

# Asylum

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**SURVIVOR STORIES**  
**'A DECLARATION OF MAD INDEPENDENCE'**



An international magazine for democratic psychiatry, psychology, and community development

Incorporating the Newsletter of Psychology Politics Resistance

the magazine for democratic psychiatry Volume 19, Number 2, Summer 2012

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Front Cover Picture: Part of work in progress towards a short film looking at mechanisms by which we may break free of negative patterns and loops. image by daniel saul and Penny Arnold; film in association with Making Waves.

Back Cover Picture taken from enus P Press r elease

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asylum magazine is a forum for free debate, open to anyone with an interest in psychiatry or mental health. we especially welcome contributions from service users or ex-users (or survivors), carers, and frontline psychiatric or mental health workers (anonymously, if you wish). The magazine is not-for-profit and run by a collective of unpaid volunteers. Asylum Collective is open to anyone who wants to help produce and develop the magazine, working in a spirit of equality. Please contact us if you want to help.

The views expressed in the magazine are those of the individual contributors and not necessarily those of the Collective. Articles are accepted in good faith and every effort is made to ensure fairness and veracity. © The Asylum Collective, on behalf of contributors.

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# EDITORIAL

Welcome to this issue of *Asylum* magazine. There are lots of highlights but you may be particularly moved by our featured piece - Stephen R Killeen's chilling call for 'mad independence'. Responding to readers' feedback, we are trying to keep articles shorter. We are also covering more 'news' stories. Please do give us any feedback on this. And send us other news items you think we should cover.

With the imminent demise of *Open Mind*, the onus is increasingly on us to make sure we maintain our regular and critical commentary on mental health issues. In the coming years, this task perhaps will be more urgent than ever.

At the same time as the Coalition Government is stressing their vision of 'involving patients' in services and clinical research trials, they are presiding over cuts to mental health services and welfare benefits which are leaving both staff and clients demoralised. Dina, one of our editorial collective members, recently asked the Director of the Patient Engagement in Research Programme at the National

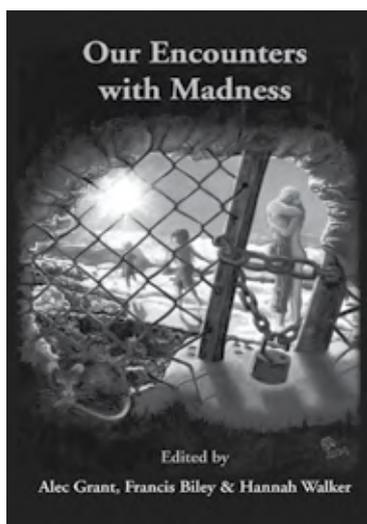
Institute for Health Research (NIHR) how this tension could be reconciled. He had little answer.

On a more (mad) positive side, a small group of academics and service users recently visited some 'mad identified' and 'mad positive' activists and scholars in Toronto, Canada. We hope to report on these events and include some articles by, and about, some of the inspirational groups and organisations we met there (such as Toronto Mad Pride, 'Voices from the Streets' and the Mad Students Society). We may even devote a special issue to these developments. Watch this space!

As promised, our next edition should be the special issue on anti-capitalism and mental health. Please contact us if you think we should be covering other special topics. Perhaps you'd like to help us put an issue together.

Also check out our updated website and thanks again to Pauline Whelan for all her efforts behind the scenes.

Helen Spandler  
On behalf of the ASYLUM collective



## ***Our Encounters with Madness***

Alec Grant, Fran Biley & Hannah Walker (eds)  
ISBN 978 1 906254 38 4  
£17.00 UK postage free.

Unedited and unsanitised first-person accounts of people's experiences of 'madness' and the mental health system.

*The various authors in this book are engaged in making sense of their encounters with madness, by telling stories. Read those stories and you may well appreciate something of 'what' they have encountered. Reflect on their stories and you may well appreciate better your own 'self' and your myriad encounters with life and its inherent madness.*

Professor Phil Barker, from his Foreword

*All the authors of these stories have suffered: some from what was inflicted on them as children, some from demons that seem to have been simply part of who they are or were, and some from the failure - at worst the betrayal - of what are supposed to be helping professions. The authors have also found resources for survival, and change, and the discovery of purpose in their lives ... Which is why I understand this book as an exemplar of narrative healing.*

Professor Arthur Frank, from his Foreword



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# SURVIVOR HISTORY

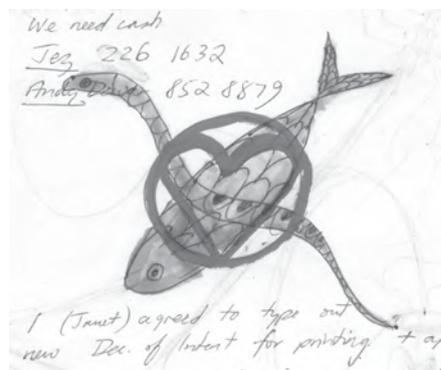
## Survivors Speak Out



anathalie f onnesu's historic photograph of Peter Campbell reciting 'The mental marching band' at A Pageant of survivor history, on 19th march, 2010, at Kingsley hall, in London. Peter's 'history of survivors speak out', updated for this edition of Asylum, was part of the performance (available online at [studymore.org.uk/pageant.htm](http://studymore.org.uk/pageant.htm)).

