

# New Vision for Mental Health

## An Ecological Paradigm



We are delighted to say that the New Vision project has received the *2018 Presidential Medal for Excellence in Person-Centred Healthcare*.



The award was made by the President of the [European Society for Person Centered Healthcare](#) (ESPCH) – Sir Jonathan Elliott Asbridge – and received during their 2018 conference in London, during which we made a keynote presentation concerning the ecological paradigm described in this document.

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# The New Vision project and website:

## Introduction:

*New and interesting things are happening in mental healthcare*

This website looks at the many new and interesting things that are happening in mental healthcare, together with taking a critical, informed and constructive look at the current mental health system, the concepts on which it rests and its constituent parts.

It hosts a growing collection of curated posts on which visitors can comment (or else themselves contribute suggested posts or provide details of forthcoming events). Including a planned *Resources* section, it aims to provide an international and interdisciplinary platform where practitioners, trainees, experts-by-experience and others can explore the emerging range of ideas, insights and approaches that might, in time, lay the foundations for a new and quite different approach to mental healthcare.

The wider New Vision project looks to help weave together these emergent ideas and approaches, providing greater coherency and aiming to translate the new vision into specific recommendations for changes in policy, structure, training and practice that will support the shift *away from*:

- A 20<sup>th</sup> century, simplistic and largely biomedical paradigm centred mainly on pathology and the treatment of symptoms ...  
*towards* ...
- A paradigm that is fit for the 21<sup>st</sup> century: namely an [ecological paradigm](#) that is inherently complex<sup>1</sup> and focused on the person-in-connection.<sup>2</sup>

The new vision is outlined below. However, being conscious of its evolving and collaborative nature, we'd like to stress at the outset that we welcome discussion and feedback concerning its further development.

## Why now?

Side by side with the emergence of a complexity-based, ecological paradigm for mental health, is the widespread sense that our mental healthcare system simply isn't working, has reached crisis point and needs a radical new vision.

To give just one illustrative example, antidepressant prescriptions from GPs in England have *doubled* in the last decade (2007-2017), rising to a staggering 67.5 *million* individual medications.<sup>3</sup>

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<sup>1</sup> Informed by the emerging field of complexity science, including (for instance) complex causality.

<sup>2</sup> The person-in-connection is also inherently complex, not least because the human mind/brain is perhaps the most complex phenomenon that we currently know of.

<sup>3</sup> Figures from NHS Digital.



It's a similar story within fields closely allied to mental healthcare. For instance see [Social services are broken. How can we fix them?](#), in which Hilary Cottam, an internationally acclaimed British social entrepreneur, talks about the need to redesign the welfare state using the power of relationships.

Lost in a fog of pseudo-science (e.g. 'schizophrenia'<sup>4</sup> as a supposed meaningful label, the 'chemical imbalance' theory of depression etc.), our mental healthcare system is confused about what it's doing and what it's supposed to be doing. It disguises this confusion by vast over-reliance on the use and supposed 'precision' of diagnostic labels (which at best merely describe, but do not explain), quantitative measurement, repeated patient assessments and the misleading (and unintentionally ironic) use of terms like 'evidence-based practice'.

This systemic confusion is reflected by muddled organisational structure (e.g. the main gatekeepers to mental health services within primary care being those, namely General Practitioners, whose training is predominantly *medical/biophysical* and who are already over-burdened in dealing with other categories of patient). It's further reflected by the misnomer 'mental', when the experiences concerned are mostly and more importantly *emotional and psychological*.

Beyond just confusion, the current system is based on flawed assumptions (e.g. the core applicability of the biomedical model) and corrupted by the pharmaceutical industry. It's (mis)informed by simplistic, mechanistic thinking. It's over-stretched. And worst of all, it's a system that is often damaging to the people it's supposed to be helping.

**So, what might a very different approach to mental healthcare look like, knowing what we know today?**

The New Vision proposes an ecological paradigm rooted in interrelationship, complexity and diversity. This manifests across three layers – Practice, Community and Society – with the person-in-connection at the centre. Within these layers the New Vision also identifies five development themes: emotion-focused care, collaborative practice, a coherent system, a wellbeing society and a balanced budget.

