SAINSBURY CENTRE
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Mental health inequalities: Measuring what counts

Summary

Just as there is no health without mental health, there is no equality without mental health equality. There is sufficient demonstrable proof that the interaction between good or poor mental health and a range of health and social outcomes is profound.

But there is little useful supporting data or measures to collect them. Developing new metrics, adapting existing ones and ensuring that data are used in the most effective way are vital not just to determine what progress is being made to reducing mental health inequalities but also to offer incentives to a range of public services to 'do their bit'.

This paper looks at what measures are currently available to create a meaningful and useable picture of inequalities in mental health in England and at what additional measures are needed to fill in the gaps. It is based on a seminar organised jointly between the Department of Health and Sainsbury Centre in 2009. It examines measures of inequality on seven key dimensions in all of our lives:

- A good start in life and the early years,
- Body and mind,
- Working lives,
- Later life,
- The places we live,
- Financial security,
- Social capital and social connectedness.

It concludes that some data already exist that can shed light both on the unequal distribution of mental ill health in society and on the unequal life chances faced by people with mental health problems. But there remain big gaps both in terms of what data are collected by public services and in the way existing data are used to shed light on people's experiences and to motivate services to do better.

Introduction

Mental health has been described by the World Health Organisation (WHO, 2009) as: "... a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community."

Mental health is critical for the well-being and effective functioning of individuals, families, communities and society; and its absence has implications far beyond individuals. In other words, although mental health is very personal, the quality of the population's mental health affects every aspect of the shared life of the country.

Mental well-being is influenced by many factors, including genetic inheritance, childhood experiences, life events, individual ability to cope and levels of social support, as well as factors like adequate housing, employment, financial security and access to appropriate health care. Gender has a significant impact on mental health and vulnerability to mental health problems. Racism, homophobia and other forms of discrimination also affect mental health and can be an underlying cause of mental health problems.

Mental health is not simply a characteristic of individuals. Schools, neighbourhoods, organisations or specific groups of people such as

refugees may have low levels of mental health as a result of poverty, deprivation, exclusion, isolation or low status (DH, 2001).

Mental health stigma and discrimination exacerbate broader social and health inequalities and present major challenges for people with mental health problems to live as equal. Intolerance and prejudice are also damaging to us all, as those with mental health concerns are less likely to seek timely care and treatment for fear of being labelled and ostracised (see www.time-to-change.org.uk).

Having common or more severe mental health problems is associated with poverty and poor general health. Conversely, being socially excluded is associated with poorer mental health. This relationship is most clearly demonstrated by the complex links between physical and mental health.

Poor mental health and its impact on physical health

There is strong evidence that supports the adverse effect of severe as well as more common mental health conditions on physical health and well-being. The 0.4% of the population with severe and enduring mental illnesses (McManus *et al.*, 2009) are at increased risk of coronary heart disease, diabetes, infections and respiratory disease. They are almost twice as likely to die from coronary heart disease as the general population and four times more likely to die from respiratory disease (Harris & Barraclough, 1998, Phelan *et al.*, 2001). A person with a diagnosis of schizophrenia can expect to live for ten years fewer than someone without a mental health problem and much of this excess mortality is caused by physical health problems (Brown *et al.*, 2000).

A far greater proportion of the adult population (16.2%) experience anxiety and depression (McManus *et al.*, 2009) and these more commonly occurring mental health problems also take their toll on physical health. Evidence has shown that sustained stress or trauma increases susceptibility to viral infection and physical illness by damaging the immune system (Stewart-Brown, 1998, Cohen *et al.*, 1991, Cohen *et al.*, 1997). Individuals with depressive disorders are about twice as likely to develop coronary artery disease, twice as likely to have a stroke and four times as likely to have a myocardial infarction as people who are not depressed, even when other risk factors like smoking are controlled for (Sederer *et al.*, 2006, Hippisley-Cox *et al.*, 1998). Up to 70% of people presenting to primary care with medically unexplained symptoms (MUS) will also suffer from depression and/or anxiety.

