COMPLETING THE REVOLUTION

Transforming mental health and tackling poverty

THE CENTRE FOR SOCIAL JUSTICE

Executive summary

This is the Executive Summary of *Completing the Revolution: Transforming mental health and tackling poverty*. To download the full report and complete list of recommendations, visit www.centreforsocialjustice.org.uk

1. Introduction

In whichever area of social policy it researches, the Centre for Social Justice (CSJ) is primarily concerned with how the most vulnerable in society are affected. The 'pathways to poverty' that the CSJ has identified also contribute to the development or sustainment of poor mental health:

- Worklessness, welfare dependency and the propensity to get into debt;
- Poor educational attainment;
- Family breakdown which leads to social isolation; and
- Addiction to drugs and alcohol.

Just as the causes of poverty are also its effects, the underlying contributory reasons for people suffering poor mental health are reproduced in their lives. It is therefore vital that all who are working with the mentally ill should see themselves as integral to the wider social movement to tackle these drivers and effects of poverty.

There is an unfinished revolution in mental health care in the UK that began half a century ago when the mentally ill were moved out of asylums so they would get the treatment and support they needed 'in the community'. The aim was to help them achieve as full a recovery as possible, but realising the full potential of this shift required a far-reaching cultural change that has stalled and many needs currently go unmet. Opportunities provided by the current health reforms can and must be maximised to take the necessary quantum leap forward in 'care in the community' and complete that revolution.

Money is still tied up in in-patient care because the services people need are not available in the community. Hospitals tend to be untherapeutic and dangerous places. Risk aversion drives much detention and insistence on medication but other psychosocial interventions and

meaningful activity are often unavailable for patients who also have to cope with the fear of attack from fellow patients. The most disadvantaged are those who are most likely to lose their liberty because of a lack of basic social support.

Bureaucracy hampers the creativity that is so often necessary to transform people's mental health. The bespoke 'human' needs that are often the sphere of excellence of grassroots third sector charities or social microenterprises are not being addressed in the community, largely due to imbalances in funding arrangements at a local level. Communities themselves need to become 'neighbourly' and places where social isolation is the exception to the norm.

Certain groups in society appear to have a higher prevalence of mental health problems and do not seem well served, such as people in some Black and minority ethnic (BME) communities. As well as poor access to treatment, they can also experience greater deprivation of liberty. Concern has also been raised about the effects of wartime service on the mental health of military veterans.

The family is largely neglected in mental health policy. Although one's family can be at the root of the mental health problems faced, it can also be at the heart of the solution. The first onset of mental health problems is commonly in childhood or adolescence; half of all lifetime cases have started by the age of 14 years.[1] This report takes a public health approach to mental illness; despite research implicating family breakdown as a cause (and effect) of mental illness, its prevention has never been recognised as a public health priority.

Stigma is the biggest barrier to tackling mental ill-health; tackling it will require unprecedented and concerted effort to achieve the necessary cultural change.

Prevention of mental ill-health is vital but so is early intervention and treatment; where help and support is lacking and needs go unmet, people can sink into dependency and become trapped. Employment can greatly improve wellbeing; primary care and other mental health services have a vital role in helping people become work-ready, even if that journey may be a long one. Yet less than one-third of mental illness is reduced by treatment. NHS mental health providers have to be better integrated with a full range of other agencies (from the public, private or voluntary sectors) given the complex social, physical and psychological needs of people with mental ill-health.

All these agencies should be focused on outcomes not process, with 'just enough' administration so that clinicians are neither prevented from caring because of the burden of administrative tasks, nor able to 'hide behind' those tasks. Accordingly, community-based services should not be deployed on the grounds that they save money but that they are most effective. There needs to be a rebalancing of existing funding that integrates these providers far more in paid-for care pathways.

