HOUSE OF LORDS

Library Note

Debate on 10 October: Parity of Esteem for Mental and Physical Health

This Library Note provides background reading for the debate to be held on Thursday 10 October:

"the implications of parity of esteem for mental and physical health, as required by the Health and Social Care Act 2012".

The first section outlines key statistics about the prevalence and treatment of mental health disorders and presents information about current spending on mental health in England. The second section sets out the requirements of the Health and Social Care Act 2012 for parity between physical and mental health and summarises the debates held on the issue during the passage of the legislation through Parliament. The final section presents the main recommendations of the Royal College of Psychiatrists from its report on achieving parity and concludes with a summary of the Government's strategy towards mental health.

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1. Mental Health in England

1.1 Definition

The Mental Health Act 1983 defines a 'mental disorder' for "the purposes of the statutory provisions for the reception, care and treatment of mentally disordered persons and the management of their property and affairs, and related matters". Here a mental disorder is defined as "any disorder or disability of the mind. Dependence on alcohol or drugs is not considered to be a disorder or disability of the mind for these purposes". The legislation states that people with a learning disability are not to be considered as suffering from a mental disorder; or requiring treatment in hospital for mental disorder, unless that disability is associated with "abnormally aggressive or seriously irresponsible conduct" (*Halsbury's Laws of England*, 'Mental Health and Capacity', para 761).

1.2 Prevalence

The last comprehensive survey that provides a picture of the mental health of people in England was published in 2009. The survey, *Adult Psychiatric Morbidity in England,* is "the primary source of information on the prevalence of both treated and untreated psychiatric disorders and their associations" among adults aged 16 and over living in private households in England (NHS Information Centre, *Adult Psychiatric Morbidity in England, 2007: Results of a Household Survey*, 2009, p 11). The data covers a range of mental health disorders or behaviours. The most prevalent are common mental disorders (CMD), defined as "mental conditions that cause marked emotional distress and interfere with daily function, but do not usually affect insight or cognition. They comprise different types of depression and anxiety" (ibid, p 25). Other conditions surveyed are posttraumatic stress disorder; suicidal thoughts, suicide attempts and self-harm; psychosis; antisocial and borderline personality disorders; attention deficit hyperactivity disorder (ADHD); eating disorders; alcohol misuse and dependence; drug use and dependence; and gambling behaviour.

The National Centre for Social Research summarised the key findings of the 2007 survey. It found:

- Just over 16 percent of people in England had a CMD at the time of interview, an overall rate which had not changed since 2000. The proportion of 16 to 64-year-old women with a CMD had increased from 19.1 percent in 1993 to 21.5 percent in 2007, while among men the difference in rate over the same period was not significant. The proportion of people with more severe psychiatric disorders (eg psychosis and antisocial and borderline personality disorders) remained under 1 percent.

- One-third (32 percent) of people with neurotic symptoms assessed as severe enough to require treatment were receiving medication or counselling for a mental or emotional problem.

- Men made up a quarter of those screening positive for possible eating disorder, indicating that this was not just an issue for women. The study found higher rates of disordered eating not only among people who were underweight, but also among obese people.

- While ADHD had been widely studied in childhood, less was known about its presence in adulthood. Although childhood ADHD was more likely in boys than girls, survey measurement using a screening tool designed to identify adults who may have ADHD characteristics found no significant difference between men and women.

(National Centre for Social Research, 'Adult Psychiatric Morbidity in England 2007—Findings', January 2009)

In 2011, the Government published its mental health strategy. To illustrate the prevalence of mental illness the document referred to the following statistics:

- One in ten children aged between 5 and 16 years has a mental health problem, and many continue to have mental health problems into adulthood.
- Half of those with lifetime mental health problems first experience symptoms by the age of 14, and three-quarters before their mid-20s.
- Self-harming in young people is not uncommon (10–13 percent of 15–16-year-olds have self-harmed).
- Almost half of all adults will experience at least one episode of depression during their lifetime.
- One in ten new mothers experiences postnatal depression.
- About one in 100 people has a severe mental health problem.
- Some 60 percent of adults living in hostels have a personality disorder.
- Some 90 percent of all prisoners are estimated to have a diagnosable mental health problem (including personality disorder) and/or a substance misuse problem.

(HM Government, *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages*, February 2011, p 8)

The paper went on to describe some of the far-reaching personal effects mental disorders can have:

> People with severe mental illnesses die on average 20 years earlier than the general population.
>
> Having mental health problems can be distressing to individuals, their families, friends and carers, and affects their local communities. It may also impact on all areas of people's lives. People with mental health problems often have fewer qualifications, find it harder to both obtain and stay in work, have lower incomes, are more likely to be homeless or insecurely housed, and are more likely to live in areas of high social deprivation.

