Scenarios for the future of mental health care: a social perspective

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Social values and concepts have played a central role in the history of mental health care. They have driven major reforms and guided the development of various treatment models. Although social values and concepts have been important for mental health care in the past, this Personal View addresses what their role might be in the future. We (DG, PH, and SP) did a survey of professional stakeholders and then used a scenario planning technique in an international expert workshop to address this question. The workshop developed four distinct but not mutually exclusive scenarios in which the social aspect is central: mental health care will be patient controlled; it will target people's social context to improve their mental health; it will become virtual; and access to care will be regulated on the basis of social disadvantage. These scenarios are not intended as fixed depictions of what will happen. They could, however, be useful in guiding further debate, research, and innovation.

Introduction

Social values and concepts reflecting a wide understanding of a social paradigm have played a central role in the history of mental health care.[1,2] They were essential for the origins of modern psychiatry during the Age of Enlightenment,[3] drove major reforms of care and deinstitutionalisation in the 20th century, and led to various treatments, including models of family and group therapies, and a range of community-based services.[1] The extent to which social aspects have been considered important in mental health care has varied over time. Over the past 40 years, arguments have been made that social values and concepts have become less prominent, at least in academic psychiatry,[4] which leads to the question: what does a social paradigm have to offer for the future of mental health care? And can a renewed focus on social concepts open up perspectives for innovation—ie, for developments that are distinct from current practice and that go beyond what has already been established?

Any attempt to envisage options for future mental health care needs to consider the changing technological, economic, social, and political context.[5,6] This inevitably entails speculation. It is not possible to anticipate with certainty how all these factors will change in the future, but they are likely to affect how people live and how mental health care can and will work.

Against this background, we (DG and SP) did a project to explore the potential future of the social approach to mental health care. The envisaged timescale covers the next 20 years, and the explicit focus is on care—ie, on what support and treatment societies might provide to help people overcome mental distress and what role professional services might serve in this support and treatment. Rather than trying to come up with accurate or most likely predictions for what will happen, we set out to develop different and not mutually exclusive scenarios. Each scenario aimed to elaborate on one specific idea of how the future might develop. Thus, we did not seek a consensus, but envisaged different scenarios and their potential effects on mental health care in the future.

The method of scenario planning is typically done by a group of experts who consider the instabilities of the present and the drivers for change, and then imagine plausible different future scenarios.[7] Instabilities are issues within a specific field—eg, mental health care—that are likely to change in the future. Drivers for change are factors that might determine the future of the field, but are external. Thus, they are not directly related to the organisational, clinical, and academic facets of mental health care itself, but are determined by more general societal changes (panel). The project was limited to western Europe to provide sufficient focus and avoid overloading the debate with too much complexity.

The instabilities and drivers for change in mental health care were first suggested during a survey of professionals. The survey findings were presented and discussed at the beginning of a workshop, specifically for the purpose of this Review, with experts from different European countries. During the workshop, the survey findings were refined and complemented. Inclusion did not require endorsement by the whole group. Informed by the discussion about instabilities and drivers for change, the workshop then developed potential scenarios for the future. The methods of survey and workshop are described in more detail in the appendix.

Four possible scenarios were identified: patient-controlled service (mental health care will be patient led without coercion); modifying social contexts (care will target people's social and living contexts to improve their mental health); virtual mental health care (care will be provided primarily online and become virtual); and partners to the poor (access to and provision of care will be regulated on the basis of social disadvantage).

Patient-controlled services

Patients would play a leading role in the planning of all mental health care. Services would be designed by

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See **Online** for appendix

Panel: **Instabilities and drivers for the future in mental health care**

Instabilities
- Biological research has a dominant status in academia
- Funding for social research in mental health is scarce
- Patients and their family members or friends (informal carers) need to be more strongly involved in care
- More collaboration with other agencies on social aspects of care (eg, primary care, social services, local authorities) is required
- Stronger theories and methods on the effects of social factors on mental health are needed
- Achieving change in social factors is difficult
- Effective and more affordable social interventions for mental health care need to be developed
- Translating knowledge into clinical practice and mental health policies is challenging
- Recruitment of mental health-care professionals can be problematic
- Patients have increased access to care information via the internet
- Keeping up with changes in cultural norms is a challenge
- Implementing a multidisciplinary approach can be problematic
- Few preventive strategies are available

