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# Psychological health and well-being: A new ethos for mental health

*A report of the Working Group on Psychological Health  
and Well-Being*

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## Summary

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The National Service Framework for Mental Health – NSF – (Department of Health, 1999) outlined a clear and positive framework for the provision of mental health care. With a 10-year timeframe for implementation of the original NSF, however, it is appropriate to consider what a new service framework should contain.

Psychology is the scientific study of people, the mind and behaviour. It is both a thriving academic discipline and a vital professional practice, impacting on all aspects of public life, particularly in areas such as education, health, the economy, industry and social justice.

Applied psychologists who offer services to the public, including clinical psychologists and counselling psychologists, are now statutorily regulated by the Health Professions Council.

Continued investment in mental health services should remain a priority for Government, but services should be planned and commissioned on the basis of need and functional outcome alongside (and sometimes rather than) diagnostic categories, ‘treatment’ and clinical outcome. Mental health services should fully embrace the recovery approach.

There should be an emphasis on and investment in preventative and health promotion work, with particular attention to adolescent mental health. Psychologists should see their roles develop and strengthen as clinical leaders in psychological therapies and the scientific evidence base for psychological models. It is essential to continue to invest in high-quality, evidence-based psychological therapies. Delivery models for such therapies need to incorporate ‘stepped care’ principles, but remain guided by expert assessments and based on psychological formulations addressing a person’s wider well-being. People have a right to expect the NHS to deliver those evidence-based, effective psychological therapies recommended by NICE – and for these to be delivered by competent therapists.

Mental health services, together with JobcentrePlus and independent sector employment providers, should help clients to return rapidly to work wherever possible, and to keep them in work. The role of voluntary work as part of a stepped recovery approach should hold intrinsic value as a contribution to local communities. Discrimination against people with mental health problems should be as unacceptable as racism or sexism, and services should adhere to the principles of Fairness, Respect, Equity, Dignity and Autonomy – the ‘FREDA’ principles – to help ensure human rights compliance. Services need to facilitate genuine service user involvement; service users and carers should be involved at the outset in setting, implementing and monitoring strategies for mental health services.

To implement this vision, we fully support the current ‘New Horizons’ initiative of the Department of Health (Department of Health, 2009) and look forward to working with Government and our colleagues to realise this. However, we also recognise that specific policies are required in order to develop this. We therefore fully support our colleagues in the ‘Future Vision’ coalition, and their recommendations (Future Vision Coalition, 2009). We also note that a range of policies developed in the European Union to aid implementation of the EU Green Paper on mental health (European Commission Directorate-General for Health and Consumers, 2008) could be very useful.

This paper, setting out a distinctively psychological perspective on these matters, is intended to complement, rather than challenge, these related proposals.

# Introduction

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The National Service Framework for Mental Health (Department of Health, 1999) set out welcome standards for mental health promotion, primary and secondary care, services for carers, and for suicide prevention. In December 2004, Professor Louis Appleby, National Clinical Director for Mental Health, published *Five Years On*, a personal reflection on the National Service Framework (Department of Health, 2004). He commented on an impressive range of improvements in quality and policy initiatives. In looking forward to the next five years (i.e. the years 2004–2009), Professor Appleby suggested that the standards in the NSF remained appropriate, and that the future emphasis for change would be in:

- promoting the mental health of the whole community (including abolishing inequalities and delivering race equality in service provision);
- promoting social inclusion for people with mental health problems, improving their employment prospects and opposing stigma and discrimination;
- improving services in primary care settings;
- improving access to psychological therapies;
- suicide prevention;
- provision of specialist mental health services (including in-patient wards, and services for people with dual diagnosis of mental illness and substance misuse);
- addressing the needs of carers;
- taking forward the ‘New Ways of Working’ programme to modernise the mental health workforce with new roles for key staff; and
- the use of better information and information systems.

It is important to note that, while the Government has achieved a great deal of progress in implementing the NSF, the evidence-based recommendations by the National Institute for Clinical Excellence for psychological interventions in a wide range of mental health conditions have developed over the past decade in parallel to NSF implementation. This has resulted in sometimes less than adequate psychology service provision against both NICE guidance and service user expectation, and we seek to support the closing of service gaps for all less well-served groups.

Dargie, Dawson and Garside (2000) also identify six key challenges for future health policy: rising public expectations, the ageing population, new technologies, information and communications technology, workforce education and training, and system performance and quality. The increasing life expectancy of the UK population may lead to a shifting burden of disease from young to old and from communicable to chronic. The next few years may also see increased trends in obesity, alcohol use, sexually transmitted disease, under-age pregnancy and increasing poor mental health in children and young people.

Changes in public expectation may see increasing access to health information and a rise in the empowered consumer. There may be an increasing role of technology in health care that allows self-diagnosis and self-treatment and home care. Scientific advances and new

technologies may see developments in genetics, screening, bio-engineering, biotechnology, robotics, imaging and telemedicine. Environmental challenges may include public and scientific concern for global warming, food quality, and pollution. Globalisation also presents new challenges, including in the emergence of new health risks caused by increasing flows of people, goods, and services. Increasingly, we will see strong links between poor housing, chronic sickness and psychological distress. We are seeing increasing levels of stress at work, sickness and absence and staff turnover attributed to 'stress'. Finally, we are seeing an increasing health gap between the most and least fortunate in society (for a comprehensive discussion of these challenges, see Dargie, Dawson & Garside, 2000). Clearly, the national economic picture is also a major issue here.

In this context, and given the National Service Framework's 10-year timeframe for implementation, it is entirely appropriate to consider its successor. The World Health Organisation defines health as '*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*' and mental health is described as '*a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community*' (World Health Organisation, 1946, 2003). The European Commission Green Paper on mental health (European Commission, 2005) echoes this: '*for citizens, mental health is a resource which enables them to realise their intellectual and emotional potential and to find and fulfil their roles in social, school and working life. For societies, good mental health of citizens contributes to prosperity, solidarity and social justice.*' It continues: '*The mental condition of people is determined by a **multiplicity of factors** including biological (e.g. genetics, gender), individual (e.g. personal experiences), family and social (e.g. social support) and economic and environmental (e.g. social status and living conditions*' (p.4, emphasis in the original).

