Professor Sir Simon Wessely, the first psychiatrist to be president of the Royal Society of Medicine, on unexplained syndromes, the Mental Health Act, and why the Cartesian divide is located in Camberwell

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The unprecedented president

To most people, Denmark Hill is a mundane stretch of road that cuts through the unlovely environs of Camberwell, south London. But the form it takes in Professor Sir Simon Wessely's telling is something altogether more auspicious. According to him, the A215 is nothing less than a pure manifestation of the Cartesian divide: the separation of body and mind described in the 17th century by René Descartes, who believed these two essential components of human existence to operate on entirely different planes.

In 1984, Simon began his career at the Maudsley, the famous psychiatric hospital located on one side of Denmark Hill. When, shortly after completing his training, he was seconded to work as a liaison psychiatrist at King's College Hospital—an institution located directly across the road and set very much on the bodily plane of Descartes' formulation—he and one of his colleagues were the only clinicians from these two vast medical establishments who regularly set foot on both sides of the street. "That road was the Cartesian divide, and we were the only people crossing it—not one person from King's ever came to the Maudsley," he says. "If you had a medical problem on a psych ward, you either had to deal with it yourself or take the patient over to A&E. That was before they put the traffic lights in, so you could quite easily get killed doing so."

Simon's point—delivered, as all his stories are, at length and with engaging wit—is that psychological medicine, in which field he ranks among the country's most prominent figures, has always been a marginalised pursuit, cut off from the nucleus of healthcare by an abiding belief that illnesses of the mind are somehow fundamentally different from illnesses of, say, the kidneys, the heart or the throat. He, though, is not a man who likes to feel constrained. His career has been driven by a conviction that this division is both artificial and unhelpful, that the health of the mind and the health of the body are often inseparable, and that illnesses with a psychological element need to be approached with the same intellectual rigour as those in any other field.

Rather than being two sides of a straight road, the brain and body form a wildly complex spaghetti junction, and it was on some of their many intersections that Simon made his name. "A lot of the areas I've worked on have been on the boundaries of medicine and psychiatry," he explains. "There are a lot of disorders that lie in this hinterland—they're not the great psychoses, but neither are they things that can be uncovered with an x-ray or a blood test, where clearly it's a physician's business. They're sometimes called 'contested diagnoses', because in some minds they're neither fish nor fowl."

His exploration of this no-man's-land, as he calls it, began with his pioneering—and, in some isolated circles, highly controversial—work on chronic fatigue syndrome (CFS), a condition that appears to have a biological, organic trigger and presents with clear physical symptoms, but which as a direct result of Simon's pioneering research is now treated by the NHS using a form of cognitive behavioural therapy (CBT). In 1993, he completed a PhD in epidemiology, an area in which relatively few psychiatrists have substantial expertise. "That changed my life," he says. The disciplines involved—the study of populations, the identification of patterns, the application of controls, the awareness of biases, the crunching and re-crunching of data—informed his work on CFS and were central to his ground-breaking investigation into another contested diagnosis: Gulf War syndrome.

After the Gulf War, which ended in 1991, reports began circulating of combat veterans displaying unexplained symptoms, accompanied by rumours of depleted uranium exposure, dodgy vaccination programmes and government cover-ups. "It was obvious to everybody that the MoD were making a balls of looking into it, because they didn't have any capability in population medicine," says Simon, who had noticed parallels between Gulf War syndrome and CFS and was keen to help. Faced by reluctance on the part of the British government ("I went to see the minister for the armed forces, Nicholas Soames, and said, 'You need to do research—big population research.' He just said no. He said, 'In my experience, doing research just makes things worse'"), he managed to secure the necessary funding from the Pentagon to carry out detailed research. "I came back from the States and said, 'We've got the money now, you're going to have to help.' And they did."

Working with the military had its ups and downs. "On the one hand, it's epidemiological perfection. We know exactly what the sample is: we know exactly how many soldiers were sent to the Gulf, we know their names, we know their histories. On the other hand, they are a tribe alone, and it takes them years before they trust you. Nobody is better than the armed forces at saying yes when what they mean is no. You're not one of them—you're the boffin. They call you 'sir', but they make it a six-syllable word, loaded with dry contempt."

