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Spotlight
Thought leadership and policy

Mental Health: The neglected crisis

Rachel de Souza
Rosena Allin-Khan MP
Richard Layard

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Quick fixes can't cure the NHS

One year into the pandemic, as experts and available data pointed to a looming mental health crisis, the government announced a recovery plan. According to the World Health Organisation, anxiety and depression had spiked globally by 25 per cent. The then health secretary Matt Hancock said that the government "not only [wanted] to tackle the public health threat of coronavirus but ensure our clinicians have the resources to deal with the impact on people's mental health".

The plan – part of which included an expansion of NHS talking therapies (Improving Access to Psychological Therapies services) with a £38m boost, and £79m for children and young people's mental health services – was worth £500m.

But the NHS reportedly spends four times that amount – nearly £2bn a year – on private mental health beds because there aren't enough in NHS hospitals. According to research by LaingBuisson, first reported by the *Guardian*, private mental health providers make 91 per cent of their income from the NHS, with profit margins at around 15-20 per cent. The report also noted that 71 out of 269 psychiatric facilities run by outside providers were deemed "inadequate" by the Care Quality Commission (CQC).

Using private providers for mental health treatment is not in itself a problem, as Paul Farmer, CEO of the charity Mind noted in his response to that report. Many sufferers access private care because of lengthy NHS waiting lists. But, he said, the fact that "providers who have been deemed by the CQC to be delivering inadequate standards of care" are providing services is "incredibly worrying".

Beyond care quality, though, the story is part of a trend of outsourcing to address pressures on the health service. In January, the NHS announced a three-month deal with "independent healthcare organisations" to fill staff shortages as the Omicron variant spread.

A major theme of the government's pandemic response was its reliance on private providers for essentials like personal protective equipment (PPE). But outsourcing will not fix staff shortages, structural issues or the legacy of austerity cuts. It looks like the government is moving away from privatisation, under some of the provisions of the Health and Care Bill. Certainly, if the government wants to meet the challenge of the mental health epidemic, it must do more than paper over the cracks.

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Spotlight

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First published as a supplement to the New Statesman of 13 May 2022.

This supplement can be downloaded from: newstatesman.com/spotlight/reports

A quarter of UK staff have missed a week of work due to stress

One in four British workers has missed a full week of work in the past year due to stress, anxiety or other mental health challenges, research from well-being platform Headspace Health has found.

Data was gathered from more than 500 CEOs and 5,400 full-time employees in the UK, US, Australia and Germany.

The research also found that nearly nine in ten UK employees (89 per cent) experience moderate to extreme stress at least once a week, and one in three feel their employer does not do enough to support them.

Across all countries, most workers believe their workplaces have reduced investment in mental health – seven in ten (71 per cent) say their company increased focus on mental health at the start of the pandemic but only a quarter say that this focus still exists.

There is also a disconnect between employers and employees around mental health provision – while 87 per cent of CEOs say it is easy to access mental health benefits at work, only 66 per cent of employees say the same.

Factors causing stress include Covid-19, workload, lack of staff, and poor management and leadership. More than a third – 36 per cent – said they are suffering burnout while a quarter said their stress was partly due to their manager.

Stress and burnout levels are particularly high in the NHS – data revealed to the *Observer* from 67 NHS hospital trusts shows that doctors and nurses took eight million mental health sick days over the past five years. This adds up to nearly 23,000 years.

Treatment backlogs, staff shortages, pandemic fatigue and overrun A&E departments are all contributing factors. There are currently 110,000 estimated NHS vacancies, and MPs have warned that staff are at "breaking point". ●

ANDRIUS KAZILIUNAS / SHUTTERSTOCK

NHS spends £2bn a year on private mental health beds

The NHS is spending £2bn every year for private hospitals to care for its mental health patients because it does not have enough capacity to deal with demand.

Independent mental health care providers now look after a majority (55 per cent) of children and young people who are hospitalised, with non-NHS operators earning £315m alone for treating under-18s, research from health market analysts LaingBuisson reveals.

More widely, the sector receives around 13.5 per cent of the £14.8bn NHS England spends on mental health.

Three for-profit operators, which make margins of 15-20 per cent – Cygnet Health Care, the Priory Group and Elysium Healthcare – and the charity St Andrew's Healthcare receive two-thirds of the total spending on private mental health care, according to a *Guardian* report.

The reliance on private beds comes despite concerning reports from the Care Quality Commission (CQC), which found that more than one in four non-NHS providers looking after under-18s were found to be "inadequate" since the start of 2017.

Over the past decade, mental health capacity fell as private bed usage increased. Between 2010 and 2021, NHS bed numbers dropped from 23,447 to 17,610, while private beds rose from 9,291 to 10,123 in the same period. ●

GPs say children's services are "unsafe"

With funding failing to meet demand, many children and young people are finding it increasingly difficult to receive help from the NHS's Child and Adolescent Mental Health Services (Camhs), research from the mental health charity Stem4 reveals.

A survey of 1,001 GPs across the UK found that 95 per cent think that services to treat children and young people's mental health are critically failing and have deteriorated over the past six years.

Many GPs have described their local Camhs provisions as "dangerous" and "unsafe". "It is just getting worse and worse," one GP told Stem4. Another said that a "patient needs to be actively suicidal to be seen".

A leaked report seen by the *Independent* also reveals that the NHS has paid out £20m in compensation due to clinical negligence in children's care over the five years to March 2020. The figure includes £3m for claims involving assault on patients by staff – the most frequent form of clinical negligence.

The stats: the impact on the NHS

55%

of children hospitalised with mental health issues are cared for by private health providers

8m

The number of mental health sick days taken by NHS staff over the past five years

5,837

The drop in the number of NHS mental health beds over the past decade

Mozilla raises privacy concerns over "creepy" apps

Mental health apps have a poorer level of privacy and security than other types of apps, according to analysis by the Mozilla Foundation, the not-for-profit organisation behind the Firefox web browser.

Researchers on the **Privacy Not Included* report gave 28 of 32 mental health and prayer apps tested a "privacy not included" rating and 25 failed to meet "minimum security standards".

"The vast majority of mental health and prayer apps are exceptionally creepy," said Jen Caltrider, Mozilla's **Privacy Not Included* lead. "They track, share and capitalise on users' most intimate personal thoughts and feelings, like moods, mental state and biometric data."

Six apps were flagged as being the worst offenders: Better Help, Youper, Woebot, Better Stop Suicide, Pray.com and Talkspace. According to the report, they have issues such as "incredibly vague and messy privacy policies" and share personal information with third parties, with one (Talkspace) collecting chat transcripts.

TIPPAPATT / SHUTTERSTOCK

Pregnant women and new parents struggling to access services

Two in five pregnant women and new parents say they have waited too long for mental health support, according to a survey by the charity Post-Natal Depression Awareness and Support (Pandas).

Demand for such services has risen by 70 per cent since before the first lockdown in 2020, in part driven by the lasting mental health impact of the Covid-19 pandemic and the current NHS crisis.

