Making up our minds: towards improving our approach to mental health

A collection of essays from Conservative MPs

April 2013
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Contents

Foreword 4
James Morris MP

Foreword 5
Professor Sue Bailey

Essays
It’s not rocket science – it’s mental health 7
Oliver Coleville MP

The importance of early intervention 9
Andrea Leadsom MP

Towards more effective treatment 11
James Morris MP

Mental health for veterans 13
John Glen MP

A time for optimism 16
Charles Walker MP

The reality of television in the representation of mental health 18
Matthew Offord MP

The role of the voluntary and community sector in good mental healthcare 21
Nicky Morgan MP

Enhancing mental healthcare among the general population 23
Robert Buckland MP

Commentaries
Dr Adrian James 27
Maurice Arbuthnott 29
Dougie Pickering 32
Evelyn Bitcon 33
Dr Andrew Camden 35
The debate surrounding mental health is rising up the political and health agenda. For too long mental health had been seen as a Cinderella service in the National Health Service (NHS) – underfunded and not given the same priority as other health conditions. Yet there is evidence that this might be changing. There is recognition among policy makers that more must be done to address the way we approach mental health. As we become more physically health-conscious and live longer, the treatment of mental health will become one of the central challenges for the NHS.

During the past 12 months there has been extensive debate and discussion about mental health in Parliament. The Backbench Business Committee brought a debate to the main chamber of the House of Commons where speeches by Charles Walker and Kevan Jones about their own experience of mental illness changed the terms of political debate; the All Party Parliamentary Group for Mental Health has done much good work on engaging with the wider health community and challenging government. The government itself produced a strategy in No Health Without Mental Health – which sets out the government’s priorities very clearly – and followed up with an implementation plan in July 2012.

These essays aim to make a positive contribution to this debate. All of the contributors are Conservative MPs who have taken an active interest in mental health, whether due to their own personal experience or engagement with the issue in their constituency. It is important that parliamentarians across the political spectrum engage in this vital discussion.

The essays give a range of perspectives on the issue of mental health. From the role of the voluntary and community sector, to the need for focused early intervention and the impact of mental health on veterans, the essays demonstrate the complex nest of policy issues we face when confronted with the growing issues of mental illness in advanced Western societies such as Britain.

The way we deal with mental health in the future will say much about our values as a society. As modern life becomes more complex and challenging, there is an urgent need to ensure that we deal with mental illness not as something with which to stigmatise people, but as a real health issue which demands a compassionate, coherent and effective response.
If more evidence was needed that mental health is moving fast up the political agenda, then this collection of essays from eight Conservative MPs helps to make the case. The collection, Making Up Our Minds, was published at a meeting at the House of Commons earlier this year, co-hosted by the independent charity Centre for Mental Health.

From the government’s strategy No Health Without Mental Health (an echo of the Royal College of Psychiatrists’ campaign a few years back) to the mandate of the new National Health Service Commissioning Board giving parity to mental health, this is one more step towards giving mental health the priority it deserves.

Policy makers and politicians increasingly recognise the central importance of mental health to the overall health of the nation and I am delighted that parliamentarians – in the Lords as well as the Commons – are making valuable contributions to the debate. As well as the detriment to individuals and families, mental ill health costs the economy a huge amount of money in care expenditure and lost productivity – something that should interest all politicians.

The Royal College of Psychiatrists is always ready to work with politicians. Together with Mind and Rethink Mental Illness, we published (in late 2012) MPs and Staffers’ Guide to Mental Health, which gives advice on supporting constituents with mental health problems. This was well received, so it is good to be involved with another mental health project that involves our elected members of Parliament.

The collection makes for interesting reading and reflective thinking, with topics ranging from the armed forces and veterans, to stigma, effective treatment, the role of television, and the voluntary and community sectors. I was interested to see the focus some of the authors put on prevention, making the case for more talking therapies and the need to consider the specific needs of young children, adolescents and older people. I am a big advocate of compassionate care that meets the needs of individuals at different stages of their lives. The funding and organisation of health services is perhaps a debate for a different time, but remains, nevertheless, an important topic to consider if we are to realise the aspirations for future services envisioned in these pages.

These essays, whether motivated by personal experience, constituency concerns or a general interest in the topic, are a welcome addition to moving mental health issues higher up the public health agenda, and for that I am grateful.

Foreword
Professor Sue Bailey
President, Royal College of Psychiatrists
Essays
It’s not rocket science – it’s mental health

Oliver Coleville MP

Upon my election in 2010, I pledged to campaign on our armed forces’ mental health. It resonated in my Plymouth Sutton & Devonport constituency because it is the home of 3 Commando Brigade which comprises the Royal Navy, Royal Marine and 29 Commando.

Parliament’s decision in 2011 to enact the armed forces covenant demonstrates that political decision makers and opinion formers are serious about providing mental health solutions and resources for our soldiers, sailors and airmen. It also sought to focus on their families’ welfare. It enshrined all of the proposals contained in retired Surgeon Commander and SW Wiltshire MP Dr Andrew Murrison’s Fighting Fit report. This report set out a route map for dealing with veterans’ mental health. It recommended setting up a mental health help line, recruiting more specialist mental health nurses and committed the Secretary of State for Defence to reporting back annually to Parliament on the progress that his department has made during the previous year. It recognised that the families are in the front line and their support is vital for morale.

I am delighted that the Prime Minister recognised Dr Murrison’s hard work and recently appointed him as a Defence Minister in the recent Cabinet shuffle. I hope that he will have a practical influence in the department’s approach towards dealing with our veterans’ mental health.

According to the highly respected charity Combat Stress, it is estimated that 960 service personnel will leave the armed forces with the likelihood of having post-traumatic stress disorder (PTSD).

Recent Ministry of Defence statistics showed an increased risk of developing PTSD – 330% from the Iraq conflicts and 530% from the current Afghanistan conflicts. Combat Stress also believes that 1 in 3 veterans are too ashamed to tell their families about their mental health disorder and 55% of general practitioners (GPs) feel that there is a stigma associated with veterans’ mental health.

However, although I welcome the excellent work that the government and Parliament have done for our regular troops, I am also keen to see a similar strategy for our reservists who are likely to play a greater part in any future conflicts. In reducing the size of our standing army, navy and air force, making greater use of our Territorial Army and deploying them as a specific united reservist unit, we need to make sure that this information is shared with charities such as the Soldiers, Sailors, Airmen and Families Association (SAAFA), Combat Stress and the British Legion so that they can receive the same amount of support as regular servicemen. They also need to be given the same amount of decompression time after their deployment.

In September 2012’s second reading of the Mental Health (Discrimination) Bill, I and many of my colleagues said mental health is society’s last taboo. Too often people are scared of people with mental illness.
I welcomed the last Labour government’s decision to pardon the 306 armed servicemen who were shot for cowardice during the First World War. I agree they were blameless and were shot for having severe psychological trauma. It is estimated that it can take up to 15 years for this mental illness to become apparent and that some veterans (and it is mainly retired soldiers) are only just coming to terms with the state of mind some 30 years after their experiences in the Falklands.

