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Psychiatry, homeless patients and welfare reforms: Historical links and chains

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Abstract

The birthplace of the specialty of psychiatry was in the asylum, which was created to divert patients from workhouses where the most disadvantaged and destitute people with mental illness were to be found. The current welfare reforms are endangering the welfare and livelihood of the most disadvantaged of our patients. These reforms in the authors' opinion are related more to the historical cycle of societal attitude to homeless people than to seeing them as the undeserving poor. This is particularly true since the current economic crisis was not caused by the poor, so it is very unfair that our poorest patients should suffer most as a result of the welfare reforms.

Keywords

Homeless people with mental health problems, severe and enduring mental disorders, disability, welfare reforms

Homelessness and destitution are caused mainly by housing shortages, unemployment, and inadequate financing of housing and community services. Throughout history, homeless mentally ill people were seen and labelled in different ways that mostly showed them to be an 'undeserving' cause. For many centuries these poor people were seen as, at best, spiritually weak and, at worse, evil (Abdul-Hamid, Wykes & Stansfeld, 1993). During the 1980s and part of the 1990s, politicians favoured linking homelessness to de-institutionalization and community care. In the US, for example, George Bush Senior said that mental illness was the 'principal cause of homelessness' while Roland Reagan claimed that a 'large' percentage of the homeless were former mental patients (Hartman, 1984).

Many well-designed studies in the UK found that few of the mentally ill discharged from mental hospitals ended up homeless (Leff, 1993) and that homelessness is largely the cause rather than the result of mental ill health (Abdul-Hamid, 1991; Westlake & George, 1994). The British Association of Social Workers in a 1985 report showed the actual cause of the problem then: 53% of all repossession orders were where the owner had a local authority mortgage. Between 1978 and 1985 there was a shortfall of 750,000 new homes due to inadequate government spending on housing programmes (Clode, 1985).

Since the last half of the 1990s political attitudes have changed again under the influence of the far-right social scientists like Charles Murray in the US. On anecdotal evidence, these intellectuals blame much of society's ills on the poor and on the welfare system that supports them. Different political parties on the left and the right were influenced by the right-wing media that started to see the remedy for society's ills to be reform of the welfare system because it was creating a class of unemployable persons, drawing on the philosophy of the earlier poor laws (Murray, 1996). Murray used the example of poor unemployed women who see getting pregnant outside marriage as an alternative to looking for a job. He stated that the child of a 'welfare mother' 'provides her with economic insurance that a husband used to represent' (Murray, 1984, p. 161). He suggested in his book that the welfare system is responsible for all the pathologies that made the 'underclass' including non-marriage, illegitimate children, crime and homelessness.

Welfare reforms started long before the current economic crisis (Brindle, 2007). However, since the economic crisis, welfare reforms have been seen as the solution to this crisis. The way these welfare reforms are being conducted may betray poor and destitute psychiatric patients at risk (Wintour, 2010a). Mangalore and Knapp (2007) have estimated the total cost of patients with schizophrenia (who constitute 10% of the totally and permanently disabled population) to the taxpayer in England as £6.7 billion for

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the year 2004/05. The direct cost of NHS treatment and care of this amount was about £2 billion. The NHS costs produce an economic burden of indirect costs to society of nearly £4.7 billion. A great proportion of this sum (around 62%) was related to the welfare benefits received by patients with severe and enduring illness. The Royal College of Psychiatrists' (RCP, 2010, p. 19) statement on the government white paper 'No health without public mental health' suggested that the total cost was estimated to be around £105 billion, of which £10 billion is direct NHS spending.

Clinical complexity

One of our patients has recently highlighted the disability associated with the negative symptoms of schizophrenia. When voluntary work was suggested as a way for rehabilitation, her reply was: 'I am just managing to look after myself and my cat with difficulty.' The burden of negative symptoms in schizophrenia is well known in psychiatry and should be included in the ability-to-work assessment of the benefit agency (Mortimer & Spence, 2001, p. 38). Similarly depressive disorders are considered the most disabling illness in the developed world (through the WHO Global Burden of Disease Study (Murray & Lopez, 1997)).