Annie Belasco, head of Pandas, said: "Lots of parents plan on having babies and they have a key... vision of what that would look like, but due to lockdown restrictions and the pandemic itself, that journey has been very, very different, which has impacted parents' mental health before they've even had a baby."

In a statement, an NHS spokesperson said that "every part of the country now has access to a specialist perinatal mental health service".

IMPACT ON THE ECONOMY

Richard Layard
Emeritus professor of economics at the London School of Economics

How poor mental health costs the economy billions

Why don't more employers invest in staff well-being?

Mental illness is the single biggest cause of misery in our society. It also wreaks havoc with the economy. We have to tackle it with better work practices and better access to treatment.

Roughly one in seven of all employees are living with a diagnosable depression or anxiety disorder. No wonder then that mental illness accounts for over 40 per cent of all sickness absence, as well as reduced productivity at work. The total output lost in the UK to such work-related issues is more than £100bn a year.

But much more serious is the suffering involved. So, what can employers do? When researchers study how happy people are during the day, work emerges as the least enjoyable activity on average. And the worst time of all is when employees are with their boss.

We need a revolution in management practice. Workers need to have much more influence on how their work is organised. Workers are 13 per cent more productive when they are happy, and research shows that managers play a crucial role in their employees' happiness, through instilling good work organisation (providing them with the guidance, tools and autonomy to do their jobs well) and psychological safety. Bonuses also need to be based on how a team performs – not on the horrible practice of forced rankings, where managers rank each worker and allocate their bonuses accordingly. When such performance pay was introduced to a group of Danish companies, 6 per cent more workers went on antidepressants or anti-anxiety medication.

Employers have duties to their employees as well as their shareholders. They can only know how they are doing if they measure the well-being of their workers on a regular basis and publish the results in their annual report. This should be a minimum requirement for

any company wishing to satisfy its social obligations in the environmental, social and governance (ESG) framework.

Morally, it is right to care for your workers – and it pays off too. For every £1 spend on mental health and well-being, employers receive an average return of £5. If you care for your workers, you provide a wholesome, friendly working environment, but you also care for them if they get sick. There are excellent treatments for depression and anxiety disorders. The National Institute for Health and Care Excellence (Nice) recommends specific psychological therapies, as well as medications. The NHS provides these treatments mainly through Improving Access to Psychological Therapy (IAPT) services across the country, and they should also be available through employee assistance (with shorter waiting times).

But how managers handle these problems is also crucial. It should be the line manager, not human resources (HR), that is trained to do this. Every line manager should be asking their employees if they are OK, offering help and advice, arranging time off, and allowing a graduated return to work once a crisis is over.

These very practical steps are essential elements in a social transformation where the goal for society becomes the well-being of the people. As the House of Lords Covid-19 committee has argued, we need to move from a welfare state to a well-being state. In the levelling-up strategy, the government has adopted the target of increasing well-being in every area of the country. Reducing mental illness at work should be a key part of that strategy.

IMPACT ON EMPLOYEES

Eugene Farrell
Chair of the Employee Assistance Professionals Association

The Covid-19 pandemic put employee well-being at the top of human resources (HR) priority lists: a healthy workforce was suddenly an imperative rather than a reason for introducing new perks. But despite the investment by employers, hard evidence on the impact of well-being spend continues to be scanty. If anything, problems with employee ill health – particularly when it comes to stress and mental well-being – have become part of the "new normal".

What we do have is evidence from the past few years of the use of employee assistance programmes (EAPs), available to around half of the UK workforce. According to Employee Assistance Professionals Association (EAPA) data from more than 3,000 employers, the pandemic led to a huge spike in the use of these schemes, providing examples of what happens when more employees get help.

The association's *Financial Returns on EAPs: the Pandemic Effect 2022* report estimated that around 347,000 additional employees turned to support from an EAP between October 2020 and October 2021 compared with previous years. For employers this also meant an increased return on investment (ROI), up to £8 per £1 spent (compared with £7.27 in the previous year's data). Returns come from direct cost savings due to reduced health insurance claims, and indirectly through lower sickness absence and improved productivity and performance.

Behind the numbers are some painful human stories. EAP providers universally have reported that the average call from an employee now involves more complexity; there are more people with multiple issues to deal with, often combining work, relationships and mental health. In turn, the demand for multiple sessions of counselling has grown. And this is where EAPs can deliver their benefits for both employees and their workplaces: by being holistic and dealing with that complexity.

Through the Covid-19 crisis, employees didn't have to depend on overstretched NHS services or physically going into a GP surgery. They could get immediate access to a professional who was able to help unpick bundles of issues (because so often mental ill health comes from a tangle of work stress, financial worries and their impact on both home and work relationships), discuss and signpost sources of practical help and provide a route to counselling in the short term.

Most importantly, EAP services aren't solely there to help people deal with ill health but to catch situations early – pre-empting stress, anxiety and depression. The focus is on building resilience among employees – the ability to bounce back from adversity, to keep going, to adapt and overcome – as a foundation of organisational resilience.

The lesson from the data on usage and ROI has been that businesses benefit from making a full commitment to mental well-being. Awareness campaigns and offering an EAP helpline as a last resort doesn't lead to the necessary change in attitudes and behaviours; employees need to feel able to ask for help more often, as a form of preventive healthcare. Employers should be engaging with their EAP, making sure promotions are proactive and targeted by benchmarking usage and impact, and making use of well-being data for management reporting.

KLAWE RZECZY

The stress disconnect

Perceptions of mental health provision in the workplace differ vastly between staff and CEOs

By Sarah Dawood

A hybrid working model may have freed many from the full-time shackles of the physical office, but it has not alleviated stress. The blurring of work-life boundaries and a heightened expectation to be "available" has created an altogether new version of presenteeism.