The five development themes and three layers are outlined [below](#), but first ...

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<sup>4</sup> Meaning "a splitting of the mind". The word is related to "phrenology": a long-discredited pseudo-science which involved the measurement of bumps on the skull to predict mental traits.

## An Ecological Paradigm:

Ecology involves looking at the *interrelationships* within any given frame of reference, whether it's urban ecology, planetary ecology or, as in this case, the ecology of mental health.

These interrelationships are inherently complex – even more so in the context of mental health since they centre on people-in-connection whose minds/brains are phenomenally complex and who are each located at a unique confluence of strands within a complex web.

This complexity spans both 'inner' and 'outer' worlds, going well beyond the scope of purely biophysical or psychosocial factors to also include those that relate more specifically to emotional, cultural, evolutionary, economic, environmental, psycho-developmental and existential/transpersonal/ spiritual factors.



See here, for instance, [Contextualising science in the aftermath of the evidence-based medicine era: On the need for person-centred healthcare](#), by Prof. Andrew Miles and Sir Jonathan Elliott Asbridge:

“ ... the patient is a person with dimensions which extend well beyond the purely physical and which include the psychological, emotional, existential/spiritual and social components of human existence which add layer upon layer upon layer of complexity to the biology of the patient and which collectively, not separately, constitute the magnificence, even mystery, of the being and relating of the individual human person.”

To be clear, the New Vision acknowledges the potential biophysical *contributory* causatives of mental ill-health (e.g. the types of bacteria in the gut), but sees these as linked mostly to underlying causative factors such as stress, social isolation<sup>i</sup>, poor diet, disrupted sleeping patterns, lack of exercise/fresh air and substance abuse.

This contrasts with the still-dominant medical model which – much to the delight of the pharmaceutical industry – continues to focus on debunked theories of chemical imbalances in the brain. It also contrasts with the ongoing failure, despite decades of research, to find any genes or DNA sequences which explain mental health to any significant degree or practical effect.<sup>5</sup>

<sup>5</sup> Concerning the inflated promises and claims made on behalf of 'The New Genetics' generally, Steve Jones observed (in 2009, in his then capacity as Professor of Genetics at London's University College): "The mountain has laboured and brought forth a mouse".

Not much has changed since then, but the stream of 'triumphal' news-stories continues, serving only to conceal the truth to the general public, namely that a genetic understanding of the human body is far, far more complex than was originally supposed.

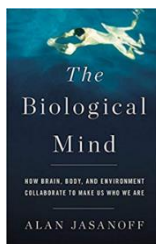
This points to some essential differences between a 21<sup>st</sup> century philosophy of science based on (for example) systems thinking and complex-causality, and the earlier, more simplistic approach to science that is still dominant in the field of mental healthcare. The latter is based generally on reductionism, demarcation through classification/labelling, binary logic, the illusion of ‘objectivity’, a quantitative emphasis and a tendency towards a linear/mechanistic thinking that is prone to conceptualise in terms of single-causes-leading-to-single-effects.



See here, for instance, [The Value of Systems and Complexity Sciences for Healthcare](#) (edited by Prof. Joachim Sturmborg, 2016), which “emphasizes the interconnectedness of the individual’s physical, psychological, cognitive, and sociocultural functioning.”

In addition to *complexity of interrelationships*, the proposed New Vision paradigm is described as ecological because it also:

- Looks at an inter-connected *whole* – not seeing the mind-brain-body as isolated systems and not seeing individual minds as necessarily isolated from other minds, far less isolated from the surrounding society, culture, physical environment, economic system (etc.).



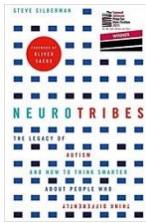
See here, for example, [The Biological Mind: How Brain, Body, and Environment Collaborate to Make Us Who We Are](#).

In this book Prof. Alan Jasanoff argues that we ignore bodily influences on our psychology (e.g. bacteria in the gut) and overlook the ways that the environment affects our behaviour (e.g. via ambient sound and the weather). He also argues that our selves aren’t just inside our heads- they’re spread throughout our bodies and beyond.