> They are more likely to have poor physical health. This is due in part to higher rates of health risk behaviours, such as smoking, and alcohol and substance misuse. Some people with mental health problems have poor diets, may not be physically active and may be overweight, though the reasons for this are complex.
>
> (ibid, p 9)

The Mental Health Policy Group, convened by Lord Layard, has estimated that mental illness accounted "for nearly 40 percent of morbidity, compared with for example 2 percent due to diabetes". Additionally, "taking together all ages up to 65, mental illness accounts for nearly as much morbidity as all physical illnesses put together. It is by far the most important illness for people of working age" (Mental Health Policy Group, *How Mental Health Loses Out in the NHS*, June 2012, p 6)

1.3 Treatment

Until the development of anti-depressants and anti-psychotic drugs in 1950s, "there was relatively little that could be done" for people with mental disorders apart from "tender loving care". In the 1970s, psychological therapies, such as cognitive behaviour therapy, began to be developed and trialled for effectiveness. Today, National Institute for Health and Care Excellence (NICE) guidelines on the treatment of depression, for example, include the following recommendations:

- Active monitoring—this is for mild depression and means keeping an eye on you while waiting to see if your depression goes away without treatment, which mild depression often does.
- Cognitive behaviour therapy (CBT), including self-help books, computerised CBT for mild depression; a series of sessions with a therapist for more severe depression.
- Mindfulness-based cognitive therapy.
- Behavioural activation.
- Other forms of talking treatment, such as counselling or interpersonal psychotherapy.
- Medication for severe depression, but not for mild to moderate depression unless other treatments have not helped. This should be combined with CBT or psychotherapy.
- Exercise.

(Mind, *Understanding Depression*, 2012, p 13)

In terms of efficacy it has been noted that for depression and anxiety disorders "the typical short-term success rate for CBT is about 50 percent" (Mental Health Policy Group, *How Mental Health Loses Out in the NHS*, June 2012, p 13).

The proportions of people receiving treatment remain low. The *Adult Psychiatric Morbidity in England* survey revealed that "three-quarters of adults with a CMD were not in receipt of medication or counselling, including two thirds of adults assessed by the survey as having a level of neurotic symptoms sufficient to warrant treatment". The survey also found that the "severity of symptoms and type of disorder were strong predictors of whether treatment was received" (NHS Information Centre, *Adult Psychiatric Morbidity in England, 2007: Results of a Household Survey*, 2009, p 35). A separate study found that 80 percent of adults with schizophrenia or bipolar disorder were in treatment. Additionally it found 28 percent of children with ADHD were receiving treatment; 24 percent of those with depression/anxiety were being treated and 43 percent of children with Autistic Spectrum Disorder were receiving treatment (Mental Health Policy Group, *How Mental Health Loses Out in the NHS*, June 2012, p 13).

In its study of mental health treatment in the NHS, the Mental Health Policy Group stated it was "a real scandal that we have 6,000,000 people with depression or crippling anxiety conditions and 700,000 children with problem behaviours, anxiety or depression. Yet three quarters of each group get no treatment". The Group argued this was more incontestable as treatment was available and "unlike most long-term physical conditions, much mental illness is curable". It added that:

> The situation is slightly different for anxiety conditions and depression. Roughly half of all mental illness consists of anxiety conditions (like social phobia, health anxiety, PTSD, OCD, panic disorder or generalised anxiety). If untreated, these conditions are frequently lifelong. But after an average of 10 sessions of CBT costing £750, a half of all patients will recover, in most cases for life. With depression, one half recover with CBT within four months, and their likelihood of relapse is significantly reduced (but not eliminated). The shortrun success rate with CBT is similar to that of drugs but the effects are more long-lasting. These 50 percent recovery rates are those expected from a mature service and are now being approached in IAPT, where recovery rates have reached 43 percent, despite much of the work still being done by trainees or newly-trained staff.
>
> (Mental Health Policy Group, *How Mental Health Loses Out in the NHS*, June 2012, p 13)

Professor Sue Bailey, President of the Royal College of Pyschiatrists, has noted the evidence suggests that in spite of the commonality of mental health disorders and behaviours in society, "mental health does not receive the same attention as physical health". She explained:

> People with mental health problems frequently experience stigma and discrimination, not only in the wider community but also from services. This is exemplified in part by lower treatment rates for mental health conditions and an underfunding of mental healthcare relative to the scale and impact of mental health problems.
>
> However this has arisen, the consequences are severe. People with severe mental illness have a reduced life expectancy of 15–20 years, yet the majority of reasons for this are avoidable. This can no longer be tolerated in the 21st century.
>
> (Royal College of Psychiatrists, *Whole-Person Care: From Rhetoric to Reality—Achieving Parity Between Mental and Physical Health*, March 2013, p 4)

1.4 Spending on Mental Health

According to the Government, mental ill health now represents "up to 23 percent of the total burden of ill health in the UK" and "nearly 11 percent of England's annual secondary care health budget is spent on mental health" (HM Government, *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages*, February 2011, p 10).

