A new vision for mental health

Discussion paper

The Future Vision Coalition

Mental Health Foundation

Mental Health Network

a part of THE NHS CONFEDERATION

For better mental health

rethink

SAINSBURY CENTRE for MENTAL HEALTH

removing barriers achieving change

together

The Future Vision Coalition

The Association of Directors of Adult Social Services

The Mental Health Foundation

Mind

Rethink

The Sainsbury Centre for Mental Health

Together

The Mental Health Network

Contents

Executive summary 2

Introduction 4

What is our vision of change?

1. An integrated approach to mental health: bringing health and social models together 6

2. Focus more attention upstream: promotion, prevention and early intervention 10

3. Focus on improving quality of life, ambition and hope, not on illness and deficiency 14

4. Change relations between individuals and services 17

What do you think? 19

References 20

Executive summary

This is a discussion paper intended to provoke a wide-ranging debate about the best direction for mental health policy. It outlines a vision of change developed by seven national mental health organisations, who together make up the Future Vision Coalition. We focus in particular on four changes that we believe need to happen to enable those with experience of mental health problems to enjoy an equal opportunity of a fulfilling life.

We hope that reading it will encourage you to think about the future and to contact us with your views. We will undertake a consultation process during July, August and September to inform further work to influence the future shape of mental health policy. **Details of how to contact us are on page 19. We would welcome responses by Friday 3 October 2008.**

Our consensus view is that much has been achieved in the past ten years under the National Service Framework for Mental Health (NSFMH) and we must build on this. Although the NSFMH is our starting point, we do not believe that mental health should be seen any longer as exclusively a health department or health and social service issue – its impacts and determinants are far wider than this.

We agree that the underlying aims of future mental health policy must be to:

- overcome persistent barriers to social inclusion that continue to affect those with experience of mental health problems
- improve the whole-life outcomes of those with experience of mental health problems
- improve whole-population mental health.

We are presenting our vision of change in four areas of mental health policy, which are outlined in the table opposite. This will not be easy to achieve, since attitudes have been ingrained over many decades of use, and because medical models of mental health problems have long dominated the debate about the appropriate focus for policy. However, we suggest ways in which we think the vision can be realised.

What is our vision of change?	How might this be realised?
1. A movement away from the dominance of the medical concept of mental health, with an **integrated model** driving policy. This model should incorporate an understanding of the social determinants of mental health, and implies that mental health is not only a Department of Health issue. Whilst an important part of the spectrum of care, clinical services should be seen as one element of a wider whole-life framework of support. We should avoid segregation of mental health service users into 'special services' where possible: being a 'service user' should not define a person.	• A cross-government strategy on mental health, actively coordinated across departments and with a champion at Cabinet level • Specialist services as one element of a spectrum of integrated support which makes use of mainstream community services when specialist mental health input is not required • Ensuring that 'experts by experience' can take a strategic leadership role in policy development and service design
2. Greater importance placed on **public mental health** and recognising mental health as a whole-population issue. It affects everyone and the policy framework should reflect this.	• A three-tier public mental health strategy incorporating whole-population mental health promotion, targeted prevention for at-risk groups and early intervention for children and families • Funding for public mental health should not come only from the Department of Health • Use existing mechanisms for pooling funding and meeting public mental health needs in a more effective way – such as local area agreements
3. For those who need support to cope with a mental health problem, services should be united in supporting the **recovery of a good quality of life** and the achievement of goals and ambitions.	• Full adoption of the 'recovery approach' across the spectrum of care • Development of supported employment as a widely available service to those who want it • Routine use of quality-of-life outcome measures, on the basis of which services should be assessed
4. Power relations need to shift in order to give real **self-determination** over the process and direction of recovery to individuals, their carers and families. This will reflect a move from care as something which is *done to* service users by the system, towards a system of support *built by* the person and their advocates. Service design should be driven by what those with experience of mental health problems believe to be an appropriate spectrum of support – whether or not this fits with the organisational structures of the past, and whether or not this includes a large role for traditional services.	• Examination of ways to facilitate increased control by individuals over the types and providers of support they need and want, including ways to give them more control over resources • Intelligent commissioning which starts from the viewpoint of an individual's stated expectations, needs and preferences • Widening availability of advocacy services • Expanding the role of the voluntary and community sectors to increase accessibility and appropriateness

Introduction

2009 will be a significant year for mental health policy in England.

The Government's ten-year plan for mental health – the National Service Framework for Mental Health (NSFMH) – will come to an end, signalling a new era. Important policy choices must be made to ensure both that its achievements are built upon and its shortcomings tackled.

Seven leading national mental health organisations have come together as the Future Vision Coalition to outline their proposals for a substantial shift in policy during the next ten years. These organisations are: the Association of Directors of Adult Social Services; the Mental Health Foundation; Mind; Rethink; the Sainsbury Centre for Mental Health; Together; and the NHS Confederation's Mental Health Network.

While our organisations come from different perspectives, we have developed a shared case for the right direction of travel for mental health services. Our contention is that, to alleviate the burden of poor mental health most effectively, a *radical rethink* of the principles underlying policy is required, rather than continued evolution.