Collectively, The survivors history group added to the history for a suresearch seminar on 14th July, 2010, at birmingham university. Peter is now leading the group's project to research and write the history of the survivors movement, starting with survivors speak out, a key organisation in the history of the survivor movement in the u.K. Asylum hopes to report regularly on the progress of this project.

readers are encouraged to send ideas and memories for possible publication to Asylum, or directly to the survivors history group, at [studymore@studymore.org.uk](mailto:studymore@studymore.org.uk)



The survivors history group was founded in 2005 to value and celebrate the contribution that mental health service users/survivors have made, and are making, to history.

## Survivors Speak Out: 1986 - 2000

### Peter Campbell

survivors speak out (sso) owes its foundation to concerns that no u.K service users were formally represented at the important world federation for mental health conference in Brighton in the summer of 1985. money was found to enable meetings of survivors and their allies to take place, and i was active in the formation of the group from november 1985, when a preliminary meeting was held after the mind Agm. four meetings were held in 1986 and 1987 at Minstead Lodge in the New Forest. At the first of these,

in January 1986, the organisation was established and its name chosen.

sso had an individual membership, with groups being able to affiliate. There were two categories of individual membership - survivor and ally. The latter was someone who supported the group's aims and objectives but did not define themselves as survivors or service-users. A number of allies played an important role in helping the organisation get on its feet, but when the constitution was developed and voted through, in september, 1990, allies were given no vote at Agm's and could not stand for the coordinating group. nevertheless, sso continued to have ally members throughout the remainder of the 1990s.

in the beginning, the main objectives of the organisation were to produce a newsletter and, most importantly, to organise a national conference where survivor activists could come together. The newsletter began in the summer of 1986. The national conference eventually took place over a weekend at edale youth hostel in the Peak district in the autumn of 1987. This event was very important in bringing people from different parts of the u.K together and stimulating activity nation-wide. About one hundred people attended, including about twenty allies. not everyone was a member of sso. Conference unanimously agreed a 'Charter of needs and demands'. A public statement opposing Community Treatment orders was also agreed.

Although sso had a nationwide origin and strove to be national, in the months following edale it became clear that it did not have the resources to adopt a regional structure. Apart from anything else, mindlink was fast developing, building on mind's then regional structure. nevertheless, sso played an important part in spreading the word about the possibilities of 'self-advocacy'. it sent speakers to local events where service-users were discussing action, and it produced and sold its self-Advocacy Action Pack which had practical advice about how to set up and run a local action group.

opinions differ about the national reach of sso. Although, after edale, it had coordinating group members from different parts of the country, most of its core group came from London and the south-east. As a result it was often seen as a London group. This London-centredness may have developed after edale, and particularly after the group gained a London office. Anne Plumb - a Manchester member - says that the two activities that did most to hold the national group together were the Annual general meetings and the newsletters.

For the first few years, the organisation had no office or paid worker, and it operated from Peter Campbell's front room. Eventually, in April 1993, it acquired an office and an information worker, gloria gifford, who ran the information service. gloria was later joined by an administrative worker, Cheryl Lygo. Throughout its history sso was run on relatively small funds.

Louise Pembroke joined sso in 1988, and became its Education Officer. In September 1989 she organised a conference on 'looking at self-harm', at the international Students House, in London. This first survivor conference on the subject in the u.K led to the publication of self harm: Perspectives from Personal experience, in 1994. This was sso's most successful publication, proving to be a pioneering work that is still in demand. A conference

on 'eating distress', organised by Louise, also led to the publication of conference papers. Louise has made copies of her publications available, free on the survivors history website. Also, stopovers on my way home from mars: a journey into the psychiatric survivor movement in the USA, Britain and the Netherlands, written by New Zealand activist Mary O'Hagan, was published in 1993.

SSO was more involved in facilitating action than in traditional campaigning. It did campaign and lobby to promote 'self-advocacy'. But it did not, by and large, have agreed policies that it campaigned around. One exception to this was compulsion and the Mental Health Act, where the group was always active, opposing any extension of compulsory powers. For some years it seemed that its work was helping to slow movements towards greater compulsory powers, but eventually amendments to the 2007 Mental Health Act, including the introduction of Community Treatment Orders, proved a defeat for its long-held position, a position it shared with much of the service user/survivor movement.

