



SAINSBURY CENTRE
for MENTAL HEALTH
removing barriers achieving change



Looking Ahead

The next 25 years in mental health

Looking Ahead

The next 25 years in mental health

© Sainsbury Centre for Mental Health 2010

Copyright for the individual articles remains with the authors

All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying or otherwise without prior permission.

Published by

Sainsbury Centre for Mental Health

134-138 Borough High Street

London SE1 1LB

Tel: 020 7827 8300

Fax: 020 7827 8369

www.scmh.org.uk

Charity registration no. 1091156

A company limited by guarantee registered in
England and Wales no. 4373019

Design: www.intertype.co.uk

Printing: Stephen Austin & Sons Ltd (UK)

Contributors

- Lord Adebawale, Chief Executive, Turning Point 6
- Louis Appleby, National Director for Mental Health, Department of Health 8
- Sue Bailey, Registrar, Royal College of Psychiatrists 10
- Anne Beales, Director Service User Involvement, Together 13
- Dinesh Bhugra, President, Royal College of Psychiatrists 15
- Dame Carol Black, National Director for Health and Work 17
- Clair Chilvers, Chair, Nottinghamshire Healthcare NHS Trust 20
- Cary Cooper, Distinguished Professor of Organisational Psychology and Health, Lancaster University 23
- Paul Farmer, Chief Executive, Mind 26
- Paul Jenkins, Chief Executive, Rethink 28
- Andrew McCulloch, Chief Executive, Mental Health Foundation 30
- Ian McPherson, Director, National Mental Health Development Unit 32
- Rachel Perkins, Director of Quality Assurance, South West London & St. George's Mental Health NHS Trust 34
- Lisa Rodrigues, Chief Executive, Sussex Partnership NHS Foundation Trust 37
- Susan Scott-Parker, Chief Executive, Employers' Forum on Disability 39
- Steve Shrubbs, Director of Mental Health Network, NHS Confederation 41
- Su Wang, Accredited Specialist Occupational Physician 43
- Melba Wilson, National Programme Lead Mental Health Equalities, National Mental Health Development Unit 46

Introduction

Bob Grove and Sean Duggan are Joint Chief Executives of Sainsbury Centre for Mental Health

In the 25 years since the National Unit for Psychiatric Research and Development (the original name for Sainsbury Centre) was established as a charity in 1985, mental health care in the UK has changed almost beyond recognition. Thanks to the pioneering efforts of service user activists, professionals, politicians and service managers, the long-stay asylums of old were all closed down and replaced by a range of (mostly) community-based services for people with severe mental illness. There have been significant changes over that period in the treatments available for a range of mental health problems and in the laws that govern the powers of the state in the four nations comprising the United Kingdom. And the importance of mental wellbeing to our health and quality of life has begun to be understood not just by the public but by policymakers and public services.

This volume, however, looks forward at the next 25 years rather than back at the last quarter of a century. It asks a number of leading commentators and experts in 2010 what, if we were to look back again on our 50th anniversary, would we be talking about? What, over the next 25 years, will be the most important changes for people with mental health problems and for the mental wellbeing of our society as a whole? And what should we be doing now to prepare ourselves for the challenges that lie ahead and the opportunities that remain to be taken to continue the process of reform that has taken us so far over the last 25 years?

We are delighted to note that the contributors to this book have all given quite distinctive answers to these questions. Mental health policy and practice continue to invite a range of different views and lively debate. Just as Sainsbury Centre's first 25 years have seen numerous controversies and changes, so we expect the next 25 to witness more twists and turns across the

many areas of policy and practice that affect people with mental health problems.

Sainsbury Centre was set up to help improve the lives of people with significant mental health problems (not simply to promote kinder forms of containment or improve the treatment of mental illness). That task, although incomplete, is now accepted in this country at least as being the primary goal of mental health services.

Last year saw the end of the ten-year *National Service Framework for Mental Health* in England and the publication by the Government of its successor, *New Horizons*, with its broader outlook and ambitious objectives. We have recently witnessed significant changes to mental health and related legislation in England, Wales and Scotland with changes expected to come soon in Northern Ireland, each of whose significance will take some time to become clear.

The NHS, responsible for the vast majority of spending on mental health care in the UK, has also undergone big changes and a rapid expansion in capacity over the last decade. With public sector spending expected to be tight for the foreseeable future, the NHS will no longer be able to add on new services for people with mental health problems without reductions elsewhere in the system. Local authorities, justice and employment services will probably be even more tightly squeezed than health services, yet how they work will have as big an effect on our mental health, and the lives of people with mental health problems, as the NHS.

As the contributions to this book make clear, there is much still to be done. People with mental health problems too often face discrimination in their daily lives, from getting or keeping a job to making friends and enjoying good physical health. Children born in disadvantaged neighbourhoods or to families excluded from the benefits of modern life are still far too likely to experience mental ill health from a young age, and for this to have a significantly adverse effect on their chances in life. And a high proportion of

prisoners have mental health problems alongside a range of other difficulties that public services have persistently failed to address.

There has recently been a shift of priorities, reflected in the adoption of the ‘recovery’ concept as an integral part of the value base in a range of services. But how far can the implications of this shift be pushed? Will it become a normal expectation for everyone who wants to work to have a paid job, irrespective of the severity of their illness? Will it become a normal expectation that users of services will negotiate the treatments they get based on their life needs and preferences? Will it be considered normal that a significant proportion of the people who staff mental health services are themselves experts by experience? Can we look forward to a time when mental illness is not something to be hidden but simply a part of life, meriting support, consideration and a collective will to create the conditions in which recovery in its broadest sense can occur? Will we as a society ever be able to weigh in a fairer and more just way the competing demands for care, rehabilitation and punishment / retribution where the exigencies of people’s lives have led them to anti-social behaviour and criminality?

If the next 25 years see as much change for the better as the last 25, we believe that there is every reason to be optimistic about the future. As Sainsbury Centre embarks on its next 25 years of work, we will continue to support change for the better in policy and practice, to challenge practices that hold back people with mental health problems from achieving their potential and to promote innovations that help people to make their lives better. We will continue in the direction we have begun and continue to test in a measured and evidence-based way how far and fast we as a society can move.

We hope that this book will inspire anyone with an interest in mental health, whether personal or professional, to set their sights high and aim towards a bright future, starting today.

Building futures

Lord Adebowale is Chief Executive of Turning Point

Current mental health policy is advancing to recognise mental health as not only a medical issue but also a social matter with great ramifications for both the individual and wider society. Despite this progress, there remains an underclass of people not receiving the care and support they need to address their mental health conditions. Addressing this inequality is one of the greatest challenges faced by the mental health sector in the coming years.

The Bradley Review (Bradley, 2009) found that one such group not receiving the support required were those with mental health conditions or learning disabilities in the criminal justice system. Estimates suggest that of the 82,000 prisoners in England and Wales, nine out of ten have a mental health disorder. When this is combined with the statistic that over two-thirds of prisoners reoffend, it is clear that prisons are becoming full of repeat offenders with mental health needs which are not being addressed. To break this cycle, the criminal justice system needs to become more responsive to the mental health needs of offenders.

