

John Pugh MP invites you to:

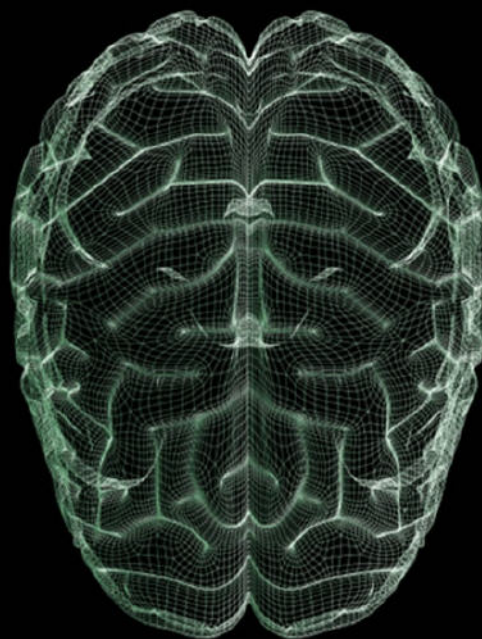
In our right minds: what works in mental health?

Prof Peter Bartlett
(University of Nottingham)

Lord David Ramsbottom
(former HM Chief Inspector of Prisons for England and Wales)

Angela Greatley
(Sainsbury Centre for Mental Health)

Tuesday 6th February 6:15pm-7:45pm
Boothroyd Room, Portcullis House,
Westminster SW1A 2JH
RSVP info@centreforum.org 020 7340 1160



CENTRE=FORUM

**In our right minds:
what works in mental health?**

**A report of the meeting held in Portcullis House
on Tuesday 6th February**

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Angela Greatley
Chief Executive,
Sainsbury Centre for Mental Health

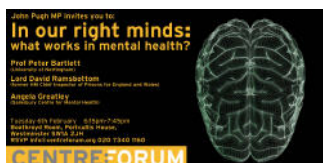
I should perhaps start by saying a few words about the Sainsbury Centre for Mental Health. We are a charity, independent of government or commercial funding, being supported principally by the Gatsby Charitable Foundation. Our work for twenty years or more has been about understanding the needs of people with mental health problems and seeking to improve services and support for them. SCMH has found, through this work and not least through working alongside and seeking the views of people with mental health problems, that it is often **not** the treatment that is of the greatest importance but the very basics – somewhere to live, a job, or at least something to do in the day and some money, contacts and relationships with others – all of this is about **inclusion** but many people with mental health problems go down the road to exclusion.

SCMH is now focused on developing our ideas further in two of these areas about inclusion: employment for people with mental health problems and how to bring about improvements for people with mental health problems in prisons and the Criminal Justice System.

Turning to our question this evening, ‘what works in mental health?’ Mental health problems are common; we have all seen that perhaps 1 in 4 of us will experience a problem at some time in our lives. However, the types of difficulty and range of problems is very wide. Mental health services have been improving for some time now and there has been greater investment in both primary care mental health and in specialist mental health care. The vast majority of people who seek treatment - over 90% - with common mental health problems - anxiety, depression and phobias for example - will be treated solely by General Practitioners and other primary care professionals. Very few people experience the serious psychotic disorders where perception and belief can be radically altered; about 1 in 200 adults. But, there are many types of mental health problem and for some people these can be serious and last for many years, whilst others will recover well.

So, mental health and mental health services matter to a great many people. Where are we now? Spending has increased over the last five years or so and services have improved. In fact, some of you might have seen that just towards the end of last year my own predecessor at the SCMH, Matt Muijen, now working with WHO, suggested that England particularly and the UK more broadly was now able to lead the way in European mental health services. He did then go on to say that many doctors and managers he meets are dealing with ‘extremely harsh conditions about which they can do almost nothing’. So we are better than the worst. It is admirable that England, though not yet the whole of the UK, has got rid of the large isolated and poorly resourced Victorian piles that created so much separation and stigma – remember out of sight out of mind? But, whilst services have got better, there is a **substantial** amount of unfinished business. This primarily is about inclusion and it is to that agenda that I want to turn.

