Promoting Mental Health in a Civil Society: Towards a strategic approach

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The Nuffield Trust

The Nuffield Trust for research and policy studies in health services was estabUshed by Viscount Nuffield in 1940. Today the Trust acts as an independent commentator on the UK health scene and the National Health Service. It has set out to illuminate current issues through informed debate, meetings and publications and has also commissioned research and policy studies aimed at the development of policy and improvement of health services.

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Foreword

Mental health problems are projected to be by the year 2025 one of the largest pressures on health care resources. Mental health services have been subject to constant reorganisation during the last 40 years yet there is little evidence that existing mental health institutions will be equipped or indeed appropriately configured to respond to this. To provide a starting point in considering alternative ways of addressing this problem, the Trustees awarded a grant to Professor Morton Warner to consider the challenges facing the providers of mental health services in the twenty-first century and the responses in terms of redesign, as distinct from reorganisation, that might be appropriate to meet these needs, with the overall objective of developing a strategic intent and direction for mental health in the United Kingdom which is inclusive in design, recognising the potential contribution of all sectors of a civic society.

The publication demonstrates that there is a clear national commitment to improved mental health services but asks, where is the strategic framework to bring in education, employment, housing and all those other aspects of a civil society that could do so much to maintain people's mental health. The premises for the work were:

- that the United Kingdom *should* develop into a more civil society;
- that the terms "mental health" and "mental health promotion" are functionally useful;
- that mental health can be improved and mental illness minimised by society action;
- that mental ill health should be a priority area for society;
- that current policies towards mental health are inadequate.

This highlights a paradox. If it is true that mental health is a major problem for society as a whole and society has the means to address it, why have recent policies been so inadequate? Professor Warner and his colleagues conclude that there has perhaps been a general lack of confidence in and desire for public health measures to promote mental health even though the cost of mental ill health and disease are obvious. This is a major challenge for those interested in developing a strategic approach in this area.

This publication, with its recommendations and the development of a strategic approach, is an important contribution to promoting mental health in a civil society.

John Wyn Owen, CB
London: December 2000

SECTION I
EMERGING MENTAL HEALTH POLICY

A critical review

This report considers several of the areas of everyday life where there is scope to protect and improve people's mental health. Previous governments have taken a very different approach, being far more concerned with caring for those who already have mental ill-health. The present government came to power with the avowed intention to develop policy with a health - rather than ill-health perspective. This section reviews how far they have been successful in this regard.

Public Health Policy

In 1998, government set out its strategy for public health in a series of White Papers. In England, for example, the two key policy objectives were to improve health and reduce the health gap (health inequalities). This was to be achieved through an emphasis on the 'four big killers'- Cancer, Heart Disease and Stroke, Accidents, and Mental Health - in England and Wales.

While the White Papers aim to set out 'the best way to improve everyone's health', their focus is actually on reducing death rather than the promotion of health *per se*. The agenda for mental health shows this clearly - the English document, for example, aims to 'reduce deaths caused by suicide and undetermined injury by at least a fifth by 2010'.

However, while the national approach to public health is orientated to reducing the incidence of the most serious mental illness and, therefore, at only a portion of the broader theme of this document, it does set out to show 'how we can all make a difference'. *Our Healthier Nation*[1] states: 'Working together, individuals, communities and the Government can save lives by preventing needless and untimely deaths. By tackling poor health, we can all live longer and live healthier.'

In this vein, there are certainly substantial resonances with the broad strategic view taken of mental health promotion in this report. Strikingly, while the target for mental health suggests that the major concern is with early detection of risk of self harm arising from mental disorder and mental illness, actions taken in each of the other three killers could have powerful impacts on sustaining and improving mental health more broadly, if only as bi-products.

Mental Health Policy

There is a clear national commitment to 'improve mental health services'. Certainly, if the volume of consultation documents and Green and White Papers is used as a yardstick, changes to mental healthcare are a high profile part of the health and social care agendas.

These official documents stand against a broad framework for modernising the NHS provided by the White Paper for England, *The New NHS,*[2] and its equivalent for Wales, *Putting Patients First.*[3] The aim is to 'provide effective and safe services more easily and quickly, in an acceptable and fair manner, making the best use of resources'. *Modernising Social Services*[4] sets a similar agenda in England to support welfare reform and social inclusion by 'promoting people's independence, improving the protection of vulnerable people and raising standards....' Similar themes emerge from the Welsh White Paper on social services, *Building for the Future.*[5]

At first sight, these titles and statements might suggest an approach to healthcare policy in which safeguarding or promoting mental health, as broadly defined, is given increased prominence. In part, this may become the case through the broader public health programme. However, the weight of evidence on mental health policy development suggests that, in parallel, much more time, effort and attention is being given to responding to people who have established disorders or who present society with the most demanding challenges.

The key thematic White Paper for England, *Modernising Mental Health Services,*[6] sets out'a radical programme for improving mental health care and building public confidence in mental health services' Whatever the reality that stems from this claim, the government's vision for English mental health services is clear in that the approach in this document, as in the later and much more detailed mental health *National Service Framework,*[7] published after an extended wait in 1999, reflects that quotation. The intention is that services should be 'Safe, Sound and Supportive'. Evidently, the orientation of these policy documents is to targeting people with established disorder, reducing dangerousness and forecasted risk of danger both to the public at large and to the self.

Elsewhere in the UK the governments of Northern Ireland, Scotland and Wales are also propelling the development of mental health services. While it appears that the different governments are pursuing broadly similar mental health policies, early signs are of differences in content, priority and emphasis and also in methods and style of implementation.

For example, the recent policy document on the health service 'Modernisation for Wales[8] confirms that mental health is included in the three top priorities. In 1999 the National Assembly commissioned a review of Wales' mental health strategy for people of working age. Consultation on a draft has taken place and the final strategy is at an advanced stage of preparation. Presently, the degree to which the National Service Framework (NSF) developed in England will be adopted in Wales is unclear. Similarly, Wales is to have an All Wales Strategy for Child and Adolescent Mental Health. This will be the first time such a national strategy has been produced in the UK. Consultation on a draft yielded strong consensus on the main themes and it is understood that the final version should be available during 2001.

The broad thrust of both of these two strategies, and the priority afforded to mental health by Ministers, has received strong cross-party support from Members of the National Assembly for Wales. Gradually, in this way, Wales is reviewing or introducing mental health policies and strategies for each of the main client groups.

