

Mental illness and its treatment today

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About the author

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1. At some point in their life, one in four adults in Britain suffers from some kind of mental illness. At any given time one adult in six is suffering from at least one mental illness¹. Most suffer from the 'common' psychiatric disorders, typically depression and/or anxiety, which may be relatively mild and short-lived but which can also take a severely disabling form². And in England in 2012 150,000 people were suffering from psychotic illness – the more severe form of mental disorder where a person's relation to reality is disturbed, leaving them unable to live an ordinary life³.
2. It is often thought that those with mental illness suffer less than those with physical illness. But anyone with experience of mental illness, whether their own or that of someone close to them, knows that the suffering is great, and is often even greater than is the case with physical illness or injury⁴. Mentally ill people are also three times more likely to die than the general population; those aged 30 to 39 are five times more likely to die⁵. In addition people suffering from psychiatric disorders have to live with the stigma that attaches to mental illness.

The neoliberal context

3. Since the turn of the century, and particularly in the last three years, mentally ill people in England have been deeply affected by two main kinds of change: on the one hand, changes in the structure and scale of the health services available to them, and on the other, a profound change in the cultural context in which they live. The second of these changes interacts with the first. The rise of neoliberal values, now espoused by all the major political parties and accelerated and intensified by 'austerity', has produced a deep shift in the prevailing 'structure of feeling' (to use Raymond Williams' expression) as regards our sense of community, our obligations to and for each other.
4. In this new world-view welfare provision is no longer seen as something that provides people with the basic necessities of life, as part of the duty of the state, but as a mechanism by which people are disempowered, creating in them a helpless state of invalidism. Instead of 'getting on their bike' and competing in the marketplace, people are seen as staying at home and 'whingeing' for the 'nanny state' to do something for them. Or to put it another way, to have one's basic needs met by the state is represented as being in a state of infantile dependence, dominated by the delusion of an inexhaustible supply of provision. People on welfare become 'scroungers'. Worse still, many

who are legitimately entitled to benefit identify with this ideology. They see themselves as having failed, as being parasites on society and undeserving, and collapse into despair⁶.

5. This kind of primitive thinking has long been the staple fare of some tabloid papers; the fact that it has now been adopted by political leaders lends it a new power. The previously unthinkable becomes quotidian, dramatically illustrated by the way the imposition of a cap on housing benefits is forcing families to vacate their homes, fuelling the sense that they do not deserve to live here. And changes driven by this thinking are taking place at such breath-taking speed that it is difficult to remain aware of their massive impact on vulnerable people, and of the erosion of our ordinary sense of responsibility for others.
6. People who are mentally ill are peculiarly vulnerable to these broader socio-cultural changes. There is a default position in relation to the mentally ill which requires continuous work to resist, namely that they are responsible for their illness; a position that of course easily fits into the characteristic self-righteousness of the mind-set just described. Baroness Hollis captured it well when she said that 'Until recently, when we introduced a bill like this [the Welfare Reform Bill] it would not have been a welfare reform bill, it would have been a social security bill⁷.'
7. The dramatic material changes in the socio-economic landscape caused by the financial crisis similarly affect people who are mentally ill in a variety of different ways which reinforce each other. Unemployment, widening inequality, loss of job security and economic hardship all cause increased psychological morbidity in the population, and those who are already mentally ill are particularly affected. Aspects of care that for generations have been regarded as essential – for example having a Community Psychiatric Nurse to provide consistency and continuity of care over an appropriate period of time – have transformed magically into luxuries that can be easily dispensed with. There has also been a crucial de-skilling of the workforce: tasks formerly done by skilled personnel are now carried out by individuals with little or no appropriate training or clinical experience.
8. These changes have a profound effect on the morale of the work force too - something which is, however, never mentioned in policy documents. Documents focus on various 'skills' or 'skill mixes', but never on the people themselves. Staff manning wards and services without adequate resources, forced to reapply for their own posts, which have sometimes also been downgraded, as bed numbers, and the staff complements that go with them, are cut (see Box 2 below), are hardly in a position to maintain the 'containment' – the capacity to

manage the intense and disturbing interactions involved in the care of these patients, to withstand pressures to act precipitately, to maintain the capacity to think - that is one of the most vital aspects of the care of the mentally ill.

