Mental Health Foundation

Centre for Mental Health, Mental Health Foundation, Mind, Rethink Mental Illness and Royal College of Psychiatrists

Health and Social Care Bill House of Lords Report Stage Briefing
8 February 2012

Amendment to promote parity of esteem between mental and physical health

Clause 1

LORD MACKAY OF CLASHFERN
LORD PATEL
BARONESS HOLLINS
LORD ALDERDICE

Page 2, line 6, after "of" insert "mental and physical"

Purpose of amendment

These amendments would clarify that the Secretary of State (clause 1) has a duty to promote a health service designed to secure improvements in the prevention, diagnosis and treatment of both physical and mental illness. They do this by inserting the words "mental and physical" before "illness".

The amendment would put the Government's own commitment to parity of esteem between mental and physical health care on a statutory footing, making it clear that the Secretary of State is fully committed to improving the nation's mental health services and the prevention and treatment of mental *and* physical illnesses.

Reasons for amendment

When the Government launched its mental health strategy, *"No Health Without Mental Health",* in February 2011 the Minister for Care Services stated that he wanted to see "parity of esteem" between mental health and physical health services. This was in recognition of the fact that, despite its prevalence (one in four people experience a mental health problem during their life time) mental health has never received the funding or attention it needs. Progress in improving the quality of commissioning and services has been much slower in mental health.

'Parity of esteem' is not defined in the document itself, however it would be reasonable to expect this would mean a recognition of the equal importance of mental and physical health and the need to consider both aspects of people's health when they present with either a physical or a mental illness.

We would expect this recognition to be evident in terms of access to mental health services and funding for services proportionate to the 'disease burden'. For years, however, this has not been the case.

In recent years things have begun to improve – for example we have seen significant and very welcome investment in talking therapies under the both present and previous Governments (£173 million from 2007-10 and £400million from 2010-14). However, since mental health services started from a very low baseline, we simply cannot afford to go backwards, and talking therapies are only one aspect of mental health care.

During previous spending squeezes, e.g. during the financial year 2005/06, mental health services have been unfairly and disproportionately targeted for cuts – perhaps because they do not enjoy the same levels of public support and understanding as other services (such as cancer or maternity).

However, mental illness is a leading cause of suffering, economic loss and social problems and it is time to recognise and act on the plentiful evidence that good mental health underlies all health: poor mental health is associated with diseases such as cancer, cardiovascular disease and diabetes and poor physical health increases the risk of mental illness.

In the current climate of scarce resources, expenditure reduction, welfare reform and cuts to legal aid, mental illness and mental health problems are likely to increase. It is vital that mental health spending should be proportionate to need, and that mental health must not be the 'poor relation' of physical health.

- While mental illness represents 23% of the disease burden[1], it accounts for only 11% of the health budget[2].
- More than a fifth of the population in England experiences a mental disorder at any one time
- Almost half of adults experience at least one episode of depression during their lifetime
- Only a quarter of affected individuals receive any intervention except those with psychosis
- Compared with people with no mental health problems, men with severe mental illness can expect to live 20 years less, and women 15 years less
- An estimated 42% of tobacco smoked in the UK is consumed by people with mental health problems, for whom smoking cessation needs to be tailored in order to be effective.

A combination of life style risk factors (such as smoking and diet), higher rates of unnatural deaths (such as suicides and accidents), and poorer physical health care contribute to this scandal of premature mortality[3].

If such a disparity in mortality rates were to affect a large segment of the population with a less stigmatised characteristic, then we would witness an outcry against a socially unacceptable neglect of this group.

Whilst the amendments cannot solve all of this, creating an explicit duty on the Secretary of State would set a clear expectation that commissioners need to give full consideration to the mental health of those with physical health problems, as well as the physical health of those with mental health problems. It is simply not acceptable for the mental health needs of both children and adults to continue to be neglected.

Benefits of mental health being regarded as equal to physical health

Parity should not only mean improving the physical health of people with mental health problems, but also the mental health of people with physical problems

There are three major ways in which placing parity of esteem on a statutory basis would improve the quality and efficiency of the system.

1. **Integration of services**

Physical health and mental health are inextricably linked. Action is needed to improve the physical health of people with mental health problems, and to make mental health a key public health priority. Poor mental health is associated with an increased risk of diseases such as cardiovascular disease, cancer and diabetes, while good mental health is a known protective factor. Poor physical health also increases the risk of people developing mental health problems.

- Depression is at least twice as common among those with cardiovascular diseases and those with diabetes.
- Depression also affects 33% of women and 20% of men with arthritis.
- People with COPD, meanwhile, are 10 times more likely than average to have panic disorder.
- Patients with chronic heart failure are eight times more likely to die within 30 months if they have depression.

Outcomes from cardiovascular care are poorer for patients with co-morbid mental health problems, even after taking severity of cardiovascular disease and patient age into account. Cardiovascular patients with depression experience 50% more acute exacerbations per year and have higher mortality rates.

People with diabetes who also have co-morbid mental health problems are at increased risk of poorer health outcomes and premature mortality. People with diabetes and co-morbid depression have 36–38% increased risk of all-cause mortality over a two-year follow-up period.

Consequently, there is a need to address the two in combination. Liaison psychiatry services in general hospitals, for example, can achieve savings to the NHS (and to social care and housing services as well) that are several times higher than their running costs. The RAID service in Birmingham City Hospital saves the NHS some £3.5 million a year by reducing the number and length of admissions into the hospital, especially among older patients.

2. Balanced investment

There is also still an imbalance between mental and physical health in both health care and health promotion in many places. A better balance could bring a number of benefits both to people living with or facing the risk of mental ill health. For example:

- Early intervention in psychosis services has been shown to save the NHS £9 for every £1 they cost and the wider economy a further £9. A number of such services are being cut because of financial constraints or being merged with generic community mental health services, which do not bring the same financial benefits.

- Proven early years parenting interventions to prevent or manage behavioural problems and conduct disorder can save some £200,000 per child at a cost of only about £1,000. Most of these savings accrue to the criminal justice system rather than the NHS. While there is clear evidence of the benefits of such interventions they are rarely offered and few health visitors are trained in how to offer them.

3. Parity in policy-making

Finally, health and social care policy should be developed with mental as well as physical health needs in mind. Payment by Results has existed in the NHS for almost a decade yet it is only now being extended to adult mental health services, with CAMHS trailing further behind again. This is one of the reasons mental health services have been singled out for spending cuts previously.

A duty to promote equality should encourage policy-makers at all levels of the system to consider mental health alongside physical health rather than making policy for the latter and later adjusting it to fit the former.

This is why we need joined up and balanced health services and public health programmes, which recognise there can be no health without mental health.

About us

Centre for Mental Health, the Mental Health Foundation, Mind, Rethink Mental Illness and the Royal College of Psychiatrists are working together to inform debate about the Health and Social Care Bill from the perspective of mental health services and those who use them.

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1HM Government (2011). No health without mental health: A cross-government mental health outcomes strategy for people of all ages

2 Department of Health (2009) Departmental Report 2009: The Health and Personal Social Services Programmes.

3 Wahlbeck K, Westman J, Nordentoft M, Gissler M, Laursen TM (2011) Outcomes of Nordic mental health systems: life expectancy of patients with mental disorders. *Br J Psychiatry* 2011; 199(6)