The influence of SSO waned towards the end of the 1990s. This was partly due to an inability to effectively replace the original core group when they stood back from involvement, and partly due to funding drying up. It seems that SSO was never formally wound-up but, in this second decade of the new millennium, it no longer plays much part in the survivor movement.

Details of important events in the history of survivors speak out can be found on the survivors history group website <http://studymore.org.uk/mpu.htm>

In the next column is the poem Peter Campbell wrote for survivors speak out.

In 2006 the collected poems of Peter Campbell: *Brown Inoleum Green Lawns* was published by the late John Rety's hearing eye, at £6. It is still available online at that price.

### The Mental Marching Band

you'd better wet your whistles  
for the mental marching band  
for we're making a wee comeback  
And its spreading through the land.  
And we'd laugh you to distraction  
if we thought you'd understand  
About the mental marching band.

There's Danny O'Genkenyu  
on the bagpipes by the way  
And when he's took his Lithium  
sweet Jesus can he play.  
you can denigrate the madness  
The song won't fade away  
from the mental marching band.

we'll all be out and running  
when the storm breaks.  
down the house of Commons  
with our fruitcake.  
you'll have to take your medicine then  
Just for the music's sake  
And the mental marching band.

we'll not be taking prisoners  
under blood red skies.  
We've had too much confinement  
in our own lives.  
we're getting our own world war out  
That everyone survives.  
Thanks to the mental marching band.  
Let's hear it.

## Alternative sources of mental health support

Readers of *ASYLUM* magazine sometimes say to us 'it's all very well critiquing the mental health system but where are the alternative sources of help?' In order to address this we are drawing up a list of resources giving practical support to help people cope with mental distress.

In particular, we are compiling a list of places in the UK – not part of the mental health system – that claim to offer alternative support to people experiencing mental distress and madness. This list will be available on our website – [asylumonline.net](http://asylumonline.net) – and will be regularly updated. If you know of any good resources or places in your local area which you feel should be on the list, please let us know.

We are always interested in feedback – both positive and negative – from people who have used any of these 'alternatives', and from workers who have had contact with them. We'd like to include discussion about these in future pages on *ASYLUM*. If you would like to share your experiences, or write a review of them, please contact us. You can do this anonymously if you wish.

Contact us at: [editors@asylumonline.net](mailto:editors@asylumonline.net) with 'alternative sources of support' as the heading, or write to: Asylum magazine, Limbrick Centre, Limbrick Road, Sheffield, S6 2PE.

## WILLIAM NEVILLE BINGLEY

24 February 1950 – 31 July 2011

Lawyer, academic and charity organizer

*An appreciation by Mick McKeown*

William Bingley had a notable career in the field of mental health, notably mental health law and ethics, spanning creative and important roles in voluntary sector organising and campaigning, reform and practice of mental health legislation, academia and the health services. Sadly, he passed away following a fall whilst out walking in the Lakeland hills last year.

All his contributions to mental health care were touched by his strong liberal and humane values, which issued in his personal charm and ease in relationships.

William's posts included spells as Legal Director for Mind, Chief Executive of the Mental Health Act Commission, and Professor at the University of Central Lancashire (where we shared an office).

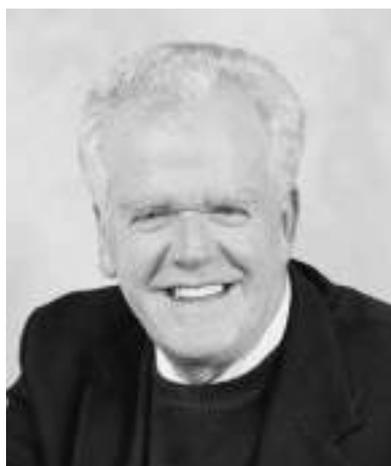
Together with his wife, Helen, he also founded the Abaseen charity which has raised funds for health and education projects supporting the poorest of communities in Pakistan. He was particularly proud of work undertaken to develop schools for all in that country – including girls who are typically not able to attend school – amongst the bonded workers of the brick kilns.

Like his mother before him, William knew the value of a strong voluntary sector, especially in the context of mental health. Early in his working life, whilst working for a firm of London Solicitors, he volunteered to work in a community Law Centre. Latterly, he was a hard-working trustee of Mind in Furness.

Whilst at the University, William joined with colleagues' efforts to establish and support a large-scale service-user involvement initiative, called Comensus. This involved developing mutually supportive links with local mental health service user groups, notably Preston User Forum. Eventually, William was asked to use his legal expertise to help the Forum members frame their constitution as an independent group.