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Dr. James Le Fanu has written ([The Rise and Fall of Modern Medicine](#), p. 463): “There is ... nothing in the genomes of fly and man to account for why a fly should have two wings, four legs and a dot-sized brain and we should have two arms, two legs and a mind capable of understanding the origins of the universe. The genetic instructions must be there, of course, for otherwise the diverse forms of life would not reproduce themselves with such fidelity from generation to generation. But we have moved ... from supposing those instructions are at least knowable in principle to recognising that we have no conception of what they might be.”

- Acknowledges *diversity* as a basic feature. This translates to a pluralistic approach to mental healthcare, not least in recognition of both neurodiversity and the uniqueness of each person.



See here, for instance, [NeuroTribes: The Legacy of Autism and How to Think Smarter About People Who Think Differently](#) (Steve Silberman, 2015). This “provides long-sought solutions to the autism puzzle while casting light on the growing movement of ‘neurodiversity’ and mapping out a path towards a more humane world for people with learning differences.”

- Sees the prime importance of a *healthy environment* – whether (for instance) the physical environs of a town or city, the local social support system, or the education system.



See here, for instance, [The Centre for Urban Design and Mental Health](#), where they work to “inspire, motivate and empower policymakers and urban practitioners to build mental health into their projects for a healthier, happier urban future.”

The environment also includes, of course, psychiatric in-patient wards/units. How might these be re-designed to create more tranquil, healing and human spaces?



See here, for example, [Madlove: A Designer Asylum](#), which asks: “Is it possible to go mad in a positive way? How would you create a safe place in which to do so? If you designed your own asylum, what would it be like?”

## Three layers and five themes:

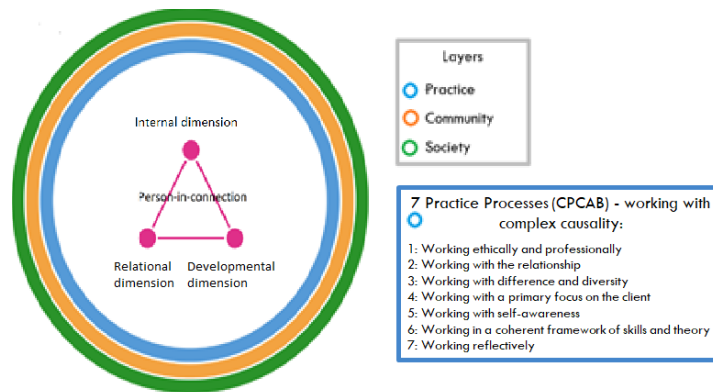
The New Vision encompasses three layers, with the person-in-connection at the centre:

Layer 1. **Practice** – e.g. therapist and client.

Layer 2. **Community** – e.g. primary mental healthcare system at local level.

Layer 3. **Society** – e.g. national government policies.





Each layer contains a set of factors that contribute to or detract from mental health (i.e. causality). Additionally, each person has psychological, social and developmental dimensions (development over time) that further contribute to or detract from their mental health.

Importantly, the ecological paradigm shifts the focus towards understanding and working with *complex causality*, although this is not to deny the importance of symptoms, especially for the person's lived experience.

Each layer involves one or more of five identified themes:

Layer 1. **Practice** (e.g. therapist and client):

- Theme: **Emotion-Focused Care** – ensuring services are emotionally safe and supportive by focusing on developing genuinely caring relationships.
- Theme: **Collaborative Practice** – working collaboratively to contextualise practice with each person.

Layer 2. **Community** (e.g. primary mental healthcare system at local level):

- Theme: **A Coherent System** – designing a service system that looks beyond the biomedical or psychosocial models, helps people with what *they* want help with (rather than what the system is pre-disposed to provide) and looks to address causes rather than simply tagging people with diagnostic labels and then looking to treat (including suppress) their symptoms.

This raises a fundamental question: *on what new basis should the mental healthcare system be broadly organised?* For example, should it be focused primarily on / organised around / orientated towards ...

- Simply asking people what their problems are and starting from there?
- Relationships?
- Outcomes?
- Service levels (e.g. as per CPCAB counselling model)?



- Something entirely different from any of the above?

