A Prescription for Psychiatry

Why We Need a Whole New Approach to Mental Health and Wellbeing

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Introduction: The Disease Model of Mental Health: A System in Crisis

Traditional thinking about mental health care is profoundly flawed, and radical remedies are required. Our present approach to helping people in acute emotional distress is severely hampered by old-fashioned and incorrect ideas about the nature and origins of mental health problems, and vulnerable people suffer as a result of inappropriate treatment. We must move away from the ‘disease model’, which assumes that emotional distress is merely a symptom of biological illness, and instead embrace a psychological and social approach to mental health and well-being that recognises our essential and shared humanity.

Jacqui Dillon is a writer and campaigner on mental health issues. She has both personal and professional experience of working with trauma and abuse, dissociation, ‘psychosis’, hearing voices, healing and recovery.1 Jacqui’s autobiography – the ‘Tale of an Ordinary Little Girl’ – tells of how she had ‘...the misfortune to be born to parents who [were] simply unable to provide the most basic necessities … to be fed and to be kept warm and safe.’ She describes a terrible but sadly not uncommon childhood where she ‘...inhabits a dual world. In one, she is a normal child with normal parents, a gifted child who goes to school, plays with her friends, and likes wearing ribbons in her hair. In the other world, she is a dirty little bitch, evil and unlovable, treated with cruelty and contempt by anyone who can get their filthy hands on her….’ Unsurprisingly, Jacqui suffers as a result, and starts hearing voices, ‘... voices that talk to her, talk about her, who comfort her, protect her and make her feel less alone. In time, they control and terrorise her but help her to stay alive’. When Jacqui herself becomes a mother, she describes how she ‘...becomes convinced that someone will try and hurt her and her baby because she knows how dangerous the world can be for little children. She becomes intensely fearful; terrified to leave the house in case someone tries to abduct them and take them to the underworld to kill them. She fears that she is going mad like she always knew she would, like they always said she would. She inhabits a dual world….’ In time, understandably, Jacqui turns to the mental health services for help. ‘She hopes to find safety and support for her and her precious child and believes that asking for help is a responsible and wise act.’ But instead ‘...to her astonishment, they reiterate the words of the devil…. She is crazy. She is ill. She was born with something wrong with her. She feels as if she has been slapped in the face, kicked while she is down, re-abused. This is insult to injury. She is wild with outrage and has to restrain herself so as not to rip them all to shreds. This reality is enough to drive anyone crazy. The place that is meant to provide her with sanctuary is the place that nearly drives her over the edge once and for all.’

The subject matter of this book – mental health and well-being – is a big topic. We all feel anxious or depressed or confused from time to time, and we certainly all know of people close to us who have had major challenges in their mental health. Throughout history, in literature and politics, we can see the impact of events on the mental health and emotional lives of leaders and citizens alike, and how their decisions, in turn, have been influenced by their psychological well-being. Our mental health and well-being are political and economic issues. The World Health Organization has concluded that mental health problems are the world’s leading cause of disability and cost an estimated $2,500 billion worldwide in 2010.2 Mental health issues have been estimated as costing the UK economy as much as £105 billion each year. In the UK, around 6,000 people take their own lives each year, and (partly as a result of advances in the treatment of infection) the most common cause of death in women in the first year after childbirth is now suicide. This is a large, complex and important issue.

All generalisations are dangerous. Generalisations about mental health care are particularly dangerous, and so are generalisations about any of the professions involved in mental health care, including psychiatry. For every conceivable problem, there are as many different explanations, and possible solutions, as there are individuals on the planet. For every opinion, stance or discipline, there is a diametrically opposed perspective. As we shall see, even within contemporary psychiatry there are opposing traditions and opinions, and there are several different ideas for how best to move forward. For every example, there is a counter-example. But, in my opinion, there are still old-fashioned and unscientific ideas about the nature and origins of mental health problems, meaning that much of mental health care remains dominated (albeit subtly) by a psychiatric ‘disease-model’ approach. Taking its lead from physical health care, our mental health care system applies ‘diagnoses’ to emotional,
behavioural and psychological issues – most psychiatrists diagnose ‘mental illnesses’. Once illnesses are diagnosed, people’s life experiences and their views on the origin of their problems are often unfortunately seen as effectively irrelevant. Adopting the medical perspective, the ‘aetiologies’ (causes) of those supposed ‘illnesses’ are investigated – with the assumption, of course, that this way of thinking is appropriate. And then, ‘treatments’ are prescribed. If, on the other hand, an illness isn’t diagnosed, it is difficult – perhaps impossible – to receive help. The assumption is that, if there’s no illness, there is no problem. All this means that vulnerable people, people in acute emotional distress, frequently suffer.

Various pressures conspire to maintain this system. For many professionals – clinical psychologists as well as psychiatrists – there is little mileage in changing a system that gives them employment, status and power (in some cases a very great deal of status and power). For professionals who lead or manage services, traditional approaches to mental health care maintain the status quo. This is, of course, particularly true for those who are in positions of the greatest power, status, and salary and would therefore apply most to psychiatrists. But the traditional ‘disease model’ benefits other people too. When a person’s problems are described as symptoms of ‘an illness’, it changes the way we think about personal responsibility. This is why many campaigns aimed at reducing stigma and discrimination against people with mental health problems tend to stress the medical model (using slogans such as ‘mental illness is as real as a broken arm’). If – it is argued – we stop seeing a person as feckless, inadequate, evil, possessed by demons, criminally recidivist or wilfully difficult, then we might have a little more sympathy. And – this argument goes – it is therefore helpful to see a person as ‘ill’. The problems with this point of view are numerous. Unfortunately, people are often sufficiently illogical as to see people as both ill and feckless, which actually increases stigma. And unfortunately for this argument, people are frequently very stigmatising and discriminatory against people identified as having illnesses (think of AIDS, cancer, learning difficulties, sexually-transmitted infections or leprosy). Identifying the various expressions of personal distress as ‘symptoms of mental illness’ change the way we think about personal responsibility, and that makes the ‘disease model’ attractive. It means we can argue for sympathy, and at the same time it locates the problems within the individual. And that means that we don’t have to harbour uncomfortable thoughts about the human cost of war, domestic abuse, rape, the sexual abuse of children, unemployment, poverty, loneliness and failure. All these troubling issues – the factors that can lead us all to become distressed – can be kept comfortably at arm’s length.

Most importantly, the ‘disease-model’ approach to mental health is attractive to pharmaceutical companies. There is a very healthy market for psychiatric drugs. In the UK, each year, we spend £800m on psychoactive drugs. So we can see a rather complex, cynical system conspiring to support the ‘disease model’. Social problems with very understandably distressing consequences are sidelined, and indeed the individual problems themselves are glossed over. Instead, the focus of attention moves to so-called ‘mental illnesses’. Conveniently for those with vested interests in the current system, the ‘illness’ idea shifts attention away from the social causes. With the problems labelled as ‘illnesses’, we now focus on looking for pathologies within the individual – whether genetic or biological abnormalities, or ‘thinking errors’. An expensive system develops to ‘treat’ these ‘illnesses’, with all the professional consequences. And the multinational pharmaceutical companies step in to offer drugs – at a profit.

This ‘disease model’ underpins too much of modern mental health care. In my experience, it often strips professionals of their ability to empathise. Because the patient’s behaviour is seen as irrational, the product of an ‘illness’, even a disease, we stop trying to understand the human reasons why they might be feeling or acting the way they are. This is horrible. When people are experiencing huge distress and feel that their sanity, even their life, is threatened, they need empathy and compassion more than ever. That requires understanding human behaviour and distress in a whole new way. It also means we need to plan the delivery of mental health services in completely different ways.