Poor physical health and its impact on mental health

Physical ill health is a key risk factor for poor mental health with both acute episodes or chronic conditions having a detrimental effect, in particular on disease prognosis. Co-morbidity of physical illness accompanied by mental illness has been shown to worsen outcomes such as life expectancy; for example stroke patients who are depressed are four times as likely to die within six months as those who are not (Sederer *et al.*, 2006). There are similar associations between poor mental health and diabetes, asthma, cancer and HIV/AIDS (Chapman *et al.*, 2005, Evans *et al.*, 2005, McVeigh *et al.*, 2006).

Measuring mental health inequalities

The interdependence of physical and mental health is only one example of the intimate and complex role that mental health plays in health and social inequalities. A similar picture could be constructed for almost any other element of the social landscape - housing, employment, education, social networks, community participation - where compromised mental health can act as cause or consequence of inequality.

How do public services respond to this intricate set of circumstances? We know that what gets measured by government is crucial to the way public services

use their resources. If we can measure what really affects people's chances of a mentally healthy life - with all its implications for a better quality of life overall - services can be held to account for how competently they achieve improvements and reduce mental health inequalities.

Despite the wealth of existing measures and metrics that strive to measure how services affect people's lives, there is often a lack of sophistication in capturing the essence of what makes an impact.

There is a tendency to separate out the person from the place into service silos. The social determinants that drive mental health inequalities are underused and as a result there is an incomplete picture of the lives people lead and how services might make a positive difference.

In order to address some of the pressing problems of measuring mental health inequalities, a collaborative seminar was held in spring 2009 that brought together acknowledged experts from mental health and related fields*. Participants attempted to define a set of measures for mental health inequalities that might influence a range of policy developments.

The seminar was organised around seven themes:

- A good start in life and the early years,
- Working lives,
- Later life,
- The places we live,
- Financial security,
- Body and mind,
- Social capital and social connectedness.

Participants' experiences, views and ideas were utilised to explore existing measures and how they were already being used or might be adapted to become more helpful. Additional topics for discussion included the extent to which current measures inform key strategic drivers such as Public Service Agreements or National Indicators; whether there are current measures that might add value but are under-used; what the gaps are and how best these might be filled; and which measures have the potential to exert critical leverage within public services.

* A full report of the seminar can be accessed at www.scmh.org.uk/publications/mental_health_inequalities.aspx?ID=606

Metrics and measures

The breadth and scope of the seven themes offered a rich menu for discussion, but confirmed that performance measurement is unevenly developed across the piece. Some topics are clearly more advanced than others; some are getting there; and some have not yet even begun to be developed. What have been the drivers for movement in some areas and not in others?

Body and mind

There are four key dimensions to health inequality within this topic:

- The physical health of people with severe and enduring mental illness,
- The impact of poor mental health on physical health,
- The impact of poor physical health on mental health,
- The impact of medically unexplained symptoms on mental and physical health.

This is an area where much has been accomplished, largely driven by the scandal of excess morbidity and mortality amongst those with more severe mental illnesses. However it is still early days when assessing the links between more common mental health conditions and physical ill health, or the prevalence of medically unexplained symptoms and their links with mental health conditions.

Such measures as do exist emanate from different parts of the service spectrum, i.e. primary or secondary care, or reflect existing trends such as smoking, mortality rates or prescribing data. But there are a range of plans to develop measures

that provide a more accurate picture of body-mind links. These include the inclusion of even more relevant data in the Mental Health Minimum Data Set (MHMDS); more extensive use of the outcome measures already being utilised within the Improving Access to Psychological Therapies (IAPT) programme; and use of Local Area Agreement targets that measure joint working between health and social care in order to improve standard mortality ratios for people with severe mental illnesses (SMI).

Working lives

Government has made reasonable progress, in particular for people with severe mental health problems, in addressing worklessness. Of note was PSA16 on adults facing social exclusion, which has acted as a catalyst against delivery of NI150 on employment for those who have been in contact with secondary mental health services. Current metrics which could be used more effectively to measure progress include more innovative use of census data and electronic sickness certification; the Care Quality Commission's survey of people using community mental health services; and adding new lines on employment to the MHMDS. An area for possible future development was the integration of electronic sickness certification and IAPT data.

