THE MADNESS OF PSYCHIATRY (in 21st Century UK):

A LARGE GROUP ANALYTIC PERSPECTIVE

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It is more than 60 years since the World Health Organisation defined health as

> *a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.(*WHO 1948)

The description is important as it reminds us of the social dimension required for both mental and physical health. Humans are social beings, and we all have a need to belong, be it to smaller groups such as a family or larger groups such as a nation. As a doctor with group analytic experience, I encounter patients who are struggling with very personal, subjective conditions, which often evoke stigma on the part of others and undermine their ability to belong to the group. Effective treatment of those with a mental illness demands attention not only to the organic and psycho-social needs of the individual, but also to the social context in which the individual exists. This paper was inspired by recent events in the UK: (1) an independent report on schizophrenia, in 2012. Despite large sums of money being spent on mental health over the last decade, increased emphasis on evidence-based practice and national guidelines (NICE), the commission's findings were damning and highlighted the chaotic state of our mental health services, particularly for those with complex and enduring illnesses. (2) The Francis Report of 2013 revealed a shocking state of health provision in one general hospital Trust, resulting in the call for a new culture of compassion. I have long believed that we have merely displaced the mentally ill from health to penal services. Statistics from the Penal Reform Trust confirm this: over 70% of prisoners have one or more mental conditions. Meanwhile there has been an exponential increase in prescription and consumption of strong 'antipsychotics',

originally licensed for specific psychiatric disorders. Is this a reflection of the 'madness', once contained in asylums, now affecting us all? To comprehend how we reached this parlous state, I discuss UK attempts to deal with the mentally ill from the 19th century Victorian asylum to 21st century community model.

My career in psychiatry began in 1986 in a large psychiatric asylum (Runwell Hospital, the last to be built in the UK (1937-2010). Ironically, it was the same year that the first psychiatric asylum (Banstead Hospital, 1887-1986), closed.

Figure 1 Runwell Hospital

Figure 2 Bethlem Royal Hospital

The asylum model. In fact, Europe's first Lunatic Asylum, Bethlem Royal Hospital in London, had been admitting mentally ill patients since 1407, though treatment amounted to little more than removal from society. Following the Madhouse Act of 1774, a license was required to treat the 'insane'. Shortly after this, William Tuke established The York Retreat, to treat the mentally ill in a humane, therapeutic setting. Further Acts (1808, 1845) required local regions to provide for the insane. Between then and the next Act (1890) over 60 asylums were built and opened, and another 40 followed. They were a product of social change following industrialisation. They became microcosmic communities, with their distinctive water towers, farms, laundries etc.: residents felt contained in an asylum group and found meaning through work and recreation. The asylums symbolise society's (the large group) attempt to contain 'the insane' and staff anxieties, in turn containing society's own

anxieties. Physical constraints may have been replaced by more humane treatments but in time those deemed morally undesirable were also being incarcerated. Consequently, asylums were overcrowded, and inevitably became autocratic and abusive, serving the needs of the organisation above those of its patients.

Figure 3 St Mary's Hospital, IoW

In the aftermath of World War 2, the National Health Service Act (1946) led to the creation of the NHS, based on a socialistic model of health care free at the point of delivery. The asylums were integrated into this system. This period also saw the development of group psychotherapy models and institutions (e.g. Group Analytic Society, Henderson and Cassel Hospitals) pioneered by ex-army psychiatrists to meet increased mental health needs.

By late 1950s, reliance on crude, non-scientific interventions (e.g. lobotomy and insulin coma therapy), had been replaced by chemical interventions (e.g. largactil [chlorpromazine] and imipramine) which raised unrealistic hope of cure. The climax came when the then Secretary of State for Health, Enoch Powell, proposed closure of the asylums and their replacement with community care. He acknowledged that ideological resistance on the part of professionals and the public would have to be overcome (Water Tower Speech, 1961). It would take 25 years to achieve this change in attitude and for the first asylum to close (cf. Menzies Lyth, 1959).

1980s: Community Care. In anticipation of the asylum closures, community-based services were established: supported housing, day hospitals and integrated health and social care. Psychiatric outpatient clinics and units were set up in general hospitals. Under new legislation e.g. Mental Health Act (1983 UK, 1984 Scotland), the focus turned to patients' rights.

