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What are people for?

Mental health in a sick society

Julian Tudor Hart

July 2008

The Bevan Foundation

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Julian Tudor Hart was a general practitioner for 35 years, first in London, then in the coal-mining village of Glyncorrwg. Between these two posts he was apprenticed in epidemiology to Richard Doll and Archie Cochrane. He pioneered community control of hypertension and other chronic conditions, with apparently substantial effects on premature deaths compared with a control population. He returned to full time scientific staff of the Medical Research Council in 1987, retired in 1992, and since then has continued lecturing and writing. His most recent book *The Political Economy of Health Care: a Clinical Perspective* was published in 2006 by Policy Press. He has published eight other books and over 160 papers in scientific journals, has been visiting professor or lecturer at many UK and foreign universities, is an honorary Fellow of the Universities of Swansea, Cardiff, Glamorgan and Glasgow, and was the inaugural winner of the Royal College of General Practitioners international Discovery Prize for research in primary care in 2006. To find out more, visit juliantudorhart.org

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Registered charity no 1104191

ISBN 978-1-904767-32-09

platform

WHAT ARE PEOPLE FOR?

Mental health in a sick society

Keynote speech to conference on mental health in NHS Wales primary care,
29 April 2008, Cardiff City Hall.

All wealth originates from work. Now that work with our hands has been replaced either by machines, or by cheaper labour in less developed economies, capacity to work depends even more on the health of our minds. The conventional illusion that capacity to work can be assessed while ignoring our specifically human qualities, measuring only those we share with draught animals, can at last be dismissed. Wealth depends on a healthy workforce, in whom mental health is far more important than any other variable.

In Wales, each year roughly one third of all adults (consulting or non-consulting) meet consensus criteria for mental illness, similar to rates everywhere else in the industrialised world.[1] Of these, about 75% consult their GP. Of these consulters, about 44% are recognised to have a mental health problem; and of those recognised, about a quarter are then referred to hospital-based psychiatrists.[2]

The division between the one-third of adults recognised to have a mental health problem and the two thirds who don't is as arbitrary as the division between people who are happy or unhappy. Everybody knows the difference between a happy person and a miserable one, but where best to place a useful division between them or to define emotional health depends entirely on what actions, if any, are justified to bring about change. The same reservation applies to most deviations from health, only a few of which ever end as medically recognised diseases, defined and named.

Fewer than 3% of all adults have a clearly defined psychotic illness (schizophrenia, bipolar disorder, or several other rare disorders of brain function) at any time in their lives.[3] [4] These are what we used to call mad people, who perceive and react to the world so differently from the rest of us, that we can hardly communicate with them. So of the one third of Welsh adults who admit they have ever been mentally ill, 10% at most have had a psychotic disorder.

In my 40 years of work in primary care between 1952 and 1992, I became very interested in helping my patients with mental illness, particularly this small number with psychotic illness, who are still mostly regarded as a responsibility for hospital-based specialists. The NHS provides some access to psychiatric care for our whole population, mostly by GPs.[5] As family doctors they still seem to me best placed to answer any emergency whatever its nature, at least in the first instance. Above all, they seem best placed to prevent such emergencies, which in my experience they certainly can, if they take the trouble to know their patients, and organise continuing care. Even if really knowing patients becomes a function delegated to nurse-practitioners, nurses, or even health care assistants, that function will still be in fact the most important element in effective care, whether or not conventional wisdom accepts this.

In my time, all referrals to specialists were strictly zoned. We had no choice. The consultant psychiatrist for our locality happened to be alcohol-dependent and held 19th century views on the mad or bad. It took seven years for the NHS machine to offer him early retirement. In that time I learned that for GPs who lived within a working class community and made friends with their patients, management of psychotic illness was usually much easier than managing so-called neuroses. We certainly needed specialist help from time to time, but infrequently.

