Institute for Public Policy Research

FAIR FUNDING FOR MENTAL HEALTH

PUTTING PARITY INTO PRACTICE

BRIEFING

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and **Mary Reader**

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Analysis undertaken by

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FOREWORD

"One... disability from which our health system suffers is the isolation of mental health services from the rest of the health services."

These are the words of Nye Bevan, the founder of the NHS, just prior to its creation in 1948. 70 years on, we have undoubtedly made significant progress: there has been an unparalleled shift in societal attitudes towards mental illness and significant improvements in access to treatment. The recent Five Year Forward View for Mental Health, adopted by the government and the NHS, has been particularly welcome.

But we must not get complacent: we cannot escape the reality that we are still some way off achieving 'parity of esteem' between mental and physical health. Too many people still suffer in silence or go without the support they need. The quality of our mental health care in the NHS requires improvement. And those who are living with severe mental illness are expected to die between 15–20 years earlier than those without.

In one of her first speeches as prime minister, Theresa May committed to tackling the "burning injustice of mental illness". She argued that it required "a new approach from government and society as a whole" in order to achieve "parity of esteem". We couldn't agree more with this conclusion, but we believe that this sentiment is yet to translate into ambitious and bold action to address the problem.

We are therefore delighted that NHS England has decided to make mental health one of its priority areas for the upcoming NHS Long-Term Plan. The NHS is a vital ally in the fight for 'parity of esteem'. We support the calls in this paper to adopt a clearer and more ambitious definition of 'parity of esteem' and dedicate significantly more resource over the next decade to helping deliver on it.

But we also know that the NHS cannot deliver this alone. Mental health is determined by a range of factors – from where someone works, to who they know; how much they earn, to where they live. We therefore also support the call for the government to create a 'health in all policies' strategy, led by the prime minister, to address the social determinants of mental illness.

Poor mental health is one of the most pressing issues of our time. It affects millions upon millions of people across the country. We must no longer allow it to be an afterthought. The NHS can help lead the way by making it the number one priority in the upcoming long-term plan. This paper sets out a bold action plan for doing just this. We hope all politicians and policy-makers take heed of its vital call to action.

Paul Williams, MP for Stockton South

Jonny Mercer, MP for Plymouth Moor View

SUMMARY

The case for bold action to address poor mental health in the UK – both on moral and economic grounds – is clear. A staggering one in four of us will experience a mental health problem each year (McManus et al 2016). Too many people still suffer in silence or go without treatment. Shockingly, those with severe mental health problems still die on average 15–20 years younger than those without. Meanwhile, the cost of mental health to the economy is about £100 billion every year – the same as the cost of the entire NHS.

Politicians have increasingly recognised this, but we are still some way off achieving 'parity of esteem'. There is a cross-party consensus that we need to invest more money in mental health to achieve 'parity of esteem' between mental and physical health. This has started to translate into policy – notably in the form of the Five Year Forward View for Mental Health (FYFVMH), against which some progress has been made. But, even if the FYFVMH is delivered, a majority of people living with poor mental health still won't receive treatment, and large inequalities will remain.

The NHS Long-Term Plan must clearly define 'parity of esteem' and commit to delivering it within the NHS by 2030. No one definition for 'parity of esteem' was agreed on when it was adopted as a system aim. This has allowed politicians to profess a commitment to it without being held accountable for specific deliverables. This must change. 'Parity of esteem' should mean that "people living with a mental health condition have an equal chance of a long and fulfilling life as those with a physical health condition". The NHS Long-Term Plan should adopt this definition and commit to delivering it within the NHS.

POLICY RECOMMENDATIONS

'Parity of esteem' means that "people living with a mental health condition must have an equal chance of a long and fulfilling life as those with a physical health condition". The NHS Long-Term Plan should adopt this definition and commit to delivering it within the NHS.

The NHS must scale up access to – and improve the quality of care – across all areas of treatment. In consultation with the sector, we have identified the following themes that the long-term plan must address:

- more investment in early intervention for children and young people (CAMHS)
- scale up access to treatment for common mental health conditions such as depression and anxiety including through Improving Access to Psychological Therapies (IAPT)
- provide universal high-quality community care for people severely affected with conditions such as psychosis, bipolar disorder, personality disorder and eating disorders
- provide universal high-quality liaison and 24/7 crisis care for people living with poor mental health
- reduce inpatient admissions, with more people treated in the community and supported at an earlier stage of their condition
- set up a Mental Health Innovation Fund (MHIF) to spread best practise across the system.

This will require mental health spending in the NHS to increase from £12 billion in 2017/18 to £16.1 billion in 2023/24 and £23.9 billion in 2030/31. This implies growth in mental health spending of 5.0 per cent, compared to 3.4 per cent in the overall NHS budget up to 2023/24 (5.5 per cent compared to 3.6 per cent by 2030/31). This would be equivalent to 17 per cent of the new NHS money by 2023. This would see mental health spend increase to 11.9 per cent of NHS spend by 2023/24 compared to 11 per cent today (and 13.8 per cent by 2030). These figures are in current prices (therefore do not factor in inflation) and assume that the new funding is slightly frontloaded in 2019/20 and 2020/21.

The government should increase spending on mental health from £12 billion in 2017/18 to £16.1 billion in 2023/24, and £23.9 billion in 2030/31. This would mean mental health funding growth of around 5.5 per cent per annum – compared to 3.5 per cent for overall NHS budget – over the next decade.

Achieving parity of esteem will also require additional funding for workforce development, capital budgets, public health and social care. All these items fall outside of the NHS revenue budget requirements set out above. Within the NHS, we estimate that we will need £500 million per annum for workforce development and £400 million per annum for capital investment. In addition, we need a significant boost in funding for prevention and public health worth at least an extra £200 million per annum. The government should also at least return those social care budgets that impact on mental health to their 2010 level, requiring an additional £1.1 billion in current prices.

The government should also provide £500 million per annum for workforce development and an immediate investment of £400 million for capital investment.

The government should provide an extra £1.1 billion per annum for social care (by 2030) and at least £200 million per annum for public health.