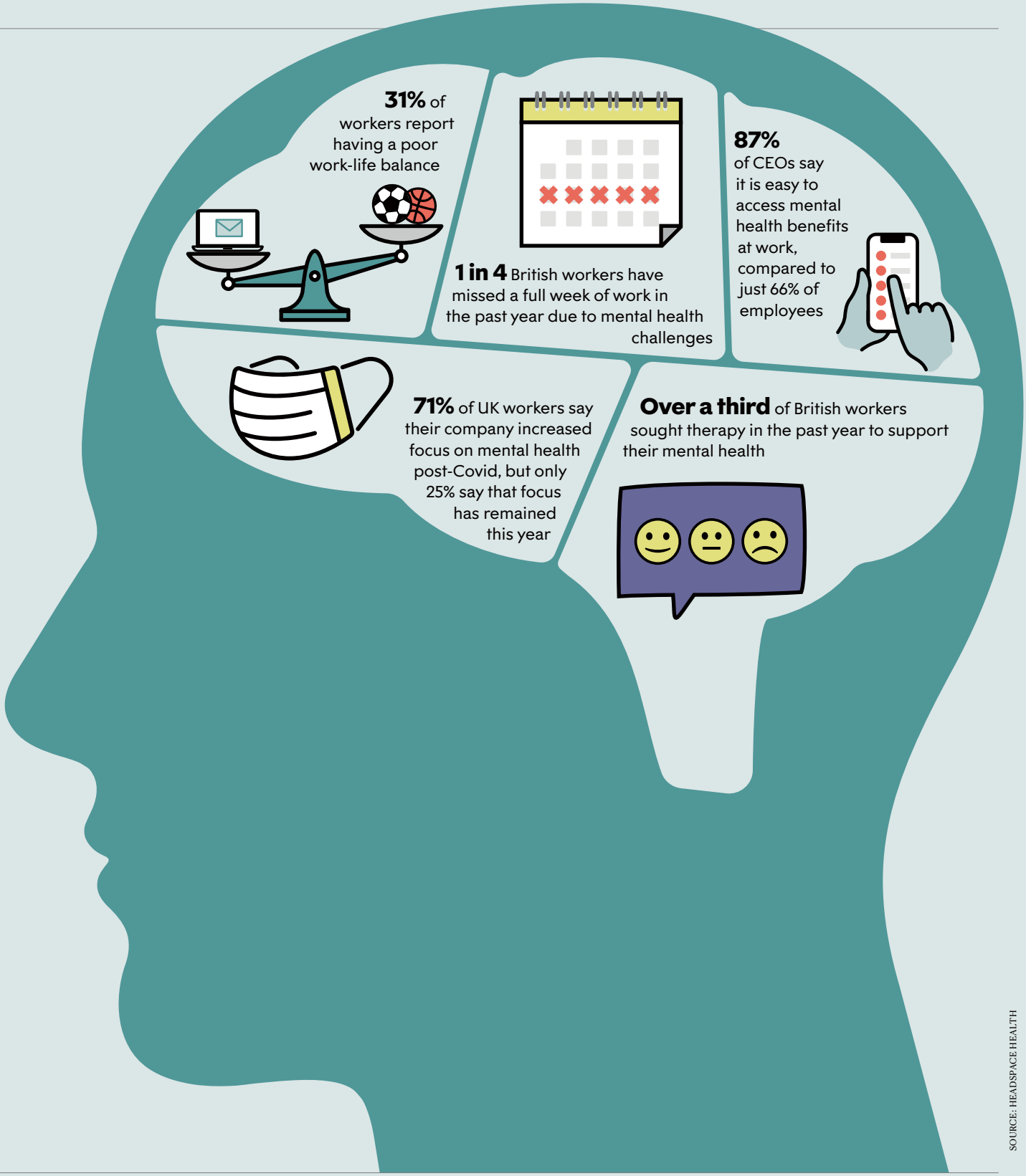
Indeed, a poor work-life balance is a major factor in the very high rate of UK employees – nine in ten – who say they experience "moderate to extreme stress" on a weekly basis. The figure comes from a study of 500 CEOs and 5,400 employees by mental health platform Headspace Health, which also found that one in four have missed a full week of work due to mental health-related absence over the past year. As labour economist Richard Layard explains (see pages 6-7), this is bad for the country as well as individuals, amounting to a £100bn annual economic loss.

Current societal issues are exacerbating the problem – the "Great Resignation" has caused nationwide staff shortages, while the ongoing cost-of-living crisis has inevitably led to more money worries, as wages fail to keep pace with consumer prices. Respondents cite being overworked and understaffed as a significant contributor to their stress, alongside financial concerns.

Through all this, one in three British workers feels their employer does not do enough to support them, according to the Headspace Health study. It found that the number of UK workers who believe their company prioritises mental health has dropped starkly since 2020, from 71 per cent to 25 per cent.

There is a clear disconnect in attitudes between staff and C-suite. While most CEOs (94 per cent) think they do enough to support their workers' mental health, only two-thirds (67 per cent) of employees agree. Managers are also benefitting more from available resources – nearly two-thirds of CEOs use their company's mental health benefits regularly, compared to a third of employees.

Perceptions are changing. The number of CEOs who feel comfortable talking about their own mental health at work has more than tripled since last year. But despite a more open national conversation around mental health, cultural attitudes of "keep calm and carry on" appear to persist in the UK. To empower more people to confront their workplace stressors, managers have a duty to create an open environment where they feel able to do so.



SOURCE: HEADSPACE HEALTH

It's not you – it's your toxic corporate culture

By Alona Ferber

In 2021, Microsoft conducted a survey which found that 40 per cent of the global workforce was thinking of leaving their jobs. In the UK, according to a study by Personio and Opinium, also conducted last year, 38 per cent of employees were considering calling it quits within the next six months. The "Great Resignation" had arrived, and employers were scratching their heads as to how to deal with the oncoming tsunami of roles to fill.

The Great Resignation overlaps with another key pandemic-era trend: a spike in mental ill health. In the first year of Covid-19, global rates of anxiety and depression increased by 25 per cent, according to the World Health Organisation (WHO).

Aside from Covid-specific triggers, such as social isolation, bereavement and fear of infection, a key contributing factor to higher levels of stress and poor well-being is, of course, work. We spend a third – or the commonly cited figure of around 90,000 hours – of our lives working and, as the economist Richard Layard points out (see pages 6-7), "when researchers study how happy people are during the day, work emerges as the least enjoyable activity on average. And the worst time of all is when employees are with their boss." Data from Headspace Health (see pages 8-9) shows that nine out of ten UK staff suffered extreme to moderate stress over the past year.

And yet, recent research indicates that working environments that contribute to higher levels of stress and unhappiness among workers persist across industries, even as openness about mental health increases. A study in the *MIT Sloan Management Review,* which attempted to unpack the reasons behind the Great Resignation, found that the top reason for staff handing in their notice was poor corporate culture. "A toxic culture," the study concluded, "is the biggest factor pushing employees out the door".

The term "toxic culture" is hard to qualify, but the study identified factors that commonly create such working environments, including: failure to promote diversity, equity and inclusion; staff feeling disrespected; and unethical behaviour.

The researchers analysed 34 million online profiles of US workers who had left jobs between April and September 2021. They found that such working cultures were far more influential in the rate at which people leave a company than other key metrics, such as salary and company benefits – the statistics show that a toxic environment is "10.4 times more powerful than compensation in predicting a company's attrition rate compared with [the industry standard]". This was followed by job insecurity and reorganisation, which was 3.5 times more powerful. The failure to recognise employee performance was only 2.9 times greater a predictor.

Employers, aware of rising rates of mental illness, are putting in place support for staff, such as running activities for Mental Health Awareness Week and providing counselling services. According to data from the UK Employee Assistance Professionals Association (EAPA) from more than 3,000 employers (see pages 6-7), the pandemic led to a "huge spike" in the use of employee assistance programmes.