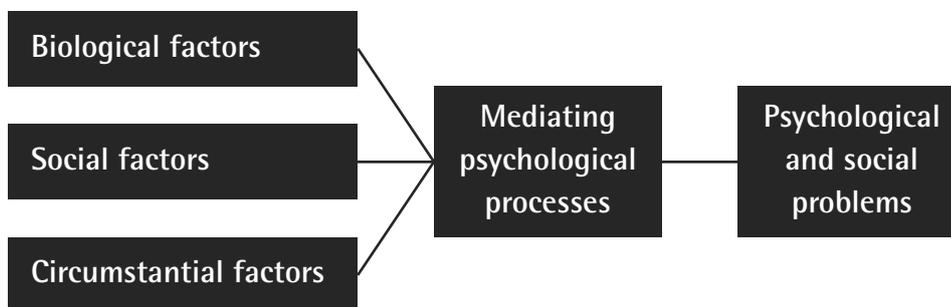
Such views are now mainstream: the recent 60-year anniversary review of the NHS recommended that '*every primary care trust will commission comprehensive well-being and prevention services*' (Darzi, 2008, p.35), while Dame Carol Black's review of the health of Britain's working age population recommended that '*...Government must therefore fully integrate the option of specialist mental health provision into its employment support programmes...*' (Black, 2008, p.13). But such integrative, multi-agency responses to complex problems do not fit perfectly with traditional bio-medical approaches derived from physical health care. A new approach is needed.

## A new ethos

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In addition to providing specialist services, many of the new professions in mental health care offer distinctive evidence-based perspectives which are valued by service users (Department of Health 2007a). Psychological models suggest that disruptions or dysfunctions in psychological processes constitute a final common pathway in the development of mental disorder (Kinderman, 2005). Biological abnormalities or physical insults, social factors such as poverty and social deprivation, and circumstantial factors or life events such as childhood sexual, emotional or physical abuse lead to mental disorder when those factors adversely affect psychological processes.

An example of a biological factor would be certain neurotransmitters (and the associated genes) believed to be significant in schizophrenia or depression. These affect people through their impact on perceptual and cognitive systems and on psychological processes associated with self-esteem, beliefs in self-efficacy, motivation and expectations of reward. The same principles apply to social and circumstantial factors. Social deprivation and poverty can lead to problems such as depression – but they operate through the disillusionment, hopelessness and learned helplessness that constitute a realisation that one's actions have no effect or purpose. Being abused or traumatised obviously leads to problems, but this association is, again, mediated by the disruption of psychological processes – the ways in which children (and later adults) appraise themselves, the people in their lives and the ways in which relationships and social intercourse should be governed.



Applied psychologists then use this understanding – the ‘formulation’ – of the impacts on each individual’s psychological functioning to develop packages of care that address the person’s needs. Of course, many psychologists focus on their own therapeutic skills in addressing psychological processes. This model, however, is crucial in helping psychologists develop more comprehensive care plans – linking the purely psychological or one-to-one psychotherapeutic work with the work of colleagues in health and social care addressing physical (‘biological’) health care needs, the social, economic, employment and housing needs of the client and indeed protecting against abuse. This conceptualisation is key to psychologists’ understanding and clinical practice, and is enshrined in the core definition of the profession’s competencies used by the Health Professions Council – the statutory regulator for psychologists (standard 3a1: ‘Understand psychological models related to how biological, sociological and circumstantial or life-event related factors impinge on psychological processes to affect psychological well-being’) (Health Professions Council, 2009).

In addition to clinical implications for individual therapists (Kinderman & Tai, 2006), such models have important implications for mental health service policy (Kinderman, Sellwood & Tai, 2008). Adopting such a ‘supporting well-being’ rather than ‘diagnosing and defeating illness’ model may help unify a number of policy drivers. Importantly, it could give an ethos or frame for commissioning services, including the development of more appropriate measurements or metrics focussing on social and functional rather than symptomatic outcomes. Important elements here would be the links between mental health and work (already an emphasis of several Government policies) and socially-inclusive services, including housing. Clearly psychosocial care should be supported – as it is being – with an expectation that psychologically health citizens will contribute to National economic and social advantage.

### **Key points: A new ethos**

- (a) Mental health care is better located within a social, not medical, framework.
  - Psychologists address this through their understanding of scientifically valid psychological models of how biological, sociological and circumstantial or life-event related factors impact on psychological processes to affect psychological well-being.
- (b) Psychological and personal well-being is a priority across Government, and Government Departments must develop integrated policies in this respect.
- (c) Integrated care plans for socially disadvantaged or excluded persons are need to link health and social agencies, education, the benefits and employment system, the justice system, etc.
- (d) Such an approach is entirely consistent with the ‘New Horizons’ initiative and the aspirations of the ‘Future Vision’ collective.
- (e) The Department of Health (or a Department for Social Care) should employ a ‘Chief Psychological Officer’, as it does a Chief Medical Officer and a Chief Nursing Officer.
- (f) All NHS mental health Trusts would benefit from having Directors of Psychological Therapies or Clinical Directors from psychology backgrounds on their Boards.

## Investment

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Across the world and in the UK, psychological problems account for around one third of the total burden of ill health. Mental health problems represent approximately 10 per cent of the UK's total health care costs and result in an estimated £23 billion of lost employment and productivity to the UK economy. Roughly 40 per cent of people receiving Incapacity Benefits do so because of mental health problems, and such psychological issues take up at least a third of GP time (see Layard, 2006). The majority of adults' psychological problems are likely to have started in childhood and many would have been amenable to intervention had they had the right input at the right time.

Such psychological processes also impact on behaviours which constitute six of the ten leading risk factors for physical disease; unsafe sex, tobacco use, alcohol use; obesity, high blood pressure and high cholesterol levels. The application of psychological science to health behaviour offers opportunities to impact on these major causes of physical ill-health (World Health Organisation, 2003). Clearly, if interventions were to be effective, there is an overwhelming case for investment in those interventions.

Our understanding of how psychological science can be effectively applied to enhance both psychological and physical well-being is increasing rapidly. There have been considerable professional and theoretical developments in recent years, and a huge amount of research evidence now firmly establishes the effectiveness of psychological therapies for the treatment of a wide range of mental health problems. Evidence-based psychological therapies such as cognitive behavioural therapy (CBT) are as effective as any available medication in the short term, with success rates of around 50 per cent of people experiencing a full recovery, and evidence-based psychological therapies such as CBT are more effective than drugs in preventing relapse. Structured parenting programmes such as the Webster-Stratton parenting programme have been shown to have a significant impact on the course of conduct problems in children and psychological interventions are similarly effective for neurological conditions, serious mental health problems such as schizophrenia and in improving the efficacy of a wide range of physical health care.

A number of related policy initiatives within the Department of Health have emphasised the importance of psychological therapies in mental health (Department of Health, 2004, 2007a). Service users increasingly demand psychological therapies of a variety of forms (Sainsbury Centre for Mental Health, 2006) which has been reflected in the media (Pidd, 2006). Policy directives have resulted from evidence of the effectiveness of manualised psychological therapies such as cognitive behavioural therapy (CBT) in randomised controlled trials (summarised in numerous NICE recommendations) and the evidence of the likely cost-effectiveness of investment in this area (Layard, 2004, 2006). Indeed, early results from the Improving Access to Psychological Therapy pilot sites are encouraging – not only from the clinical perspective, but also in terms of return to work and therefore economic effectiveness (Clark, Layard & Smithies, 2008).