Our organisations agree that:

- The NSFMH has made a substantial difference to the lives of those suffering mental health problems, through raising the profile of mental health, focusing resources on vital aspects of the mental health system, and promoting a philosophy of inclusion and independence.
- However, some of its recommendations are yet to be meaningfully implemented and not all new models of care have yet been fully evaluated.
- Inequalities in access to the system, social exclusion and poor life outcomes persist (and by some measures are getting worse).[1]
- These inequalities are reflected in consistently high levels of dissatisfaction from service users and other stakeholders about the national variability in standards of care and support.[2]
- Communities and groups historically under-served by the mental health system are still not having their particular needs met – for example, many services are still provided on the basis of age rather than need.
- Failure to adequately address the mental health needs of offenders is a fundamental cause of the chronic dysfunction of our criminal justice system.
- Many of these persistent challenges are rooted in deep-seated, often unconscious, public attitudes of fear and stigmatisation of mental illness, which leads to discrimination in all areas of life against those given such a label.
- The economic costs of mental ill-health have been estimated at £77 billion per year in England, more than the total costs associated with crime.[3]
- Tackling the burden of mental ill-health is, therefore, a political and social imperative.

Our shared view is that all future policy relating to mental health must have three central aims:

- to remove barriers to social inclusion – in particular, stigmatising public attitudes and discriminatory behaviour – for all those experiencing and recovering from mental health problems

- to improve the life outcomes of those suffering and recovering from mental health problems
- to improve the overall levels of mental health in the population.

These aims must be pursued using methods chosen because they are *known to work* and *have the confidence of those who use services*, rather than because they fit existing service configurations and professional comfort zones.

Delivering against these aims will require four fundamental policy changes:

1. A shift from the current medical model of mental health to an integrated model, where policy takes into account the impact of social and economic circumstances on mental health alongside individual psychological factors.
2. A positive approach to the mental well-being of the whole population through improving public understanding, creating conditions conducive to good mental health, increasing early recognition of problems, and preventing escalation of problems to crisis point.
3. For those who need support beyond that of family and friends, a change in focus away from simply reducing symptoms and towards enhancing their quality of life and supporting them to fulfil their ambitions.
4. Ensuring that the individual wanting support has the right to determine how and when that support is delivered, and is involved in its design, with the support of carers, family and community.

These policy changes are not new suggestions in themselves, but to overcome social exclusion they will need to be carried out at the same time. We are convinced that such changes would have benefits for individuals and their families in terms of quality of life and life outcomes. There would also be wider social benefits and economic benefits to the state through the increased participation and contribution of those previously excluded.

Mental health is more than the absence of mental illness: it is vital to individuals, families and societies. Mental health is described by the World Health Organisation 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."* [4]

In this positive sense, mental health is the foundation for the well-being and effective functioning of individuals and communities.

Throughout this document we use this definition of mental health, and our policy recommendations are informed by the assumption that mental health is everyone's concern. We also contend that the ways in which society and the state respond to those experiencing mental health problems should aim to promote quality of life and meet individual needs, goals and aspirations.

We are describing very broad principles which we believe should underpin future mental health policy for *all* those experiencing mental health problems. We do not focus in this document on specific services, diagnoses, age or cultural groups.

"Mental health is 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."

1. An integrated approach to mental health: bringing health and social models together

Our vision

- a government which recognises the importance of social and economic factors underpinning mental well-being
- all government departments working together to combat mental ill-health and supporting people to recover from it
- individuals and their families having significant input into the design of services which meet their needs and take account of what they see as important
- continued improvement of existing specialist services, informed by evaluation of differing ways in which they might be provided.

"A model of mental health which locates problems solely in the individual will continue to ignore critical factors that influence mental health and well-being."

Historically, mental health policy has largely been seen from a health service point of view, underpinned by medical models and assumptions. This has created a division between those who are diagnosed as mentally ill and those who are not.

We believe a more realistic and helpful approach is to position mental health along a continuum where *everyone* has varying levels of mental health need at different times in their life, and where some people will need formal intervention and support to help them regain a good quality of life.

This approach is more *realistic* because mental health status is influenced by factors such as society's attitudes and social and economic circumstances. It is more *helpful* because the health and illness division acts to perpetuate 'us and them' attitudes which can contribute to stigma and discrimination.

Health services alone cannot remove barriers to social inclusion for those given a mental ill-health diagnosis. Mental health policy for the coming decade should not perpetuate this misconception. We would argue that mental health is a whole-population issue and should be treated as such by government.

Risk and protective factors for mental health

A model of mental health which locates problems solely in the individual will continue to ignore critical factors that influence mental health and well-being.

Our friends, family, occupation, community networks, housing and education can act as protective factors against the deterioration of mental health. Conversely, family history, family breakdown, unemployment and poverty, insecure housing, poor educational attainment, difficult experiences in childhood such as abuse or neglect, and weak social networks are all strongly associated with an increased risk of developing mental health problems.

Policy-makers must recognise that many personal and social factors enable people to overcome, or be protected from ever developing, these difficulties and

can create a virtuous circle of personal fulfilment and social participation and contribution. These factors include:

- autonomy and empowerment
- positive childhood experiences
- education or employment
- social participation and positive relations with other people
- social support and community networks
- physical health and exercise.

It should be a priority across government to reinforce these protective factors and create the conditions which promote them. Such a wide agenda cannot be achieved by health services alone. It requires integrated responses and integrated solutions.

From silos to integration

The perception of mental health as primarily a health service issue best met with a health service response has led to a tendency for interventions to focus mainly on the elimination of symptoms. Insufficient attention has been paid to factors that people experiencing mental ill-health value most highly.

These factors – which can include having a job or other meaningful occupation, somewhere to live, social relationships, and equality of participation as citizens – can lead to improvements in mental well-being.