The current opposition of the Labour party and the two political parties in the current coalition government are all influenced by the idea of reforming the benefit system in a way that gets people off benefits. One way used to achieve this is by the benefit agency using general practitioners (GPs) who do not know these patients to decide if they need to be on benefits or not (Brindle, 2007). This is done without giving much weight to the opinions of the patient's own GP or specialist hospital consultant. This is clearly a very unfair way of assessing patients' needs and particularly those of psychiatric patients. One female patient who underwent this assessment last year suffered from treatment resistant depression and harmful alcohol use; she was at that time on the verge of losing her house to homelessness and her children to adoption. The benefit agency assessment at the same time revealed that they had overlooked her negative symptoms, which we detected through comprehensive psychiatric assessment, and they made judgement on her work capability assessment using a simple one-page test administered by the benefit agency (Figure 1).

There are recent epidemiological findings from the Adult Psychiatric Morbidity Study of 2007 that showed that those on benefits have a significantly higher prevalence of common psychiatric disorders (CMD). The study found that receiving benefits significantly associates with higher CMD. This is particularly true with care or housing benefit. Income benefit also associates with higher risk of CMD, but further analysis of individual benefits showed that Jobseeker's Allowance was not associated with CMD. The risk of having CMD increases with the number of benefits received (Ford et al., 2010). This study indicates that regardless of welfare reforms, these benefits were mostly correctly targeted to the more severe spectrum in the case of non-psychotic psychiatric problems like depression.

History repeats itself

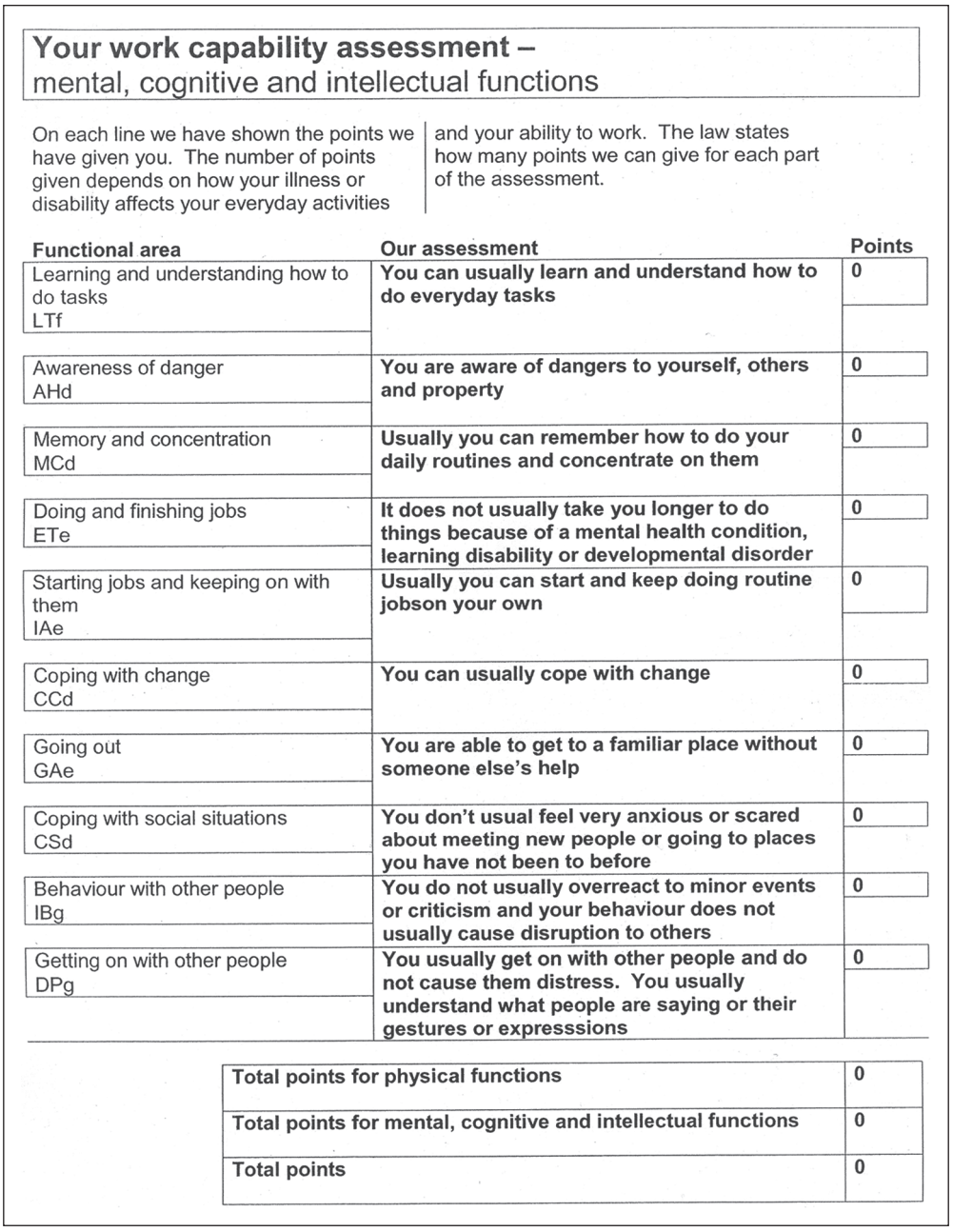
The specialty of psychiatry was born from the midst of the workhouse and it still looks after the most vulnerable patients who are most disadvantaged and in the poorest sector of the population. Our profession needs to make a clear stand against these unfair reforms that will make psychiatric patients its most needy victims.