## **Key points: Investment**

- (a) Supporting personal well-being across society is an investment in people, the current relative under-resourcing of mental health care represents a missed opportunity.
- (b) Residential ('inpatient') establishments should receive capital investment to make them genuinely therapeutic and signal to vulnerable people that their well-being is a priority.
- (c) Since the vast majority of mental health is a personal, professional, rather than technological issue, capital investment in decent accommodation for staff is a priority.

## Quantifying and commissioning

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Services should be commissioned on the basis of social care provision and functional outcome as much as on the basis of ‘treatment’ and clinical outcome, and new assessment and evaluation frameworks should be developed, to match these priorities. The well-being approach to mental health implies that a wide range of needs are appropriate targets for intervention. A genuinely cross-Governmental and integrated approach to well-being would imply the need for coherence between the needs assessed and addressed in different areas: health, housing, education, employment, etc. The well-being approach to mental health also implies that a broad range of interventions – broader than currently used, and conventionally associated with agencies outside of health – should be integrated into service development plans; and this has implications for professional bodies and agencies such as NICE and Care Quality Commission responsible for making and auditing such recommendations.

One key recommendation in the Darzi review of the NHS was that ‘all patients will receive drugs and treatments approved by the National Institute for Health and Clinical Excellence (NICE) where the clinician recommends them’ (Darzi, 2008, p.10). Although one consequence of the approach described here may be that NICE will have to alter its processes and the nature of its recommendations – from a diagnostic framework to an evaluation of the ‘transdiagnostic’ evaluation of therapies – this recommendation has clear implications here. NICE has reviewed the evidence-base for the care of a wide variety of problems, and structured, evidence-based, psychological interventions delivered by competent professionals have been recommended in nearly every case. Dame Carol Black’s review (Black, 2008) and academic research (for example, Wang, Patrick, Avorn, Azocar, Ludman, McCulloch, Simon & Kessler, 2006) clearly indicate the benefits of integrative care plans involving employment support (for example) as well as more conventional mental health care. Patients do indeed have a right to those evidence-based interventions recommended by NICE, and this therefore includes psychological therapies based on integrative psychosocial care plans.

Outcome measures should equally be straightforward and immediately relevant: number of days of employment or education lost as a result of mental health problems should reduce; the number of people in employment, education or training (or other identifiable activities such as voluntary work) should increase. The number of looked after children experiencing multiple placement moves should decrease with appropriate psychological consultancy and training available to foster carers. The number of days spent in custody by young people who were recognised as meeting the criteria for a diagnosis of conduct disorder in childhood should decrease. It is perhaps a sign of how much progress still remains to be made that there are few well-developed tools available to measure psychological well-being (see Conway & MacLeod, 2002, for a discussion of some of these issues).

## **Key points: Quantifying and commissioning**

- (a) Services should be commissioned on the basis of social care provision and functional outcome as much as on the basis of 'treatment' and clinical outcome.
- (b) Social and 'third-sector' as well as 'health' provision should be commissioned.
- (c) New assessment and evaluation frameworks should be developed, to match these priorities.

# Psychological formulations

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Psychological specialists should lead on the development of individual formulations based on need and functional outcome; these formulations should in time become as universally incorporated in care planning as diagnostic categories. Clients and communities would benefit from care planning based on a clear, shared understanding of predisposing, precipitating, maintaining and protective factors which lead to or mitigate distress; at present, care is often uniformly driven by an understanding of illness as represented by patterned clusters of symptoms which risks ignoring or subordinating psychological and psychosocial stressors.

Because of their particular training in the linkage of theory to practice, applied psychologists draw on a number of different explanatory models and so a formulation may comprise a number of inter-connected hypotheses. What makes this activity specifically psychological is the knowledge base and information on which these formulations draw. The background and training of applied psychologists is rooted in the science of psychology – the application of psychological science to address human distress and disability. The skills of psychologists as applied to intervention are therefore built on a body of psychological theory which extends beyond cognitive theories and cognitive behavioural therapies, and this knowledge base is then applied to helping people solve personal, family, group, work or organisational problems. This perspective makes psychology distinctive in health and social care (Quality Assurance Agency for Higher Education, 2004). For psychologists, evidence-based psychological interventions such as CBT should be incorporated into formulations and care plans that address the person's personal, social and interpersonal circumstances more fully. Clearly, such individual case formulations support personalised services and choice. Psychological specialists should offer further consultation and leadership for other professions in their use of psychological knowledge, principles and interventions. But despite offering a comparatively evidence-based range of treatments, psychology service leads remain, to an extent, marginalised within services (where they typically answer to a Director of Nursing) and similarly within Government Departments. We therefore suggest that the Department of Health (or a Department for Social Care) should employ a 'Chief Psychological Officer', as it does a Chief Medical Officer and a Chief Nursing Officer, and all NHS mental health Trusts would benefit from having Directors of Psychological Therapies or Clinical Directors from psychology backgrounds on their Boards (British Psychological Society, 2007).

## Key points: Psychological formulations

- (a) Services would benefit from planning based on need and functional outcome rather than diagnostic categories.
- (b) Clients and communities would benefit from care planning based on individual case formulation; a matrix of judgements incorporating the complexity and severity of clients' needs.
- (c) Such formulations should focus, in particular, on psychological processes.
- (d) Clearly, such individual case formulations support personalised services and choice.

## Prevention and promotion

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There should be emphasis on and investment in preventative and health promotion work, with particular attention to adolescent mental health and the links between mental health services and education services. The recovery approach, the well-being agenda and psychological perspectives all strongly support prevention work – particularly ‘secondary prevention’. The social and economic environment is a primary cause of mental health problems, and this means that there is a significant responsibility for politicians and executive agencies of Government outside the mental health care system in primary prevention of mental health problems. The well-being approach, however, does offer considerable potential for primary prevention too. A wide range of psychosocial factors promote positive mental health, and a focus on these factors, through a well-being approach, could be of particular value.

Secondary prevention of mental health problems is perhaps most helpful in this context. Mental health professionals and a wide range of colleagues in health, education, social services, the justice system and employment may be able to identify problems which, if addressed early and appropriately, could forestall the development of mental health problems. It is important to note that this secondary prevention is significantly different from ‘early intervention’. Although early intervention is hugely valuable, it is equally valuable to identify issues which are not symptoms of illnesses, but are nevertheless worthy of intervention, because such intervention may prevent future functional difficulties. Good examples of this approach may be approaches identifying work-place stress or interventions aimed to care for looked-after children (see below).

### **Key points: Prevention and promotion**

- (a) There should be emphasis on and investment in preventative and health promotion work in this area.
- (b) There should be particular attention to adolescent mental health.
- (c) This necessarily means greater links between mental health services and education services.
- (d) Again, a social well-being ethos is likely to be maximally effective.

## The 'silvering society'

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We are all well aware that the UK and other nations are experiencing a significant demographic change, towards an ageing (or, as the Japanese say 'silvering') society. In order to maximise both the mental health and physical health of this sector of the population, the Foresight Report (Beddington, Cooper, Field, Goswami, Huppert, Jenkins, Jones, Kirkwood, Sahakian & Thomas, 2008) highlighted the importance of policies and services aimed at maximising the social inclusion and psychological well-being of older people.