Responding to mental health needs requires diverting repeat offenders from the courts and directing them towards appropriate support. This means improved identification of repeat offenders with complex needs such as substance misuse, mental health conditions or a learning disability. The acknowledgement of this within the Bradley Review is a positive development for mental health policy as it recognises the necessity for a person-centred approach to address the needs of repeat offenders.

My organisation, Turning Point, has been working to address the deficiencies in service provision for rehabilitating offenders back into the local community through our Building Futures model. Traditionally, there has been an over-reliance on out-of-area treatment services which place offenders away

from the networks of support that could further help their recovery. The level of security within these services is often too high which can prevent progress in the management of mental health conditions. Nevertheless, appropriate supervision is still required to ensure these offenders do not present a threat to themselves or others. Building Futures provides a middle-level service which maintains this supervision while also acting to support those with complex needs in their rehabilitation into the community.

Building Futures is a result of a £15.2 million investment from the Futurebuilders fund. Services are to be developed across five sites to ensure people with complex needs access the support they require in an appropriate secure setting. A person-centred approach is taken with the promotion of service user involvement in the structuring of care packages to assist social inclusion. This encourages independence at a suitable level for the service user while also supporting them in their social care needs. We, at Turning Point, believe this model of service provision has the potential to act as an early diversion from the courts which improves access to appropriate mental health treatment.

The progression within mental health policy shows a positive understanding of the effects of an untreated mental health condition. However, it is necessary to remember the inequality still present in the provision of services and actively to promote challenges to this.

Reference

Bradley, Lord (2009) *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the Criminal Justice System*. London: Ministry of Justice.

New Horizons

Louis Appleby is National Director for Mental Health, Department of Health

Some people said that the most important thing about the National Service Framework (NSF) for mental health was that it existed at all. Our NSF, published just over 10 years ago (DH, 1999), was the first to appear – a clear statement that the neglect of mental health would not be allowed to continue.

Now we have *New Horizons*, the Government's vision for the future of mental health (HM Government, 2009). *New Horizons* is our chance to shape the priorities of mental health care for the next phase of reform. It is our chance to position mental health at the heart of social progress, as a key step towards achieving what matters to the individual, the family, and the community as a whole.

It is our chance to future-proof the reforms that the NSF has made possible – the transformation of community care, in particular – so that whatever comes our way in the next few years, there is an enduring set of values on which services can be built. And it is our chance to recession-proof the changes that are still needed by presenting them as good value for money.

New Horizons highlights the need to prevent mental illness as well as treat it, and to intervene early with benefits to long-term quality of life. It emphasises too the importance of 'personalised' care – a clumsy term but a vital concept.

But alongside the policy priorities, there are – for me, at least – certain signs to look out for that will tell us that mental health is what it should be – a social as well as a clinical priority. And in every case I believe we are on the right track.

Increasingly, schools will address the emotional health of young people, seeing it as vital to educational success and what are often called 'life

chances'. As a result, children will have the self-respect and optimism to steer clear of binge drinking and teenage pregnancy, to stay off drugs and out of the courts, to become well-adjusted adults with a stable home life.

Increasingly, people with mental illness will be able to get a job and a decent place to live. Insulting terms for mental illness will, like racial abuse, be socially unacceptable and banned in the media.

Critics in the press and elsewhere will stop depicting mental health care as a bleak Gothic underworld and realise that this only adds to stigma. All of us in mental health will give up that cliché about the Cinderella service that is self-pitying and out-of-date.

A mature discussion will take place about risk – an honest public debate about the link between mental illness and violence in which professionals are neither too defensive nor too easily blamed when something goes wrong.

And health services will turn their attention to offenders – the next frontier in mental health care. This will provide a test of our commitment as professionals to tackling inequalities and defeating stigma, and a test of our values as a society.

References

Department of Health (1999) *National Service Framework for Mental Health: Modern standards and service models*. London: Department of Health.

HM Government (2009) *New Horizons: A shared vision for mental health*. London: HM Government.

Mental health across a lifetime

Sue Bailey is Registrar of the Royal College of Psychiatrists

We entered the 21st Century with a positive 20-20 vision. During the first decade of this millennium, public services such as health and education “received largesse in unprecedented quantities. And then, in a strange slow motion show, the world economy fell off the cliff” (Aaronovitch, 2009).

The next 20 years of mental health are to be played out against the tensions of economic restraint, the drive towards localism, and a society and political culture that is risk averse and has a love hate relationship with those working at the front line of mental health and social care.

There are now the early signs of a transformation of attitudes about mental health and those who experience episodes of mental illness. There is a growing opportunity to deliver health services in which there is ‘no health without mental health’ and to improve mental health awareness across the whole of medicine, so that GPs can recognise mental health problems early and start a pathway of care that makes sense to its users.

The current focus on ‘back to work’ affords opportunities to improve mental health and wellbeing for adults in the workplace and for children in schools, but also allows us to pursue equal opportunities for those who have had to leave the world of work, or have never entered it, because of mental illness. This as we know is such an important step on the road to recovery. But will such initiatives allow for those with mental illness to return to work at a pace and a manner suited to their needs or become a one size fits all?

The risk of considering radical redesign to mental health services is that it could be used in the economic downturn as an excuse to cut services, but we

have to heed what users tell us. What they want, above all, is continuity of care and someone who understands their needs and their mental illness in their unique context.

The move towards public mental health, wellbeing, and the achievement and maintenance of resilience is a great opportunity for mental health services and social care to work together more closely. The research literature has long told us what will prevent a child of two becoming an adult with long lasting mental illness. We have a secure financial argument in the cost benefits of intervening early. The challenge is the perception that prevention does not deliver short term gain. Yet in the family setting, for example, an intervention with a 12-year-old child experiencing difficulties will also help and enable the parents to ensure that younger children in the family do not develop the same problems.

So we need a government brave and visionary enough not to look at short term cost and gains but at quality of life over the lifetime.

As professionals what does this mean? We need a fit for purpose workforce where all mental health practitioners understand the origins of mental ill health and can tackle the psychological impact of abuse, domestic violence and trauma. We need a workforce that understands the impact of developmental disorders and learning disabilities across a lifespan.

We need to strengthen transitional services from adolescence to adulthood not just for early onset psychosis but for those with emerging personality disorder and substance misuse. And mental health services need to be empowered and developed for those in later life, both with dementia and mental illness; supporting and safe-guarding vulnerable people across a lifespan by both listening to their voices and responding to their needs.

What would good outcomes look like in 20 years time? Mental health trusts, or their successors, will be working in a locality with the third sector in social enterprises driven by local need informed by local people. If we have ‘no health without mental health’, we will enable those looking after the

physically sick to understand the impact and risk of mental health problems. We will 'Think Families' and take advantage from adversity, achieving and maintaining resilience. Above all, governments and communities at a local and national level will no longer be accused of knowing the cost of everything but the value of nothing. They will embrace the concept of mental health and have respect for those who experience mental illness, living in 'communities that care'.