The NHS cannot deliver parity of esteem alone: the government should commission a 'health in all policies' strategy to address the social determinants of health. Over 60 per cent of health outcomes are determined outside the NHS – and welfare, housing, criminal justice and schools and early years policy are particularly important in determining mental health outcomes. Without action across all these dimensions – as well as the NHS – we will never achieve parity of esteem.

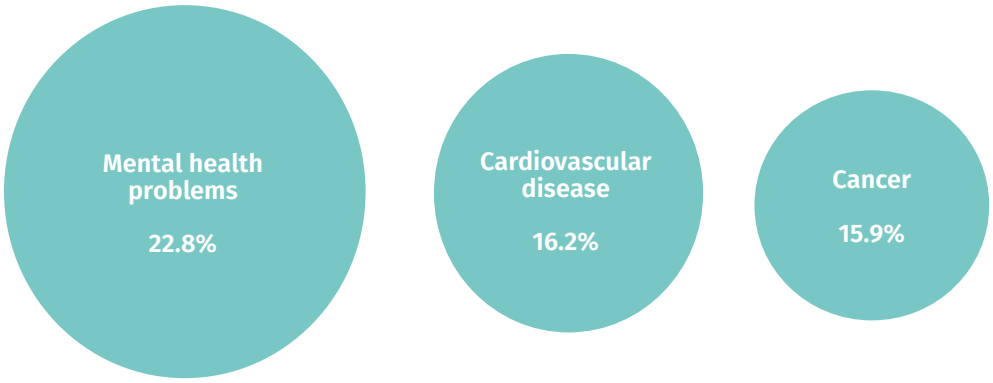
The government should commission a 'health in all policies' strategy to address the social determinants of health. This should be overseen by a cabinet committee to be chaired by the prime minister, as recommended by the Lord Darzi Review (Darzi 2018).

1. INTRODUCTION

Poor mental health is one most significant challenges of our time. A staggering one in four of us will experience a mental health problem each year (McManus et al 2016). Fewer – but still significant numbers – experience more severe forms of mental health, such as psychosis, bipolar disorder and personality disorder. These conditions have a significant impact on people's ability to live long and fulfilling lives. Too many people still suffer in silence as result of the stigma of mental health, go without treatment because of underinvestment in research and treatment, and end up dying younger than those with physical health conditions.

FIGURE 1.1

Burden of disease in the UK



Source: FYFVMH 2016

But poor mental health is not just a personal burden: it is a societal one as well. The cost of mental health to the economy is about £100 billion every year – the same as the cost of the entire NHS (Parkin and Powell 2017). This is because people with mental health conditions are less likely to be in employment than those without, leading to more people dependent on the welfare state and fewer people paying taxes. Likewise, those who are in employment can suffer from absenteeism or presenteeism – both of which impact on productivity (Centre for Mental Health 2011).

The case for bold action to address poor mental health in the UK – both on moral and economic grounds – is strikingly clear. Fortunately, politicians of all political persuasions are increasingly recognising this fact. This has primarily manifested itself in calls for investment in mental health treatment – and to a lesser extent actions on the social determinants of mental health – to help achieve 'parity of esteem' between mental and physical health. More recently, the prime minister, Theresa May, has personally made this one of her priorities, accurately describing it as a "burning injustice".

These political pronouncements have started to translate into action. Notably, the Five Year Forward View for Mental Health (FYFVMH) (Mental Heath Taskforce

2016) – published by an independent commission in 2016 – has subsequently been adopted as government policy. It sets out a range of ambitious targets for scaling up and improving mental health provision, and commits to investing £1 billion of further funding in mental health, with the aim of reaching 1 million more people with mental health conditions. This progress is to be welcomed.

Moreover, it has begun to pay off. Polling shows that public attitudes towards people living with mental health problems have generally become more tolerant in recent years (Darzi 2018). It is also encouraging that more people can access mental health treatment as a result of government policy, and that suicide rates have decreased from 14.7 to 10.1 deaths per 100,000 since 1981 (ONS 2018). But we must not congratulate ourselves too soon: there is still a long way to go.

Almost nine out of 10 people with mental health problems still say that stigma and discrimination have a negative effect on their lives (Mental Health Foundation 2017). Even if we are able to deliver on the FYFVMH – which is far from guaranteed – 65 per cent of children and young people with a diagnosable condition, and 75 per cent of adults with common mental health problems (in any one year) will still not be receiving access to treatment. And, shockingly, those with severe mental health conditions such as psychoses and eating disorders still die on average 15–20 years younger than those without (RCPsych 2013).

The NHS's 70th birthday present – a new funding deal worth an extra £20 billion per year by 2023 – is an opportunity to deliver a better life for those living with poor mental health. The NHS is in the process of authoring a long-term plan that will set out what it wants to achieve with this additional funding and how this funding will be allocated. It is crucial that this plan raises our ambitions on mental health: despite accounting for 23 per cent of the disease burden, mental health gets just 11 per cent of the NHS budget (Mental Health Taskforce 2016). This must change: we need to be clear what success – 'parity of esteem' – looks like and how much it will cost to get there. These are the questions that this briefing paper sets out to answer.

2.
DEFINING PARITY OF ESTEEM

There has long been recognition of the inequalities suffered by people with poor mental health relative to those without. The term 'parity of esteem', as a means of explaining this injustice, can be seen in the mainstream public and political discourse from 2010 onwards. The Coalition government's 2011 strategy for mental health, *No Health Without Mental Health*, put it at the heart of policy for the first time, and the Health and Social Care Act in 2012 subsequently enshrined it in law.

Despite the adoption of the concept of parity of esteem by the political and policymaking community, no formal definition was proposed. Numerous attempts have subsequently been made to address this oversight. The most widely referenced of these attempts is the work of the Royal College of Psychiatrists (RCPsych) which states that parity of esteem means "valuing mental health equally with physical health" (RCPsych 2013).

This definition is undoubtedly compelling – it leaves little to disagree with – but on its own is also ambiguous. While RCPsych provided a more detailed definition behind it, this was not reflected in the 2012 Health and Social Care Act or in the surrounding political dialogue. As a result, policymakers have been able to profess a commitment to mental health without being held accountable for specific and measurable deliverables.