It is unfortunate that, at least at present, an ageing population represents an increased risk of dementia. It has been estimated (Knapp & Prince, 2007) that the annual costs of dementia care exceed £17 billion. The demographic changes noted earlier indicate that prevalence of dementia is set to grow substantially in the future – perhaps from 680,000 in 2007 to 1.7 million people by 2051 (Knapp & Prince, 2007). Clearly this could place considerable strain on health and social services as well as family and carers. Indeed, of the annual £17 billion estimated costs, only eight per cent of this was due to health services costs, with informal care and lost employment estimated at 36 per cent of the total. This finding suggests that care for people with dementia cannot be separated from care for carers.

At the same time, not all aspects of ageing are negative. At least some studies of mental health indicate that both younger and older people have higher levels of psychological well-being than people of working age – a group which appears to have the highest prevalence of common mental disorders. There is some evidence that some aspects of psychological well-being – especially if assessed using measures of aspects such as a sense of coherence, rather than symptoms of formal mental disorder – improve with age (Stephens, Dulberg & Joubert, 1999). Again, this suggests that a policy focus on well-being, rather than merely mental 'illness' may have benefits.

### Key points: The 'silvering' society

- (a) Dementia, and the physical health problems of an ageing society, represent major policy challenges.
- (b) Informal carers shoulder a significant burden of care, and policies must protect the mental health and well-being of carers.
- (c) Again, a policy focus on well-being, rather than merely mental 'illness' may have benefits.

# The psychological well-being of young people

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Psychological models of mental health, quintessentially, emphasise the key role of a healthy, loving, supportive, connected childhood in producing well-adjusted adults. As psychologists, therefore, we fully and unequivocally support the emphasis in ‘New Horizons’ and elsewhere on the importance of a healthy start in life. As elsewhere, investment in positive policies to support parents, families and communities will pay dividends in terms of a healthy adult population.

In respect to major threats to the mental health of children, however, we know that adverse life events – and indeed abuse – in childhood significantly increases the risk of mental health problems later in life (Dube, Anda, Felitti, Chapman, Williamson & Giles, 2001). Perhaps as many as one child in four is at risk from abuse, 10 per cent of children have a mental health problem, and many continue to have problems into adulthood (Office for National Statistics, 2004). It must clearly be a key policy aim to protect children from abuse, to identify children at risk from abuse, and to help address any problems resulting from abuse at the earliest possible stage. We fully support the proposals in the ‘New Horizons’ initiative to develop policies to ensure a healthy start in life for children.

When, however, specialised care is needed, as elsewhere in mental health care, CAMHS often employ a very medical model; locating a ‘problem’ or ‘illness’ within the child or young person. Frequently the diagnosed problem will then be addressed by the use of medication or a ‘prescribed’ course of, for example, cognitive behaviour therapy (CBT). Non-medical, psychological approaches offer alternative or at least usefully complementary perspectives, but are both less dominant and available. Children who are in care will by definition have received less than adequate parenting and in addition will usually have experienced significant negative life events. Their generally poor outcomes in a variety of areas of adult functioning (e.g. being 50 times more likely to spend time in prison, 66 times more likely to require social care for their own children, etc.) are more appropriately attributed to the way in which these events have been processed psychologically rather than their presenting difficulties being labelled as mental illness.

Clearly, there is no suggestion that being a ‘looked-after-child’ is any sort of diagnostic label. But it is well recognised that children cared for by statutory agencies have experienced a range of threats (from other people and in their intimate relationships) to their well-being that can lead to internalised difficulties (and increased demands on mental health services) in later life. Offering services for such children is an investment in their future and their children’s future, and needs to go beyond offering ‘treatment’ for those meeting diagnostic criteria for ‘mental illness’. Other ways in which a psychological approach can improve outcomes for this most vulnerable group of children include improving understanding of the processes involved in placement breakdown, better matching of children and carers, improving professional understanding of children's needs, improving understanding of when rehabilitation home to birth families is appropriate and improving care planning when this is not in the child’s best interests. These areas of work have the potential to vastly improve childhood experience and thus improve psychological well-being and reduce negative outcomes.

A well-being focused approach should be used within services to address a child's or young person's physical and psychological needs in a more holistic manner by engaging supportively with the human systems that children are dependent on for their upbringing. Clear psychological formulation and evidence-based interventions for young people who offend have been shown to have a significant impact on psychiatric symptomatology, rates of re-offending, and number of days incarcerated, compared with standard probation services or individual therapy (Henggeler, Melton, Brondino, Scherer & Hanley, 1997; Schaeffer & Borduin, 2005). The Department of Health have committed to investing in trialling the establishment of 10 Multi-Systemic Therapy Services in the UK. This is a model which capitalises on the use of complex psychological formulations and evidence-based interventions. Innovative use of psychological expertise in this way is an important step forward in improving outcomes for these young people and society. Investment in well-being services for young people is a vital moral imperative but is also likely to be an 'invest-to-save' initiative. Care pathways should be designed using a psychological approach focused on well-being; a well-being approach is particularly relevant to children, where services for (for instance) looked-after children could prevent future distress and dysfunction without there being any necessary symptomatic marker. CAMHS services should also offer help directed at the level of the family unit, and the needs of children of parents with mental health problems must be addressed. CAMHS services need to be better integrated with other services – both other services offering mental health care and other services meeting the needs of children (particularly education and social care services). Clear strategies should be developed and shared in the planning for a young person's future so that they are able to access further education or employment, suitable housing and health care. Approaches to risk (including risk to self, risk to others, substance use, eating difficulties and safeguarding) should be preventative rather than reactive and accountability should be shared between agencies.

### **Key points: The psychological well-being of young people**

- (a) Psychological models of mental health, quintessentially, emphasise the key role of a healthy, loving, supportive, connected childhood in producing well-adjusted adults.
- (b) It must clearly be a key policy aim to protect children from abuse, to identify children at risk from abuse, and to help address any problems resulting from abuse at the earliest possible stage.
- (c) We therefore fully and unequivocally support the emphasis in 'New Horizons' and elsewhere on the importance of a healthy start in life. As elsewhere, investment in positive policies to support parents, families and communities will pay dividends in terms of a healthy adult population.
- (d) When specialised care is needed, a well-being focused approach should be used within services to address a child's or young person's physical and psychological needs.