1 Kim-Cohen J et al, 'Prior juvenile diagnoses in adults with mental disorder: developmental follow-back of a prospective longitudinal cohort', *Archives of General Psychiatry,* 60, 2003, pp709-717

Working Group members receiving evidence from a range of organisations working with homeless people who are mentally ill in Brighton

2. Polling

Confirming our analysis, our polling found that:

- Almost a third thought poverty was a major cause of poor mental health – but 40 per cent considered mental health to be a major contributor to poverty;
- More than 60 per cent cited poor mental health as a major contributor to family breakdown and half thought family breakdown caused poor mental health;
- 43 per cent said they or their relative/close friend received 'a lot' of help and support from their GP, a much greater proportion than those who said a psychiatrist (18 per cent), a therapist (26 per cent) or their friends (29 per cent), but 51 per cent said their family;
- 92 per cent agreed we should do more to safeguard the mental health of adolescents (the same number said the same thing about the elderly), and 88 per cent agreed we should do more to safeguard the mental health of children;
- Two-thirds agreed that gaining access to the correct mental health services means coping with a lot of red tape; and
- Of those with experience of hospitalisation, more than half did not feel that the settings and facilities aided recovery and 44 per cent felt the treatment they received was fairly or very ineffective; 14 per cent of those felt very unsafe and only 15 per cent felt very safe.[2]

Our recommendations summarised below are spread over six major subject areas:

1. Tackling mental ill-health and stigma through a public health approach;
2. Trauma and the mental health of military veterans;
3. Children and young people;
4. BME groups;
5. The role of primary care; and
6. Secondary care – hospitals and 'care in the community'.

2 CSJ/YouGov polling of 1,005 British adults who had experienced mental health problems or were a close friend or relative of someone who had, July 2010

3. Putting mental health at the heart of public health

The contribution a successful public health approach could make to improving mental health at a population, community, family and individual level is potentially enormous not least by helping to reduce misconceptions and stigma surrounding mental illness. Associations between mental health and violence are vastly exaggerated but persist partly because of over-emphasis in media reporting. It is essential to put the dangerousness associated with mental illness in its appropriate and proportionate context. Risk is often displaced onto the mentally ill person themselves. Their recovery and quality of life are placed at risk by depriving them of liberty. This is sometimes though not always necessary, and it can take the place of finding creative and flexible ways to provide social and other support in the community.

3.1 Our recommendations to central and local government on public health include:

- Professor Eileen Munro, in her recent review, challenges the current risk-aversion that characterises child protection; her conclusions apply equally as well to mental health, therefore we are calling for the same cultural change in mental health that Professor Munro is calling for in child protection.
- Ensuring that vision, priorities, provision and outcomes for public health and mental health are more closely aligned to transform the outcomes for vulnerable people with a range of overlapping needs. It is essential that mental health is a higher priority for the cross-cutting Cabinet Committee on Social Justice, as they address the interlocking causes of poverty in which mental health is so heavily implicated.
- Revoking discriminatory legislation, either directly or through Lord Stevenson's Private Members Bill which seeks to repeal discriminatory legislation relating to jury service, school governance and company directors.
- Investigating ways to encourage GPs to work in deprived areas.
- Fulfilling Coalition pledges to tackle binge drinking by banning the sale of alcohol below cost price and reviewing alcohol taxation and pricing.
- Health and wellbeing boards should ensure the public mental health of the community is addressed by commissioners locally and be accountable for this.

4.Addressing trauma and the mental health of military veterans

Around two-thirds of the population experience one or more traumatic event in their lifetimes.[3] Those who are the most socio-economically disadvantaged tend to be more at risk of being exposed to traumatic events and more vulnerable to the effects of such trauma. Military mental health has been of significant public and political concern because of British Armed Forces' involvement in a series of major military operations over the last 20 years.