Layer 3. **Society** (e.g. national government policies):

- Theme: **A Wellbeing Society** – developing a society that recognises the wider factors that impact on mental health and takes meaningful account of these across all government policies.
- Theme: **A Balanced Budget** – a budget more fairly divided between biophysical and mental & emotional healthcare.

These development themes are outlined further below:

### 1. Emotion-Focused Care (applies to Layer 1: Practice)

Perhaps the most fundamental human needs (physical needs aside) are for meaning and relationship.



See here, for instance, [Power Threat Meaning \(PTM\) Framework: a slideshow presentation](#), which looks “towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis.”

Within the PTM framework, rather than asking “what is wrong with you?” the practitioner asks:

- *What has happened to you?* Translated as “how is power operating in your life?”
- *How did it affect you?* Translated as “what kinds of threats does this pose?”
- *What sense did you make of it?* Translated as “what is the meaning of these situations and experiences to you?”
- *What did you have to do to survive?* Translated as “what kinds of threat response are you using?”

Clinical psychologist Dr. Lucy Johnstone (one of the PTM framework’s lead authors) has written:

“The simplest answer to the question of ‘What do we do instead of diagnosing people?’ is ‘Stop diagnosing people’. The argument that we need a fully worked-out alternative system before we can abandon something that is admitted to be non-valid even by the people who invented it is, in my view, a complete red herring. And the simplest current alternative is to ask people what their problems are, and start from there.”

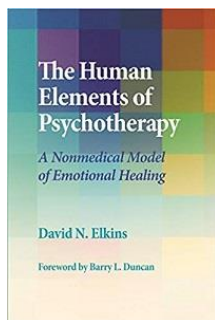
Yet the currently dominant approach to mental health continues with a largely unhelpful (and often damaging) focus on diagnostic labelling and an attempt to

categorise almost every type of emotional, personal and mental distress as a ‘disorder’, ‘illness’ or ‘syndrome’.

### *The rational-technical approach:*

The rational-technical approach of current science philosophy has brought about enormous technological development, and because of this our culture has assumed that mental health problems can also be solved by this approach. But within what is called ‘mental’ distress, the core experiences are *emotional* – fear, anxiety, paranoia, sadness, grief, guilt, shame, anger and so on. This is especially so for people needing help with common life problems, such as bereavement or divorce, or with common mental health problems, such as depression or anxiety.

Emotions are by definition not rational, and we need to accept that emotional problems require emotion-focused solutions. This is especially true of mental health services which need, first and foremost, to develop emotionally therapeutic relationships with their service users, rather than – except as a last resort and for short-term purposes of stabilisation – attempting to suppress or numb emotions through prescribed drugs. People have feelings, not ‘disorders’.



See here, for example, [The Human Elements of Psychotherapy: A Nonmedical Model of Emotional Healing](#), by Dr. David Elkins.

The publishers say: “The dominant paradigm in psychotherapy is the medical model, which views therapy as a clinical treatment rather than a healing interpersonal connection. ... Elkins presents a nonmedical model of psychotherapy – one that places common factors, particularly human factors, at the centre and moves modalities and techniques to the periphery.”

In addition to emphasising non-technical, emotion-focused solutions, emotion-focused care also includes:

- Valuing the practitioner’s emotional knowing.  
Listening to someone else’s emotional pain can be very hard. This is because, outside of the counselling and psychotherapy profession, few mental healthcare professionals have been trained to uncover and care for their own emotional pain. So, when they are working with people who are, for example, experiencing intense grief, they may *avoid* empathising for fear that their own emotions will overwhelm them.  
Experienced practitioners also draw extensively on intuitions derived from practice wisdom, but this type of knowing hasn’t yet been properly acknowledged, valued and researched.
- Valuing the mental and emotional health of practitioners themselves.  
A major long-term study of psychotherapists concluded that practitioners who were stressed were less effective. Because of the strong emotions and stressful situations encountered, ‘burn-out’ is also a professional hazard.

- Acknowledging that that emotional and psychological and issues very often underpin the lifestyle habits – such as smoking, obesity or addiction – that have the biggest impacts on biophysical health.