## Employment

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Not having a job is perhaps the single most important cause of social exclusion among adults of working age, most obviously because it is usually associated with low income. It also contributes to social isolation, loss of confidence and lowered self-esteem (Social Exclusion Unit, 2004). Prolonged unemployment is linked to worsening mental and physical health, including an increased risk of suicide and premature death. Conversely, having a job can lead to a reduction in symptoms, fewer hospital admissions and reduced service use. Work and employment are the primary means through which people connect with their communities and build their lives. They have been shown to be strongly predictive of more positive, long-term clinical and social outcomes (Warner, 1994). In short, ‘work is good for you’ (Waddell & Burton, 2006) and being excluded from work is bad for both mental and physical well-being. Despite all the benefits of work, people with long-term mental health problems have the lowest employment rate of any of the main groups of disabled people – less than 25 per cent, compared with a rate of around 75 per cent in the working-age population as a whole. This is not generally because of an unwillingness to work, as survey evidence indicates that 70 to 90 per cent of people with mental health problems in the community want to gain or return to work (Rinaldi & Hill, 2000; Secker, Grove & Seebohm, 2001). Most people with mental health problems therefore want to work, if only they can be provided with the right kinds of help and support. Nevertheless, there has been a conspicuous reluctance on the part of many mental health professionals to accept the value of work and to think that they have any role in improving employment outcomes (Shepherd, 2007).

As recommended in Dame Carol Black’s report (Black, 2008), mental health services, together with JobcentrePlus and independent sector employment providers, should therefore help clients of mental health services to return rapidly to work wherever possible, and to keep them in work. We perhaps also need to consider a more flexible approach to what is meant by ‘work’, with active support for engagement in a continuum from unpaid (but meaningful, activity), through casual work to paid, full-time, employment. All mental health services – across appropriate specialisms – should include employment advisors. Providing opportunities for everyone with mental health problems who wishes to return to paid employment to do so, in a position consistent with their own aims and ambitions, would probably make the single largest contribution to improving the psychological health and well-being of the population of this country. Individual Placement and Support or IPS (Becker, Drake & Concord, 1994; Bond, 2004) has demonstrated, under random controlled trial conditions, that it can deliver employment outcomes which are at least twice as good as traditional alternatives (Burns, Catty, Becker, Drake, Fiaritti, Knapp, Lauber, Rosler, Tomov, Busschbach, White, Wiersma & EQOLSE Group, 2007; Rinaldi & Perkins, 2007; Salyers, Becker, Drake, Torrey & Wyzik, 2004; Becker, Whitley, Bailey & Drake, 2007).

## Key points: Employment

- (a) The costs to society from lost employment resulting from mental ill health are huge. The consequent benefits to society from investment in effective mental health services, as well as benefits to individuals, are equally huge.
- (b) There are a range of interventions known to be effective in terms of improving mental health as well as effective in allowing people to return to work.
  - Cognitive behavioural therapies – as developed through the Improving Access to Psychological Therapies programme – are known to be effective, as is Individualised Placement and Support.
  - Investment in these services should be extended.
- (c) More generally, mental health services, together with JobcentrePlus and independent sector employment providers, should help clients to return rapidly to work wherever possible, and to keep them in work.

## Improving access to psychological therapies

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Clearly, access to psychological therapies is an inevitable facet of any recommendations for mental health care provision predicated on the basis of a psychological well-being approach. We therefore fully support the Government's new Improving Access to Psychological Therapies Programme (Department of Health, 2007a). Of course, psychologists argue that they offer much more than psychological therapies – and without question more than cognitive behaviour therapy (CBT) (British Psychological Society, 2001). It is essential to continue to invest in high-quality, evidence-based psychological therapies; clients should have the choice of evidence-based psychological therapy such as that recommended by NICE if they want it. Indeed, NICE-approved psychological treatments for mild to moderate depression and anxiety (the conditions which form the basis for IAPT) would, given the capacity-building promise of IAPT, hopefully become the first psychological interventions offered as a legal entitlement to individuals who need them. The Care Quality Commission and similar bodies should monitor – and aim to reduce – the waiting time targets for psychological therapies. This aim should extend to all service users including those people who have traditionally experienced limited access: older people, children and adolescents, people with intellectual disabilities, people with chronic health problems and those from BME communities.

Clearly, economic circumstances may affect the NHS as much as any other area of public life. However, we also know that economic and social circumstances impact severely on people's mental health. Investing in the nation's mental health is crucial to economic recovery and societal well-being. This clearly includes continued investment in psychological therapies. Many service users, especially those most at risk, are typically only offered medication when both medication and psychological therapy are recommended. Outcomes, accordingly, are too frequently suboptimal; and this negatively impacts on both individuals' potential economic contribution and on service-related costs. To ensure the best possible outcomes for service users and, hence, for economic recovery, all mental health service users, current and potential, should have the same access to NICE-recommended evidence-based psychological therapies as they would to NICE-recommended medications.

Delivery models for such therapies need to incorporate 'stepped care' principles (Department of Health, 2008), but guided by expert assessments and individual case formulations; evidence-based psychological therapies such as CBT are valuable because of their demonstrable effectiveness, but should be used in integrative care plans based on psychological formulations addressing a person's wider well-being. A simplistic adoption of 'stepped care' may mean that someone requiring intensive support would have to fail to respond to several lower-level interventions before receiving the care required. In contrast, a formulation-driven 'matched care' model could ensure that, while proportionately fewer people may be offered higher-intensity (and more resource-intensive) interventions, these decisions are likely to be more clinically appropriate. Outcomes should be broader than mere clinical or symptomatic change but should also address functional outcome. It is very welcome that this emphasis is already part of the IAPT programme ... at least in principle. Perhaps most importantly – as mentioned above – the key recommendation that

*'all patients will receive drugs and treatments approved by the National Institute for Health and Clinical Excellence (NICE) where the clinician recommends them'* (Darzi, 2008, p.10) should be implemented. The effectiveness of CBT and other psychological therapies is clearly well established, and patients have a right to receive them. Clearly, a policy for implementing this admittedly ambitious aspiration is necessary. The IAPT programme is a good start, but a more comprehensive, appropriately staged and resourced, approach is necessary. We believe the proposals in this paper offer a framework for progress.

### **Key points: Improving access to psychological therapies**

- (a) It is essential to continue to invest in high-quality, evidence-based psychological therapies.
- (b) Delivery models for such therapies need to incorporate 'stepped care' principles, but guided by expert assessments and individual case formulations.

## Improving inpatient mental health care

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In-patient mental health wards are routinely criticised for a lack of meaningful activity and engagement, a lack of understanding and basic empathy, a paucity of therapeutically trained and supervised staff and a lack of strategic, co-ordinated care planning which addresses unmet needs. It is regrettable in this context that only 17 per cent of English mental health in-patient wards have a dedicated clinical psychologist (Bowers, Whittington, Nolan, Parkin, Curtis, Bhui, Hackney, Allan, Simpson & Flood, 2006); and fewer than 20 per cent of wards offer access to CBT (Sainsbury Centre, 2005). The inevitable over-reliance on medical treatment options, and under-emphasis on psychological and social interventions, means that service users on in-patient wards often fail to receive the care recommended by NICE. While promising initiatives have been undertaken voluntarily by some progressive mental health trusts, this gap in service delivery can only be resolved through action by the Department of Health and bodies such as NICE and the Care Quality Commission in setting minimum standards for psychology service provision to all in-patient service users alongside guidance as to which psychological and psychosocial interventions are most effective during hospital admissions. In-patients, like any other mental health service user group, would benefit from an approach to care focussing on psychological well-being. The Department of Health should significantly increase the contribution of applied psychology to in-patient care environments, both to provide direct care to service users and to train and develop staff. The British Psychological Society (2004) as well as the Sainsbury Centre (2005) recommend a ratio of one clinical psychologist for every 20 in-patients. Interventions during the in-patient stay should be integrated with multidisciplinary care and pre-admission and post-discharge care formulations, linked to developing understanding of the crisis, understanding distress, promoting self-knowledge and positive engagement with services, identifying unmet psychosocial needs and bringing about a safe and optimally early discharge.