But there were still gaps that needed addressing such as the absence of good mental health analysis of the Benefits claimant count; the failure by the Department for Work and Pensions to use the claimant count for measurement purposes; and the inability to link different data sets together to maximize their intelligence.

The places we live

Access to secure accommodation is critical for mental well-being. There has been some positive achievement against this theme and current or potential metrics that were identified as especially useful included the Summary Care Record, which can capture presentations at A + E; and the Supporting People Client Record and Outcomes data, which can capture the characteristics and recent history of people needing support to achieve or maintain independence. Once again the MHMDS was identified as of particular use for those in contact with secondary care mental health services and used to support the PSA16 target on settled accommodation.

Areas for development of measures and metrics on this theme included monitoring and analysis of Housing Benefit claims and delays in payment; developing datasets for homelessness assessments and outreach; and for specialist supported housing and resettlement services; and adaptation of housing services' datasets to incorporate terms better suited to identify mental health issues.

A good start in life

Despite the critical importance of this theme, and the amount of work that has been done on the early stages of the life cycle, there was a lack of clarity on the metrics and data that might be of most use. An identified gap was a clear link between the Department of Health and the Department for Children, Schools and Families, e.g. the latter's substantive work in development on links with emotional well-being. Similarly there was a gap in knowledge about Office of National Statistics and its current work on children's well-being.

But there were some measures identified including the strengths and difficulties questionnaire (SDQ) linking in with Child and Adolescent Mental Health Services data; the Health of the Nation Outcome Scores (HONOS); KIDSCREEN - generic quality of life measures for children and adolescents aged between 8 to 18 years; and the Dartington model for local authorities to prioritise what they want to achieve for young people (see www.preventionaction.org).

Financial security

While this theme is crucial to our mental health, especially in the current critical economic situation, few obvious metrics or measures were identified.

The consensus was that this theme has only emerged as a priority in recent years and there is still much groundwork to be done. Three national indicators were proposed and are in pressing need of development:

1. A reduction in the mental and physical impact of problem debt on:
   - people with debt and mental health problems,
   - people with mental health problems who are at risk of becoming over-indebted,
   - people who are over-indebted who may be at risk of developing mental health problems.

2. The establishment and monitoring of partnerships between local agencies working on aspects of debt or mental health, including:
   - rates of referral from primary care/secondary care to accredited money advice agencies,
   - numbers of individuals referred from primary/secondary care who were successfully 'received'/assisted at a money advice agency.

3. Numbers of people for whom an assessment is conducted (by health or advice sectors) of their entitlement to benefit, their uptake of relevant benefits and the financial impact of benefit uptake (i.e. additional income achieved).

Later life

Recent work on the theme of later life (see www.mihilli.org; NICE, 2009) has highlighted a range of relevant issues, but there has been insufficient work to date exploring mental health inequalities among this growing cohort of the population. A profusion of data on morbidity and mortality already exists, but the inequalities aspects must be incorporated and relevant data collected accordingly.

A range of current indicators were identified that could be utilised to capture a more accurate picture of mental health inequalities amongst those in later life. For example, the Audit Commission will be assessing a range of 'dashboard indicators' on the well-being of older people, e.g. is a locality a good place to grow old? Does it foster healthy life expectancy? What is the use of adult education or leisure services by the old? Are they involved in volunteering?

These are very positive measures that endeavour to depict lived experience. They contrast with some of the measures from health services (such as discharge from hospital to home, GP prescribing of anti-psychotics and suicide and self-harm rates) that largely reflect service performance.

Social capital and social connectedness

Metrics and measures associated with this theme were perhaps the least well developed. Simply having a discussion of relevant issues and possible measures and metrics was in itself groundbreaking.

No existing measures could easily be identified, but lateral thinking pinpointed some of the possible areas for development including NI6 on national rates of volunteering; the data collected to support the Independent Living agenda; and the process measures linked to Place Shaping agendas e.g. expecting public services to improve access for those with mental health conditions; the New Economic Foundation's National Accounts of Well-being (see www.nationalaccountsofwellbeing.org); and the Department for Communities and Local Government surveys on citizenship.

