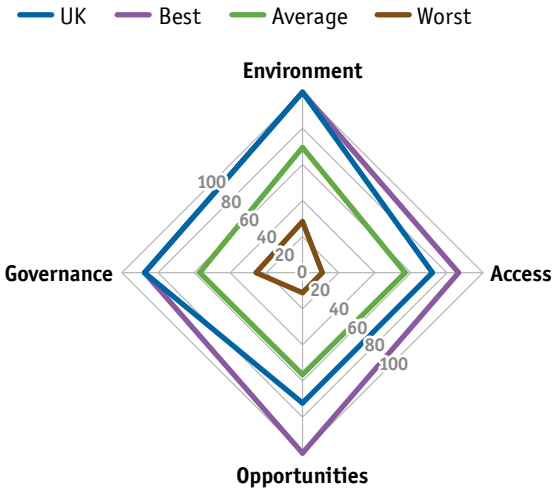
UK Country Report
UK: The journey towards "parity of esteem"

Mental Health Integration Index: Results for UK



Mental Health Integration Index Results

Overall:	84.1/100 (2nd of 30 countries)
Environment :	100/100 (1st)
Opportunities:	72.2/100 (9th)
Access:	72.0/100 (8th)
Governance:	87.5/100 (1st)

Other Key Data

- Expenditure: Mental health budget as proportion of government health budget (2011): 13%[1].
- Burden: Disability-Adjusted Life Years (DALYs) resulting from mental and behavioural disorders as proportion of all DALYs (World Health Organisation—WHO—estimate for 2012): 13.7%[2].
- Stigma: Proportion of people who would find it difficult to talk to somebody with a serious mental health condition (Eurobarometer 2010): 20%[3].

Highlights

The UK ranks second overall in The Economist Intelligence Unit's Mental Health Integration Index and first in two individual categories.

Although each constituent part of the UK has its own story to tell in this field, this article focuses on England, because it contains the large majority of the total population.

English policy towards those with mental illness has seen a steady improvement, bolstered by a generally supportive political environment.

Current policy is strong, and aims to create a "parity of esteem" between mental and physical health services (ie, giving equal value to mental and physical health).

Turning aspirations into reality, however, takes time and faces hurdles including a lack of investment and the structure of government agencies.

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[1] Data from The Economist Intelligence Unit's Mental Health Integration index, which ranks 30 European countries based on their commitment to integrating people with mental illness into society and employment (www.mentalhealthintegration.com).

[2] Figures derived from World Health Organisation (WHO) national figures for individual index countries for 2012, available at http://www.who.int/entity/healthinfo/global_burden_disease/GHE_DALY_2012_country.xls?ua=1. The WHO estimates do not include dementia as a mental illness, although it is listed as one under the WHO's International Classification of Diseases (ICD-10).

[3] Eurobarometer, Mental Health, Special Eurobarometer 345, 2010.

The UK ranks second overall in The Economist Intelligence Unit's Mental Health Integration Index with a score (of 84.1 out of 100) just slightly lower than that of first-placed Germany. The UK also finished first in two categories: "Environment"—a measure of policies and conditions allowing those with mental illnesses to live a stable home and family life—where its perfect score tied with that of Germany; and "Governance", a general category including the extent of human-rights protection and of anti-stigma efforts, where it scored 87.5 out of 100.

A complete discussion of the performance of the UK as a whole would involve several distinct stories—since the turn of the century the governments of Scotland, Wales and Northern Ireland have set their own health policies, including for mental health. Even before then, implementation of such policy involved separate national health services for each of the UK's four constituent parts, with distinct structures for the commissioning and provision of care. As a result, each of these countries has its own separate record of activity and innovation.