The most notable example of this is former health secretary Jeremy Hunt's claim that 85 per cent of the country is "achieving parity of esteem" in 2017 (Royle and Evan 2017). This assertion was made based on the mental health investment standard – a requirement stipulating that Clinical Commissioning Groups (CCG) spending on mental health needs to go up faster than the overall increase in health spending – as a metric for parity. While delivering on this investment standard is undoubtedly an important achievement, claiming that it represents parity of esteem is misleading at best, and disingenuous at worse.

There is little doubt that parity should mean 'valuing mental health equally with physical health'. Undoing the stigma felt by many people who live with mental health conditions is hugely important. But ultimately 'value' only means something if it leads to better lives for people living with mental health. Parity of esteem cannot just be about changing attitudes or talking about mental health as well as physical health; it must put the health outcomes of people experiencing poor mental health front and centre, and then hold policymakers accountable for delivering on them.

Therefore, we argue that parity of esteem should be defined as: "people living with a mental health condition must have an equal chance of a long and fulfilling life as those with a physical health condition". This puts outcomes at the heart of the definition of parity: we need to focus on improving the length of life (for example, life expectancy) and the quality of life (including healthy life expectancy, wellbeing etc) experienced by those living with poor mental health. After all, this is ultimately people care about most.

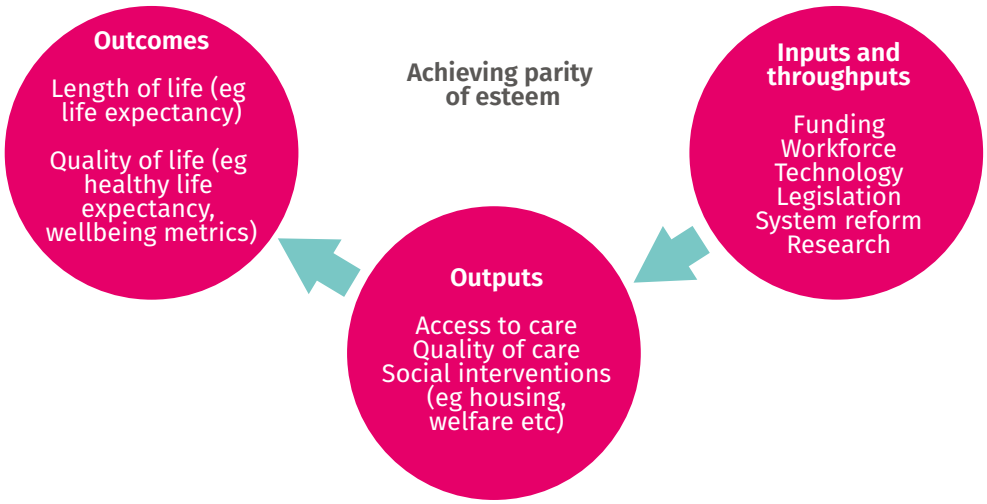
POLICY RECOMMENDATIONS

'Parity of esteem' means that "people living with a mental health condition must have an equal chance of a long and fulfilling life as those with a physical health condition". The NHS Long-Term Plan should adopt this definition and commit to delivering it within the NHS.

Based on this definition we can set out a clear theory of change which describes how parity of esteem can be achieved (see figure 2.1 below). This theory of change highlights the importance of three key deliverables (outputs) that would need to be scaled up to deliver parity of esteem: access to care (within the NHS and social care), the quality of that care (within the NHS and social care), and wider social interventions (such as welfare and housing). It then recognises the range of inputs (or throughputs) that would be required to achieve this including funding and workforce (which are discussed at length in later chapters).

FIGURE 2.1

Theory of change for delivering parity of esteem for mental health



Source: Authors' analysis

A comprehensive delivery plan is needed across all these aspects of mental health policy to achieve parity of esteem, and we call on the government to commission a 'health in all policies' strategy to address the social determinants of health, including mental health. NHS England will also need to address the other enablers of progress towards parity of esteem – especially the mental health workforce and availability and use of data – in its long-term plan. However, this is beyond the scope of this briefing paper.

Instead, we primarily focus on the cost of increasing access to – and the quality of – mental health treatments within the health and care system (NHS, social care, public health). As such, the next chapter sets out several shifts in the availability and type of interventions delivered by the health and care system that we believe must occur to deliver parity of esteem. We then estimate the additional funding requirement needed to deliver these changes.

The government should commission a 'health in all policies' strategy to address the social determinants of health. This should be overseen by a cabinet committee to be chaired by the prime minister as recommended by the Lord Darzi Review (Darzi 2018).

HOW ARE WE DOING SO FAR?

Length and quality of life

We know that those with severe mental health problems have a lower life expectancy than those without by between 15–20 years on average (RCPsych 2013). This is a result of suicide as well as higher levels of other preventable illnesses associated with mental health conditions (CEP 2012). This may be starting to change given the fall in suicide rates, but a large gap remains. Meanwhile, on quality of life, we know that people with mental ill-health are more likely to go to prison, receive poor GCSE results or face exclusion in school, experience unemployment and suffer from drug and alcohol addiction. Indeed, there is evidence to suggest that mental illness can be up to 50 per cent more debilitating than comparable physical illnesses (ibid).

Access to care

The average treatment rate via the Improving Access to Psychological Therapies (IAPT) programme for people with common mental health conditions has improved, but is still nearly four times lower than comparable physical health treatments. Access for children and young people with eating disorders remains significantly below the FYFVMH target of 95 per cent (Darzi 2018). There has been progress on Early Intervention in Psychosis (EIP) pathways, but unmet treatment requests were about seven times more likely among people with a psychotic disorder than in the rest of the population (APMS 2014). Specialist services for severe mental illness are becoming less accessible, and treatment is becoming more coercive (e.g. detentions under the Mental Health Act) (Dormon 2015).