This is a book about mental health care and about social support for mental well-being. It proposes a radical, social and psychological model of care. And yet its title refers to ‘a prescription for psychiatry’. The implications of the message in this book extend beyond one profession, and yet I think it is reasonable to highlight one profession in the title. While this is a manifesto for a ‘psychobiosocial model’, the dominance of medical thinking in this area is such that the word ‘psychiatry’ is used interchangeably with the term ‘mental healthcare’ – much to the annoyance of people like myself in non-medical professions. And perhaps there is more to be changed in respect to this medical perspective. My intention, however, in choosing a title was not to target psychiatry and to label that one profession as the root of all evil. It was chosen because of the current dominance of that profession in
the field, and because it’s the term most people use. Now is a good time for us to rethink the basic principles both of how we understand problems and how we provide services. In response to the American Psychiatric Association’s latest version of its diagnostic manual – DSM-5 – in 2013, which I will discuss in more detail in Chapter 2, the British Psychological Society called for a ‘paradigm change’ in our thinking. I have a few personal credentials for this task. I’m a practising clinical psychologist, and have seen these issues in my day-to-day work. I’ve twice been Chair of my professional body (the British Psychological Society’s Division of Clinical Psychology) and from a policy-maker in many of these debates. I’m currently a line-manager of psychiatrists, psychologists, nurses, public health doctors and GPs. I am the sibling of someone with serious mental health problems and I’ve seen how help from mental health professionals can be life-saving but also how the mental health system can cause untold misery to someone who is already suffering. And I’ve been a personal user of mental health services: I received NHS psychotherapy from a medical (psychiatric) psychotherapist for two years.

‘… you’ll need some running shoes…’

We all have nightmares from time to time. The dark, early, hours of the morning are full of various terrors. Mine have always included the idea that I might be detained on a secure psychiatric ward. I know I could rage and fulminate or even attempt to escape, but I’d be overpowered, sedated and restrained. I could argue with the nurses and try to persuade them that I’m fine to go home, but from personal experience I’m pretty sure they’d simply ignore me. Rather depressingly, I’m forced to conclude that the best way to get out of my nightmare would be to go along with the system. This exact scenario, in fact, was the topic of a recent blog3 which outlined three options for escape: ‘the runner’ (‘you’ll need some running shoes, a good hiding place’), ‘play the game’ (‘you’ll need good acting skills, some knowledge of psychiatry’) and ‘the Tribunal’ (‘you’ll need a solicitor’).

Back in 1973, David Rosenhan conducted a now-celebrated study into the invalidity of psychiatric diagnosis.4 He arranged for eight ordinary people from conventional backgrounds to present themselves to a number of psychiatrists at hospitals in the USA. In each case the individuals complained of hearing disembodied voices saying ‘empty’, ‘hollow’ or ‘thud’. Apart from complaining of this distressing ‘symptom’ (which, of course, was intended to resemble what conventional wisdom regards as ‘hallucinations’) the eight undercover researchers were told to answer all questions honestly. Published with the title ‘on being sane in insane places’, the research reported how all eight individuals were admitted to psychiatric hospitals, in most cases with a diagnosis of schizophrenia. Despite behaving entirely normally after admission, the researchers remained in hospital for an average of 19 days (with a range of seven to 52), during which time they were prescribed a total of 2,100 pills (that’s 260 pills each, or 14 per day). The undercover reporters took careful notes of their experiences – and it is interesting that this behaviour was also interpreted as obsessional and pathological. Rosenhan’s research has been criticised. It is perhaps fair to point out that it is reasonable to offer help – even medical help – to someone who reports that they are hearing auditory hallucinations and are becoming distressed. One criticism of this research is that it’s hard to come to a valid and reliable diagnoses if the ‘pseudo-patient’ in front of you is lying (the researchers were, of course, guilty of faking their experiences). But it is nevertheless shocking that, once admitted, nothing resembling real care was offered. It is important and interesting, for example, that staff members only spent 11% of their time interacting with patients, and that comments like ‘Come on, you mother f-----s, get out of bed’ were reported as common. Despite the prescription of 2,100 pills, daily contacts with psychiatrists, psychologists and nurses totalled only seven minutes.

It could be argued that this is a historical account; that things are better now than in 1973. Which is probably true. But not much better. The client of a colleague of mine had been admitted to an in-patient psychiatric ward under a section of the Mental Health Act in response to her quite distressing self-harm. Because she would take pretty much every opportunity to harm herself, she was under constant observation by nurses. This observation extended to accompanying her to a physical care ward to have her wounds attended to (where, incidentally, the nurse told her that she was ‘just there to observe, not to talk to you’) and to her mother’s funeral. On returning from the funeral, a vase of flowers from her mother’s memorial service was removed from her room. The rationale given to her was that her ‘bad behaviour’ would be punished by their removal and her ‘good behaviour’ rewarded with their return. This is as crazy as it is callous; if the woman was considered to be able to control her behaviour by sheer force of will, surely she shouldn’t be detained and observed on a secure psychiatric ward. And if she were ill, insane, and unable to control her behaviour, why would the contingencies of reward and punishment make any difference? It seems as if the presumption is that the pain of the
punitive treatment needs to be severe enough to penetrate to the mind of the insane patient. We can see some of the ways in which the ‘disease-model’ ways of thinking can lead to quite callous approaches when we see ‘observation’ in mental health care settings. It’s not uncommon for people who report hearing voices, or that they have had thoughts of harming and even killing themselves to be placed under ‘observation’. Not very much therapeutically is actually done, but the person is ‘observed’, and prevented from harming themselves. The underlying assumption seems to be that the voices or the suicidal thoughts are the result of an illness, and the client needs to be kept under observation while that illness is being treated. Perhaps the most striking example of this that I came across was when I was asked to write a commentary for a book chapter describing clinical dilemmas on an in-patient psychiatric ward. In brief, the case involved a woman who was very distressed and agitated. She was described as experiencing a ‘manic episode’. As I read the description, the story became both very clear and rather disturbing. The clinical dilemma was written from the perspective of persuading her to take medication. While nursing or medical staff were sitting with her and talking with her about her various (admittedly rather incoherent) concerns, she was described as being relatively calm. Whenever the subject of medication was raised, or if the nurses suggested that they might have to leave, she would become very distressed. The account ended with a rather heart-felt description of how the staff felt that they had no option but to force medication on her; a very distressing experience. I remember being struck by the contrast between the medical approach – the principled feeling that the client needed to receive the medicine that would help her – and my own feeling that, since she seemed to be comforted by having a professional sitting with her and listening, then that should continue, for hours if necessary, until sleep offered reprieve. The contrast in assumptions seemed striking to me.

More personally, I remember visiting a psychiatric hospital to see a relative a few years ago (at that point receiving in-patient care). We were sitting on or near his bed, and a fellow patient shuffled past. My relative gave him a friendly greeting, but the other patient offered little more than a grunt in reply. I asked if he was OK, and my relative replied that his friend had received ECT earlier that day, and was still a little groggy. I then made a rather foolish mistake; I asked if it was ‘working’. My relative looked at me, wrinkled his nose, smiled in a sardonic kind of way, stroked his beard and said: ‘Well… He came in here a few days ago and told them he was depressed. They electrocuted his head; what do you think he’ll tell them now?’ My point isn’t really to discuss the effectiveness and ethics of ECT, although I fear the side effects outweigh any benefits, the benefits may in fact be close to non-existent, and I would not include ECT in my prescription for an ethical service. My point is that many people, including my relative, experience the mental health care system – dominated by a ‘disease-model’ ideology – as punitive, oppressive and punishing.