Drivers for change
- Increasing social inequalities and injustice
- Ageing population
- Reduced social role of families
- Digital age
- Increasing loneliness and social isolation
- Privatisation of mental health care
- Increasing urbanisation
- Globalisation
- Mass migration
- Increasing individualism
- UN Convention on the Rights of People with disabilities

health services, and service culture would be based on patient and carer involvement at all levels—ie, planning, provision, and assessment of care. Personal budgets would be the main form of care funding, and the focus of services would be on patient capacity building instead of capacity and risk assessment. Response to threats of violence and actual violence would be the remit exclusively of the criminal justice system, following the same legislative framework as for anyone else in society. Consequently, offenders with mental disorders would be sent to prisons rather than hospitals.

Such a focus would have implications for research and the training of mental health professionals. Mental health research would be more determined by patients, taking into account their understanding and experience of care, and producing information that patients request to inform their decisions on how to make best use of services and treatments. Mental health professionals would develop skills to engage with communities to advocate for patients, and with patients to fulfil their new role. They would be trained to assist and support patients to help them achieve their goals, and take no responsibility for patients' decisions. As a consequence, psychiatrists and other mental health professionals might or might not lose part of their status, and overall funding for professional mental health care might be reduced.

Modifying social contexts

Mental health services would provide interventions aimed at modifying the social context of people who are experiencing psychological distress. These interventions could include support with parenting, the provision of educational and occupational opportunities, and initiatives for social activities and relationship building within local communities.

Implementing such interventions would be part of the role of psychiatrists and other mental health professionals. People who are likely to benefit could either self-refer to services or be identified through data at a community level. Continuous data collection (data cycles) from people exposed to the interventions would be needed to monitor the creation (or dissolution) of toxic or unhelpful social determinants and the effects on mental health. If mental health services take an active role with regard to the social aspects of peoples' lives, there would be very close collaboration——or even amalgamation— with social services and local authorities. Modification of social contexts would affect not only individuals with mental distress, but also whole families and communities. Targets and outcomes of interventions would be discussed in consultation with stakeholders, including patients and their families, and the general public. With respect to research, there would be investment in understanding how social factors and interactions could have a beneficial effect on mental health and how to facilitate this effect. Collaboration with social scientists would be key. Mental health training would include

patients and provided in response to their requests and preferences. Treatment decisions, including admissions to hospital and referrals to specific therapies, would be controlled by patients. Coercive measures, including both formal and informal types of coercion, would not be part of mental health-care provision.

Resources would be used to fund codeveloped services on the basis of the entitlements and rights of patients. In these services, the main role of professionals would be to advocate for patients' rights on a societal level and respond to patients' preferences on a personal level. The main function of professionals would be to assist individual patients by providing expertise when in contact with them, and to be available if and when support or medical interventions are requested. Peer workers would be members or leaders of all mental

substantial contributions from the social sciences, including community psychology and geography, and of partners from local authorities and social services. Accurate methods for testing change in social relationships would have to be developed and all professionals would be trained to use at least some of them.

Virtual mental health care

All mental health care, with the potential exception of emergency care, would be provided online and by virtual mental health professionals. The virtual professional would not be a human being, but an avatar with artificial intelligence. It would be reliable, always available, and equipped with the best information on evidence-based interventions. It would never forget anything the patient has ever said, and be able to communicate in any style that the patient might prefer. Patients would be able to choose the gender, age, ethnic group, appearance, and other characteristics of the virtual professional. The software could be developed on the basis of the best available mental health-care expertise and evidence and it would provide data for consistent quality improvement.