Reference

Aaronovitch (2009) The decade that changed who we were. *Times*, 20 October 2009.

The future role of the service user movement

Anne Beales, MBE, is Director of Service User Involvement at Together and a member of the management committee of the National Survivor User Network

The service user movement in the UK is still in its infancy and remains under-resourced and overstretched. Yet against the odds we have already achieved an incredible amount. As we become more organised and proactive, our biggest challenge is to attract the right levels of funding and create the partnerships needed for us to become a more independent and powerful force for change.

Our experiences of distress and accessing mental health services have enabled us to see first-hand the restrictions of today's system, and its response to human need. But to date our involvement in using our experiences to re-shape the support we receive has, in the main, been about being 'given' opportunities to put forward a perspective or opinion.

While some of these opportunities have certainly led to an improved experience for many people accessing services, and have helped to change wider attitudes to mental health and wellbeing, they still do not challenge power relationships between professionals and service users, and do not lead to a partnership where service users can engage on an equal basis. Increasing pressures on funding and our unequal role in decision making mean that our ideas, even our language, run a real risk of being absorbed into the very system we are trying to change.

Therefore the future role for the service user movement must be based on achieving more independence, particularly around implementing our ambitions through practical examples. We need to demonstrate in a way that

investors can understand that alternative approaches based on our real life experiences can and do work. Because of this, and my own personal experiences, I strongly believe that the development of independent peer-led support has a key role to play in the service user movement over the coming years. In doing this, building the right partnerships with professionals, providers and local communities is incredibly important.

To date, the value of people with experience of mental distress helping others in distress in a mutually beneficially arrangement, based around principles of understanding, trust and respect, has been undervalued and under-researched. This is why peer-led support must be a focus for investment, development and evaluation.

As part of our own cultures and communities who have direct experience of mental health issues, we know what works for us and what hurts us. This makes us well placed to offer sensitive leadership and, over time and where appropriate, to deliver mental health services to those who are troubled and in distress.

One thing is certain about peer-led support: it must be service user-led. In the same way that others cannot 'give' service users empowerment or inclusion, you cannot 'give' people peer support. As a movement we simply need the resources to be able to do it for ourselves, in equal working partnership with others where needed. We need our allies now more than ever.

Those who wish to be remembered in history as allies, who supported the service user movement to bring about changes such as peer-led support, will need to invest in leadership which has been earned via the experience of mental distress.

The role of the psychiatrist

Dinesh Bhugra is President of the Royal College of Psychiatrists

A psychiatrist is a medically qualified mental health professional who is trained in the understanding and management of mental illness. In addition to their role as physicians, psychiatrists take responsibility for clinical leadership and public health. This brings unique benefits to patients and the multi-disciplinary team in psychiatry. The following article looks at the evolving role of the psychiatrist in the 21st century.

A psychiatrist must deliver not only high quality care, but also meet the needs and expectations of patients and their carers. That care, especially now that we are faced with major economic challenges, must be evidence-based, clinically effective, safe and person-centred. As a medical expert the psychiatrist must apply medical knowledge, clinical skills and professional attitudes in the provision of care in culturally and ethnic sensitive services. In addition, they must be good communicators: able to communicate with patients, across ages and psychiatric conditions, their carers and families, and other stakeholders such as commissioners of services, the public at large and policy makers.

Psychiatrists should work in a collaborative manner within a team, showing due respect for other team members' skills, to develop the best treatment plans for patients. They must also take part in service planning and development; be involved in developing environmentally and otherwise sustainable practices; allocate resources as needed; and contribute to the effectiveness of the health care system.

Another significant aspect of the psychiatrist's role is to be a firm advocate for patients and their families: to advance the health and wellbeing of individual patients, local communities, and populations at large. Like any medical professional, the psychiatrist must be committed to lifelong reflective

learning. They should be able to interpret new research and apply it appropriately to improve care. As a professional a psychiatrist must show the highest possible level of commitment to improve the health and wellbeing of individuals and society. Their clinical practice must be ethical with high personal standards of behaviour.

Public expectations, containment of risk and limited resources, along with the stigma experienced both by patients in society and by psychiatrists within the medical profession, are all challenges to be addressed.

In the 21st century the psychiatrist must take on clinical leadership roles within which they can demonstrate responsibility and accountability. They must deal with both ambiguity and complexity at many levels – within the self, within the team and with their patients.

Psychiatrists are uniquely positioned to lead a team in such a way as to ensure that practice and outcomes for patients are good and are continuously improving. This does not necessarily mean being a ‘team leader’ but being a ‘clinical leader’. As a clinical leader a psychiatrist must be accountable for clinical decision making in multi-disciplinary contexts. These decisions should be evidence-based, manage team dynamics and encourage the professional development of colleagues. Psychiatrists must strive continuously for improved quality of care and ensure equity of access to services. They should be proactive in anticipating developments in policy and practice, and encourage relevant changes in service delivery.

In the 21st century the profession of psychiatry must renegotiate its contract with society by ensuring that the profession is responsive to society’s needs and that society has realistic expectations of the profession.

Moving forward in the workplace

Dame Carol Black is National Director for Health and Work and author of *Working for a Healthier Tomorrow: A Review of the health of Britain’s working age population*

We have come a long way. Progress has been uphill but there are measured improvements in the provision and outcomes and experience of care provided by mental health services. We can now see further and also how far we have yet to go in creating a society in which a mental health condition is no longer a bar to a fulfilling, rewarding and health enhancing life.

There is better recognition of the needs of people whose mental health condition limits the quality of their lives, their wellbeing and functioning. There is less reticence in bringing the matter out into the open, with a new determination to deliver even more effective treatment, support and care. It has to do with addressing not only the vocational barriers to work but non-vocational impediments too.

Let me comment from my particular viewpoint as National Director for Health and Work. We must overcome a widespread assumption, by employers, health professionals, and even by many patients themselves, that people with mental health conditions requiring specialist care should be guarded from the stresses of productive employment. The assumption, that they are unable to undertake work except in a protected environment, often means that their wishes to undertake even modest work cannot be realised, leading to social exclusion and the persistence of correctable inequalities.

There is a growing body of evidence of the effectiveness of collaborative, purposeful multi-disciplinary interventions, with continuing support, that enable sustained secure rewarding work for people with mental health

conditions. The most effective models are strongly work-focused but also address non-vocational barriers. These principles must be applied realistically to address the needs of people with mental health conditions, who account for over 40% of those flowing on to Incapacity Benefit.

We must also acknowledge more fully the quite vast numbers of people who at any time and frequently for many years suffer from mental health conditions that are masked or hidden. There is something seriously amiss when one in six working age adults in Britain is experiencing symptoms of distress bad enough to interfere with their ability to function.

Mental strengths and vulnerabilities are part of our biological endowment. Understanding them, and developing adaptive realistic responses to a myriad of life influences, is essential to establishing and refining personal resilience. The importance of this lifelong process – beginning in childhood, shaped by family, social, economic, educational and work experience – is increasingly recognised as an essential factor in easing the burden of mental health conditions. Resilience, even of the hardiest, is challenged by adverse influences, the now well-known and measured factors that we call the social determinants of health – of mental health and physical health, closely intertwined.

