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'If I were you I wouldn't start from here'
Working for real change in societal responses to distress

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Systemic therapists are well-used to considering the multiple layers of context within which our lives are embedded so I thought I'd use the invitation to write an article on alternatives to traditional psychiatric practice as an opportunity to look, from a societal perspective, at the issue of psychological distress and conduct which others find troubling – the kinds of things which might be currently labelled as 'functional psychiatric diagnoses'. Why do we have the kinds of mental health systems that we have? What positive changes have occurred in recent years and what problems still remain? How might we develop a new vision, one where there is real change?

Let's begin with a thought experiment. Imagine you're sat down with a blank sheet of paper in front of you. Forget the current structures, kinds of professions and interventions we currently offer to help people in distress. Try to step back from currently culturally dominant constructions of distress. What would be the key elements in designing a society-wide response? What kinds of societal measures would we need to take to address the inequalities that are the 'causes of the causes' of distress? What kinds of help would be available for those who have experienced hurt in their lives? In what context would this help be given? At a neighbourhood or community level or in hospitals and clinics primarily designed to help people with bodily disease? Would this help be primarily expert-driven or be available from peers? Would it be primarily individually- or family- or community-focused? What ideas about distress would circulate in the media and popular culture? Would it be seen as a health-related concern or viewed some other way? What would be the place of medication? Would there be therapies available and, if so, what kinds and how would they be accessed?

I think it's important to ask these questions as, it seems to me, calls for change in mental health are often blunted by a lack of ambition. We often lack a vision of how we would really want things to be because we are surrounded by so many givens – the legacy of the history of society's attempts to address psychological distress.

Mental health services as 'legacy systems'

Western industrialised societies spend large amounts of money on mental health. Where does it all go? Primarily it goes into buildings (hospitals, clinics and the like), employing a variety of different professional staff and on medication budgets. The majority of money in research still goes into biomedical interventions and little on social and preventative measures, despite considerable amounts of evidence that these are more effective and are more amenable to change (Bentall & Varese, 2012). And also despite the fact that the media-hyped long-promised simplistic 'gene for schizophrenia'-type genetic breakthrough is unlikely ever to arrive as there are hundreds of genes associated with distress (as there are for many other aspects of

human beings), and the genetic influences are modest in their effect and are, anyway, as we know from the field of epigenetics, responsive to the social environment (Bentall & Varese, Cromby, Harper & Reavey, 2013). Also despite the fact that psychiatric medication manages our relationship with 'symptoms' (i.e. managing our emotional response to them) and doesn't treat an underlying bodily dysfunction as is common in the rest of medicine (Healy, 2008; Moncrieff 2008, 2013). Indeed, there is evidence that Big Pharma is withdrawing from psychiatric research because the chances of breakthroughs are receding (Hyman, 2012). Yet, despite the money spent, every year prescriptions of medication increase as do the numbers of people referred to various therapies (Harper, 2016).

How have we ended up with the mental health systems we have? Over the last few hundred years our constructions of the causes of distress have been in constant tension, viewed as, variously: lying primarily in physical changes in the body (somatogenesis); lying in the mind (psychogenesis); or as lying in the structures of society and in our social relationships (sociogenesis). These changes have often been linked to wider social and political changes and in the history of ideas. We've gone through cycles of institutionalisation, exposure of abuses and reforms. The middle of the nineteenth century saw the gradual homogenisation of facilities for those seen as mentally ill. Prior to this time, much mental health care was governed by non-medically trained lay people or religious groups (like the famous Quaker-run York Retreat). However, in the mid-nineteenth century when, to outlaw quackery, medical practitioners were granted legal status, medical professionals sought to lead the asylums.

The asylum populations in the US and the UK reached their peak in the mid-1950s and the spiralling costs and exposures of abuse led policymakers to consider alternatives. Some of these institutions were huge:

Pilgrim State Hospital in Brentwood, Long Island in New York State was the largest psychiatric hospital in the world when it opened in 1931. By 1954 it had 13,875 patients and over 4,000 employees. It was so large that it had its own railway station as well as its own stations providing water, heat, electric light and sewage treatment as well as its own fire department, police department, courts, farm, post office and cemetery.

Cromby, Harper & Reavey (2013, p.44)

There were approximately 148,100 people living in the old Victorian asylums in 1954 whereas, in 2012, there were about 22,300 beds on psychiatric wards. Although it is often claimed that de-institutionalisation was due to the discovery of chlorpromazine the reality is more complicated. Firstly, the 'discovery' of chlorpromazine was rather accidental. It was designed as an anti-histamine but, when given to psychiatric patients, its sedative effects were noted. Secondly, in Japan, asylum populations continued to increase despite the use of chlorpromazine (Healy, 2002). Thirdly, if the sharp increases in national populations throughout the twentieth century are taken into account, the asylum population began to fall after 1915, forty years before the introduction of chlorpromazine (Healy, 2002).