Approaches to *implementation* of policy vary across the UK. By contrast, England has appointed a Director of Mental Health to oversee implementation of its NSF, whereas, so far, this is not the chosen route in Wales. In April 2001 the Health Minister told the Assembly that she is to establish All Wales Implementation Groups for the first two mental health strategies. Judging from the consultation documents (in the public domain since mid 2000) and the NHS Plan, the approach being taken in Wales is a broad one that emphasises:

- The importance of strategy as a link between policy and practice through involving all key stakeholders, including users, clinical staff of all disciplines and service managers;
- Strengthening the accountability for action on policy and strategy between components of the NHS and the Assembly;
- The role of communities and, within them, Local Health Groups as responsible for commissioning healthcare within each local authority; and
- The importance of partnership between services and between the public, voluntary and independent sectors of care as key to success.

In summary, there are many overlaps in policy and priorities across the countries in the UK, but each is also adopting its own distinctive approach and style. This reflects devolution in the UK, with each country assuming direct responsibility for healthcare services and the differing needs of their populations. But core issues in common for all appear to be:

- How to connect policy to the services received by users through practice and service management 'policy connect';
- How to manage the translation of older style services into more modern approaches without losing core values;
- How to achieve a workforce of sufficient size and training working to agreed standards of quality.

Each government appears to be taking a distinctive approach and a review in years to come may yield interesting comparisons and insights into success factors in strategic leadership.

Other clues as to the overall intentions for the direction of mental healthcare emerge from recent key documents. Three streams of policy development are relevant relating to:

- Reform of the Mental Health Act 1983;
- Mental incapacity; and
- Managing dangerous people with severe personality disorder (now dubbed with the acronym DSPD).

Together, these could also be taken as reinforcement for a conclusion that government policy is presently focusing upon more severe disorder, protection of those who are unable to express their own views, dangerousness, public safety, and the legal framework for decision making.

In 1998, the government established a Scoping Review as a prelude to formulating its own proposals for a new Mental Health Act. A range of research studies into performance of the current Act was also commissioned. In November 1999, three documents were published together by the Secretary of State for Health and the First Secretary of the National Assembly for Wales:

- The report of the Scoping Review;[9]
- The results of the research;[10] and
- A Green Paper seeking opinion on the proposed changes.[11]

The overriding priorities are reflected in four guiding principles for mental healthcare:

- Informal care and treatment should always be considered before recourse to compulsory powers;
- Patients should be involved as far as possible in the process of developing and reviewing their own care and treatment plans;

- The safety of the individual patient and the public are of key importance in determining the question of whether compulsory powers should be imposed; and
- Where compulsory powers are used, care and treatment should be located in the least restrictive setting consistent with the patient's best interests and safety and the safety of the public.

Overall, the Green Paper suggests enhancing some protections for patients through a new type of Tribunal, and a simplified set of compulsory procedures based on a broad definition of mental disorder. Some have expressed concern that this definition, when taken together with apparent removal of a treatability requirement, or without dealing with the position of those who have disordered personalities, could result in more people being cared for compulsorily.

The Green Paper states, 'A separate, but related area of policy development, is the work we are doing to address the problems presented by the small group of people with severe personality disorder who because of their disorder pose a risk of serious offending.[11] The Department of Health also states 'The focus of the proposals in the July [1999] consultation paper, as with the proposals set out in this paper, is on managing risk and providing better health outcomes within a framework that safeguards the rights of individuals and the interests of the public'.[12] The consultation period on the options - which included the controversial possibility of moving to a form of preventative detention - ended in January 2000.

In December 2000 the Government produced a White Paper outlining its intentions for a new Mental Health Act. So far it is unclear when a Bill will be brought before Parliament, though this is anticipated soon. It is in two parts which highlights the weight of concern:

Part 1,'The New Legal Framework'[14], outlines key changes to current legislation. Substantial changes are proposed to the mechanisms whereby certain mentally ill people may be lawfully detained. At once the proposed orders appear simpler than before but also much more demanding of legal and professional time, testing and monitoring. The mechanisms appear to be modelled on and, in effect, to bring the Care Programme Approach (a policy in England since the mid 1990s) into statute for formally detained patients. Other changes to be put to Parliament may well include alterations to the wider framework for consent by minors, and a new array of safeguards to protect the interests of patients includes formal patient representation and a Commission for Mental Health. The new framework encompasses the legal requirement for certain people to submit to treatment in the community in defined circumstances.

Part 11,'High Risk Patients'[15], deals separately with mental disorder and public protection and, particularly, with managing Dangerous People with Severe Personality Disorder (DSPD). The government proposes to introduce new statutory powers for the assessment and treatment of high risk patients in civil proceedings and to alter the present framework for the assessment and treatment of high risk mentally disordered offenders. Substantial service developments are proposed.

There appears a view, widely expressed in mental health services, that the intentions of Part 1 of the White Paper might prove unrealistic with present staffing levels and resources. A Workforce Development Plan that is successful in recruiting many more staff and in persuading others to delay retirement plans is seen by professionals and managers as vital to effective discharge of the tasks framed by the White Paper. There are widely held professional concerns about the DSPD proposals.

Finally, there is the work undertaken by the Lord Chancellor's Department on policy for changes in the law relating to mentally incapacitated adults. The proposals, published in October 1999, for making decisions on behalf of mentally incapacitated adults[16] were followed by its consideration of responses to the proposals contained in *Who Decides?*[17]

Summary

National policy, therefore, is generally supportive of a broad, inclusive and 'joined up' approach to health promotion, and sets mental health firmly within this context. However, most attention has actually been devoted to the development of detailed policy for mental health *services,* and for the appropriate protection of the public from those with mental illness. Such issues are clearly important, but largely irrelevant to maintaining and improving the mental health and well-being of most citizens.

SECTION II
PROMOTING MENTAL HEALTH

A strategic approach

During the course of 1998, a small group of people from a variety of backgrounds* came together to explore the potential role of the 'civil society' in maintaining the mental health of its citizens. The remainder of this document summarises the conclusions of their work.

The impetus came partly from a sense of frustration. Mental well-being is substantially a product of the way in which society treats its individual members. Exclusion from those aspects of social life and functioning that most people regard as essential - education, employment, shelter - is often clearly harmful to mental health. However, the policies of successive UK governments have failed to recognise this. There has been a series of well-meaning attempts to provide effective and humane services through the NHS - working in collaboration with a limited range of other agencies, such as Social Services Education. But where is the strategic framework to bring in education, employment, housing and all those other aspects of the civil society that could do so much more to maintain people's mental health?

Drawn together by their interest in developing a better way to promote mental health at the beginning of the 21st century, the brief was to break out of the confines of short-term pressures and constraints. The task was to think beyond the self-imposed artificial boundaries of particular organisational 'boxes'- *society* has a problem with mental ill-health, *society* must address it. The goal, therefore, was:

> *To develop a strategic intent and direction for mental health, which is inclusive in design and recognises the potential contribution of all sectors of a civil society.*

Strategic here refers to long-term change, requiring the mobilisation and co-ordination of a wide range of resources. *Intent* is the ultimate objective of the strategic approach; and the *direction* comprises the various interlocking objectives and 'nature' of the journey to be undertaken.