The Mental Health Policy Group has put total expenditure on healthcare for mental illness at about £14 billion a year, with the "largest expenditure" being "on people with schizophrenia, bipolar disorder and personality disorder (the majority of the latter are in forensic care)". Elderly patients, largely those with dementia, were the next largest spending category, a group that "also attract large social care expenditure from local authorities". The Group estimated that drug and alcohol services cost over £1 billion and the "700,000 children with mental disorders get only £0.8 billion spent on CAMHS [Child and Adolescent Mental Health Services], while for the 6,000,000 adults with depression and anxiety disorders the main discrete service is Improving Access to Psychological Therapies, costing roughly £0.2 billion in 2010/11". The cost of providing support from GPs was put at "some £1.9 billion" (Mental Health Policy Group, *How Mental Health Loses Out in the NHS*, June 2012, p 10). However, the Group's study thought these costs were inadequate, as they did not capture spending on related physical conditions:

> Nearly a third of all people with long-term physical conditions have a co-morbid mental health problem like depression or anxiety disorders. These mental health conditions raise the costs of physical health-care by at least 45 percent for a wide range of conditions including cardio-vascular disease, diabetes and COPD [Chronic obstructive pulmonary disease] at each level of severity, costing at least £8 billion a year. Moreover, a half of all patients referred for first consultant appointments in the acute sector have medically unexplained symptoms, such as back pain, chest pain and headache. These patients cost the NHS some £3 billion a year, and many of them should be treated for mental health problems. So, if we add in the £8 billion or more above, untreated mental illness is costing the NHS over £10 billion in physical healthcare costs.
>
> (Mental Health Policy Group, *How Mental Health Loses Out in the NHS*, June 2012, p 10)

In terms of the levels of investment in mental health, the most recent official analysis by the Department of Health of spending on adult mental health services found that:

- Total investment in adult mental health services in 2011/12 (reported investment plus estimated unreported investment) was £6.629 billion or £198.3 per head of weighted working age population.
- Total investment increased from £6.550 billion in 2010/11 to £6.629 billion which is a 1.2 percent cash increase and a real decrease of -1.0 percent.
- Since 2001/02, the total investment, after allowing for inflation, has increased by 59 percent in real terms. At 2011/12 prices, £4.162 billion was spent in 2001/02 and £6.629 billion in 2011/12.

- The percentage of investment reported in direct services (as opposed to overhead or capital costs) is now at its highest recorded level of 82.9 percent compared to 81.9 percent in 2010/11.

(Department of Health, *2011/12 National Survey of Investment in Adult Mental Health Services*, August 2012, p 1)

The following tables provide figures for the total cash investment in adult mental health services since 2001/02 and the total real term investment each year over the same period:

Cash Investment in £' Billions

Year	Reported Investment	Estimated Unreported	Total Investment	Annual Increase	% Cash Increase
2001/02	3.129	0.125	3.254		
2002/03	3.489	0.220	3.709	0.455	14.0%
2003/04	3.910	0.033	3.943	0.234	6.3%
2004/05	4.474	0.046	4.520	0.577	14.6%
2005/06	4.679	0.225	4.904	0.384	8.5%
2006/07	4.991	0.172	5.163	0.259	5.3%
2007/08	5.512	0.018	5.530	0.367	7.1%
2008/09	5.849	0.043	5.892	0.362	6.5%
2009/10	6.001	0.322	6.323	0.431	7.3%
2010/11	5.655	0.895	6.550	0.227	3.6%
2011/12	5.717	0.912	6.629	0.078	1.2%