Discussion

Existing or potential measures, metrics or indicators are critical to developing an accurate picture of mental health inequalities. They are not however the end in themselves, but serve as important tools to lever improved services that can make a difference to people's lives.

Clarity of purpose

Measuring service outcomes is not the same as measuring inequalities. Given their limitations, it's necessary to look beyond current data sources that

may only provide a sense of the issues for those in contact with services. By default such an approach would be missing out on the complete picture and persistent uncertainties would remain about what the inequalities actually are.

There are currently a range of developments that can support and enable a more comprehensive approach to data collection for mental health inequalities. For example the new integrative mechanisms such as Joint Strategic Needs Assessment (DH, 2007) and Comprehensive Area Assessment (One Place, 2009) will allow for more contextual interpretations of data than were possible under single sector accountability approaches, while still providing objectivity and external verification. The user-focused outcomes enshrined in World Class Commissioning (DH, 2009a) offer a different slant on equitable service delivery. And the Mental Health Minimum Data Set has begun to collect data pertinent to building an accurate picture on mental health inequalities (see www.ic.nhs.uk/mhmds).

Local or national?

Many of the targets that indicators seek to demarcate impact most on local authorities. Social care data is key to engaging locally elected members with this agenda. The most useful interpretation of these data, as well as a reasonable approach to what the data are saying, occurs at that local level. And so even though many targets are set at a national level, data must be able to be used locally to have maximum impact.

Measures - ideally that go down to ward level and that best reflect the concerns of local populations - must be available to incentivise local commissioners, service providers or local authority councillors into taking an interest and acting. Despite real and perceived tensions between national and local targets, experience demonstrates that as long as a target is being delivered, that tension can be productive.

Streamlining the data

The profusion of current data raises the need for a genuine re-examination of what is being collected - and perhaps an end to collecting some of it. More important now is to get a handle on a range of interconnected issues such as:

- how the data are being used once collected,
- at which tiers and at what level data are collected,
- what the collected data mean,
- how – if at all – different measures work together,
- how the most effective connections between different data systems can be made,
- how best to develop transparent data collection mechanisms,
- which measures would most effectively focus public services on mental health inequalities.

Data that reflect policy trends

Future measures, indicators and metrics must be flexible enough to respond to the full breadth of modern mental health policy and practice that increasingly encompasses promotion and prevention as well as care and treatment (DH, 2009b). For example, well-being, positive mental health and public mental health are likely to require the development and implementation of new ways of measuring and collecting relevant data. Similarly data and measures on social inclusion and social justice, including anti-discrimination measures, are also important. Ascertaining employment and housing outcomes for people will also be critical.

The policy arena relevant to mental health inequalities has also been and continues to be very dynamic with initiatives in employment, offender mental health and health and social inequalities. It would be a major missed opportunity if measures for mental health inequalities were not coherent across a range of service and interest areas such as employment, housing and debt.

Recognising and working with the social determinants of health, and the broader social impacts or outcomes of health services, will involve both broader and subtler metrics that can recognise both the appropriate contribution of health care to other services' efforts and the contribution of other services to health outcomes.

Liberating data from silos

The array of data that exists needs to be cross-referenced urgently to capture as accurate a picture as possible of mental health inequalities and their effects.

This would make a huge difference at all levels. For example, establishing stronger links between the Deparment of Health and Department for Children, Schools and Families, local authorities and local schools would connect the evidence base that includes teacher knowledge, service delivery and quality of services. Similar improvements could be achieved by integrating health and Department for Work and Pensions data; or linking education/ training data with employment data to build a comprehensive picture of the links between mental health inequalities and education and employment.

Improved cross-fertilisation and collaboration are also needed between IT and mental health specialists, many of whom do not understand each other's areas of expertise. Such development holds out the potential to ensure that, as far as possible, data and the information systems are responsive to population level changes in mental health.

What next for measuring mental health inequalities?