Work Capability Assessments

9. The work capability assessment process, WCA, run by the French IT company ATOS, expresses very clearly the transformation in attitudes which has such a disproportionate effect upon the mentally ill. The brutal way in which it has been managed, the lack of skill of those carrying out the task and the profoundly traumatic effects it has, even for those who have the wherewithal to appeal and get an adverse decision reversed, have been well documented⁸.

Box 1: Work Capability Assessments

Before 2009, those with disabilities received Incapacity Benefit (IB). After 2010 IB was replaced with Employment Support Allowance (ESA). New claimants are assessed, and those who were recipients of IB are re-assessed, as either as Fit For Work and moved onto the much lower Job Seekers Allowance, or as in need of ESA. People placed on ESA are assigned to one of two groups: the Work Related Assistance Group, through which they receive help to enable them to become Fit For Work, or the Support Group. Recipients of ESA in the Support Group receive financial support similar to Incapacity Benefit, but are regularly re-assessed, at intervals up to a maximum of 24 months.

From the start of the WCA programme until November 2012 887,500 people who were formerly on IB have been re-assessed. Of these 23% have been judged Fit For Work, 36% have been placed in the ESA Work Related Assistance Group, and 46% in the Support Group. The proportion of those who were formerly on IB on account of mental illness is unknown.

10. The mentally ill are particularly disadvantaged here, as few of those carrying out the assessments have any knowledge of mental illness or any understanding of how the process of assessment so regularly traumatises mentally ill people. I have known a number of patients suffering from enduring mental illness, who feel so persecuted by the WCA process that terror of it comes to dominate their mental state. It needs to be understood that many people who are mentally ill are already, internally, persecuted by a terrible kind of inner self-judgement

that relentlessly tells them they are worthless, filling them with humiliation and shame⁹. In this situation, they need to find reassurance in external reality that provides some degree of protection/insulation against this inner persecution. But the WCA process itself, and in particular the assumptions which it has come to embody – that those on benefits are trying to get away with something, the whole atmosphere of distrust of claimants – creates an external reality that far from providing reassurance, reinforces these menacing internal processes.

11. I have known patients with enduring serious mental illness who inform the panel that they are 'feeling much better and are ready to work'. This is of course not based on any real assessment of their own capacities, but arises from a wish to prove themselves worthy, while the panel are quick to accept such statements as it is not in the nature of the exercise to question their veracity, or to discuss them with the mental health professionals who know the patient. Other patients have not even attended the assessment because they are so scared of it. There are cases of people dying not long after ATOS has considered them fit for work, including cases of suicide.
12. A GP who has given a very disturbing account of the WCA experiences of patients with mental illness concludes: 'I am fearful that more of my patients will be put at risk of homelessness and suicide by this brutal new system. From my perspective, the most disadvantaged in our society are being punished. Work is good for all of us, if we are lucky enough to be in employment. But not all of us have the skills to work and some of us are so unwell or damaged by past experiences that they cannot do a job. We should accept that some people, for many different reasons, need supporting'¹⁰.
13. A case in point: F was a woman in her 50s who suffered from chronic severe depression and drug addiction, with multiple serious physical complications. She was malnourished and could barely walk as a result of physical difficulties arising from her drug addiction. The only time she left home was to attend sessions at a psychotherapy centre and to see her GP to get her prescription for Methadone. Slowly she was trying to think about herself and make the first moves towards life. She lived in dread of her housing benefit being taken away if she 'failed' at the WCA panel. In the end, having suffered months of terror, she was deemed incapable of work, but only for one year, after which she would have to go through the same thing again. For such patients a further assessment in a year's time is not experienced as something in the future but as a continuous hovering presence that acts to interfere with the prospect of recovering some function. A brief conversation

with any of those directly involved in her care would have quickly clarified the medical and psychological realities of her life and would have spared her this whole process which has so traumatised her, and continues to do so.