So-called neuroses were the other 90% of psychiatric workload. They included the most time-consuming, recurrent, challenging and exasperating parts of primary care, concentrated disproportionately in our most deprived communities (as was also psychotic illness, and almost all other sorts of illness).[6] So-called neuroses were our heaviest burden, but they were easiest to dismiss as outside our responsibilities. If patients who can't make sense of their world find no help from their doctors, eventually they no longer ask for it. A large part of this mental ill-health presented as physically inexplicable incapacity to work. Of all clinical problems, this is the most complex and difficult, demanding all the skills of an experienced practitioner. Ignoring this, we hear confident assertions, over and over again, that the problem would soon be solved if we took certification of illness away from personal doctors, and created an independent medical police force to act boldly and with common sense.[7] Holland took that path more than a century ago.[8] By 1990, Dutch sickness absence was 7.1%, compared with 5% in Germany and 2.6% in UK, a stable ranking through many years.[9] The difficult, delicate, complicated work being done by Mansel Aylward at the Wales Centre for Health is far more likely to help than any police measures.[10] The less doctors act as critical advocates for their patients, the more they appear to be uncritical advocates for employers.[11]

Even today, when NHS GPs are paid on fixed tariffs rewarding specific interventions, but ignoring much that is hard to measure or define, most UK GPs accept responsibility for frontline psychiatry. The biopsychosocial model of disease has been nominally accepted since the early 1970s.[12] However, research shows that GPs still rate their responsibility for care of acute physical problems about twice as high as for chronic physical problems, and more than three times higher than for psychological problems.[13] They know that consultations for psychological problems take much more time than physical disorders. Time rather than skill is their perceived limiting factor,[14] but they often under-estimate their urgency. It seems only those who have suffered it know that suicidal depression can be more painful than any other disease, and more dangerous.[15]

How people think largely determines *what* they think, and what they want to know. Most doctors, and most patients, seem to believe that no sickness is real unless it can be named as a disease, qualitatively different from health, with a label recognised by an insurance company. In a civilised society, sick people have a right to sick roles, and thus to support from other people through services paid from taxation. In a civilised society, we recognise that sickness of all kinds is a misfortune to which everybody is liable, so the cheapest, most efficient and effective insurance

system must be to pool risks and share costs: we all pay for care we hope we may never need. One price we must apparently pay for this is medically certified possession of a named disease, however irrational that naming may be.

This apparently inevitable but essentially irrational reification of illness is only part of a much larger, dominant global tendency to push everything we think, do or create into clearly defined categories, each with its own place in the market inventory. It is powerfully reinforced by product and process promotion. Drugs have certainly made psychotic illness more manageable. So the idea that the other 90% of mental sickness might somehow resemble psychosis, but in attenuated form, could potentially increase their market tenfold. Can we really believe that every sort of dysfunctional thought and behaviour is classifiable as some kind of disease, that this truly reflects human biology, and therefore justifies tinkering with the brain chemistry of unhappiness and fear in ways similar to treatment of psychosis, albeit with smaller doses of less potent agents?

However irrational, this idea has a powerful appeal to both clinicians and the general public. Mental illness of any kind presents complex and difficult problems, often apparently insuperable. Who would not welcome so simple a solution as swallowing a pill? It takes much less time to write a prescription than to explore disordered thought or behaviour, let alone change a world that seems to make so many people miserable. The industry employs an army of friendly, flattering, and in their own way sincere brainwashers to promote chemical solutions for social problems. The European Union is even now pressing for such drugs to be freely advertised directly to the public, as they already are in USA, so that the companies can bypass the growing proportion of doctors who reject their brainwashing, and reach consumers with all grades of mental distress directly.[16]

As each tranquilising or antidepressant drug has come into fashion, it has become so widely prescribed that we might as well have it in the tap water. Eventually all these panaceas turn out to be no more effective, and to create just as much dependence and as many harmful side-effects (including suicides) as their predecessors. Over the centuries we have seen these come and go: gin, opium, cocaine, bromides, barbiturates, benzodiazepines, serotonin uptake inhibitors - on and on and all to nowhere except colossal profits, and damage to our most obvious means for recovery, the brain itself.[17]