### **Key points: inpatient mental health care**

- (a) Where residential care is necessary, 'hospital' care based on medical principles should be avoided.

## Staffing

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The adoption of a psychological well-being approach to mental health care has significant implications for staffing. Clearly, *psychiatry* would be expected to share clinical leadership of multidisciplinary teams, as consistent with New Ways of Working, whereby it remains a key profession, but with emphasis placed on a return to the core principles of applying medical expertise as it assists a multidisciplinary team in the understanding and treatment of mental disorder. *Nurses* could develop increasing competencies in psychosocial interventions. *Social workers* might see their roles develop and strengthen; consideration needs to be given to developing new roles of ‘social pedagogues’ along the European model. Occupational therapists could see their roles develop and strengthen. Clearly, *psychologists* would see their roles develop and strengthen as clinical leaders in psychological therapies and the scientific evidence base for psychological models.

Psychological specialists, including psychotherapists and counsellors expert in the delivery of particular types of psychological therapy, as well as applied psychologists, should lead on the development of individual formulations. Clients and communities would benefit from care planning based on individual case formulations; judgements incorporating the complexity and severity of clients’ needs. These should focus, in particular, on psychological processes. Clearly, such individual case formulations support personalised services and choice, a key policy objective of recent years (Care Services Improvement Partnership, 2006).

The role of these psychological specialists should be divided between different areas. Psychologists offer direct clinical intervention (whether with individual, group, couples, family and employment or educational systems) with service users presenting with high degrees of risk and complexity. Psychologists also offer training and support staff to deliver interventions at a range of levels of expertise (Management Advisory Service, 1989). Psychologists develop and support a supervision structure to develop staff potential and to recognise, acknowledge and address problems with workplace stress, morale and burnout. Psychologists develop formulation-based care plans with staff and service users. They provide clinical leadership on the use of psychological thinking throughout multidisciplinary care provision, particularly in developing improved care pathways into and out of inpatient environments, taking into account unmet psychological and psychosocial needs and promoting health and well-being, with enhanced responsibility for well-being agendas linked to behavioural change.

We believe, to reflect the increasing use of psychological approaches in the NHS, and to reflect the increasing adoption of a psychological perspective on well-being, that a post of Chief Psychological Officer should be established to ensure that advice concerning such psychological expertise is readily available to Government. We further believe that there should be development of the, to date, rather piece-meal use of inter-disciplinary bodies within the NHS and Department of Health. We believe that such multidisciplinary bodies should be supported and used by policy-makers.

Finally, as noted above, nearly all psycho-social interventions require dedicated and professional staff. Indeed, many (if not all) forms of psychological therapy achieve their

effects through the active engagement of the ‘therapeutic relationship’; where the relationship between the therapist and the client is the active agent for change. In addition to simple personnel management, therefore, it is absolutely essential that employing organisations take active and effective steps to maintain and support the positive mental health of their employees.

## **Key Points: Staffing**

- (a) Psychiatry:
  - Psychiatry should remain a key profession, but emphasis placed on a return to the key principles of applying medical expertise as it assists a multidisciplinary team in the understanding and treatment of mental disorder.
- (b) Nursing:
  - Nurses could develop increasing competencies in psychosocial interventions.
- (c) Social work:
  - Social workers might see their roles develop and strengthen.
  - Consideration needs to be given to developing new roles of ‘social pedagogues’ along the European model.
- (d) Occupational therapy:
  - Occupational therapists could see their roles develop and strengthen.
- (e) Psychotherapists and counsellors:
  - A range of psychological therapists, psychotherapists and counsellors who are expert in the delivery of particular treatment modalities should see their roles develop and strengthen.
  - We should adopt a collaborative approach across this multi-professional workforce, seeing each other as partners in this multidisciplinary new vision.
- (f) Psychologists:
  - Psychologists could see their roles develop and strengthen as clinical leaders in psychological therapies and the scientific evidence base for psychological models.
  - Psychologists need to be prepared to offer consultation and clinical leadership.
  - Psychologists should be based within the communities they serve.
- (g) Employing organisations must take active and effective steps to maintain and support the positive mental health of their employees.

## Clinical leadership and care-co-ordination

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The Mental Health Act 2007 offers considerable potential for the development of a more appropriate approach to psychological well-being – even for people in extreme distress. As envisaged in the New Ways of Working programme (Department of Health, 2007b), responsibility for compulsory care will now be better distributed across competence-based teams, capable of providing efficient person-centred care and appropriate choice. The allocation of a responsible clinician must be based on the individual needs of the patient and should be the approved clinician with the expertise best suited to oversee that patient's most pressing and significant treatment needs. With the growing evidence of the effectiveness of psychological approaches, care provided under the auspices of the Mental Health Act 2007 is explicitly intended to reflect a full multi-disciplinary care plan. Clearly this is intended to support – even in compulsory situations – a well-being approach. The Mental Health Act 2007 includes the provision for 'supervised treatment in the community for suitable patients following an initial period of detention and treatment in hospital'. In the light of a well-being approach to mental health care, and especially the benefits of non-medical, non-hospital, community-based care where appropriate, many psychologists support such provisions (although we are mindful of the controversies and concerns) as representing a benefit to people in terms of more appropriate treatment, or be a least restrictive alternative, or better preserve and support or create the person's private and family life.

The extended professional roles under the new Mental Health Act constitute a significant development in 'a cultural shift in services that enables those with the most experience and skills to work face-to-face with those with the most complex needs' (Department of Health, 2007b, p.14). It also takes forward the promotion of distributed responsibility and leadership across teams. Applied psychologists are committed to and are in the vanguard in supporting the Government in the successful implementation of the new mental health legislation that will contribute to the delivery of safe and effective modern mental health services. Psychologists and other mental health professionals with appropriate skills and competencies should be given autonomy and seniority. Implementation of the Mental Health Act 2007 should proceed assertively on this basis and a full programme of research into the progress of the implementation the Mental Health Act 2007 and into the effects and consequences of the legislation should be instituted. Early opportunity should be taken to complete the half-finished process of legislative reform, and further legislative reform should also ensure that the provisions of mental health legislation should be limited to persons whose ability to make decisions about the provision of care is significantly impaired.