Quality of care

Measuring quality in mental health services is challenging. There are some signs of improvement. Recovery rates for adults with anxiety and depression have been improving over recent years (with IAPT recovery targets met since 2016/17) (Darzi 2018). This is corroborated by CQC ratings which show that 74 per cent of mental health services are rated as good or outstanding. But this leaves nearly one in four that are not. Moreover, the proportion of patients in the care of crisis resolution and/or home treatment teams who commit suicide has increased (NHS England 2016). Likewise, patients who are given out-of-area placements – when they are treated miles from their home – have also seen an increase in suicides in recent years (ibid).

Social interventions

There is a significant social gradient in mental health outcomes, with those on low incomes and marginalised groups (such as BAME and LGBT+ people) more likely to face poor mental health and the worst consequences associated with this. There has been some focus on addressing the social determinants of health, with the government putting forward plans to increase mental health capacity in schools (DFE and DH 2017) and introducing more policy on mental health in the workplace (Farmer and Stephenson 2017). But these plans need to be fully implemented, and without bolder and targeted action – spanning all known effective social interventions (LSE 2017) – they will be unable to overcome the entrenched inequalities that result in the social gradient in mental health outcomes. This action should include reversing some of the more damaging cuts that have been introduced over the last eight years. Until we get this right it will significantly undermine the extra investment into NHS care.

3. PAYING FOR PARITY OF ESTEEM

In order to set out the changes required to the health and care system needed to deliver parity of esteem, we have undertaken an extensive consultation exercise with the mental health sector, including all members of the Mental Health Policy Group. We have also undertaken an analysis of the open call for evidence through the All Party Parliamentary Group (APPG) on Mental Health. Based on this consultation exercise, we have identified several shifts required in the health and care service in order to deliver parity of esteem. These themes are set out below, along with the headline results from our modelling on the cost of achieving them. Our modelling is based on the best costed, evidence-based treatments at the present time, but ultimately it is up to policymakers, clinicians and commissioners to channel this funding towards the best evidence-based treatment (including new innovations as and when they are developed). All funding asks are in current prices, and hence do not take inflation into account.

1. More investment in early intervention for children and young people

Mental health problems are usually established early in life: half have started by the age of 14, and three-quarters by the age of 24. It is estimated that one in 10 children aged 5–16 has a diagnosable problem. Those with more severe conditions are more likely to leave school without any qualifications, become a teenage parent, end up in prison, or suffer from drug and alcohol addiction. Yet most children and young people get no support.

The FYFVMH has started to change this, but more action is needed. The findings of our consultation were clear: there is an urgent need for expanding psychiatrists and specialised practitioners to manage the most complex children and young people, such as those with complex trauma, gender identity disorder, refugees, and developing specialist treatments for vulnerable children with severe, complex and enduring mental health difficulties who require specialist services. Our modelling suggests that this would require an extra **~£265 million per annum by 2023/24** and **£1.1 billion per annum by 2030/31,** including expanding psychological therapies and mental health support teams.

2. Scale up access to treatment for common mental health conditions

Common mental health conditions, including depression and anxiety, affect more people than any other mental health problems: 15 per cent of the population are estimated to be impacted at any one time. The new national IAPT programme (Improving Access to Psychological Therapies) has expanded access to treatment aimed at supporting this group. But even if the FYFVMH is delivered, 75 per cent of adults with common mental problems will go without access every year.

We model the expansion of access to IAPT to match the equivalent treatment levels seen in similar physical conditions treated in primary care with a variety of treatment options. This would ensure availability of services to those in need, but still allow for choices to be made between treatments, as is the case in physical care. To increase access to IAPT to 61 per cent of people on average and 75 per cent as a stretch target, it would cost an **additional £260–333 million per annum by 2023/24** and **£1–1.3 billion per annum by 2030/31**.

3. Provide universal high-quality community care for people severely affected by mental illness

Currently, people with severe mental illness – including psychosis, bipolar disorder, eating disorders and personality disorder – are waiting months for secondary care treatments in the community, or not receiving it at all. This means more investment in community secondary care treatments is crucial – where people can stay integrated in society and embedded in their support networks. To increase access to therapies for people with psychosis to 70 per cent, bipolar disorder to 50 per cent, personality disorder to 50 per cent and eating disorders to 70 per cent will cost an **additional £564 million per annum by 2023/24** and **£2.3 billion per annum by 2030/31**.

4. Provide universal, high quality liaison and 24/7 crisis care for people living with poor mental health

Even with an investment in services, there will be people reaching crisis and care in the NHS remains inadequate. Even if the FYFVMH is delivered, only half of hospital accident and emergency (A&E) departments will have 24/7 cover from a liaison mental health service and community services. Meanwhile, too many community services fail to offer 24/7 crisis services, and only see people registered with a community mental health team.

Our consultation with the sector made it clear that a consistent 24/7 crisis service should be available in the acute sector – with all hospitals benefitting from a liaison service – and more investment should be put into crisis support in the community. Our modelling suggests that this would require **an extra £57 million per annum by 2023** and **£227 million per annum by 2030**. We also suggest that the NHS open up non-urgent community treatment to seven days **and allow ~£400 per annum million for this by 2030/31.**

Improve and reduce inpatient admissions

With the right crisis care and secondary services in the community, we should reduce pressure on the acute mental health sector and allow more people to receive care in the community. Too often, the acute sector is not the safe and therapeutic environment it should be. We have modelled a reduction in the need for inpatient admissions by 10 per cent, but – assuming occupancy rates are currently too high – we propose maintaining the total number of beds but reducing occupancy below the recommended 85 per cent of beds taken. This will lead to an improvement in the quality of care and space to respond to urgent needs.