In USA in the 1990s, they began herding unreasonable children into the same market, labelling just under 8% as having Attention Deficit Hyperactivity Disorder,[18] and sweeping many others into treatments doubtfully validated even for adults.[19] Where the US market leads, the UK market follows, albeit more sceptically.[20 21] Writing in 1991, George Dunea suggested a collective brand name for all these simple answers to complex problems – *Nonsenserine*. [22]

How will we ever learn? Even to start, we need to look in an entirely different direction - to causes within the structure of our economy. If we understand them, we can change them, so understanding itself can become the first step toward restored mental health.

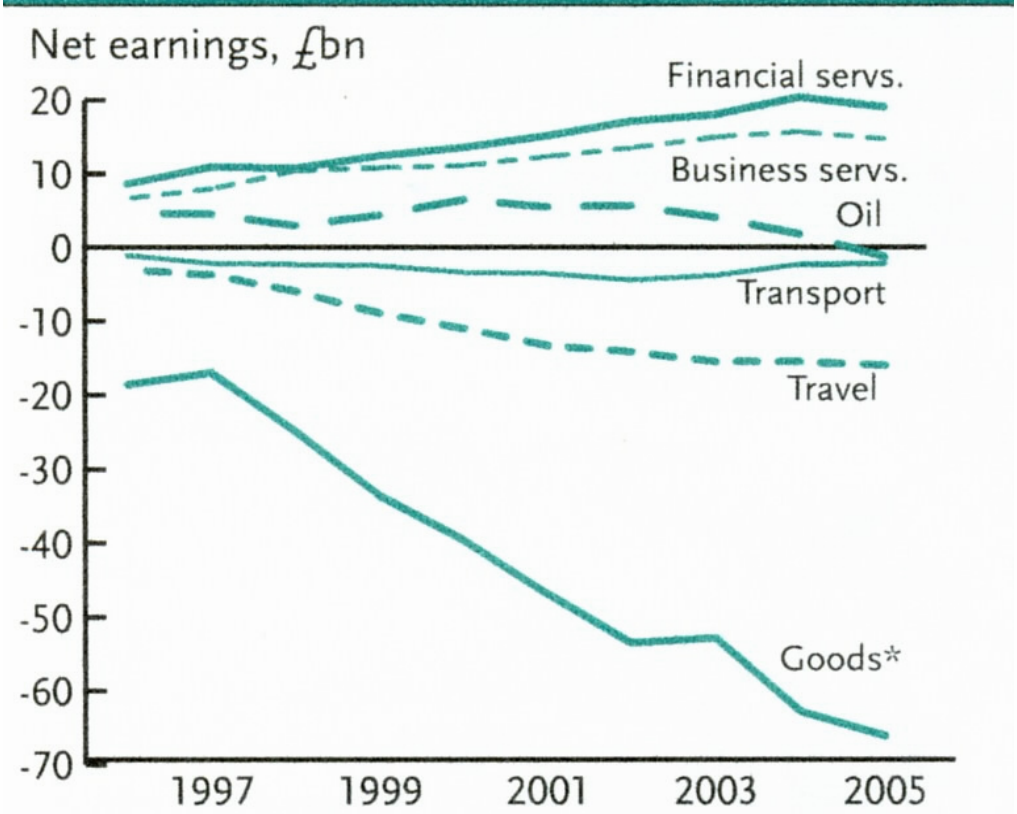
That doesn't mean that primary care should wash its hands of people with serious organic brain disorders, or attribute all these to damaging formative experiences of a personal or social kind. Psychotic illness is real, and most if not all its diseases

probably do start from disturbed brain chemistry, which may be reversible by biochemical means. But in population terms, psychotic illness is a small and more or less constant problem, similar in all economies.[23] If every practice accepted responsibility for primary care of its average dozen or so people with psychotic illness,[24] referring to specialist psychiatrists only when generalists couldn't cope, and with continuing support from psychiatric nurses based in communities rather than in hospitals, we could achieve a great deal more than we do now, though primary care would need more staff and more in-service training. Compared with the cost of occupying Iraq and Afghanistan, now running at £3.3bn a year,[25] or the £15-20bn immediate replacement cost of Trident nuclear missiles,[26] costs for such services would be trivial.