The first really critical issue is that of employment or rather of unemployment:



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- Three quarters of working age adults who have a severe problem – principally a psychosis – are out of work. Most would like to work and can with the right support.
- About 1 million people with common mental health problems – often associated with physical ill health – are living on benefits. More than 40% of all Incapacity Benefit claimants.
- Estimates of between 80 million and 91 million working days are lost to mental health problems in the UK – a cost to the economy of perhaps £23 billion a year
- However, we also need to think about the costs to individuals and families too. Isolation for individuals and long periods of relative poverty for them and their families.
- For most people, work is actually good for one's health and we know that unemployment is not! "Work is good for your health and wellbeing"

But, why are people with mental health problems workless? The obstacles to work include:

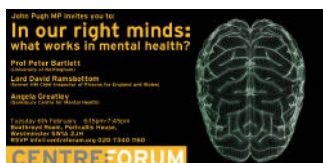
- Discrimination – one third of people with a mental health problems say they have been forced to resign or have been dismissed. Two thirds say they fear to apply because of the stigma they feel.
- Employers say they fear employing people with mental health problems.
- Also, there are considerable disadvantages in the welfare benefits system – benefit traps that deter people. It is hard to take that first step – perhaps into training or volunteering or into work itself when you fear that if anything goes wrong you will be hit hard financially.

But – and this is critical when we ask the question what works in mental health - mental health services **themselves** are often a deterrent:

- Staff may have very negative attitudes about capabilities. Services are predicated on people not being in work – e.g. timing of appointments.
- Despite the improvements already mentioned, there is a considerable problem in gaining access to talking treatments in many parts of the country. By talking treatments I mean that whole range on psychological interventions from counselling through CBT to psychoanalysis. Despite the fact that NICE has supported this approach in the treatment of anxiety and depression and supported psychological therapies for schizophrenia, there is still a postcode lottery. Lord Layard has been key in pointing out the costs to happiness as well as to the economy in not dealing with this issue.

So, in my view if we are to see a change for those with mental health problems we need to see new focus for services – employment, special support to marginalised groups – black and other ethnic minority service users, prisoners, asylum seekers, young people – all helping people to **recover**.

We have to ensure that the new kinds of specialist mental health services that have now been established are operating in the optimum way:



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- Properly resourced crisis resolution teams to support people in acute crises in their own homes or crisis houses and keep them within their communities
- Assertive Outreach Teams who work intensively and over long periods with those with complex problems who are hard to get to want to use mental health care – do help people to stop going further down that road to exclusion
- Early intervention for young people who experience the first onset of a potentially serious mental health problem and need not experience the discrimination and feelings of stigma that were the norm in the past.
- We need much improved inpatient care; physical fabric, levels of staffing, range and availability of therapies and activities.

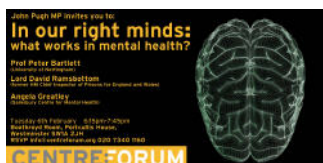
However, we also need to see properly skilled and resourced primary care. That's where care is delivered to most people and where the right kind of investment – especially in talking therapies – will really pay off in improved mental health **and** in keeping people in work.

I am not going to say much more about services; I know that fellow panel members will pick up on critical issues such as mental health care for people in prison or in custody in the community, the need for advocacy and so forth.

But, I do think it important to leave you with the thought that none of the approaches I have suggested will work without a good legal framework. Government has spent eight years or more trying to change the current Mental Health Act and has been unsuccessful. Now we have the attempt to do so by amending the 1983 Act. It is important that we do not lose sight of this once in a lifetime opportunity to get the best Mental Health Act that we can.

***Angela Greatley** is Chief Executive of the Sainsbury Centre for Mental Health (SCMH). She joined SCMH in 2003 as Director of Policy & Research. Prior to joining SCMH Angela was Fellow in Mental Health at the King's Fund from 1997. Angela has also worked as a manager and a commissioner in the NHS in north and east London. She is a non-executive director of a mental health NHS trust and sits on the boards of two mental health charities.*

SCMH is an independent charity working to improve the quality of life for people with mental health problems. It carries out research, development and training programmes to influence policy and practice. Its priority programmes are focused on employment for people with mental health problems and on mental health care in the criminal justice system.