It might be hard for those charged with responsibility to hear this, but standards of care in many mental healthcare clinics are disgraceful. I receive a fair number of unsolicited letters. One summed up the situation nicely: ‘...Rather than engaging with the patients on the ward, the staff instead shepherded them around like sheep with bullying commands, threats of ‘jabs’ (injections), and removal to an acute ward elsewhere in the hospital, if they did not co-operate. The staff also stressed medication rather than engagement as a way of controlling the patients. And the staff closeted themselves in the ward office, instead of being out and about on the corridors and in the vestibule where they should have been. The staff wrote daily reports on each patient on the hospital’s Intranet system; these reports were depended upon by the consultant psychiatrists for their diagnoses and medication prescriptions, but were patently fabricated and false, because the staff had never engaged or observed properly the patient they were writing about in their reports. The psychiatrists themselves were rarely seen on the ward, and only consulted with their patients...’

I believe that the care offered to people with mental health problems in the UK is amongst the best in the world. But rather sadly that merely points out how bad it must be elsewhere. Caring people would, I think, agree that we should encourage all nations to invest appropriately in mental health care. Until recently, Britain had a good record here. We spend around 10% of our (substantial) GDP on healthcare; a figure which has risen steadily (although that’s recently reported to have dropped very slightly). In general we spend that investment efficiently (because we have the NHS). And we spend a relatively high proportion (around 12%) of that healthcare budget on mental health (5.5% is the European average). That’s all good, but it doesn’t look as if the investment is paying dividends in terms of high quality care and greater well-being. Although my hard-working colleagues will regard my words as undermining their efforts, I believe that the care that people receive in both community and residential care settings (I shall try to avoid the terms ‘in-patient’ and ‘out-patient’, because I don’t think the word ‘patient’ is appropriate when discussing emotional well-being) falls short of what’s expected. In 2011, the independent *Schizophrenia Commission* was established by the charity and
pressure-group Rethink Mental Illness, and in 2012 published the report ‘Schizophrenia - The Abandoned Illness’. Among other recommendations (which echo many of the calls I’ll be making later in this book, for example, calling for greater access to psychological therapies, a right to a second opinion on medication, greater reliance on the skills of pharmacists and general practitioners, etc.) the Commission called for ‘a radical overhaul of poor acute care units’.

The Schizophrenia Commission, helpfully reviewing decades of research, suggested that acute residential mental health care (in-patient psychiatric wards) is likely always to be part of the services we provide. The problems faced by people in acute distress mean that community services are unlikely ever to completely replace residential, in-patient, care. But the Commission did not find a happy picture. There has been a plethora of recent guidelines and initiatives in an attempt to refocus and improve the quality of residential care, most notably and recently by the influential NICE, the National Institute of Health and Clinical Excellence. But residential care remains highly unpopular with service users and carers. There is also a ‘shortage of beds’. In the medical language of healthcare, planners like to talk about ‘beds’ – the resources available are calculated on the basis of how many beds the medical wards have available for patients. I personally fear that even this jargon dehumanises and reminds us that this is a highly medical approach to care. There is a shortage of alternatives, and the services that we do deign to provide are often very stretched. That often has a complex impact, as it means that people are reluctant to enter residential units because of the pressurised and stressful atmosphere. Pressure for ‘beds’ also means that people are often discharged before their problems are resolved or without proper care having been planned for after their discharge. At the same time, people who could leave hospital if there were appropriate alternative specialist services are often detained for far too long; longer than would be the case if appropriate services were available in the community. On these residential units, there are worrying levels of violence against both staff and service users, sexual harassment, and theft, with drug and alcohol problems common. This is wholly unacceptable. When people are distressed, we need an ‘asylum’, a place of safety and calm, where we can resolve tension and stress and overcome trauma... not be exposed to abuse and assault. And finally, in this maelstrom of stress, residential units are also plagued by boredom, a lack of purposeful activity, a lack of staff–patient interaction, and inadequate physical environments. Indeed, the Commission Chair, Professor Sir Robin Murray, stated that; ‘the message that comes through loud and clear is that people are being badly let down by the system in every area of their lives.’

It’s perhaps not too surprising, therefore, that in the UK, our official surveys of the quality of care of in-patient wards explicitly exclude mental health care. Unsurprising, perhaps, because politicians are generally unwilling to encourage publicity of failings in the care systems for which they are responsible, and because traditionally the voices of those seen as ‘mentally ill’ have been silenced. As I suggested earlier, respectable commentators have suggested that the UK has one of the best mental healthcare systems in the world (at least in 2006) and so we should, we’re wealthy enough to afford it. Rather unfortunately, that suggests that people in other countries have much worse provision still.

In the USA, for example, it’s widely estimated that until very recently – with the very welcome development of ‘Obamacare’, which made healthcare insurance mandatory, universal and automatic – some 40% of citizens had no healthcare insurance. Despite ‘Obamacare’, we’re still living with that legacy, meaning that only about half of all people with mental health problems receive any form of planned care. For the rest, there’s a mixed picture; from various forms of charitable services through to state mental institutions with poor reputations. America, as is often the case, presents a mixed picture, with very high levels of investment in all forms of mental health care for the wealthy, but also neglect for poor and socially disadvantaged people. There is also an extraordinary range of approaches. It is striking that it was some American techniques for people who have been given a diagnosis of autism that were described by a recent UN report as being ‘akin to torture’. The particular techniques that gave such cause for concern involved children wearing special devices that administered electric shocks to modify their behaviour. In the developing world, the picture is again complex. It seems likely that for people who avoid formal psychiatric care, the prognosis is if anything at least as good as in the industrialised world. Formal, institutional, care in much of the developing world is concerning, with disturbing stories of physical restraint, chemical sedation and very poor standards of care.

We need to invest appropriately in mental health care. We need to maintain Britain’s enviable record in this respect. But we also need to ensure that our investment is in fact leading to high quality care and ensuring greater well-being.
A flawed ethos

The work of medically trained psychiatrists is a vital contribution to mental health care. But this doesn’t necessarily mean we should assume that people are ill. Pregnancy is a good analogy. Doctors in a variety of specialisms (general practitioners, obstetricians, paediatricians) all offer valuable care for pregnant women. Pregnancy can sometimes have potentially serious medical complications. But pregnancy, itself, is not an illness. Similarly, when a multidisciplinary team offers care to a person in distress, I believe medical colleagues have much to offer. But many aspects of the ethos of ‘care’ in current, traditional, mental health care are actively harmful – people are effectively told that they are ‘ill’, and have an underlying biological abnormality. In my opinion, this ‘disease model’ is scientifically incorrect, inherently illogical and has serious harmful consequences. I believe that this ‘disease model’ contributes to the negative, punitive, controlling ethos that often prevails in services. It undermines genuine empathy and compassion; instead of seeing people’s difficulties as understandable and natural responses to the terrible things that have happened to them, the person is seen as having something wrong with them – an ‘illness’.