But if a working environment is part of the trigger for employee stress, there is a risk that, while valuable, such measures will do little to address underlying problems. Employers must interrogate the structures and working practices that are driving the Great Resignation, both for the sake of their own productivity and for their employees' well-being. ●

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Fantastic mental well-being strategies and where to find them

Health insurers have developed tailored workplace support for businesses

By Paul Murray

In association with AVIVA

The Health and Safety Executive's annual report on mental health in the workplace makes for sobering reading. The most recent edition shows that 50 per cent of all work-related ill health absences in 2020/21 were caused by stress, depression or anxiety.

Research conducted on behalf of Aviva at the end of last year highlighted that 70 per cent of employers had seen an increase in employees with mental health conditions over the past three years.

However, in the workplace, one in five would wait for their employee to talk to them before they offered appropriate support and a similar amount say they wouldn't feel confident talking about mental health.

Think mental well-being and you'd normally think NHS, but in recent years you can also find helpful services embedded within workplace health insurance provision. Of course, workplaces come in all shapes and sizes. For the UK's 5.6 million small to medium-sized enterprises (SMEs), challenging issues such as growth, revenue and the fuel crisis dominate today's agenda. In the current climate, a workforce mental health strategy is, for many, low on a list of priorities. And yet, mental well-being should be seen as an integral part of business culture to aid staff retention, motivation and morale.

Delivering a strategy and well-being options

What are the concerns of SME businesses when it comes to mental health and what do insurance companies find that they want? The first thing SMEs usually request is general guidance around a strategy. Unlike their large corporate counterparts, most SMEs don't have a dedicated resource for mental health or an extensive human resource function, so knowing where to start can be the most challenging step. Having a strategy helps.

Next, offering SMEs options can help to get the ball rolling. This might include well-being check-ins, line manager training, mental health "ambassadors" and "first-aiders" and providing staff awareness training. That's the infrastructure, but it's at the line manager level where it really counts.

No one can force employees to get help, but line managers can be there if employees change their mind. Employers

can address this by ensuring clear and helpful signposting is in place. This might be regular company-wide reminders of the well-being services available to them, possibly via email, posters, a company intranet or from leaders at team meetings. For new starters, the workplace environment won't be familiar and these employees may need support to feel comfortable in a new job. This could include launching a buddy system, so new joiners have someone within the team they can talk to, and ensuring that a strong communication plan is in place so that employees know what to expect.

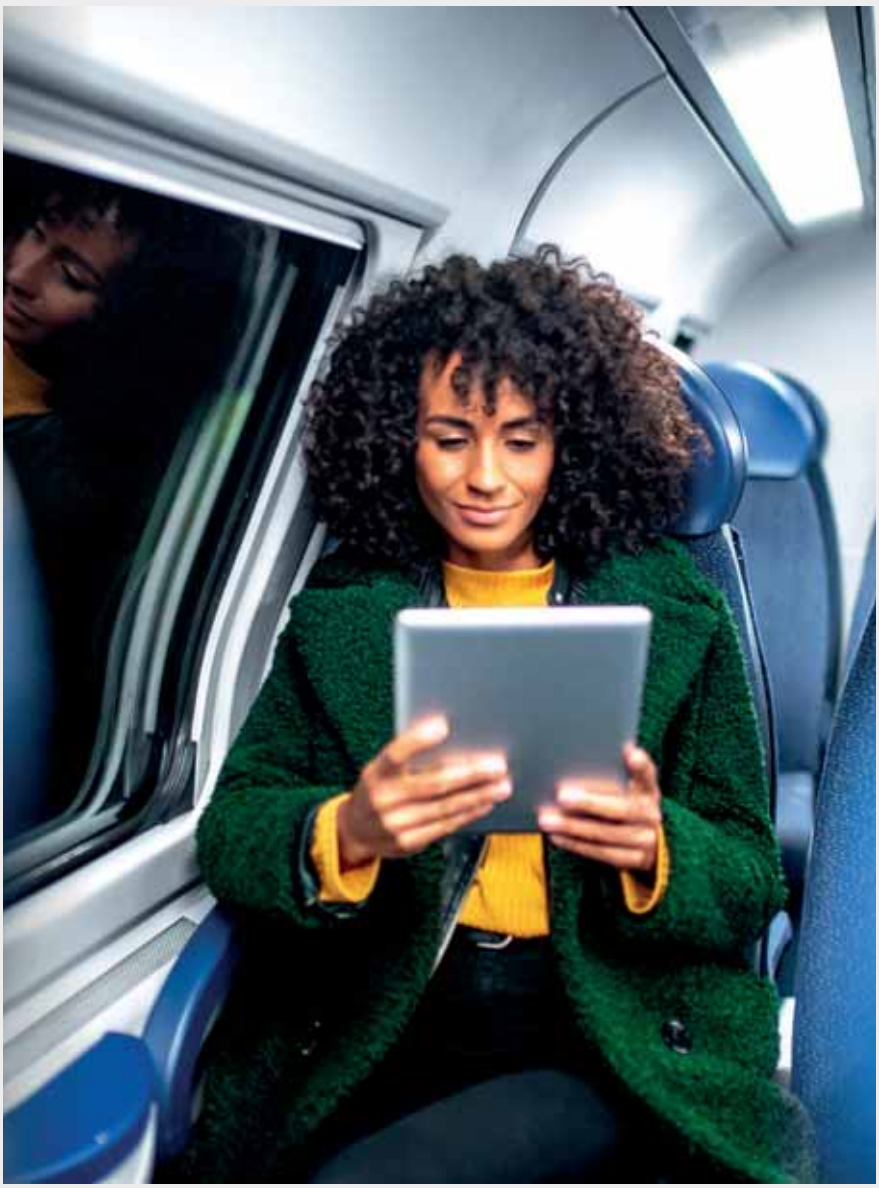
For many service sector workers, the post-pandemic workplace might look and feel different. There may be new homeworking patterns and more flexibility. It's important that employers remind employees of the social well-being benefits of being back in the workplace so that it's seen as a place for collaboration and mentoring. It's also important to help them to build a return-to-work plan that works for them.

What we've delivered for businesses

As a major private sector health insurance company, Aviva is committed to helping drive positive change in the workplace and frequently shares its knowledge and insights to help organisations support employee mental well-being.

More recently, we introduced expert-led mental health training, specifically aimed at line managers in SME organisations who didn't have access to the breadth of support that larger organisations can often benefit from. The training was in a series of webinars, which provided a unique insight into the challenges SMEs face and the support they need when it comes to mental well-being.

Our Digital Line Manager Toolkit – Mental Health offered line managers online training modules developed in conjunction with our mental health pathway provider. Over the past year, we've complemented the online modules and enhanced our employer support through the introduction of a regular webinar programme. The events are designed to educate our corporate customers and empower them to make positive changes to improve health and well-being in their organisations. We then share comprehensive Q&A documents and best practice guides to support them. That's just one example of what we recently achieved.



MSTUDIOIMAGES

Different needs for different businesses

Different businesses will naturally have different needs when it comes to mental well-being. For businesses that are run solely online, this can mean that working collaboratively from an office may not be an option, but providing access to online resources may help.