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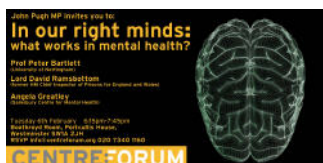
Professor Peter Bartlett
Professor of Law,
University of Nottingham

The “Professor” title gives you a clue that I’m an academic. That is relevant to our current purposes for a couple of reasons. One is that I have been asked to speak to you for no more than 10 minutes, which, for an academic, is not a length of time I am used to - I am used to an hour. Are you sitting comfortably? Then I’ll begin... The other reason is that as I was preparing I did what any good academic does, I looked for some research material. The research material I had a look at was the material that the speakers all received about where this evening is going and, of course, the poster.

This evening’s event, as you will recall, is called “In our right minds: what works in mental health?” My brief was to talk to you about advocacy and rights, and I found myself wondering: “what works for *whom* in mental health?” What exactly do we understand to be a good result if we’re looking at setting up a mental healthcare system, or a social services system, which is actually caring for people in this context?

Now, the brief that we got from CentreForum gave us some ideas. We noted that the nation’s mental health is deteriorating; record numbers of people are on income incapacity benefit – how can we get that number down? Most of these people live in profoundly deprived areas, so what interventions are most appropriate in those areas? How do we protect ourselves from dangerous people and how do we avert stigma? CentreForum is, of course, a think-tank, and these are perfectly sensible questions for a think-tank to be asking, but I did find myself wondering: “what exactly does this look like if we think about the problem not so much as a problem for government, but as a problem from the perspective of someone on the receiving end – a user of the services that we are talking about?”. There is certainly some common ground. In terms of overall health, people want to be healthy, they want to be relatively happy and they want their problems to go away. Who could be in favour of stigma? Again, it would be difficult to imagine a user of the services in question having any reservations about that. Incapacity benefit? Somewhat trickier, but as Angela Greatley pointed out, these people really do want to work. There are some systematic disincentives to doing that with incapacity benefit - there probably is considerable common ground again with that kind of area. Remedial action in deprived areas - what exactly does that mean? If it means improving neighbourhoods, improving housing in those neighbourhoods, who could be opposed? But, if you’re a government... the elephant in the living room is of course the Bill, and I’m desperately going to try not to talk about the Bill unless people want to, but inevitably bits of that discourse are going to come through.

If you’re a government, it means CTOs – Community Treatment Orders. That’s going to be much more problematic, because that is about coercion, and it raises the question – when is it appropriate to coerce? A similar set of problems arise with dangerous people. How do we understand a “dangerousness” criterion? And where is all that going? It is about *coercion*. Now, as I say, I am desperately going to try not to debate the Bill. But, a couple of things one can’t avoid. The most recent Cochrane studies – Cochrane studies are the systematic reviews of medical literature which are designed to



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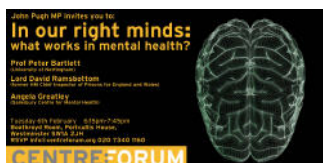
tell you what works and what doesn't – say that there really isn't any convincing argument that Community Treatment Orders work. They don't seem to reduce dangerousness. Instead, if you really want people to stay on the treatment, what you should be doing is providing people with treatments that they want to take, that they understand would be useful.

It doesn't do to suggest that people with mental health problems are somehow unaware of their problems. I think they are profoundly aware of their problems - they may not phrase it quite the same way that we do - but they are usually in touch with what is going on with themselves. Similarly, about dangerousness, all the indications are that when we have a "dangerousness" value, we massively overconfine people. Two to three times the number of people who wouldn't go on to commit crimes, or be dangerous, get swept in with that kind of criterion. This gives the question about how many false positives, how many unjustified confinements, do we really want to put up with in order to confine at least a certain number of people who would go on to be dangerous. In criminal law, we've all heard the phrase it is better to have 100 guilty people go free than one not-guilty person convicted. It's interesting that we don't tend to hear that phrase in the mental health business.