By repealing Section 141 of the Mental Health Act 1983 which deals with the disqualification of MPs and members of devolved bodies as well as preventing people from serving on juries, we will be allowing all our veterans to play a full part in civic and public life. They will not be stopped from playing a full part in the decision-making process.

Like most physical ailments, mental ill health can be cured. It isn’t a life sentence – it is a pain barrier that can, with help, be worked through.

I am concerned that although politicians and the government are keen to talk a good story over mental health and pass legislation, it doesn’t always get picked up on the ground; we need to work much harder in ensuring that those people who are responsible for delivering our public services, like our policemen and women, our accident and emergency nurses, our firemen and our GPs, are better trained. I want to see more coordination between all of these services on the ground and avoid mental health funding being considered just an add-on.

Last summer, in my role as a vice-chairman of the All Party Parliamentary Group for the Armed Forces, I was asked to help a young man who had seen action in Afghanistan and who had obsessive–compulsive disorder and was forced to remain in barracks until the last day of his service despite a worsening in his mental health condition. I was asked to contact the Ministry of Defence as it appeared that the family was having real difficulty in explaining the young lad’s problem to the ill-informed military chain of command.

We also need to ensure that our GPs – especially in garrison towns and cities like Plymouth – have a better understanding of combat-related mental health problems.

But we also need to recognise that many people who come in contact with the police and the judiciary quite often face real mental health challenges.

During the summer recess I visited Plymouth’s Charles Cross Police Station’s custody suite – named in 2006 as the second busiest in the UK. I was told that quite regularly people with mental health problems have to be put into the cells when they should be referred to Derriford Hospital’s Glenborne Unit in line with Section 136 of the Mental Health Act; it appears Plymouth, like most towns, unfortunately doesn’t have the necessary facilities.

My local police feel this is inappropriate treatment and in some cases makes matters worse. The custody officers don’t feel they receive the necessary training. They would welcome a qualified mental health nurse being attached to their unit.

To sum up: I want more training for our front-line service providers and a more joined up approach. By removing the stigma surrounding mental health, we can remove the last taboo and end another form of discrimination.
Life can deal us some unfortunate cards at times, whether it’s a relationship that breaks down, being bullied or developing an addiction. But as arbitrarily dished out as these may seem, some of us will be more likely to experience these difficulties than others, and it’s all down to our earliest life experiences.

During the first 2 years of life, a blueprint is mapped out that determines how a baby's life will look in the future. In the majority of cases, a loving and nurturing caregiver will be able to lay the foundations for a future of emotional pliability and security. When this does not happen, we are instead priming our young people to be dealt some of those raw-deal cards. It is easy to think that these are distributed indiscriminately, but the truth is that the majority of individuals with an insecure attachment are much more likely to experience these acute difficulties later in life.

There is evidence that shows that more than 80% of long-term prison inmates have attachment problems that stem from babyhood. It is also now believed that you can predict two-thirds of future chronic criminals by behaviour seen at the age of 2.

Some of the statistics issued by the Office for National Statistics over the past decade show that almost 80,000 children and young people have severe depression and that 95% of imprisoned young offenders have a mental health disorder. All of this points to the devastating consequences of poor early relationships.

Parent-infant psychotherapy seeks to address a whole spectrum of cases where a child’s relationship with their primary caregiver is compromised. From minor cases of postnatal depression to more severe cases of neglect, early years’ intervention seeks to promote secure attachment between parent and infant.

The human brain is itself only partially formed when you are born. The billions of neurons in the brain are largely undifferentiated at birth, and there are parts of the brain that are simply not there. In the space of 2 years, a baby’s brain goes from being 25% of its adult weight to 75%. But just as you would expect a baby’s limbs and abilities to develop, so too does the brain. This ability for the brain to grow is called the maturational base, where a baby’s in-built developmental programme unravels, providing that environmental factors allow for this. It is the earliest experiences of the human baby that literally hard-wire his or her brain, and it is these earliest experiences that will have a lifelong impact on the baby’s mental and emotional health.

We encourage our children’s growth in many ways. Breast milk protects them from illnesses and allergies, and we help them to their feet as they toddle. The brain is no different, and playing games like peek-a-boo, responding to their cues and singing songs will contribute to their brain’s healthy development.
There are many circumstances, however, when this will not be taking place; from young single mothers who have come from abusive backgrounds themselves, to successful professionals becoming first-time parents: insecure attachments, as the technical term describes it, are no respecter of wealth or class.

Human misery is only one feature of insecure attachment. There is also a vast financial impact on the public purse in dealing with the consequences of poor early attachment. Each Looked After child costs the taxpayer £347 a day. Each adult prison inmate costs the taxpayer £112 per day. And each person in acute psychiatric in-patient care costs the taxpayer £225 per day. Comparatively, one session with a psychotherapist will cost about £45.

Parent–infant psychotherapy offers a life-changing intervention for struggling families. Yet it is not widely available and not yet widely understood. The perception of mental health itself needs to change if we are to overcome the view that depression or other mental health problems are something that simply 'happen' to people and that they can snap out of it. That simply is not the case. A step-change could be achieved through better front-line training, so that health visitors and social workers are aware of the implications of insecure attachment. The increasing awareness of parent–infant psychotherapy means that front-line staff will be able to signpost cases where intervention is required.

Children’s centres are the ideal base for early years’ intervention, and some already seek trained parent–infant psychotherapists to complement their support for new families. There is an urgent need for more trained parent–infant psychotherapists and for proper evaluation of the positive impact of support on the earlier relationship.

Most important for public policy is to understand how early years’ intervention can break the intergenerational cycle of misery, where a baby girl who fails to form a secure bond with her mother becomes herself the teenage mother who is emotionally incapable of forming a bond with her own baby.

Prevention is not only kinder, but also much cheaper, than the cure.
Mental illness is a growing problem in the UK. A recent report from the London School of Economics and Political Science (LSE), *How Mental Illness Loses Out in the NHS*, estimates that among people under 65, nearly half of all ill health is mental health related. As our knowledge and understanding of the range of mental health conditions that affect people’s lives grows, so the sheer scale of the challenge becomes apparent. It is estimated that mental illness is costing us £105 billion per year in lost economic output and imposes £20 billion of costs on the National Health Service (NHS). There is not only a clear philosophical reason why in a humane, compassionate society we need a better approach to the treatment of mental illness; there is also a compelling economic rationale for dealing with the problem. As the LSE report puts it:

‘Only a quarter of all those with mental illness are in treatment, compared with the vast majority of those with physical conditions. It is a real scandal that we have 6000000 people with depression or crippling anxiety conditions and 700000 children with problem behaviours, anxiety or depression.’

How do we, therefore, address this growing and complex problem? The government has published its strategy – *No Health Without Mental Health* – which is welcome, but the question that needs to be addressed is the extent to which there are fundamental flaws in our approach to treating mental illness within the NHS.

For too long the approach to mental illness within the NHS and the medical establishment has been to apply a ‘psychiatric’ model. By that I mean that it is assumed that mental health problems can be successfully treated by medical intervention alone. We have seen, for example, the exponential rise in drug-based therapies in the NHS. Many general practitioners see drugs as an easy solution when it comes to dealing with people who present with challenging mental health problems. This reflects a view that mental illness and the symptoms of it need to be controlled rather than creating the conditions in which the underlying causes can be properly addressed.