Psychosis is a far more manageable problem than the other 90% of recognised mental illness, linked with the apparent failure of unhappiness and dysfunctional behaviour of entire societies to diminish, even when average incomes and measures of physical health have substantially improved.[27] We should stop looking for biochemical mechanisms and start looking at social causes, and what we can do to reduce and oppose them.

What do most of these unhappy, fearful, or unreasonable people have in common, who have no disease but are certainly ill? They can find no secure or satisfying place in this world, or belief in any alternative. Their views are not so much irrational, as dysfunctional responses to an irrational society. Have a look at the graph in Figure 1, showing what has happened to our balance of earnings in the British economy over the period 1995 to 2005. It reflects a social earthquake which has almost destroyed the robust industrial working class culture which took us about 200 years to build:

Chart 3 UK sector trade balances



Source: ONS Balance of Payments Yearbook

As you see at the top, UK net earnings from financial and business services rose from about £17bn in 1995, to about £33bn in 2005 (standardised for inflation). Now look at earnings from production of goods – real objects, not paper transactions. In 1995, UK net losses from trade in goods, the excess of imports over exports, were valued at about £19bn. By 2005, the UK economy was losing about £67bn a year in exchange of real things - the consequence of destroying most of our industry in the 1980s, and shifting to a paper economy. This accelerated a process that started before the first world war. Our masters demoted manufacture and promoted financial services whenever the country was at peace. Big investments in new manufacture, research and technology development were prompted chiefly by wars or preparation for wars. In the intervals, investors returned to what gave them the highest profit, paper transactions in the City of London, Wall Street, and other finance casinos.

How does this connect with mental health or mental wealth? At least till last month, the casino end of our economy was thriving. It didn't make anything itself, but decided where investment should go, and consequently, which things were made, which tasks were performed, which priorities were pursued and which were neglected, throughout the world economy. It ensured that we produced as much as possible of whatever could be sold most profitably, no matter how trivial or even harmful to health and happiness this might be, and wasted as little as possible on unprofitable human needs, no matter how urgent or necessary.