### **Key points: Clinical leadership and care-co-ordination**

- (a) Psychologists and other mental health professionals with appropriate skills and competencies should be given appropriate autonomy and seniority.
- (b) Implementation of the Mental Health Act 2007 should proceed assertively.
- (c) The current care co-ordinator role needs to be revised from a generic role with considerable administrative emphasis, divorced from clinical leadership and instead be transformed into a role more akin to the 'Responsible Clinician' role created by the Mental Health Act 2007.

## Recovery

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The ‘recovery’ approach stresses the benefits and importance of building a meaningful and satisfying life, as defined by the persons themselves, whether or not there are ongoing or residual difficulties associated with mental health problems. The recovery approach therefore represents a movement away from a focus on pathology, illness and symptoms to health, strengths and wellness (Shepherd, Boardman & Slade, 2008). The recovery movement stresses the importance of finding and maintaining hope: believing in oneself; having a sense of personal agency; remaining optimistic about the future. It emphasises the benefits of re-establishment of a positive identity: finding a new identity which incorporates illness, but retains a core, positive sense of self. People are encouraged to build a meaningful life: making sense of their difficulties and finding a meaning in life, despite such problems. Finally, people are encouraged to take responsibility and control of their mental health problems and their wider lives (Andresen, Oades & Caputi, 2003). By focussing on psychological processes and the environmental factors that impinge on these processes, psychosocial models are likely to be particularly applicable to the recovery approach. The recovery approach also requires a different relationship between service users and professionals. Instead of exercising ‘authority’, professionals would behave rather more like a personal coach or trainer: *‘offering their professional skills and knowledge, while learning from and valuing the patient, who is an expert – by experience’* (Roberts & Wolfson, 2004). Professionals should therefore aim to provide people with the resources – information, skills, networks and support – to achieve their own recovery as far as possible and to help them to get access to the resources they think they need to live their lives. This is entirely consistent with the orientation described in *New Ways of Working* (Department of Health, 2007b). Repper and Perkins (2003) have neatly summarised this change as professionals being ‘on-tap, not on top’. Government departments must develop integrated policies in this respect; integrated and comprehensive care plans for socially disadvantaged or excluded persons must link health and social care agencies, education, the benefits and employment system, the justice system and beyond. These care plans should address rather than avoid all aspects of a person’s well-being beyond symptoms of mental ill health, including; physical health care, educational opportunities, housing, employment. Staff should facilitate service users’ progress towards recovery and offer support in maximising well-being. Of course, these ideas are not new. As outlined above, Lord Darzi and Dame Carol Black recommended exactly these ideas. But clear steps need to be taken to implement these shared aspirations.

### Key points: Recovery

- (a) By focussing on psychological processes and the factors that impinge on these processes, psychosocial models may be particularly applicable to the recovery approach.

## Services need to facilitate genuine service user involvement

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The users of mental health services and their carers make up a large proportion of users of public health services in Britain. One in four people in the UK experiences a psychological problem of significance at some point in their lives, and around one in seven at any one time. It seems rather unnecessary to argue that we should actively include such a large proportion of the population in decisions involving these hugely significant services. The involvement of service users and carers in all aspects of mental health services – planning, designing, commissioning, implementing, delivering, governing and managing and evaluating – can improve the effectiveness and quality of services and, ultimately, mental health outcomes. NHS Foundation Trusts should have governing bodies with full executive authority similar to those in education, where service-user governors and local authority governors would serve alongside management representatives.

Obviously, service users and carers are a very diverse group and thought must be given to representing different experiences and in ensuring inclusive approaches which will maximise the chance of people with very significant levels of mental impairments and social problems to play full participatory roles in such systems. Service planners must do more to improve the communications strategies and communications standards employed across the health care sector to ensure that service users, carers and the public at large can understand and interact fully. We believe that developments such as the ‘experts by experience’ initiative of the National Institute of Mental Health in England should be supported. We believe that full involvement of service users in the design and governance of the health and social care system would be facilitated by better clarification of the roles and responsibilities of service user colleagues, by equitable remuneration and by the payment of reasonable expenses. We believe that such steps would help reduce tokenism and encourage further positive involvement. Finally, of course, discriminatory practices that make it difficult for people with a history of mental health difficulties to work in the NHS should be removed.

### **Key points: Service user involvement**

- (a) Models explaining distress and disorder in terms of the way various factors impinge on psychological processes tend to emphasise the normality and explicability of individual experiences.
- (b) This may serve to undermine ‘them-and-us’ attitudes and thus support genuine service user involvement.
- (c) Full participation by service users and carers as colleagues might be helped by better clarification of roles and responsibilities, and by payment of reasonable remuneration and expenses.

## Equality and inclusion: Stigma, discrimination and human rights

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In 2006, the Sainsbury Centre for Mental Health commented that a more tolerant and understanding society *'would bring about the biggest improvement in the lives of people with mental health problems'* (Sainsbury Centre for Mental Health, 2006, p.12). The British Psychological Society Division of Clinical Psychology has stated that it aspires to a society that regards discrimination against people with mental health problems being *'as unacceptable as racism or sexism'* (British Psychological Society, 2000, p.7). Negative attitudes can be seen in three areas: ignorance, prejudice and discrimination (Thornicroft, Rose, Kassam & Sartorius, 2007). These require distinctive responses; information aimed at countering ignorance, social inclusion programmes designed to increase contact between people with mental health problems and the wider community and thus combat prejudice, and legislation aimed at identifying and addressing discrimination.

Public 'anti-stigma' campaigns often attempt to address the media presentations of mental health issues which emphasise dangerousness and risk with more appropriate messages. Messages with a clear theme of social inclusion; such as *'all different, all equal'* (<http://alldifferent-allequal.info/>) are very welcome (Huxley & Thornicroft, 2003). Other programmes may be misguided, however. Simple educational approaches appear largely ineffective in changing behaviour. For example, campaigns that stress biomedical explanations of mental health problems are undeniably well-meaning, but too much emphasis on the concept of a biologically-based (even genetic) illness may reinforce notions of dangerousness and stigma, and actually increase social distance (Read & Harre, 2001; Read, Haslam, Sayce & Davies, 2006).

Psychologists, in contrast, tend to argue that a psychosocial approach to mental health problems – stressing how we all respond to stressful situations, normalising mental health problems and explaining how mental health problems are distressing and eminently deserving of help, but also understandable and inherently part of the human condition – is most likely to reduce prejudicial attitudes. Truly positive responses from services and the community as a whole will be facilitated by a general appreciation that mental health problems are not something completely other and alien, but are something we might all experience in certain circumstances, and which should be thought about in the same way as other human experiences. Discrimination is common in the field of mental health, with harassment and denial of job and housing opportunities and other services being commonplace. Indeed, the term 'discrimination' should perhaps be preferred to the term 'stigma', which implies that there is something shameful about mental health problems. Issues of discrimination in mental health care, including 'multiple discrimination', require particular attention, and Government should take the lead in this area.