## 2. Collaborative Practice (applies to Layer 1: Practice)

Each individual person knows best their own unique life context and current life-situation. This means practice needs to:

- Be person-centred and collaborative rather than practitioner or treatment driven.

People need to be engaged, along with their practitioner, in their own therapeutic process, rather than being simply passive recipients of treatment. And research<sup>6</sup> has shown that simply listening to the voices of service users has a positive effect on their engagement and the therapeutic process.

- Strike a much better balance (compared to now) between the emotional, psychological and pharmacological approaches to therapy.

- Be contextualised for each person, rather than one-size-fits-many.

Each person is *unique* ... no two people have the exact same combination of psychological make-up, life story, current life-circumstances, cultural background and so on.

### Contextualisation:

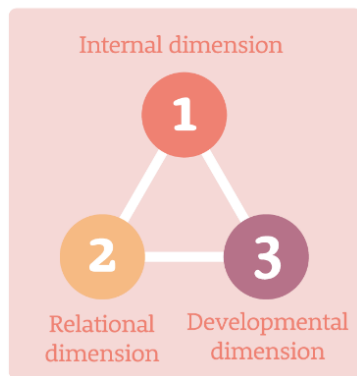


Concerning the last item above, and within the sphere of talking therapies, the [CPCAB model](#) (for example) offers a useful and trans-theoretical way of understanding and working with a person's context. It divides this context into three broad areas: (1) the internal context of the patient/client's thoughts and feelings; (2) the context of their relationships; and (3) the context of their development and personal history.

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<sup>6</sup> [A new therapy for each patient: evidence-based relationships and responsiveness](#), by John C. Norcross and Bruce E. Wampold in the *Journal of Clinical Psychology*, October 2018 - this recently published paper summarises a meta-analysis by the American Psychological Association 3rd Task Force on evidence-based therapy relationship.

### Three dimensions of client problems



The model also describes what kind of change is possible: (1) the person can't change who they are, but they can change how they relate within themselves; (2) they can't change other people, but they can change how they relate with them; and (3) they can't change their past, but they can change how they relate with their past.

### 3. A Coherent System (applies to Layer 2: Community)

This is clearly a very broad topic. The following are simply two illustrative examples:

- [A new type of mental health professional](#)
- [Street triage, policing and beyond](#)

#### *A new type of mental health professional:*

In each local community, General Practitioners (GPs) are currently the main primary-care gatekeepers to mental health services in the UK. However, GP training is based mostly on the medical model within a treatment paradigm, whilst mental health problems are largely *non-medical* in nature. So we are entitled to ask:

- *How appropriate are GP referrals/diagnoses/prescriptions/treatments when it comes to mental health?*
- *Is this GP gatekeeper role an illustration of why and how our mental health system is an incoherent, tangled mess?*

The New Vision proposes the training of a new type of mental health professional. These would be placed in every GP surgery (and elsewhere in each local community), to work in tandem with GPs by seeing/consulting with every person who would otherwise occupy a GP but is thought to have a *non-biophysical* ailment or problem.

Studies suggest that such patients comprise perhaps up to 50% of those who currently make a GP appointment – a prime reason why GPs are hugely over-burdened:

See here, for instance, [A Very General Practice](#), Citizens Advice Bureau (2015), found that: “GPs in England report spending almost a fifth (19 per cent) of their time on social issues that are not principally about health. The implied cost to the health service of this time is almost £400 million a year.”

This new type of mental health professional would largely take over the current role of GPs as primary care gatekeepers to mental health services, albeit working in tandem with GPs. They would therefore hold a budget and have the authority to issue *non*-medical and social prescriptions (referral) ... e.g. for counselling, exercise coach, psychiatrist, local authority housing officer, visits to a ‘care farm’, cold-water swimming club, forest-walks group etc:



See here, for instance, [Health Connections Mendip](#): “... a new and exciting service which provides peer support, social prescribing, one-to-one and group support to enable people living in Mendip to improve personal and community resilience ... This support is in addition or instead of the support they have traditionally received from their GP practice and other healthcare services.” *Health Connections Mendip Annual Report 2016*.

In relation to this new type of mental health professional:

- The main focus would be on what the patient/person wants or believes might help and making a collaborative assessment that is not centred on dysfunction/deficit or symptom identification.
- People could make appointments with them directly. And GPs would refer patients/people across.