Scotland has made some advances in the field of mental health, although this is a relatively recent phenomenon. For many years, the country's health service lacked any detailed policy, and the pockets of progress towards the de-institutionalisation of mental health services tended to draw on expertise from those involved in the process in England.[4] Pressure began to build towards the end of the 1990s and, just before devolution in 1999, the government in England established the Millan Committee to conduct a major review of the area. When this reported in 2001 to the new Scottish government, the latter took up its recommendations for more community-based care and made mental health an issue to which it has since given substantial attention. It has even been active in this field in its own right (rather than through the UK authorities) on the international stage, through direct co-operation with the World Health Organisation (WHO). NHS Scotland as a whole is a WHO Collaborating Centre in the field of preventing and managing mental illness.[5]

Although overseen by the Scottish Ministry of Health, mental health care and services are provided at the local level in Scotland by NHS boards and local government. A series of detailed legislation and plans since 2001, including the Mental Health (Care and Treatment) Act of 2003, have used measured targets to push more care into the community and to improve outcomes. Overall, the country has seen some marked successes: the rate of psychiatric readmissions to hospital dropped by over one-quarter between 2004 and 2010, suggesting better community provision, and the suicide rate declined by about 14% between 2000 and 2010.[6] Looking to the future, the current policy aims to provide faster care as well as a greater focus on patients and carers, more support for self-management and better outcomes. Other challenges remain as well. Dr Donald Lyons, a former head of Scotland's Mental Welfare Commission—the country's mental health watchdog—told the press that some facilities remain dilapidated and provision is uneven across the country. Overall, though, he says, "mental health care has come a long way in Scotland over the past decade. There has been a shift in the culture from doing things to people with mental health issues, to doing things with people."[7]

Since devolution Wales has also had a series of policies and national service frameworks designed to promote community-based, locally organised care. Since 2010 it has accelerated these efforts. In that year the National Assembly for Wales

[4] Jennifer Smith et al., The social and cognitive mapping of policy: the Mental Health Sector in Scotland, Knowledge and Policy Working Paper 6, 2008.

[5] Richard Freeman et al., WHO, mental health, Europe, Knowledge and Policy Working Paper 11, 2009.

[6] The Scottish Government, Mental Health Strategy for Scotland: 2012-2015.

[7] "World looks to Scotland after mental health care improved," Herald Scotland, February 7th 2014.

(the Welsh government) passed The Mental Health (Wales) Measure, which places duties on local NHS boards and local authorities to improve and co-ordinate different elements of care. The aim is a patient-focused, integrated care based on the recovery model. It took a number of years to plan what this meant in practice, but in 2012 the country launched a ten-year policy, Together for Mental Health, along with a delivery plan for the first four years.

Northern Ireland is also seeing innovation. It is in the process of drafting legislation that jointly deals with both the provision of mental health care and the legal rights of those with a mental illness. It is one of the first jurisdictions anywhere in the world to treat these two together, with the hope of reducing potential inconsistencies between policies.

A fuller treatment of all parts of the UK, though, would be well beyond the scope of a short article. Since England contains 84% of the UK's population, and because it has the longest record of reform in the area of mental health, the rest of this article focuses largely on its experience.

A long period of evolution...

For more than five decades the English authorities have pursued strategies aimed at improving care for those with mental health illnesses. The specifics of these policies, however, have had to evolve regularly, sometimes substantially, as partial successes made clear pressing additional needs.

De-institutionalisation was already on the agenda as early as 1961, when the health minister at the time, Enoch Powell, called for the halving of the number of beds in psychiatric hospitals and their replacement with accommodation in specialist general hospital wards or community-based care. Numbers in psychiatric institutions declined steadily thereafter, but specific community services for those with mental illness received little if any attention during the following decades, especially as the country saw prolonged periods of economic difficulty. By the 1980s, however, it had become apparent that general community services were insufficient, especially after the Care in the Community policy further accelerated de-institutionalisation. As a result, reforms in the early 1990s required the assessment of those with mental illness and the provision to them of necessary health and social services through specialist NHS mental health trusts, each covering a specific geographic area. An important tool for delivery of these services was the creation of community mental health teams, which included both health and social workers.

Further evolution ensued as fears—arising in part from a number of murders committed by people with a mental illness—grew that the new system did not address the needs of the most seriously ill or provide sufficient protection to the public. In 1999 a new National Service Framework required mental health trusts to create assertive outreach, crisis resolution, and early intervention teams across the country. These well-funded reforms greatly expanded the range of what was available for community-based care. Helen Gilburt, fellow in health policy at the King's Fund, a leading UK healthcare think tank, says that an important strength of this reform was "that it was a national decision. Everybody had to implement it, but one of the weaknesses was that implementation of the models was prescribed, and in different localities those models might not seem appropriate." As a result, in the last decade, many of these models have been modified to meet local need.