This is not to dismiss the role of medical and therapeutic interventions: specialist services have an important role to play in the recovery of a good quality of life and mitigation of distress. However, we would argue that such approaches must not drive mental health policy. They should be nested within a broader framework of understanding of mental health as influenced by personal, cultural and social experience.

The integration of specialist clinical interventions within a wider framework of support is necessary because those who experience mental health problems face many barriers to their full inclusion in the social and economic life of the community. This acts to inhibit their quality of life as much as clinical symptoms do, especially once recovery is underway. The absence of symptoms does not lead to a fulfilling life or achievement of goals if, for example, an employer is put off employing someone because they have experienced mental health problems.

As the ten-year life-span of the NSFMH comes to an end, we now have the opportunity to reshape systems of support based on the views of people who have used services. Policy-makers must exploit the potential of service users and their families not just to advise but to take on a strategic leadership role in policy and system design.[5]

Policy levers

A cross-government approach to mental health

The Department of Health cannot achieve such an ambitious agenda on its own. Professor Sir Michael Marmot, a world authority on health inequalities, stated recently:

> *"We can actually do this, we can figure out what we need to lead a healthy life. We know that that is unequally distributed throughout society and we can make the policy choices to change that… It's not a lever that the Secretary of State for health has in his hands, but it is a lever that government has in its hands…"*[6]

Similarly, the General Secretary of the Fabian Society, Sunder Katwala, has suggested that the Labour Party adopt a "non-health manifesto for a healthy nation" at the next election, implying that the determinants of good health largely lie outside the power of the health system to influence. In mental health this is especially true and the time is right for a cross-government approach to mental health policy.

There is already a model for such an approach. *The independent living review* was published in February 2008 with support from six Departments of State. In his foreword, Prime Minister Gordon Brown stated that:

> *"A guiding principle of the review has been to work across Government to improve the outcomes for disabled people by breaking down the artificial barriers created by fragmented initiatives and organisational boundaries…"*[7]

The NHS needs to be seen as one provider of a specific type of support which is integral to a person's recovery of health, but only one out of a wide range of providers that have a role to play in inclusion and recovery.

The actions of all government departments should be explicitly assessed in terms of impact on whole-population mental well-being, and on whether policies have the potential to create barriers to inclusion or exacerbate stigmatising attitudes. Equally, many aspects of government policy have the potential to promote mental health (such as sustainable communities, pathways to work, educational attainment and social welfare) and these need to be explicitly recognised and coordinated. There should be active coordination of mental health policy across government, with a Cabinet Minister's oversight and championing. This would not only be a symbolic recognition of the whole-population impacts of mental health, but would also perform a practical function of integrating and aligning mental health policy.

Integration of high-quality clinical care within a wider quality-of-life framework

The response of the 'system' can sometimes seem not to tally with what those experiencing mental health problems see as their key interests and needs on the road to recovery. This is partly due to the fact that the structures and block contracts within statutory services dictate what the system's response can be – form constrains function.

We believe that mental health policy should be driven not by existing professional mindsets and organisational forms but by the goal of meeting the mental health needs of individuals. 'Form' of services should be decided *after* 'useful function' has been determined and should help meet service users' stated interests, expectations and needs.

Support to develop a good quality of life can greatly improve someone's mental well-being and reduce symptoms of distress, while good clinical care can also improve quality of life. These need to be available together.

However, at times of crisis it is likely that the focus will be on clinical care, and this should remain an essential foundation of high-quality mental health services. Pressure to improve the quality of inpatient care must not be allowed to lapse. However, this clinical care needs to be nested inside a wider framework of support which promotes recovery and quality of life.

Inpatient services are a core element of specialist health services which care for people when they are at their most vulnerable. Many improvements have been made in the last ten years but there is still an urgent need to find evidence-based approaches in this area and to explore alternatives to traditional hospital-based care. Further policy attention must ensure that continued improvements to inpatient services are made and that they are an integrated part of the specialist service care pathway for those experiencing acute problems.

Users of highly specialised services should not find themselves cut off from the other things that contribute to mental well-being and a full life, such as good quality physical healthcare, access to fresh air and exercise, and family and social contacts.

Such specialist services, including inpatient services, need to be seen as one element of a wide spectrum of available supports and interventions. Some of these will be provided by statutory services but many will not be traditional health and social care services. For example, debt advice, meaningful occupation, leisure activities, a reasonable income and decent housing should all be seen as part of the spectrum of appropriate support.

Some integrated schemes are emerging which might provide a model for a more balanced approach to the social, economic and physical health needs of those diagnosed with a mental health problem. These are generic community-based services which include some specialist mental health elements where these are appropriate. Examples include Connected Care in Hartlepool and the Community Bridge Builder Project in St Leonards, East Sussex.

"Mental health policy should be driven not by exisiting organisational forms but by the goal of meeting the needs of individuals."

Policy levers: summary

We are calling for:

- a cross-government approach to and coordination of mental health policy which moves away from a health/illness perspective towards a recognition of the whole-life importance of good mental health
- a Cabinet-level champion to lead on this approach.

We believe there is a need:

- to explore the potential of service users and families to give strategic leadership on policy and service design issues
- to decide the form of services (i.e. structure and design) *after* 'useful function' has been determined; both form and function should help to meet service users' stated interests, expectations and needs
- to investigate integrated support systems, where specialist clinical input has an important role to play but where it is recognised that being a 'service user' does not define someone
- to support people who use services to participate in mainstream leisure activities, occupations and social networks, which are not part of 'mental health services.'