So what does that mean for advocacy? What does that mean for rights? The first thing that I would suggest to you is that advocacy can mean a bunch of different things in a variety of different contexts. Sometimes, it means having a friend that you can go to who will interface with the professionals for you. In some ways, that's a really good thing. Sometimes people are frightened by professionals - if you've got someone you trust who you're prepared to go with you that's great. Professionals, it has to be said, listen more closely to other professionals. But as soon as you start saying that, you start seeing where some of the problems are going to arise, because all of a sudden the advocate becomes powerful.

I'm aware that we have a tremendously erudite audience. Are people aware of the Mental Capacity Act? One of the things that is going to happen is that advocates will be involved in some cases, by no means all, to help determine the best interests of people who lack capacity. I suspect they will be profoundly influential in that decision. But in what sense are they being an advocate, if they're also being a decision-maker? Do you need an advocate to talk to your advocate? And, if the person that your advocate is supposed to be talking to is, for example, your doctor, shouldn't we be dealing with this by helping doctors communicate better with patients, rather than going through a middle-man? I made my career for a while involved in patient advocacy, I'm obviously in favour of it, but I do think that we have to think about those issues very carefully.

Another problem with advocacy is what's referred to as "capture". The system starts manipulating the advocate. The advocate becomes aware that they have a reputation in the system - they have to sound good. In one hospital I heard the comment "oh we like that advocate; he knows which cases he ought to push". Well, with respect, there is a big question: "is it really up to the hospital to be making that kind of decision?" As an advocate, you find yourself in a really massive bind. Either you represent your clients differently, pushing some, not pushing others, in which case there is a big question of people being left behind, or you don't, in which case the people at the hospital freeze you out. So how much power in this kind of system does the advocate actually have?



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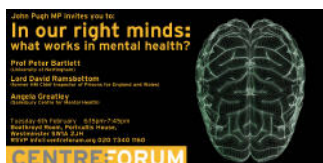
That raises a second question. If we move to a harder model of advocacy, where we do give advocates power, that means introducing real criteria for how compulsion and how services work. I have to say that both the courts and the legislation have been appallingly bad. That's both the positive rights and the old-fashioned due process human rights. If the bill which is proposing Community Treatment Orders goes through, you're going to be able to slap them on with not much more evidence than it is an appropriate treatment and you ought to receive it; that is beneficial that you be under one of these. Well that isn't really, with respect, a meaningful criterion. It's also a problem, of course, because whether you end up under one of these things depends which doctor assesses you, and with things like treatment, which is a profoundly invasive violation of human rights, beneficial though it often is, it shouldn't be about the luck of the draw as to which GP or psychiatrist you get.

I would also gently suggest to you that there are costs, in social terms, of coercion, and very little discussion in the current legislative debate has focussed on those. The more power you give to your psychiatrist or to your social worker to intervene and twist your arm... these people aren't stupid right? They're not going to talk to their doctors! Why would you give your doctor information that he or she is going to use to lock you up? It's not rocket science. What you're doing is you're building in a disincentive to talk to doctors, and if you're looking at systems that are going to work, you have to be able to talk to your doctor.

As a different image, those of you with a particularly sharp ear for accents will notice I don't actually originally come from this country. I come from Ontario, where we have a different system. Treatment decisions, not confinement decisions, are done entirely on the basis of capacity. If you're an inpatient, if you're a confined patient, if you're an outpatient, we don't care, it's done on the basis of capacity. The medical profession was rather apprehensive when that was brought in, but now, if you talk to them, you realise that firstly, they seem to have bought into it fairly big time, and secondly, you have to talk to the patient, and negotiate something which you're both prepared to go with. Now, because of the way this happened, there are not yet any studies on the before or after effects of that. However, I would suggest that it has to be a good thing, because you have to talk to the patient and you both have a stake in the outcome. Surely that has to mean people stay on their meds, or whatever other treatment it is they're on, and, sorry, isn't that what we wanted?