The ‘medical model’ of mental health care – the belief that psychological distress has a biological cause, and that mental health problems are essentially medical diseases – is controversial even within psychiatry. ‘Social psychiatry’ takes a different view to ‘biological psychiatry’ and has a different view about the future of psychiatry as a discipline. Many psychiatrists (and, indeed, psychologists) feel these terms are misleading or meaningless. Nevertheless, a ‘disease model’ is ubiquitous. Naturally, the pharmaceutical industry promotes this approach heavily. It makes sense to take a medical drug to ‘cure’ a medical ‘illness’.1 Some people also find this approach helpful in certain ways – for example it is one way of explaining problems without blaming the person. The problem is that it is misleading.

Firstly, there is only very weak evidence for genetic causes of mental health problems. On a very technical level, much of the evidence used to support a biological model is dubious. The fact that many problems appear to have high ‘heritability’ – that they tend to ‘run in families’ – does not necessarily imply that there are biological, genetically inherited characteristics at work. I’ll illustrate this with two slightly odd – but entirely factual – examples. Because rich people tend to have children who turn out themselves to be rich, and people living in developed countries tend to have children who also live in those countries, car ownership is highly ‘heritable’; car ownership runs in families. On the other hand (sorry about the pun), the likelihood of having five fingers (or, to be exact, four fingers and a thumb) on each hand has a statistical ‘heritability’ close to zero.16 Despite the spurious correlation that you may find if you search for ‘heritability’ and ‘IQ’ or ‘mental illness’ on the internet, simple biological determinism is difficult to sustain on close examination. It’s also almost certainly the case that a very large number of genetic variants all conspire to offer generally increased or decreased risks of a wide variety of problems (rather than ‘a gene for X’). At the same time, a very wide variety of injuries and insults to the body and brain (influenza in pregnancy, birth difficulties, injury, drug use etc.) again all conspire in very general ways to increase our risk of developing problems.

Researchers have used a number of techniques to explore genetic influences on mental health and well-being. We have compared identical and non-identical twins, and we have studied the biological and adoptive relatives of people who were subsequently given a diagnosis of a mental health problem. More recently, scientists have begun to use a technique called ‘genome-wide association study’ or ‘GWAS’, which is used to look very precisely at genetic differences between people with or without a particular disease.

It is clear that the tendency to experience mental health problems can run in families. But this is not necessarily a result of genetics. It is very difficult to disentangle genetic inheritance from environmental factors such as upbringing and social circumstances. The methodology and results of studies relating to genetic factors in ‘schizophrenia’, for example, are hotly debated in professional journals. In the early days of genetic research, it was common to discuss the idea of a ‘gene for schizophrenia’. Now, it is much more common to discuss more general genetic ‘risk’. This means that there may be many heritable characteristics which each increase the likelihood of someone experiencing mental health problems if they are exposed to particular life events.

Modern biological science has given us remarkable insights into the genetics of these phenomena. The findings are both striking and thought-provoking. But it is clear that the picture is much more complex than: ‘…schizophrenia is a genetic disease…’. Genetic factors play a role in all human phenomena, from voting for political parties to falling in love and aggression, as well as mental
health and well-being. The genetic parts of this jigsaw are both common to many different experiences, and also interact with environmental factors, so it is difficult to suggest any one element is more important than any other. Perhaps it’s a little like asking: what’s more important in a water molecule, hydrogen or oxygen?

It does seem clear that there are (a very large number of) genetic factors that increase the (general) vulnerability or likelihood of people to experience mental health problems. But there is no inevitability, and the genetic factors interact with environmental factors. These genetic factors apply to a wide range of mental health problems – psychosis (hearing voices or experiencing paranoia), mood swings, social communication and difficulties in concentration. Modern approaches to genetics have also highlighted the role of ‘epigenetics’: the phenomenon whereby important parts of our genetic mechanisms are ‘switched on’ or moderated by external or environmental factors. So, for instance, a gene that is responsible for the production of a specific protein may be more or less active, and may produce more or less of that protein, in different environmental conditions.

It is fundamentally important to remember this interaction between genes and environment. Imagine a world in which everybody – every single human being without exception – smoked 40 cigarettes a day. The prevalence of lung cancer would, of course, be enormously high. But not everybody would develop lung cancer. Some people would be genetically more vulnerable than others. And – since everybody smokes – these genetic differences would be the only real source of differential risks. The same, incidentally, is true if nobody smoked – again, genetic differences would be important. In the real world today, about 20% of people in the UK smoke cigarettes. And it is whether or not you expose yourself to this massive risk factor that is more important than the degree of your genetic vulnerability. The same seems to be true of mental health. Of course genetic factors are important, but we often ignore the ‘elephant in the room’ – the environmental causes of distress.

More to the point, there is no reason to assume that any biological ‘abnormalities’ are necessarily biological causes. We know, as an illustration, that the hippocampus is a physical area of the brain involved in memory. It’s fascinating that taxi-drivers’ hippocampi physically change as they develop their ‘mental maps’ of London. That’s a physical change in the brain as a result of environmental factors – in that case, learning. It would be ludicrous to suggest that the changes in the brain, in the hippocampus, are unrelated to the taxi-driver learning more about the physical geography of London, but it’s equally ludicrous to suggest that the changes in the hippocampus have ‘caused’ changes in the taxi-driver’s behaviour. So brain studies in mental health are vitally important as we struggle to understand ourselves better. But we have to be careful how we interpret them, and in particular not to use biologically reductionist arguments. For instance, there is widespread acceptance that a particular brain chemical called dopamine plays a role in psychosis; but the details are far from clear-cut. Some of the psychological processes involved in psychosis (for example making creative links between apparently unrelated things) appear to use dopamine as a principal neurotransmitter. Biological differences between, for example, people who are or are not experiencing psychosis are also small and inconsistent. It is not the case, for instance, that everybody with a diagnosis of schizophrenia shows any particular biological abnormality, most people who receive a diagnosis of ‘schizophrenia’ report no family history of similar problems, and everybody responds to medication differently. And, in any event, as with taxi-drivers’ brains, we know that dopaminergic pathways are influenced by, among other things, abuse and chronic victimisation. Life events and experiences can alter our brain biology.

This is important, because there is evidence that the ‘disease model’ leads to stigma and discrimination. Many people assume that promoting a biological understanding of mental health problems will reduce stigma. But there is quite strong evidence that the opposite is the case; biological models actually promote stigma. We know that people in receipt of mental health care experience high levels of stigma and discrimination. Traditional attempts to reduce this stigma have – of course – stemmed from the ‘disease model’, biomedical approach, and have tried to make the case that ‘mental illness is an illness like any other’. On the whole, these have had only limited success; negative attitudes towards people with mental health problems seem to have either remained stable over time or even got worse. That’s actually hardly surprising. People experience stigma with many physical illnesses such as cancer, AIDS and leprosy. It simply does not follow that to be seen as ill protects a person from stigma... although it seems superficially attractive. In fact, in my opinion the most biological of biological explanations – genetic abnormality – is quintessentially stigmatising. Genetic explanations suggest that people experience difficulties because their genetic blueprint, their DNA, is faulty. If we say that a particular trait is: a) undesirable, and b) part of the most fundamental, heritable (that is, transmissible to the next generation) and immutable genome of the individual, we are clearly
associating that person fundamentally with the undesirability. We may well feel some sympathy with someone who is ‘ill’, but locating an undesirable social phenomenon within the essential nature of a person is also very stigmatising. Although it is entirely possible for psychological models themselves to be stigmatising (they still focus attention on what goes on inside people’s heads, rather than on what has happened to them), there is evidence that explaining things in terms of biology tends to lead to greater discrimination. A non-medical approach to understanding and helping is likely to be the most effective in reducing stigma and discrimination.