That is not to say that drug-based interventions are never appropriate in some cases of severe mental illness. However, the easy option of using drug-based interventions as the default mode of treatment needs to be challenged. We need to de-medicalise our approach to treating mental illness.

Those with mental health problems – across a range of different conditions – need real choice over what kind of therapy is available to them. They need to feel that what they are experiencing is ‘normal’ and that they have the personal resources to deal with it. They need to be confident that

Towards more effective treatment
James Morris MP
when they come into contact with the NHS (particularly through primary care) they are going to be given appropriate advice from an experienced practitioner as to the best treatment options available to them. It has been welcome, therefore, that there has been further investment made in Improving Access to Psychological Therapies (IAPT) in an effort to integrate talking therapies into the treatment mix.

The government has committed £500 million to the further rollout of IAPT. However, in terms of broadening choice and challenging the dominant treatment model I have described, there is still a long way to go. Improving Access to Psychological Therapies is very much focused on cognitive–behavioural therapy because it is the one talking therapy which the National Institute for Health and Clinical Excellence (NICE) recognises as having a sufficient evidence base which describes its effectiveness as a treatment. The NICE guidelines for talking therapies are, therefore, very strict and effectively limit the choice that is available to NHS patients who are not able to access longer-term psychotherapeutic or psychoanalytical therapies that are widely available in the private sector. As the Centre for Social Justice argued in its recent report Commissioning Effective Talking Therapies, there needs to be a radical change in the way the NHS commissions talking therapies to allow for inclusion of a wider range of therapies. In order to move to a new model of mental health treatment, we need real choice in talking therapies.

As we tackle the complex issues raised by the epidemic of mental illness in our society, we need to focus on giving individuals the ability to chart a better understanding of mental health issues and to recognise how they can improve their own lives and become stronger people. We will not be able to do this without moving away from drugs as the default treatment option. A real and profound understanding of the causes of mental ill health requires a broad range of therapeutic approaches. We need more money invested in talking therapies but we also need much more flexibility in the way that the NHS commissions services so that we don’t continue to limit the choice available.

Many mental illnesses can be cured. Most can be treated. We have a duty to ensure that our health system is properly equipped to give people the best possible chance to recover.
Mental health for veterans

John Glen MP

The mental health of military veterans is such an important issue because of the particular duty of care that the country, and the government, has towards our armed forces. The statistics make for disturbing reading; almost a quarter of a million veterans have post-traumatic stress disorder (PTSD), and there are likely to be 960 new cases this year.

Delivering effective treatment is further complicated by the fact that it takes an average of 13 years from discharge for a veteran to take their first steps to seek help from a health professional.

The characteristics of this problem are similar to that of mental health across the general population and highlighted by Parliamentary colleagues: significant stigma attached to mental health problems and difficulty in targeting effective prevention and early intervention strategies. But the issue within the armed forces comes with its own unique problems. Instances of poor mental health are much higher than in other groups because of combat stress, and experience has shown that it is especially difficult to trace veterans and monitor their mental well-being after discharge from the armed forces. It is in light of the particular duty of care owed to servicemen and women that it is so vital to tackle this issue despite the practical difficulties.

Through the work of a number of excellent charities and other organisations, the Department of Health’s report No Health Without Mental Health and the report Fighting Fit produced by my Parliamentary neighbour Dr Andrew Murrison, significant steps have been taken to address this issue. A number of strategies stand out: the Big White Wall (BWW) early intervention service for servicemen, veterans and families; the e-learning package on mental health in the armed forces produced by the Royal College of General Practitioners; and Combat Stress’ 6-week PTSD treatment programme.

It is commendable that the government has been able to act so swiftly on the recommendations in Fighting Fit, and I urge them to drive ahead with their ongoing implementation.

As we look to the future and consider long-term strategies to tackle poor mental health in the armed forces, three key themes stand out.

**Context**

Strategies to tackle poor mental health must be attentive to the unique armed forces context. In areas where there is a high concentration of service personnel, for example my own constituency of Salisbury, greater resources may be needed in order to effectively tackle mental health problems, so attention must be paid to demographics when designing strategies and commissioning services.
Given the evidence of difficulty in tracing veterans after leaving the armed forces, the Department of Health was right to highlight the risk that there will be a low response rate to the Veterans’ Information Service, a questionnaire and follow-up project using the NHS Personal Demographics Service. This recommendation from Fighting Fit has yet to be fully implemented but would provide effective follow-up after an individual leaves the armed forces, and could provide useful contacts and information to veterans concerned about their well-being following deployment.

This project therefore requires careful calibration to ensure high response rates and effective cooperation to make sure that existing procedures are not replicated, and that the powerful resources of the Personal Demographics Service can be acted on effectively.

DE-STIGMATISATION

A key theme in the Backbench Business Committee debate on mental health in June 2012 was that of the stigma attached to mental health problems. This was picked up in the government’s report No Health Without Mental Health, but needs to be applied specifically to the armed forces – the BWW project is an excellent start, but given that 55% of general practitioners felt that there is still stigma associated with veterans’ mental health problems, more needs to be done to raise awareness and change a culture that construes poor mental health as weakness. It is then that early intervention strategies will be more successful and personnel with combat stress can swiftly get the help that they need.

CONTINUITY AND CONSISTENCY

For the recommendations in Fighting Fit to be effective, there has to be a high level of continuity in order to generate familiarity and credibility among service users. I hope, for example, that ongoing discussions will be successful in securing long-term funding for the BWW project.

General practitioners and local mental health trusts need to remain fully familiar with the unique challenge and context of combat stress and associated mental health issues surrounding the armed forces so that they can provide an effective service. Closer links and systematic referrals between NHS and provider organisations are also important: only 6% of callers to the Combat Stress helpline had been given the number by a professional. It is only by working in partnership and cooperation that different strands of provision and expertise can be fully realised to care effectively for armed forces’ personnel.

CONCLUSIONS

Although it is too early to predict the long-term effect of these strategies, encouraging signs have been seen already – the reaching of capacity in the BWW project and the promising work of the Veterans’ Mental Health Clinical Network focused on increasing the NHS’ capacity to work with veterans with poor mental health. I want to praise my colleague, Dr Murrison, for his work in this area and trust that it will bear fruit into the future.
The challenge is now to be attentive to the unique context so that all the adopted strategies will be carefully calibrated towards military veterans; to tackle stigma, so that early intervention strategies are effective and that there is no barrier to seeking advice and help; and secure continuity, to ensure that existing work can continue long term.
There she was. A broken child on the Piccadilly Line at South Kensington Tube station. Weeping, incoherent and distressed. Busy people shuffling by, rushing home after a hard day’s work, barely noticing her on the bench.

I can see her now, nearly 20 years after the event, as if it were yesterday. For some reason I stopped. I am no saint, no Samaritan, but on this occasion, unlike so many others, I stopped.