Even if there is no dedicated office space, having regular catch-ups in person will help employees to come together. For example, meeting for breakfast or coffee in a local cafe is a great informal way to speak with employees and support local businesses, without high costs. Maintaining good mental well-being requires constant engagement and should ideally be a permanent priority for businesses of all shapes, sizes and industries.

In a perfect world, employers should focus on creating a positive culture around mental health, equip line managers with the skills to identify risks, and ensure resources are appropriately signposted for employees so they're accessible when needed most. In the insurance world, we're getting there. ●

Paul Murray is clinical consultant, well-being and rehabilitation, at Aviva

Wounded healers

How clinicians with lived experience of mental illness bring value to the profession

By Samir Jeraj

In the late 1990s, when she was training to be a GP, Rebecca Lawrence "became unwell very quickly". Newly married and with a baby on the way, she was diagnosed with psychotic depression and later bipolar disorder. She would spend the next two years in and out of hospital.

It was a difficult time, being a new parent and undergoing treatment. Following her recovery she went back to train as a GP, but then she decided to become a psychiatrist.

"Those first years were extremely difficult. At the time, I just thought I have to do this," she tells *Spotlight*. She found it challenging to deal with people who reminded her of herself. "You can't help, I think, but compare your own experiences [to theirs]," says Lawrence, who now specialises in addiction and substance misuse.

Mental health campaigners have long advocated the importance of listening to patients as voices of "lived experience", with mental illness sufferers encouraged to take up roles such as peer mentors and support workers, where their experience can help others. That openness rarely extends to more clinical roles, however, despite research estimating that 45 to 75 per cent of mental health professionals have used mental health services.

"I like talking about it because I think stigma needs to be broken down," says TS, a mental health support worker. TS had a high-flying career working for a large international pharmaceutical company and went on to set up his own business. "To say that I had a bad work-life balance is probably the best way to put it," he recalls.

The 20-hour days, bad diet and intense lifestyle eventually caught up with him. "It all kind of came crashing down really and I went into mania," he says. "It was a happy mania, like I wasn't sleeping for days on end." A friend of a friend called the police, who were "very, very rough", he recalls, and the experience tipped him from "happy mania" over into a "florid psychosis".

He was detained under the Mental Health Act and given a diagnosis of bipolar disorder. The medications he took over the next two years did little to help, plunging him into a suicidal depression along with other side effects. Eventually, he was able to start taking charge of his recovery. Better

sleep, a healthy and nutritious diet, and exercise all had a profoundly positive impact for him.

"Once the medication has done its job, I think, then something else should take over. And that's how I tried to work. I've seen great successes with people," he says. He doesn't tell every client about his experiences, but, he notes, sometimes it unlocks the relationship "because there's always a dynamic of professional and service user".

Ahmed Hankir, a psychiatrist, performs a one-person show using his experiences as a patient to tackle stigma. It's called *The Wounded Healer* after the archetype used by Carl Jung to describe analysts who are compelled to treat others because they themselves are "wounded".

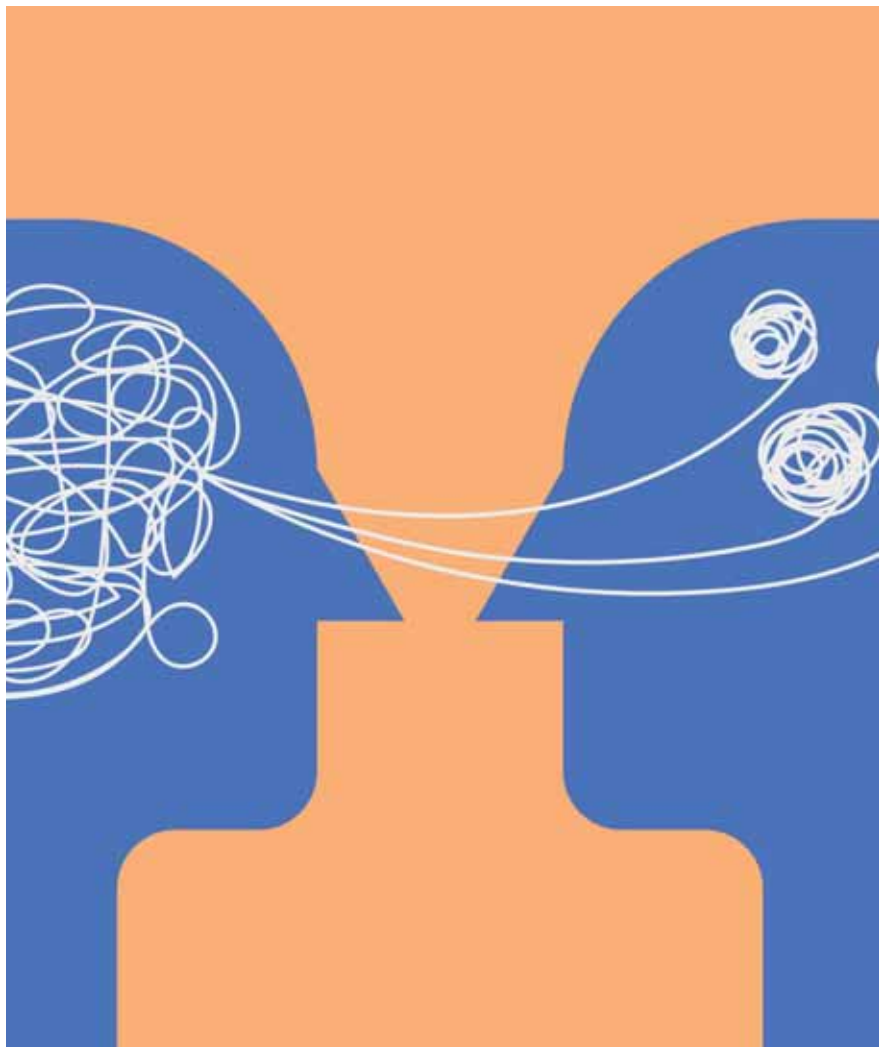
"I always wanted to be a doctor; I didn't always want to be a psychiatrist," says Hankir. His parents migrated to Belfast from Lebanon in the 1980s at the height of the Lebanese Civil War, but it was the 2006 conflict between Israel and Lebanon that turned the then medical student's world "upside down".

"I saw harrowing and horrific images of dead bodies," he recalls. This was the trigger, but not the only factor, for an episode of "psychological distress". Although his recovery was a long and painful process, he never gave up on his medical studies. "Debilitating though the symptoms of psychological distress are, it was the stigma that was far worse," he says.

"The moment someone labels you as having a mental health condition or mental disorder, then it feels like people blame you and not the system," Hankir says. Structural factors such as racism and discrimination, or interpersonal issues like bullying and harassment, are downplayed, he says.