This all means that, despite enormous volumes of scientific evidence that social factors lead to mental health problems and, consequently, widespread acceptance of the social basis of much of the associated distress, routine mental health care in practice relies on the attempted treatment of illnesses assumed to reside, physically, in the body (more specifically the brain), as opposed to helping people to address these social challenges. In fact, the dominance of this disease model is so pervasive that sometimes we have to step back before we realise how powerfully it’s affecting our thinking. In Liverpool recently, colleagues of mine conducted an elegant analysis of the impact of the economic recession on suicide rates. They concluded that around a thousand people had taken their own lives as a result of the recent financial crisis and recessions – the economic mismanagement of our bankers really is a matter of life and death. My colleagues John Read and Richard Bentall and others have conducted an extensive review of the effects of childhood trauma (abuse) on our mental health. It’s kind of obvious… abuse has consequences; trauma is traumatic. There is overwhelming evidence that poor housing, unemployment and social disadvantage of all kinds contribute to mental ill-health.

Interestingly, there’s also plenty of evidence that inequalities, both economic and social, are particularly important. In their book ‘The Spirit Level’, Richard Wilkinson and Kate Pickett argued that, once a nation has achieved a certain basic level of economic performance, the well-being of its citizens is much more closely linked to economic equality than to average economic performance. Wilkinson and Pickett compared a range of successful, industrialised nations (the ‘G20’ nations) and found that, on a series of measures such as physical health, obesity, substance misuse, education, crime and violence, and (of course) mental health, the greater the difference between the rich and poor, the worse a nation performed.

It’s easy to see why this could be the case. Human beings have an innate tendency to compare (it’s actually part of the way our neurones work) and comparison between people in terms of material success and all its implications can be invidious for our sense of self-worth. The point is that social and economic factors are – quite understandably – strong predictors of mental health problems. But these social factors are simply squeezed out – the very real, very important, very pressing, social factors that lead to mental health problems are minimised and ignored.

We know that issues such as poverty, deprivation, social isolation, childhood abuse (of various forms) all lead to distress or what are (mis)diagnosed as mental disorders. Systematic research into both social and biological causes of mental health problems has revealed, for example, that the more abuse and deprivation suffered by individuals, the more likely they are to experience psychological or mental health problems. This ‘dose–response’ effect is hardly surprising… what is surprising is the way that mental health professionals sometimes respond. It is not uncommon, for instance, for quite senior scientists simply to deny that social factors play any role in the origin of, for example, ‘schizophrenia’. Then, when the evidence starts to emerge, its impact is minimised or sidelined. Social causes of mental health problems can be turned into consequences – for example unemployment described as a consequence of depression rather than the other way around. And people sometimes seem to go to extreme lengths to fit emerging facts into their existing world-view. For example, one commentator on a recent paper discussing the emotional impact of childhood abuse suggested that: ‘the possibility cannot be ruled out that a child destined to develop schizophrenia may show characteristics in childhood that increase the risk of abuse’. In other words, even if we find that mental health problems are the consequence of abuse… maybe there we can still find genetic abnormalities that ultimately put you at risk of abuse! This begins to look slightly self-serving logic, ironically even perhaps delusional.

An alternative take on this theme was reflected in a recent discussion about the genetics of ‘attention deficit hyperactivity disorder’ or ‘ADHD’. I recently attended a meeting of (mainly biological) psychiatrists which generated a great deal of heated discussion over the treatment of a colleague in the media. It was generally felt that she had been subjected to unwarranted criticism. She had presented what was described as excellent research into the genetics of ADHD – reporting on a statistically significantly greater prevalence of a particular genetic abnormality in children who had
received a diagnosis of ADHD. The research had revealed that 16% of children who had been given a diagnosis of ADHD had a particular genetic variant, in comparison with only 8% of children without the diagnosis.\(^24\) This research had been subjected to considerable criticism (unfairly, in the opinion of those attending my meeting) by opponents of biological psychiatry. I pointed out that Ben Goldacre had explicitly drawn attention to this work in his column ‘bad science’, because, although the researcher had discovered a statistically significant association, 84% of children with a diagnosis of ADHD did not possess the particular genetic variant at the heart of the research.\(^25\) I suggested that this hardly justified the comment that ‘now we can say with confidence that ADHD is a genetic disease’, and that the statement was potentially misleading. The response (by colleagues nonplussed by my outburst) was to suggest that she (the quoted researcher) really meant nothing more than that there was a genetic element to ADHD, it didn’t mean environmental factors were unimportant. My view is… when a doctor states ‘with confidence’ that a particular problem is ‘a genetic disease’, then that’s exactly how this kind of statement will be interpreted. And, I have to say, I strongly suspect that this is what some people believe.

This is not just an academic issue. In my view, a strong belief in the ‘disease model’ of mental health and in the genetic origins of mental health problems, despite lack of evidence, is at least partly responsible for the relentless assault that the system itself seems to inflict on vulnerable people. The enormous weight of evidence showing that people are distressed as a result of the sometimes terrible and sometimes just miserable things that happen to them appears not to permeate into care. A profound change is needed both in the way we think about ‘mental health’ and in how we try to help people in distress.

**Invalid diagnoses**

A medical approach naturally relies on diagnosis. I shall expand on this issue in Chapter 2, but there is precious little science in psychiatric diagnosis. I chose to work in the mental health system anticipating that I would be part of a vital and life-saving system of committed and caring professionals, eager to understand their clients’ lives. Over more than twenty years as an active clinician and researcher, I am reluctantly coming to the conclusion, shared by many of my colleagues, that the dominant diagnostic framework in mental health is unreliable, invalid and inhumane and even bizarre. Committees of experts (with clear financial as well as professional advantage in coming to a consensus that supports a ‘disease model’ in the face of scientific evidence) fail to agree on diagnostic criteria. Statistical analyses fail to identify clusters of symptoms that correspond to the putative ‘disorders’. In fact, the abject failure of diagnostic approaches has led the enormously wealthy and enormously influential US NIMH (National Institute of Mental Health) to declare that its strategy ‘cannot succeed’ if it uses the diagnostic categories enshrined in the influential ‘Diagnostic and Statistical Manual’ of the American Psychiatric Association (which I shall describe in more detail in Chapter 2), and henceforth will ‘be re-orient its research away from [those] categories’.\(^26\) And, as I shall detail in Chapter 2, there is widespread opposition from a wide group of professional and service user-led groups.

Despite this, in the current (flawed) system, diagnostic labels have huge implications – they affect access to healthcare (but they shouldn’t), they affect legal issues (but they shouldn’t), they affect employment rights (but they shouldn’t) and they lead to discrimination and stigma. They are hugely ‘sticky’; like zombies, they may well be dead, but they don’t realise it and carry on walking. Fortunately, again, however, alternatives are available. A combination of simple problem identification and psychological formulations would address people’s problems. As I explain in Chapter 2, a simple list of problems would permit sensible and appropriate planning, and would result in much higher levels of reliability. Validity, too, would be significantly improved, as invalidity in psychiatric diagnosis stemmed not from the identification of specific problems – whether ‘symptoms’ (effectively, ways of thinking and acting) or environmental stresses – but from the complex rules for combining these to form diagnoses and the meaning of those diagnoses as representing ‘real illnesses’.

**The drugs don’t work**

Not surprisingly (since the diagnoses don’t match onto any patterns of problems we recognise in the real world, and don’t relate to any ‘biomarkers’ – indicators of underlying biological abnormalities), the drugs don’t really work, as I’ll discuss in more detail in Chapter 3. It’s not surprising that pharmaceutical chemicals can affect our mood; the vast majority of us regularly buy mind-altering chemicals every day. Coffee, tea, alcohol and nicotine show both that chemicals can affect our
thoughts, moods and behaviour, and that these can have effects (both good and bad) without necessarily treating any illnesses.