1990s: Community Scare. Over the next 10 years, there was rapid closure of most of the asylums. Initially there were no problems, but major difficulties began to emerge when patients with complex needs were discharged into the community, sometimes with serious consequences (e.g. homicides by Christopher Clunis 1992, and Michael Stone 1996). Such events led to reappraisal of the legislation and introduction of stricter supervision of patients, which fell just short of compulsory treatment in the community. This also failed to achieve its goals.

In order to make the NHS more efficient, a market economy model was introduced. This led to the division of health and social care. Health Authorities were replaced by not-for-profit Trusts, with the introduction of Chief Executives and Directors. The first group of Trusts included mental health services as part of their overall provision but a decade later, financial and ideological needs resulted in mental health services being provided mostly in discrete Mental Health Trusts.

By the mid-90s, the rapidity of closure of the asylums had led to severe shortage of beds in the NHS. Considerable expansion in the provision of private hospital psychiatric beds for NHS patients ensued. In response, the NHS developed different community-based services designed to reduce the number of hospital beds required. To meet this demand, there was further expansion of clinical staff and new services e.g. crisis and home treatment teams. By the end of the decade, the number of general psychiatric beds in both the private and NHS sectors began to reduce.

This was the beginning of psychiatric services being split, inevitably raising the anxieties of staff and society (the larger group).

2000s: Community Chaos. In response to these anxieties, more and more guidelines were produced for clinicians. Long-term 'non-efficient' (but containing) therapies and models of care were replaced by short-term, evidence based, 'efficient' treatments (Henderson Hospital closed in 2008). 2005 saw the introduction of the early intervention service, promising better outcomes for those with serious mental illness. The drive for efficiency also led to the 'traditional' model being replaced by the functional (dysfunctional?) model, which split the services even further (inpatient consultants/ outpatient consultants etc. etc.). Smaller Trusts began to merge into large Trusts, with bigger budgets and, if they had the right star-rating, Chief Executives could demand salaries commensurate with those of big industry. In 2007/8, further changes to mental health legislation saw the introduction of compulsory community treatment orders (CTOs). It was anticipated that in the first year around 600 patients would be subject to a CTO in England; in reality, it was over 4000. The private hospitals, which had undergone a reduction in use of their beds by the NHS, saw an opportunity to expand services for those with more complex care needs (personality disorder units, medium/low secure forensic services), contributing further to the split.

Now: Community Scarce. The current decade has brought global economic crisis and fierce competition raising the levels of anxiety to a psychotic degree, forcing us to commodify illness, justify our treatments and measure outcomes. Unsurprisingly, mental health services are facing the brunt of this. Local authority staff once seconded are now being pulled back to focus on commissioning rather than

providing integrated care. Experienced staff are attracted to work in areas where there are short, sharp interventions, and measurable outcomes.

On the advice of a professor of economics (Layard, 2006) there was a drive for Cognitive Behaviour Therapy. There has been an explosion in Improving Access to Psychological Therapy (IAPT) services across the country, treating vast numbers of patients based on a CBT model. These services have been deemed a great success because they produce measurable positive results. In my area, what was called a Primary Mental Health team also became an IAPT service, attracting many of our experienced staff. Since its inception, this service is treating thousands more patients, with outputs and effectiveness being based on tick-box rating scales. The sad reality, though, is that neither the early intervention service nor the IAPT has had any significant benefit for those with long-term mental illness.

The paranoia for justification is forcing therapies and therapists to develop assessment tools to filter in 'good' patients thereby improving statistics, rather than contain complex patients who have greater need. Just as the asylums, prior to closure, were abusive and self-serving, so have some of today's Trusts, boosting their star-ratings to the detriment of patients. The Schizophrenia Commission and Francis reports have confirmed this and, sadly, noted that the impact goes beyond the UK's mental health services.

Conclusion. When the asylums closed, madness entered the community – and I do not mean patients! We responded to large group anxiety by imposing new forms of constraint (manuals, tick boxes, categorisation). The need for mindfulness to be incorporated in an effective treatment such as CBT illustrates how mindless these practices actually are. If we act without reflection and awareness of the individual's uniqueness any intervention will remain mindless. Ironically many of the old asylums,

built to segregate the mentally and socially undesirable have now become exclusive, gated housing communities which ‘protect’ the wealthy from the rest of society.

Figure 4 Then: Friern Barnett Hospital

Figure 5 Now: Friern Barnett Gated Housing

We would do well to heed the words, expressed by many, not least Mahatma Ghandi, that

A nation's greatness is measured by how it treats its weakest members.

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