Changes in the care of patients with serious mental illness

14. The deterioration in the care of the mentally ill has a long history but not one that is easy to chart. Although closure of the large mental hospitals embodied a potentially beneficial change in attitude to psychiatric care, there has never been adequate investment in properly organised, integrated, community care. Serious neglect and institutionalization were endemic in the asylum era, and the wish to care for patients in the community was a laudable aim, but this vision was always a hostage to fortune. Real care in the community would have required a very significant injection of resources but as the years rolled by serious lack of provision and neglect became a familiar story, which has turned into an accelerated decline in care over the last five years.
15. As regards in-patient care I can best use some of my own experiences to show the contrast between how it was, say, 20 years ago, and how it is now (I have discussed this with numerous consultant colleagues who have had similar experiences) . Twenty years ago occupancy rates on inpatient wards were about 80%, which is generally agreed to be about right. It means that on a twenty-bed ward 16-17 beds would be occupied at any one time. This allowed nurses to have more time with patients, and time for teaching or discussion of difficult issues. The wards I worked on would have perhaps less than a quarter of the patients held on section (that is, detained compulsorily). Some of the voluntary patients would originally have been compulsorily detained, but almost always stayed on the ward after they had been released from their section. This was a crucial period for establishing the vital therapeutic relationships with the staff, as it is obviously very difficult to establish such trusting relationships when patients are being held against their will.
16. Patients would stay for a number of weeks or months. They would prepare for discharge by going home for a trial period and then would return to the ward to report to their key-workers on how they had got on. And even after complete discharge these patients would return to the ward to meet informally with the staff. A patient would be seen in the outpatient clinic by the same team that had admitted him or her as an inpatient - as it was understood that continuity of care is of central

importance because patients feel safer with those who have known them at their worst and share with them a knowledge of their history.

17. Now the current situation. Bed occupancy rates are very often over 100%¹¹. This means that wards are overcrowded and that the beds of patients on leave (even for one or two days) are immediately taken by other patients, regardless of the impact on the returning patients, who then have to be moved to other vacant beds. Acutely psychotic patients are sometimes admitted to wards where there are no beds and given mattresses on the floor¹². Patients are discharged well before they are ready (partly because of the pressure on beds), and the result is often early re-admission.

Box 2: Mental health bed closures

Freedom of Information requests were sent to 53 of England's 58 mental health trusts, by BBC News and Community Care, and 46 trusts replied. The figures show that a minimum of 1,711 mental health beds have been closed since April 2011, including 277 between April and August 2013. This represents a 9% reduction in the total number of mental health beds - 18,924 - available in 2011/12. Three quarters of the bed closures were in acute adult wards, older people's wards and psychiatric intensive care units. Average occupancy levels in acute adult and psychiatric beds are running at 100% according to the FOI figures from 28 trusts. Half of these trusts had levels of more than 100%; all of them had occupancy rates above the 85% recommended by the Royal College of Psychiatrists. The problems of running at capacity are highlighted by the tragic case of Mandy Peck. The 39-year-old told psychiatric staff she was feeling suicidal but her local mental health service centre said they had no beds available. A day later she jumped to her death from a multi-storey car park. A subsequent investigation found that a bed had actually been available. (Source: BBC News and Community Care Magazine 16 October 2013)

18. And instead of only a minority of patients being held compulsorily, the majority of patients on the ward are now in this category. Not only must the few available beds be given to the most acutely ill, but there is even some evidence of patients being held on a section simply to ensure they will be given a bed¹³. And as soon as these patients move to voluntary status the pressures to discharge them, to free up beds, are impossible to resist, so that patients are regularly discharged before they can really manage in the community.
19. The increased rate of bed occupancy, and the fact that most patients are now held compulsorily, both have very powerful negative effects

on the ward atmosphere: wards are overcrowded with acutely psychotic patients. No wonder that patients and psychiatrists try to avoid admissions to this very disturbing environment. The high intensity of the atmosphere on wards coupled with the declining capacity to contain it, combine to create a toxic environment that of course impacts upon the mental states of the patients¹⁴. However this deterioration is most unlikely to be thought of as brought about by these environmental and systemic causes. Instead it will be recorded in terms only of the individual factors in the patient, and is then seen as indicating a need not for a more containing environment, but for increased medication.