A range of determined, coherent policy movements is now under way, encompassing government strategies such as *Working our Way to Better Mental Health* (DWP & DH, 2009), *Realising Ambitions* (Perkins, Farmer & Litchfield, 2009), *Work, Recovery and Inclusion* (HM Government, 2009) and *New Horizons* (HM Government, 2009) and contributions by voluntary and professional bodies. These mark a new commitment to supporting people with mental health conditions to enter and stay in employment – and to supporting employers to recruit, and keep in work, people with such conditions. They aim to encourage a workplace culture that values and promotes wellbeing in the broadest sense, with the compassionate understanding necessary to banish pernicious stigmatisation and a visible acknowledgement that good work is good for health and wellbeing generally.

We should not expect to see an overnight flowering of these aspirations; but I should be dismayed and disappointed if a decade from now – not 25 years – there is not clear evidence of the change and improvement that an enlightened society needs. Sainsbury Centre has had a major part in influencing thinking and action. I am delighted to be asked to share in its 25th anniversary celebration.

References

Department for Work and Pensions & Department of Health (2009) *Working our Way to Better Mental Health: A framework for action*. Norwich: The Stationery Office.

Perkins, R., Farmer, P. & Litchfield, P. (2009) *Realising Ambitions: Better employment support for people with a mental health condition*. London: Department for Work and Pensions.

HM Government (2009) *Work, Recovery and Inclusion: Employment support for people in contact with secondary mental health services*. London: National Mental Health Development Unit (NMHDU).

HM Government (2009) *New Horizons: A shared vision for mental health*. London: HM Government.

The future of mental health research

Clair Chilvers is Chair of the Nottinghamshire Healthcare NHS Trust

Mental illness has long been at the bottom of the pile for research funding. Investment in research is small when considered in terms of the impact of mental illness on the economy and the personal suffering of people.

More years of good quality life are lost through mental illness than through cancer. Yet cancer research receives five times more funding than mental health in the UK (Kingdon, 2006).

There are two main reasons for the low volume of mental health research funding. The first is the lack of a major mental health research charity. There is no equivalent of Cancer Research UK, The British Heart Foundation, or Diabetes UK. Cancer Research, for example, funds approximately £300m of research each year. These established charities perform a valuable role not only in terms of making funding available but also in raising the profile of research in their area of expertise.

The second reason is that mental health research is perceived (rightly) to be difficult to do. This applies less to the brain science end of the mental health research spectrum than to the clinical end. Patients do sometimes live chaotic lives; they are less likely to conform to timetables and outpatient appointments than those with cancer or cardiovascular disease. I suspect also that some of the research questions proposed by mental health researchers are not seen as a priority by the panels that award grants from general funders.

The question that immediately comes to mind is why there is not a large charity dedicated to funding mental health research? Is it the stigma

associated with mental illness? Successful charities are often started by people who have a family member who has been diagnosed with a particular condition. They are proud to talk about what they have done and to engage their friends and business contacts in supporting the charity. But would this happen with mental illness? To an extent, yes, but the charities tend to be small and to provide services rather than research.

That there is a need for more research is indisputable. From epidemiology to brain science and potential cures, the need is there. A strategic analysis of mental health research funding in the UK (MRC, 2005) identified some major gaps in research funding – notably, research into the promotion of mental health and wellbeing, research into common mental illnesses such as anxiety disorders, and research into suicide. Sainsbury Centre was commissioned to research the views of service users and carers and other stakeholders as to the research questions that they would like to see answered. It reported in 2006 (Naylor, Wallcraft & Samele, 2006). The Medical Research Council is currently undertaking a review of mental health research and the Wellcome Trust also has a real interest in this area.

In 2009, I set up Mental Health Research UK (www.mentalhealthresearchuk.org.uk) with John Grace, QC and Laura Davidson. This initiative is supported by the Royal College of Psychiatrists, the Wellcome Trust and a number of influential individuals. Our aim is to work with others to lobby for a fair share of government funding for mental health research. We want to build on the success of the Mental Health Research Network in fostering collaboration and the work of the two mental health led Collaborations for Leadership in Applied Health Research and Care. The Government's *New Horizons* report also provides a helpful lead for mental health research (HM Government, 2009). We believe that there is merit in small charities working more closely together on the research agenda to ensure that funding is co-ordinated and productive. So, I approach the next 25 years with a feeling of excitement that there will be more funding for research, which will have a lasting and fundamental impact on the lives of the one in four people who suffer from mental illness at some point in their lives.

References

HM Government (2009) *New Horizons: A shared vision for mental health*. London: HM Government.

Kingdon, D. (2006) Health research funding: mental health research continues to be underfunded. *British Medical Journal*, **332** (1510).

Medical Research Council (2005) *Strategic Analysis of UK Mental Health Research Funding*. London: Medical Research Council.

Naylor, C., Wallcraft, J. & Samele C. (2006) *Research Priorities for Service-user and Carer-centred Mental Health Services*. London: Sainsbury Centre for Mental Health.

Mental wellbeing in the workplace

Cary L. Cooper, CBE, is distinguished professor of organisational psychology and health at Lancaster University Management School, and was lead scientist on the Foresight Mental Capital and Wellbeing project.

There have been numerous reports over the last few years on how we might improve mental wellbeing in the workplace, from Dame Carol Black's Review of Health and Work (Black, 2008) to the substantial evidence-based government Foresight work on Mental Capital and Wellbeing (Cooper *et al.*, 2009) and the MacLeod Report on employee engagement (MacLeod & Clarke, 2009). These have all advocated both remedial and preventative approaches to reducing the enormous financial and human burden to the health of the working (and unemployed) population. Sainsbury Centre for Mental Health calculated these costs at the end of 2007 to be roughly £25.9 billion from absenteeism, presenteeism and labour turnover (Sainsbury Centre, 2007). This did not even take into account the £12 billion cost of incapacity benefit, 40% of which is due to stress and mental ill health.

The recession has meant that even more people are now suffering from job loss or fear of job loss, the latter resulting in even higher levels of presenteeism. People come to work earlier and stay later, even if they feel ill or excessively stressed, to show commitment in the hope that they will not be among the next tranche of people to be made redundant. The cost to the economy is even higher in terms of the lost productive value of people being overly stressed at work or from not being integrated back into work fast enough after a period of sick leave. There is also the inevitable knock-on impact on a family when one member is stressed or unemployed.

These reports have suggested a range of solutions, from the immediate practical interventions like the ‘Fit for Work’ initiative in primary care, to the longer term remedies such as training managers in how to manage people so that they do not experience excessive pressure or stress in the first place.

It is in the prevention arena where, I believe, we need to make substantial inroads over the next decade. It is certainly the case that, on balance, ‘work is good for you’, but ‘bad work’ is not and can be as damaging as no work at all. If we are to improve the quality of working life, we do need to consider longer term strategies for making work less stressful and more meaningful to the millions who spend more of their waking hours at work than they do in their private lives. As Studs Terkel, the social communicator and acclaimed author concluded in his book, *Working*, (Terkel, 1974), “work is about a search for daily meaning as well as daily bread, for recognition as well as cash, for astonishment rather than torpor, in short, for a sort of life rather than a Monday through Friday sort of dying”.