Her hair was matted with filth and grime. No shoelaces, and her tears cut little muddy paths down her soot-stained face. I sat next to her, I asked what was wrong, could I help. She was incoherent, then lucid, then incoherent again. Crying uncontrollably, disturbed and desperate. What could I do? She was not responding, it was as if I wasn’t there. Perhaps she was aware of my presence but she was so unhappy, so inconsolable.

I sat for what must have only been minutes, running out of ideas but not patience. I didn’t want to retreat defeated back to my flat, leaving this tragedy ongoing and unresolved. But I was out of my depth and went in search of help. At the top of the stairs, I found two police officers and explained the situation – they were sympathetic and kind. They said they would look after her and thanked me for taking an interest. And that was it; my intervention was complete.

The meeting on the platform almost two decades ago has stayed with me ever since. How could a child of perhaps no more than 16 or 17 be so let down by the ‘grown-ups’ that she ends up alone, ill and desperate in the depths of an underground station?

Throughout my adult life, I have made many promises, most of them meaningless and broken within days. But I have kept one. That promise I made in the hours after the minutes I spent with that young stranger on the Piccadilly Line. Although I had failed her, I swore, if given the chance to make a difference in the future, I would take that chance and not let it go to waste.

Twelve years later, I entered the House of Commons as the Member of Parliament for Broxbourne. A new and exciting world that I had wanted to be part of since I was a teenager, now that I had arrived I didn’t have a clue where to start. Everybody wanted a piece of my time. It was a challenge to separate the important from the useful and, all too often, the frivolous. But one invitation was irresistible and that was to visit a mental health charity in my constituency.

The visit went well. I was warmly greeted and I met many of the service users it supported. They all had their problems – some had overcome them, others were still dealing with them – but there was an overwhelming sense of optimism and hope. As things wound up, I was asked by one of the managers if I would meet a service user in private. This I readily agreed to.
I met a gentle, softly spoken man who wanted to talk about his experiences of schizophrenia. He needed to do this because he didn’t want me to be frightened or depart from the charity thinking the worse of him. His story was moving and heart rending, but why was it necessary, why did I need to know? How could my constituent think that someone as inadequate as myself would choose or want to sit in judgement of him? He was ill, and aren’t we taught to treat illness with compassion and understanding? Yes, of course we are. But bitter experience had taught my constituent that this compassion all too frequently ran dry when challenged by mental illness.

So, two stories separated by more than a decade have shaped my political life. I don’t know what became of that young girl on the Piccadilly Line platform. I hope that she is happy, settled and fulfilled. That somehow in the chaos of her life and illness she found support and then hope. Now, as a father to my own daughter, I think what I would want for her if she was alone, frightened and distressed. The answer is always the same: a great deal more than was on offer 20 years ago.

I also don’t know what became of my constituent. Has he gone on to find happiness and acceptance? I sincerely hope so. But there’s a good chance that neither of these stories ended happily because people with mental ill health not only face the challenges presented by their illness but also the hurdles thrown in their way by a society that in some quarters persists in remaining fearful of the unknown.

Prejudice remains a reality. Discriminations still exist in law. But of course, it’s not all doom and gloom – far from it. Attitudes are changing. People are speaking up. The stigma of mental ill health is being challenged. The media at last seems to understand that its unforgiving portrayal of mental ill health, far from winning its audience over, has made many feel uncomfortable. People nervously laugh along so as to fit in, but on the inside know that the ones being mocked could just as easily be their son or their daughter, their husband or their wife.

Politicians too are rising to the challenge. Many are championing mental health in their own constituencies and are making the point of raising their concerns in Parliament after too many decades of relative silence, finding their voice and thereby giving a voice to those who elect them. Times are changing for the better: outdated prejudices are being challenged. Things will not happen overnight but this decade holds out the hope of being the one in which stigma and prejudice is put to the sword.

I like being an optimist. I am hopeful for the future. We will never stop people becoming ill but we can accelerate their progress to recovery and wellness. I am not naive. There is still so much more to do but at least we know now what needs to be done. And that’s a good place to be.
Medical advancement in the treatment of illnesses has abounded since the Victorian era. At that time ailments were ‘cured’ through a range of treatments including ‘a change of air’ (such as a visit to a seaside resort), emetic and laxative purgation, and bleeding by cup or leech to clear ‘impurities’ from the body. In addition to these treatments, a limited reliance was placed on the use of medication that was accompanied by the invocation of the power of prayer. However, many of these practices were not suitable for those who had mental health issues and as a consequence these individuals were simply locked away. The County Asylums Act 1808 established institutions for those who were termed as criminally insane, but the more sympathetic Lunacy Act 1845 later changed the status of mentally ill inmates to that of patients. Regardless of the patients’ description, the treatment dispensed at such places did not relieve suffering but was effectively designed to protect the public from having to deal with the spectacle of mental health on a daily basis.

Since Victorian times the manner in which mental health is treated has changed immensely. In fact, it is possible to differentiate the treatment of mental health in England into two separate periods – the era of the Victorian asylum (which continued into the latter part of the 20th century) and the period of community care. Most of us look back with horror at the thought of the great asylum hospitals, which were little more than prisons. Their abolition may be evidence that the treatment of mental illness has improved but can it truly be said that the stigma of mental health has also been eradicated? Evidence from the public attitudinal survey in 2010 showed that although people are broadly sympathetic towards those with a mental illness, some attitudes are worse than when compared with the Department of Health’s first commissioned poll in 1994.

As the final painting in Hogarth’s *The Rake’s Progress* shows, the public were historically interested in mental illness, but more as a source of entertainment than as a medical condition to be treated sympathetically. In 1818, Lord Hatherton wrote about his visit to Bethlem Hospital in London:

‘The arrangements seemed admirable. Saw Margaret Nicholson who made an attempt on the Queen and Hatfield who shot at him. Saw a very fine handsome fellow who said he was Emperor of Russia and offered me immense sums from his imperial coffers if I would tell him of the arrival of his Cossacks to release him. All the maniacs talked of the loss of their liberty but liked their present residence better than the old one “because they could see out of the windows”. Saw two persons who had been chained down in old Bedlam for many years, at liberty though quite mad. All the medical attendants declared violent coercion of that description unnecessary. Only saw one person out of 180 in a straight waistcoat.’
Such voyeurism is not just a practice of the past. The Victorian asylums may not exist but mental illness continues to be a source of entertainment that reinforces negative stereotypical representations. In television and films, people with mental illnesses are usually depicted as violent or childlike and certainly outsiders from the rest of society. The association between violence, criminal behaviour and mental illness has been prevalent for decades, with psychosis in particular being portrayed as threatening. Whether it is the representation of a dissociative disorder (Psycho), an antisocial personality disorder (One Flew Over the Cuckoo’s Nest), an obsessive–compulsive disorder (As Good As It Gets) or schizophrenia (Conspiracy Theory), the protagonists of such films always represent a threat to the establishment of an orderly society by virtue of their very existence. Film producers may reject criticism of stereotypical representations of mental health in films by claiming they are fiction and consequently the viewer is aware they are not real-life depictions and, in addition, that not all mentally ill people behave as depicted. This is arguable but what has been most concerning is the rise of reality television and the predisposition of producers to cast people with indisputable mental health issues.