"I felt suicidal," he continues, something that is taboo both in society at large, but particularly, he adds, in the Muslim community to which he belongs. "I think for a long time I was in denial," he says. It was his imam who persuaded him to seek professional help, and Hankir credits his faith as playing an important role in his recovery and ongoing resilience.

The profession "must listen" to people receiving psychiatric care, says Hankir. "We must... amplify their voices and consult them for advice on how to design, develop and deliver better mental health care".



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Lived experience can "enrich practice", the British Psychological Society states

The profession has started to recognise the value that mental health professionals with lived experience bring to their practice. In 2020, the clinical psychology division of the British Psychological Society issued a statement highlighting the "unique and valued contribution" of clinical psychologists living with mental health difficulties. Lived experience "can help to enrich practice and improve service provision", it said. The American Psychological Association recently published a special edition of its journal with a focus on clinicians with lived experience of mental ill health, noting the challenges of stigma and bullying for clinicians who are open about their health histories.

Meanwhile, in the Netherlands, the mental health system incorporates more of the "experiential knowledge" of clinicians. While the hypothesis that openness improves patient-clinician relationships and care in mental health is still the subject of research, there is evidence that it improves the attitude medical students have to mental illness.

Lawrence is now a senior consultant. She also gives talks to trainees about her experiences in an attempt to break some of the stigma around mental health.

"I was inspired to do it by my colleagues in addiction, who quite often will tell their stories," she says. Lawrence still comes across people who remind her of herself, and her experiences do inform her work, but they are not something she would disclose to a patient.

"The one thing that I think one has to be very careful with," she says, "is not to assume that your experiences are like anyone else's... You shut everything off with that."

Comment

“Children have sacrificed so much – we must prioritise them”

RACHEL DE SOUZA

By Rachel de Souza

On taking up my post as children’s commissioner for England last year, the first thing I had to do was listen to England’s children about their lives today – their aspirations, and how the pandemic had affected them. That’s why I launched The Big Ask – and I was overwhelmed by the response: over half a million children replied, making this the largest-ever consultation of children in England.

Reassuringly, despite the Covid pandemic, the majority of children are happy with their lives. Eight out of ten children told me they were happy or OK. They are an ambitious and passionate generation, optimistic about the future. The majority felt they would have a better life than their parents, and their top priority is to get a good job. They also want to change the world and make a difference on issues like climate change and building a fairer society.

To help them achieve these dreams, it is our responsibility to provide them with the support they need to have a good childhood and a successful future.

Children were very aware of the importance of good mental and physical health. But one in five said they worried about their mental health, and for older, teenage girls, this rose to two in five.

I have made it my mission as children’s commissioner to make sure I am advocating for these children. I have used my unique data-gathering abilities to ask the NHS how much it is spending on children’s mental health and about children’s access to care.

In recent years, good progress has been made to increase access to mental health care for young people. Spending has increased, tens of thousands more children are accessing treatment, and new waiting time targets and services have been introduced. Mental Health Support Teams are being rolled out in schools and more areas are providing access to support online. NHS England has an ambition to ensure that all children who need specialist care can get it by 2028/29.

But the pandemic has taken its toll on children’s mental health, and that makes this ambitious goal even more challenging. The pandemic saw demand rising – the NHS statistics show that the

The pandemic has taken its toll on children's mental health

LEON NEAL / GETTY IMAGES

number of children with a probable mental health disorder has jumped from one in nine before the pandemic to one in six.

Alongside this, the pressures of the pandemic have impacted children accessing care, with a sharp drop in referrals. Only around a third of children with a probable mental disorder are accessing treatment. Across the country there is also far too much variation in how easy it is for children to access the care they need.

In their responses to The Big Ask, children spoke of their frustration at not being able to access this support. They often simply need someone to talk to as problems emerge – someone they trust and who has the capacity to listen. Time and again, we have heard from children who say that if they had support early enough, they would not have reached a crisis point later.

Children tell us that they really want support in school, and research shows that children are more likely to talk to a teacher than any other professional when they are concerned about their mental health. We need to support schools to know how to promote good well-being, to adopt a "whole-school approach" to mental health – covering it effectively in the curriculum and all policies and procedures. Mental Health Support Teams should also be expanded to every school, with joint training for school leaders and NHS professionals so that those with more severe clinical needs can get help within school and referred on to the right specialist treatment.

We need to change the system to invest in the right support, in the right place, at the right time. It is great to see more local NHS services spending their budgets on mental health, but we need to see more of them going further to help more children access care and support.

For children who are absent or not in education, support through school is not the right approach. It is also important that there are other ways for children to access early support, either online or through a drop-in centre in the community, rather than simply joining a waiting list for an NHS clinic.

For children with problems that are just starting to emerge and for those with clinically diagnosable conditions we need to reimagine children's mental health services to make them much more accessible to young people – and that means a clearer national offer for online and community support. There are some excellent examples of best practice, such as community hubs in Manchester as well as in Lambeth in London. What is needed now is a higher level of ambition so that every area in the country can learn from the best.

It is also important that children who hit crisis point have quick access to high-quality care. NHS England has started the process of introducing new access and waiting time standards for crisis care and for improving the quality of inpatient care. There is a long way to go to improve this care and this work must continue.

Now is the time to refresh the plans to reform children's mental health care and set a new level of ambition. Children have sacrificed so much during the pandemic to keep us all safe. That's why I have prioritised making it my mission to shine a light on this important topic and to ensure that every child gets the care they need when they need it, no matter where they live in the country. ●

Rachel de Souza is the children's commissioner for England

The unacknowledged epidemic

Sexual violence haunts survivors long after the event. Are health services equipped to cope?

By Zoë Grünewald

Eighteen months after a stranger subjected Lucia Osborne-Crowley to a violent sexual assault at the age of 15, she started experiencing severe abdominal pain. Following ten gruelling years of surgical procedures and tests, the Australian writer and journalist was eventually diagnosed with endometriosis and Crohn's disease.

Around this time, she opened up to her doctor about the rape. In her book *My Body Keeps Your Secrets*, Osborne-Crowley describes the disclosure as a "house of cards" that "began to fall, slowly at first and then very, very quickly". Her doctor promptly linked her symptoms to the sexual assault, and she began physiological treatment with psychological therapy.

"I really think this is something we as a society need to understand a lot better," she tells *Spotlight*, "this differentiation between psychological symptoms of trauma and the physical symptoms of trauma [is] such a fine line, because they interact with each other."

In recent years, society has been confronted by just how common sexual violence is. The "Me Too" movement, from 2017 on, and the Everyone's Invited revelations by schoolgirls around the UK last year, triggered a public conversation about the culture of silence and shame around sexual assault, abuse and harassment, the majority of victims of which are women.

The exact extent of sexual violence in the UK is hard to gauge. According to the Crime Survey for England and Wales as many as one in four women will experience rape or a serious sexual assault in their lives. A harrowing report from Ofsted in June 2021 estimated that as many as 90 per cent of girls had experienced some form of sexual harassment. By the time women reach the age of 24 that figure is as high as 97 per cent.