Although there are over 47 million prescriptions per year for antidepressant medication in the UK alone, there’s plenty of evidence that antidepressants are much less effective than we would like. As I’ll explain in more detail in Chapter 3, careful research comparing the long-term outcomes for people taking antidepressant medication with people taking placebos suggests only at best a very marginal benefit.

The same applies to long-term so-called ‘anti-psychotic’ medication. These drugs often have serious, life-changing (and occasional very noticeable) adverse effects. Because they affect various physical systems, such as our heart, liver and kidneys, as well as our brains, and because one of the common adverse effects is a significant gain in weight (which is, of course, very harmful), these drugs can significantly affect one’s health.\(^{27}\) Outcomes for patients suffering from ‘schizophrenia’ have not improved since the Victorian age and an increasing number of people are disabled by mental health problems. This contrasts with what has happened in physical medicine, where genuine advances have led to improved outcomes and reduced disability.\(^{28}\) There is evidence that some forms of pharmacological medication may be helpful in the short term (this is discussed in depth in Joanna Moncrieff’s books).\(^{29}\) But this is, first of all, unsurprising – drugs that act on the brain are not new in human history, and we are well aware of their effects on mood and behaviour. It is also important to note that these effects are not ‘cures’ (and are even probably not ‘treatments’) and can have significant negative effects in the longer term. And all this is without mentioning ECT (electroconvulsive therapy).

**Coercion**

Mental health care is unusual within healthcare specialities in the use of coercion. Whilst the usual argument goes that coercion is necessary because people ‘lack insight’, my experience suggests that the main reason is different. While there is a great deal of demand for care, the ‘care’ and ‘treatment’ on offer is often not what people want or need. Indeed it can be aversive to the extent that we need to coerce people into accepting it. At any one time, nearly 20,000 people are being detained in psychiatric hospitals against their will, ‘sectioned’ under the Mental Health Act. These are not just extreme or rare cases, people with a wide range of problems can find themselves caught up in coercive practices.\(^{30}\) The history of mental health care is an unfortunate history of coercion, with many mental health treatments clearly rooted in moral judgements and punitive approaches.\(^{31}\) Today, in the context of a general disquiet about a perceived lack of compassion in healthcare, the extent and nature of coercion in mental health care is a clear cause for concern.

Some form of mental health legislation may well be needed, as some people’s low mood, risk of suicide, confusion or disturbed behaviour puts them at extreme risk or, in very unusual cases, renders them a risk to others. I contributed to the drafting of both the Mental Health Act and the Mental Capacity Act. It is important to legislate for people whose difficulties put them at significant personal risk, or who pose a risk to others. But this is a social and psychological problem, not a medical one. Diagnosis and even severity of an ‘illness’ do not relate to risk and dangerousness. Decisions do need to be made about the necessary care of people with serious problems who are at risk. And, after the fact, decisions need to be made about how to deal with people who have committed crimes. In both cases, current practice in a ‘disease model’ driven system is flawed. A more coherent and fair approach would be to agree to take decisions on behalf of other people if they are unable to make decisions for themselves, regardless of whether they have a diagnosis … and to make judicial decisions in the criminal justice field on the same basis. This doesn’t mean ‘letting them off’; it means making appropriate decisions on rational bases.

**Psychiatry in crisis and schism**

Psychiatry is itself in crisis. As outlined in the major Department of Health report into the status and future of psychiatry (‘New Ways of Working’, in which I was a major participant)\(^{32}\) rates of divorce, alcohol and drug use, sickness absence and even suicide are higher in psychiatrists than in the general public or other medical specialities. At the same time, recruitment into psychiatry is also in crisis – psychiatry is one of the least popular medical specialities, and consequently the quality of recruits into psychiatry generally tends to be low. Psychiatry is also under fire from outside. Instead of forming groups with names like ‘…Friends of …’, former patients describe themselves as ‘survivors’, and they
frequently explicitly regard themselves as having survived psychiatry itself rather than being survivors of the distressing experiences for which they sought help.

The discussion of alternative models for the delivery of mental health care is absolutely not a dispute between psychologists and psychiatrists. Sadly, many psychologists themselves use diagnostic labels and, publicly at least, do not question the ‘disease model’ or the widespread use of psychiatric medication. (Privately, I sometimes wonder whether their beliefs are at least partly influenced by the financial consequences of their practice and our traditional reluctance as a profession to challenge the presently dominant world-view). Equally, many psychiatrists reject these views. Historically, psychiatrists such as R.D. Laing and Jacques Lacan as well as the arch anti-psychiatrist Thomas Szasz all rejected the biomedical, diagnose–treat, model of psychiatry. More recently, a total of 29 eminent psychiatrists co-authored a paper entitled ‘Psychiatry beyond the current paradigm’,33 arguing that ‘…psychiatry needs to move beyond the dominance of the current, technological, paradigm…’.

There is a big difference, then, between what I regard as entirely justifiable scientific scepticism, frustration, sadness, even anger at unscientific, unhelpful, old-fashioned biomedical determinism, disease-model thinking and a diagnose–treat model on the one hand, and scorn for the profession of psychiatry on the other. I have great respect for my colleagues who are psychiatrists, and feel I have learned greatly from those clinical leaders with whom I’ve worked. As will be made clear throughout this book, my vision for the future of mental health care is predicated on a central role for psychiatry and for psychiatrists. I am opposed to ways of thinking, of service organisations and modes of practice that I believe to be profoundly unhelpful but that doesn’t mean I am critical of psychiatrists. This means I need (as I’ve learned over the years) to distinguish carefully between criticisms of the current ethos and practice of mental health care and criticisms of psychiatry. This occasionally leads to clumsy language – for which I apologise. I shall try to use the phrase ‘mental health care’ rather than ‘psychiatry’. And if, in my frustration, I tar all my psychiatrist colleagues with a biomedical brush, I also apologise.

This crisis is also revealed in internal schism. In the past few years we have seen three very different visions for the future of the profession – from within the profession. The psychiatrist Professor Nick Craddock, in an editorial in the British Journal of Psychiatry, argued that psychiatry needs to re-establish itself as a branch of medicine, re-establish mental ill-health as a medical concept, re-establish the biological and neurological basis of ‘real’ mental illness and re-establish the authority and status of the psychiatric, medical consultant.34 Professor Craddock suggested that much of the business of psychiatry is – as I would argue – normal human emotional response to difficult social circumstances. But he suggested that this should be separated from the ‘genuine’ mental illnesses – leaving the profession of psychiatry in what he would regard as appropriate hierarchical authority in a disease model, medical model, mental health care service. It seems (reading somewhat between the lines of Craddock’s article) that he is suggesting that psychiatry should have little to do with ‘normal’ responses, although this presupposes (wrongly in my opinion) that this is a valid distinction. Pat Bracken, another psychiatrist, and also in an editorial in the British Journal of Psychiatry, argued almost exactly the opposite. He suggested that the vast majority of mental health problems, including those traditionally seen as symptoms of serious ‘illnesses’ such as ‘schizophrenia’ should instead be understood from the perspective of social psychiatry – as normal, human, responses to difficult social circumstances. He argued for a social, psychosocial, empathic response. Refreshingly, and rather wonderfully, this stance has been repeated by Dinesh Bhugra, as incoming president of the World Psychiatric Association.35 Not that different from my own position… except that Pat Bracken, Dinesh Bhugra and colleagues also argued that this psychosocial perspective was the proper role for psychiatry in a mental health care system still centred on medical primacy. Personally, I would argue that the logical consequence is that, therefore, a medical subspecialty (psychiatry) should play an important contributory role in a predominantly psychosocial service.