More recently, efforts to improve services for those with mental illnesses and better integrate them into society have accelerated. Paul Farmer, chief executive officer of Mind, a mental health charity in England and Wales, says that "policy attention and visibility has improved significantly in last five to ten years under this and the previous government." A series of three new major policy documents and action plans since 2009[8] have restated and extended government commitments in order to address perceived weaknesses and needs. Now the government is formally committed to, among other things: expanding access, including to primary care; ending discrimination against those with mental illness; making sure the right services are available at the right time; and supporting the active participation of patients in their own treatment and management.

The overarching principle of these commitments, set out in the government's 2011 policy statement, *No Health Without Mental Health*, is creating a "parity of esteem" between mental and physical health services.

Government policy has also tended to shift towards outlining measurable goals and commitments rather than prescriptive descriptions of how these will be achieved. This has led to a greater interest in outcomes data, a rare quantity in European mental health provision. Notably, the UK is one of only eight countries in The Economist Intelligence Unit's Index that are committed to developing and using Patient Reported Outcomes Measures (PROMs) to monitor the effectiveness of mental health services and to develop policy. The use of PROMs has already begun locally.

...has led to significant progress.

Underlying this decades-long development has been a long-term, cross-party commitment to better care for, and integration into society of, those with mental illness. Mr Farmer says that the result has been "a gradual improvement towards mental health as a subject." Ms Gilburt agrees: "in focusing on people with mental illness as a specific population, we have achieved a lot. It hasn't been watered down. It is on the agenda compared with other countries." The positive impacts of this commitment began with the early closure of psychiatric hospitals in comparison with other European countries, which Mr Farmer calls "a significant achievement."

Index data also show that legal protection for those with mental illness is strong. The UK gets maximum points for its laws and regulations on: involuntary placement; child custody for parents with a mental illness; ratification of human rights treaties and the existence of local regulatory bodies to protect human rights; and supported decision making for those with impaired capacity. Neither is it resting on its laurels. In 2012, with the support of all parties in government, a private member's bill was passed—a rare occurrence—that removed limitations on those with mental illness serving as jurors, company directors, or even members of parliament.

Mr Farmer notes, however, that although legislation around rights is strong, the actual practice does not always match up. Some equality laws remain relatively untested in the courts. More worrying, the House of Lords (the UK's upper house) recently issued a report on the UK's Mental Capacity Act, which protects the rights of vulnerable adults. It found that "prevailing cultures of paternalism (in health) and risk aversion (in social care) have prevented the Act from becoming widely known or embedded," and that the sections protecting the liberty of persons were so badly drafted that they were failing in their purpose. The report suggested a number of revisions to address these weaknesses.[9]

[8] The three policy documents are: New horizons: towards a shared vision for mental health, 2009; No health without mental health: A cross-government mental health outcomes strategy for people of all ages, 2011; and Closing the gap: priorities for essential change in mental health, 2014.

[9] House of Lords, Mental Capacity Act 2005: post-legislative scrutiny, 2014.

A widespread willingness to improve provision does, though, allow for fruitful co-operation among relevant stakeholders. A recent example is the Crisis Care Concordat, signed in February 2014. The agreement involves 22 national bodies with some level of interaction with those experiencing a mental health crisis. The range of these signatories is impressively broad, including those representing health, policing, social care, housing provision, and local government. The agreement describes how they will work together in a co-ordinated way to support people experiencing mental health issues.

This willingness to co-operate also includes government agencies working in a variety of ways with the UK's mental health non-governmental community, which includes campaigning, patient, and family groups. Five of these, for example, take an active role in the Crisis Care Concordat, either as signatories or formal supporting organisations. Similarly, England's largest anti-stigma campaign, Time to Change, often cited as an example of best practice internationally, is run by a consortium of two mental health non-governmental organisations (NGOs), but its current £5m (US$8m) annual budget is covered largely by Department of Health grants.

Mental health provision has also made some progress in providing integrated services. Ms Gilburt says that community mental health teams, which include healthcare and social workers, provide "a fairly good method of integrating" some locally based services. This success, however, remains partial. Mr Farmer believes that England, like the UK as a whole, has seen "encouraging progress, but there is still a long way to go. The weakness [in provision for those with a mental illness] has been embedding real change on the ground and helping people get access to the right services at the right time."