The traumatic effects of sexual violence are often misunderstood. The NHS's *Strategic Direction for Sexual Assault and Abuse Services* acknowledges the "damage and devastation" that sexual violence can cause, but makes scant reference to the more complex physical and emotional symptoms of resulting trauma.

But, as Osborne-Crowley's story highlights, unacknowledged trauma can present in complex ways. Markus Reuber is a professor of clinical neurology at

As many as one in four women will experience rape or serious sexual assault in their lives

HOLLIE ADAMS / STRINGER / GETTY

Sheffield Teaching Hospitals NHS Foundation Trust, and a world-leading expert in non-epileptic attack disorder (Nead). He focuses on the link between physical symptoms that present to neurologists, such as non-epileptic seizures, and the mental health causes of these symptoms.

"We are increasingly aware of physiological links between a lot of traumatic experience and health consequences in later life," says Reuber.

Somatisation – a term that encompasses functional neurological disorder – is the conversion of psychological concerns, such as trauma, into physical symptoms. It is not mentioned in the NHS strategy, much to the dismay of Reuber, nor is the difficulty of discussing traumatic events.

Suppressing memories of trauma is often the only way to live with them. A 1994 paper published in the *Journal of Consulting and Clinical Psychology* demonstrated how common it is for people to repress sexual abuse. In a study where women were sexually abused as children, 38 per cent of the survivors had forgotten their abuse two decades on.

The denial of a memory does not mean that the body has forgotten the abuse, however. Reuber explains: "Long-term effects on how the body and brain respond to their environment may be caused by experiences that cannot be recalled. Trauma can be 'stored' in the body in different ways – for instance, in the brain's basic level of arousal, persistent activation of the body's immune system, changes in how the brain's endocrine system responds to stressful events, and which bits of the genetic code in the cells of our body are activated."

Aimee Morgan-Boon, a specialist psychotherapist in neurology based in Sheffield, works with patients who have functional neurological disorder, a condition "whereby the patient has neurological symptoms, and what appears to be organic illness, but it's not caused by any disease". Instead, difficulties with emotional processing interrupt messages the brain is receiving from or sending to the body, and may result in symptoms such as seizures, physical pain, paralysis and impaired vision. Often, Morgan-Boon tells *Spotlight*, this condition is caused by trauma – and most of those patients are women with sexual trauma.

"It's very difficult to quantify because so much of it is unspoken and undisclosed... in my work, it feels like the vast majority of women that I see have experienced sexual violence," says Morgan-Boon.

Often her patients have no memory of a traumatic incident, but ▸

◂ Morgan-Boon is trained to spot the kind of symptoms that may be indicative of somatisation. "This kind of dissociative response is a reflection of what happens during sexual trauma. Because it's intolerable to the psyche on many levels, people kind of switch off... there's a part of the self that holds that traumatic memory and the person isn't necessarily consciously aware of it."

She emphasises that sometimes the patient may never recover the traumatic memory, but that treatment is still possible. "The very fact that they're having that kind of attack suggests that they are not able to tolerate the memory... but work can build up their tolerance to experiencing emotion, to the point they can regulate it," she says.

Morgan-Boon explains that for some patients their memory never returns. "If it doesn't, then that's the way it needs to be," she says.

Marian Peacock, a lecturer in public health at the University of Sheffield, worked as a clinical practitioner for 16 years in a mental health counselling service where she saw how "widespread experiences of sexual abuse and sexual violence were among women". She developed the kind of interview techniques that are helpful for getting patients to open up in situations where they either can't acknowledge their trauma or won't.

Much of Peacock's research has highlighted the "enormous social gradient" around trauma, including "a link between poverty and the incidence of sexual abuse, particularly among girls". Peacock believes that shame and stigmatisation are also factors in women's acknowledgement of trauma.

"You don't necessarily see things as traumatic, and that's putting it bluntly... there's so much crap in your life and the lives of those around you, it seems normal," she says.

Morgan-Boon concurs: "Sometimes they don't identify it as trauma or abuse, particularly where they've grown up in a culture where violence from men towards women is experienced as the norm."

This social disparity can play out between the patient and doctor. Due to this correlation between socio-economic circumstances and trauma, conflict can emerge between the middle-class, highly educated practitioner and a socially disadvantaged and sick patient. One doctor, who wished to remain anonymous, explained that he had to caution his staff in South Yorkshire for using the phrase "normal for Barnsley", when referring to patients who had functional neurological disorder.

Peacock points to a 2007 study in the *Journal of General Internal Medicine*, by psychologist Peter Salmon, which showed that some GPs actively disengaged from patients with chronic pain. In the paper, one GP describes patients as "pestering" and "dependent". Reuber has come across practitioners resorting to pejoratives when referring to somatisers, such as using the term "pseudo-seizures", implying the disorder is made up and the patient unreliable.

And he emphasises that if a patient is presenting with physical pain, it is rare that a GP would associate this with trauma. As Peacock explains: "There isn't the training – people don't know about it, and even if there was the training, people don't know what to do with [the patients]. Where do you send people?"

Even when trauma is suspected, eliciting admissions of past trauma is hard, especially when patients are not aware of it themselves. "Do you give people a questionnaire? Do you interview them? Do you interview them twice? Do you give them time to reflect?" asks Reuber.

Peacock and Reuber believe that the NHS, in its current form, is poorly equipped to deal with the issue. For Peacock, there are obvious resourcing and funding issues, but the issue also highlights the difficulty of accessing mental health services without a diagnosis.

"It has to be a diagnosis of a [psychiatric] thing, an illness or an event... We can't seem to find a way of legitimising and validating the aftermath of suffering without giving it some medical name, and a medical name is a prerequisite to accessing services," she says.

> "Trauma can be 'stored' in the body in different ways"

Reuber emphasises that even with a diagnosis, trauma services in the UK are "non-existent".

"If you wrote to all the CCGs [clinical commissioning groups] in the country and asked them 'do you have a trauma service', they would almost invariably say 'yes we do'. But the reality of it is that trauma services are completely inadequate," he says.

Spotlight understands that the NHS is developing new support services for those living with complex trauma as a result of sexual assault and abuse, which will launch within the next two years. The Department of Health and Social Care is also investing £2.3bn into mental health services as part of the NHS Long Term Plan, while the new Health and Care Bill and this year's upcoming Women's Health Strategy will include support for victims of violence and abuse.

Often, Peacock says, patients "don't want to hear a psychological explanation". This can act as another barrier to treatment. "They want to be told they've got a physical condition that can be treated and will be seen as legitimate," she says. People with functional neurological symptoms have "incredibly difficult lives of both physical suffering and largely speaking, emotional dismissal", and when functional neurological disorder is suggested, many patients hear that they are "faking it".

"It's a very hard thing to convey to people in a way that doesn't make them feel that what you've just said to them is it's all in their head," she adds.