Spread best practice across the country so that everyone can benefit from it

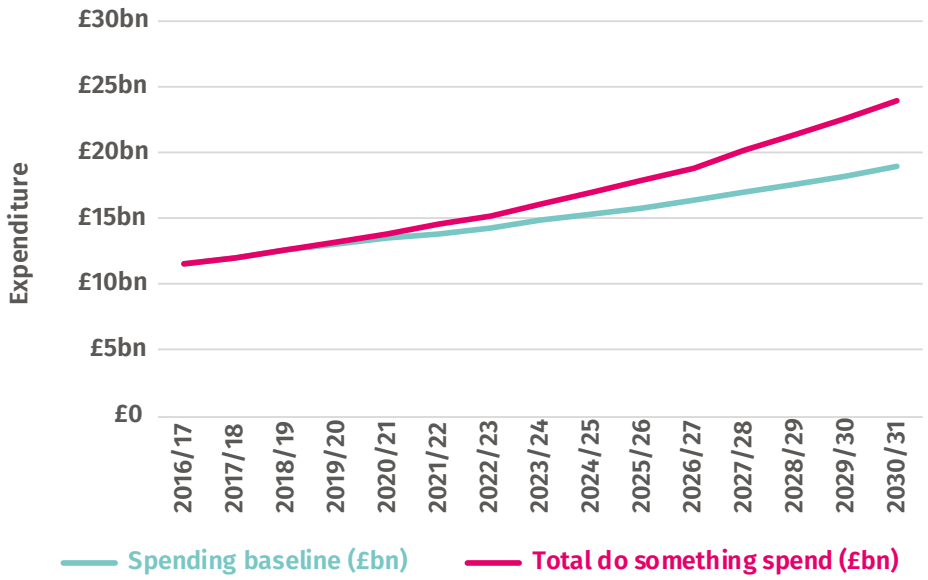
Across the country, a number of innovative providers and commissioners have been pioneering new ways of addressing mental illness in the NHS. Recent examples include: the use of social prescribing as a means of addressing loneliness, isolation and depression; interventions such as mental health cafes as a way of reducing crisis admissions; and other interventions being tested under the New Models of Care (NMC) process (Naylor et al 2017). We estimate that 1–2 per cent of the NHS mental health budget should be set aside for a transformation fund **requiring an extra £200 million per annum by 2023** and **£300 million per annum by 2030**.

Together, these additional commitments imply significant extra spending on mental health in the NHS, as shown in figure 3.1. The green line shows the baseline NHS spend on mental health, assuming that spending grows by either 3.4 per cent (the overall NHS funding settlement) or the pre-existing commitment made by the FYFVMH (whichever is higher), and then grows at the NHS long-term trend growth (GDP + 1.5 per cent) thereafter.

The pink line shows the total incremental spend implied by the spending commitments set out above. We assume that this funding builds on the commitments already outlined in the Five Year Forward View to invest in the changes that are required to deliver more and better mental health provision. This implies **an extra £1.2 billion spending (per annum) on mental health by 2023/24** and **£5 billion (per annum) by 2030/31**, over and above expected growth. In this scenario, mental health spending grows at 5.5 per cent over the next decade or so, compared to a forecast of approximately 3.5 per cent growth in overall NHS spend.

FIGURE 3.1: NHS MENTAL HEALTH SPENDING WILL NEED TO DOUBLE BY 2030 TO ACHIEVE PARITY OF ESTEEM

Growth in NHS mental health spend (£), 2016/17–2030/31



Source: Carnall Farrar analysis

We have assumed that the increase is backloaded (as figure 3.1 demonstrates), given the time lag inherent in building up capacity (in particular, training staff).

POLICY RECOMMENDATIONS

The government should increase spending on mental health from £12 billion per annum in 2017/18 to £16.1 billion per annum in 2023/24 and £23.9 billion per annum in 2030/31.

The government should provide an extra £1.1 billion per annum for social care (by 2030) and at least £200 million per annum for public health.

PUBLIC HEALTH, PREVENTION AND SOCIAL CARE

Another clear theme to emerge from our consultation with the sector is the need for upstream prevention to promote mental wellbeing. This is crucial in improving outcomes, reducing cost to the NHS and reducing the gross inequalities in our society. Setting out the cost of investing in all the social interventions needed to achieve parity of esteem is beyond the scope of this paper, but we can set out what parity of esteem in public health requires.

Using data on the comparative burden of illness attributable to mental and physical health and comparing this with comparative public health spend, we can estimate that public health spending on mental health should **rise fivefold to £200 million per annum to achieve parity on the existing public health budget.** This would **rise to £400 million** if the government properly invested in public health[1] – and would **grow to £480 million per annum by 2023** and **£600 million per annum by 2030**, assuming the public health budget grows at the same rate as NHS spend.

To support the shift of care out of the acute sector and into the community, there will also need to be more significant investment in social care. This is because social care provides vital support for people living in the community with mental health conditions, including supported housing. Restoring mental health related adult social care budgets to 2010/11 levels (adjusted for inflation) would require an additional £1.1 billion per annum over existing social care spending by 2030.

1 Based on doubling public health spend.

4. DELIVERING PARITY OF ESTEEM

A fair funding settlement for mental health is undoubtedly a pre-requisite of achieving parity of esteem in England. We need an extra £1.2 billion (per year) in day-to-day spending for mental health by 2023/24 and £5 billion (per year) by 2030/31 to deliver parity of esteem in the NHS. In addition, social care would require an extra £1.1 billion of investment per annum by 2030/31 and at least £200 million per annum in public health. But money alone will not be enough: as set out in our theory of change in chapter 3 there are several broader changes in the policy environment that will be needed to invest this funding effectively and deliver true parity of esteem. Without action across all these dimensions, high quality care for all people with poor mental health will remain out of reach.

The most important enabler of progress – apart from funding – is the workforce. Mental health care is relatively labour-intensive and capital-light. Simply delivering the existing commitments set out in the FYFVMH requires an additional 21,000 new posts in England by April 2021. Scaling up provision will require an even larger workforce. This is challenging because the sector often struggles to attract and retain talent: there are more than 20,000 vacancies for mental health staff in the English NHS, which is nearly 10 per cent of the funded posts (Nuffield Trust 2017), with staff reporting higher levels of stress and poorer job satisfaction than their acute counterparts (CQC 2017).