The post-War period saw a boom in the growth of the 'psy' disciplines. The American Psychiatric Association, grew from a membership of 13 asylum superintendents in 1844 to 35,000 in 2003. The UK equivalent grew from 600 members in 1921 to over 15,000 in 2009 -- though the number of consultants and associate specialist grade posts are much smaller (4,525 and 1,885 respectively in

2013 according to the Royal College of Psychiatrists, 2015). In the UK there were about 600 clinical psychologists in the mid 1960s but there are now about 12,000 (Harper, 2016). This growth in the number of psy professions is matched by a growth in the prescription of psychiatric medication. To take one example, prescriptions of Methylphenidate for children (better known by one of its trade names: Ritalin) have risen from 6,000 in 1994 to just under a million in 2014 (Harper, 2016). Despite the increased availability of psychological therapies the ever-increasing demand still outstrips supply (Mental Health Taskforce, 2016). For example, despite the NICE guideline for schizophrenia recommending all service users should be offered psychological therapy, less than a fifth actually receive it (Royal College of Psychiatrists, 2014). Of course, the current cuts to mental health services only worsen these problems – indeed, many psychological therapists themselves are feeling under significant stress as a result of increased targets and cuts to services (British Psychological Society, 2016).

The reformist call is that services need more funding and this is certainly true but all of us who have worked in, or received, mental health services know that money alone is not enough, we need to change the way we think about and respond to distress; the system needs a total overhaul. A quote on a banner at ‘tent city’ at Occupy St Pauls in London in early 2012 -- adapting a quote from Albert Einstein -- captures the challenge nicely: ‘problems can’t be solved with the same mind-set that created them’. As American psychologist George Albee argued ‘[i]ndividual psychotherapy is available to a small number only. No mass disorder has ever been eliminated by treating one person at a time’ (Albee, 1999, p.133).

Our mental health service is what IT professionals would describe as a ‘legacy system’ – it is outdated. Why is it that problems that are essentially about human relationships and problems in living are located in medical and health systems whose predominant focus is on bodily health, rather than, say as an issue of social care or, indeed, as a moral and political problem? It seems simply to be a legacy of the medical profession assuming leadership of the asylums in the mid-nineteenth century.

Why is it that we continue to use diagnostic categories of contested validity and reliability? This seems to be a legacy of the post-war attempts to combine the plethora of classificatory systems, many of them dating back to the rough and ready administrative systems developed in the asylums at the end of the nineteenth and early twentieth centuries. For example, our notions of personality disorder arise from the system used by US armed forces during the second world war a context, one presumes, where idealised norms of social conduct might make sense but which might not translate to a peacetime civilian world (Lane, 2009). And, with the rise of an ‘audit culture’ (Power, 1997) in public and commercial health bureaucracies and electronic information systems, these categories seem more resistant to change and, indeed, seem destined to expand their reach further into what might have been seen previously as ‘normal’ behaviour and, with globalisation, across the rest of the world (Mills, 2014)

Why is it that we have such a range of professional groups each focusing on a separate aspect of a person’s life? This seems to be a legacy of different professional groups developing their own approaches to distress with their own professional traditions, developing their own training programmes and research and practice literatures. Moreover when each profession considers mental health-related needs they tend to see them through the prism of their own discipline. A prism which is, often unintentionally, distorted by each profession’s guild interests.

As others have argued before, in order to develop a new vision for how we might address the challenges of distress we need to try to step out of the assumptive framework we have inherited from our history.

As a precursor to thinking about what change we'd like to see it might be helpful to produce a balance sheet of things that have improved in recent decades and things that have remained the same or even worsened.

A balance sheet of societal responses to distress

Things that have improved

- There is less pessimism about the chances of understanding the meaning of distress and learning from it about important changes in our lives and in our relationships with others which we might need to make
- Many countries have seen the closure of the old large asylums
- There is more understanding of the personal and social context of distress
- There has been inspiring work from activists in the psychiatric survivor movement and some examples of innovative work – for example the international Hearing Voices Movement (e.g. Romme et al., 2009) and the development of 'mad studies' (LeFrancois et al., 2013)
- Service users are more involved in the planning and provision of mental health services
- There is more awareness of the effects of social inequality on people's lives
- Mental health has moved up the agenda of politicians and policymakers
- There is increasing recognition that people need to talk to others about their distress – leading to increased provision of psychological therapies
- There have been some welcome innovations in psychological therapies – like Open Dialogue – and good examples of collaborative work between professionals and service users.
- A range of mental health-related campaign groups have sprung up, particularly in the context of ongoing cuts to services, for example: the Alliance for counselling and Psychotherapy (<https://allianceblogs.wordpress.com/>); Boycott Workfare (<http://www.boycottworkfare.org/>); Disabled People Against the Cuts (<http://dpac.uk.net/>); the Mental Health Resistance Network (<http://mentalhealthresistance.org/>); Psychologists Against Austerity (<https://psychagainstausterity.wordpress.com/>); and the Social Work Action Network (<http://www.socialworkfuture.org/>)