Real Term Investment in £'Billions

Year	Reported Investment	Estimated Unreported Investment	Total Investment	Annual Increase	% Increase
2001/02	4.002	0.160	4.162		
2002/03	4.348	0.274	4.622	0.460	11.1%
2003/04	4.773	0.040	4.814	0.191	4.1%
2004/05	5.309	0.055	5.364	0.550	11.4%
2005/06	5.442	0.262	5.703	0.339	6.3%
2006/07	5.618	0.194	5.812	0.108	1.9%
2007/08	6.066	0.019	6.085	0.274	4.7%
2008/09	6.249	0.046	6.295	0.210	3.4%
2009/10	6.298	0.338	6.636	0.341	5.4%
2010/11	5.780	0.914	6.694	0.058	0.9%
2011/12	5.717	0.912	6.629	-0.066	-1.0%
Increase in the 10 years 2001/02 to 2011/12			2.467		59.3%

These show that cash investment rose between 2010/11 and 2011/12, but real term investment did not kept pace with inflation and fell by -1.0 percent. The authors of the analysis sounded a note of caution as to why this may be, having been advised the difference may be accounted for by: monies saved by bringing services previously provided by the non-statutory sector back into 'in house NHS provision', or monies saved by using non-statutory providers instead of 'in house' as they offered lower unit costs (Department of Health, *2011/12 National Survey of Investment in Adult Mental Health Services*, August 2012, p 9).

Nevertheless, in the assessment of the Royal College of Psychiatrists, mental health was an underfunded service, particularly when compared with the spending on other conditions:

> Mental illness is responsible for the largest proportion of the disease burden in the UK (22.8 percent), larger than that of cardiovascular disease (16.2 percent) or cancer

> (15.9 percent). Overall, the economic and social costs of mental health problems were estimated at £105 billion in 2010.
>
> In comparison, the wider annual UK cost of obesity is £15.8 billion and the wider annual UK cost of cardiovascular disease is £30.7 billion. However, only 11.1 percent of the NHS budget—£11.9 billion—was spent on NHS services to treat mental health problems for all ages during 2010/11.
>
> The funding gap for older-adult mental health services is particularly large, not just in terms of the funding available compared with disease burden but also in comparison with the level of service provision (also underfunded) in adult mental health services. It was estimated in 2008 that around £2 billion of additional funding would be required to eliminate the inequality in service provision between middle-aged people (aged 35–54) and people aged 55 or over.
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> (Royal College of Psychiatrists, *Whole-Person Care: From Rhetoric to Reality—Achieving Parity Between Mental and Physical Health*, March 2013, p 23)

1.5 Economic and Social Costs

Beyond spending on mental health care, there has also been work on the total estimated cost of mental health disorders. In its strategy paper, the Government summarised these costs as follows:

> Detailed estimates in 2003 put the costs of mental health problems in England at £77 billion, including costs of lost productivity and the wider impacts on wellbeing. More recent estimates suggest that the costs may now be closer to £105 billion, of which around £30 billion is work related. Sickness absence due to mental health problems costs the UK economy £8.4 billion a year and also results in £15.1 billion in reduced productivity. Mental health problems add considerably to the costs of the education and criminal justice systems and homelessness services. They are also the most common reason for incapacity benefits claims—around 43 percent of the 2.6 million people on long-term health related benefits have a mental or behavioural disorder as their primary condition.
>
> (HM Government, *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages*, February 2011, p 10)

The paper also acknowledged a number of "further, incalculable costs to the individual, their family and their community of lost potential and unrealised hopes and goals". It noted that the "majority of mental health problems affect people early, interrupting their education and limiting their life chances". This, the paper argued, was an avoidable outcome:

> We spend a great deal of public money on dealing with the consequences of mental health problems. Much of this money could be spent more efficiently, and many of the personal, social and economic costs could be prevented, by addressing the causes of these problems and identifying and treating them if, and as soon as, they arise.
>
> (ibid, p 10)

2. Parity of Esteem

2.1 Definition

In the foreword to the Government's mental health strategy, Andrew Lansley, the then Secretary of State for Health, and Paul Burstow, the then Minister of State for Care and Support, stated that "the title of this strategy, *No Health Without Mental Health*, perfectly captures our ambitious aim to mainstream mental health in England. We are clear that we expect parity of esteem between mental and physical health services" (HM Government, *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages*, February 2011, p 2). For the Government, this commitment meant "that mental health should be a priority alongside equally pressing physical health problems" (HL *Hansard*, 2 November 2011, col 1295).

In its study of how to achieve parity, the Royal College of Psychiatrists explored the meaning of the term. It referred to the common usage of parity in US literature where 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.
>
> (Royal College of Psychiatrists, *Whole-Person Care: From Rhetoric to Reality—Achieving Parity Between Mental and Physical Health*, March 2013, p 20)

Following on from this, parity of esteem was "best described" as "valuing mental health equally with physical health" and:

> 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.
> - equal status in the measurement of health outcomes.
>
> (ibid, p 20)

2.2 Health and Social Care Act 2012

Section 1(1) of the Health and Social Care Act 2012 provides 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". This provision was added to the Bill in the House of Lords and accepted by the Government in the House of Commons on the Bill's return to the lower house.