*Street triage, policing and beyond:*

Many of those in need of help with mental and emotional health problems simply fall through the cracks. They will never make an appointment to see a GP or a counsellor – some may not even be registered with the NHS. Their only contact with the health service may well take place in hospital A&E departments. And their first contact with any public service may well be with the police, out on the streets, perhaps ending up in custody.

A new approach to street-triage is therefore required in which police officers to such call-outs are accompanied by a mental health professional. This is being trialled in a few areas (in the UK at least) but needs extending nation-wide.

Beyond this, police forces are being left to pick up the pieces in a “national crisis” in mental-health care and so cannot deal properly with crime, according to a

report by *Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services*.<sup>7</sup> In London, for example, the police receive a call about mental health every four minutes and send an officer to respond to such calls every 12 minutes.

And further beyond this, a very large proportion of those in prison have mental/emotional health problems: a radical re-think of our prison and judicial systems is required.

#### 4. A Wellbeing Society (applies to Layer 3: Society)

Prevention is of course better than cure. And in the longer run, the creation of a wellbeing society is the best way to maximise prevention and so minimise the need for cure. This obviously has many dimensions.



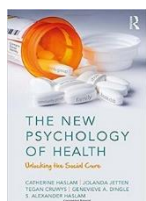
See here, for instance, [Wellbeing Manifesto](#), prepared for the New Zealand government.

As a result of work in the fields of psychology, anthropology, evolutionary biology and other human sciences, the current depth of understanding of the human condition is unprecedented. Because of this – and because of technological progress – we are now in a position, more than ever before in human history, to choose the kind of society that we want to create.

The New Vision looks forward to a society that recognises the wider factors that impact on mental and emotional health ... and which therefore promotes wellbeing through its policies in education, the environment, economics and beyond.

#### *Wellbeing factors:*

The emotional and psychological factors that make for an individual's long-term wellbeing are well-known. They include a sense of valued purpose and usefulness – a life with real meaning. They include a sense of personal identity and 'agency' – the ability to pursue goals that the person values, to be more than just a cog in the machine. They include a feeling of connectedness to – and warm regard from – others. They include a human-scale environment, access to tranquil and beautiful places, and the feeling of living in a non-judgemental, 'live and let live' society.



See here, for instance, [The New Psychology of Health: Unlocking the Social Cure](#). This looks at questions such as:

- Why do people who are more socially connected live longer and have better health than those who are socially isolated?

<sup>7</sup> [Police cannot fix a broken mental health system](#), November 2018.



- Why are social ties at least as good for your health as not smoking, having a good diet, and taking regular exercise?
- Why is treatment more effective when there is an alliance between therapist and client?

Another relevant factor concerns the reduction of economic and social inequality: greater inequality heightens status competition and insecurity across all income groups and among both adults and children.



See here, for example, [How economic inequality harms societies](#), a TED-talk given by Prof. Richard Wilkinson.

*Gross Domestic Product as surrogate for ‘wellbeing’:*

Many of the largest negative impacts on wellbeing stem from a relentless and unbalanced striving – across governments of all shades – for never-ending growth in Gross Domestic Product (GDP). This pursuit has become a surrogate for societal ‘wellbeing’, despite the stress-and-anxiety-inducing effects that trail in its wake: more urbanisation, less work-life balance, more community disruption, less social cohesion, more roads, more traffic, more airports, more runways, more noise, fewer green spaces, less countryside and so on.

The rise or fall in monthly growth figures, the change in stock market indices ... these pieces of information are presented to us as key indicators of how well we are doing as a society, when they often show the opposite. For instance, road traffic accidents cause a rise in GDP figures, whilst a ban on the expansion of strip-mining may well cause the stock market to fall.



See here, for example, [International Forum for Wellbeing: Beyond GDP What Comes Next?](#)

The fixation with GDP also twists our education system out of shape, largely reducing pupils to mere units of future economic potential. Hence, for example, school ‘league tables’, a misshapen national curriculum, a centralised control system and an exam-based regime that ramps up stress levels.