William was always championed the civil rights of people diagnosed with mental health problems, and especially those whose liberties were curtailed by the law and practices of the mental health services. To this end, he was the architect of the Code of Practice which accompanied the 1983 Mental Health Act, and he was also a member of the expert reference panel convened under the Chair of Genevra Richardson in the early stages of the review and reform of that 1983 Act. This process eventually led to the 2007 amended Mental Health Act which was, for William, in many ways a disappointment. For there had been various hopes and expectations, and associated campaigning by the Mental Health Alliance, for a much more radical reform of the legislation – one which might have emphasised the rights and entitlements of mental health service users rather than simply constructing new legal instruments to frame compulsory treatment and detention.

William was consistently against the sort of political rhetoric that, in the face of the actual statistical evidence about how little danger such individuals represented, highlights the



apparent risks posed by people with a mental health diagnosis. He preferred to view that constituency in terms of their being subjected to mental distress and deserving compassion. He supported their right, like ordinary citizens, to be left unharrassed to build their lives amongst (hopefully) inclusive and supportive

communities. Of course, the prominence of the motif of danger throughout most of the media and in public perceptions makes such support and inclusion more elusive.

For William, one of the consequences of such problems was to re-affirm his commitment to independent advocacy as one means by which the rights and entitlements of mental health service users could be assured, or their empowerment achieved.

\*

William's colleagues report heartfelt appreciations of his character, humour and humility in his working relationships. He was a workmate in the best sense of the word. He could be serious and committed when it warranted, but equally he could have a laugh, often in a self-deprecatory way. William's command of language was supreme and he could navigate meetings and write papers in a down-to-earth style that would not alienate people. At the same time, when necessary he could engage with complex ideas, rendering them understandable for audiences or readers.

William was very modest and wore his intelligence lightly. His title of 'Professor' sat even lighter on his shoulders. Although he would probably have scoffed at the appellations 'intellectual' and 'scholar', William stood against 'ivory-tower' intellectuals: he was not so interested in knowledge for its own sake but for whether it could make a difference to the lives of others. He was interested in substance rather than presentational gilding: for him, the message was the message!

William was careless about his appearance in a good way. Not for him the shiny suits or power dressing of the careerist - he definitely got his allotted wear out of his corduroys and jumpers! Similarly, and endearingly, he was an IT Luddite.

Paul Farmer, who recently resigned from MIND to register his opposition to government policy, said:

*as mind's Legal Director, William was a powerful force for good, in standing up for the rights of people with mental health problems. his contribution to mental health legislation in the 1980s helped to balance the power of the state with the rights of the individual. as chief executive of the mental health act commission, he acted as the champion for patients who had been detained, to ensure that the legislation was used fairly. the mental health community has lost a powerful advocate and a man of principle.*

# US Mental Health Users' ALTERNATIVES CONFERENCE

## Will Hall

When journalist Robert Whitaker headed to the stage at the Alternatives Conference, the skies were clear and it was a sunny day outside the southern California meeting center. But storm clouds had formed high above by the time he was done addressing more than 1,000 participants gathered in the grand ballroom, and his speech was punctuated by loud rumbling thunder. As Whitaker stopped and started with each new thunderclap, it was as if the gods themselves were listening in. And when the floor was finally opened to questions, the storm cut out the power and the room was plunged into darkness.

The cosmic drama outside the ballroom was a dreamlike parallel to the human drama occurring around Whitaker's historic talk. 'Alternatives' is the world's largest and most prominent annual gathering of mental health consumers. They attend from every US state, and from as far away as Guam. This annual conference is organized by leading consumer/survivor groups in the US. It is federally funded and has workshops which range from wellness to youth, housing, employment, advocacy and diversity issues. Yet, until now, in its twenty-year history, the agenda of Alternatives has consistently avoided any discussion of medication, much less featured a prominent investigative reporter who indicts the harm that psychiatric drugs frequently cause those who take them.

It was a long journey for Whitaker to make it to the stage at Alternatives. Conference organizers were pressured by federal political players to block his speech when he was announced as a keynote speaker. That, in turn, prompted a social network uprising through Facebook and across the internet - and he was reinstated. That kind of back-and-forth struggle was repeated when it was then announced that my own workshop on coming-off medications would have its title changed, effectively so as

to censor me and my message. Again, news spread across the internet, and mounting opposition forced the organizers to reverse their decision. In the end both Whitaker and I were able to present at the conference, amidst widespread support and an atmosphere of congratulations. And part of the opening session was devoted to an apology for the fiasco by the conference organizers.

Since almost everyone diagnosed with a serious mental disorder takes medication, and since medication is central to mental health policy world-wide, why does the largest and most prominent conference for mental health consumers try to block any discussion of medications? And at a conference that takes its very name - 'Alternatives' - from the need for new approaches?

The answer lies in the history of the Alternatives Conference. Alternatives grew out of the independent psychiatric survivor movement in the early days of activism - before federal funding and state programs emerged to offer budgets to consumer groups. As Alternatives began to receive federal funding it also received oversight and strings attached to the funding. Any groups and issues felt to be politically unacceptable were systematically excluded from the conference agenda: a boundary was set between acceptable system-reforms and topics that were not to be included.