As the previous section has shown only over the past eighteen months or so has there been the development of a new policy framework in this area. This is to be welcomed, but of course - as with all public policy - it represents a compromise. An additional purpose here is to provide a statement of key principles by which to assess the emerging policies, and to highlight areas for further work throughout the UK.

The starting points

There were several premises on which the exploration was founded, and which underpin the rest of the discussion.

* See Annexe

1. That the UK should develop into a more civil society

The definitions of 'civil society' are legion, and much disputed at the margins. For our purposes, the term was taken to indicate a society in which there is considerable recognition of mutual dependence and responsibility between citizens, and which acknowledges that collective behaviour and attitudes can both support and undermine the mental health of individuals in areas such as education, employment, and shelter and community. A civil society would wish to ensure that its members are not excluded from vital elements of communal life, and would take collective action to improve the preconditions for individual mental health.

2. That the terms 'mental health' and 'mental health promotion' are functionally useful

The definition of Mental Health used here is borrowed from a 1996 WHO document:[18]

- A positive sense of well-being;
- A belief in one's own worth, and the dignity and worth of others;
- The ability to deal with the inner world of thinking, feeling, managing life and taking risks;
- The ability to initiate, develop and sustain mutually satisfying personal relationships; and
- The ability of the mind to heal itself after shock or stress.

The promotion of mental health is an umbrella concept covering all positive activities, including individual, inter-actional, structural or cultural approaches, aiming both to increase the value and visibility of mental health, and to encourage concrete efforts to protect, maintain and improve it, the WHO publication concludes.

3. That mental health can he improved - and mental ill-health minimised - by societal action

Mental health is not a state determined by factors outside human control. It is possible to identify a set of circumstances that is likely to impair people's mental health, and similarly, which will support it. Such circumstances can be greatly affected by collective action.

4. That mental ill-health should be a priority area for society

The burdens of mental ill-health are enormous. It causes suffering, disability and premature death on a scale comparable to the worst physical illnesses, and affects individuals, their families, the economy, and society at large. The recent work by Murray and Lopez,[19] which projects disability-adjusted life years through to 2020, indicates a significant presence of mental ill-health for both men and women amongst the top ten items. Since much of it is avoidable, or can be minimised or remedied, promotion of mental health manifests all the criteria necessary for it to be made a major public health priority.

5. That current policies towards mental health are inadequate

There has been much debate about mental health services, and almost all observers agree that they are far from perfect. But there is a marked absence, even of significant debate, about

society's strategy for mental health or well-being. Current approaches are piecemeal and fragmented, where they exist at all. There is an urgent need for concerted, 'joined up' policy in this field, which brings in all the stakeholders and does not leave sole responsibility for mental health in the hands of the NHS and Social Services. The strategic intent and direction identified later will be an important element in this.

A paradox... and a challenge

To the dispassionate observer, the foregoing premises constitute a major paradox. If it is true that mental health is a major problem for society as a whole, and that society has the means to address it, why have recent policies been so inadequate?

There are at least three parts to the explanation. *First,* the UK has for some years failed to develop as a civil society. Therefore, there is little appetite in popular political discourse for policies that seek to mobilise the various resources of society towards such a common goal. In part this may be a product of British history, in part the legacy of the political climate of the past two decades, in part the lack of inspired leadership. Whatever the cause, there are very few examples of co-ordinated, multi-sectoral public health initiatives in the UK, at least at the national level. A recent evaluation of the English Health of the Nation policy[20] - which began in 1991 - has shown clearly that little headway has been made in this area.

Second, the position of mental health itself is highly ambiguous. As a result, popular attitudes towards mental ill-health are often characterised by an unhelpful mixture of ignorance and misconception, fear and stigmatisation, and a false sense of personal immunity - 'it's not going to happen to me'. Although many of these features are also typical of attitudes towards physical ill-health, their particular mixture and potency makes mental ill-health significantly different from conditions such as cancer or cardiovascular disease. The result is often a lack of public willingness to address issues of mental ill-health.

Third, attitudes towards health promotion, of any sort, are complex. This reflects our view of disease and health, including what is perceived to be the fallibility of various attempts at health promotion, on an individual or collective basis. In the case of mental health, there seem to be just too many social factors that can influence it, that it is too easy to throw up one's hands in despair. Fundamentally, there is a commonly-held scepticism about our ability to improve health, especially through collective action.

Putting these elements together, there has perhaps been a general lack of confidence in, and desire for, public health measures to promote mental health, even though the costs of mental ill-health and disease are obvious. This is a major challenge for those interested in developing a strategic approach in this area.

Moving from the individual to the collective

It is not surprising, therefore, that what little mental health promotion has been practised has concentrated on the individual, and has often been based on secondary or tertiary prevention - i.e. addressing the needs of those who already have experience of mental illness. There have been some exceptions to this - including, for example, pioneering work with children, young people and families, where programmes to raise self-esteem, improve skills or tackle stress have

had notable success. But generally there has been almost no primary prevention of mental illness, either on an individual or collective basis.

There are various 'ways in' to primary prevention. One is to address *individual pre-disposing factors,* such as early childhood experiences, poor parenting, or stressful social and environmental events. In the future genetic interventions may be added to this armoury. Another approach is to look at *target groups in the population,* and quite a lot is already known about which features of society are predictors of mental disorder (Figure 1).

Figure 1 The main socio-demographic predictors of mental disorder

Predictor		Key features
1.	Homelessness	Multiple needs; difficulty in accessing services
2.	Age structure of the population	Needs, and availability of informal carers, vary with age
3.	Minority ethnic groups	Social disadvantage results in greater need; generally poorer access to health care
4.	Household composition	Lone parents and people living alone at a greater risk
5.	Unemployment	Short term impact of job loss; chronic health impact of long term unemployment
6.	Low occupational status	Lack of autonomy and control
7.	Inner city areas	Clusters of known risk factors eg poverty, unemployment, poor housing and services

Source: adapted from Jenkins, R., McCulloch, A., and Parker, C, (1996) *Nations for Mental Health: Supporting governments and policy makers* Geneva: WHO

A third way of categorising entry points is according to *methods of action and intervention.* Examples here might include dissemination of information, development of public services, integration of mental health issues into education and curricula, or re-orientating research on mental health towards improving the effectiveness of health promoting interventions.

Finally, one can concentrate on the *settings of interventions* - such as the family, day care, school, work place, health and social services, media, prisons or armed forces, or on the *level* - international, national, regional, local or individual - at which mental health promotion takes place. It is these last two approaches, in combination, which are taken here, although with frequent allusion to the others, according to the setting that is being considered.

