"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 psychological distress and conduct that others find troubling – the kinds of things that 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 sitting 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 current 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 psychotherapies 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). Such funding ignores 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 behaviour), 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, 2012; Cromby et al., 2013). It also ignores the fact that psychiatric medication manages our relationship with ‘symptoms’ (that is, it manages our emotional response to them) it doesn’t treat an underlying bodily dysfunction as is common in the rest of medicine (Healy,
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) rose 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 on schizophrenia recommending that those with this diagnosis 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, “Individual psychotherapy is available to a small number only. No mass disorder has ever been eliminated by treating one person at a time” (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 being viewed 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 that is, often unintentionally, distorted by each profession’s guild interests.

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.
- 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), the development of ‘mad studies’ (LeFrancois et al., 2013) and the independent mental health magazine Asylum: An International Magazine for Democratic Psychiatry founded in 1986 and still going strong (http://www.asylumonline.net/).
- 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/).
- 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). There are a number of 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 also provided by therapists who feel stressed as a result of challenging targets.
- In 2010, 60% of CMHT staff and 49% of staff on acute admission wards reported being emotionally exhausted even before the cuts introduced by the coalition government (Johnson, 2011).
- The proportion of temporary staff (for example, ‘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 community treatment order 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-traumatised by their contact with mental health services, especially when detained under the Mental Health Act (Meyer et al., 1999). Also, compulsory treatment rates may be rising partly because of cuts in the kinds of services which could have provided 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.
- According to MQ (2015), for depression, £2.71m was spent on aetiology, £1.05m on treatment but only £0.3m on prevention whilst, for psychosis, £1.67m was spent on aetiology, £0.3m on treatment but only £0.19m on prevention.
- Research funders are biased towards bio-genetic research and against psycho-social research (Bentall & Varese, 2012; Knapton, 2016).
- Despite claims that mental health services and research are bio-psycho-social, this model is poorly thought through (Cromby et al., 2013) and, in practice, acts as rhetorical cover for what Read (2005) argues is really a ‘bio-bio-bio’ model.
- Despite little evidence that bio-genetic research has had any real impact on services for those with functional psychiatric diagnoses, psychiatric journals still continue to report, uncritically, the results of bio-genetic studies – results that are rarely replicated (Cromby et al., 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).

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.
- Many people seeking help are emotionally exhausted even before the cuts introduced by the coalition government (Johnson, 2011).
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- 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 community treatment order in March 2014 compared with March 2011 (Health & Social Care Information Centre, 2015).
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• Despite promising outcome evidence for non-medical services like the Soteria model (for example, Bola & Mosher, 2003), residential alternatives to hospital have become almost totally medicalised – in a recent survey, only 11 out of 131 alternatives to in-patient wards were non-medical community-based services (Johnson et al., 2009) and, no doubt, given the heavy cuts to local authorities who fund such alternatives, there are even fewer now.
• Diagnostic categories have been heavily contested – even the NICE guidelines often include a critique of the diagnostic classification in their introductory sections, particularly in the longer versions of the guidelines. Despite this, they continue to be used uncritically in the psychiatric research literature.
• These categories are further reified by electronic information-systems that often require the assigning of a diagnosis. And the maintenance of such systems takes huge amounts of time – go into the average NHS mental-health-staff office and most people are sitting in front of computers for much of the day.
• Despite the evidence 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, and, if anything, is worsening.

What then must we do?

It doesn’t seem to me 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 neo-liberalism (Moncrieff, 2008b). I think we need to gather together collectively, as professionals, as service-users and as citizens, to develop a more ambitious and sustainable vision of 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 that 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 from the Public Conversations Project (PCP). The PCP “designs and facilitates conversations among people who are experiencing intense polarization” (Herzig, 2001, p. 2). Originating at the Family Institute of Cambridge, Massachusetts, it was 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” (p. 2). Psychologists Against Austerity (2016) also make some suggestions about 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.aeinsein.org/). I’ve written elsewhere (Harper, 2013) on Sharp’s suggestion of how, in order to bring about the social change we might want, we need rigorously to 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, some 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 we need a vision of what changes 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 Yrjó Alänen and his co-workers (e.g. Alänen 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 policy interventions over time.

We might develop a five-to-ten-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 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 that 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?

References

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