Political limits to the survivor/activist agenda have proven disastrous for mental health care. In the twenty years since the Alternatives conference began, rates of medication, for diagnosis with severe disorders, and for disability payments have each skyrocketed. More and more children have been put under the care of a psychiatrist. And as Robert Whitaker discusses in his book *Anatomy of an Epidemic*, the research focus on brains rather than social issues has put us no closer to a meaningful understanding of how people get into emotional distress and how to best help them.

Perhaps it's time for the Alternatives Conference to live up to its name and start embracing new ways of thinking about mental health care. The thunderclaps above Whitaker's talk in Anaheim in 2010 might be signs that a change is in the air!

RIP



We have been contacted by a number of service user and survivors saddened to hear that *OpenMind*, the popular MIND publication, is folding. We, too, regret its passing.

Over the years OpenMind has played an important part in challenging traditional, medicalised mental health care. It was also a magazine where many leading survivor activists cut their writing teeth on important topics of the day, without necessarily needing an 'evidence base' or loads of references to back themselves up. It has reported milestone Survivor events, and it used to have a lively letters page.

We hope *Asylum* magazine will be able to carry this torch in the coming years, and it is fitting that this issue is Survivor/User focused. We encourage writers and readers of *OpenMind*, past and present, to help us by subscribing, contributing and helping *Asylum* magazine so we can survive and grow.



Ken Kesey

## THE DAY I MET KEN KESEY

Scott Michael

The day I met Ken Kesey I knew I was ill. Flickering, shadowy people following me through the streets, whispering voices, and the ever present thought of suicide.

Kesey was a tall man, taller than me, his firm handshake surprised me, but not as much as meeting him in the first place. He was on a spoken-word tour, and hung around the citycentre, meeting and greeting.

I didn't realise that I had schizoaffective disorder at the time. I thought the occasional glimpses of the future, the sense that I was dislocated in time was the way that everybody felt. It was only when I was in hospital that I understood that it wasn't.

The court sent me there for an undisclosed time. Hours and days all turned into the same fabric of what is normally understood as time.

The feeling never left me of an ever-watching presence that monitored and documented what I did. That took years, but leave it did.

Arson is an ugly word, but not as ugly as suicide. The death plunge that I took from the bridge over the busy

road left me shattered, broken like a doll, not only with the strings broken but the will, as well. In moments of quiet I think 'How did I survive, why did I survive?'

Perhaps Kesey could have come up with an answer. Perhaps not. He was only a writer, after all, with no personal history of mental health issues. No doubt he met people who had such a history – people like me – and he loved them, loathed them but never understood them. How can anybody understand somebody that doesn't understand themselves – which is true for everybody. Ask somebody a question a hundred times and the question itself becomes meaningless, more than meaningless: it becomes an irritant, something that creates more anguish than the answer can relieve.

During those days interred within the stone-clad corridors of the hospital, I thought of Kesey and his white suit and his American schoolbus, outside Macdonald's, and I thought ...What if he had met me? What then for his book? Occasionally I thought of the staff in the hospital and smiled and thought how wrong Kesey was – he never understood what it's like, he just wrote.

*Ken Kesey wrote the best-selling psychiatric novel, made into a popular film: One Flew Over the Cuckoo's Nest.*

## Rachel Perkins and Hairdressing Sandra Smith

A while ago now i was fortunate enough to hear Rachel Perkins, the famous psychologist and service-user, give a talk. Rachel is an excellent speaker and the talk was a memorable and inspiring. She took us right back to the days of the old asylums and spoke about the progress that had been made in the decades since. She also spoke about her vision for the future. In a particularly memorable phrase, she told us of her hope that, in the future, seeing a psychiatrist would be like going to a hairdresser.

I think she was talking about that thing called *stigma*. Now, I don't see why we have to have a special word for it when it applies to mental health, so I prefer to use the word *prejudice*. I think that makes it easier to understand. It's easier to draw parallels with other oppressed groups.

Many of us have experienced arrogant hairdressers who think they know what will suit us and how our hair should be, and carry that out regardless of our wishes. There are hairdressers who have fixed ideas about us according to age-grouping, socio-economic groups or other categories they have read about in books or newspapers or on their hairdressing courses. Some hairdressers are downright incompetent. But we can always vote with our feet and even, if we are very cross, refuse to pay them. Good hairdressers, it should go without saying, are the ones who try to find out what we want and then try to make that a reality. I think there are probably more good hairdressers than there are good psychiatrists.

Personally, I don't go to a hairdresser. It's too expensive and I'm quite happy with my hair the way it is. I find that all it needs is combing and a shampoo once or twice a week. I

haven't yet been turned away from a hotel or a restaurant, so I presume other people think it's okay, too.