3 Galea S, Nandi A and Vlahov D, 'The Epidemiology of Post-Traumatic Stress Disorder after Disasters', *Epidemiologic Reviews*, 27, 2005, pp78-91

While there is some evidence of higher levels of mental health problems among ex-service personnel, prevalence is to some extent distorted by those who leave the Forces prematurely (although alcohol misuse is a pervasive issue among all troops who have deployed). Early leavers tend to have higher levels of *pre-existing* risks for adverse mental health outcomes. We note the concerns of ex-service organisations and recognise the valuable advocacy, services and practical care they offer former service personnel and their families but occasional differences exist between their views and conclusions of research.

4.1 From the range of evidence on trauma and military mental health our recommendations include:

- All health and support services should be mindful of the unique experiences of deployment and war and of the distinctive self-identity of ex-service personnel. Their needs should be understood within the context of the culture and community of the Armed Forces, and the challenge of adjustment and integration some face on leaving the services. Specific efforts must be made to ensure health (and other public service) organisations and staff recognise and positively respond to their specific cultural traditions, expectations and perspective.
- Efforts should be made to reduce the stigma and improve access to appropriate therapy for ex-service personnel with mental health problems. There may be more of a need for specific ways to signpost and facilitate ex-service personnel into mainstream therapy as opposed to particular treatment programmes for the ex-military.
- Benefits of military Trauma Risk Management (TrIM) should be more widely distributed to civilian organisations where there is an increased risk of exposure to trauma.
- The Armed Forces should do more to reduce alcohol consumption in service personnel as part of a wider societal acknowledgement of the public health dangers of excessive alcohol consumption that is addressed, for example by a minimum unit pricing policy or an alcohol treatment tax.
- There should be more emphasis placed on dealing with multiple social disadvantages and life problems, particularly in the early leavers group, than on imagined high-prevalence PTSD in longer serving ex-servicemen.

5. Improving mental health of children and young people

Childhood mental disorder in the UK is closely related to poverty: children from the poorest 20 per cent of household income are three times more likely than those in the richest 20 per cent to have common mental health problems[4] and nine times as likely to have psychotic disorders.[5] Children's future relationships, their ability to fulfil their potential both educationally and in the workplace, and their basic enjoyment of life are all threatened by mental illness and unmet emotional needs. Interventions need to be grounded in an understanding of mental health's continuity from conception to adulthood.

4 Green H et al, *Mental Health of Children and Young People in Great Britain,* London: Office for National Statistics, 2005

5 Marmot M et al, *Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England Post 2010,* The Marmot Review, London, 2010

There must be an obligation built into services that they meet the needs of children and their families; they are designed not for the convenience of professionals but user-led to the greatest degree possible, with an appropriate level of power resting with those whose lives are most affected. Evaluating the long-term impact of services, given that much of mental illness is chronic and episodic is vital as families need help in the long term.

5.1 To tackle children and adolescents' poor mental health our recommendations include:

- Local health commissioners should ensure provision for premature babies (and their parents) is commensurate with the need and opportunity to prevent subsequent development of physical and mental health problems.
- Maternal mental health must be recognised as a priority, on a par with maternal physical health, and health professionals must be better trained to identify symptoms of depression. Health and wellbeing boards have an important role to play in ensuring adequate resources are provided by local commissioners of services, and in recognising the strong role to be played by the voluntary sector and wider community.
- The provision of infant mental health services should be seen as the next frontier for early intervention in every locality where high levels of need are identified, to ensure good foundations are laid for future development.
- The establishment of a family-centred mental health service where parents are supported rather than blamed, and helped with their as well as their children's mental health needs with timeliness and sufficient resource.
- The Government should require local authorities to collect data on children whose parents are in custody, not only to track their welfare, but also to ensure that planning and delivery of services provide effective support.

In our polling 25 per cent said mental health treatment should be focused mostly upon the individual patient themselves but two-thirds said mental health treatment should be focused on the patient, their family and relationships.[6]

- Prison mother and baby units should, as standard, take the opportunity to help these often highly vulnerable mothers and their babies with evidence-based courses that can give infants a better relational start in life and provide a range of support to mothers.
- Wherever possible and appropriate, Children and Adolescent Mental Health Services workers should be integrated with other agencies as part of an interdisciplinary team.
- More universal and targeted mental health services must be available in schools as a key component of a public mental health approach. A whole-school approach which promotes a positive school ethos and culture will more effectively promote the mental health of children than 'bolt on' programmes.

