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EDITORIAL

Are kindly and efficacious mental health services possible?

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The above question was explored by Peter Sedgwick in his classic text *PsychoPolitics* at the very moment when “anti-psychiatry” was giving way to “critical psychiatry” and the emergence of a New Social Movement of disaffected patients (Sedgwick, 1982). Although he expressed many reservations about the excesses of those hostile to orthodox psychiatric theory and practice, he also largely sympathised with the reasons for their concerns (Pilgrim, 2016). For those of us who have been around these debates for decades, it sometimes feels as though little if anything has really changed.

I am reminded of the film *Groundhog Day*, as we go round and round the same block about service quality. I think that what we mean by a “good mental health service” comes down to several foundational points of contention, such as the scientific legitimacy of psychiatric diagnosis, the cost-effectiveness of routinized medicinal psychiatry, the desirability of recovery and the recurring matter of the coercive social control of troubling conduct by those who are sane by common consent.

Mental health professionals offer a service to whom and about what? An inherent problem for services is that they are trying to reconcile different interests in society. Sometimes, these are synergistic but at times they are not. The right of some people to act unintelligibly, without constraint and the right of others to remove them from society is an example. Mental health services regularly consider the expressed needs of identified patients *and* their significant others *and* the general public and so this organisational challenge is enormous.

It is not self-evident that the views of professionals, the pharmaceutical industry and differing lay groups (especially, the problematic taken-for-granted orthodox amalgam of “users and carers”) will be seamlessly aligned (Robotham et al., 2016). Moreover, given that many of the social conditions that inflect mental health, especially poverty, urbanicity and variants of childhood adversity, are outside of the control of health services then the prospect of a *medical cure* for their adverse psychological impact may be a non-starter (Lederbogen et al., 2011; Rogers & Pilgrim, 2015; Schilling et al., 2008). Given this dilemma about the over-determination of mental health problems by our contingent

biographical circumstances, then care and compassion, rather than techno-centric curative aspirations, become particularly important criteria of service success.

The capacity of mental health work to be both humane and effective could be re-framed as a set of quality control questions about the accessibility, appropriateness, acceptability, equity, clinical effectiveness and cost-effectiveness of those structures and processes we dub collectively as “mental health services”. However, we get different answers, to these sub-questions, depending who we ask and which item is our focus (Pilgrim, 1997). For those who are sane by common consent, “efficacious” might mean keeping troublesome patients always out of sight and mind. This expectation might extend to ensuring treatment compliance and recurring staff surveillance, post-discharge. Community treatment orders indeed now offer the latter public service in some national jurisdictions. However, they do not seem to prioritise an acceptability to patients themselves (Fabris, 2011; Riley et al., 2018).

For those who voluntarily seek help and want talk not pills, a “take it or leave it” response from professionals might be considered by them to be both inappropriate and unacceptable. For them, the service is not being “kindly”, when and if their legitimate expectation of an existential exploration of their nuanced biography is being denied. At the same time (and as an indication of the difficulty in satisfying “consumer” needs), some patients hold a neurochemical view of their condition and actually expect medicinal solutions. Others may accept the ameliorative role of medication but still demand or expect more holistic care from services. Thus, the notion of “patient-centredness” brings with it competing criteria of success, with patients varying in their reliance on, or rejection of, medication (Fullagar, 2009).

Critical arguments about the yoked interests of the drug companies and unimaginative biomedical routines are now well rehearsed. Those routines would not be inherently problematic, if they were clearly efficacious and had no iatrogenic toll. They should not be life diminishing; after all these interventions ostensibly exist in order to *improve* mental health. They certainly should never be life threatening. However, honest academic psychiatrists, not swayed by drug company funding, show us unequivocally that this positive image of psychotropic drugs is thoroughly unsustainable (e.g. Healy, 2004; Moncrieff, 2013). User-based campaigns

reinforce this scepticism about a chemical fix for the complexities of psycho-social problems, notwithstanding the above caution that some patients embrace biomedical interventions. The over-reliance on a failed chemical fix has been evident in primary mental health care, not just specialist services. For example, some GPs now realise the need to reduce chronic patient dependency on ineffective antidepressants: a problem created partly in the first place by the intention to displace the earlier iatrogenic consequences of both anxiolytics and older mood altering drugs (Kendrick, 2015).

A similar point about service user disappointment could be made about the experience of involuntary detention and treatment. To detain some people without trial and without their consent, when their imagined future risky conduct is a concern to others, is very *effective* as a form of social control. However, the likelihood of it also being experienced as a *kindly* act by the identified patient is not exactly great; who amongst would savour being locked up against our wishes and with no advocate for our freedom?