That contempt has certainly softened over time. "The research went really well and we got really big impacts," says Simon. "We showed that it wasn't a unique syndrome, but we showed that something had definitely gone wrong in the Gulf, so that guaranteed all the lads their pensions." While the pattern of symptoms was shown to be normal, the incidence of them was significantly heightened, so something about the operation had clearly gone awry. "We were able to show that the medical countermeasures weren't to blame, that it wasn't depleted uranium or smoke from the oil fires, that it wasn't any of the individual vaccines." As well as the chance that some kind of anxiety disorder was involved, sparked by the significant and highly justified fear of Saddam Hussein's proclivity for chemical weapons, Simon could not rule out the possibility that the rushed and poorly

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recorded delivery of multiple vaccines in a short period of time might have played a part. When in 2003, the Iraq War started and “they essentially went and replayed the Gulf War: the same enemy, the same terrain, the same countermeasures”, vaccinations were delivered in a more considered way and the management of information about the health of the troops was markedly improved. “There was no Iraq War syndrome,” says Simon.

The unit set up by Simon to research Gulf War syndrome has since morphed into the King’s Centre for Military Health Research, which continues to provide vital insights into the health and wellbeing of servicemen. “Nowadays, if you’re an academic, you have to show ‘impact’,” says Simon, and one of the most rewarding things about working with the military is that, if recommendations are accepted by the top brass, a genuine impact can be felt almost immediately. “When we published the first set of results on the Iraq War, we showed that the mental health of our regular forces is actually very good, and the simple act of deploying to Iraq was not associated with an increase in PTSD [post-traumatic stress disorder]. Deploying there was no more psychologically damaging than anything else the forces were doing elsewhere in the world, which came as a surprise to many people. But what we did find was that reserves were having a doubling of PTSD—it had gone up from 3 per cent to 6 per cent. We published in the Lancet in the morning, and in the afternoon the secretary of state stood up and made a statement saying that on the back of independent research from King’s he was setting up a new programme for the mental health of our reserves. There was impact.”

There has been impact too from his parallel work on how populations beyond the military respond to severe adversity—in short, much better than you’d think—and what the authorities can best do to help in the immediate aftermath of a disaster. For example, he has helped shake the received wisdom that providing rapid, single-session counselling to everyone caught up in an incident must be beneficial. “Whether civilian or military, it used to be that within 24 hours a trained counsellor would come along and say ‘How was it for you? How are you feeling? What happened?’ This was absolutely standard.” The presumption was that having a friendly professional voice asking you how you’re feeling is automatically beneficial. “My colleagues and I would say, why? We were able to show that not only did it not work, it made things worse. Actually, what you should be doing in those first few days is not asking people, ‘What was it like to see someone blown to bits in front of you?’ Well, it was awful, obviously.”

Instead, he says, the best thing that the authorities can do for the mental health of all concerned is focus all their efforts on providing essential practical support: safety, shelter, food and—most notable—communication. “After the London bombs [in 2005], we showed through a random survey of ordinary Londoners that the natural thing to do was call your loved ones and check they were okay, and the ones who couldn’t get through were more anxious than those who could. Hardly a surprise. The surprise was that we followed them up six months later and the ones who couldn’t get through on that first day were still more anxious.” As a remedy against trauma, being able to connect with your family is, Simon says, much more powerful than any cursory psychological debriefing. “I was really pleased to see when Grenfell happened that the local authority brought in big sacks of plugs, chargers and spare mobiles. That makes an impact.”

Last year, Simon became immersed in a major project that required him to march rapidly back from the no-man’s-land of unexplained symptoms to a place he calls “the bedrock of psychiatry”: the treatment of people with severe mental illness. The Mental Health Act is an important piece of legislation, one of the key elements of which is the power it gives to the state to ‘section’ people whose mental illness presents a risk to themselves or others. “Essentially, we have the authority to detain people who have done nothing wrong; they’ve just become very seriously ill. You haven’t killed anyone—you might be at risk of harming someone or more likely yourself, but you haven’t committed a crime, and yet we are still going to detain you against your will”

After Theresa May announced a review of the efficacy and fairness of the act, Simon was tasked with leading it, despite, he says, being “way off the pace in all the areas of psychiatry where the mental health act is used”. In fact, somewhat counter-intuitively, this lack of experience was one of his main qualifications for the role. “The laws of British political life say that if you want to have an expert review, you have to bring in someone who is not an expert,” he explains. An investigation was carried out to ensure that his ignorance of the workings of the Mental Health Act was as marked as he claimed. “You can see the point,” he says. “If you know a lot about something, you inevitably have views, and nobody could find that I had any views at all.”