Perhaps there is a local hairdresser who thinks I'm in urgent need of a complete restyle. They can advertise their services to me so that I know they are available if I want them - but the choice of whether I approach them is mine and mine alone. If they have a good reputation I might feel more inclined to take their advice, but if I find out they've been treating their customers in an arrogant and uncaring way I would be quite justified in avoiding them at all costs. They might well go out of business.

Although hairdressers are specialists in hair, their opinion carries no more weight in law than anyone else's. In my personal nightmare, hairdressers can take action under the infamous Thatcherite law, the Untidy Hair Act of 1983 (amended by the Blairites, in 2007). They can go to the magistrates and get the police to intervene. The Blairite refinements of this law are particularly pernicious as they provide for people living peaceably at home to be required to attend regular hairdressing appointments, whether or not they feel they any benefit, under threat of being forced to take up residence in the hairdresser's special lock-up.

Then there are dreadlocks. As I understand it, dreadlocks are a way of saying "I totally reject hairdressers and all they stand for." I don't know Rachel Perkins' position on dreadlocks.

Psychiatry is a very expensive business. It has cost many of us far too much, and many of us are still paying. I share Rachel's hope that one day it will be just like hairdressing: optional.

## Jackie Patiniotis

ReVision is an alliance of service users, academics, students and community activists who are committed to promoting the social model of mental health. We have developed out of the Joint Forum (JF), a Liverpool based mental health user group. We chose the name ReVision to reflect the revisionist ideas of critical thinkers in the 1960s and 1970s - the 'antipsychiatrists' - who applied social constructionist critiques to the bio-medical approaches embodied within most psychiatric discourse. We hope to reawaken these ideas and go even further by turning our critical lens to the wider social structures and forms of social oppression which were beyond the gaze of even these critical thinkers.

As a service user group, the JF was unique in bringing together service users' lived experiences and linking these to wider social and structural issues so as to provide an informed, political response to consultations and to support our lobbying and campaigning work. The strength of this approach lay in a small number of activists and the development worker having:

1. an understanding of the politics of mental health,
2. a critical awareness of the social model of mental health,
3. a belief in prioritising the diverse voices of service users,
4. knowledge of public policy and equality legislation, and
5. lobbying for social and equality analyses to be applied by public bodies at every level of community engagement and service development.

It was this agenda that drove the organisation forward, gave it political direction and credibility and gave it a distinct radical voice in local mental health user engagement initiatives.

Unfortunately, this radical agenda was brought to a temporary halt in March 2011, when the JF lost all of its funding as a result of the public spending cuts.

But we believe that by changing into an alliance we will be able to work to a much more critically focussed agenda, by drawing on the energy and ideas of a wider range of people dedicated to political activism.

Recently we undertook research into the best ways forward for our organisation. This confirmed what a number of us already believe: that the social model of mental health is the only model that provides the knowledge, theories, arguments and possibility for political action to challenge the dominant psychiatric 'medical model'.

We intend to ground our work in raising awareness about the social, economic and political causes of mental distress, and it makes a great deal of sense that we work with *Asylum* magazine to do this. We are all struggling to survive in a tough economic and culturally conservative climate. Mental health conditions are endemic. Yet, rather than looking to explain this as due to poverty, financial insecurity, punishing

workloads, redundancies, racism, gender-based violence and abuse, and benefits and service cuts, medication continues to be the default option for treatment. And, in looking for answers, individual 'lifestyle choices' are usually given more prominence than structural factors.<sup>1</sup>

In working with *Asylum*, we will be able to add our voice (and perhaps some new perspectives) to the arguments that expose the flaws in individualised and psychiatric approaches. We believe that *Asylum* will add ideological endorsement to our research and campaigning: together we can strengthen and maximise our collective voice and be a bigger force for change.

Education plays a key role in raising or transforming awareness, and as a catalyst for political action. Using politically-engaged education has been very successful in the work of our Women's Group, where the facilitator combined feminist education, critical research, discussion of gender and mental health issues, and knowledge of policy and lobbying tools to develop the group into an effective voice for change. Women gained individual awareness of the multiple ways that gender oppression affects women's mental wellbeing, and shapes how women see and experience the social world. At the same time, the group obtained a collective campaigning identity and a reputation for challenging the patriarchal mental health system. This approach automatically placed the work of the JF Women's Group within the social model. In other words: 'The Personal is Political'!

We intend to use this method of connecting consciousness-raising to activism in the future work of ReVision: both in a ReVision Women's Group and with other education action projects with service users and wider communities.

One of the reasons why an alliance of critically aware thinkers and activists is so important to our work is that we have learned through experience that user-led groups, whilst being a laudable ideal, cannot always capture the mix of commitment, enthusiasm, independence of thought and politically aware engagement that is needed to challenge the dominant, fixed thinking behind much mental health practice. Having personal experience of using services can offer valuable insight into an individual experience but it does not necessarily provide a critique of the wider picture: the ideology and practices that underpin psychiatry, the vested interests of the pharmaceutical companies, and the different forms of oppression and disadvantage that blight many people's lives before they even arrive at the doors of the mental health system.