The pace at which new staff can be trained and deployed – and the degree to which they are able to increase retention of the existing workforce – will be crucial in determining how soon parity of achieved delivered. This in turn is a key determinant in how quickly new funding can be usefully invested. As a result of consultation with the sector, we believe that – if workforce expansion and retention is prioritised – the interventions needed to deliver parity of esteem as modelled in the previous chapter could be achieved by 2028. However, if this does not occur, it will be delayed beyond 2030. This will also require additional investment (see details below).

INVESTING IN THE WORKFORCE

Fully modelling the workforce implications of achieving parity of esteem is beyond the scope of this paper. Health Education England (HEE) should lead on undertaking this responsibility. But, based on the additional staff requirement required for the FYFVMH, we can estimate the total additional staffing requirement to achieve parity of esteem. We estimate that an additional £500 million will need to be invested in the workforce (over and above the existing HEE budget). At least this amount will need to be allocated to the mental health workforce as part of the upcoming spending review.

CAPITAL FUNDING REQUIREMENTS

Investment in the mental health estate must also be a priority to ensure that NHS buildings are fit for purpose and to enable new models of care and transformation. Based on NHS data on backlog maintenance and planned improvements and new builds, we estimate that a total of ~£400 million per annum is needed in the short term.

POLICY RECOMMENDATION

The government should provide need £500 million per annum on workforce development and an immediate investment of £400 million on capital investment.

In addition to this, action will be required on a much wider range of enablers to deliver parity of esteem.

- National data on mental health services is severely lacking: going forward, this will need correcting in order to measure progress and hold providers accountable.
- The system architecture in health and care urgently needs reform to better integrate mental and physical health provision and deliver whole-person care for all patients.
- The government's Industrial Life Sciences Strategy must put more emphasis in research into mental health to unlock new treatments and models of care.
- There is an urgent need to address the social determinants of mental ill-health, with a focus on housing, criminal justice and welfare policy.

Without action on these areas – as well as further funding for the sector – parity of esteem will remain a political slogan rather than a practical reality for people living with poor mental health. This would be economically and morally unjustifiable: the time for bold action is now.

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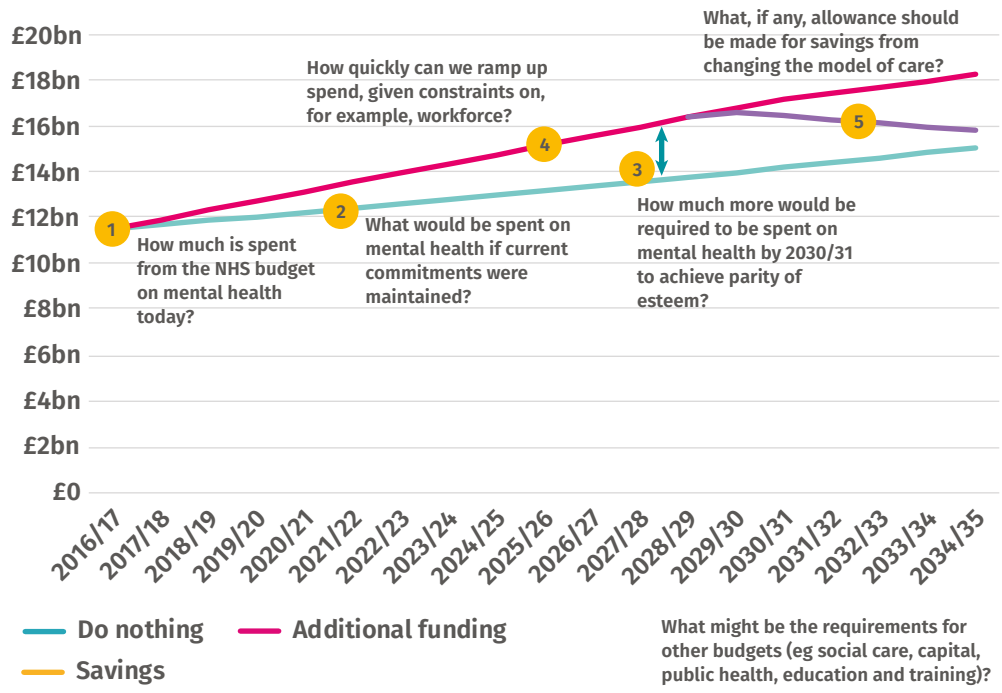
APPENDIX: RESEARCH METHODOLOGY

This report estimates the required funding for mental health by considering six questions, as laid out in figure A1.

1. How much is spent, from the NHS budget, on mental health today?
2. What would be spent on mental health if current commitments were maintained?
3. How much more would be required to be spent on mental health by 2030/31 to achieve parity of esteem?
4. How quickly can we ramp up spend, given constraints on, for example, workforce?
5. What, if any, allowance should be made for savings from changing the model of care?
6. What might be the requirements for other budgets (for example social care, capital, public health, education and training)?

FIGURE A1

Modelling mental health expenditure



Source: Carnall Farrar analysis

A separate slide pack is available on IPPR's website for those wishing to examine the underlying numbers in more detail.

HOW MUCH IS SPENT, FROM THE NHS BUDGET, ON MENTAL HEALTH TODAY?

We have taken the number reported in the 2016/17 mental health dashboard of £11.6 billion, and the 2017/18 number of £12.0 billion. This includes CCG and specialist commissioning spend. It should be noted that it also includes learning disabilities which we have not considered as part of our definition of parity.

WHAT WOULD BE SPENT ON MENTAL HEALTH IF CURRENT COMMITMENTS WERE MAINTAINED?

We have split the growth of current commitments into three phases.

1. The next two years (2019/20 and 2020/21) where the FYFV overlaps with the new offer of 3.4 per cent uplift for the NHS budget.[2] To maintain both the FYFV commitment and the mental health investment standard, we have assumed the higher of the two numbers. In practice, this is the mental health investment standard.
2. The remaining three years of the 3.4 per cent funding offer for the NHS. We have assumed that the mental health investment standard is maintained throughout this period, resulting in the mental health expenditure increasing by 3.4 per cent.[3]
3. The years after 2024/25. We assume that overall NHS expenditure reverts to its long-term growth rate of 1.5 per cent over GDP, and that the mental health investment standard would be maintained. This is consistent with *Better health and care for all* (IPPR 2018).