For me, the footprint or benchmark of a high quality working life environment is one in which managers manage their subordinates by ‘praise and reward’ and not in a ‘command and control’ mode through fault-finding. Employees should be entitled, wherever possible, to work flexibly and not in a long hours culture. They should be given more autonomy and control over their jobs and, most important of all, should feel that they are trusted colleagues in a joint venture involving management and workers. This is, of course, a nirvana but one which could prevent many illnesses, accidents and unhealthy work environments.

In 1965, Kornhauser wrote a book, entitled *The Mental Health of the Industrial Worker*, in which he described a mentally healthy work environment. Sadly we have moved very slowly toward his dream since then: “what is important in a negative way is not any single characteristic of his [the worker’s] situation but everything that deprives the person of purpose and zest, that leaves him with negative feelings about himself, with anxieties, tensions, a sense of lostness, emptiness and futility”. Our challenge is to reverse this.

References

- Black, C. (2008) *Working for a Healthier Tomorrow: Dame Carol Black’s Review of the health of Britain’s working age population*. London: The Stationery Office.
- Cooper, C.L., Field, J., Goswami, U., Jenkins, R. & Sahakian, B. (2009) *Mental Capital and Wellbeing*. Oxford: Wiley-Blackwell.
- Kornhauser (1965) *The Mental Health of the Industrial Worker*. New York: John Wiley & Sons Inc.
- MacLeod, D. & Clarke, N. (2009) *Engaging for Success: Enhancing performance through employee engagement, A report to Government*. London: Department for Business, Innovation and Skills.
- Sainsbury Centre (2007) *Mental Health at Work: Developing the business care*. London: Sainsbury Centre for Mental Health.
- Terkel, S. (1974) *Working: People talk about what they do all day and how they feel about what they do*. New York: Pantheon Books.

The litmus test

Paul Farmer is Chief Executive of Mind

It is a testament to the foresight of the Sainsbury Centre for Mental Health that this is the first time I've been asked to think about mental health in 25 years' time. It's also a good time to do this, just after the publication of *New Horizons* (HM Government, 2009) and at a time when the *Time to Change* campaign is starting to show what might be possible if a long-term approach to tackling stigma and discrimination can be sustained.

Twenty-five years is a generation away. By 2035 I hope to be commencing a happy retirement surrounded by grandchildren, although it's more likely that I'll still be working. But a generation does allow time for significant change with the potential for things to change radically for the better.

Picture this: a young person, Stephen, in 2035 will have a good knowledge of his own mental health, thanks to the introduction of wellbeing classes in every school in the country. If he's concerned about his mental health, he'll go online and review his wellbeing indicators. If he needs specific help, he'll use his personal health budget to access the therapist (and therapy) of choice, or to sign up to a brief course of green exercise. If he continues to become unwell, he will be able to check in to a crisis house (renamed asylum in a nostalgic recognition of the value of safe space), run by a voluntary organisation.

Thanks to a change in legislation, and sustained work by UK businesses, Britain is widely seen as the best place to work, with flexible working and mentally healthy workplaces a standard requirement. So Stephen will be able to keep working while he can, but if he needs time out, he will be supported by his employers over that period.

The numbers of people detained under mental health legislation will plummet as more people seek and receive help early. Meanwhile, our cultural attitudes

to madness are transformed as first the Prime Minister and then the captain of the England Football team, both disclose their mental health history, and this merely registers a blip in the blogosphere.

Is this all a pipe dream? Not necessarily, but it would require five key areas to be pursued over the next 25 years:

- A sustained and long-term commitment to public education about mental health, including directly addressing stigma and discrimination;
- A focus on speedy and effective person-centred services, which enable early intervention to take place and offer real choice of approaches, potentially backed by a right to access services such as therapy;
- Providing high quality care for the most vulnerable in our society;
- A cross-governmental approach to mental health policy, with a public sector responsibility for assessing the mental health impact of all legislation;
- Employers fully to embrace the business case for mentally healthy workplaces and embed it in their organisations.

Sadly, without these components, those ambitions could easily be reversed – less investment leading to more detention, poorer services and an increase in stigma.

Twenty-five years ago, *Wham* ruled the charts, most long-stay asylums were still open, and people were just starting to talk about community care. Anything can happen in a generation, but the approach they take to mental health must be a litmus test for all future governments.

Reference

HM Government (2009) *New Horizons: A shared vision for mental health*. London: HM Government.

No longer second class citizens

Paul Jenkins is Chief Executive of Rethink

There is no doubt that, in general, the prospects for someone developing a severe mental illness such as schizophrenia in 2010 are better than they would have been for someone in the same position in 1985. New investment has put some flesh on the bones of community care and new approaches to care, such as early intervention, have meant that it is possible that someone will get help before they are so ill that they have to be admitted to hospital.

This is progress and perhaps we should be grateful. However, any gratitude should be coloured by the recognition that, by any measure, people who have experienced a mental illness continue to be second class citizens. Second class in terms of their civil rights to be jurors or company directors or even MPs, if they have been undergoing hospital treatment for more than six months, and second class as candidates in the labour market in the face of continuing widespread discrimination from employers and a lack of appropriate support. Second class in terms of the response they receive from the NHS, their access to NICE [National Institute for Health and Clinical Excellence] approved treatments, such as psychological therapy, and in the attention given to their physical health care.

So how might the future be different?

First and foremost will be the continuing battle against stigma and discrimination. Not just as a way of correcting the current injustices faced by people who have experienced a mental illness, but also as a vehicle for normalising the concepts of mental health and mental ill health. When the majority in society see mental illness as their business, as something which could happen to them and their families, then they will exert the pressure on

politicians and other decisions makers which is required to deliver change. This is the journey that the ‘cancer lobby’ has made over the last 50 years and mental health would do well to emulate it.

The second priority must be to continue the development of an effective range of services, based on the principles of personalisation, prevention and early intervention that support recovery and social inclusion. Despite recent progress there is still a lot to do to. The *New Horizons* report (HM Government, 2009) puts down some important markers for the direction of travel but national strategy has to be matched by sustained investment. The recession and the impact of reductions in public spending could be catastrophic for what is still a very fragile system. We need the political will to protect and over time increase the proportion of health and social care budgets that are spent on mental health. Some of this should be funded by biting the bullet and diverting the budgets earmarked for expanding prison numbers to providing treatment and care for people affected by mental illness who avoidably end up in contact with the criminal justice system.

If we get it right, we could be at a tipping point. Severe mental illness does not have to leave a legacy of a lifetime of disability, poverty and social exclusion, as it does for many people now.

Reference

HM Government (2009) *New Horizons: A shared vision for mental health*. London: HM Government.