A third model emerged from the multi-professional discussions that were part of the ‘New Ways of Working’ project,36 championed by the consultant psychiatrist Christine Vize. This model suggested that proper care for people in deep personal distress was a team effort: a multi-professional effort. Since people have a range of needs, from social, through psychological to medical needs (and in different proportions for different people), the team requires a range of specialists who would work together (in different cases in different ways) to offer help. In this model, psychiatry would be a valuable partner, but would have an entirely different – more ‘democratic’ and much more along the lines of genuine consultancy, contributing to a multidisciplinary mental health care team’s work where necessary, rather than necessarily having hegemonic authority.
I strongly orientate to the third model in practice, but have a lot of sympathy with Bracken’s approach in terms of ethos and framework of understanding. Rather unexpectedly, I also think that Craddock’s approach has merit. In my clinical experience, I have frequently been disappointed at the medical care offered to clients. I am unconvinced that clients are offered the physical healthcare that they need and which is particularly important for people who are both often poor and taking powerful medication. In particular, I think it would be ideal if all clients were able to consult with an expert psychiatrist who was able to understand and explain the mode of action of the medication and its potential risks. I do not always find this expertise in practice. I agree with Nick Craddock that expert medical input should be part of every mental health team. What I do not agree with is that this expertise renders a medical colleague the natural leader of a clinical team, or that a medical perspective is a natural guiding ethos for the service. I therefore conclude that none of these models fully addresses the depth of psychiatry’s malaise, and none has a fully-developed solution.

A psychological ethos and model

We need to develop and implement a new approach to understanding mental health problems. As I outlined in ‘New Laws of Psychology’, a psychological approach offers a coherent alternative. Our social circumstances, and our biology, influence our emotions, thoughts and behaviours – our mental health – through their effects on psychological processes. This psychological model of mental health and well-being proposes that our biology and our life circumstances both exert their influence through their effect on psychological processes. Of course, all mental health problems involve the brain, for the simple reason that all thoughts we ever have involve the neurological functioning of the brain. But that’s not an explanation; merely a more detailed description (it’s like explaining warfare in terms of muscular contractions in the fingers on the triggers). In statistical terms, variance in neurological processes seems to account for very little in terms of mental health – or indeed human behaviour in general. Most of the variability in people’s problems appears to be explicable in terms of their experience rather than genetic or neurological malfunctions. Neurotransmitters such as serotonin and dopamine are associated with a variety of emotional problems. That’s hugely unsurprising; reward mechanisms involve serotonin and dopamine... but that’s true for everyone.

Since the 1950s psychologists (and psychiatrists who understand cognitive psychology) have developed sophisticated and practically useful models of how people understand the world. In straightforward terms, people are born as natural learning engines, with highly complex but very receptive brains, ready to understand and then engage with the world. As a consequence of the events we experience in life, we develop mental models of the world, including the social world. We then use these mental models to guide our thoughts, emotions and behaviours.

Understanding things this way suggests that notions such as ‘mental illness’ and ‘abnormal psychology’ are old-fashioned, invalid and demeaning, that diagnostic categories such as ‘depression’ and ‘schizophrenia’ are unhelpful, and that the concept of mental illness is relatively meaningless. I am certainly not arguing that people are not distressed or that psychological problems do not exist. Many people clearly experience severe psychological distress. As I said above, in the UK, suicide is the most common cause of death in women in the year after the birth of their first child. We all have emotional problems from time to time, and there is a well-recognised statistic that one in four of us will, at some point in our lives, have difficulties severe enough to meet the criteria for a ‘mental disorder’. The cost to the state from mental ill-health is estimated at over £100 billion per year, and antidepressant drugs are among the most common – and most profitable – products of the major multinational pharmaceutical companies. But ideas of disease or illness are unhelpful. Even the concept of ‘abnormal’ psychology is unreasonable: we don’t talk about ‘abnormal chemistry’ or ‘abnormal physics’ – the same principles apply whatever value we ascribe to their effects. Instead, we know a lot about the key psychological and developmental processes that make us human, and we know how events in our lives, social circumstances and our biological make-up can affect those processes. Addressing well-being from that perspective is simultaneously radical and common-sense. Scientific research into the psychological processes we all use to understand the world and interact with other people offers a scientifically valid and more helpful approach than the idea of ‘mental illnesses’. I will reinforce the World Health Organization’s definition of health (that health is more than the absence of illness) and suggest that, rather than researching so-called mental illnesses, we should acknowledge that the concept of mental illness is probably misleading and unhelpful in the first place. Rather, an evidence-based approach to mental well-being – developing and applying our scientific understanding of the key psychological processes that underpin our humanity – offers great hope.
Like Pat Bracken, I believe that human distress is largely a social phenomenon, but I therefore conclude that the role of the psychiatrists within mental health services needs radically to change. In essence, we need to see psychiatry adopt an approach that is both more modest and more democratic. Like Nick Craddock, I believe that psychiatrists have very real and valuable specialist knowledge and skills… and that these should be available to the democratic, team-based, multi-disciplinary services envisioned by Christine Vize. This approach would reverse the current dominance of psychiatric modes of thinking – the ‘disease model’ and the ‘diagnose–treat’ model – and place psychiatry in a more appropriate relationship with social and psychological models of care. Although such a change would be challenging both for psychiatrists and for psychologists (who would then be expected both to shoulder the burden of responsibility and to acknowledge the importance of social as well as psychological factors) it is worth spelling out – in detail – the practical consequences of such an approach.

The difficulties that are traditionally thought of as ‘mental health’ issues are in truth primarily social and psychological problems. Of course, there are physical, biological aspects to them. That’s true for all human experiences. But we need to understand that we’re trying to respond to social and psychological problems, not treating diseases. And we therefore need a profound change in how we try to help people. We need to move away from a state of affairs where the default response to distress is medical care, whether in the community or in hospital. We need to stop diagnosing ‘mental illnesses’ and we need to stop prescribing drug treatments. Instead, we need to offer social and psychological interventions. Happily, these can be very effective. Even when people need residential care for very serious crises, there is no reason that this needs to be in hospital; non-medical residential crisis centres which provide social care and support are likely to be much more helpful. That means that a formal transfer of responsibilities of mental health care to local authorities (as has recently happened with public health and is very common across Europe, with a strong tradition of city governance) would be appropriate. This would represent a return to an approach which was common in the past, before distress began to be medicalised in the 19th and 20th centuries. But all that would mean profound changes for the professions of psychiatry and nursing in particular. It would be financially affordable for the nation, but might be challenging for powerful and well-paid professionals. However, the bitter pill I’m prescribing is necessary to cure the grievous sickness of the current system.