We are convinced that:

- good quality clinical care is a vital aspect of recovering a good quality of life for many people
- it follows that pressure to improve inpatient services must not be allowed to lapse.

We acknowledge that:

- inpatient mental health services are resource intensive and provide care for people when they are most unwell
- there is, however, an urgent need to investigate their evidence base and to examine how they might best integrate with other elements of the system to facilitate recovery of quality of life
- services should, therefore, always be assessed on the basis of whether they contribute to social inclusion and improve quality of life.

2. Focus more attention upstream: promotion, prevention and early intervention

Our vision

- a society where mental well-being is encouraged but those experiencing mental health problems do not feel stigmatised
- early intervention and support for those who need it
- action to reduce the known risk factors for mental ill-health
- the adoption of measures which reach the whole population and are aimed at improving mental well-being.

The benefits of positive mental health and well-being are wide-ranging and significant for individuals, communities, and society as a whole.

Positive mental health not only makes for a better individual quality of life; it is also associated with better physical health outcomes, improved educational attainment, increased economic participation and rich social relationships.

Mental health is, therefore, a whole-population issue; its personal, social and economic impacts affect everyone.

For example, Lord Layard and others have emphasised improving population mental health as a universal social good, not just for individuals but for national prosperity, cohesion and well-being.[8] The government's investment in the Improving Access to Psychological Therapies programme demonstrates its recognition of these basic principles.

A recent report from the King's Fund on the future costs of mental healthcare suggests that both direct health and social care costs, and the cost of lost employment through mental health problems in the workforce, will double in real terms over the next 20 years. However, some of this extra cost could be reduced if there is a greater focus on whole-population promotion and prevention, alongside early diagnosis and intervention.[9]

More cross-government policy attention and resources must be focused on promoting positive mental health, recognising problems early, and preventing mental health problems in at-risk populations.

The potential benefits of this approach include improved mental health across the population, with fewer people needing the 'expensive end' of services.

In particular, focused attention on children's mental health and emotional well-being offers the possibility of building emotional resilience and preventing interrupted education and fewer qualifications, both of which can mean an early entry into a life of social exclusion.

Policy levers

A strategic approach to population-wide mental health

We urgently need a public mental health strategy on three levels:

- improving early recognition and intervention in emerging problems, particularly in children
- targeted prevention initiatives for groups of people with risk factors for mental illness
- whole-population initiatives, including education, awareness raising and mental well-being promotion.

The resources needed to fully implement this strategy should not come just from the Department of Health but from across government. There are long-term and wide-ranging benefits from investing in population mental health.

There are already examples of inter-departmental funding and recognition of the benefits of improving population mental health. These include the joint work by the Department for Work and Pensions and the Department of Health on improving access to psychological therapies, and the joint strategic review of children's mental health services by the Department of Health and the Department for Children, Schools and Families.[10] The 2007 Comprehensive Spending Review highlighted joint departmental responsibility for achievement of public service agreements. However, the government still needs to recognise that a range of its policy objectives across different departments can be addressed and perhaps even achieved by tackling underlying mental health issues.

The case for whole-population mental health promotion and education

Aiming to improve the overall level of mental health in the population may sound ambitious. But there is evidence that this can be done:

> *"Population-level interventions to improve overall levels of mental health could have a substantial effect on reducing the prevalence of common mental health problems, as well as the benefits associated with moving people from 'languishing' to 'flourishing' (Huppert, 2005). In addition, applying the principle of 'herd immunity', the more people in a community (for example, a school, workplace or neighbourhood) who have high levels of mental health (i.e. who have characteristics of emotional and social competence), the more likely it will be that those with both acute and long-term problems can be supported (Stewart-Brown 1998; Blair et al 2003 p 143)."*[11]

The Scottish Government has recently consulted on a population-based mental health improvement strategy for 2008–11 called *Towards a mentally flourishing Scotland*. Its reasons for undertaking a wide-ranging promotion and prevention programme for the whole population hinge on the belief that:

> *"…there is no health without good mental health, where we know how to support and improve our own and others' mental health and well-being… and where our flourishing mental health and mental well-being contributes to a healthier, wealthier and fairer, smarter, greener and safer Scotland… "*[12]

Promotion and education efforts can also help to increase awareness of the common nature of mental health problems and thereby start to reduce stigma and discrimination. The National Institute for Mental Health in England has advocated 'marketing' mental health as everybody's business – letting people know that mental distress is a part of human experience but at the same time raising awareness of how to recognise early problems.[13]

The National Institute for Health and Clinical Excellence (NICE) reports strong evidence to suggest that mass media campaigns, particularly those that include community activities, can have a beneficial effect on attitudes towards and knowledge of mental health issues. They can also support and promote a change in people's behaviour to improve their own mental well-being.[14]

In New Zealand, an anti-stigma advertising campaign, led by the Ministry of Health, has had positive effects on public attitudes towards mental health and illness.[15]

In England, the Big Lottery Fund and Comic Relief are supporting *Moving people*, a four-year, £18 million programme addressing mental health stigma and discrimination. The programme, which builds on evidence from Scotland, New Zealand and Australia, aims to achieve a measurable change in attitudes and behaviour through a range of social marketing and other interventions.

Broad health promotion initiatives should explicitly address mental health issues because a healthy lifestyle can have significant positive effects on mental health.