In 2007, the producers of Channel 4’s Big Brother decided to introduce two housemates who had long-established mental health issues. Nikki Grahame divided public opinion (but increased audience figures) with her repeated temper tantrums over trivial incidents. Unlike children who tend to display such behaviour when they don’t get their own way, it emerged that Grahame had spent most of her childhood in psychiatric institutions being treated for anorexia nervosa. Although she was voted out of the ‘house’, Grahame’s reward came by her being given her own reality show entitled Princess Nikki. Her co-star in the same year, and subsequent ‘winner’, was Pete Bennett, who was described by Channel 4 in a press release as being ‘diagnosed with Tourette’s syndrome at the age of 14, started wearing women’s clothes aged 16 and impersonated Freddie Mercury at his mother’s wedding’. Bennett’s erratic behaviour led to Channel 4 receiving numerous complaints from viewers who claimed he had been chosen as a participant for no other reason than as a source of amusement.

Certainly, the producers of Big Brother would not have known in advance how these contestants would behave – but they should have been wary about repeating their experiment. Anyone who watched Kerry Katona during her infamous interview on This Morning would have known that she has some serious problems with various addictions, but 2 years later she also appeared on Big Brother. Katona admitted that when she sought to enter the ‘house’ in 2010, she failed the psychological tests as she had just come off medication to treat her bipolar disorder and her doctor advised that it would not be sensible to appear. However, in 2011, when the show transferred to Channel Five, the broadcaster allowed Katona to be a contestant, the consequences of which could be seen each day.

Representations of mental health in entertainment and films can go a long way to changing public perceptions about those who suffer its effects. For many people, aside from personal experience, the media is the channel which constructs their opinions and prejudices. But the motivation of producers to introduce people who have mental health problems into reality television is no different to that of opening up 19th-century asylums to visitors. Just like the visit to the asylum, television enables the introduction of the viewer to those who have mental illness – without the embarrassment of having to actually engage with the objects of their gaze. Mental health
treatment may be more compassionate in the 21st century but the stigma of its condition remains and continues to be a source of entertainment. Reality television fills the desire for entertainment and voyeurism but at a great cost to millions of people with mental illness. The irony is not lost in that it is the Big Brother programme that continues to control and dominate public perceptions through an on-screen representation of mental health.
The role of the voluntary and community sector in good mental healthcare

Nicky Morgan MP

The phrase the ‘Big Society’ is used perhaps less often than it was but I think it has huge potential in the provision of local mental healthcare than might, at first sight, seem likely.

Mental ill health can be a lifelong and fluctuating burden. At times of acute crisis, medical intervention, whether through drugs or in-patient treatment, is almost always going to be the correct answer. However, hopefully these acute episodes are followed by periods of recovery and relative normality. The hope at that point is for successful care in the community – which should mean exactly what it says, i.e. care and appropriate support outside a medical/hospital setting among family, carers and friends.

As we all know from our own lives there are days which seem a bit darker than others and often a kind word, supportive comment or even a hug can lift the mood. Why do you think the Members Tea Room is such a popular place in the House of Commons? It isn’t because we are all hugging each other but because there is a sort of informal mutual support network in there with people able to share the same experiences and pressures. Everyone needs such a space and it is often the voluntary or community group which offers that forum to those with a mental health condition.

Within my constituency the highly successful Charnwood Mental Health Forum has been running for about 30 years. It provides a network of individuals who share common experiences and want to have their say about local services. Age UK operates both Welcome House in Loughborough, a drop-in service for those with mental health problems, and two very popular morning coffee drop-in sessions. The Changes Mental Health Group which meets every Wednesday in Shepshed provides a similar forum for people to swap views and simply to relax, and the Rethink Carers Support Group offers a place of mutual support and advice for those caring for loved ones with mental health conditions.

There are other facilities too which, perhaps unexpectedly, offer sanctuary and support. I recently heard about a very popular Zumba class which provides huge benefits for people with mental health difficulties, in addition to those without. The teacher of the class forwarded to me a letter from one of her class members, who says:

‘I’ve suffered from depression now for 12 years, and it is a horrendous illness which is still so taboo and hidden about. I self-harmed for 10 years, tried to commit suicide once, and ended up on a psych ward because of it. Through most of it I put on a painted smile because so many people made judgements on me because of it, and that was one of the worst things. People didn’t get it...they didn’t get me.

I tell you this, because during the time I was suffering from depression I put on well over two stone, which often dragged me down considerably...’
further. I hated myself, and my body. When I started doing your Zumba classes it filled me with so much euphoria and love, and it was just a couple of hours a week where that depression lifted. I'm still re-building my life after depression and know that even though things are better depression is something I still fight. Zumba somehow just helps with depression, and especially the way you do it. What I love about you and your classes is just how much passion and effort you put into them – you can really tell you love it, and I think it helps other people love it just as much – your love was certainly what kept me coming!' 

So, there is no doubt in my mind what a massive difference voluntary and community activities can make to those with mental health conditions. The task now is to ensure this is recognised in the new commissioning environment within the National Health Service (NHS). For example, could we see prescriptions for Zumba classes being handed out? In the June 2012 debate on mental health in the House of Commons it was reported that prescriptions for debt advice had been handed out with great success.

As we know that people do not suffer from mental ill health in isolation, surely commissioners have to recognise that there are more imaginative and/or additional services and activities which can aid a patient’s recovery and sustain them in the longer term.

The recent report by the All Party Parliamentary Group on Mental Health on making the Health and Social Care Act 2012 work for mental health records that the Minister of Care Services believes that the Any Qualified Provider policy should enable voluntary organisations to assume a more prominent role in providing NHS services.

The important role of community groups is also reflected in the government’s July 2012 No Health Without Mental Health: Implementation Framework. The framework states that: ‘Voluntary, community and user- and carer-led organisations have considerable knowledge and experience of local services and the needs of local people.’ It recommends that community groups can help to ensure the best local mental healthcare by: proactively providing input to local needs assessments and commissioning processes; raising awareness of services and support; supporting communities to hold public bodies to account; and raising awareness of mental health among relevant organisations.

It is up to all of us who want to see mental healthcare focus on quality and outcomes, and who know the immense value which voluntary and community sector services can provide in this area, to ask our local commissioners how they are working with local community groups for the benefit of patients. If the answer is that it isn’t really happening, then the next question is to ask ‘Why not?’, and to keep asking until we see the change happening.
Enhancing mental healthcare among the general population

Robert Buckland MP

It is a sobering fact that one in four of the population will have had some direct experience of mental illness at some point in their lives, either personally or by knowing someone affected by a mental health issue. On a positive note, overall understanding of mental health conditions is improving in the UK and the stigma attached to mental health is falling, both in the workplace and in society as a whole. In this contribution to the debate, I set out a range of measures that can be taken at every stage of life in order to enhance positive mental health and to prevent the development of mental health problems in many cases.