20. Overcrowding and high turnover of patients also have, inevitably, a massive impact on the nursing staff. The labour process is intensified, and the space for reflection and carrying out the 'emotional labour' which is a crucial part of nursing is compromised, resulting, again, in a lowering of morale and in many cases, burnout.

The transformation of day hospitals

21. A further major deterioration in services arises from the reorganization of day hospitals. Until recently patients with enduring mental illness have been well managed in day hospitals, which provided a non-toxic environment where they could gradually develop interpersonal skills and receive emotional support in a structured environment, this often requiring many months and often more than a year. However these centres have been re-designated as 'recovery centres'. The implication here is that in a quite limited amount of time, measured in weeks, these patients can recover from years of mental illness and return to ordinary living. This conception not only bears no relation to the nature of most of these patients' difficulties, but also creates a kind of tyranny for the staff. Patients are now supposed to recover, and there are performance targets against which this will be judged: if they don't recover the conclusion drawn is that the staff have failed.
22. A local policy statement (from Camden in London) illustrates the new thinking: 'Since the Day Hospitals opened in 1992, there have been changes to the way mental health services are provided... Research shows that people do better if there is a strong and persistent emphasis by services on rehabilitation and recovery. We need to adapt all the services that we provide to ensure that they are as effective as possible at helping older people to avoid admission to mental health inpatient wards, and to be able to support older people returning to their own home as quickly as possible¹⁵'.

23. In my view this statement makes an unsubstantiated global claim whose real function is to justify cuts¹⁶. What is missing here is any recognition that a great deal of the care of those with enduring mental illness is more to do with damage limitation and providing forms of support and care, skills which are now much less valued. And as so often in discussing mental illness, the word 'community' conjures a picture of a caring, cosy hearth; but the reality of life in the community for those with psychiatric disorders is very different, all too often friendless and even homeless. The recognition that patients are damaged by institutionalisation is twisted into a justification for not providing services they can depend upon¹⁷.
24. Moreover day hospitals were staffed by teams, often established over many years and composed of individuals with high levels of skill. But the de-skilling process, driven by financial pressures, results in patients being looked after by well-intentioned individuals who have virtually no experience of working with the mentally ill. The parallel with the reduction of the skill mix already familiar in social care, and now taking place in NHS hospitals, is obvious¹⁸. The sweeping changes in NHS mental health services have resulted in a perversion of care where the realities of suffering, dependence and vulnerability are now being disavowed¹⁹. Since the focus is on quick outcomes that behavioural therapies are alleged to provide, the complexities of managing those in psychological distress are systematically evaded. The NHS 'market for care' turns a blind eye to the emotional realities of suffering, instead constructing what has been identified as a 'virtual reality' where attention to targets, outcomes, protocols and policies is privileged over attention to the patient's psychological needs²⁰.
25. In a perverse logic some of these changes in health care are presented as providing the patient with more freedom to choose the services they want. But patients can't choose a service that has been closed. A colleague reports that when a day hospital in Nottingham was recently closed the budget was transformed into personal budgets given to individual patients who were then asked how they would like to use them. The patients replied that what they wanted was their day hospital back. In general, the 'choice agenda' serves to make people feel they have more freedom and to mask the fact that they have less.

Marketising the care of the mentally ill

26. As NHS care is increasingly converted into a healthcare market there is pressure to divide care up into marketable packages for which contracts can be put out to tender to be competed for by rival bidders.

While this may be possible for some standard medical treatments such as hip replacements it is totally inappropriate for long term chronic disorders, and is in this latter category that much of the care of mentally ill belongs.

