events and he did not become isolated.

As his condition deteriorated, Fred's care package was increased but eventually, four and a half years after starting to experience symptoms, Fred was unable to manage at home. His care team took him to view suitable homes and he chose one that provided the sort of activities that he enjoyed.

He would rather be at home, but the staff had more time to engage residents and they had been trained in dementia care. They receive support from the challenging behaviour team in the CMHT. Fred avoided antipsychotics, did not suffer a stroke, and was not admitted to hospital. At the end of his life, a clear palliative care plan, which was discussed with him shortly after initial diagnosis, was implemented.

How can we make this happen? A role for everyone

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.

Contributors

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