*Whilst personal experience undoubtedly influences one's perspective and understanding, many current references to it are determinist and essentialist. Experience/ identity is substituted for, or deemed to be equivalent to, politics, as if critical awareness and understanding are inscribed on a person through forms of oppression, with an implicit or explicit presumption that such awareness is inaccessible to those who have not 'lived' such experiences. Whilst not seeking to deny*

*critical consciousness involves developing a perspective on, a politics of experience.*<sup>2</sup>

This quote illustrates what we mean when we talk about an alliance of critically aware thinkers and activists, whether or not they are service users. For us, the key is to combine a radical agenda, critical thinking and effective campaigning with the skills needed to ensure a well-run, sustainable organisation. In the next twelve months, we want ReVision to stand out in Liverpool and beyond as a unique radical voice, with a reputation for successfully challenging the medical model of mental health.

We are looking for new members who share our vision

and aims, who are keen to help us develop our group, and who could attend occasional meetings in Liverpool.

To find out more about ReVision, contact Malcolm Kinney: [mal\\_kinney@btopenworld.com](mailto:mal_kinney@btopenworld.com)

### Endnotes

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2. Kelly, L, et.al: 'Researching Women's Lives or Studying Women's Oppression?' in Manyard, M and Purvis, J. *Researching Women's Lives from a Feminist Perspective*. Taylor & Francis, 1995.

## DECLARATION OF MAD INDEPENDENCE

I stand here, a soul completely mad, not fearing the punishments and tortures of Sanity, not fearing the Sane System of Slavery and Oppression known as Psychiatry. Not fearing anyone or anything.

We suffer. We struggle. We crawl, beaten down in the dark. We crawl on broken knees across your wretched asylum floors.

No More! Now we STAND. Now the Mad finally STAND!

I stand here, as a Diagnosed Schizophrenic (meaning, I am twice blessed) ... Guilty by Association with Divine Madness.

That simple diagnosis instantaneously convicted me as a deviant criminal in the watchful, nervous, fearful eyes of Society, before any crimes had been done. I was judged by the illusory textbook of psychiatric disorders listed in the infallible DSM-IV.

I am Mad, therefore I am guilty.

I stand here, as one furious Genius (meaning, I have chosen and possess Exceptional Difference, exquisite Imagination and the Revolutionary Spirit of Art).

If you are Mad you are mine.  
Bring me the sick and I will make their minds strong.

I will turn them on to being Alive, and make them livid to live.

I am the self-proclaimed Emperor of the Mad, crowned by everlasting scars and rage, pierced with consciousness, tattooed with lust... and filled with relentless passions immeasurable.

I wear my scars proudly. Funny how Sanity should think they can harm me - my whole existence is scarred. My mind is impossible.

I am writing the future, rather than being submissive and swallowed mind, body and soul, by the increasing avalanche tide of Sanity's totalitarianism.

I question and mistrust Sanity, its intentions and means and motives.

Madness is natural. Sanity is the accepted aberration.

Sanity's just a delusion that the unthinking masses have adopted as their truth.

Madder and madder, sicker and sicker, crazier and crazier.

That is the path to Imagination, which leads the mind and soul to complete Liberation and Beauty.

I was not born an 'Indian Savage', as mentioned in the Declaration of Independence brought to the U.S. Congress, July 4, 1776. However, it is with their blood, their spirit, their minds seething within my own mind, that I stand against you.

Throughout the Ages, without provocation, the fearfully ignorant, terrified Sane have gathered in mass numbers with the common goal of scapegoating and destroying the Mad.

The Sanity Machine has obsessively hunted the Mad with a lawless, voracious appetite for our skulls and blood. Their thirst for our annihilation is insatiable, deranged and hell-bent.

And this they have so thunderously proven by their own actions, with our mad blood on their hands.

Trepanning was rampant in the Middle Ages.

The Mad were also 'put to the question' on the Rack, on the wheel, Torture of Water, Branded with hot irons, Burned at the Stake, Whipped, Flogged, and Boiled and Stoned to Death.

Frontal Lobotomies, eye-socket lobotomies, insulin shock therapy, hydro-shock therapy, electroshock therapy, anaphylactic shock from meds, drug-induced strokes and heart attacks, forced injections of tranquilizers, sedatives, psychotropic drugs, neuroleptics, forced high level doses of LSD, sodium amytal, potions and poisons hidden under myriad drug names, solitary confinement in lockdown cells without trial or conditions, stripped of all clothing and personal possessions, straightjackets, restraint beds.

ALL THIS BARBARISM DONE IN THE NAME OF SANITY!