Peter Bartlett is Nottinghamshire Healthcare NHS Trust Professor of Law in the School of Law at the University of Nottingham. He was called to the bar of Ontario in 1988, and received his PhD in Law from the University of London in 1993. With Ralph Sandland, he is author of *Mental Health Law: Policy and Practice* (OUP, 3rd edition forthcoming). With Oliver Lewis and Oliver Thorold, he is author of *Mental Disability and the European Convention on Human Rights* (Brill/Martinus Nijhoff, 2006). He is also author of *Blackstone's Guide to the Mental Capacity Act 2005* (OUP, 2005).

Professor Bartlett serves on the Board of Directors of the Mental Disability Advocacy Center, an NGO based in Budapest that promotes and protects the human rights of people with mental health problems and intellectual disabilities across central and eastern Europe and central Asia, and on the Board of Directors of the International Academy of Law and Mental Health.



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Lord Ramsbotham Former Chief Inspector of Prisons

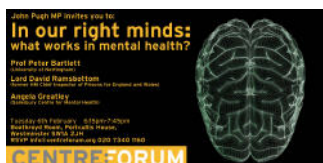
My experience of what works in mental health stems from when I chaired a hospital board and we had a marvelous Director of Mental Health, who insisted that I should train as a mental health assessor so I could be a useful chairman, rather than a useless one. And I was very glad I had that experience when after a year or so I was invited to be Chief Inspector of Prisons and found myself in Holloway, where it was said that half of the place was a mental health hospital, and I found women in conditions and without treatment that I simply wouldn't have tolerated.

Your chairman asked me to comment on my conclusions about mental health from my time as Chief Inspector of Prisons so I will focus on that, declaring an interest that the Sainsbury Centre for Mental Health is working on employment but also on mental health in prisons, and I am working with them on this. And, although numbers of people in prison and coming out of prisons are not vast in terms of national population, when you look at the well of psychiatric morbidity that is represented by people in prisons, their coming out does represent a considerable surge on the population that has to be treated outside. It is on that surge that I want to start.

One of things that shook me most when I took over as Chief Inspector was to find that alone in the UK, prisons were not part of the NHS. Therefore, what happened to people in prisons was not the responsibility of the NHS and the NHS did not have an arrangement either for passing on information or collecting information from prisons about people, which would enable continuous treatment to be maintained. As Angela Greatley has mentioned there is a vast amount work to be done. When I looked at the doctors in prisons - the health directors - I discovered that only 10% of them qualified to be doctors in NHS, which gave an indication of the quality of what one was seeing, quite apart from the quantity.

When I began to look at the mental health care, it was almost non existent. It wasn't helped by the fact that nurses largely came from agencies and passed in and out. The numbers of psychiatrists was virtually nil, particularly in adolescent psychiatry, and I found there was only one building in the whole of the prison service that was designed as a secure place for people with mental health problems. That was in a Young Offender establishment but, as they didn't have an adolescent psychiatrist, it was taken out of use and used as a classroom.

So what was my conclusion from all this? My conclusion was, quite simply, that it was high time that the problems of mental and physical health in prisons should be taken over by the NHS and not left in the hands of the prison service. Because only by doing that would the problems be part of a proper system. There were also masses of others with mental health problems for whom no provision was made. And unless provision was made, there would be no help in the future. To cut a long story short, I published a report in 1996 called "Patient or Prisoner?" which recommended that this happen and in 2003 it actually happened.



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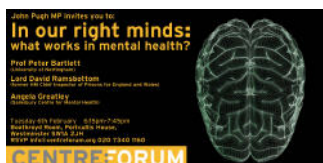
Why do I think that is important? I think it is important because of two things which say we ought to take the issue of prisons seriously. One is because time in prison is an opportunity to assess and begin treatment, or to continue treatment, for conditions which may well not have been identified before. Secondly, when you look at the prison population of 80,000, all except about 40 are going to come out, and what matters then is their mental and physical state and that becomes a public health issue. Therefore, figures must be included in public health estimates.