Moreover, rather than feeling safe and secure in themselves and their lives, many people feel insecure, anxious and fearful. In this condition, encouraged by the advertising industry, they will often look to use consumerism as a means of comforting themselves and securing their ‘status’ in a society that currently measures such things mainly in terms of wealth.

A wellbeing society, however, will look for other ways to calm anxiety and other ways in which to define status.



### *Children and young people:*

The New Vision places special focus on children and young people. This is partly because they are subject (via cyber-space) to levels of perceived competition and performance/image-anxiety unknown to any previous generation. But it's also because three-quarters of the people who have mental health problems in adult life first experience symptoms in childhood or adolescence – so this period in life is vital in preventative terms.

Moreover, by improving the mental health of young people, we better enable them to later, as adults, carry an enhanced awareness forward into their various workplaces and cultural/social peer groups.



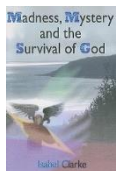
See here, for instance, [Bad Education](#), by Richard Oldfield. This argues that to bring about large-scale, long-term improvement in mental health we must radically reform the National Curriculum ... since the latter currently centres on many things that most pupils don't need to know and will never use, at the expense of barely teaching everyday interpersonal and intrapersonal understandings and skills.

### *Spiritual emergence or psychosis?*

A wellbeing society is also a society that provides greater space for one of the perhaps most neglected – or ignored – aspects of human culture as far as mental health is concerned, namely spirituality. This is not a reference to any particular religion, nor even necessarily to *any* of the mass-scale religions or anything to which the label 'religion' is attached.

The renowned psychologist Carl Jung said “I have treated many hundreds of patients. Among those in the second half of life – that is to say, over 35 - there has not been one whose problem in the last resort was not that of finding a religious [i.e. spiritual] outlook on life.”

However, our current rational-technical system of mental healthcare tends to use labels like 'psychosis' to describe some distressed states that might, from a differing perspective, be seen as something rather different.



See here, for instance, [Madness, Mystery and the Survival of God](#), by Dr. Isabel Clarke. This includes an exploration of the overlap between transliminal/spiritual experiences and psychosis, all in relation to the Interacting Cognitive Subsystems (ICS) model of cognition. The ICS model sees control in the mind/brain being passed back and forth between two 'boss' sub-systems, namely:

- a) The rational or 'propositional': verbal, logical organising, boundary-maintaining, either/or binary logic, as distinct from ...

- b) The emotional or ‘relational’: ‘both and’ logic, no boundaries, its function is emotion, which is the human way of organising relationships.

## 5. A Balanced Budget (applies to Layer 3: Society)

The National Health Service in England spends roughly *seven times more* on bio-physical healthcare compared to mental healthcare. This huge imbalance cannot be justified.

The situation is even more astounding given that amongst the most prevalent bio-physical illnesses are those which are mostly ‘lifestyle’ in origin (e.g. many cardiovascular diseases) and thus can best be prevented or lessened through psychological means and the alleviation of emotional and psychological distress.

There are also the economic costs to consider. See for instance [Thriving at Work](#), a government-commissioned report (2017). It estimates that poor mental health costs the UK economy £74bn - £99bn annually, including a £33bn - £42bn cost to employers. And it says that up to 300,000 people with long-term mental health problems have to leave their jobs each year.

In addition, the money spent on mental healthcare could be spent *much* more effectively than is currently the case – e.g. spending less on psychiatric diagnosis/prescribed drugs and more on talking therapies.

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### End Note:

This website has been created primarily with regard to those – including policymakers, professionals and trainee professionals – working within the very broad field of mental health.

Within a UK context, one aim of the wider New Vision project is radical reform of the mental healthcare provided by National Health Service (NHS). And here we return to the question posed earlier: *what might a very different approach to mental healthcare look like, knowing what we know today?*

Another aim of the wider project is the creation of a wellbeing society, prevention being better than cure. What does a wellbeing society look like? What does it feel like? How is it created?

As stated in the introduction, the wider New Vision project aims to help to weave together emerging ideas and approaches, provide greater coherency and translate the new vision into specific recommendations for changes in policy, structure, training and practice.

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<sup>i</sup> The percentage of UK households in which people live alone has risen to nearly a third this century.