Parliamentary brief
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Mental health

House of Commons, Opposition day debate
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The British Medical Association (BMA) is an apolitical professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care. We have a membership of over 160,000, which continues to grow each year.

Key points

- The BMA has repeatedly raised concerns that mental health in the UK is not held in the same regard as patients' physical health and does not receive comparable levels of funding.
- Despite the recent announcement of additional funding for mental health services in the autumn statement, there has been a historic underinvestment in mental health services and the overall annual spend per head of population on mental health is not proportionate to need.
- The integration of mental health and physical healthcare should be improved. The current organisational structure of mental health services inhibits the provision of an integrated, co-ordinated response to the multiple mental and physical needs of patients, leaving them with unmet needs.

Background

In the UK, there is a significant disparity in morbidity and mortality rates experienced by people with mental illness. One in three of the 100,000 people who die prematurely each year in England have a mental illness.[1] On average, life expectancy is considerably shorter amongst people with a mental illness with men dying 20 years earlier and women 15 years earlier than the general population. [2,3,4] In May 2014, the BMA published a report, *Recognising the importance of physical health in mental health and intellectual disability – achieving parity of outcomes*[5]. The report examines ways to reduce the excess morbidity and mortality among vulnerable groups and stresses the urgent need for action to ensure equal value is placed on mental and physical health. Too often the physical health problems of patients with a mental illness or an intellectual disability are under-addressed, while the mental health of patients with a physical illness is often neglected.

Relationship between physical health and mental health

People with Serious Mental Illnesses (SMIs) such as schizophrenia, bipolar disorder, and major depressive disorder have higher morbidity and mortality rates than the general population.[6,7] The exact impact of this 'mortality gap' on the life expectancy of SMI patients is unclear; it has been found to reduce life expectancy from anywhere between 13 to 30 years.[8] Among patients diagnosed with physical health problems, the prevalence of probable mental health problems – particularly depression – has been found to increase as the number of chronic physical conditions rises. [9,10] People living in deprived areas also have a greater number of physical and mental health problems requiring simultaneous management when compared to people living in more affluent areas.[11]

Survival rates for a number of conditions, including cardiovascular disease, respiratory disease, stroke, HIV infection and some cancers[12,13] are considerably lower amongst patients with mental health problems. A mental health 'treatment gap' also persists. The difference between the number of people needing treatment for mental illness and the number of people receiving treatment is – with the exception of psychosis – universally large although the reasons for this 'treatment gap' are unclear.

Reporting health problems

People with mental health problems are less likely than other patients to report physical symptoms which can delay help-seeking behaviour and reduce the chance of the illness being detected and diagnosed. [14,15] People with mental health problems may avoid registering with a GP or find it difficult to make and keep appointments, while the challenging behaviour displayed by some mental health patients also increases their risk of losing their registration.[16] Under-recognition and under-treatment of depression in patients diagnosed with chronic illnesses may also be associated with the patient failing to report symptoms of mental ill health. Not seeking healthcare, or delayed care-seeking, may be associated with a perceived lack of effectiveness of the treatments on offer, thinking the problem will resolve itself, or fear of being hospitalised against one's will.[17]

Integration of care

The BMA believes that the integration of mental health and physical healthcare should be improved. The current organisational structure of mental health services inhibits the provision of an integrated, co-ordinated response to the multiple mental and physical needs of patients, leaving them with unmet needs. Directors of Public Health and local commissioning bodies must ensure that clear pathways of care, and allocation of responsibility are established regardless of whether the patient presents with a physical or mental illness.

There is evidence to suggest that monitoring of physical healthcare amongst those with mental illness is limited. A 2012 survey of 15,000 users of community mental health services in England, conducted by the Care Quality Commission, reported that 43 per cent of respondents said that no one in NHS mental health services had asked them about their physical health needs in the last twelve months.[18] For many SMI patients, their only contact with health services is through a mental healthcare team and this type of contact does not necessarily guarantee good physical care, despite higher rates of physical ill health, and the shortened life expectancy. This raises important considerations for the adequacy of medical training. The confidence of mental health clinicians to manage physical health problems may also be compounded by being part of separate organisations from physical health services: this can leave mental health professionals without easy access to routine physical tests and lacking the necessary educational and peer support.

Funding for mental health

There has been a historic underinvestment in mental health services and the overall annual spend per head of population on mental health is not proportionate to need. Over 20 per cent of the disease burden in the UK is attributed to mental health problems, yet the funding allocated to mental health services across the UK does not reflect this burden: the Royal College of Psychiatrists estimates that nine per cent of the NHS and social services spending in Northern Ireland, 11 per cent in Scotland, 12 per cent in England, and 12 per cent in Wales, is allocated to mental health services.[19]

These figures stand in stark contrast to the costs that mental illness imposes on the NHS. Since approximately one-third of all people with long-term physical health conditions have a co-morbid mental health problem, mental health problems are estimated to raise the costs of physical healthcare by at least 45 per cent. Untreated mental illness is also thought to be costing the NHS over £10 billion in physical healthcare costs per annum.[20] Data obtained from 36 mental health trusts in England showed that spending on community mental health teams rose from £397.7m in 2011-12 to £412.4m in 2013-14; a decline of 0.03 per cent in real terms compared to 2011-12. In the same period, the average number of referrals being handled by community mental health teams rose by 13.3 per cent.[21]

The number of beds available has also been subject to cuts. In England 1,711 mental health beds have been closed since April 2011.[22] In addition, the number of mental healthcare jobs are declining, with one NHS Foundation Trust setting out plans to cut 502 mental healthcare jobs, including almost 50 psychiatrists, by 2016.[23]

Education and training

To ensure mental health patients receive equal levels of care, improved training is required for trainees and doctors. Achieving parity of outcomes between mental health and physical health is complicated by gaps in training and workforce planning, apparent during medical school, the Foundation Programme (FP), and speciality training. A better understanding of mental health achieved through training at all stages of a doctor's medical career, holds the potential to raise doctors' aspirations for these groups while at the same time improving access to, and the quality of, care for mental health patients.

Currently, medical school curriculum is centred on physical health with psychiatry often taught in a 'bloc' or module format. There also tends to be a focus on the management of severe and enduring mental health problems which can exacerbate the idea that mental health patients are 'difficult' and untreatable.[24,25] While a focus on SMIs is important, training should also consider prevention, recovery and rehabilitation, as well as ways to improve the lives of people with mental health problems.

Achieving parity of outcomes requires all doctors to have a better understanding of the relationship between physical and mental health. While speciality training must focus on skilling the doctor in the speciality at hand, it should not lose sight of the need to treat the 'whole' patient, and to recognise physical and mental co-morbidities.

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