The next 25 years

Andrew McCulloch is Chief Executive of the Mental Health Foundation

Our country faces unprecedented challenges over the next 25 years. Our population will rise rapidly and we will live longer. But at the same time we will need drastically to reduce carbon emissions and probably to spend huge amounts on sea defences. Mental health may be well down any future list of government priorities yet as a nation we will require the collective mental capital to face these threats.

In mental health we can expect to see a rapid increase in knowledge and this may lead to further blurring of the concept of ‘mental illness’ as well as a better understanding of how we can stay mentally healthy. As increasingly effective treatments for illnesses like dementia arrive, services will be hard pressed to cope with demand. However, in theory at least, it may be possible to reduce the incidence of mental illnesses like depression where there are a range of effective treatments beyond but including pharmaceuticals, becoming more and more widely available.

Despite this backdrop my vision is essentially optimistic. I believe that increased understanding will lead to an increased ability for us to accept people with mental health problems and to invest in research, mental health promotion and treatments. I suspect that a more integrative approach to health will help because there will be a less simplistic mind/body dichotomy. We will start to recognise phenomena such as medically unexplained illness for what they really are. We will also have much more strategic approaches to mental health in areas such as criminal justice and employment. And I hope that by the end of the 25-year period we will see a major reduction in the remaining institutional approaches to mental ill health such as psychiatric hospitals, with more local approaches for those who still need a place of safety. We will also see a population better equipped to look after their own

mental health and if necessary better able to access a range of cost effective treatments. This could lead to a reduction in the incidence of mental illness or at least a shortening of the duration, severity and recurrence of crises.

Many solutions will have to combine being science driven with being economically beneficial. This is not necessarily something to be afraid of. My vision is that more ‘value for money’ solutions will be available for mental health problems such as group psychotherapy, solution-focused interventions and practical low-cost support for the problems of daily living. Professionals will, of course, remain and some will be highly specialised, working mainly in knowledge transfer to support and empower others. Solutions will be adapted more to the unique needs of service users and families, but will rely less on buildings and institutional approaches.

Critical to achieving maximum economic benefit is early intervention both in the course of mental illness but also in the life cycle. Part of my vision is that effective, practical interventions will be offered during the pre-birth and infancy period using generic workers such as health visitors and nursery staff, together with non-judgemental parenting programmes and advice. Universal mental health promotion interventions around emotional literacy and psychological first aid should also play their part in helping to build individual and family resilience. In a sense the vision is not just to prioritise mental health but also to move beyond it to a more integrated view of individual, family and community health and wellbeing.

Recovery and beyond

Ian McPherson is Director of the National Mental Health Development Unit

One of the, admittedly few, advantages of having been involved in mental health services for almost 50 years in a variety of overlapping roles (clinician, trainer, manager, policy advisor and service user), is that it gives a long-term perspective from which to consider future developments.

Specifically, having seen massive changes, from the closure of the institutions to improved access to psychological therapies, it is reassuring to realise that these have been achieved despite regular changes of government and frequent financial crises. Therefore, in considering what could happen over the next 25 years, while we have to acknowledge current pressures, we need to avoid being distracted from the long-term aims of improving the quality of services and the mental health of the whole population.

The report, *New Horizons: A shared vision for mental health* (HM Government, 2009), offers a broad framework for this based on a high level of consensus across differing communities of interest. The fact that *New Horizons* lacks targets or additional investment has caused some to question its value in driving change. However, while targets may have been central to establishing new services and increasing the overall level of provision, they do not necessarily in themselves improve the quality of services. Indeed, focusing on these may have sometimes distracted us from addressing basic concerns about what is currently available in our core mental health services.

In this respect, the fact that *New Horizons* was published during an economic downturn may be paradoxically advantageous. Having less finance may empower us to be more radical by forcing an open debate about how we are using existing resources and whether these are achieving the best outcomes for individuals or for society. In doing so we need to remember that recovery is

not just about individuals, but how we collectively engage in promoting changes that make a real difference, rather than allow current pressures to reinforce professional or organisational territoriality.

A related advantage of *New Horizons* appearing now is that there is increasing recognition of how the economy affects the mental health of the population and how mental health affects the economy. This makes it clear that a co-ordinated response from many agencies is required, not just from mental health services. Improving mental health is a whole population agenda requiring a cross-government approach that focuses on improving wellbeing and resilience, as much as on providing effective interventions and support when problems arise.

Finally, in mental health we have a tradition of detailed debates on the potential value of differing interventions. While this is necessary to establish an evidence base, it is important to realise that in 25 years' time many of the approaches that we are debating now will have been superseded. Rather than contrasting particular models, as if they were competing descriptions of reality, we need to synthesise all the evidence at our disposal to achieve the ultimate aim of supporting the development of communities that promote positive mental health and services that can be used with confidence by our families, our friends and ourselves.

Reference

HM Government (2009) *New Horizons: A shared vision for mental health*. London: HM Government.

Professionals: from centre stage to the wings

Rachel Perkins is Director of Quality Assurance at South West London and St. George's Mental Health NHS Trust and is lead author of *Realising Ambitions: Better employment support for people with a mental health condition*

The most common prescription for improved mental health services is to spend more – on bigger, better and faster services. While better and faster may be desirable, I would challenge the need for bigger mental health services. The aim over the next 25 years should be to reduce the centrality of mental health services in people's lives and completely rethink the balance between professional help and wider support with life – based on peer learning, support and coaching. This would make more difference to people's lives than increasing professional support of any kind.

In 25 years it should be as absurd to think of someone's primary identity as a 'mental health service user' as it is now to identify as a 'general practice service user'. Mental health services, like general practice, should be there in the background, providing easy access to the best treatment available when needed to assist people to thrive in all the roles that are important to them: as partners, family members, workers, football players ... not just 'mental health service users'.

This is not a call for mental health services in primary care. Nor for a transfer of services from the statutory to the voluntary, or indeed private, sector. It is a call for a fundamental change in the role of mental health services.

Mary O'Hagan argued in *Parting Thoughts* – on her departure from the New Zealand Mental Health Commission in 2007 – that mental health professionals often prevent people from recognising their own

resourcefulness (O'Hagan, 2007). Services perpetuate marginalisation, albeit unwittingly, in a kind of vicious cycle.

As large professional mental health services have developed, people experiencing mental distress have increasingly come to believe that expert professionals hold the key to their problems. Their nearest and dearest believe that those they love are unsafe in their untrained hands: they should leave it to the experts. This means that everyone becomes less and less used to embracing cognitive and emotional distress as a part of everyday life. And those with mental health conditions remain stuck in services and the identity of 'mental patient' eclipses all other roles.

In short, the assumption that mental health professionals and services have a monopoly on expertise has disabled both communities and individuals.

Following Judi Chamberlin's groundbreaking 1978 work, *On Our Own*, we know that people with mental health conditions can individually and collectively find their own solutions. The early work of Richard Warner found, for the most part, an inverse relationship between recovery from schizophrenia and the number of learned mental health professionals around (Warner, 1985). Traditional mental health professionals do not hold the key to recovery. Pioneering services like Recovery Innovations (META) in Arizona (www.recoveryinnovations.org) show that much of what has traditionally been done by professionals in mainstream mental health services can be better achieved by a different kind of workforce: one where the majority of traditional workers have been replaced by peer support specialists. This creates a new form of relationship, based on mutuality and a shared journey where people can learn and grow as equals.