This results in baseline mental health spending increasing from £11.6 billion in 2016/17 to £18.9 billion in 2030/31. It assumes that the FYFV commitments are delivered by 2020/21, and that hence the asks in this report are in addition to that. It could be argued that some of the additional ask would be delivered by the 3.4 per cent uplift between 2019/20 and 2023/24; we instead believe that this spending increase will, in practice, be used to restore wages and other costs to historic relative levels and hence not be used for service improvement.

We have chosen to model in current prices, and hence do not take inflation into account.

HOW MUCH MORE WOULD BE REQUIRED TO BE SPENT ON MENTAL HEALTH BY 2030/31 TO ACHIEVE PARITY OF ESTEEM?

First, we pick out service improvements that are likely to incur significant cost. IPPR and Rethink's call for improvements received responses from appointing champions to significant increases in access to certain types of provision. While important, we chose not to model improvements that would not make a significant difference to the overall ask, assuming the continued tracking of the mental health investment standard would cover these.

Second, we take several approaches to modelling service improvements and expansions. These are:

1. uprating to equate to a similar level of access to treatment as physical disease
2. assuming that a percentage of those experiencing a particular condition should be offered treatment

2 We have in fact modelled the increase in the mandate at 3.6 per cent, 3.6 per cent, 3.1 per cent, 3.1 per cent, 3.4 per cent from 2019/20 onwards as per the suggested phasing. The anticpated uplift to account from increased pension expenditure (estimated at £1.25 billion) is not included.

3 See footnote 1.

3. modelling the availability of urgent services, such as Core 24 liaison and crisis and home resolution teams
4. modelling several significant new treatment increases.

UPRATING TO EQUATE TO A SIMILAR LEVEL OF ACCESS TO TREATMENT AS PHYSICAL DISEASE

For services such as IAPT, we have assumed that the FYFV target treatment rate of 25 per cent is achieved by the additional funding already allocated. We have then modelled what might be necessary to deliver IAPT to the same percentage of people who are currently receiving treatment for physical ailments. In this case, we have taken diabetes, hypertension and asthma as analogues for common mental health problems. Treatment rates for these vary from 47.6 per cent (diabetes) to 75 per cent (hypertension). Reaching a similar portion of those with common mental health conditions would suggest investment of between £1 billion and £1.3 billion. We have not assumed universal coverage of psychological therapies – there would always be some people for whom psychological therapies are inappropriate or who refuse. Within these rates, we assume psychological therapies for those with chronic physical disorders (such as diabetes).

We take a similar approach to scaling up psychological therapies for children and young people, requiring an additional investment of ~£240 million by 2030/31.

Expanding community treatment

For greater treatment in the community, the modelling starts from prevalence rates, assumes a percentage of those with a diagnosable condition would not respond to therapy or counselling and hence excludes those. It then recognises that a number of people are already being treated or will be treated under already planned expansion and excludes those. Of the remaining number that would respond to treatment, we then assume that half would require treatment in any given year. This suggests significant increases in community treatments for psychosis, borderline personality disorder and bipolar personality disorders of around £644 million, £907 million and £699 million respectively.

We assume that this expansion of community provision is sufficient to absorb 10 per cent of those currently occupying inpatient beds. We have not modelled a saving from these inpatient beds. While it is true that community treatment should be more cost effective, occupancy rates for inpatient beds are currently in excess of 90 per cent, compared to the Royal College of Psychiatrists' guideline of 85 percent, and there are widespread staff shortages. In practice, we believe that reducing inpatient numbers would reduce the pressure on occupancy and short staffing, rather than result in actual cost reductions.

Modelling the availability of urgent services, such as Core 24 liaison and crisis and home resolution teams

Some services are not scalable by demand, and are required 24/7. Two such services are Core 24 liaison in acute hospitals, and crisis and home resolution teams. The FYFV already includes funding for Core 24 services in 50 per cent of hospitals; we therefore assume the other 50 per cent are rolled out over this period at a cost of £25 million. Crisis and home resolution teams currently cover ~30 per cent of the country – the number able to deliver selected core functions is less than one-quarter. Expanding these to cover the whole country with all functions would require investment of £200 million. As we also call for non-urgent community services to be available seven days a week, we have allowed a further £400 million for this.

Modelling a number of significant new treatment increases

For core CAMHS services, we take the existing level of spend on CAMHS by CCGs across the country, uprate to the spending of the top decile and adjust to reflect that estimates suggest only 1 in 4 children with a diagnosable mental health condition receive support in any given year[4]. This suggests an investment of £280 million in core CAMHS. Adding £240 million for psychological therapies, and £645 million to expand the rollout of mental health support teams from 25 per cent of the population to the whole population totals an investment in CAMHS of £1.1 billion.

The total of these interventions is an additional investment of £5 billion in 2030/31, for a total mental health expenditure of £23.9 billion. This would increase mental health expenditure from 11 per cent of NHS mandate spending today, to 13.8 per cent of mental health mandate expenditure in 2030/31.

For more detail, see the slide pack available at: http://www.ippr.org/research/publications/building-the-workforce-of-the-future.

HOW SWIFTLY SHOULD THAT SPEND BE RAMPED UP?

The modelling considers three possible scenarios for the rate at which spending is increased.

1. A straight line increase over the time period, with even increases in expenditure on the additional ask every year. This results in increases in mental health expenditure of around 5–6 per cent every year to 2030/31.
2. A front-loaded investment profile, with larger increases in funding in the first half of the period, and lower increases in the second half of the period. This would reflect the urgency of improving mental health services. This results in increases in mental health expenditure of ~8 per cent in the next three years, tailing off to 4 per cent by the end of the period.
3. A back-loaded investment profile, with smaller increases in funding in the first half of the period, made up by larger increases in funding in the back half of the period. This could reflect the reality that much of the expenditure would need to be direted towards increasing staff, which is limited by the current capacity to train staff and the time it takes to train them once capacity is available. This starts with increases of 4–5 per cent, rising to 7 per cent by the end of the period.