Early years’ care

There is much evidence to suggest that good parenting from birth has a very dramatic positive impact on a child’s mental health all the way into adulthood. Early years’ care is therefore crucial. Parents should be strongly encouraged to start beneficial eating habits and active lifestyles in their children from a young age. The state should not fear to intervene where families need help. Evidence suggests that helping the 200 000 families most in need strongly improves their life chances and therefore the positive mental health of their children. In my own constituency, the Swindon LIFE Programme has already made a positive difference to the lives of a number of troubled families.

Teaching good mental health to children

Good mental health should be promoted in schools from the primary stage. The importance of eating healthy foods and playing sport should be emphasised and forming friendships at school and healthy family relationships should be encouraged. In secondary schools, perhaps as part of the personal, social and health education (PSHE) curriculum, mental health should be discussed openly in the classroom. Discussion could deal with the myths of mental health conditions, the way that the media portrays mental health, and the language used in talking about mental health. Young people should learn about the difference between ‘healthy stress’, ‘unhealthy stress’ and ‘depression’. More work can be done to integrate messages about bullying, body image and confidence as part of a coordinated mental health strategy. Young people should be taught resilience and that through taking risks and making mistakes you can learn how to respond to setbacks. Greater support into the world of work will be of real value to a range of young people who have displayed some form of vulnerability.
MENTAL HEALTH AND UNEMPLOYMENT

In a measure akin to health checks for those aged between 40 and 74 every 5 years, general practitioners (GPs) should be encouraged to invite for a consultation the long-term unemployed, with particular emphasis on young people who remain unemployed more than a year after leaving school or returning from university, to talk to them about their mental health and offer support if needed. This could be coordinated with organisations that are running work programmes for the long-term unemployed.

GPs DIAGNOSING MENTAL HEALTH CONDITIONS

There is a difference of degree between serious mental health conditions such as depression, bipolar disorder and schizophrenia, and conditions of stress or mild depression. In non-acute cases, the emphasis should be on well-being with the use of talking therapies such as cognitive–behavioural therapy, rather than the GP prescribing automatically a pharmaceutical solution. Regular monitoring of the patient, however, remains important. Sleeplessness for example, which can be an indicator of mild depression, may be better treated in a holistic fashion in the first instance, with the GP recommending mild fitness or a variety of sleep strategies. Only if the condition persists should the GP look for a pharmaceutical solution.

When it comes to a more serious mental health condition, a correct diagnosis needs to be made as soon as possible, so that the patient can begin their recovery. There can be, for example, up to an 8-year delay before a diagnosis is made for people with bipolar disorder. In one national survey, 70% of people with bipolar disorder were initially misdiagnosed, and on average someone with bipolar disorder sees four different doctors before a correct diagnosis is made. Often a bipolar disorder diagnosis is only made when a severe manic episode occurs. This is not acceptable.

HOSPITAL AND OTHER CARE

Patients need to be seen more quickly at accident and emergency centres, particularly if they need acute care during the night. More listening lines, run by people with personal experience of mental health issues, such as the Swindon Service User Network listening line, should be available. Patients need to be aware that a common side-effect of medication is weight gain and an increase in appetite. Patients should therefore increase their sport participation or cardiovascular exercise in response to this. There is too large a variation in the availability of good community psychiatric nurses nationally, and patients would appreciate these nurses knowing their case histories before appointments begin, as too much of the appointment is taken up with reviewing their history. Community psychiatric nurses could monitor physical changes in patients, give advice on preventing relapses and promote healthier lifestyles.

There is a continuing need for more acute care places. Prisoners with severe mental health problems often languish in jails which are completely unsuitable for people with mental health conditions and therefore they cannot recover from their illness. Such prisoners need to be transferred to
acute hospitals. In order to improve access to a range of therapies, there should also be a focus on building well-being centres, which can promote general well-being among the population and be a gateway to mental health services in local communities.

The quicker a patient can accept the diagnosis, the earlier that patient will be able to self-manage, benefit from the treatment and support, regain control and self-esteem, renew relationships, interests and employment, and feel more secure. Health professionals should support patients and their families through their learning, and a positive message of recovery and successful condition management is achievable in just the same way that a patient may manage diabetes. Expectations that people may recover from mental health conditions are still far too low.

MENTAL HEALTH AMONG OLD PEOPLE

Many old people admit to feelings of loneliness. More opportunities to be good neighbours should be fostered in local communities. Everyone should know who their neighbours are. If elderly, their younger neighbours could get food for them in winter or check on them to see if they need anything. Many people already do this. There is an opportunity for charities and voluntary organisations to get involved with the welfare of elderly people. With people living longer, it is likely that loneliness will increase.

I believe that by adopting a range of preventive measures at an early stage, the lives of thousands of people can be improved. In many cases the development of mental health problems can be anticipated and prevented, which not only means better quality of life but is also a more efficient use of resources. At the acute end of the spectrum, the use of prisons to detain people whose primary issue is one of mental health has to be reduced, and then ended.

Well-being and mental health are issues for all of us. We cannot afford to fail another generation.
Commentaries
Dr Adrian James  
Chair, Royal College of Psychiatrists’ Westminster Parliamentary Committee

‘These men asked for just the same thing, fairness, and fairness only.  
This, so far as in my power, they, and all others, shall have.’

Abraham Lincoln

We ask a lot of our politicians and in the public and media eyes many may appear to disappoint. These Conservative MPs have really stepped up to the plate.

Apologies for the Lincoln quote but I have just seen the film and it is compelling viewing. I couldn’t help seeing the parallels between the fight against slavery and the political machinations that went on to resolve this, and the current anti-stigma campaigns in relation to mental illness and the fight for parity of esteem.

James Morris is to be congratulated for coordinating an extraordinary collection of essays on mental health issues that follow swiftly on from the House of Commons mental health debate where MPs of all political persuasions spoke about their own experience of mental ill health.

The essays are personal and relate to MPs’ individual experiences of mental health issues and how these are being addressed nationally and in their own constituencies. Andrea Leadson focuses on the very early years and how ‘during the first 2 years of life, a blueprint is mapped out that determines how a baby’s life will look in the future’. Others identified the need for more holistic approaches, with attention to medically oriented treatments but also the psychological. Veterans’ mental health loomed large. The role of the wider community is a focus for Nicky Morgan, and Robert Buckland takes a lifelong approach to promoting mental well-being.

All are agreed that mental health as an issue and mental health interventions generally have been neglected for too long and stigma has been much to blame. If one theme runs through all of the essays, it is the importance of public mental health; the role of prevention, early detection and intervention, healthy family and community approaches, and the valuable role of a fulfilling place in society, including employment and education.

So where do we go from here? Another Lincoln quote I’m afraid:  
‘If we could just first know where we are, and wither we are tending, we could then better judge what to do and how to do it.’

Well, where are we? We had unprecedented cross-party support for the Mental Health (Discrimination) Act 2013 which gained Royal Assent on 28 February 2013. Although MPs are talking about mental health and even discussing their own experiences, spending on mental health fell last year in England.
Where should we go? We should press for parity of esteem and for the narrowing of the gap of disease burden (23%) and spending (12% of the total) on mental health. A more realistic target could be perhaps a 4% increase in spending for the 1 in 4 people affected by mental health problems. We should also focus on good public mental health as the opportunity to deliver the best outcomes.