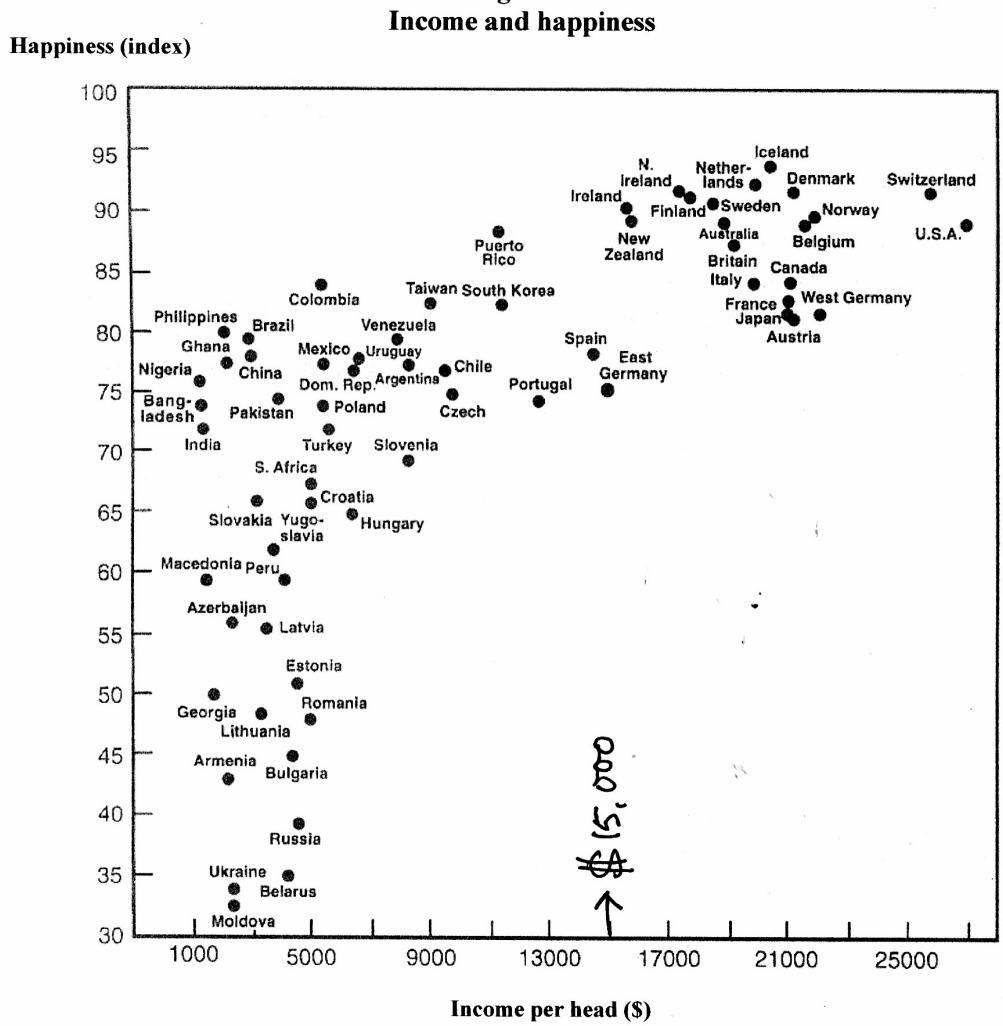
Our manufacturing sector has been in free fall since government allowed our machine tool industry, the foundation of our industrial independence, virtually to disappear in the 1980s.[28] Figure 2 is a picture of six Glyncorrwg boys, schoolmates of my own three children, taken around 1980:

All were unemployed for most of the next 10 years, and one was murdered.

Their fathers, miners and steelworkers, were profitable to their employers and therefore accepted as useful to society. These boys were no longer profitable, so they no longer seemed useful. Over the whole of the next decade, youth unemployment in my practice (16 to 24) never fell below 60%. We had to survive a tidal wave of drug and alcohol dependence and demoralised behaviour not seen even during years of hunger and cold in the 1930s, only recently receding. For the casino, goods and services are means to maximise profit, not means to a better life for us all. When I emigrated to Wales in 1961, the steelworks at Port Talbot employed about 15,000 workers in a nationalised industry. Today it employs fewer than 3,000 to produce three times as much steel. It is now owned by Tata Steel of Mumbai. Tata dates from 1904, with a good record as enlightened employers: the company introduced an 8-hour day for its Indian workers in 1912, when our steelworkers still had to work 12 hours. However, an Indian steelworker today earns 88% less than a UK steelworker. Port Talbot lives in dread of the day when the new owners decide to produce even more with even fewer workers at far lower cost and higher profit,[29] leaving our steelworks and all its supporting local industries to rot as a giant carcase – not their responsibility.

By those who live from what they own and control, including our media of mass communication which set the agenda for public discussion, people are valued by their usefulness not to themselves and their communities, but to a handful of remote billionaires who own and control most of the world we live in. People are there to be used, a flexible labour force to do anything or nothing whenever they're needed or discarded by players at the casino. Producers are losing their value. Regardless of their skills, nobody can be sure that in ten years time they will still be needed. Stripped of their dignity, is it any wonder that people once strong enough to face any eventuality, now fall victim to weaknesses they never thought they had?