The variety of factors conducive to supporting good health - and specifically, mental health - is displayed in Figure 2.

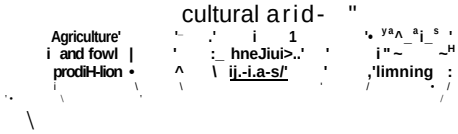
Here we focus upon key aspects of people's living and working conditions and on the social and community networks that are inextricably linked to them.

The sections which immediately follow (three to five) concentrate in turn on same key settings which can have a critical impact on an individual's mental health:

- Pre-school and school education;
- The workplace;
- Shelter and community.

Figure 2 The Main Determinants of Health

Figure 2 The Main Determinants of Health



Source: Dahlgren, G., *The Need for Intersectoral Action for Health*, in European Health Policy Conference: Opportunities for the Future, Vol 2, Intersectoral Action for Health. World Health Organisation, Regional Office for Europe, Copenhagen, 1996.

We do not consider the influence of the family in any great detail, or of other 'settings' such as the criminal justice system. This is not to deny the contribution which they can make to mental health or ill-health. The family, for example, is probably the single most important contributor of all to mental health. However, these settings are already appropriately high on the national and local policy agendas and much good work is taking place. The intention here, therefore, is to move beyond these topics, to map out the key elements for a strategic approach in settings which have hitherto received little attention.

The final section identifies some of the common strategic issues to emerge from the analysis of all three sectors which can form the basis of a strategic intent and direction for promoting mental health in the UK.

SECTION III
PRESCHOOL AND SCHOOL EDUCATION

Opportunities and barriers

It is the health promoting schools' movement[21] which has perhaps best summarised the essential feelings that we would want all children to have on a day-to-day basis: they should feel valued and secure.

There is now a considerable body of evidence which points towards the potential impact - both beneficial and harmful - of pre-school and school education on children's mental well-being. This ranges from the more obvious - bullying, for example - to the more subtle and complex - including the 'culture' of the institution and its attitude towards individual differences and development. There are also many examples of successful interventions with very young children aimed at supporting and enhancing the skills of their teenage parents. The impact of this early development, on mental health and other aspects of the child's growth, can of course carry through to adulthood.

However, difficulties of definition and measurement abound here, as they do in the other settings considered later. It can be difficult to establish cause and effect in relation to specific aspects of the environment and mental well-being - both at group and individual levels. This presents a particular problem in the current context of education where there is an overwhelming emphasis on the need to judge policy initiatives by their impact on government-selected, objectively measurable criteria (such as examination results). Many teachers argue that time spent on activities which they know from experience to be healthy for their pupils - play, for example, or the various activities labelled as 'pastoral care' - is difficult to defend against more time on subject-specific lessons which are believed to lead to better examination results. Herein lies the key policy dilemma: many of the critical things which influence good emotional health are not capable of definition in these terms, and are also the first areas to be disgarded or disinvested from when core curriculum is being considered.

This difficulty is made more acute as the propensity of central government to prescribe the content of the school day increases. The recent introduction of the 'Literacy Hour' is an example of this. However, it is also argued by advocates of this specific initiative that effective action to reduce adult illiteracy is a potent way of reducing social exclusion, and the potential associated mental ill-health. This demonstrates, in microcosm, the difficulties of evaluating different approaches in the absence of clear evidence on cause and effect and relative impact.

Lack of certainty, however, should not be an argument for inaction because there is sufficient consensus to suggest the way forward. One practical approach is to view the responsibilities of schools and similar institutions against Maslow's 'hierarchy of human needs' (see Figure 3). The fundamental (physiological) needs should be addressed first, progressively moving up through the hierarchy: only when all have been met can the school feel confident that it has discharged

its responsibilities in full. The outcome should be pupils (and ultimately adults) with the ability to achieve love, and feel joyful, and who are energetic and full of life.

Figure 3 Maslow's hierarchy of human needs

1. Self-actualisation
2. Esteem
3. Belonging and love
4. Safety
5. Physiological

Source: *Maslow, A., (1954)* Motivation and Personality *New York: Harper and Row*

To do this effectively requires the coordinated and concerted effort of the whole school - from the governors' policy-making level to the Head and teachers and including support staff and parents. It also means that the children themselves must be encouraged to participate in decision-making so that they develop an understanding of - and come to value - the civil society. There are many successful examples of this approach in action, in the 'health promoting schools' movement and elsewhere. These include:

- Schools which have developed a 'buddy' system of support by senior pupils for new pupils entering the secondary system;
- Training for primary school headteachers in promoting mental health which includes school 'action' planning, and the sharing of good practice on re-call days.

What they have in common is an inclusive approach that starts with local needs and develops local solutions, empowering the key actors in the process. The powerful impact of anti-bullying initiatives illustrates how the need for such strategies to safeguard mental health can easily be communicated to all concerned. It is easily apparent to all that failure to prevent bullying undermines the entire hierarchy of needs. The coverage afforded by Wales' national newspaper[22] to a recent conference on this subject in the Principality - the front page headlines and two full inner pages - demonstrates this clearly.

Teachers in particular have a crucial role to play - in the relationship that they have with pupils, in 'active listening', and managing change and stress. There is usually a series of 'balances' to be struck, which allows for progress and development, but in a way which minimises harmful consequences. For example, a balance between:

- major change and stagnation;
- imposition and spontaneity - finding the right locus of control; and
- authority and responsibility.

Teachers themselves need support in promoting mental health and emotional well-being, with a greater emphasis on employing effective strategies, both in their initial training and in continuing professional development. They need easy access to other professionals and agencies in order to clarify their own role and identify those who can contribute.

Finally, teachers are unlikely to be able to promote pupils' mental health if they themselves feel disempowered and under-valued. Attention therefore should be paid to teachers' well-being as

well as to that of pupils. The concerns raised in the following section - on mental health in the workplace - are equally valid for teachers.

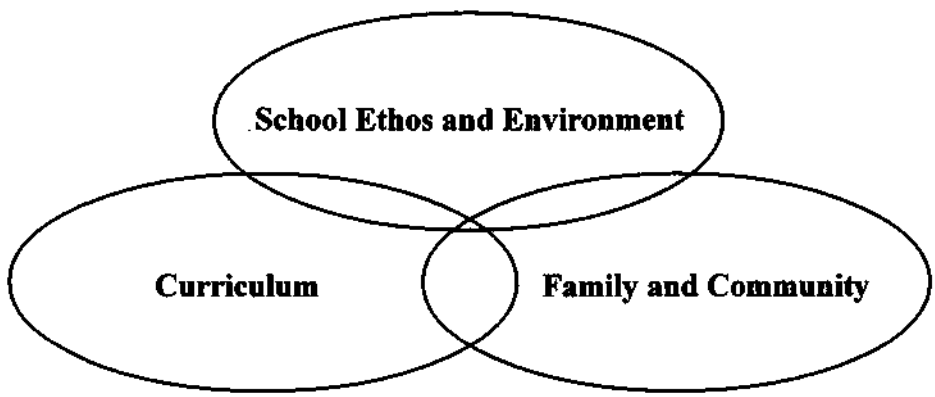
Strategic issues

Several key strategic issues emerge. If children are to be both valued and secure - a key objective - education must move beyond the principle of 'do no harm' and develop policies designed to 'do good' in the area of mental health. Three are particularly important - and mutually reinforcing (see Figure 4):

- school ethos and environment;
- curriculum;
- family and community.