Committee Stage in the House of Lords

The issue was first debated during committee stage on the Bill. Baroness Hollins (Crossbench) moved an amendment that would replace the word 'illness' (in what is now section 1(1b) as then drafted) with the words 'physical and mental illness'. This, she argued, was so there could "be no question about the Government's commitment to ensure parity between services for physical illness and services for mental illness" (HL *Hansard*, 2 November 2011, col 1274). In addition, the amendment, she argued, would enshrine "a principle in law so that commissioning bodies can be under no illusion that they have equal responsibility to commission high-quality and continuously improving mental health services as they have for services for physical illnesses" (ibid, col 1275).

It was important, Baroness Hollins continued, that mental health was seen as "part of the continuum of health". More was needed, she maintained, to recognise that principle in the health service:

> The mind/body split has unhelpfully been set in concrete within the NHS, which uses different NHS trusts to treat mental and physical illnesses. This unfortunately fails to recognise the fact that depression, for example, is a very common co-morbid condition associated with diabetes, stroke and heart disease. It is not surprising, really, given that the brain is just one organ among many.
>
> Mental illness in someone with a recognised physical illness is often overlooked, delaying that person's physical recovery... just as mental illness in those with physical illness is overlooked, so is physical illness overlooked in people with mental illness. We need to do more in all health services, including public health, to ensure that the connections between mental and physical illnesses are better understood; that service responses are co-ordinated; and that diagnostic overshadowing of one by the other is avoided.
>
> (ibid, cols 1274–6)

Responding for the Government, Earl Howe, the Parliamentary Under Secretary of State for Quality at the Department of Health, agreed the importance of mental health. He then set out key features of the Government's mental health strategy, but in considering the purpose of the amendment observed that:

> The term illness is defined in section 275 of the National Health Service Act 2006 as including mental disorder within the meaning of the Mental Health Act 1983. As a result, references to the prevention, diagnosis and treatment of illness would already apply to both physical and mental illnesses without the need for those additional words. The definition is already there.
>
> (ibid, col 1293)

On this basis Earl Howe explained that he could not support the amendment, adding that:

> I do not think that it would be desirable to make an express distinction between the two in the provisions of this Bill, particularly when we need the service to think holistically about both the physical and mental health needs of patients.
>
> (ibid, col 1296)

Following these remark, Baroness Hollins withdrew the amendment.

Report Stage in the House of Lords

At report stage on 8 February 2012 Lord Patel, who put his name to the original amendment at committee, moved the amendment again in the absence of Baroness Hollins. The purpose of the amendment, he reminded the House, was to put the Government's commitment to parity into statute. It would, he said:

> ... place an explicit duty on the Secretary of State to promote parity of esteem between mental and physical health services. The duty would sit within his or her existing duty to improve the quality of health services. It also clarifies that the Secretary of State has a duty to promote a health service designed to secure improvements in the prevention, diagnosis and treatment of both physical and mental illness. The amendment would put the Government's own commitment to parity of esteem between mental and physical healthcare on a statutory footing and make 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 illness and expects the NHS board and the CCGs to do the same.
>
> (HL *Hansard*, 8 February 2012, col 264)

Lord Patel explained that mental health remained a challenge in the health service and set out the rationale for why the House should support the amendment:

> ... 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, and to the physical health of those with mental health problems—and to give full consideration to mental as well as physical health. It is simply not acceptable for the mental health needs of children and adults to continue to be neglected.
>
> There is an imbalance between mental and physical health in both healthcare and health promotion in many places. A better balance could bring a number of benefits to people living with, or facing the risk of, mental ill health. Health and social care policy should be developed with mental as well as physical health needs in mind. A duty to promote equality should encourage policymakers at all levels of the system to consider mental health alongside physical health, rather than making policy for the latter, and later adjusting to fit the former.
>
> (ibid, col 265)

Earl Howe responded for the Government. He told Peers that he understood why the issue was of importance and why a number of Peers believed "that there is a declaratory value in inserting these additional words at this point in the Bill". He said that the House would be aware that achieving parity of esteem for mental illness was "a priority for the Government" and therefore, he added, he did "not dissent in the slightest from the central principle being argued for here" (ibid, col 272). However, the Minister went on to explain that in his consideration of the amendment he had asked himself whether it "would add real value". The answer, he said, in the "strictly legal sense", was that it would "not add value because legislation already makes it clear, through the definition in section 275 of the National Health Service Act 2006, that any reference to illness in the Act shall include both mental and physical illness". Earl Howe struck a note of caution by saying the amendment could have the opposite effect to that which was intended:

> Having reflected very hard on these words, I believe that they could be positively unhelpful to his case, as well as to the business in which we are jointly engaged, which is the drafting of clear, economical and unambiguous legislation. 'Illness' is already defined in the Act and, for me, these words are not only legally superfluous, they also suggest that there is a divide between mental and physical illness rather than a convergence.
>
> The noble Lord may believe that little harm would be done by his amendment, but I respectfully suggest to him that that may not be so.
>
> (ibid, col 273)

The Minister added that as a concession he was willing to explore the possibility of making more explicit the current legislative definition in the Bill's explanatory notes and that he would happily meet with Peers further to discuss the subject. He urged the House not to support the amendment in any division that followed. The amendment was then put to a vote and was supported by 244 votes to 240 (ibid, col 274).

Although the Government had not supported the amendments in the House of Lords, on the Bill's return to the House of Commons, Simon Burns, the then Minister of State for Health, told MPs that the Government had decided it would not now oppose the amendments. Mr Burns explained:

> Although our view is that the most important work in achieving genuine parity of esteem will be non-legislative—for example, through our recent mental health strategy, "No Health without Mental Health"—we recognise the symbolic significance of including these words in clause 1.
>
> (HC *Hansard*, 20 March 2012, col 693)

3. Achieving Parity

3.1 Royal College of Psychiatrists Report

Following the passage of the Health and Social Care Act 2012, in March 2013 the Royal College of Psychiatrists issued its study into how the requirement for parity between mental and physical health could be achieved. The College thought that 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" (Royal College of Psychiatrists, *Whole-Person Care: From Rhetoric to Reality—Achieving Parity Between Mental and Physical Health*, March 2013, p 9). As part of its report, key features were identified as to what a 'parity' approach would look like:

- 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.

(ibid, pp 20–1)

The report made a number of policy recommendations that the College felt were required to make parity a reality. The key recommendations were:

- The Government and the NHS Commissioning Board should work together to give people equivalent levels of access to treatment for mental health problems

as for physical health problems, agreed standards for waiting times, and agreed standards for emergency/crisis mental healthcare.

- Action to promote good mental health and to address mental health problems needs to start at the earliest stage of a person's life and continue throughout the life course.

- Preventing premature mortality—there must be a major focus on improving the physical health of people with mental health problems. Public health programmes must include a focus on the mental health dimension of issues commonly considered as physical health concerns, such as smoking, obesity and substance misuse.

- Commissioners need to regard liaison doctors (who work across physical and mental healthcare) as an absolute necessity rather than an optional luxury. 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.

- Mental health services and mental health research must receive funding that reflects the prevalence of mental health problems and their cost to society. Mental illness is responsible for the largest proportion of the disease burden in the UK (22.8 percent), larger than that of cardiovascular disease (16.2 percent) or cancer (15.9 percent). However, only 11 percent of the NHS budget was spent on NHS services to treat mental health problems for all ages during 2010/11.

- Culture, attitudes and stigma—zero-tolerance policies in relation to discriminatory attitudes or behaviours should be introduced in all health settings to help combat the stigma that is still attached to mental illness within medicine.

- Political and managerial leadership is required at all levels. There should be a mechanism at national level for driving a parity approach to relevant policy areas across government; all local councils should have a lead councillor for mental health; all providers of specialist mental health services should have a board-level lead for physical health and all providers of physical healthcare services should have a board-level lead for 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. Mental and physical health should be integrated within undergraduate medical education.

(Royal College of Psychiatrists press release, 'Landmark Report on Achieving Parity Between Mental and Physical Health Published', 26 March 2013)

3.2 Government Strategy

In February 2011, the Government published its mental health strategy. It stated that the Coalition's success would be "measured by the nation's well-being", not just economic

prosperity, and this meant giving equal weight to both physical and mental health (HM Government, *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages*, February 2011, p 2). The Government's approach, the strategy explained, was based on "a set of shared objectives to improve mental health outcomes for individuals and the population as a whole". The six objectives were:

- More people will have good mental health.
- More people with mental health problems will recover.
- More people with mental health problems will have good physical health.
- More people will have a positive experience of care and support.
- Fewer people will suffer avoidable harm.
- Fewer people will experience stigma and discrimination.