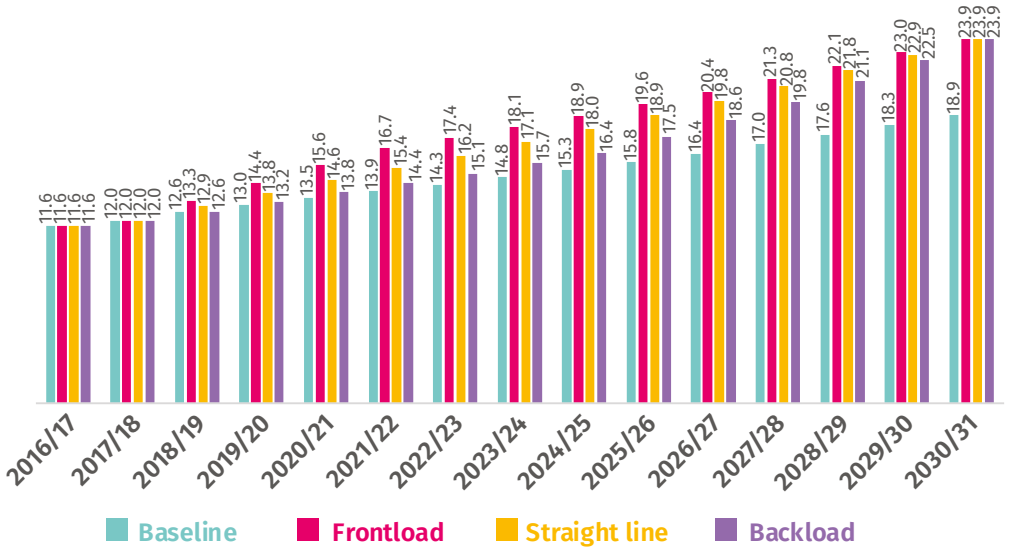
For the main report, we have chosen the frontloaded scenario which is reflected in figure 3.1.

Figure A2 shows the different scenarios.

4 Children's Commissioner - Briefing: Children's Mental Healthcare in England, October 2017, p. 4

FIGURE A2

Mental health expenditure scenarios



Source: Carnall Farrar analysis

WHAT, IF ANY, ALLOWANCE SHOULD BE MADE FOR SAVINGS FROM CHANGING THE MODEL OF CARE?

In theory, changing the model of mental health care can be more economical, more efficient and more effective. For example, improving community and crisis care such that people who are currently treated in secure facilities can be treated in the community would result in a better experience for patients, higher recovery and lower expenditure. However, as explained above, in practice this would depressurise inpatient care, supporting a better experience, rather than result in savings. Similarly, mental health support teams should result in earlier intervention and/ or greater resilience in children and young people, which could reduce the pressure on CAMHS.

In addition, we know that better mental health care can lead to savings in physical health budgets. People with physical long-term conditions often develop anxiety and depression, reducing their resilience and increasing their use of physical health services. Similarly, people experiencing severe mental ill health neglect their physical condition, resulting in higher demand for physical care. As this report concentrates on mental health spending, we have not attempted to model savings in physical health.

WHAT MIGHT BE THE REQUIREMENTS FOR OTHER BUDGETS (SUCH AS SOCIAL CARE, CAPITAL, PUBLIC HEALTH, EDUCATION AND TRAINING)?

The 3.4 per cent increase in NHS funding announced for the first five years of the long-term plan is a 3.4 per cent increase in NHS England's revenue budget. This means no commitment has been made for other budgets. The most significant of these (for mental health services) would be the public health budget, spent by local authorities and overseen by Public Health England; the healthcare education and training budget, overseen by Health Education England; the capital budget, spent largely by providers of care and overseen by the DHSC; the social care budget, spent by local authorities, and the housing budget, again spent by local authorities. This report has focused on mental health spending within NHS

England's revenue budget, as that is the focus of the long-term plan. Nevertheless, care for those experiencing mental ill health is not limited to NHS England revenue budget, and we have therefore called for increases in these other budgets.

Innovation Fund

We estimate an innovation fund of 1–2 per cent of expenditure would be required to stimulate the transformation of services. This is equivalent to £200–300 million per annum.

Public health

We know that the public health budget has been reduced in recent years, and that expenditure on prevention for mental health is disproportionately low – only 4 per cent of the pot. If mental health expenditure increases to a similar amount per DALY[5] as physical health, and then grows in line with NHS revenue funding, this would see expenditure on prevention for mental health expand from £200 million to £242 million by 2030/31. Given we already underinvest in public health and prevention, a more effective approach would be to double this expenditure on public health and prevention to £400 million to recognise the burden of illness linked to mental ill health. In an ideal world this change would happen immediately and then the public health budget would grow at the same rate as the NHS reaching £480 million per annum by 2023 and £600 million per annum by 2030.

Education and training

Implementing the Five Year Forward View and the *Mental Health Workforce Plan* assumed that 14 per cent of the extra investment (£180 million over the five years) would be needed to increase training and education as the workforce expands. Health Education England's future workforce budget totals £4.4 billion in 2017/18. Assuming the share of education and training budgets matches mental health's share of NHS spending (11 per cent in 2017/18) implies £500 million is currently spent on the future workforce for mental health. As we call for mental health expenditure to double by 2030/31, both comparison to the FYFV and HEE's further workforce suggests a further £500 million will be required to deliver the mental health workforce.

Capital budget

Mental health trusts estimate that in 2016/17, £425 million will be required to address backlog maintenance and develop critical infrastructure. Based on the averages of the last three years, and the overall ramp-up of healthcare services, we estimate that a further £300 million to £400 million will be required by 2030/31.

Social care

We know that people living with mental ill health require social and housing support as much as treatment services. Nonetheless, changes to the social care budget lie outside the scope of this report. We do believe that, at a minimum, the cuts to social care and housing since 2010/11 should be reversed. This would be equivalent to an additional £1.1 billion of social care expenditure.

5 A measure of overall disease burden, expressed as the number of years lost due to ill-health, disability or early death.

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