Now, if the opportunity is to be seized, there must be an equivalence of treatment available from experts in both the quality of mental and physical health treatment. When I look around at what the well of psychiatric morbidity means and ask if equivalence is being met, the answer must be a resounding 'no'. Professor Bartlett mentioned the challenge posed by dangerousness. In 1998, the government published a paper about the incidence of dangerous and severe personality disorders, words which I was told by my distinguished psychiatric medical adviser were not recognised by the profession because they were subjective. But the figures were interesting because they showed there were 400 people in this category in hospitals, 700 somewhere in the community and 1400 in prisons, and there were no facilities to deal with this vast number. And when I compared what was being done in Rampton, Ashworth and Broadmoor with what happening in prisons, of course, it was laughable. Where does equivalence lie in this?

So I set about trying to do something about this, bearing in mind that nothing had happened since 1947. Sisyphus had an easy time with his stone really, compared to trying to persuade people there was a problem here. That report was matched by the equally important report called "The Psychiatric Morbidity in Prisons in England and Wales" published by the Office of National Statistics in October 1998, frequently quoted as the best evidence so far. The figure that has always stood out for me was that 70% of those in prisons have some form of identifiable personality disorder. That doesn't necessarily mean they are sectionable, but it does mean that something is affecting their behaviour. Talking to psychiatrists, they tell me that if you can identify what it is affecting behaviour, you can do something to mitigate it by designing treatments or a programme which make allowance for that and counteract it.

As an aside, one of things that interested me particularly looking around was when I went St. Andrews hospital in Northampton, where I found a marvellous head injuries unit. I was told there that it was possible to produce treatment related to head injuries which caused behavioural changes which could be predicted, not completely but sufficiently to design a programme. And, of course, the basis of the programme was always stimulus and what stimulus are prisons giving to people sitting in cells all day, doing nothing?

What was interesting to me when I went to inspect the Close Supervision Centre, where prisoners who have committed crimes in prisons are held - the worst people in the system - 41 there, I asked my doctor to check how many had recorded head injuries - 34 had. And I have always believed that if you took, as well the normal assessment of people that came in and asked about head injuries, there are an enormous number more of the population who end up in prison, which suggests there is a very definite link, which needs more work.



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I mention that in passing because I think that looking at the opportunity that prison presents, there is a great deal of work that can be done, looking at these sort of problems, because people are there. It's a place in which I think more research ought to be directed.

But the research will only be conducted if people recognise that prisons are not isolated from the community, but are part of it. People are in there for a period of their lives and that must be regarded only as a period. The key is information flowing in which can be followed, and information flowing out which can be followed, because nothing is going to be solved in prisons alone. The person coming into prison is going to come out with a problem, particularly if that problem has been exacerbated. We have got to take account of what is being thrown out to the public. Therefore, it seems to be entirely appropriate that while Angela says that things are getting better, mental health bills coming out and so on, what worries me about this bill is that it is not applying to prisons, despite all the evidence that we gave to Genevra Richardson when she was doing her work on the earlier edition of the bill. I believe that what is laid down for outside, must apply inside. Advocacy was mentioned; who is going to be the advocate for people in prison, particularly for juveniles and others, unless they are trained and appointed? My reason for saying this is because I think it's a microcosm of what is going on elsewhere; it is not an isolated incident. There are a great deal things to be learned about, there's a huge amount of research to be done, provided that they are regarded as individuals and part of the problem, not an aberration.

Lord Ramsbotham was commissioned into the Rifle Brigade on coming down from Cambridge in 1957. He retired from the Army in 1993, in the rank of General, having served in Germany, Kenya, Hong Kong, Borneo, Gibraltar and Northern Ireland as well as England. Between then and 1995, when he was appointed HM Chief Inspector of Prisons, he was Director International Affairs with Defence Systems Ltd, a private security company working with the UN and World Bank on post-conflict reconstruction including de-mining, and Chairman of the Hillingdon Hospital NHS Trust. He retired as Chief Inspector in 2001, having by then visited and/or inspected every prison in England, Wales and Northern Ireland, as well as prisons in the USA, Canada, Australia, Germany, the Overseas Territories and Scotland. He was appointed a cross-bench member of the House of Lords in 1995, where he majors on penal reform. He is an advisor to the Sainsbury Centre for Mental Health.