At any moment in time, most people deemed to be mentally disordered in society are not compulsorily detained, though some supposedly voluntary inpatients are admitted under the leverage of threatened coercion; they are pseudo-voluntary patients (Szmukler & Appelbaum, 2001). “Mental health legislation” exists to manage, at times very robustly, some people but not others. It is about the lawful control of one group of problematic patients and not the promotion of mental health. It is a misnomer; “Risky Versions of Mental Disorder Legislation” would be more accurate, even if inelegant.

Decision making about compulsory detention is always contingent. It variably mixes considerations of risk, with those of mental capacity, and it inevitably involves a normative aspect: professionals make value judgments on behalf of their host society (Shaw et al., 2007). For example, this means that if a societal norm is to perceive young, black men as being abnormally dangerous, then that will be mirrored in admissions to psychiatric units and risk-averse staff decision making, thereafter, about discharge and security levels (Audini & Lelliott, 2002; Pilgrim, 2012).

Despite the euphemism about “treating mental illness under the Mental Health Act”, in self-evidently benign acts of *parens patriae*, mental health professionals are still ultimately rule enforcers (Bean, 1980). Moreover, the state has never been able to ensure the *principle of reciprocity* as an outcome of this medico-legal jumble of decision making. Each and every detained patient is not guaranteed the best care available to them, in exchange for a serious human rights violation. Their loss of liberty, without trial and with no ensured advocacy for their freedom, offers no guarantee of optimal care at all (Eastman, 1994). By this criterion, the state habitually fails detained patients.

In the US, where more stringent criteria about risk to self and others are applied than in the UK, we still find one part of the state taking the other to task on this matter. For over 15 years, the US Department of Justice has been involved in suing states for failing to offer the right to the most effective treatment in the least restrictive setting and for failing to offer effective community care for people with long-term mental

health problems. This invites a simple question about whether, despite its progressive façade of protecting patients, “mental health” legislation is *inherently* discriminatory and will thus habitually lead to human rights violations.

For example, in the UK, the 1957 Royal Commission, which preceded the 1959 Mental Health Act for England and Wales, ensured that the anti-social action and evidence of risk to self or others of *sane* people should, and must, be dealt with differently than similar or identical conduct linked to those deemed to be mentally ill (Bean, 1980). Thus, risk is not dealt with by the state in a consistent manner. Sane people act in a range of risky ways. They smoke, eat fatty and sugary food, enjoy unprotected sex, indulge in extreme sports, enter boxing matches, play rugby, ride horses, ski, binge drink, climb mountains and speed in their cars. This is not an exhaustive list. Save, for example, a brief sobering up period in a police cell, sane people are rarely detained without trial to reduce the risks evident from their common habits. This unchanged legal context, with the sane having a taken for granted permissive privilege, sets limits on the next aspiration for scientific and ethical advances in service quality.

Some progress has been made recently in developing a post-diagnostic rationale to challenge at least one aspect of our *Groundhog Day* experience. The diagnostic inflation ensured by the appearance of DSM-5 prompted the argument that we can have too much of a good thing (Wykes & Callard, 2010). Others have pushed a more ambitious agenda, which is to abandon psychiatric diagnosis in favour of co-created formulations and action plans that are more acceptable and appropriate for service users. We find in the recent *Power Threat Meaning Framework* (Johnstone et al., 2018) an opportunity to go beyond the obvious professional shortcoming of habitually putting complex and shifting social-existential challenges into fixed medically-invented boxes.

The *Framework* does not merely critique the wisdom of the latter, it poses more pertinent questions. Instead of focusing on what is wrong with people we might foreground what has happened to them. Staff in mental health services should be doing this already, by routine, but generally they do not (Hepworth & McGowan, 2013). Staff should be routinely psychologically informed in their practice, but this is still an innovation not a norm (Araci & Clarke, 2017). If that norm were to now truly emerge, then professionals would explore with patients the detrimental operation of forms of power in their lives, both as children and as adults, at the intersection of class, race, age and gender. They would explore with them the meanings they attach to their unique experience and the particular way in which they tend to respond in order to cope, albeit often in a dysfunctional or unintelligible manner: their habitual “threat response”.

A focus on the corrosive or traumatic impact of the real operation of various forms of power differential in our lives, would be a radical shift of ethos in mental health services. It implies that currently the latter are knowingly, or otherwise, housing the psychological casualties of life from unsafe families, schools, workplaces and of course actual war zones and torture rooms. It remains an open empirical question about how often layers of chronic adversity and traumatic history affect those with a psychiatric diagnosis. The call now for more “trauma-informed” services is an important demand

but we should be cautious of simplistically replacing bio-reductionism with trauma-reductionism, as a blanket explanation for all mental health problems. However, by offering a trauma-informed approach at least it might move us some way to services that are truly “kindly”. And if expecting them to be “efficacious” is asking too much, we might at least expect that they should at all times be acceptable to patients. Currently, all too often, Sedgwick’s lament remains.

Declaration of interest

No potential conflict of interest was reported by the author.

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