Figure 4 Areas for strategic development to promote mental health in schools

School Ethos and Environment
For example:
- creating a climate which fosters good relationships, respect and consideration for others
- improving safety and security
- providing a stimulating environment (internal and external)
- effective policies related to mental health, e.g. anti-bullying, substance misuse
- clarity of boundaries (goals, roles and rules)
- involving staff and pupils in decision-making, e.g. through a school council or increased consultation
- developing pupils' self-esteem and confidence, e.g. through positive behaviour policies
- promoting the mental health of staff
- increasing awareness (of staff, parents, governors, pupils) of the importance of mental health promotion



The curriculum
For example:
- planning a coherent curriculum to promote pupils' mental health, e.g. through personal & social education
- education to increase emotional literacy
- education to increase understanding and tolerance of mental health problems
- teaching methods which encourage active learning and pupil participation
- providing stimulating challenges for all pupils though a wide range of activities

Family and community
For example:
- good liaison with pupils' parents and other schools on initiatives related to mental health
- effective use of outside agencies and specialist services, for advice and support as well as referrals.

Furthermore, there must be a much greater recognition of the importance of the issue of mental health and emotional well-being for mainstream education. This should include not only the potential good that can be done by schools and other institutions in terms of life-long mental health, but also of the harm that they can cause. Finally, the approach to promoting mental health should be inclusive not only of all those in school, but also of parents, local community groups and other statutory agencies with a role to play - some important constituents of a civil society.

SECTION IV
THE WORKPLACE

A neglected issue

Health in the workplace is an issue which has commanded attention from professionals and legislators for many years, with the result that there are numerous statutory agencies and occupational health departments with responsibilities in this area. But on the specific issue of *mental* health and the workplace there is a dearth of activity, or even interest, either in terms of minimising the harmful effects of employment on mental health, or in dealing with mental health problems derived from elsewhere when they present in the employment setting. Employers and trade unions have been equally neglectful in this respect; even occupational health departments, with their specific remit, have tended to devote little attention to mental health. Thus far it also has warranted only spare attention by the Health & Safety Executive.[23]

To a large extent this reflects the paradoxical position of mental health discussed earlier in Section Two. This is further complicated in the occupational setting where some of the risk factors for mental illness - such as conflict - are often unavoidable. To employers' ignorance of mental health issues can also be added the technical difficulties of the economic calculus: it is often impossible to *prove* the cost implications of not adequately addressing mental health in the workplace.

The relative neglect of mental health does not reflect the objective importance of the issues. The 1995 Household Survey, for example, suggested that an estimated 2 million people in Great Britain are affected by work-related ill health, of whom 500,000 had a stress-induced condition. Mental ill-health in the workplace results in disruption, financial burden for the employers and burdens on society. It is often met with a denial of issues, maladaptive mechanisms to 'manage' the problem and often exclusion of the individual with long-term disability. In short: misery for the individual, harmful effects on their family and economic, social and personal decline.

Causes of mental ill-health in the workplace

The causes of mental ill-health in the workplace are complex, numerous and problematic (given the relative lack of understanding of the aetiology of mental illness generally). There is a measure of consensus, however, about the importance of the following:

- Employing fewer staff to carry out the same volume of work, to 'increase efficiency';
- Increased hours, responsibility and workload;
- Problems with interpersonal relationships;
- Bullying, by colleagues or superiors;
- Discrimination, in its various guises;
- Bad working practices;

- Boring or repetitious work;
- Lack of individual control over work;
- Inadequate training of staff, supervisors and managers, both in the specialised elements of their work and also in dealing with mental ill-health and stress;
- Misuse of disciplinary and other procedures; and
- Failure to adhere to health and safety policies.

Some of the manifestations of these issues can be seen in the case study of the NHS, summarised in Figure 5.

Figure 5 The NHS workforce: Mental ill-health

- 21% - 50% of doctors suffering from psychological disturbance (most severe in women doctors)
- 29% - 48% of nurses suffering psychological disturbance ranging from emotional exhaustion to suicide
- Emotional exhaustion predicts sickness absence and has doubled in community nurses between 1991 and 1995
- 30% - 50% of managers report increased psychological disturbance (which is higher than non-NHS managers)

Problems in the NHS include:

- increased workload, workload pressures and the effects on the individual's personal life
- staff shortages, unpredictable staffing and scheduling
- not enough time to provide emotional support to patients
- poor management
- low levels of involvement in decision-making
- ambiguity about role

Source: Williams, S., Michie, S., Pattani, S., (1998) *Improving the Health of the NHS Workforce* Report of the Partnership on the health of the NHS Workforce. The Nuffield Trust

'Stress'

One 'catch-all' term that has acquired considerable popular currency in this context is 'stress'. It has various meanings:

- positive stimulation which we all need for health and development;
- an external stressor which if excessive and prolonged may be harmful; and
- the internal bodily reaction to the external stressor.

There is a commonly-held perception that 'stress' is created in the workplace, that there is more of it now than in the past, and that it is harmful to mental health. All of these contentions are problematic. It is notoriously difficult to agree on one particular definition of 'stress' (and therefore to argue that anything in particular creates it); even if it can be defined, there is no evidence that it has increased; and stress *in itself is* not harmful. A concentration on stress can also lead to the identification of the wrong causes for real problems, and therefore a reluctance to contemplate other models of health promotion which do not accept the centrality of stress.

Despite its limitations, though, stress can be a useful concept for two reasons. First, it avoids some of the stigma and received ignorance about mental illness - stress is something to which we are all susceptible. Second, it can empower people - it suggests approaches to changing working conditions that reduce stress.

These strengths and weaknesses should be balanced in any strategic approach. An over-concentration

on 'stress' is clearly unhelpful; but as part of an educational approach for employers, employees and trade unions, the term stress - with all its imperfections - can be a usefu 'point of entry' to popular discourse. In particular it is helpful for people to recognise that whilst some stress is beneficial, too much becomes harmful.

