The Flourishing Society

What is “more useful stuff” in a mental health context and how do we make it work?

MACC has long argued for a shift in the way people with mental health needs are supported: a move towards facilitating a range of activity rather than simply providing a defined, rigid service. This is the shift between “doing with” rather than “being done to”: the co-production ethos.

If this approach is adopted, one thing which you would see is a reduced dependency on expert professionals and the “magic bullet” approach where the latest drugs or the currently fashionable prescribed intervention (such as Cognitive Behavioural Therapy) are seen as the only solution. What would increase would be the range of activities which engage people in meeting their own everyday needs.

The incidence of mental health problems continues to rise and has reached epidemic proportions. 1 in 3 GP appointments in Manchester are for a mental health issue. The state makes a massive investment in psychiatric care and treatment yet: why is there apparently no progress in getting to grips with mental health? Research indicates that medical or clinical fixes have been shown to have little positive impact, indeed they often make the problem worse. Nonetheless they are often the only response on offer.

In the US, the director of the National Institute of Mental Health has stated that “the current status of all known treatments for mental illness is palliative at best”; and according to Insel and Scolnick (2006) “none are even proposed as **cures** which begs the question why do we invest so much in such treatments?

That is not to dismiss drugs entirely: there is evidence that anti psychotic drugs can be helpful for **short** periods at **low** doses for about 10% of people affected. Where this approach is adopted the long term outcomes for recovery are significantly improved compared with those who remain on medication. Yet they are routinely offered in irrationally high doses to everyone for long periods. These drugs are marketed as correcting a chemical imbalance yet there is no conclusive evidence to support chemical imbalance theories as being causes of “schizophrenia” or “depression”:

- People on antidepressants do not do better than people who don’t take them (Brugha et al, 1992; Ronalds, 1997)

- Increased antidepressant use is associated with increased prevalence and duration of depression, and increased sickness benefit claims (Patten, 2004; Moncrieff & Pommerleau, 2000)
- Long-term outcomes for treated depression are poor (Goldberg, 1998, Tuma, 2000; Kennedy, 2003)
- Antidepressant use is associated with increased time off work compared to no use (Dewa 2003)
- For a detailed review of the evidence on antipsychotic medication see Robert Whitaker "Anatomy of an epidemic".

However there is an evidence base for interventions which seek to make people or communities more resilient. Resilient people tend to be healthier and are quicker to recover from periods of illness:

> Levels of mental distress among communities need to be understood less in terms of individual pathology and more as a response to relative deprivation and social injustice, which erode the emotional, spiritual and intellectual resources essential to psychological wellbeing. While psycho-social stress is not the only route through which disadvantage affects outcomes, it does appear to be pivotal.
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> Dr Lynne Friedli (2009).

During the 1940s, Abraham Maslow rejected the investigation of pathology and instead studied why some people fulfil their potential. This is now referred to as an "asset based approach". He concluded that personal fulfilment was underpinned by a range of factors which he called a hierarchy of needs. These include basic physical needs for food, water, clothing and shelter; social needs in belonging with family, friends and neighbours; enough money; a sense of purpose through work/creative activity; sense of meaning through spiritual or some other personal philosophy. At the top of the hierarchy Maslow placed the idea of personal fulfilment. He also argued that such fulfilment or mental health could not be achieved if needs lower down the hierarchy are not met.

The prevalence of mental ill health is not surprising. For most people, the world is one of poor social, environmental, political and economic conditions that most people experience. Add to this a Western culture which has cultivated the idea of fulfilment as being the individualistic acquisition of consumer goods, fame as the highest measure of success and the increasing sense of powerless felt by people living in a local area but finding that their lives are shaped by global economic forces.

Wilkinson (2010) says that "given the importance of social relationships for mental health, it is not surprising that societies with low levels of trust and

weaker community life are also those with worst levels of mental health. Low position in the social hierarchy is painful to most people so it comes as no surprise that the use of illegal drugs is more common in unequal societies"

The Big Society approach promoted by the Government appears to be rooted in this kind of thinking. We are told that key to it are concepts of co-production and asset based approaches which, at their best, seek to shift the emphasis away from "dependence" on institutions and towards greater self reliance and increased social inclusion and cohesion or "interdependence". But the political presentation of the Big Society concept and the Government's agenda has conflated the reduction of "dependence" with the reduction of public spending: as if society needs weaning off the state. We do not intend to argue that there is no place for the public sector or professional expertise, merely that it should change.

We need to retain ownership of the real meaning of these ideas of co-production and asset based approaches: it is not, despite the stories in many of the media, about dependence being an entirely negative thing associated with scrounging or fecklessness but an inevitable outcome of an over emphasis on professional or technological fixes for what are ordinary problems of living. This dependency is a paradox entirely born out of the inevitable rigidity of institutions: many people who have long term mental health problems have few meaningful friendships. Often, the one thing which would make most difference to them is friendship. The paradox is that in such cases the person they have most contact with is a worker such as a Community Psychiatric Nurse and professional guidelines forbid the development of friendships. It's entirely understandable how this situation has evolved but it does mean that the institutional approach is incapable of delivering the one thing which would bring most benefit.

None of this is any different to the conclusions of a succession of high profile studies over the last two decades: we need to invest more in prevention. The most intensive support should be targeted at those with the greatest need but investment in prevention will reduce the levels of need. Everybody seems to agree with this yet the missing element has always been the investment, even when there has been more money in the system: why hasn't it worked?

This is an issue of power: there is a need for people who control resources to release power to people who are not like them and who don't make judgements on the same basis. Institutions are "organisations which have become a tradition": therefore they have the more established and secure position. While we argue that challenging the institutional culture of planning and delivery are important we are making a case for a more effective use of the investment which currently sustains them. This is about changing the way the state works, not about dismantling it. At present the infrastructure doesn't

really exist which can both lead and manage this. As noted in the "More Useful Stuff" article, commissioning has come to mean the bulk-purchasing of pre-defined services: the processes which could be creating the flexible co-production approach are binding the voluntary and community sector into ever tighter contracts, institutionalising the sector which is noted for its informality.

We therefore need to find ways for commissioning to enable communities and individuals to work with professionals in an equal and reciprocal way to create the conditions which strengthen personal and community resilience.

One example is the concept of "timebanks". This and other social innovations[1] enable people to be part of the solution in a more sustainable way. It is different to the idea of professional services in which there are "providers" and "users". It is a form of volunteering but goes much beyond the traditional view of volunteering as public spirited "giving up your time": there is an exchange of benefit and it is therefore more sustainable through not being reliant on an adrenaline rush or temporary enthusiasm.

Initiatives such as time banks or recovery programs underpinned by effective peer mentoring schemes may offer greater opportunities for developing the kind of relationships which are essential to recovery and for enabling people to develop a more socially valued role in the process. This is not about providing a predetermined service but creating a culture which facilitates and supports people to define and get for themselves whatever it is they need to recover from mental and emotional distress: enabling people to flourish.

How commissioning could put this in place would be to support the important job of facilitating this activity: grant funding using an outcomes approach. It could be provided by local voluntary sector groups, social enterprises, Registered Social Landlords, the NHS, Local Authorities or any combination of the above. In MACC's experience it helps to have a range of partners involved. Motivation and approach are more important than organisational form.

MACC has been working with a range of partners in North Manchester to develop this kind of approach. If you are interested in finding out more, please contact me.

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[1] (For a broader range of examples see Urban Forum's *Guide to Community Resilience*.)