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COMMENTARY

Mental health *v.* mental illness

COMMENTARY ON … ETHICS AND ECONOMICS†

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†See pp. 468–473, this issue.

SUMMARY
This commentary focuses principally on the semantics of using the term 'mental health' rather than 'mental illness' and the effect this has in creating a paradigm shift in psychiatry in relation to other medical specialties. The consequences, intended or unintended, are demonstrated and the relationship between ethics and economics in mental health is discussed. The view that economic evaluation is methodologically unsound in 'mental health', that it is a special case because of its complexity, does not acknowledge the significant paradigm shift that has occurred. Casual acceptance of the term 'mental health' in a serious economic debate about resources for people with mental illnesses is worrying and further diminishes the medical specialty of psychiatry that deals with mental diseases.

DECLARATION OF INTEREST
None.

Byford & Barrett (2010, this issue) describe a topic that is of considerable interest to psychiatrists and is particularly topical in the current financial climate. They give a good introduction to the area, outlining key ethical principles and raising a number of ethical issues that may be relevant to clinicians. The authors explore two generic questions particular reference to mental healthcare: whether economic evaluation is unethical and whether the methods of economic evaluation are unsound for the purpose of achieving an ethical distribution of resources.

Mental health or mental illness?

It is in the application of their questions to mental health that the authors stray into more contentious ground. Their use of the term 'mental health' (as opposed to 'mental illness') is in my view oxymoronic and continues to perpetuate a myth that the disease model of mental illness is invalid. Using the term 'mental healthcare' is analogous to using the term 'cancer healthcare' rather than 'cancer care'. Similarly, the term 'mental disorders' is vague and often used to avoid using the term 'disease'. Psychiatry, according to the Oxford English Dictionary, is 'the study and treatment of mental disease'. I think the authors do a disservice to psychiatry as a medical specialty in attempting to separate it from the rest of medicine and perpetuate the mind/body split. Rejecting the term 'mental disease' may also explain why we run into problems when we make comparisons with diseases in other medical specialties because we are often comparing apples with pears when we use the wider terminology of mental health.

Public mental health and its populations

In taking a population-based view, public mental health considers the needs of four groups: the general population, in terms of mental health and well-being; individuals with mental health problems accessing primary care; individuals with mental illness accessing secondary care services; and individuals referred to tertiary care for specialist treatment.

When comparing psychiatry and its ethical and economic arguments with other medical specialties, it is not helpful to jump between these populations. For example, there is a direct correlation in the population between early symptoms of high blood pressure and elevated blood glucose with the final disease processes of stroke (cardiovascular disease) and diabetes (endocrine disease). Screening for hypertension and blood glucose on a population basis and providing early interventions is useful because it may lead to prevention of the diseases and/or cost savings on treatment and care post-stroke or in end-stage diabetes.

This direct relationship allows for a cost–benefit analysis to be made more easily. This may not be the case in psychiatry as there is little evidence that screening for unhappiness, stress or even mild depression will reduce either the costs or the prevalence of mental illnesses such as schizophrenia and bipolar disorder. By straying in this discussion from mental illness and the antecedents of specific diseases such as schizophrenia, we risk making the economic and ethical arguments more complex than they need to be and find it more difficult to agree the opportunity costs for alternative resource allocation decisions.

Specific ethical issues in psychiatry

Byford & Barrett then go on to argue a 'special case' for psychiatry. They make a fair point when

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they say the additional ethical issues that occur in psychiatry around the detention and treatment against the patient's wishes may lead to a greater emphasis on the ethical principles of patient autonomy and beneficence. Presumably this arises as a result of both medicine and the law being concerned to avoid the misuse of power by a professional group. The additional emphasis on patient autonomy, however, may have origins other than in ethical principles and may be more related to the growth of the concept of individualism in Western culture.

I am not sure why some writers quoted by the authors say that this would lead to a diminution of the principle of 'justice' specifically in psychiatry. A focus on the individual may lead to poorer resource allocation decisions but this could equally apply to other medical specialties, for example paediatrics and medicine of the elderly, which also involve the law and issues around coercion.

Specific ethical issues around complexity

In my view the discussions about cost-effectiveness in treatment decisions that may be in conflict with medical ethics are no different from those occurring in other medical specialties. The methods that the National Institute for Health and Clinical Excellence (NICE) uses to calculate cost-effectiveness should be uniform to achieve parity and not vary across medical specialties. One quality-adjusted life-year (QALY) gained is the same, whatever diseases are being scrutinised in any medical specialty. This fulfils the ethical principle of justice. The example of the issues raised around acetylcholinesterase inhibitors is similar for other disorders reviewed by NICE, for example cancer treatments or chronic physical disorders such as arthritis, where in using broader methodologies a range of psychological and non-pharmacological treatments may prove their worth. The issues that Byford & Barrett raise, however, are not only about broadening the type of evidence but also about the complexity of mental disorders and again I do not think they make a robust argument for complexity being different in psychiatric illness and physical illness.

Conclusions

In an era of major medical advances often leading to financial pressures on healthcare systems, it does seem appropriate to try to match evidence to spend. NICE has begun this process with its health technology appraisals and although these may be imperfect, they are a start. NICE's processes are relatively transparent and it continues to revise guidelines in the light of new evidence. As NICE's methodological framework evolves, they will start to broaden and become more inclusive of different paradigms of health and illness, while still maintaining a scientific rigour. This rigour is essential to the practice of psychiatry, which has increasingly been drawn into a broader 'mental health' paradigm with a limited evidence base for practice.

Although the authors criticise the quality of some of the randomised control trials included in NICE's deliberations, this form of trial remains the gold standard for research in medicine. A greater worry, in my view, in 'mental health' is the qualitative studies that directly inform policy as 'evidence' and often shift resources 'downstream' from intervention to improvement without applying the same rigorous analysis of evidence. For this reason, I think economic evaluation is ethical not only in theory but in practice, despite the imperfections described well in the article.

The emerging range of methodological models to address complexity are more inclusive of diffuse costs and outcomes, for example quality of life, and will improve NICE assessments. However, there is a danger in overemphasising the impact of quality-of-life measures in mental illness as key outcomes while ignoring clinical or symptom outcomes. Although the organisational and financial dynamics of mental healthcare are often different from those of care in other medical specialties, I would like to see mental healthcare as part of that overall process, not separate from it.

We cannot, in any medical specialty, avoid evidence-based decisions around cost-effectiveness of treatments and the resource allocations decisions that have to be made in healthcare, but we can improve how they are made. The article has made a good start on opening the discussion on how to move forward.

References

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