In the 1990s, Richard Inglehart organised sociologists all over the world to study the relation of material wealth to happiness. The results are shown in Figure 3:[30]

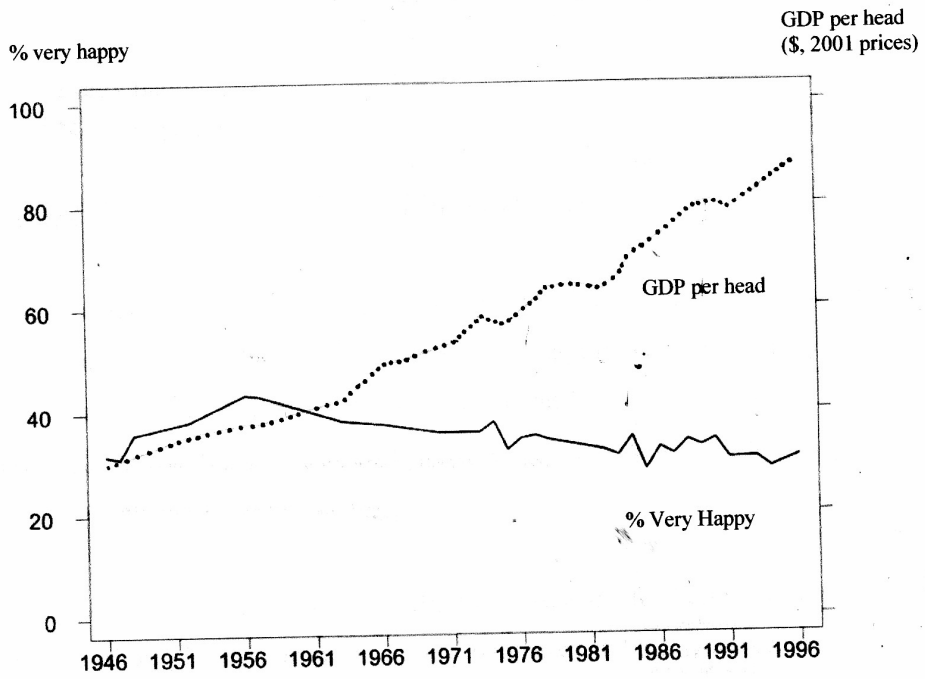


Source: Inglehart and Klingemann (2000), Figure 7.2 and Table 7.1. Latest year (all in 1990s).

An index of happiness, derived from expert studies of large population samples, rises from 30 to 100 on the left, and annual incomes per head range from less than $1000 to over $25,000 average annual income per head, along the bottom. Predictably, the most miserable countries lie in the wreckage of failed socialist societies, both poor and demoralised. Most of the happiest countries are above a threshold of $15000, with capitalist economies but varying degrees of state intervention. Above that $15000 threshold, there's no clear association between wealth and happiness, nor does there seem to be any obvious difference according to existing individualist or collectivist cultures, so far as these can be perceived.

Figure 4 shows data from the same source on USA. Increasing average wealth ceased to promote happiness around 1956, and slowly diminished thereafter, as inequality grew.

Figure 4
Income and happiness in the USA



According to the United Nations Report on world development, by 1996 there were 358 $US billionaires. Their total wealth equalled the combined incomes of the poorest 45% of the world population, 2.3bn people.[31] Classical economists, and our present UK government and official opposition, justify this by utilitarian arguments. They believe that an economy fuelled by greed leads paradoxically to the greatest good for the greatest number; an irrational distribution of wealth and investment nevertheless creates the happiest societies the world has so far achieved. I have to admit this evidence supports them. Beyond this, they suggest it may be neither prudent nor possible to go. We should accept the residue of unhappiness we still have as more or less inevitable, and concentrate on getting more psychiatric help for people apparently unfitted for our competitive society. Professor Lord Richard Layard, a Labour peer and my source for these data, has called for 250 new centres to provide cognitive psychotherapy to do just this.[32] Cognitive therapy is no panacea, but it works as least as well as any medication, and usually better.[33]