For example, the link between exercise and good mental health is well established. NICE has concluded that "there is [robust] evidence... to suggest that participation in physical activity, sport and exercise is positively associated with mood, emotion and psychological wellbeing." [16]

The case for targeted prevention programmes

Prevention programmes can be tailored and targeted to specific groups at increased risk of developing mental health problems. Such programmes can also work to reduce risk factors. There are many ways to tackle risk factors, for example:

- programmes to reduce bullying in schools
- 'good parenting' classes
- improving conditions in the workplace to reduce chronic stress
- screening workers for early signs of depression and offering treatment [17]
- screening infants at primary care clinics for risk factors
- carefully attending to the mental health needs of children in care and children with experience of abuse.

The experiences of later life can pose particular risks to mental health. Age Concern and the Mental Health Foundation have highlighted the 'double whammy' of ageism and mental health stigma and discrimination. Bereavement, chronic illness, pensioner poverty and increased social isolation can all precipitate anxiety and depression. Their inquiry [18] recommended that a number of actions were needed to prevent mental health problems in later life. These include:

- tackling pensioner poverty
- removing barriers to continued participation in the workforce and the sharing of skills and experience by, for example, introducing a flexible retirement age
- promoting healthy lifestyles and providing facilities accessible to older people
- providing support to maintain existing social relationships, such as help to get out and about.

The case for early intervention for children and families

Investment in children's mental health can help prevent social and economic exclusion, entry into the criminal justice system, unemployment and deteriorating mental health with resulting costs to the individual's quality of life, to public services and to the economy.

This approach means early intervention well before child and adolescent mental health services need to get involved. Identification of families needing support to ensure their child's mental health – sometimes even before the birth of that child – is a vital aspect of promotion and prevention strategies. A report on the evidence base for mental health promotion cited a study which found that "parenting is the single largest variable implicated in health outcomes for children, notably accident rates, teenage pregnancy, substance misuse, truancy, school exclusion and under-achievement, child abuse, employability, juvenile crime and mental illness." [19] Early childhood experiences, mediated by a positive relationship with the main carers, are strongly predictive of later resilience, ability to cope with adversity and, ultimately, mental health.

There is considerable evidence that failure to tackle emerging problems in childhood leads to development of adult mental health problems and social exclusion. One study estimated that, quite aside from costs to the individual, the lifetime costs of public service intervention (including benefits and costs to the criminal justice system) for those children who exhibit anti-social behaviour can be ten times as great as for children without such behaviours. [20]

"Investment in children's mental health can help prevent social and economic exclusion."

Policy levers: summary

We would urge the government to:

- adopt a three-tier approach to public mental health – promotion and education for whole-population mental health, targeted prevention for at-risk groups, and early intervention for children and families
- channel resources from a range of departments into promotion and prevention efforts
- assess new policies in terms of their impact on population mental health – mental well-being impact assessments – and in particular to focus on creating opportunities and environments conducive to positive mental health
- learn from precedents for such cross-government impact assessment, i.e. the Chief Medical Officer Liam Donaldson's proposals for a global health strategy, *Health is global*[21]
- prioritise research into evidence-based public health interventions to promote positive mental health and prevent mental ill-health.

At a more local level, local government is best placed to coordinate promotion and prevention efforts. There are existing mechanisms for pooling of budgets between local government and health. We would encourage:

- local area agreements to incorporate commitments to promotion and prevention
- spending on children's mental health and emotional well-being to be seen by education, health and other agencies as an investment for the future, i.e. 'invest to save'
- the promotion of healthy ageing to consider the effects of later life experience on mental health and the response of services to be based on need, not age

- a particular focus on the mental resilience and well-being of groups known to be at risk: looked-after children; ex-service personnel; prisoners; victims of crime, including domestic and child abuse; people who misuse alcohol and drugs; and young offenders
- ways of extending existing programmes, such as *Delivering race equality in mental health*, that can identify synergies across government departments
- training for health visitors, obstetricians, primary care professionals and school teachers in the early recognition of mental distress or risk factors in children and parents. The Mental Health First Aid initiative has been used successfully in many countries, including Scotland, Northern Ireland, Wales, Australia, the USA and Canada.[22]

3. Focus on improving quality of life, ambition and hope, not on illness and deficiency

Our vision

- a system where success is judged by how quality of life is improved for those experiencing mental health difficulties
- people with mental health problems helped into employment and once there, supported as long as appropriate.

"A commitment to the recovery approach by mental health and other support services offers a framework that builds a flexible and holistic approach into the design of services that can deliver against quality-of-life outcomes."

Our view is that the overarching aim of all health, social care and voluntary sector mental health services must be to help restore, and then enrich, the quality of life of those who turn to services for support – not simply to aim at removing symptoms.

People with a mental health condition that requires support beyond their family and friends should be able quickly to access a range of services which meet their expectations and needs.

These supports and services will not only sit within formal health and social care services; they should include a range of meaningful choices that are culturally and age appropriate.

A commitment to the recovery approach by mental health and other support services offers a framework that builds a flexible and holistic approach into the design of services that can deliver against quality-of-life outcomes.

The Sainsbury Centre for Mental Health has defined recovery as follows:

> *"At its heart is a set of values about a person's right to build a meaningful life for themselves, with or without the continuing presence of mental health symptoms. Recovery is based on ideas of self-determination and self-management. It emphasises the importance of 'hope' in sustaining motivation and supporting expectations of an individually fulfilled life."*[23]

In other words, the most important goals for all services adopting a recovery orientation are to hope and expect that people can reach a better quality of life, and to support this directly. This may involve facilitating someone to make their own decisions about how they will move forward, or it may involve services withdrawing to allow a person to take back this control.