Our patients might be experiencing a cut in welfare benefits – ironically, recreating the suffering of generations of destitute mentally ill who were punished for their poverty in workhouses, police cells and prison. Far-right political views have dominated social policy thinking since the 1990s and through the publicity they were given by some of the right-wing press. The current economic crisis is only a convenient excuse for politicians to achieve the welfare reforms that were planned by different parties of different colours in the political spectrum at a faster and more ruthless pace.

Psychiatrists whose patients are poised to lose most in these reforms are called upon to make it clear that they are standing as they stood in the past as 'alienists' through the history of the profession in support of their most deprived and destitute patients. Psychiatrists also need to fulfil their public health role as doctors in the advocacy for their patients' rights. They should be inspired by the history of the profession to make a collective stand against these welfare reforms in a way that minimizes their disastrous effects on psychiatric patients. These effects are serious because of the level of poverty and vulnerability of psychiatric patients that make them easy victim for the cuts and deprivation imposed by the welfare reforms.

Conclusion

There is clearly a need to reassess the new medical test for work capacity assessment in a completely different and professional way. This has become urgent in view of the fact that results showed that only 6% of those tested in 2010 were deemed to be incapable of working (Wintour, 2010b). From our experience, we can easily predict that many psychiatric patients lost their benefit as a result and they were found to be capable of working by this medical test regardless of the severity of their psychiatric disability. The whole system of welfare reforms needs to be reviewed taking into account the opinions of patients' GPs, psychiatrists and



Your work capability assessment –
mental, cognitive and intellectual functions

On each line we have shown the points we have given you. The number of points given depends on how your illness or disability affects your everyday activities and your ability to work. The law states how many points we can give for each part of the assessment.

Functional area	Our assessment	Points
Learning and understanding how to do tasks LTf	**You can usually learn and understand how to do everyday tasks**	0
Awareness of danger AHd	**You are aware of dangers to yourself, others and property**	0
Memory and concentration MCd	**Usually you can remember how to do your daily routines and concentrate on them**	0
Doing and finishing jobs ETe	**It does not usually take you longer to do things because of a mental health condition, learning disability or developmental disorder**	0
Starting jobs and keeping on with them IAe	**Usually you can start and keep doing routine jobson your own**	0
Coping with change CCd	**You can usually cope with change**	0
Going out GAe	**You are able to get to a familiar place without someone else's help**	0
Coping with social situations CSd	**You don't usual feel very anxious or scared about meeting new people or going to places you have not been to before**	0
Behaviour with other people IBg	**You do not usually overreact to minor events or criticism and your behaviour does not usually cause disruption to others**	0
Getting on with other people DPg	**You usually get on with other people and do not cause them distress. You usually understand what people are saying or their gestures or expresssions**	0

Total points for physical functions	0
Total points for mental, cognitive and intellectual functions	0
Total points	0

Figure 1.

other medical specialists in the whole process and in the review of individual patients.

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