Just as there is no health without mental health, there is no equality without mental health equality. Clear cause and effect relationships between compromised mental health and inequalities cannot always be easily determined. But the onsequences are invariably negative for individuals and for society. There is sufficient demonstrable proof that the interaction between good or poor mental health and a range of health and social outcomes is profound. Mental health itself is situated as the key variable differentiating positive from negative outcomes.

There now exists a chance to craft a comprehensive vision of health and social equality for the new decade that offers something other than economic growth as the main driver. But that vision will be weakened by the absence of useful supporting data and the measures to collect them.

Metrics are not significant in and of themselves. Rather they most usefully act as political drivers - 'tin openers' - to lever change in the commissioning and delivery of services.

They hold out the possibility not only of exposing the deficiencies and problems in people's lives, but also of describing a more optimistic and hopeful landscape.

Developing new metrics, adapting existing ones and ensuring that data are used in concert in the most effective way will allow for a more positive story to be told that not only captures the lives that people lead, but also one that can reduce the mental health inequalities that hinder improvements in their lives.

References

Brown, S., Inskip, H. & Barraclough, B. (2000) *Causes of the excess mortality of schizophrenia*. British Journal of Psychiatry 177: 212-217

Chapman, D.P., Perry, G.S. & Strine, T.W. (2005) *The vital link between chronic disease and depressive disorders*. Prev Chronic Dis. 2 (1):A14 (from www.cdc.gov/pcd/issues/2005/jan/04_0066.htm)

Cohen, S., Tyrrell, D.A.J. & Smith, A.P. (1991) *Psychological stress and susceptibility to the common cold*. New England Journal of Medicine 325:606-612

Cohen, S., Doyle, W.J., Skone, D.P., Rabin, B.S. & Gwaltney, J.M. (1997) *Social ties and susceptibility to the common cold*. Journal of the American Medical Association 277:1940-44

DH (2001) *Making it happen: Implementing mental health promotion*. (from www.dh.gov.uk/mentalhealth)

DH (2007) *Joint Strategic Needs Assessment*. (from www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_081097)

DH (2009a) (from www.dh.gov.uk/en/Managingyourorganisation/Commissioning)

DH (2009b) *New Horizons: Working together for better mental health*. (from www.dh.gov.uk/en/Healthcare/Mentalhealth/NewHorizons/index.htm)

Evans, D.L., Charney, D.S., Lewis, L., Golden, R.N., Gorman, J.M., Krishnan, K.R. *et al.* (2005) *Mood disorders in the medically ill: scientific review and recommendations*. Biol Psychiatry. 58(3):175–189.

Harris, E.C. & Barraclough, B. (1998) *Excess mortality of mental disorder*. British Journal of Psychiatry 173: 11-53.

Hippisley-Cox, J., Fielding, K. & Pringle, M. (1998) *Depression as a risk factor for ischaemic heart disease in men: population based case control study*. British Medical Journal 316: 1714-1719.

McManus, S. *et al*. (eds) (2009) *Adult psychiatric morbidity in England, 2007. Results of a household survey*. (from www.ic.nhs.uk)

McVeigh *et al*. (2006) *Integrating care for medical and mental illnesses*. Prev Chronic Dis. 3 (2):A33.

NICE (2009) *Occupational therapy interventions and physical activity interventions to promote the mental wellbeing of older people in primary care and residential care* (from www.nice.org.uk/PH016).

One Place (2009) (from http://oneplace.direct.gov.uk/Pages/default.aspx)

Phelan, M., Stradins, L. & Morrison, S. (2001) *Physical health of people with severe mental illness*. British Medical Journal 322:443-444.

Sederer, L., Silver, L., McVeigh, K. & Levy, J. (2006) *Integrating care for medical and mental illnesses*. Preventing Chronic Disease 3 (2) 1-3.

Stewart-Brown, S. (1998) *Emotional well-being in relation to health*. British Medical Journal 317:1608-1609

WHO (2009) (from www.who.int/features/factfiles/mental_health/en)

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Sainsbury Centre for Mental Health
134–138 Borough High Street,
London
SE1 1LB

T 020 7827 8300
F 020 7827 8369

www.scmh.org.uk

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