(ibid, p 6)

The document explained that the Government's health service reforms had produced "three outcomes frameworks" that provided "a coherent and comprehensive approach to tracking national progress against an agreed range of critical outcomes", and that improving mental health outcomes were "central to achieving the outcomes in all these three frameworks" (ibid, pp 13–14).

In 2012, the Government set out in a follow-up paper—*No Health Without Mental Health: Implementation Framework*—what local organisations could do to implement the mental health strategy and improve mental health in their areas. The document set out some examples of what had already been achieved and what further action was needed:

- Government is investing over £400million to increase access to NICE-Approved Psychological Therapies. This includes giving patients a choice of therapies through the Any Qualified Provider (AQP) programme. We are also extending the Improving Access to Psychological Therapies (IAPT) programme to provide therapies for children and young people and people with severe mental illness.

  We now need to go further, ensuring a choice of NICE approved therapies are commissioned and provided in all areas of the country, and that they are accessible to all, including older people and people from BME communities.

- Government and the NHS Commissioning Board Authority are working to drive improvements in the quality of mental health services. Work is already underway to move towards a payment system for providers which is based around the needs of people accessing services, and quality and outcomes indicators will be embedded into this new approach. NHS providers who meet Quality Standards will be paid more than those who fall short.

  We now need to go further, ensuring providers assess and improve their services in line with relevant standards—including in relation to user experience and involvement as

well as clinical outcomes. Commissioners should ensure they use the levers available to them to drive improvements in service quality.

- The NHS Equality Delivery System will help NHS services address the needs of people with mental health problems as an equality (disability) issue, and will ensure that the mental health needs of Equality Act protected characteristic groups are understood and addressed. Government has also introduced, for the first time, a duty on the NHS to reduce health inequalities. This includes inequalities in mental health access and outcomes.

  We now need to go further ensuring all organisations meet their equality and inequality obligations in relation to mental health, and that they ensure equality of access and outcomes for groups with particular mental health needs, which include many of the most vulnerable in society.

- Government will provide a picture of overall progress in implementing the strategy and improving mental health outcomes for all by bringing together relevant measures into a mental health dashboard.

  We now need to go further, ensuring local organisations' information on local mental health needs are properly identified, made available and considered as part of Joint Strategic Needs Assessments (JSNAs), and that, if appropriate, these needs are reflected in Joint Health and Wellbeing Strategies (JHWSs) and commissioning plans. This will need the input, and cooperation of a wide range of organisations with an interest in mental health, including those outside the health and care system.

- We will ensure that the new NHS commissioning system delivers for mental health. Aspiring Clinical commissioning groups (CCGs) are required to demonstrate that they have sufficient planned capacity and capability to commission for improved outcomes in mental health, as part of the CCG authorisation process carried out by the NHS Commissioning Board.

  We will then need to go further. To do this CCGs, once authorised, may wish to continuously improve their mental health commissioning capability, and the quality of the mental health services they are commissioning. This framework sets out actions which can contribute to this.

- We will put mental health and wellbeing at the heart of the new public health system. Public Health England will integrate mental health throughout its key functions and approaches.

  We now need to go further. Local Public Health services need to develop clear plans for public mental health, to ensure they integrate mental health and wellbeing into all aspects of their work, and to provide local leadership in supporting better mental health for all.

(HM Government, *No Health Without Mental Health: Implementation Framework*, 24 July 2012, pp 8–9)

In addition, the framework described what parity of esteem would look like once the Government's vision had become reality:

- Local planning and priority-setting reflects mental health need across the full range of services, agencies and initiatives.
- National policy integrates mental health from the start, and takes into account how physical and mental health are interconnected.
- Mental health and wellbeing is integral to the work of CCGs, health and wellbeing boards and other new local organisations.
- Mental health and wellbeing is integral to the work of the NHS Commissioning Board, Public Health England and other new national organisations.

(ibid, p 9)

In November 2012, the Government published its Mandate to the NHS Commissioning Board. This, it said, played a "vital role in setting out the strategic direction for the Board and ensuring it is democratically accountable". In terms of mental health the Mandate stipulated that:

> Treating mental and physical health conditions in a coordinated way, and with equal priority, is essential to supporting recovery. Yet people with mental health problems have worse outcomes for their physical healthcare, and those with physical conditions often have mental health needs that go unrecognised. The NHS Commissioning Board's objective is to put mental health on a par with physical health, and close the health gap between people with mental health problems and the population as a whole.
>
> By March 2015, we expect measurable progress towards achieving true parity of esteem, where everyone who needs it has timely access to evidence-based services. This will involve extending and ensuring more open access to the Improving Access to Psychological Therapies (IAPT) programme, in particular for children and young people, and for those out of work. The Board has agreed to play its full part in delivering the commitments that at least 15 percent of adults with relevant disorders will have timely access to services, with a recovery rate of 50 percent. The Board will work with stakeholders to ensure implementation is at all times in line with the best available evidence.
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> (Department of Health, *The Mandate: A Mandate from the Government to the NHS Commissioning Board: April 2013 to March 2015*, November 2012, p 14)