Policy levers

Full adoption of a recovery philosophy across formal services

The recovery approach requires a new underpinning philosophy for the formal and informal services making up the range of support to anyone experiencing mental health problems. According to the Sainsbury Centre,[24] this entails:

- an emphasis on the whole person and re-establishing a positive personal identity, with the focus on strengths and goals rather than defining people by their illness
- an emphasis on self-determination and self-management, to attain personal fulfilment; this approach promotes recovery of meaningful life with or without a reduction of symptoms
- the relationship between clinicians and service users moving away from the 'expert/patient' paradigm towards the clinician being a 'coach' or 'partner' in the journey towards recovery, with the individual regaining control over their progress
- an emphasis on attaining meaningful social and occupational roles within the community, rather than in segregated services
- defining successful outcomes not exclusively in terms of symptom reduction, but also in terms of housing, education, employment and participation, making the role of non-NHS agencies all the more important.

Adoption of this approach would mean assessing current services, configurations, workforce skills and training in terms of whether, from a service user point of view, "they allow us to lead the lives we wish to lead." [25] If the system or elements of it do not facilitate this, what are the barriers and what needs to change?

Tools that can be used to promote this approach include the *inControl* system for self-assessment of need.[26] This uses responses to simple questions such as "What is important to you in your life?" and "What are your hopes and goals for the future?" to guide planning of care and support by that individual. The DREEM assessment tool has been used in Devon to ascertain the levels of recovery orientation in NHS mental health services and what needed to change to facilitate the recovery approach.

An implication of the recovery approach is that formal health and social care services will not necessarily coordinate the support a person chooses to help them recover a good quality of life. Such services will be integrated into a system of support designed by the individual in partnership with a professional, if appropriate, and with advice from an advocate or carer. The NHS and social services will play a greater or lesser part according to individual need and preference.

Supported employment

Attaining and remaining in mainstream competitive work has therapeutic, social and economic benefits, both for the state and the individual. The current debate about mental health and work has mainly been played out negatively in terms of aiming to get people off incapacity benefit. This is unfortunate because it sounds as though people will be forced into work with no consideration of their needs, and has obscured the quality of life gains made when people are supported to remain in work or to gain competitive employment.

Employment plays a key role in tackling social exclusion, helping self-esteem and sense of purpose, as well as knock-on effects including income for a decent standard of living and a pension. Loss of employment or long-term unemployment destroys factors that are conducive to good mental health, as well as potentially creating strain on family relationships, finances and status within the community.

However, getting employment when you have mental health problems is difficult. Most employers say that they would not employ someone with a mental health problem,[27] the benefits system creates perverse incentives against attempting to start a job, and there is little specialist support to help someone get into, and stay in, a job. Only 21 per cent of people with a long-term mental illness and just 4 per cent of people with schizophrenia are employed.[28]

The evidence in support of formal programmes of supported employment is strong, both in terms of economics and individual outcomes. McDaid [29] notes that health and social care costs account for only a third of the costs to the economy of someone having poor mental health – the other two-thirds is through lost employment. EQOLISE, a six-country European randomised controlled trial,[30] has compared the employment and non-employment outcomes for those with severe mental illness receiving individual

placement and support (IPS) with a control group receiving usual rehabilitation and vocational services. The IPS group exhibited superior employment and general functioning outcomes.[31]

It is important to stress, however, that where full-time employment is not possible, this should not be seen as a failure to achieve recovery. Options surrounding part-time working, volunteering and other activities can also play a major role in supporting the quality of life of people experiencing mental health problems.

A new understanding of 'good outcomes' in mental health

At present there are few agreed outcome measures for mental health, principally because it is hard to agree what constitutes a 'good outcome'. Many concentrate on psychiatric assessments such as degree of symptom reduction as measured by clinicians. These may not take into account how symptoms link to an individual's actual levels of distress.

The effectiveness of any intervention, service or support for those suffering mental distress must be evaluated according to much broader quality-of-life dimensions which are identified by service users as important to them. There are already a number of accepted scales for measuring quality-of-life outcomes, such as the Manchester Short Assessment of Quality of Life (MANSA) and the Lancashire Quality of Life Profile.[32 33]

We are convinced that it is necessary to move towards a system that rewards providers of services for the extent to which they have helped the service user progress towards a better quality of life. There are barriers in some sectors to such a system, such as the absence of a tariff for NHS mental health services. There is now a need to move ahead to routinely and consistently implement appropriate quality-of-life outcome measures.

Policy levers: summary

To help improve quality of life for those experiencing mental health problems, we would suggest:

- full adoption of the recovery model ethos and practice across support services in statutory, voluntary and independent sector services
- thorough exploration of how to systematically implement supported employment initiatives and alternatives for those who are unable to work
- a concerted effort to test and implement an agreed set of quality-of-life outcome measures so that services are rewarded for the extent to which they improve quality of life for those using them.

4. Changing relations between users and services

Our vision

- service users taking control of their own healthcare and making decisions for themselves, wherever possible
- a range of care and support services which individuals can choose from to enhance their quality of life and achieve their goals
- a different relationship between healthcare professionals and service users.

We believe the changes we have outlined in previous sections must be underpinned by a change in power relations, so that control over support and recovery lies with individuals, families and communities.