Osborne-Crowley wishes she had known more about the relationship between the mind and body. She sees a role for schools in teaching this to ensure "much earlier interventions" so that someone like her "doesn't have to be living with chronic trauma symptoms for ten years".

"We need to start thinking about health and bodies when we're really little, to stop splitting mind and body," says Peacock. "That has to fundamentally change right across society, because all we do is shovel that problem into GP surgeries and expect GPs to resolve it."

As with any health issue, of course, prevention is better than cure. Sexual violence is a product of patriarchy, says Morgan-Boon. Men need to be taught that this "behaviour is not OK, and it has long-lasting impacts on women". ●

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Legislation

How the Mental Health Act perpetuates systemic racism

Black people are four times more likely to be held in hospital against their will

By Sarah Dawood

In April 2021, Hannah was pinned down and restrained by six male staff at a psychiatric hospital. She was left traumatised.

"It was horrendous," she tells *Spotlight*. "I had nightmares about it for weeks on end. I remember curling up in the foetal position on the floor and crying myself to sleep. I didn't leave my room for two days. I couldn't move, I couldn't eat."

This was the second time Hannah, a 22-year-old mixed-race woman, had been physically restrained while detained on a mental health ward. She was also subjected to chemical restraint, by being injected with a sedative.

Both times, Hannah had already been extremely mentally unwell. Staff had restrained her after she attempted to harm herself by strangulation with a ligature. "Staff said they shouldn't spend time verbally de-escalating me because I'd 'probably turn violent' or 'I may hit them'," she says. "But I've honestly never shown an ounce of aggression."

Since 2019, Hannah has been sectioned six times by the police and healthcare professionals, once being detained in hospital for 45 days. She lives with borderline personality ▸

◂ disorder, anxiety, depression and post-traumatic stress disorder. Prior to being sectioned for the first time, she says that she had repeatedly asked her GP for help.

She has now been able to start an 18-month therapy programme. "I had been asking for therapy for [four] years and had contacted my local MP. I'd been in hospital ten times before I was offered it. One of my [white] friends was offered it after her first admission," she says.

From what she has seen as an in-patient, black and mixed-race people are vastly over-represented on mental health wards, will be detained for longer, and are treated more brutally. "I've been on wards where black men have died after being held down for too long or injected too many times," she says. "It's soul-destroying. Someone comes in for help and they leave in a body bag."

Hannah's story reflects a pattern of systemic racism across NHS mental health services that is borne out by available data. The Mental Health Act 1983 provides powers to section people against their will if they meet the necessary criteria following assessment by a team of health professionals. This includes if their safety or someone else's safety is at risk, if a doctor thinks they could get worse if they are not admitted, or if they have started new medication and need to be monitored. Official data shows that black people are over four times more likely than white people to be sectioned and detained under the act, subjected to restraint and held in isolation. They are also over ten times more likely to be subject to a community treatment order (CTO) – supervised treatment in the community where you could be returned to hospital if you do not uphold set conditions.

This trend is indicative of similar discrimination across wider society: black people are nine times more likely to be stopped and searched by police. Between 2008/9 to 2018/19, they accounted for eight per cent of UK deaths in police custody, despite only making up three per cent of the population. The recent case of Child Q, the 15-year-old who was strip-searched at her school after a teacher wrongly assumed she had cannabis, demonstrates the vulnerability of children to such systemic prejudice.

Many mental health patients end up in A&E due to long therapy waiting lists

Campaigners have long called for change, and an independent review led by psychiatrist Simon Wessely concluded in 2018 that the act was desperately in need of reform.

Wessely, who has conducted psychiatry research since the 1980s, acknowledged in his review that people of black African and Caribbean heritage have consistently been over-represented in terms of detentions and certain mental health diagnoses, such as schizophrenia. "Now 30 years later, it is sad to record that little has changed," he wrote. "There does appear to be more consensus that this... is related to experiences of discrimination, exclusion and racism."

He stated that while there will be times where it is "reasonable to make a temporary infringement of liberty and autonomy", the mental health profession has an obligation to ensure its interventions do not make people worse, that "more are made better" and that "all have their dignity respected".

The review's recommendations centre around safety and autonomy. "Patients must be supported to make choices for themselves," Wessely wrote. It also includes proposals around reducing the use of force, ensuring treatment provides therapeutic benefit, and treating people as individuals by providing more tailored care. Suggestions included: new rights of appeal against compulsory treatment, such as better access to tribunals; the creation of "advance directives" (where patients can make decisions about their treatment in advance); safeguards such as rules around length of detention and better oversight by the healthcare regulator, the Care Quality Commission; improved access to long-term support; and greater representation of black people working in mental health.

Last year, the government published a white paper saying that it would take forward "the vast majority" of the review's recommendations. It will also use evidence gathered from a consultation that took place in 2021 with patients and experts to reform the act. The government is yet to confirm when the revised bill will be introduced.

Exacerbated by the pandemic, NHS mental health services are under immense pressure with growing waiting lists, a lack of funding, and a record 4.3 million referrals in 2021. According to the Royal College of Psychiatrists, one in four people with mental health problems waits at least three months to start NHS treatment, and two-fifths of patients who are waiting end up contacting emergency services. The NHS also reportedly pays £2bn a year to private hospitals for mental health beds because it does not have enough.

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But discrimination starts long before patients reach the hospital. Resource scarcity coupled with unequal access to services means that many people like Hannah are often extremely ill by the time they receive care. The government has committed £2.3bn per year, starting in 2023 to 2024, towards providing earlier support to prevent people reaching crisis point, as well as alternatives to detention, quicker discharges and improved community care. A new ten-year mental health plan is also in development.

After years of lobbying from campaigners, the government has also changed laws around the use of life-threatening restraint methods. The new Mental Health Units (Use of Force) Act – better known as "Seni's Law" after Olaseni Lewis, a black British man who died after being restrained by 11 police officers in 2010 while in a hospital mental health unit – aims to curb the use of unnecessary restraint by holding staff to account. Under this legislation, mental health units have to provide training for staff, keep records on the use of force and publish annual statistics, and make patients aware of their rights. Police officers going into units must also wear body cameras.

The Department of Health and Social Care's newly created Office for Health Improvement and Disparities also aims to "break the link between background and prospects for a healthy life", says Gillian Keegan, minister for mental health. "We know disparities exist in mental health," she tells *Spotlight*. "I am working to bring [laws] into the 21st century and ensure [they] help everyone get the best possible care."

Shadow mental health minister, Rosena Allin-Khan tells *Spotlight* that the government should also speed up NHS reform through the roll-out of the Patient and Carers Race Equalities Framework – a new competency tool that will help mental health trusts provide better and more nuanced care to ethnic minorities. "There must be culturally appropriate services and the freedom for local areas to look at their specific populations [to develop] suitable approaches," she says.

Hannah agrees that patients cannot be treated as a homogenous group. "A black person might be more unwell because they've dealt with something alone for so long," she says. "They might be angry because no one has listened to them. Different communities need different care."