Re-entry to work for those with a history of mental illness

Mental illness, when it occurs, often results in exclusion from the workplace and re-entry becomes a vital component of many people's rehabilitation. Such (re-)integration can be problematic. People are often caught in a mis-match between their level of ability to cope and the demands which work places on them. In such cases, there is a need to equip the individual with the skills required for the situation in which they find themselves - to 'place and train' as well as the usual 'train and place' approach.

In addition to these various 'internal' obstacles which have to be overcome there are a variety of 'external' barriers. One is the sometimes perverse operation of the social security system, which at the margin can impose financial penalties on those moving from benefits to part-time work. Another is the attitude of employers to recruiting 'risky' employees; various pioneering employment schemes around the country are demonstrating ways in which such reluctance can be overcome. Yet another is the damage often inflicted by the episode of mental illness on individuals' social networks, which can in many cases be destroyed. The community, in its various guises, has a role to play here in helping the individual to re-build such networks.

Strategic issues

Given the complexity and multiplicity of factors involved a strategic approach is needed to resolve these issues: there are no easy, quick fixes.

There are several key actors, including - within the workplace - employers, the workforce, and trades unions; and outside it, health agencies, employment agencies, national and local government, the EU, and users of mental health services themselves.

There is a need, therefore, for this area to be set in a national policy context, which evaluates where progress is needed, and deploys the various mechanisms open to government to inform, persuade and cajole others to change. The inter-relationship between the elements - together with some specific examples of each - is shown in Figure 6.

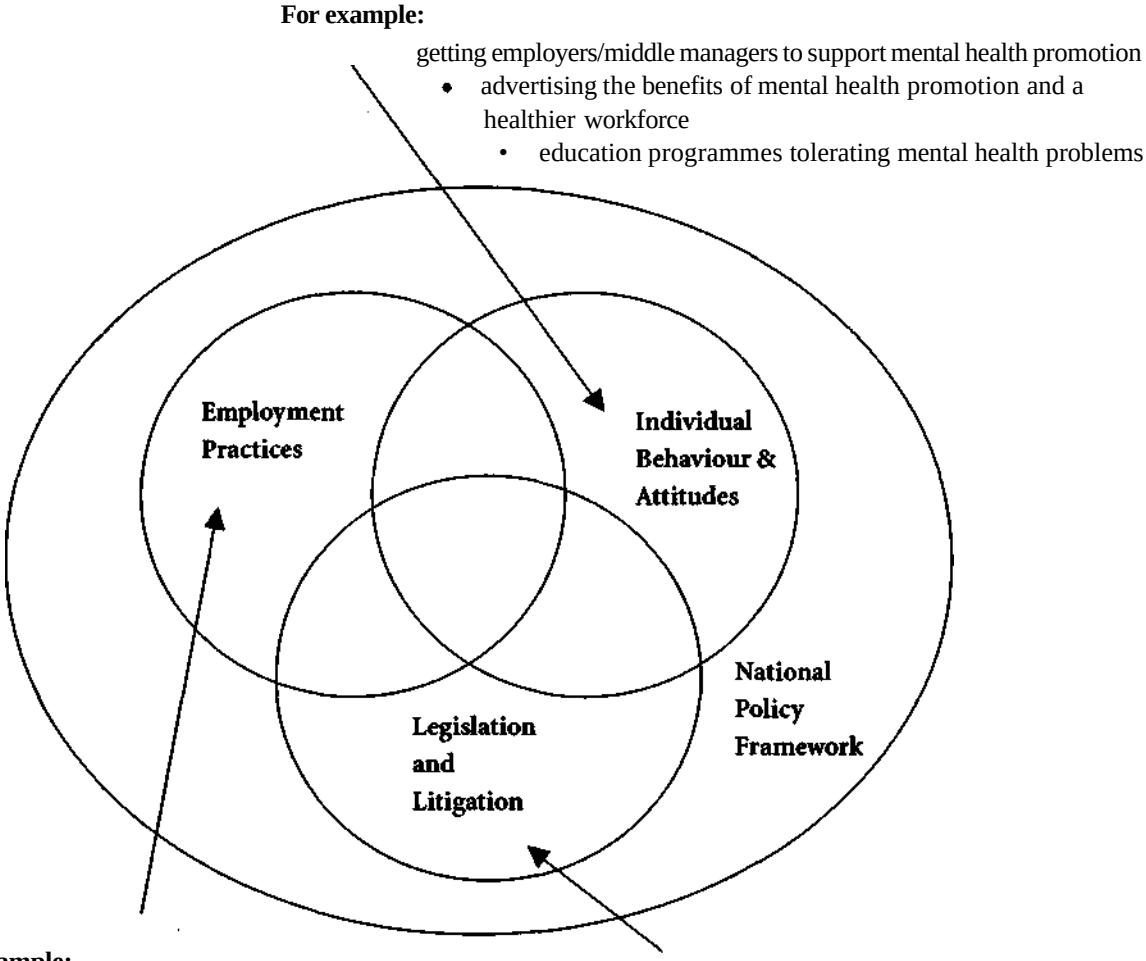
There are, then, three key elements to the strategy:-

- *Changing employment practices* - initiatives which are largely at the discretion of the employer. The ability of the employer to act in this sphere is, in part, conditioned by the size of the business (few small companies have an occupational health department, for example) and the nature of the industry, but all employers should be able to carry out some simple risk assessment for psycho-social factors given appropriate training and support.
- *Changing individual behaviour and attitudes* - individuals within the workplace must examine, and if necessary change, their own attitudes in key respects. One of the ways to reduce stigma and isolation would be to acknowledge mental illness as a 'disability' which therefore acquires certain 'rights'; and

- *Changing legislation and litigation* - encouraging a more healthy climate through legislative change and enforcing change in individual cases through litigation where necessary. The Health and Safety at Work Act, as well as the Disability Discrimination Act, embrace mental health and the HSE has operated within this legislative framework to work towards better mental health in the workplace.

Managing the inter-relationships between these elements to enhance the civil society will be crucial, and is especially challenging in the context of a dis-aggregated public policy.

Figure 6 The elements of a strategic approach to better mental health in the workplace



For example:
- policies to establish the integrity of teams
- family-friendly policies
- improved communications
- better training for managers and staff
- improved occupational health facilities, including on-site counselling services
- clarity of role
- adequate staffing levels, manageable workloads and realistic allocation of responsibility
- functioning complaints/grievance procedures
- effective health and safety and H&S-related policies e.g. anti-bullying, discrimination
- involvement in decision-making processes

For example:
- using the Social Chapter and other legislation
- improved employment security
- clear rights of trade union representation

SECTION V
SHELTER AND COMMUNITY

Fundamental protection

This setting relates simply to the places where people live, both the immediate circumstances of their'home' (or state of homelessness) and the surrounding neighbourhood.