Serious flaws remain

Evidence of this weakness can be seen in the ongoing, substantial treatment gap in mental health care. The UK ranks in eighth place in the Index's "Access" category, one of the country's worst results. This may seem a good outcome, but the success is only relative on a continent where poor provision is the norm. The absolute figures for those receiving care are concerning. Only 65% of people with psychotic disorders get any sort of treatment at all, and for less severe conditions that figure is around one-quarter. Moreover, the care received is not necessarily appropriate or rapidly accessed: in some parts of the country a two-year wait is routine. For high blood pressure and diabetes, on the other hand, over 90% receive treatment. As Simon Wessely, the president of the Royal College of Psychiatrists said in a recent press interview, if mental health treatment data were about cancer, people would be "screaming from the rooftops."[10]

The government's emphasis on achieving "parity of esteem" shows a recognition of, and wish to, address the problem. Doing so, however, would require substantial investment; yet limited funding is another difficulty facing mental health provision. A recent investigation using Freedom of Information requests found that, on average, mental health trusts had seen their funding drop by 2.3% over the last two years, leading to a reduction in specialised medical staff.[11] This is consistent with cost-driven, rather than policy-related, cuts in relatively expensive inpatient beds in recent years, says Mr Farmer. The savings have not been channelled into greater spending on community-based services, while reduced bed numbers have lowered the ability of the system to help those experiencing a mental health crisis. Mr Farmer notes that, although a lot of government policy is good, the challenge is "how in times of austerity money is channelled into mental health services."

Insufficient funding is also an impediment to better integration of social and medical services. Although data from the Index show that the UK ranks sixth in Europe for the number of psychiatrists and psychiatric nurses per head, it is in 18th place for mental health social workers, with just 2.9 per 100,000 people. Ms Gilburt says that the low availability of these specialists is a "prominent issue," and that their ability to do their job is stretched. Martin Knapp, professor and director of the personal social services research unit of the UK's National Institute for Health Research, warns, though, that jobs such as employment specialists on community health teams are the ones "that go when the budget gets tight."

Even if the funding situation was better, structural barriers within government would impede further alignment of service provision. Ms Gilburt explains that much integration takes place within mental health trusts. These organisations, however, are not only distinct from local primary and acute care trusts, but are also funded through entirely different methods. The different funding mechanisms make it harder for such bodies to find ways to work together. "One of the big lessons from the UK," she says, "is that integration is difficult when there are different budgets. You have to think about outcomes and where the money is. While we have pushed mental health forwards on its own, this possibly has had a negative impact on how well it is integrated elsewhere."

Employment services are a case in point. In the "Opportunities" category of the Index, the UK is tied in ninth place, its worst result. Mr Farmer notes that improvement of employment services is one of the greatest needs currently for those with a mental illness. He explains, though, that while responsibility for mental health care and social services is local, employment policies are a national issue, making co-operation more difficult. Ms Gilburt adds that, "We have a programme across the UK to get people into work, but it has largely failed people with mental health issues because it is a generic programme. [The availability of more specialised services tailored for people with mental health problems] varies and is dependent on what local commissioners have procured. Some mental health trusts have developed their own employment services. It is very patchy."

Looking ahead, the current difficulties will need to point out the direction for the next round of evolutionary change if England's approach to those with mental illness is to meet current challenges and achieve true "parity of esteem". The will is there. Ms Gilburt notes that current policy involves "a real push for integration and for people taking a role in managing their health and in society." She does not expect this to change. "The burden of mental illness is highlighted on regular basis," she continues, and "it is understood that if we tackle mental health it will improve health outcomes overall." On the other hand, inside existing healthcare structures "it is difficult to see how [mental health and other parts of the health service] will join up."

About the research

This study, one of a dozen country-specific articles, draws on The Economist Intelligence Unit's Mental Health Integration Index, which compares policies and conditions in 30 European states for integrating people with mental illness into society, employment and mainstream medical care. Further insights are provided by three interviews—with Paul Farmer, CEO of Mind, a mental health charity; Helen Gilburt, fellow in health policy at the King's Fund, a leading UK healthcare think tank; and professor Martin Knapp, director of the personal social services research unit of the UK's National Institute for Health Research—as well as extensive desk research. The work was sponsored by Janssen. The research and conclusions are entirely the responsibility of The Economist Intelligence Unit.