27. In the case of mental illness it now means trying to fit every patient into one of 20 diagnostic 'clusters', each with a prescribed package of care, with a price attached²¹. Not surprisingly it is difficult and often impossible to categorise mentally ill patients in this way. Although the policy was introduced in 2005, the following extract from the Department of Health's Guidance on Payment by Results for mental health in 2013-14 shows that it is still not working as its advocates wish: 'Diagnosis is an area... where there is currently great variability between the percentage recorded by providers. It is important that wherever possible, diagnosis is captured'. The mental health clustering booklet sets out how this should be done. Currently not all clinicians are recording every item in Health of the Nation Outcome Scales (HoNOS). It is very important that they do, as this data will be used when looking at whether particular outcomes have been achieved²².
28. In other words, the care of mentally ill patients must be forced into a market model in which outcomes can be measured and paid for accordingly, regardless of whether it makes sense²³. What we are witnessing is an accelerating commodification and instrumentalisation of mental suffering.
29. In addition, integration across services is vital for the needs of the mentally ill just as much as it is between health and social care services for patients with physical illnesses, if not more so. But this becomes impossible when services are marketised. For example it is characteristic of mentally ill patients that because of their difficulties they often move from one place to another; yet when they move from one purchasing area to another the commissioners in the new area may not feel under any obligation to pay for their care, and thus the service provider has to stop their treatment.
30. Marketisation also involves serious costs in terms of staff resources. Many consultants spend a significant part of their time discussing not patients but the contracts their unit or department has with a range of different commissioners, and responding to pressure to treat patients more rapidly if a contract is 'underperforming' (or where there is even a threat that it may not be renewed, with potentially catastrophic consequences for the department's ability to function). Where contracts are 'over-performing' – i.e. the service, perhaps because local GPs are

satisfied with it, is treating more patients than are provided for in the contract - there are very powerful pressures to discharge patients from care.

Conclusion

30. We have taken an extraordinary step backwards in our attitude towards people with mental illnesses. The several hundred thousand people disabled by depression and anxiety, and the 150,000 with psychotic illnesses, unable to cope with normal life, are once again being represented as closer to being delinquents than being ill. Instead of being cared for they are increasingly being deprived of adequate services and pushed out to fail and suffer again. A century and a half of advance in our understanding of mental illness, and in our sympathy for its victims, is being brusquely jettisoned. To marginalise and neglect the needs of sick people in this way would be judged intolerable if applied to the physically ill. And it is not even clear that what is happening will save money.

31. If we are serious about caring for people who are mentally ill some basic principles must be reasserted. Resources for these most vulnerable members of the population must be restored. Bed occupancy rates for in-patients need to get down to 80% and patients need to be able to remain voluntarily in hospital long enough to establish therapeutic relationships with staff. Continuity of care must be restored, so that those looking after patients as in-patients continue to look after them in the community. Day hospitals must be restored to their original mission of caring for people on a long-term basis, accepting that most of them will need permanent help. Work Capability Assessments of mentally ill patients must be based on recommendations by professionals who have knowledge of psychiatric illness and who know the patients. The myth that everyone can and must recover – and in short order – must be dropped. We have to recognise that much of the care of the mentally centres upon damage limitation and rehabilitation, but not on cure.