The links between mental health and shelter

There is little doubt that shelter and community can have a profound impact upon mental health - as a cause or aggravating factor in mental ill-health, or as a positive contribution to mental well-being. Housing problems are a frequent presenting complaint when people contact mental health services. Issues include problems with neighbours, drug abuse in the locality and - often in deprived communities - the objective unsuitability of housing.

This inter-relationship is also reflected in the inter-dependence of mental health and housing *services.* For example, housing providers are an important source of referrals to mental health services, and can be vital colleagues of those services in relieving many of the external problems affecting the clients. More negatively, housing providers can be a source of stress for individuals and families- including the possibility of threats from the landlord and eviction. The housing benefit system, which is frequently inefficient and inaccessible, can place vulnerable members of society at risk of losing their tenancies. Some mental health services often overlook the potential value of an improvement in housing for the mental health of their patients.

Something of the nature of this link between shelter/community and mental health services can be glimpsed in Figure 7, which summarises the housing component of the last ten admissions to a reasonably typical, inner-city psychiatric service. All but one of the consultations had an important housing-related element.

Figure 7 Housing and the last ten admissions to an inner-city consultant psychiatrist

- recendy re-housed, paranoid about new neighbours, cannot cope in ordinary housing
- angry with noisy neighbours, seeking move
- re-housed by health authority in new area, transfer problematical
- exploited by neighbour even in low-support accommodation, re-housed prior to discharge
- homeless, penniless, illegal immigrant living in back of car, cannot be re-housed
- street homeless man living in (inadequately) supported housing, psychotic ideas about neighbour
- refugee with dementing illness, requires nursing care
- badly housed wife of illegal immigrant, housing stress severe
- homeless man no mental illness, stabbed himself to get admitted, refused housing
- acutely psychotic man, no housing issues

Source: *Workshop Contribution*

Strategic issues

The interlocking issues are displayed in Figure 8. The link between poor housing conditions and poor mental health is clear. A society which values collective action to safeguard its members will wish to ensure that everyone is able to live in conditions which protect their health. The physical quality of the housing stock is a vital component in this and many parts of the UK currently suffer from years of neglect in this respect. Social conditions within the neighbourhood are also important and collective action to prevent crime, to reduce anti-social behaviour and to improve the quality of people's lives are all essential parts of a 'joined up' strategy, and are the subject of current government attention.

Figure 8 Components of a Shelter & Community Strategy to promote mental health

The appropriate housing and shelter of people with mental illness also raises many of the challenges to a civil society which are familiar in the other settings. In particular there is a need to balance the right of the individual to have some control over where they live, with the right of that community to be 'insulated' from behaviour which they find unacceptable. The definition of what is 'unacceptable', however, should be moderated in a civil society by the community's responsibility to accept people with serious mental illness and to protect them from harm. There is clearly a need to provide a 'spectrum' of housing for people with disabilities, from ordinary housing at one end, through various forms of support in the community, to more sheltered settings.

Three particularly difficult strategic issues emerge. The first relates to *caring and providing for especially vulnerable groups*, which typically include people with severe and enduring mental illness, prisoners, people with multiple disabilities, care leavers, the homeless and asylum seekers. These people have needs which are currently often poorly addressed by the responsible agencies - because the needs themselves are intrinsically difficult and also because they are already marginalised groups, often suffering from multiple deprivation.

The second issue relates to *society's rejection of the severely mentally ill*, resulting in considerable difficulty in providing adequate accommodation in the community. Such people are sometimes ill-served by the naivete of policy makers, who operate from the premise that complex needs can easily be resolved, even though housing needs have been inadequately considered. There are - thankfully - a growing number of examples of successful integration

which have succeeded as a result of considerable investment of time in informing the community and involving it in the shaping of local policy.

Finally, the *unintended consequences of Government action* in one sphere can have a significant impact on highly vulnerable people in another. An example is the most recent housing legislation in relation to vulnerability, which is resulting in local authorities refusing to re-house people who are due to lose their tenancy until the moment that they are actually evicted from their property. This can lead to extreme stress for most people who are already highly vulnerable to the consequences of life stress. Planning support for this becomes a lottery. Another example concerns asylum seekers, who have only recently received entitlement to benefits and social care provision. Mentally-ill asylum seekers still risk being inappropriately cared for within the hospital system, with the only alternative being discharge into highly stressful and inadequately supported circumstances.

There is a set of short-term measures which can be helpful, together with longer-term approaches. The former is essentially comprised of improved administrative practices and co-ordination between agencies (for example, health, housing, DSS) with the injection of additional resources where they are most needed. There are already numerous examples of good practice in this field. They include specialist interagency teams providing assessment and support for vulnerable people with mental health problems in need of housing, training initiatives in mental health for generic housing workers, and regular face-to-face contacts between housing providers and mental health workers. Steps currently under way to integrate the social and health components of mental health services - with the fusing of Care Management and the Care Programme Approach - should be built upon by including housing as a key stakeholder in mental health promotion partnerships.

Longer-term measures often fall within the term 'community development', a range of approaches to developing within the community the capacity to shape its own development in a way which embraces hitherto marginalised minority groups. There is also a need for government to assess the impact of legislation and regulations within the social welfare sector on the mentally ill and other vulnerable groups prior to its introduction. This should become a routine feature of 'joined-up Government'.

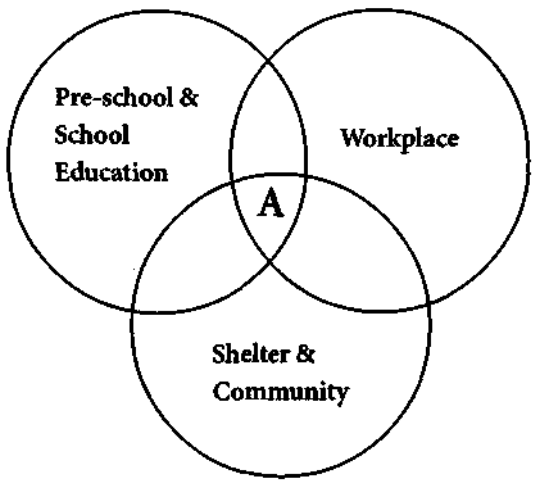
Both the short- and longer-term are needed. But above all, the *sine qua non* of progress in this setting is decent, affordable housing for all.

SECTION VI
TOWARDS A STRATEGIC INTENT AND DIRECTION FOR MENTAL HEALTH

Common themes

The discussion in the preceding sections has revealed several key strategic issues in the areas of education, occupation and shelter. This final section identifies the common issues which emerge from this analysis as an important step towards developing a strategic intent and direction for mental health in the UK, which is inclusive in design and recognises the potential contribution of all sectors of a civil society. The intention is to map the territory shown as 'A' in Figure 9 - where the various settings come together in the context of the civil society.