The technical expertise of traditional mental health professionals remains important, but must be viewed and used in a different way. Professionals should be 'on tap' rather than 'on top': putting their expertise at the disposal of those who may need it; easily accessible when it is needed, in the background when it is not; recognising and augmenting the expertise of lived

experience; supporting individual and community resources and resourcefulness and helping people to find their own solutions.

However, most of what mental health services currently provide is not specialist, technical treatment but day-to-day support. Whether as a consequence of mental health conditions, physical impairments, trauma of war and migration, learning disabilities, addiction issues, dementia, or other slings and arrows of outrageous fortune, some people will need assistance to negotiate our increasingly complex world. This is not a specialist therapeutic exercise, or ‘mental health’ service, but one more akin to coaching that should be available to all citizens who need it and might best be delivered by peers who have experienced similar challenges. Such a support service would stop the currently too common situation where people facing multiple challenges are handed between, and deemed unsuitable for, the different ‘specialist’ services.

The most challenging decisions ahead are not how to increase access to professional services but how to maximise life chances and enable people with mental health conditions to make the most of their lives. The real challenge is how to do things differently and use resources differently: to recognise the limitations of traditional professional expertise, the value of the expertise of lived experience and to rekindle the belief that citizens hold most of the solutions to human problems.

References

Chamberlin, J. (1978) *On Our Own: Patient controlled alternatives to the mental health system* 1988 edition. London: Mind Publications.

O’Hagan, M. (2007) Parting Thoughts, *Mental Notes* No. 18, September 2007.

Warner, R. (1985) *Recovery from Schizophrenia: Psychiatry and political economy* (2nd edition). London: Routledge.

Talking about our mental health

Lisa Rodrigues is Chief Executive of Sussex Partnership NHS Foundation Trust and Chair of the Mental Health Network, NHS Confederation

In my job, I get asked to a lot of wonderful things, but rarely do I have the privilege of doing something as exciting as predicting mental health changes over the next 25 years.

Twenty-five years ago, when Sainsbury Centre for Mental Health began, I was at the University of Sussex studying psychology. The asylums were closing. And as a nurse and health visitor, I already knew what community mental health services could do to help people.

A GP asked me to visit a woman who, it turned out, had untreated postnatal depression. She hadn’t been out of her house since her husband left several years before, and slept on a folding bed with her eleven-year-old son. Tree branches had grown through the windows and birds were living inside, roosting among the remains of rotting food. Her hair was matted, her nails talons, her clothes unspeakable. She seemed physically and psychologically frozen. When I eventually persuaded her to speak, her voice was a croak. But within four weeks of joining a voluntary group, being allocated a CPN and starting anti-depressants, she was unrecognisable. Six months later she had a job and was looking after her boy, not the other way round.

Mental health services don’t usually get into the headlines unless something has gone wrong. We are expected to prevent people from hurting themselves or someone else, and at the same time use minimum interventions and maximise choice. People with serious mental illness have not been inclined to

speaking out about their experiences, for fear of being ostracised, because of the attitude of some newspapers and others to anyone who seems a bit fragile.

But all that is changing. A few brave souls are coming forward. I predict that in 25 years, talking about one's own mental health will be commonplace.

As mental illness comes out of the closet, its massive financial and social impact will hopefully be looked at more rationally. Over the next 25 years, I believe there will be increased investment in research and development in the mental health field. As a result, I predict we will have more agreeable and individually tailored treatments for schizophrenia, bipolar disorder and Alzheimer's disease, which will in turn reduce reliance on services and state benefits.

And finally, before the Sainsbury Centre 50th anniversary, I hope as a nation we stop ignoring the negative impact of alcohol on mental health and wellbeing. Drinking alcohol is very nice for those who can take it. But it is also highly addictive, and when drunk to excess reduces inhibitions and makes people do things they later regret. And it is a depressant. What very few people know is that many years ago I briefly used mental health services myself. Like many people, I thought alcohol helped, but in the end I found that giving it up was one of the best things I could do to improve my mental health.

Helping people to find and keep jobs

Susan Scott-Parker, OBE, is Chief Executive of Employers' Forum on Disability

The last 25 years have heralded a significant attitudinal shift around all aspects of mental health, particularly mental health and employment. The language of mental health has changed from 'care in the community' to the 'New Horizons', 'Realising Ambitions' and 'Inclusion' of recent reports. We have also witnessed extensive changes to the way that welfare-to-work services and support are delivered.

The changing landscape means that the moment is now right to strengthen our efforts in getting people with a mental health condition who can work into employment. This amounts to around 42% of the 2.6 million people on health-related benefits. Not surprisingly, people with mental health problems have the highest 'want-to-work' rate of any disabled group, yet fewer than four in ten employers are willing to, or know how to, take them on. Indeed the low expectations of this group's employability are often shared by those involved in mental health related service provision.

Unemployed people with a mental health condition are now 'pushed' towards the labour market through a complex array of public initiatives and schemes. Disappointingly, this approach often fails to make a real difference. While the stigma surrounding mental health is undoubtedly a factor, the systemic failure to meet the needs of the employer and line manager, as well as the individual, make it unnecessarily difficult for more people to find and keep jobs. Fortunately, there is some good news on the horizon. The 'Access to Work' scheme is piloting a more targeted and flexible provision for this group and the Department for Work and Pensions is providing an occupational

health advice line for small businesses; both are encouraging steps in the right direction.

If we want employers to recruit from this talent pool, we need to understand what the employer needs if they are to say ‘yes’ to a job candidate. We need to make it easier for both the employer and the person, by providing support to managers while putting a stop to unnecessary barriers to employment such as complex benefits packages. Employers need practical advice on workplace adjustments and how to meet the duties of the Disability Discrimination Act (DDA). Recruitment agencies and welfare-to-work contractors, tasked with getting people into employment, must also be able to deliver good quality, job-ready candidates to employers to fit the vacancies available.

Many employers want to employ people with mental health conditions but do not know how. By giving individuals control over their funding streams, and making it easier for the employer to say ‘yes’, there is the opportunity to transform the labour market. Traditional employment-related systems need to evolve and adapt in the same way as power over individual budgets is adapting. If current routes to the job market are not working for individuals, there is an opportunity to create alternative ones.

Progress has been steady but there is still a long way to go before the talents of job hunters with mental health conditions (and of those at risk of losing their jobs) can be fully realised. If we want to make the most of the opportunities the current focus on mental health affords us, we need to raise expectations across the system regarding the potential of employers and people with mental health conditions to make it work.

No health without mental health

Steve Shrubbs is Director of the NHS Confederation’s Mental Health Network

Over the next 25 years I believe we will see meaning put behind the term ‘there is no health without mental health’. Governments will realise that the mental wellbeing of individuals and communities is as important as the current focus on obesity and coronary health. Public health strategies will have funded programmes which deliver the interventions currently described within the *Foresight Mental Capital* report (Kirkwood *et al.*, 2008).