Services planned on the basis of a psychosocial model, would offer a very radical alternative. Instead of seeing care for people with mental health problems as a specialist branch of medicine, with links to social care, we would see such support as essentially part of social provision, with specialist input from our medical colleagues. In such a world, people would default to a psychosocial explanatory model, and the disease model of mental disorder would be redundant. That would, at least in my opinion (but substantiated by considerable evidence) lead to more empathy, more compassion, more understanding of people’s needs both by professionals and in wider society, and put a stop to stripping people of their sense of agency – their ability to help themselves. People’s problems would be understood as just that – problems, and diagnoses would be largely replaced by formulations. For people in extreme distress, places of safety would still be needed to replace the niche filled at present by in-patient wards. However these should be seen as places of safety, not medical treatment units, should therefore be led by social workers, or possibly psychologists, rather than doctors or nurses, and physically designed as homely, welcoming houses rather than ‘wards’. On those units, our medical, psychiatric colleagues would still play a valuable role, but would act as consultants to the care team on specifically medical issues, not necessarily leaders of those teams. The ethos of care on such units would be based on recovery, not treatment or cure, and be firmly based on a psychosocial formulation of the problems facing each service user. Good quality, humane, care, and taking seriously the person’s own views about their difficulties and needs rather than insisting that they see themselves as ‘ill’ and accept medication, would minimise the need for compulsion. When compulsion is needed, however, the legal criteria should be based on the principle that people should only be subject to coercion when they are unable to make the relevant decisions for themselves – a capacity-based approach.

For the majority of us, though, mental health care is already community based. In the vision of care proposed here, reconfiguring services as psychosocial rather than medical would transform care. Links to other community-based services such as primary care (GP) and public health services are strong and should remain so. Interestingly, public health services are already based in local authorities. As with in-patient care, medical psychiatrists would be valued to consultants to community mental health teams rather than necessarily leading them. Their ethos would shift from a medical to a psychosocial one, and shift from medical dominance to a model whereby medical colleagues offer
consultancy on primarily medical issues (for example the prescription of drugs) to those psychosocial teams.

There should be a very significantly reduced emphasis on drugs. In particular, long-term drug use should be avoided. Where medication is used (sparingly, and short term) it is important that high-quality (and that emphasis is important) medical and pharmaceutical advice is available. Most especially, we must see a significant increase in the range, quality and availability of a wide range of psychosocial interventions – both practical help and psychological therapies. However, the emphasis should be on care and support rather than ‘treatment’. This is obviously true in community settings – where it is frankly appalling that people seeking help for social and personal issues are diagnosed with illnesses and given drugs – but is also true in residential settings. In episodes of acute distress, a few people would benefit from very short-term prescription for medication (mainly to help them feel calmer if they are deeply distressed and agitated, or to help them through the depths of despair and ‘depression’) but three key points follow. First, such use of medication should (following the advice of Jo Moncrieff) be very brief, targeted and practical. Second, following from that, medication should be used to help people through difficult times, not to ‘treat’ putative ‘illnesses’. And finally… there are very real effective alternatives to medication. Many problems resolve from crisis-point to a more manageable state if people are simply offered high quality, genuine care and support. Psychological therapies such as cognitive behavioural therapy (CBT) can be effective for very many people with a wide range of problems, even when those are serious. And non-medical whole-service alternatives such as the Soteria approach38 appear extremely effective.

**A prescription for mental health and well-being**

Drawing this all together, my prescription for our mental health and well-being services could be summarised as:

1. **Get the message right.** The first step towards a humane, scientific, approach to mental health and well-being is to ensure that we get the message right. We need to change our whole framework of understanding from a ‘disease model’ to a ‘psychosocial model’. I shall explain this more in the next chapter.

2. **Drop the language of disorder.** We must stop regarding people’s very real emotional distress as merely symptoms of diagnosable ‘illnesses’. A simple list of people’s problems (properly defined) would have greater scientific validity and would be a better basis both for individual care planning and for the design and planning of services. Again, I will explain more below.

3. **Be careful with medication.** We should sharply reduce our reliance on medication to address emotional distress. Medication should be used sparingly and on the basis of what is needed in a particular situation – for example to help someone sleep or to help someone feel calmer. It should rarely be used long term, and we should not look to medication to ‘cure’ non-existent underlying ‘illnesses’. In practice, this means adopting Dr Joanna Moncrieff’s ‘drug-based’ approach in contrast to the more common ‘disease-based’ approach.

4. **Offer holistic psychosocial services.** Services should be equipped to address the full range of people’s social, personal and psychological needs and also address prevention. Where individual therapy is needed, effective, formulation-based, psychological therapies should be available to all. That means involving a wide range of community workers and psychologists in multidisciplinary teams, and promoting psychosocial rather than medical solutions. All such therapies should be evidence-based and delivered by qualified, competent professionals. Decisions about what therapy or therapies should be offered to whom should be based on a person’s specific problems and on the best evidence for the effectiveness of the intervention, not on diagnosis, and individual formulations should be used to put together an individualised package of care suitable for addressing each person’s unique set of problems. Using psychological therapies as part of a psychosocial, rather than biomedical, approach would significantly change the way clinical psychologists and others work, particularly psychiatrists. Working within a psychosocial ethos, supporting well-being and recovery rather than treating illnesses, is a perfectly respectable medical role for our psychiatric colleagues –
exemplified in the roles of those such as general practitioners and public health physicians, and the role of professional medical advisors to athletes.

5. **Offer non-medical residential care.** When people are in crisis, residential care may be needed, but this should not be seen as a medical issue. Since a ‘disease-model’ is inappropriate, it is also inappropriate to care for people in hospital wards; a different model of care is needed. Residential units should be based on a social, rather than a medical, model. Residential social workers may well be the most appropriate people to be in charge of such units. The nature of extreme distress means that medical colleagues may well be valuable members of the team but again they should be consultants to the unit, rather than in charge of the ward. It is likely that the power of the Mental Health Act to detain someone against their will would be needed much less frequently in such a system. Where their use is being considered the decisions we take should be based on the risks that individuals pose to themselves and others, together with their capacity to make decisions about their own care, rather than on whether they have a ‘diagnosis’. This approach is already the basis for the law in Scotland. The law in England and Wales allows for the professional who is legally responsible for a person’s care – known as the ‘responsible clinician’ – to be a psychologist, nurse, or social worker. This should be routine. When we abandon a ‘disease model’ of care and adopt a more humane psychosocial approach, the law relating to mental health could change significantly, with new roles for new professions, and a greater focus on social justice and judicial oversight.

6. **Establish democratic multidisciplinary teams.** Teams should be multidisciplinary, democratic and take a psychosocial approach as their starting point. In the multidisciplinary teams delivering these services, psychiatric colleagues should remain valuable colleagues. An ideal model for interdisciplinary working would see leadership of such teams determined by the skills and personal qualities of the individual members of the team. Our medical colleagues would be consultants to the team, not leaders of the team.

And so…

7. **Plan for mental health and well-being alongside other social, rather than medical, services.** Mental health services should be based in local authorities, alongside other social, community-based services. That doesn’t mean creating teams of doctors and nurses managed out of hospital-based NHS trusts but in a building away from the hospital site. It means that we should locate the whole service in the community – put the service entirely under local authority control. In the UK, we have the model of public health (recently transferred to local authority control) to build upon. Services would then be under democratic local governance. I recognise that some local authorities – especially, perhaps, in developing countries, may not yet be robust enough for the task, but this should be the vision and aspiration, rather than aiming for a medical model.

Adopting this approach would result in much lower reliance on medical interventions, and a much greater reliance on social and psychological forms of help. We would – we may as well be honest – need fewer psychiatrists. As we see a move towards community-based social services, we could look to primary care (general practice – GP) colleagues for much of the necessary medical consultation and input; linking psychological care to the wider well-being of patients in the community. We would, in contrast, require much greater emphasis on, training in, and staffing of, psychosocial approaches. What I’m proposing would be a very major revolution in mental health services and in psychiatric practice.
Notes


36. See note 32 above.