But what is cognitive therapy? It treats mental illness by helping people to understand their own lives, and how these relate to the world they live in – to make sense of the world. Surely that should include understanding why whole communities suddenly find themselves redundant to the larger society within which they live, why 384 billionaires have come to command as much personal wealth as more than 2½bn poor people, and now have greater power than any elected government to decide how global wealth is made or spent? They need to rediscover a political literacy that once we had,

because our ancestors fought for it, and lost because we stopped fighting. John Hutton, Business and Enterprise Minister in our UK New Labour government, proclaimed recently:

> "Rather than questioning whether huge salaries are morally justified, we should celebrate the fact that people can be enormously successful in this country. Rather than placing a cap on that success, we should be questioning why it is not available to more people. Our overarching goal that no one should get left behind must not become translated into a stultifying sense that no one should be allowed to get ahead." [34]

If we ever believe that an entire society can ever consist entirely of billionaires, we really will be insane. Happiness, contentment, mental health, or whatever we choose to call it, depends on creative work and good company; respect and affection from others, which we can ourselves return. People need to believe that they serve and share some socially useful and respected purpose, that they are of value to others and therefore valued in return, and that at the end of their lives, they have achieved something. It is capitalism, an economic system that hands all moral responsibility to market decisions, and threatens even that slender thread of human responsibility still embodied in ancient cultures and religions, which drives people with normal brains into fear, confusion, desperation and destructive behaviour.

Yes, the world's first clumsy attempts to construct a socialist society in impossible circumstances and without the economic and social development that we can now see as preconditions for success, more or less completely failed – not only because rich countries did, and still do, their best to ensure that failure, but chiefly because of fundamental faults inherent in the original social development of those new states, which had not yet produced the abundance necessary for the next step toward sharing society. We now have that potential abundance. If we continue to allow this to be used only to make more weapons and more billionaires, we shall earn only the contempt of our posterity.

In previous economic systems and previous cultures, to produce more wealth always required more people. Capitalism began, for the first time on a mass scale, to produce more with fewer people. We are nearing the end of that process. In all advanced economies, most of their manual workforce is now approaching redundancy for manufacture production. What's left of their jobs is being transferred to less developed economies with larger and cheaper reserves of labour, more recently driven from the land. We now have over 6bn people in the world, nearly all of whom will eventually enter this relentless progress toward redundancy.

At this final stage, we still have some value as consumers. In the age of commodity production, we were told that to save the nation, our duty was to work harder, spend less, and save more. Since the demise of manufacture, our duty has changed: to save the nation, we must still work harder, but only until our jobs can be done more cheaply somewhere else; from then on, our duty is to spend – to buy the goods now produced by poor people

This puts a preposterous question on the agenda: “What are people for?” It is Capitalist society’s failure to provide any consistent answer to this question which drives most of our unhappiness and some of our madness.

It is dangerous to generalise about mental illness, but for the 90% who have no chemical disturbance of brain function, what they need is not more biochemical tinkering, but greater understanding of our world and their own relation to it, so that they can begin to take an effective share in making a better future for us all. Some, indeed any, participation in struggle against what is irrational in our lives is our only rational means of escape. Not to any immediately different society, because that is not an option for the people we now have, but participation in struggle toward such a society for our children and our children’s children, learning as we go with sceptical humility.

That requires that we dare to emerge from about 30 years of political illiteracy, to rediscover the idea of true participatory democracy, rebuilding on deeper and wider social and material foundations than were ever possible before. What right do we have to be happy in a world of such growing extremes both of unhappiness, and of material capacity to relieve it, unless we play some part in ending this absurd situation? Only by this can we as an entire society begin to recover our mental health – not just for those identified as having a mental illness, but the much larger number of people who don’t yet admit their sickness or understand its cause.

Whatever else we may do, these should be our first steps toward the mental health we need to operate a knowledge-based and evidence-based economy with a rationally balanced product. True wealth will follow.

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