Figure 9 Common strategic themes



Each of these settings - and others not considered here (such as the criminal justice system, the family) - has an important contribution to make to the mental well-being of society and of all citizens. Their *proportionate* contribution (i.e. the amount which each can contribute to mental well-being) is unknown, and probably impossible to discover. However, there is little doubt that the areas listed in Figure 10 are all features of a healthy society. They are already present in many communities.

The challenge - and one of the prime objectives of a Mental Health Strategic Intent and Direction - must be to cultivate or maintain *all* of them in *all* communities. This requires a definition of 'community responsibility' and coordinated action to honour that responsibility.

Figure 10 Protective social factors

1. Supporting existing social support systems (e.g. family, neighbours, helpers)
2. Creating new, 'natural' support systems (e.g. setting up self-help groups for widows, young mothers)
3. Educating carers
4. Consultation with schools, police, social services, and criminal justice system
5. Development of community networks to increase community involvement in tackling issues that affect mental health (e.g. prostitution, rape, domestic violence, child abuse)
6. Educating general public about mental health problems, available treatments, health promoting resources
7. Mental health education in competencies to improve the capacity to cope with life transitions and stresses
8. Employment, particularly where there are good personnel and health policies

Source: adapted from Jenkins, R., McCulloch, A., and Parker, C, (1996) *Nations for Mental Health: Supporting governments and policy makers* Geneva: WHO

Key emerging messages

• *There is no health without mental health*

Whilst many agencies and individuals acknowledge the importance of maintaining working and living conditions which are conducive to good *physical* health there is still only limited recognition of the potential of these same environments to support or damage people's mental health. Until there is widespread acceptance of the links with *mental* health in these settings - and the prospect of realistic strategies to protect mental health - little progress is likely.

• *Inaction is costly*

The burden of mental ill-health - personal, social, economic, financial - is enormous; and all those with a contribution to make to the strategic approach must understand this. The key message should be: improving mental health is in *everyone's* interests. There is, of course, some difficulty in substantiating *beyond all doubt* the causal links between environmental factors and mental ill-health, and also between particular interventions and improved well-being. The communications approach will therefore need to recognise this and marshal expert opinion.

• *Strategies should tackle risk factors and increase resilience*

The overall approach of each agency should be two-pronged - making the environment more 'healthy' (ensuring the Precautionary Principle is observed, of not acting when harm could ensue), and the improvement of individuals' ability to cope with unwanted developments in their lives. The balance between the two will be dictated *inter alia* by the circumstances of the setting, knowledge about cause and effect and the relative effectiveness - and cost-effectiveness - of interventions. In many instances, greater emphasis will be given to improving resilience, to addressing unrealistic expectations of personal happiness, and helping people to cope with adverse life events. In other cases, the most appropriate approach will be to improve the quality of life of the most vulnerable.

• *Overall improvement requires greater equity*

The distribution of mental health throughout the population exhibits similar patterns of inequity to physical health. In some cases the causes are relatively clear - low incomes, poor housing - and in others are probably the result of the interaction of several different factors.

Any strategic attempt to improve mental health must recognise this inequity and target resources accordingly to derive the greatest aggregate improvement in mental health.

- *Stigma must be reduced*

Stigma about mental illness is widespread and pernicious. Society must recognise this as a major barrier to the inclusion of people with mental illness and one that lies within its own control. Various approaches do work, including increasing contact between the general public and service users, informing the public and addressing misconceptions and ensuring the greater empowerment of service users. But there are no 'quick fixes' - it requires determined and continued effort, and every section of the civil society has a role to play, from teachers and employers, to politicians and ordinary citizens.

- *A multifaceted approach is required*

There is no one 'magic bullet' to improved mental health: many strands must be pursued simultaneously. Figure 11 illustrates the range of possible and helpful interventions.

Figure 11 A multifaceted approach to promoting mental health

« Primary health care - **education, support, resources**
- Links between primary and secondary care - **referral criteria, shared care, communication**
- Local specialist health and social care - **properly integrated**
- Mental health legislation - **to include promotion of mental well-being**
- Good practice guidelines - **for interventions, interagency collaboration**
- Public health measures - **to reduce suicide and homicide**
- Research and development strategy **for mental health**
- Mental health promotion strategy - **embracing generic settings e.g. workplace, schools, general healthcare**
- Educate school staff - **to prevent and manage mental health problems**
- Involve users and carers - **in policy and service delivery**
- Mental health information systems **in secondary care**
- **Link strategy across government departments** - including policy makers, scientists, delivery system

Source: adapted from Jenkins, R., McCulloch, A., and Parker, C, (1996) *Nations for Mental Health: Supporting governments and policy makers* Geneva: WHO

Such a multifaceted approach will require the urgent attention of the mental health 'Czar' in England, Professor Louis Appleby, as he attempts to address the need for co-ordinated policy and action.

A strategic intent for promoting mental health in the UK

From the foregoing it is possible to devise a strategic intent for mental health. The following is offered to stimulate discussion:

To develop and support a civil society which acknowledges its responsibilities for promoting the mental health of its members, and which pursues co-ordinated policies and ways of life which are conducive to that end

The sense of journey, or strategic direction, might include the following actions:

Laying the foundations
In every setting, this involves:

- Improving knowledge about mental health and ill-health;
- Changing attitudes towards mental health;
- Increasing skills in mental health promotion; and
- Devoting resources to change the environment appropriately.

Sharing responsibility for mental health
Across agencies, this requires:

- Improving cooperation to deliver joint objectives;
- Developing appropriate consortia;
- Creating new models of governance to ensure joint responsibility and accountability.

Broadening responsibility for mental health
All agencies should be:

- Seeking to ensure they define their role in mental health promotion;
- Ascertaining the potential results - financial and otherwise - of inaction;
- Working with the NHS to identify its specific role.

Moving on

The causes of mental ill-health and loss of mental well-being are numerous and complex, and often still poorly-understood. But what is clear is that the various 'settings' in which people lead their normal lives all have a contribution to make, and that poor mental well-being tends to be associated with multiple social disadvantage. If the concept of a 'civil society' is to have any meaning, then it must surely be in the mobilisation of the resources to promote mental health.

The emerging policy frameworks throughout the UK - which now address broader public health issues, the role of the NHS, and possible changes to mental health legislation - are to be welcomed. As suggested earlier, they represent a compromise between various interests and objectives, as does all such public policy. But nevertheless they mark a helpful move towards the more ambitious Strategic Intent set out above. For the first time in many years national policy makers now lay considerable emphasis on the multiplicity of causal factors in mental ill-health and the need for a broad range of responses. The next stage is the creation of the sort of civil society which is required to deliver substantial and sustained improvements.

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Annexe

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