6 CSJ/YouGov polling of 2,084 British adults, September 2011

Three quarters of those polled agreed that councils should have a duty to monitor children whose parents are in prison.[7]

- Central government should give a strong lead by setting outcomes for local commissioners to deliver against so they find the best ways of supporting families and autistic young people make key transitions to adulthood in their area.
- Local commissioners should ensure authentic services, genuinely fit for purpose for the modern teenager are available, easily accessible, non-stigmatising, integrated with other services and designed with the involvement of the young people in the target population.

6. Black and minority ethnic groups – a priority area for action

The problems BME communities face in the health system highlight the general failings of mental health care for the most vulnerable people throughout wider society. BME mental health has been the subject of many official enquiries and policy initiatives yet has seen little or no progress in some of the most important indicators. Surveys show BME patients' dissatisfaction with mainstream services (although voluntary and community sector organisations receive higher scores), high detention rates and excessive restraint, seclusion and medication.[8, 9]

Research suggests that family breakdown and early separation as well as unemployment, living alone and limited social networks, affect rates of psychosis in the African-Caribbean population where there is a greater prevalence of these factors.[10]

6.1 To improve mental health in BME communities our recommendations include:

- Implementing and evaluating the 'locked hexagon' approach with its six elements of: clear, locally set targets for improvement in outcomes; service users shaping services; use of narrative approaches; promotion of education, employment, training and volunteering; staff and manager knowledge and skill development; and carer and community engagement.
- Acting to ensure no people with severe mental health problems are in prison, but instead in secure hospitals, through early and appropriate diversion, greater use of independent sector providers where necessary and freeing up secure services by tackling risk-aversion and other causes of bed-blocking involving non-forensic patients.

7 CSJ/YouGov polling of 2,084 British adults, September 2011

8 Keating F and Robertson D, 'Fear, black people and mental illness: a vicious circle?', *Health and Social Care in the Community,* 12, 2004, pp439-447

9 University of Central Lancashire International School for Communities, Rights and Inclusion, *Delivering Race Equality in Mental Health Care: Report on the findings and outcomes of the community engagement programme 2005-2008*, Preston: University of Central Lancashire, 2010, p19

10 Morgan C and Fearon P, 'Social experience and psychosis: insights from studies of migrant and ethnic minority groups', *Epidemiologia e Psichiatria Sociale,* 16, 2007, pp118-123

- The use of health- and community-based places of safety rather than police stations.
- Right to advocacy *before* detention, when patients attend tribunal hearings and on discharge to help them access aftercare services.
- Innovative outreach projects based around statutory services for 'hard to reach groups' to enable a shift to a more community-based and culturally appropriate pattern of care for this group.
- Community 'places to go' for refugees and asylum seekers should be prioritised in local mental health service planning, one-stop agencies that can provide a range of person-centred services including therapy and work-related training.

7. The role of primary care

GPs and nurses play a significant but often unacknowledged role across the full spectrum of mental health needs; primary care helps people struggling with everyday, but profoundly demanding life events and problems as well as with severe disorders. Current health reforms provide a significant opportunity to integrate mental and physical health and social care to address more effectively the complex and entrenched difficulties in vulnerable people's lives. But primary care will have to maximise the unique contributions of voluntary and private providers. Forming strong, properly resourced partnerships is vital but the current funding 'playing field' is tilted against them and towards statutory services.