Things that are the same or worse

- Services are often fragmented and people seeking help often have to recount their problems to a succession of people before being referred on.
- People from a black and minority ethnic background have less access to psychological therapies (Glover & Evison, 2009; We Need to Talk Coalition, 2013) and are more likely – especially young black men -- to be treated compulsorily (Care Quality Commission, 2011) and there are a range of other ways in which services institutionally discriminate against a range of groups in society (Caplan & Cosgrove, 2004).
- Many people seeking help receive little choice over the form of help offered. Psychiatric medication is still the default treatment and prescription rates, for example of anti-depressants, increase year on year.

- Although psychological therapies are increasingly available they are often of very short duration and are often provided by therapists who feel stressed as a result of challenging targets
- 60% of CMHT staff and 49% of staff on acute admission wards were emotionally exhausted in 2010 even before the cuts introduced by the coalition government (Johnson, 2011)
- The proportion of temporary staff (e.g. 'bank' staff supplied by commercial providers) has been increasing over recent years (Addicott et al., 2015) due to high staff sickness rates and a shortage of staff.
- Twice as many people are sectioned now compared with the 1980s. After a sharp increase in the 1990s and a plateauing in the 2000s the use of the Mental Health Act is now increasing with 6.7% more people sectioned and 20% more people on a CTO in March 2014 compared with March 2011 (Health & Social Care Information Centre, 2015).
- Acute psychiatric wards are often scary places rather than places of retreat and service users may be re-traumatized by their contact with mental health services especially when detained under the Mental Health Act (Meyer et al, 1999). And, increases in compulsory treatment may also be increasing with the reduction of other forms of support which might have been able to provide support at an earlier stage.
- NHS commissioning incentives like Payment by Results have meant that only direct therapy is paid for rather than other alternatives like community projects, training, consultation, supervision, research, preventative work and service development.
- Vastly more money is spent on research into treatment and (bio-genetic) aetiology than prevention. For depression, £2.71m was spent on aetiology, £1.05m on treatment but only £0.3m on prevention. For psychosis, £1.67m was spent on aetiology, £0.3m on treatment but only £0.19m on prevention (MQ, 2015).
- Research funders are biased towards bio-genetic research and against psycho-social research (Bentall & Vaerese, 2012; Knapton, 2016).
- Despite claims that mental health services and research are biopsychosocial, this model is poorly thought through (Cromby, Harper & Reavey, 2013) and, in practice, acts as rhetorical device to cover for what Read (2005) argues is really a 'bio-bio-bio' model.
- Despite the scarce evidence of bio-genetic research having any real recent impact on services psychiatric, journals still continue to uncritically report the results of bio-genetic studies -- results that are rarely replicated (Cromby, Harper & Reavey, 2013). Apart from notable exceptions like the Critical Psychiatry Network and some social psychiatrists there is little debate in the psychiatric literature about the utility of a primarily bio-genetic approach.
- The assessment and management of risk has become a central concern since the 1990s (Rose, 1996) with high rates of defensive practice reported by staff (Mullen et al, 2008).
- Despite promising outcome evidence for non-medical services like the Soteria model (e.g. Bola & Mosher, 2003), residential alternatives to hospital have become almost totally medicalised – in one 2009 study only 11 out of 131 alternatives to in-patient wards were non-medical community-based services and, no doubt, given the heavy cuts to local authorities who fund such alternatives, there are even fewer now.
- Despite much professional and public debate about their utility contested psychiatric diagnoses continue to be used with, again, little debate in the psychiatric literature about their utility. Even the NICE guidelines often

include a critique of the diagnostic classification in their introductory sections, particularly in the longer versions of the guidelines.