For psychologists, issues of human rights are not abstract, legal, provisions, but reflect formalised systems for ensuring that people's basic needs are satisfied – talking about 'human rights' is another way of describing how well-functioning societies work. In practice, this means that human-rights compliant services adhere to the principles of Fairness, Respect, Equality, Dignity and Autonomy – the FREDA principles (Butler, 2005),

but also that services operating in this way are likely to be offering highest-quality care (Kinderman & Butler, 2006). It follows that we must be vigilant, perhaps through bodies such as the Care Quality Commission as well as the Commission for Equality and Human Rights, in ensuring that services adhere to anti-discriminatory practice (Sayce, 2003). This could, for example, mean addressing the equality consequences of particular services' inclusion criteria – women tend to experience some forms of psychological distress later in their lives than men, meaning that age restrictions on early intervention services may need careful consideration.

Access to psychological therapies for Black and Minority Ethnic (BME) communities is particularly poor. Mental health problems are related to social isolation, racism, poor housing conditions, lowered employment status and poor educational opportunities in BME communities. To help address this issue, services should move the focus from the individual to address the psychological needs of the wider community. Mental health services should promote equality in access to mental health services for all, and should ensure that BME patients and their carers are engaged at all levels of planning and implementation. They should provide accessible and meaningful information in a user friendly, meaningful manner, should ensure that mental health services are offered in nonstigmatising, non-institutional settings in the community and take steps to work with community groups and the voluntary sector, and should ensure that staff of all different professional backgrounds and grades of seniority are trained and competent in equality and diversity awareness and cultural competency skills and knowledge.

The social inclusion of people with mental health problems must be promoted; as positive contact between people with and without mental health problems is increased and social distance and in turn stereotyping is reduced (Alexander & Link, 2003; Corrigan, Edwards, Green, Diwan & Penn, 2001; Gale, Seymour, Crepaz-Keay, Gibbons, Farmer & Pinfold, 2004). In the specific field of mental health care, this means developing services other than those forms of treatment and therapy which target the individual – and this extends not only beyond medical treatments to the psychotherapies, but also, crucially, beyond the psychotherapies to social interventions designed to achieve change at the level of the system, the community or even at societal level. This approach is, of course, entirely consistent with the 'New Horizons' initiative. 'New Horizons' is about, in part, non-medical/non-health services which promote mental health and well-being at a community level. Developing these services, and the policies that support them, may particularly help people from BME communities.

## **Key points: Equality and inclusion: Stigma, discrimination and human rights**

- (a) The term 'discrimination' should be preferred to the term 'stigma'.
- (b) Issues of discrimination in mental health care, including 'multiple discrimination' require particular attention, and Government should take the lead in this area.
- (c) A social or 'well-being' ethos is most likely to reduce prejudicial attitudes.

## Connected communities: connected services

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From a psychological perspective, one of the most welcome aspects of the ‘New Horizons’ initiative is the (perhaps belated) acceptance of the fundamental role of social factors in the development of mental health difficulties and, conversely, in the maintenance of well-being. Of course, this view is well-supported in the literature (see World Health Organisation, 2003; European Commission, 2005). Nevertheless, it is welcome that New Horizons and the Future Vision approaches both stress the importance of a public health or social approach to supporting well-being.

As is clear from all these sources, perhaps especially the EU Green Paper on mental health (European Commission, 2005), the difficulties addressed here are multi-factorial and require multi-agency solutions (see also Kinderman, 2008). As envisaged in the ‘New Horizons’ initiative, this requires the building of healthy connected communities – of service providers as well as in wider civil society. An individual attending a debt management clinic may require a parenting support service to further enhance or preserve their well-being, but under typical current arrangements, this need will not be recognised by the debt management service; it might be picked up at the next GP visit, or might be identified by the individual, if luck will have it, should they see a poster at their children’s primary school. Chances are, however, that this need will go unrecognised, and unmet, for some time after debt issues are resolved, maintaining suboptimal well-being in the interim.

We are concerned that services have been unwittingly set up as stand-alone silos and that too much emphasis is placed on the GP surgery to act as sole care co-ordinator, responsible for traditional primary care but also for developing a prioritised care pathway for newly validated interventions. We are confident that the early detection of problem areas can be shared out to service leads, can be entrusted to individuals through self-assessment and referral, and can be sequenced by priority, and communicated and networked via technological advances. We further believe that the responsibility for societal well-being rests across services, many of which are provided through primary care but also through other Governmental departments and the voluntary and social care sectors, and that the solution to preserving and enhancing well-being requires a holistic, across-network strategy.

The ‘New Horizons’ initiative aspires to this, but lacks clear policy initiatives to achieve this aspiration. Psychologists have proposed evolutionary developments in the way that services in the community may work together better (for instance, the ‘Connecting Communities Network’ model). These approaches envisage a subtly new type of service network, linked into a ‘connected communities network’. In this approach, each link organisation in the ‘connected communities network’ provides a vital yet relatively distinct service which contributes to societal well-being. The model seeks to raise the degree of interconnectivity through two distinctive tools: the ‘connected communities network champion’ and comprehensive multi-agency assessments.

The role of the ‘connected communities network champion’ in each member organisation could be envisaged as ensuring that the member organisations are linked and working together, but would also be responsible for ensuring that staff and service users are able to conduct comprehensive assessments (possibly using computer-based self-assessment

technology) which address issues pertinent to well-being across the areas of functioning of the whole ‘connected communities network’, and then share that information across all agencies.

With the help of the ‘connected communities network champion’ and such a comprehensive cross-agency assessment, service users attending one network organisation could be linked more effectively to another where they have an identified unmet need.

If this were facilitated with new technology, such shared care planning could be instantaneous and automatic. For example, someone seeking debt advice might, through undertaking self-assessment with the assistance of a champion, identify that they would benefit from IAPT services (as they appear to meet criteria for moderate depression) and parenting support and training (as their self-rated score for their child’s emotional well-being identifies a potential problem). They might seek advice on medication use from a community pharmacist as well as from their GP and community psychiatrist.

A model such as this could provide a relatively simple and cost-effective solution to the challenge of providing comprehensive, connected, services, combining the full potential of trained personnel, technology and, crucially, the self-initiated efforts of the service user requiring help to improve their health and well-being. It may go some way towards connecting communities as envisaged in ‘New Horizons’.

### **Key points: Connected communities: connected services**

- (a) Multi-factorial problems require multi-agency, community-wide, solutions.
- (b) As envisaged in the ‘New Horizons’ approach, maximal psychological well-being depends upon connected, health, communities.
- (c) We therefore fully support the emphasis given to these issues in ‘New Horizons’ and the work of the Future Vision coalition.
- (d) Novel mechanisms of integrated, comprehensive, service delivery should be developed to facilitate such community development.

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