How to do it? We need to continue to lobby MPs to ensure that action flows from words. We need to engage with Local Authorities and public health, and work with and encourage the emerging mental health strategic clinical networks. Above all, we each individually need to take up the challenge laid down in the Francis Report to establish strong partnerships with service users and carers as the best way of providing safe, effective services.

My personal reflection is that parity of esteem starts in relation to practitioners and service users and carers and how they feel about each other. It is only by achieving parity here that we will really achieve parity of esteem in relation to physical and mental health.
I found the essays well meaning and well intentioned. Some talked positively about preventing mental disorders and there was good emphasis on giving service users and carers choice and options. The essays came over as being optimistic, anti-stigmatic and promoting education, enlightenment and debate about mental health issues. I will offer brief comment on the individual essays.

‘IT’S NOT ROCKET SCIENCE – IT’S MENTAL HEALTH’

Mr Colville says: ‘Like most physical ailments, mental health can be cured’. My understanding is to substitute Mr Colville’s word ‘health’ for disorder. If so, I would suggest that there is plenty of evidence to show that most mental illnesses (e.g. schizophrenia) remain a permanent disability for which there is ongoing treatment rather than any sort of cure. It is unclear whether Mr Colville meant here that post-traumatic stress disorder among ex-servicemen can be cured – I do not have enough information about this condition to give an opinion.

‘THE IMPORTANCE OF EARLY INTERVENTION’

Ms Leadsom does not state her sources for this article. I felt that there are also many incidents where people who have enjoyed the most loving, caring and supportive family upbringing succumb to serious mental illness and social disorder. Mental illness can affect anybody at any time and it is not restricted to those who experienced poor parenting. I found the comment about the ‘teenage mother’ at the end of the essay rather a generalisation, as I am sure there may be many good and caring teenage mothers.

‘TOWARDS MORE EFFECTIVE TREATMENT’

I felt rather uneasy about comments such as: ‘Many general practitioners see drugs as an easy solution’ and ‘the easy option of using drug-based interventions’. First, this undermines the trust that service users have in medical professionals to care for them and to give them the right treatment – it implies that service users are nuisance people who are given anything to shut them up. Second, drug therapy is not an easy solution – it may demand much of the medical professional’s skills to find the right drug to
suit the service user’s mental health needs. Third, just as drug therapy may not work for everyone, so it is similar that talking therapy does not work for everyone – many people find psychotherapy distressing and intimidating. On the positive side, I am very pleased that Mr Morris implies that there should be more types of psychotherapy on offer other than just cognitive–behavioural therapy (which I think was promoted because it was one of the cheaper treatments). The more choice the better.

‘MENTAL HEALTH FOR VETERANS’

I have very little knowledge about this area of mental health. However, I felt I wanted to say that – without any disrespect to armed service personnel who are making serious sacrifices on a daily basis – an altered version of Andrea Leadsom’s final comment is applicable here: ‘Prevention is [...] kinder [...] than the cure’.

‘THE REALITY OF TELEVISION IN THE REPRESENTATION OF MENTAL HEALTH’

I found this essay very stimulating and thought-provoking, although I have not seen the television programmes in question myself. However, I think that in fairness to the media there is a fine balancing act in portraying the mentally ill: even the most sensitive and sympathetic documentary-type programme about the mentally ill can make the viewers feel like ‘voyeurs’ of a freak show and make it seem that the mentally ill are being exploited for their entertainment value, as of old. I do not know the background to Big Brother but maybe there is something positive about this, i.e. at least people are not being barred from appearing on the show because of their mental disorder.

‘ENHANCING MENTAL HEALTHCARE AMONG THE GENERAL POPULATION’

I found this a kindly and well-meaning essay: to guide us into good mental health through our ‘seven ages of man’ – from infancy to old age. I would have liked more information about what sources Mr Buckland based his range of measures on. A few things struck me, however.

THE IMPORTANCE OF [...] PLAYING SPORT

As we know, sport is not for everyone and it is well documented how some competitive sportsmen may succumb to mental disorder (e.g. eating disorders). However, I feel here Mr Buckland’s message is that outside the rigours of the academic curriculum, school children should be encouraged to engage in organised recreational activity, whether it be stamp collecting, playing the trombone or indeed running around the playing field. But did Mr Buckland really mean playing sport?
MENTAL HEALTH AND UNEMPLOYMENT

I was really pleased that Mr Buckland showed his concern for the mental health of the unemployed of all ages. Unemployment is extremely stressful and can exacerbate mental disorder, especially as unemployment seems to play a part in almost everybody’s life.

...A COMMON SIDE-EFFECT OF MEDICATION IS WEIGHT GAIN. PATIENTS SHOULD THEREFORE INCREASE THEIR SPORTS PARTICIPATION OR CARDIOVASCULAR EXERCISE

Unfortunately, many service users find that such activity has no effect on weight gain induced by medication, as this is a more complex metabolic problem rather than just an increase in appetite. It is because of this inability to stop gaining weight, whatever measures are taken, that drug therapy is so unpopular with some service users.

MORE OPPORTUNITIES TO BE GOOD NEIGHBOURS SHOULD BE FOSTERED [...] EVERYONE SHOULD KNOW WHO THEIR NEIGHBOURS ARE

In urban areas, especially with a transient population, it can be difficult for people to know who their neighbours are. Indeed, I feel we must accept that in reality many people are happy not knowing who their neighbours are. People with a mental disorder can feel that their neighbours are hostile, intrusive, judgemental and prejudiced about mental illness – at best, neighbours can be patronising. However, I feel that Mr Buckland means here that elderly people would find both mental and physical health benefits from various forms of regular social contact and through being socially included. I agree with Mr Buckland’s point that medical evidence suggests that isolation is detrimental to the mental and physical health of the elderly.
None of us expect a visit from mental health problems, no matter who we are or what our ‘previous’ life has been, successful or otherwise, young or old; it is most unwelcome, and can hang about for the rest of our lives. But circumstances and life events can alter our lives, and even end them by our own hand. That is why the services that are out there are so important, be they the National Health Service, voluntary sector or the ‘system’ that we find ourselves having to cope with. Many mental health conditions can fluctuate and the systems in place have to allow for this. And it is not always the case that pills can solve all ills. We have to be more imaginative, adventurous and even daring if we are to succeed and help people with mental health problems.

Many words are spent in ‘helping’/appeasing (or trying to) those of us so visited, but perhaps not enough is actually being done. Many mean the words and platitudes they say, but does the system actually accommodate us all? Do we have to be a Churchill or similar to be taken notice of or can we be the ‘wee timorous beastie’ and still be listened to and our views respected and, more importantly, ‘acted’ on?

I actually don’t know all the answers, but I do know how others treat me and how I would wish to be treated, and how the ‘systems’ would/should deal with me/us. I have a ‘classification’, a label, but I am not a label. I am much more than that. We are all unique.