- These categories are further reified by electronic information systems often require the assigning of a diagnosis. And the maintenance of such systems takes up huge amounts of time – go into the average NHS mental health staff office and most people are sitting in front of computers all day.
- Despite the evidence that income inequality is associated with a range of health and social problems, including psychological distress (Psychologists Against Austerity, 2015; Wilkinson & Pickett, 2009), the UK is still one of the countries with the highest levels of income inequality in the world and figures from the Equality Trust show that income inequality remains high, following a sharp increase in 1979 (<https://www.equalitytrust.org.uk/how-has-inequality-changed>).
- Social mobility has stagnated in the UK and, if anything, is worsening.
- Despite some improvements in attitudes many service users face discrimination especially in the work setting.
- Although it provides symptomatic relief for about a third of people, medication seems to make little difference to another third with a final third having their problems worsened by medication. There is growing evidence that medication may also impede recovery and long term users of neuroleptics die, on average, about ten years earlier largely because of health problems that are associated with side effects of medication (Whitaker, 2011; Whitaker & Cosgrove, 2015).

Some idea of the lack of progress can be seen by examining the 24 demands included in the declaration of intent of the Mental Patients Union (Roberts, 2008) set up in late 1972 following an occupation of the Paddington Day Hospital by patients and staff (<http://studymore.org.uk/mpu.htm>). Today, only nine of these demands have been met and some of those only partially.

What then must we do?

It doesn't seem to me that these problems can be solved by piecemeal reforms. We need a fundamental rethink both of the current culturally dominant ways in which we respond as a society to distress and of how we currently order and structure our society given the close links between distress and the political economy (Warner, 2004) especially its recent manifestation of neoliberalism (Moncrieff, 2008b). I think we need to gather together collectively, as professional groups and as citizens, to develop a more ambitious and sustainable vision for a society with less inequality – Psychologists Against Austerity (2015) includes some suggestions about what might characterise such a society. We might think of ways in which we can increase trust in our communities and create a more nurturing society (Biglan & Hinds, 2009). Moreover, in such a society it would be important to create ways of acknowledging social and interpersonal harm in a manner which doesn't require people to have recourse to either 'blame or brain' explanations and responses.

How might systemic therapists apply their skills to help create the kind of deliberative democratic debate necessary for the voting public to be persuaded to vote for significant social change? Herzig (2001) offers some suggestions about what has been learnt about this might from the Public Conversations Project which 'designs and facilitates conversations among people who are experiencing intense polarization' (Herzig, 2001, p.2). The project was formed from the Family Institute of Cambridge, Massachusetts, based on the insight that family therapists might have

ways of working with conflict that could be 'adapted and applied to divisive issues of public significance' (Herzig, 2001, p.2). Psychologists Against Austerity (2016) also make some suggestions of how we might engage in better conversations about inequality in order to create the political demand for change.

We might also draw on the work of political theorist Gene Sharp who has written extensively about how social movements can create the conditions for change (<http://www.aeinstein.org/>). I've written elsewhere (Harper, 2013) about how, in order to bring the social change we might want, Sharp suggests we need to rigorously analyse the 'pillars of support' for the status quo and to develop tactics and strategies to address them.

In the shorter term, we might try to change our current constructions of distress, for example, we might consider that their institutional pillars of support might include the mental health professions, other institutions (including the academy, funding bodies and journals), the pharmaceutical industry, many of those in distress and their relatives, the wider public, the media, policymakers and public and commercial health bureaucracies. We might learn from successful campaigns like the de-pathologisation of homosexuality or the 1980s BBC *That's Life* campaign against the over-prescription of minor tranquillisers. We need to connect the problems of mental health services to more widely understood problems.

One thing is for sure and that is that we need a vision of what changes and we'd like to see and a plan of how we're going to achieve them. The Open Dialogue model, for instance, didn't arise in a social vacuum. As Seikkula and Arnkil (2006) note, it emerged following work by people like Yrjö Alanen and his co-workers (e.g. Alanen et al, 1991) who developed the Turku Schizophrenia Project and went on to lead the Finnish National Schizophrenia Project (which aimed for a more psychotherapeutic and humanistic approach) and the Committee of Mental Health which led to a 1991 Mental Health Act. In other words, such changes require structural and policy changes.

We might develop a 5-10 year plan to articulate a vision and develop a strategy to achieve it. For example -- and these are just elements of my vision which you might not personally share -- what might need to happen for the demand for medication and therapy to decrease and for us to spend less on medication and hospitals and clinics? What kinds of accessible local community-based self-help supports could be developed if we planned from the bottom up rather than, as now, in an expert-driven top down manner? How might we develop community-based retreats rather than increasingly medicalised risk-driven services? What kinds of training and support could be offered to community facilitators in non-medical ways of understanding and responding to distress? How might we learn from innovative and liberatory approaches (Afuape & Hughes, 2015), particularly those with gather people together (Byrne et al., 2011; Denborough, 2008; Holland, 1992)? What might be the facilitators of increased social trust in communities?

So, although you might not start from here, what kind of shorter term and longer term vision of change do you have?

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