It is a pleasure to follow Jeremy Corbyn, who made some powerful points. Perhaps I might add to what he said about the appalling difference in respect of the use of compulsory detention under the Mental Health Act 1983 for those from black and ethnic minorities. We heard in evidence that the fear of this among some communities is acting as a deterrent to seeking early help. We must address that, making sure that people do have that access and that that fear is removed from communities in order to improve health for everybody.

I wish to begin by stating for the record that I am married to a consultant NHS psychiatrist who is also chair of the Westminster liaison committee for the Royal College of Psychiatrists, which provides impartial advice to all political parties on psychiatry. He is also now a clinical director of NHS England's mental health and dementia network in the south-west.

The corresponding debate last year focused importantly on the issue of stigma in mental health, and I congratulate the ongoing work of Time to Change in reducing stigma. The other issue that was raised, which many Members have focused on today, was parity of esteem. It is wonderful that that important principle is established within the Health and Social Care Act 2012, but we need to ensure that that translates into action and practice on the ground. As we have heard, 23% of the overall disease burden lies in mental health, but we all recognise from stories that we hear in our constituency surgeries, and from clear evidence, that that does not translate into either funding or our constituents' experiences of services. How are we going to see that translated into action? We need to look at the evidence of what works and to focus on the outcomes.

We know that 30% to 65% of hospital in-patients have a mental health condition and that mental health and physical health are inextricably linked. Not only is someone more likely to suffer from a mental illness if they have a chronic long-term condition, but someone who has a mental illness will find that there is an impact on their physical health. We have heard again about the scandal that the life expectancy of people with a serious mental illness will be shortened by between 20 and 25 years.

My hon. Friend is picking up on the point made by the hon. Member for Islington North about there being a real link between public health issues such as smoking and alcohol, and mental health issues. Does my hon. Friend agree that we can do great work in this area at a local level, especially under the new arrangements whereby public health is devolved back down to local authorities, where it used to be and always should have been?

I am grateful to the Minister for that intervention. There has been a consistent tendency to ignore physical health problems in those who have severe mental health illness. She is right to say that putting in primary prevention work locally is important, but the Government could
perhaps do more on primary prevention, through having a relentless focus. I am grateful to her for the personal support she has given to addressing issues such as alcohol pricing and the availability of ultra-cheap alcohol. Such issues are very important, and the Government need to deal with them to support the work that is being done. Minimum pricing is, of course, not a magic bullet, but unless we address the issue of ultra-cheap alcohol all the other measures that public health directors wish to take within local communities risk being undermined.

Anna Soubry (Broxtowe, Conservative)

Does my hon. Friend agree that we can do great work on the minimum pricing of alcohol at local level? I urge her to examine the work being done in Newcastle and, in particular, in Ipswich, where all the agencies are coming together. We have seen supermarkets and many off licences agreeing not to sell cheap beer and lager. Does she agree that such an approach has the potential to be a better way of dealing with this issue than minimum unit pricing?

Sarah Wollaston (Totnes, Conservative)

Although I absolutely agree that those projects in Newcastle and Ipswich are impressive, there will, unfortunately, always be ways in which they can be undermined. In my area we can find an example of maximum alcohol pricing, whereby white cider is being sold at a maximum price of 23p a unit, and that is destroying areas. There will always be a way for people to get around a minimum pricing level and, although we can see real benefits from these projects, particularly for street drinkers in isolated pockets, I feel overall that minimum pricing would be a good way of addressing this issue on a wider level. But I will not focus on that today.

I want to draw attention to the evidence on providing integrated services. Mental health and physical health services should be much better integrated. Is the Minister aware of the recent report by the Centre for Mental Health and the London School of Economics, which evaluated the use in Birmingham city hospital of the RAID service—the rapid assessment interface and discharge psychiatric liaison service? Is the Minister aware of the role that liaison psychiatry plays? Such services are greatly appreciated by patients and provide an excellent way for them to receive services; moreover, they are incredibly cost-effective. By providing rapid access to a professional service, not only for in-patients but for people who attend accident and emergency services and those who are seen by the poisons unit, it reduces re-admission rates, provides better care and far better outcomes, and saves money. The pressure on A and E services has been much in the news in recent weeks. Liaison psychiatry reduces re-attendance at minor injury units and A and E departments, so such services are vital. It would be really helpful to know whether the Minister is aware of the evidence base and will be promoting liaison psychiatry services.

I want to talk about social exclusion and the role of mental health services in social exclusion. If a person is homeless, they are far more likely to suffer from mental health problems. Equally, if a person has mental health problems, they are very much more likely to end up homeless and on the streets. In my area of Totnes, we tragically have suffered some deaths among our homeless population. We know from those who provide help to the homeless in south Devon the level of dual diagnosis—the number of people who have both mental illness and, for example, addiction problems. I would very much like to hear from the Minister in her summing-up what work will be done to improve access to dual diagnosis. I pay tribute to Mark Hatch and the work that he has been doing, alongside very many dedicated volunteers, with the Revival Life Ministries and with Shekinah, providing an
I want to raise a point about access to GP services for the socially excluded and homeless. In coming months, there will be much focus on how we reduce health tourism. If, in reducing health tourism, we require people to bring a passport to their GP in order to be registered, very many people who are socially excluded will not be registered because they simply do not have access to identification. I ask the Minister, in addressing an important problem of great concern, to be particularly careful to avoid making it even harder for the socially excluded to obtain help with their problems. That would be a real avoidable tragedy.

Prior to the debate, a constituent wrote to me most movingly about the Cinderella service around autism, and lack of access to mental health services for those who suffer from autism, which has a knock-on effect on their carers. Listening to accounts from parents, who have been struggling for so long to obtain the help that their children need, and their description of what happens as their children move into adult services, it becomes clear that that is an area where services genuinely need to be improved. I look forward to hearing from the Minister what more can be done.

Finally, I return to the Health Committee's review of the Mental Health Act. Would the Minister look at the evidence on the variation in the use of community treatment orders around the country, and tackle that variation? It cannot be right that in some parts of the country they are not used at all, while in others they are heavily used. The evidence base on their effectiveness is very poor. Should the Government lead on that, or should the royal colleges take a lead, so that we have a system that is transparent and used equally around the country?

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