So where do we go from here? Many un-enlightened years ago we were locked up in an institution – in many cases without a proper diagnosis – just because we were different and didn’t ‘conform’. Would that be considered today? Can we not be different and unique? I sincerely hope we have moved many miles from that position, and I actually believe we have. But there is still a journey ahead, and that has to be considered and taken on board by those who can make those momentous decisions. It is conceivable that we could go backwards rather than forwards: moving forward in today’s society should be where modern society and thinking should be.
I was relieved to feel a consensus that change is needed around how mental health and/or mental illness is approached, understood and supported by those making political and clinical decisions for the benefit of patients/public at very vulnerable times in their lives.

During these times of austerity measures and welfare reforms, the likelihood of ever-increasing suffering for people living in or near poverty and/or deprivation is bound to have a further detrimental impact on the health and well-being across all ages and communities.

A country ... a public service ... should be judged as to how it treats its most vulnerable. But what about genuine accountability, positive outcomes and the Seven Nolan Principles of Public Life? Or, are health and social care services more about targets and jobs?

There are nearly 300 recommendations in the Lord Francis Report and none appear to be rocket science. In many cases it is about very basic principles of care/communication – a very good starting point to implement effective research, business planning and risk management protocols with all appropriate and relevant stakeholders at the table.

Not a job that can only be done by national decision-making, as it must also be driven down into localities, looking at all people (including patients) as ‘assets’, researching their needs, and mapping service provision and availability, fitting the needs of patients/service users/carers, and not to pigeonhole them into expensive, ineffective services!

Public health should be actively involved with all public services, working across prevention, research, education and information-sharing towards a recovery model. (‘Recovery’ meaning different things to different people.)

Reading about further involvement of third-sector organisations must be seen as a positive, not a stop-gap, solution. For too long this sector have felt undervalued – even discriminated against – while being able to adapt to changing needs, support individuals and being pro-active. Many are very willing to work in partnership with other sectors.

No Health Without Mental Health – relating to ‘parity of esteem’ and looking holistically at a person’s needs, appropriate multi-agency working, listening to service users and carers – is about supporting a cultural change which is not tokenistic, and therefore putting the patient first. This actually could help the economy and reduce staff sickness in public services, while empowering the patients and public, and building personal and community resilience alongside improved health and well-being.

Early intervention for me also includes early acceptance of needs by all! For me this is relevant to the essays on veterans and follows on from my son’s 20-year ongoing living nightmare after his 2-year army tour (1992–1994) in Northern Ireland. This resulted in psychological issues,
dysfunctional and challenging behaviours, post-traumatic stress disorder (PTSD) and complex PTSD, which appeared shortly after injury. This may be because he also had an existing learning disability which was evident when he was recruited as a very fit 20-year-old.

I also would like to highlight the enormous cost and high numbers of prisoners with mental health and/or intellectual disabilities (challenging behaviours). I am sure there could be a smarter, rehabilitative way that is much more cost-effective and appropriate to all their needs. The Lord Keith Bradley Report (2009) recommendations should be instigated nationally.

I wish to conclude that from my many years of experience, not all mental health problems are science-based. Many come from deteriorating social and economic factors, family breakdown and bereavement. Therefore, medications are not always the only answer.

We must all find ways to meaningfully ‘listen and learn’ from lived experience stories in a non-judgemental way to understand the meaning of hopelessness and the journey to empowerment, humanity and hope, especially if we want to mend our broken people and our broken society. We need workshops to discuss specific issues with relevant stakeholders across the board, including the third sector, the public and patients, to work together to investigate and develop future strategies. This could be both enlightening and lead towards a much-needed cultural shift.
I am a junior doctor in my second year of work and am currently completing rotations across a range of medical specialties, one of which was in psychiatry. I have had an interest in mental health since medical school and in August I will start my specialist training in psychiatry.

As a doctor planning a career in this field, a collection of essays on mental health written voluntarily by MPs is an encouraging sign of growing political awareness of the importance of mental health and of psychiatry as a medical discipline. Any criticism expressed about the content of the essays should be balanced by gratitude to the contributors for taking time to prepare them. I found all the essays interesting and engaging, and will write a few words on four of them.

Oliver Coleville’s essay discusses the interesting topic of post-traumatic stress disorder (PTSD), a condition I have encountered in just a handful of patients. His interest in PTSD is clearly communicated and his work of increasing awareness of a condition which many people find stigmatising is very welcome. I wonder whether Mr Coleville may be rather optimistic in stating that mental health is ‘society’s last taboo’. It may be true that within the medical field mental health is often the area patients find hardest to discuss, but I am sure that societal taboos will continue to exist even if mental health patients no longer find their condition stigmatising. Mr Coleville’s statement that ‘like most physical ailments, mental health can be cured’, is debateable. Many common, chronic medical conditions, such as diabetes and obstructive airways disease, cannot be cured but can be effectively managed. The same is true of many psychiatric disorders, for example schizophrenia, which are rarely ‘cured’ but can be effectively controlled.

Andrea Leadsom’s essay on early intervention discusses the fascinating topic of how early childhood experiences shape personality development. It is hard to argue with her central assertion that experience in early life is a critical determinant of longer-term mental well-being, although it may be an exaggeration to state that the likelihood of being dealt ‘unfortunate cards’ is ‘all down to our earliest life experiences’. Ms Leadsom’s discussion of the ‘intergenerational cycle of misery’ at the end of the essay appears to suggest that a failure to form a secure bond with children necessarily passes from generation to generation. Anecdotal evidence of parents who have a close and loving relationship with their children, despite having a dysfunctional relationship with their own parents, suggests that the mechanisms by which an inability to form a secure bond are more complex than this, and may well not be properly understood. Ms Leadsom’s brief discussion of the economic rationale for providing early intervention is important and highlights the danger of reducing funding for community mental health services, which is a concern among most senior psychiatric doctors I have encountered.
James Morris’ essay on treatments for mental health conditions and his assertion that the approach to mental illness has been the ‘psychiatric model’ is very interesting and I am sure would lead to lively debate between mental health professionals. I feel that assertions such as the ‘exponential rise in drug-based therapies’ used to treat psychiatric disorders must be treated with caution. At a conference I attended last year in Edinburgh, one speaker presented evidence to suggest that, according to guidelines from the National Institute for Health and Clinical Excellence, antidepressants are actually underprescribed in primary care. Mr Morris advocates patient choice in the variety of ‘talking therapies’ that are available, which would be welcomed by many patients, but which in the current economic climate may not be feasible. However, further research into the efficacy of various talking therapies is no doubt important.

Charles Walker’s essay is the most personal of the collection. His experiences have obviously sparked an interest in mental health and his optimistic outlook on how societal views on mental health will develop are very welcome! Psychiatry is not held in high regard by many doctors working in other medical fields, something people who work outside medicine are often surprised by, as mental illness fascinates most people. Indeed, as a discipline it can sometimes be sidelined and stigmatised in a similar way to people with mental illness.

I hope that contributions such as these essays will help to raise awareness of mental health, to push mental health up the political agenda and eventually ensure that it is as well-funded and respected as physical health.
Making up our minds: towards improving our approach to mental health

A collection of essays from Conservative MPs

April 2013