People who need to use mental health services will as a matter of routine have access to individual health and social care budgets and will use them to ensure that they do not become disconnected from their families, friends and work. As a result, service providers will offer personalised care and support. Peer provided services will be part of the landscape.

Access to services will be easier and more direct. Primary care will offer mental health services as a key part of their work. They will offer not only psychological therapies but properly resourced services providing direct care without referral on to specialist services, which often in the past have functioned at a distance from primary care.

Services will be judged by life outcomes and specialist services will have a significant focus on employment and housing. Mental health services will have developed new relationships with schools. Supporting the emotional wellbeing of children will be a key priority. Intervening early will be seen as economically and morally the right thing to do.

Services for people with long-term conditions will be commissioned by single organisations. They will focus on a range of support much of which will come from beyond conventional health services.

Criminal justice mental health services will ensure that we no longer imprison vulnerable people.

The national anti-stigma and discrimination programme, meanwhile, will be funded by government and will be celebrating its most recent evaluation with the lowest levels of stigma recorded anywhere in the world. This will be underlined by the Prime Minister praising the mental health treatment he has recently received.

Reference

Kirkwood, T., Bond, J., May, C., McKeith, I. & Teh, M. (2008) *Foresight Mental Capital and Wellbeing Project. Mental capital through life: Future challenges*. London: The Government Office for Science.

The world in 2035

Su Wang is an accredited specialist occupational physician

“Living a life that has a sense of purpose and meaning is also important for our mental wellbeing; whether it is achieved through work, family, volunteering, or through developing creativity and shared values.” *New Horizons* (HM Government, 2009)

2035: *iPad news headlines: All targets achieved. Instant access to mental health care with the latest evidenced-based therapies. Full access to employment, no stigma, no discrimination. Full engagement with organisations across national and local government, voluntary and statutory agencies, as well as local communities and individuals. Everyone working towards a society that values mental wellbeing as much as physical health. And yet ...*

Prediction is a risky business. At the start of the technological revolution predictions included easier work, copious leisure time, retirement by age 50. Time has revealed otherwise.

By 2040, China and India are predicted to overtake the western world in economic and social development. Poorer economies are associated with poorer health provision and poorer health. But wealth is not the answer, as evidenced by psychological distress and the rise of medication for anxiety and depression. By 2035, UK demographics will show an ageing population and the increasing impact of dementia on individuals, families and communities.

A baby born this year will be 25 years in the new world. What will be the challenges? I will limit myself to three.

1. The business case

UK Plc will need to recalibrate thinking about our place in the global economy, our power and prestige, and reappraise national identity. Within the context of health and wellbeing, mental health should be reintegrated with physical health because physical health affects mental health, and poor mental health brings poorer physical health outcomes. Financial reporting will need to be redesigned. Mental health budgets should relate to regional community measurements and be presented as a mental health business case, showing the return on investment (i.e. impact on the community). Social outcome measurements should include crime rates, unemployment rates and health morbidity. This integrated thinking means that, for instance, the cost impact of mental health on policing will be quantified. Each region should have interventions to better or aspire to national norms.

2. Technological change

2035 people will be the children of Facebook, Twitter and electronic devices. To communicate we must dream alongside them and participate in their world. They may be more isolated (iPODs, earphones, handheld devices), with different social skills. The nuclear family, the building block of society, may be in decline as different associations, loose or permanent, prevail and change communities. We should start building health social networks, Facebook equivalents, and virtual communities.

3. Clarity

An integrated model requires moving onwards from the diagnostic and therapeutic model. Mental health is not a commodity 'out there' for purchase, in the form of a pill, or some talking therapy, which makes no recognition of the 'inner' life. Patient rights and human rights tempt medicalisation of society's difficulties. A key challenge for mental health professionals is to offer clarity about what is within their remit, and what is not, and how to lead

the way. Education in mental health hygiene, responsibility, and self-care are fundamental blocks to be built into the new model.

New Horizons has summarised it well. Human beings thrive when life has purpose and meaning. Without identity mankind is lost. The search for identity goes beyond material wealth and pleasures to spiritual wealth. Man shall not live by bread alone stands the test of time.

Reference

HM Government (2009) *New Horizons: A shared vision for mental health*. London: HM Government.

Communities of diversity

Melba Wilson is National Programme Lead for Mental Health Equalities at the National Mental Health Development Unit

The challenges and the priorities in mental health over the next 25 years should be about accurately understanding and reflecting the needs and aspirations of individuals and of communities of diversity.

‘Communities of diversity’ is a more useful description for what we now refer to as black and minority ethnic communities. One of the key learning points for many of us who have been directly involved in promoting equality and reducing inequality, is that this term is not always helpful in enabling a real understanding of the richness which exists within and between communities. This can locate itself in race, but can also relate to other aspects of how people live their lives – age, gender, culture, faith, sexuality – and may include physical disabilities.

Such a shift in thinking and terminology could lead to systemic responses based on a flexible view about individual need, one which started with the person – not the diagnosis nor the stereotype.

The longer term implication would in turn mean that effective approaches for people with mental health problems could and would better encompass issues of equity, social inclusion and social determination.

These are not new concepts and they formed the basis of the World Health Organisation’s Investment for Health Charter, more than 20 years ago, and are echoed in the excellent report on health inequalities by Dr. Lynn Friedli.

It requires (to paraphrase the Investment for Health Charter) viewing the promotion of good health and mental health within a context that values:

- Building healthy public policy across government and other social institutions;
- Creating supportive environments (real or virtual) to foster a catalyst for change;
- Strengthening community action and engagement;
- Developing personal skills; and
- Re-orienting health and public health services.

This is not just a mental health agenda, but a public health one.

Success requires tapping into strengths and resiliencies at an individual as well as a community level. Ultimately, it is about developing and building good relationships in a range of contexts and environments. It involves having a keen ability to make connections and an ability and awareness to address visible as well as invisible barriers to change. It is, quite literally, about improving the quality of conversations in a range of spheres.

In many ways it is the shift which has been signalled within the *New Horizons* mental health strategy (HM Government, 2009). This emphasises:

- Making everyone’s mental wellbeing better;
- Helping everyone to understand mental health problems and not to treat people with mental health problems unfairly;
- Spotting mental health problems early;
- Providing services and treatments in ways that meet people’s individual needs;
- Ensuring people have a say in the treatment they get; and
- Making it easier for people to find and get the help they need.

Sainsbury Centre and others are well placed to lead this agenda by helping to promote and support a new language and a new discourse which recognises and acknowledges this shift.

References

Friedli, L. (2009) *Mental Health, Resilience and Inequalities: A report for WHO Europe & the Mental Health Foundation*. WHO/MHF: Copenhagen/London.

HM Government (2009) *New Horizons: A shared vision for mental health*. London: HM Government.

SAINSBURY CENTRE
for MENTAL HEALTH



removing barriers achieving change

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

Charity registration no. 1091156. A Company limited by guarantee
registered in England and Wales no. 4373019.