When people are empowered to be in control of their own health, including their own mental health, their recovery is accelerated. We argue that the most effective way of achieving the culture change outlined above is to develop a new relationship between individuals and the services in place to support them. In other words, there will need to be a real shift in control over support and intervention away from professionals and services and towards individuals, their families and communities.

Autonomy and personal agency have positive effects on mental health. It is essential for people to move on from being 'service users' to being people with fulfilling lives, with hopes and ambitions, in control of what happens to them. They may well continue to use services, but this should not define them.

Policy levers

Self-determination and assumption of competence

We believe that self-determination should be the underlying ethos of mental health policy. At present, the public policy rhetoric is all about 'personalisation'. However, it is still possible to 'personalise' a service (in terms of tailoring it to individual needs) whilst retaining control and power with professionals and the systems in which they work.

A self-determination philosophy means that all services, support and interventions for those with mental health problems view people as competent to choose their own route to recovery, with appropriate support as needed. The term 'self-determination' reflects a move away from care as something which is done to service users by the system (which 'personalisation of services' implies), towards a system of support built by the person and their advocates to help them achieve their ambitions and goals.

This is not to deny that some people experiencing acute mental health problems may lack competence at some points, and that decisions have to be taken for them at these times. However, it is essential that crisis cards, advance directives and other mechanisms are routinely put in place to allow an individual's agency to continue through someone else they have nominated. The availability of appropriate advocacy is vital in this respect.

Full adoption of a self-determination ethos would require a substantial change in the way people are viewed by services and professionals and in the way they interact with them.

Self-determination means:

- starting from the assumption that service users are competent to know what a 'good life' for them would mean, and that the role of support services is to help map out the path towards that
- individual needs and preferences shape the organisation, planning and delivery of support and intervention; convenience to the service user overrides convenience to the system or the professional
- the individual has control over the planning and delivery of their own care and support, with access to advocacy where helpful
- individuals choose not only their care and support options, which may or may not fall within the traditional boundaries of 'health and social care'; they also choose the path they want to follow towards achieving their goals and a good quality of life

- people needing support can choose interventions most likely to reduce their levels of distress, rather than simply focusing on those symptoms which are traditionally considered to be most important.

The realisation of true self-determination would change the dynamics between system and user, between professional and patient, and between purchaser and provider. There are many barriers to overcome, such as:

- the power of the status quo – professional interests and institutional thinking, and loyalty to different models of mental illness which do not promote self-determination
- low expectations about the competence and capacity of those with a mental health diagnosis; perception of risk; potential public reaction to individual budgets
- existing fragmented funding streams, organisational boundaries and commitments to block contracts.

The vision is, therefore, a long way off, but we can start to make the first steps.

Policy levers: summary

For the Department of Health, we would advocate:

- the programme of system reforms must be strengthened and fully implemented for specialist mental health, as many of these mechanisms will be a useful foundation for implementing the principles of self-determination, such as a national tariff
- promoting more intelligent, flexible commissioning, which is required to meet the whole-life needs of those experiencing mental health problems (without segregating them in separate services when specialist input is not required); we would expect a world-class commissioner from the NHS, for example, not to be constrained by the mindsets and structures of the past, but to start from the viewpoint of their population's stated expectations, needs and preferences.

In terms of resource management to promote self-determination, we would stress that:

- mechanisms for coordination of funding streams already exist and should be better exploited – an approach of particular importance to the implementation of a cross-government approach to mental health
- local area agreements, joint ventures, strategic partnerships and pooled budgets have the potential to make this happen
- there is a need to extensively pilot and evaluate the benefits of ways to give individuals control of resources; the Social Market Foundation and others have estimated that 25 per cent of mental health spending could be allocated using individual budgets [34]
- these pilots should determine both the effectiveness of individual budgets in improving quality of life, and their economic viability within a range of communities. There is international experience to draw on: Austria, the Netherlands, France, Sweden, several US states and Scotland have established personal budgets programmes for those with mental health difficulties [35]
- training programmes should be piloted to enable people to participate in commissioning decisions in their localities, to commission their own care or to pool individual budgets in groups, to offset any threat individual budgets might present to the collective good
- wider availability of advocacy – which may require funding – is needed to help people develop and implement their own support plan
- there is a need to explore the potential for 'experts by experience' to drive or participate meaningfully in planning and research; in the US there are well-developed programmes of support organised and run by 'peer specialists' [36]
- meeting the needs and preferences of people with a wide variety of backgrounds, cultures, experiences and ages may entail a bigger role for the voluntary (third) sector in service provision; such organisations are often more attuned to people's needs, and seem more accessible, than statutory services as they are frequently small and rooted in the communities they serve
- such a diversification of providers will require more intelligent commissioning, robust quality assurance, and coordination to ensure that systems of support do not become fragmented
- careful consideration of the workforce implications of the self determination ethos will need to be made.

What do you think?

We hope that this discussion paper has made you think about what shape you would like mental health policy to take in future.

This is only the start of an initiative to influence future policy, and we will be seeking the backing of a range of government departments and each of the main political parties.

To help us develop a more comprehensive vision and consider in more detail how it might be delivered we want to know what you think. We are consulting a wide range of groups and stakeholders during Summer 2008 and would like to hear your views on the following questions:

- Is this a vision you share? Why or why not?
- What needs to be done nationally and locally to achieve the four aspects of the vision?
- What do you think are the top three priorities for the next ten years of mental health policy?

If you would like to contact us directly with your views and thoughts, please email future.vision@nhsconfed.org by Friday 3 October 2008.