In June 2013, Norman Lamb, the Minister of State for Care and Support, gave a speech to the Royal College of Psychiatrists in which he provided an update on the Government's approach to parity of esteem between physical and mental health. He opened by saying that the Mandate given to NHS England was "very strong on mental health, including specific objectives on parity and on improving access for mental health services" (Gov.uk, 'Achieving Parity of Esteem Between Mental and Physical Health', 19 June 2013). Mr Lamb added that the Government were currently working on a consultation "to refresh NHS England's Mandate for 2014 to 15" and that he was "determined to build on the excellent platform for parity—and for mental health more widely—which the current Mandate provides. This will remain a priority". He also

said that there were mental health measures in the NHS Outcomes Framework, "including the all-important measure of excess mortality—a measure that is all about parity". Beyond that there was also "a requirement to champion Time to Change" in the Mandate, which he said showed "that we expect the NHS to lead the way in tackling stigma and discrimination".

Mr Lamb went on to describe parity as sitting "at the heart of the reformed health and care system" and that "the new national bodies are ensuring that this happens". He explained that:

> NHS England is working with a number of National Clinical Directors and others to develop a programme of work specifically to support the delivery of the Mandate objective on parity of esteem. As part of this, they are working to identify the most effective way to use commissioning tools—one of the key sets of levers and incentives which will support delivery of parity.
>
> There will be a specific and significant focus on mental health and wellbeing from Public Health England. Improving population mental wellbeing is one of five strategic priorities for PHE's health improvement work. Over the summer they will be developing a national programme plan for public health mental health. This will support 'No Health without Mental Health', prioritising the promotion of mental wellbeing, the prevention of mental health problems, and the prevention of suicide, and the promotion of wellbeing for people living with and recovering from mental illness.
>
> ... Public Health England are working with the NHS to identify—and tackle—poor access by people with mental health problems to the kind of public health interventions which the rest of the population takes for granted. This includes a number of specific interventions recommended in the report, such as smoking cessation, NHS healthchecks, screening programmes and immunisation.
>
> Health Education England will play their part too. Their Mandate—which we published at the end of last month—makes parity a clear priority.

Mr Lamb also acknowledged the role of information in achieving parity and said that the Government recognised "the importance of gathering the basic information, so essential for both policy and practice". The Minister said, as an example, that the Government had "commissioned the next Adult Psychiatric Morbidity Survey—to run in 2014—updating our most robust and detailed evidence about mental ill health across the population as a whole". Additionally, the Healthcare Quality Improvement Partnership had been commissioned to undertake a second annual National Audit of Schizophrenia. There was also recognition in Government of the importance of sharing information and Mr Lamb explained the role of the "newly-formed mental health intelligence network, led jointly by NHS England and Public Health England" which would "draw in expertise from across health and care services". He said the network would "strive to put the intelligence we have about mental health and illness on a par with that which we have about physical health". However, the Minister said that while these were improvements there was "still a long way to go" and that although "we now have a huge amount of data about mental health... its range is too narrow".

Data was also important to service organisation. The Minister said the "inefficiency of the current system" was "clear" and referred to a Schizophrenia Commission report that had stated too much money was spent on secure care. By "gathering the data that matters—building the evidence about what services work best for people" he argued the case for making changes in areas of such service delivery would be "unanswerable". For parity in crisis care, Mr

Lamb said he had asked a number of bodies—the Home Office, the Association of Chief Police Officers, the Department of Health, the Royal College of Psychiatrists and others—to agree a plan to "tackle the most stark differences between the treatment received by people with physical as opposed to mental health needs when they are at their most vulnerable".

Finally, Mr Lamb spoke about access and waiting times for mental health services. At present, he argued, the "de facto exclusion from the 18-week access standards means that, at the moment, we know little about how long people are waiting". This, he maintained, was unacceptable, and the Government had tasked NHS England as part of its Mandate "to comprehensively identify levels of access to, and waiting times for, mental health services; to work with CCGs to address unacceptable delays and significantly improve access and waiting times; and to work with us to consider new access standards, including waiting times standards, for mental health services".