References

- ¹ NHS Information Centre. *Adult psychiatric morbidity in England, 2007: results of a household survey*. London (2009)
- ² The Office for National Statistics. *Psychiatric Morbidity report, 2001*.
- ³ Mental Health Bulletin. *Annual report from MHMDS returns - England 2011-12, initial national figures* (2013)
- ⁴ It is also estimated that ten per cent of the cost of treating patients' physical symptoms is due to symptoms caused or exacerbated by mental illness. www.iapt.nhs.uk/wp-content/uploads/2008/11/medically-unexplained-symptoms-positive-practiceguidetxt
- ⁵ Mental Health Bulletin. *Sixth report from Mental Health Minimum Dataset returns – England 2011/12*, initial national figures, p. 5. Nearly six per cent of mentally ill patients who die aged 19-74 have committed suicide. Mental Health Bulletin. *Annual report from MHMDS returns - England 2011-12* (2013)
- ⁶ The catch-word 'nanny state' perfectly expresses this perverse logic and hatred of vulnerability. Some of the issues touched upon here and elsewhere in this paper are explored in more depth in David Bell (1996) 'Primitive Mind of State', available at <http://www.tandfonline.com/doi/abs/10.1080/02668739600700061>
- ⁷ HL Hansard, 4 October 2011, cols GC 331–332
- ⁸ Notably by Dr Greg Wood who worked as a WCA assessor; see <http://www.theguardian.com/society/2013/may/16/atos-doctor-claimants-biased-medical-assessments>; see also <http://www.theguardian.com/commentisfree/2013/jul/23/work-assessments-atos-dwp-test>
- ⁹ In technical language one would say that a very harsh persecuting superego is a very common feature of mental illness.
- ¹⁰ <http://www.guardian.co.uk/commentisfree/2013/jan/04/gp-atos-work-capability-assessment>.
- ¹¹ <http://www.guardian.co.uk/society/2011/jun/20/mental-health-services-in-crisis-over-staff-shortages>
- ¹² E.g. <http://www.mirror.co.uk/news/uk-news/vulnerable-mental-health-patients-forced-2343568>
- ¹³ House of Commons Health Committee Post-legislative scrutiny of the Mental Health Act 2007 *First Report of Session 2013–14*
- ¹⁴ There is vast amount of evidence that psychotic patients are highly sensitive to the emotional intensity of their environment.
- ¹⁵ http://www.candi.nhs.uk/_uploads/documents/corporate/camden-mews-piercy-consultation-document.pdfm
- ¹⁶ Although it is stated that 'research has shown' no information is given about this research, so this is in effect just an ex cathedra statement .

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- ¹⁷ The Care Quality Commission's 2011 Mental Health Survey in the community found that 31 per cent of respondents who needed support from someone in NHS mental health services with their physical health needs said that they had not received support but would have liked it. 42 per cent of respondents received care under a Care Programme Approach – an approach which should include support on housing, employment and financial advice. However, the survey found that 35 per cent had not received any help with finding or keeping work; 27 per cent had not received any help with finding or keeping accommodation; 27 per cent had not been given any help with financial advice or benefits. Mental Health Network/NHS Confederation Factsheet November 2011.
- ¹⁸ The Centre for Health and the Public Interest, *The Future of the NHS: lessons from Social Care*, October 2013, para 35.
- ¹⁹ Rizq, R. 'The perversion of care: Psychological therapies in a time of IAPT'. *Psychodynamic Practice*, 2012, 18, 1, 7-24.
- ²⁰ Rizq, R. 'States of abjection'. *Organization Studies*, 2013, 34, 9: pp. 1277-1297.
- ²¹ Lee, SW, Morley, M., Taylor, RR., Kielhofner, G., Garnham, M., Heasman, D., Forsyth, K. (2011) 'The development of care pathways and packages in mental health based on the Model of Human Occupation Screening Tool', *The British Journal of Occupational Therapy*. June 2011, 73(6): 284-294
- ²² Department of Health, Mental Health Payment by Results Guidance for 2013-14, p.6. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/232162/Mental_Health_PbR_Guidance_for_2013-14.pdf. Monitor has recently stopped talking about 'payment by results and instead talks of 'payment and pricing systems.'
- ²³ There are eight non-psychotic clusters, eight psychosis clusters, and four cognitive impairment clusters. Individuals can be allocated to a different cluster if their care plans need to be changed, but this does not overcome the problems of the poor inter-rater reliability of clustering; clusters becoming tariffs, with the cluster numbers becoming "gateways to particular services". See Kearney, T., Dye, S., Sethi, F. (2013) 'Patient journeys within psychiatric intensive care: Payment by results versus lean pathways development', *Journal of Psychiatric Intensive Care*. 9(1): 4-11. The model has also been criticised as being of questionable efficiency, but if it were efficient it would be an efficient perversion of mental health care.