References

1 *Equal treatment: closing the gap, one year on.* Disability Rights Commission, 2007

2 *No voice, no choice: a joint review of adult community mental health services in England*. Healthcare Commission/Commission for Social Care Inspection, 2007

3 *The social and economic costs of mental illness.* Sainsbury Centre for Mental Health, 2003. Available at www.scmh.org.uk

4 See www.who.int/mental_health/en

5 See Together's *Wellbeing approach to involvement*. www.together-uk.org/service~user~directorate/wellbeing

6 Marmot, M. Speech to Fabian Society Health Inequalities Forum, 14 March 2008. See http://fabians.org.uk/events/events-news/marmot-inequalities

7 *Independent living: a cross-government strategy about independent living for disabled people.* Office for Disability Issues, 2008. See www.officefordisability.gov.uk/docs/ilr-executive-report.pdf

8 Layard, R. *Mental health: Britain's biggest social problem*. Prime Minister's Strategy Unit, 2004. See www.cabinetoffice.gov.uk/strategy/seminars/mental_health.aspx

9 *Paying the price: the cost of mental health care in England.* Kings Fund, 2008

10 See www.dfes.gov.uk/CAMHSreview

11 Friedli, L. (forthcoming) *Mental health, resilience and inequalities*. WHO Europe and the Mental Health Foundation

12 *Towards a mentally flourishing Scotland: the future of mental health improvement in Scotland 2008–11*. Scottish Government, 2007, page 2. Available at www.wellscotland.info/towards-a-mentally-flourishing-scotland-resources

13 *Making it possible: improving mental health and well-being in England*. NIMHE, 2005. Available at www.csip.org.uk/silo/files/making-it-possible-full-version.pdf

14 *Public health interventions to promote positive mental health and prevent mental health disorders among adults: evidence briefing*. NICE, 2007. Available at www.library.nhs.uk/SpecialistLibrarySearch/Download.aspx?resID=236093

15 For more information see www.likeminds.org.nz

16 NICE, 2007, op.cit.

17 Wang et al. 2007: 'Telephone screening, outreach, and care management for depressed workers and impact on clinical and work productivity outcomes: a randomized controlled trial.' *JAMA*, Vol 298 (12): pages 1401–11

18 *Promoting mental health and well-being in later life: a first report of the UK Inquiry into Mental Health and Well-Being in Later Life*. UK Inquiry into Mental Health and Well-Being in Later Life, 2006. Age Concern. See www.mhilli.org

19 Hoghughi, M. 1998: 'The importance of parenting in child health.' *British Medical Journal* 316:1545, cited in Friedli, *Making it effective: a guide to evidence-based mental health promotion*. Mentality, 2003. Available at www.scmh.org.uk/pdfs/makingiteffective.pdf

20 Scott, S. et al., 2001: 'Financial cost of social exclusion: follow up of antisocial children into adulthood.' *British Medical Journal* 323:191

21 *Health is global: proposals for a UK government-wide strategy*. Department of Health, 2007. Available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_072697

22 See www.mhfa.com.au

23 Shepherd, G. et al. *Making recovery a reality*. Sainsbury Centre for Mental Health, 2008. Available at www.scmh.org.uk/pdfs/Making_recovery_a_reality_policy_paper.pdf

24 ibid

25 Perkins, R. quoted in Repper, J. and Perkins, R. *Social inclusion and recovery: a model for mental health practice*. Elseiver Health Sciences, 2003, page 27

26 See www.in-control.org.uk

27 Thornicroft, G. *Actions speak louder than words*. Mental Health Foundation, 2006, page 16

28 *Mental health and employment*. Sainsbury Centre for Mental Health, 2007. Available at www.scmh.org.uk/pdfs/briefing+33_mental_health_and_employment.pdf

29 McDaid, D. 2007: 'Mental health policy: time to focus on promotion and prevention?' *Eurohealth* 13(1) pages 17–20

30 www.eqolise.sgul.ac.uk/

31 Burns, T. et al., 2007: 'The effectiveness of supported employment for people with severe mental illness: a randomised controlled trial.' *The Lancet*; 370: pages 1146–1152

32 Priebe, S. et al. 1999: 'Application and results of the Manchester Short Assessment of Quality of Life (Mansa).' *International Journal of Social Psychiatry*, 45:1, pages 7–12

33 Oliver, J. et al. 1997: 'Measuring the quality of life of severely mentally ill people using the Lancashire Quality of Life Profile.' *Social Psychiatry and Psychiatric Epidemiology*, 32(2)

34 Alakeson, V. *Putting patients in control: the case for extending self-direction into the NHS*. Social Market Foundation, 2007. Available at www.smf.co.uk

35 Some examples in Leadbeater, C. et al. *Making it personal*. Demos, 2008

36 US Department of Health and Human Services: *Free to choose: transforming behavioral healthcare to self-direction*. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration

Mental Health Foundation

Mental Health Network

a part of THE **NHS** CONFEDERATION

For better mental health

rethink

SAINSBURY CENTRE for MENTAL HEALTH

removing barriers achieving change

together

This is a discussion paper intended to provoke a wide-ranging debate about the best direction for mental health policy. It outlines a vision of change developed by seven national mental health organisations, who together make up the Future Vision Coalition. We focus in particular on four changes that we believe need to happen to enable those with experience of mental health problems to enjoy an equal opportunity of a fulfilling life.

© The Future Vision Coalition, 2008.
This document may not be reproduced in whole or in part without permission.

INF14401