One voluntary sector organisation visited by the Working Group has a garden, which provides therapeutic and purposeful activity for people with mental health difficulties

7.1 Our recommendations on primary care include:

- Secondary mental health services should be closely aligned to primary care practices to reduce barriers to referral and facilitate advisory conversations between specialists and GPs.
- The commissioning reforms offer an opportunity for creative and flexible service design that breaks out of current professional silos. We recommend that CCGs, especially those serving the more deprived areas, should make this a priority and vigorously use the new paradigm of competition, choice and payment by results/outcomes to increase access (for example to psychological therapies) and drive up quality.
- Mental health should form a greater part of postgraduate training for GPs and the Royal College of GPs should review their curriculum accordingly.
- There should be more specialist GPs in mental health (GPSIs) and the qualification required to be a GPSI should be clearer.

In our polling six in ten people supported or strongly supported using health budgets to pay community organisations or charities to support patients.[11]

- Social prescribing should become a common feature of local health economies and increasingly pervasive where appropriate to meet local need, with a clear role for health and wellbeing boards to facilitate local partnerships that can deliver more comprehensive solutions to mental ill-health.
- Smoking cessation services should be properly designed for and focused on the mentally ill given evidence of effectiveness and smoking's huge negative impact on their life expectancy and overall experience of health inequalities.

8. Secondary care – hospitals and 'care in the community'

Even though secondary care services address more severe need, they should be focused to a much greater extent on helping people break out of vicious cycles of mental illness, disadvantage and worklessness. 'Completing the revolution' to embed high quality, integrated and recovery-oriented care in the community requires secondary care to be a) much more of an enabling gateway to the whole range of support many people need, and b) guided by an early intervention approach. These are essential if the most vulnerable are to be cared for in the least restrictive setting and in such a way that their human potential is unleashed.

Too often dependency on costly and more restrictive services is inappropriately maintained because of defensive practice, a lack of therapeutic intervention or perverse incentives in funding structures.

8.1 To improve the care patients receive in hospital and the community our recommendations include:

- Acute inpatient psychiatric wards should become Psychiatric Intensive Care Units which have higher status, better defined models of care and work more intensively with the patient, so their care can be 'stepped down' to a community setting at the earliest, most therapeutically appropriate point.
- All nurse training should start with generic skills and knowledge, including about mental illness. It should reflect the prevalence of mental health problems, the co-existence of mental and physical ill-health and the need to avoid stigma and promote good mental health behaviours in whichever specialism they practice.
- Local authorities should bolster the provision of 'family-sized' care through initiatives such as Shared Lives that provide viable and more compassionate alternatives to residential care.

11 CSJ/YouGov polling of 2,084 British adults, September 2011

- Forward funding models which ensure money follows the patient into the community and is not tied up in hospitals should be adopted by local commissioners as part of the broader project of aligning social and mental health care funding and delivering services through Payment by Results/Outcomes. Patients' needs should not be at the mercy of inflexible and disconnected funding and organisational structures.
- Shift responsibility for care brokerage over to independent voluntary sector services, to ensure better access to specialist treatment and all the other support patients need to break out of vicious cycles of dependency and poverty.
- A major review of the use and impact of the 2007 Mental Health Act after a sensible waiting period. This should prioritise positive risk taking, for example by scrutinising how Community Treatment Orders are being used if numbers remain high and ensuring the law is fit for purpose for twenty-first century expectations surrounding mental healthcare.

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About the Centre for Social Justice

The Centre for Social Justice (CSJ) aims to put social justice at the heart of British politics.

Our policy development is rooted in the wisdom of those working to tackle Britain's deepest social problems and the experience of those whose lives have been affected by poverty. Our Working Groups are non-partisan, comprising prominent academics, practitioners and policy makers who have expertise in the relevant fields. We consult nationally and internationally, especially with charities and social enterprises, who are the champions of the welfare society.

In addition to policy development, the CSJ has built an alliance of poverty fighting organisations that reverse social breakdown and transform communities.

We believe that the surest way the Government can reverse social breakdown and poverty is to enable such individuals, communities and voluntary groups to help themselves.

The CSJ was founded by Iain Duncan Smith in 2004, as the fulfilment of a promise made to Janice Dobbie, whose son had recently died from a drug overdose just after he was released from prison.

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