This virtual form of care would be available all over the world, would not require any professionals for local services, and would therefore cost very little. It would be eco-friendly because patients would not need to travel to access mental health care. Patients might also wish to present themselves with different characteristics and as different virtual patients to different virtual professionals. Drones might be used to deliver medications, and patients might even be able to give a physical body to their virtual clinicians in the form of a robot. Some patients might still want some contact with real human beings to supervise or validate their interactions with the virtual clinicians. The software developer might need to take responsibility for malpractice and have the power to charge costs for access to clinical services. Research would be mainly focused on the quality improvement of software programs utilising process and outcome data. Human facilitators could help patients navigate the software. However, virtual care would drastically reduce the human workforce required and the need for training in mental health care provision.

Partners to the poor

Mental health care would be part of a holistic service for people who experience social disadvantage. There would be a single unified access point to services based on social disadvantage criteria. Social disadvantage cutoffs would be defined according to various dimensions, including poverty, social isolation, homelessness, unemployment, marginalisation, discrimination, and other more specific aspects such as forced migration. The distinction between physical, psychological, and social distress and care would not be clear. All assessments would be comprehensive and adopt a generic approach, mainly aimed at understanding the social context in which the conditions have developed. Pharmacological or specific psychotherapeutic interventions would be applied and assessed, taking into account the social context.

On a societal level, this scenario would require advocacy for socially disadvantaged groups, and calls for political decisions aimed at reducing social disadvantage. At a community level, services would try to target risk factors for social disadvantage and health disorders. Specific services for socially disadvantaged families might be set up. Care would be provided via face-to-face interactions and require colocation of services for physical and mental health care and social services. Research would focus more on social factors establishing both physical and mental disorders and on overall care provision. Attention to evidence and interventions focused on social determinants of health would increase. Most professionals would receive non-specialised training in physical and mental disorders, and specialist professionals might be fewer and work in a smaller number of services than they do presently.

Discussion

The four scenarios are presented with a large degree of speculation about what their implications might be, and without addressing the likelihood and desirability of each scenario. If one of the proposed scenarios materialised substantially, the other scenarios might be less relevant. However, each of these different scenarios is more likely to develop to differing extents, in which case some aspects of the different scenarios might coexist.

Although the scenarios are based on different ideas, all share an emphasis on social concepts. They consider the importance of understanding a person's social context and acting upon and within it. Each scenario would entail fundamental changes to practices and require fairly dramatic reorganisation of services. The roles and work of professionals would be different. Across the different scenarios, today's professions would either mostly disappear, being replaced by peer support workers or artificial intelligence, or take on different roles as social advocates or assistants to patients.

How mental health services would collaborate with other agencies varies across the different scenarios. Two scenarios would involve strengthening the links with local authorities and social services or with physical health services. Other scenarios require incorporating virtual world expertise in designing mental health care models or having a more explicit and comprehensive model for stakeholders' involvement in mental health care with no use of formal or informal coercion.

Common to different scenarios is the relevance of stakeholder involvement. Patients, their families, and members of the general public play an important part in the transformation of mental health services in all imagined future scenarios. Their potential roles range from a leading position in the design and operation

of mental health services to a consulting and monitoring role in the application of social intervention models in practice.

At the core of the scenarios is the question of where the expertise for mental distress and mental health care lies. The scenarios provide different responses to this question. One of them bases mental health care expertise on patients' personal experience and on their preferences. Other scenarios involve a holistic model for health and social care or aim to incorporate insights from social sciences or community psychology more formally in mental health research and training curricula.

The different scenarios have more or less likely features and persuasive aspects. Their appeal will vary, depending on the underlying values, ideals, and concepts that are preferred for mental health care specifically, or even for societal life in general. Yet, each of them has some potential to develop in reality, either as indicated in this Personal View or in different forms. The scenarios were developed by a selected group of professionals with expertise in mental health care, who were all from Europe and could have been influenced by a shared background of working in fairly well-resourced institutions. Future projects might assess the views of professionals with other expertise, patients, their families, and further stakeholders on these and potentially other scenarios. Also, similar projects could be done for areas other than western Europe.

Considering these scenarios and others enables professionals to participate proactively in influencing and shaping the future of mental health care, which might be achieved through new theories, research, service development, training for new roles, or political action, or any combination of these. In any case, we hope that mental health care will benefit from a lively debate about its future, identifying and addressing different visions and ideas.

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