After a year spent completely immersed in the subject (“They told me it would be one-and-a-half days per week; it was one-and-a-half days per day!”), during which time he heard the accounts of hundreds of

patients and professionals, Simon certainly has no shortage of opinions now. Those views have formed the basis of a set of recommendations that have been warmly received by most interested parties, including the government, and are highly likely to be implemented in full once the fetid fatberg of Brexit has been cleared from the legislative pipelines.

At the heart of the panel's report is a desire to reset the balance between compulsion and choice, and in the process make the experiences of patients who need to be detained less uniformly miserable. "What really influenced me was the service users who said: 'Looking back, I can see why I needed to be detained, I understand that it saved my life, but why did it have to be so awful?'," Simon says. He agrees with the premise that it can sometimes be appropriate to deny a seriously ill person their liberty, but he also believes they should have the right to retain as much agency as possible. "Just because you've been detained shouldn't mean you no longer have a choice over anything. We heard ridiculous stories about people not being given a choice of having sugar in their tea—that's just petty, but it applies to the bigger things too. You should be able to say, 'I'm ill, but I know that the last time I had that drug I had this awful side effect, so I'd rather not take it.' Now, we tend to just ignore you."

The changes recommended in the report should ensure that service users' views and choices are given more weight. Its aim is that each person be treated as a rounded individual rather than an aggregation of risks, and that every decision taken about their detention has a clear therapeutic benefit, based on the understanding that locking them up is part of a process not just of safeguarding but of treatment. When the last review of the act took place in 2000, in the wake of the Michael Stone and Christopher Clunis murders and with the Labour government still seeking to prove its toughness to the popular press, such a humane approach would not have been palatable, but political responses to mental illness have undergone a change in the past two decades. "That review was run by the Home Office; our one was run by the Department of Health—these things tell you a lot," says Simon. "Politicians today have the general view that our mental health services should be doing more to help the most vulnerable, not less. And it's all parties—this is not a party-political issue."

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Underpinning this change is the ongoing evolution, slow but perceptible, of public attitudes towards mental illness—the growing understanding that the mentally ill are sick people who need care and empathy, not monsters who should be shut away. "People's attitudes have definitely become more tolerant," affirms Simon. "Not as much as you might like to think—we're only as good as the next Daily Mail headline—but it has improved, particularly with young people. When young people are asked what they think the most important issue for the NHS is, in poll after poll they say mental health."

The bifurcated world of medicine is also starting to change. In 2017, when Simon was appointed president of the Royal Society of Medicine, he became the first psychiatrist to lead the institution since its foundation in 1907 (and, indeed, since the foundation of the RSM's precursor over a century earlier). "It's another infinitesimally small straw in the wind," he says. "Not that long ago, there were people who did not believe—genuinely did not believe—that psychiatrists should be members of something called the Royal Society of Medicine."

As president of the Royal College of Psychiatrists, a role he fulfilled for three years before moving to the RSM, Simon spoke at every one of the 37 medical schools in the UK, and he is determined that bright young medics should see psychological medicine as a field with genuine depth and status. "There is still a lingering presumption that most psychiatrists just weren't good enough to do medicine," he says. "There are two things people say behind your back: if they don't like you, they'll say that you weren't good enough for medicine; if they like you, they'll say you're too good to be stuck doing psychiatry. Each is demeaning in its own way. I always say that it's the other way round: that I'm only just good enough to do psychiatry. It's the most difficult branch of medicine."

Even the hard border on Denmark Hill has started to be breached. "It's different now," says Simon. "A lot of my Maudsley colleagues can now be found on the other side of the road." This same shift is being seen throughout the country, with hospitals showing a growing acceptance of the role that psychiatry can play in improving the health and wellbeing of patients with all sorts of physical conditions. "We were among the pioneers in putting psychiatrists into all the medical clinics in King's, but it is a pattern that we are seeing develop across the NHS. If you look at Oxford, probably the leader in integrating psych medicine, they have consultants in nearly all their clinics now, and that is a really positive change." The Cartesian divide hasn't gone away, but for as long as he still has a voice, Simon will keep cajoling his colleagues to bridge it.

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