Sanity, you have failed in your brutal war to destroy us all.

I'm still here, still breathing, still speaking and writing. I am a psychiatric survivor with a tongue of terror. I'm still a madman raging against you. You can never medicate that away. You can never sedate or shock me into sameness and Sanity. I will always reject and resist you and your shackles and chains.

I'm the screaming Ghost of all the mad you have murdered.

The Sane are the great pretenders. From the abusive alcoholic father who pretends to be sober, to the callous mother who pretends to be sweet, and the gay Priest hiding in the parish. The Sane will lie and self-deceive and hide and deny their behaviour. And in a heartbeat they will betray their own kind, their own blood, to save themselves. The Sane will always claim ignorance and innocence, to the end. Falseness is their mantra. Brainwashing, cradle-to-grave indoctrination and mental conditioning are the inhuman ways of their fallacious Cult-ure of the cruel.

Pretence is their oldest toxic dogma.

Sanity is the great obfuscation of every lucid vision, every gifted illuminated voice in all human Civilizations - vile debasement of our Artists, belittled, stalked and terrorized.

Make no mistake, retrace my words if you must - I am Mad.

I will never deny what I am, what I have seen, what I have seen fit to do.

It's haunting. It's chilling how very little the Sane can truly see.

I have the insane vision of mad children laughing, imagining, and living with Freedom ... safe from the psychiatric claws of Sanity's drugging and murder.

I sincerely pledge to my people, with a heart of fire and without sadness, without any hesitation or future regret, my Life, my Fortunes and my sacred Honour.

I shall not ask for, nor foolishly expect, the Sane ever to understand.

Rather, we DEMAND for all Mad people, the civil treatments of equality, tolerance, human rights and independence.

We will be relentless and united in these rightful pursuits.

This document, a formal Declaration of Madness, was built on centuries of tears, centuries of enslavement and human experiments, mind-control and mind-torture, committed on the Mad, my people.

I stand here, unashamed and unable to stop my voices from within. I can't stop listening to the voices of my people. I can't forget or forsake them. I can't silence the screams or the tremendous pain or the cries for freedom. I can't stop my terribly beautiful visions. I can't stop speaking out against the endless Atrocities of Sanity.

And for that, I am eternally unforgiven and forever damned.

Here and now I STAND, eternally mad and grateful.

Here with me, lucid, aware and defiant, the Madwomen and Madmen STAND.

"But he who without divine madness comes to the doors of the Muses, confident that he will be a good poet by Art, meets with no success, and the poetry of the sane man vanishes into nothingness before that of the inspired madman." (Plato: Phaedrus, 245a)

There's no turning back now. We will not disappear. We will not be strangled and suffocated by Sanity's collective fear. We will not be locked away in your dungeons and devoured so easily. Sanity, we Defy you with our Gifts of Difference.

**Signed in my proud blood, with Mad Love,**

**Stephen R Killeen (stephenkilleen@gmail.com)**

## Background

In 1995 I was hospitalised at Barnet General Psychiatric Unit suffering from psychosis and hearing voices. I was diagnosed with schizophrenia and submitted to a regime of medication, then released back into the community. In 2006 whilst studying for a Masters I read Michel Foucault's book *Discipline and Punish*, and I recognised in his description of military schools and borstals the physical architecture of the school where I had experienced the trauma I now associate as partly behind my psychosis. But it was in his description of the famous Panopticon<sup>1</sup> that I recognised the psychic architecture of my psychosis and voice hearing.

During this time I also started to attend a hearing voices group and got interested in the Hearing Voices Network. This experience together with my understanding of Foucault came to form the basis for a PhD. However within two years of starting my research my daughter was born with Crouzon's Syndrome and I was in and out of Great Ormond Street hospital; combined with the fact that I had recently managed to withdraw from my medication after 15 years, the stress associated with my daughter's disability brought on a new psychosis.

This time though, because of my studies, I had new research to hand to understand what was happening. And through this I attempted to regain my autonomy and find new ways of recovering.

This is an attempt to tell a narrative of my new experience of psychosis. The original narrative was written at a time when I was very psychotic. The narrative here is an edited version that is, hopefully, far clearer. As Hemingway said "Write drunk; edit sober", or as I say 'Write psychotic, edit stable'.

## Signifier Surfing

Many people involved in the hearing voices movement have started to show evidence for a link between traumatic experiences and mental health issues - especially in psychosis. In the first issue of the re-launched *Asylum* magazine, Marius Romme argued that perhaps voices are emotions.

There is a suggestion that the unconscious may be making a come back. As Nietzsche said *Das Es* [the Id/ Thing/ Unconscious] speaks.

So what can one make of the supposedly psychotic hearing voices experience with regard to the language if the unconscious may be structured as a language as the psychoanalyst Lacan argued?

Recently I have been in a few positions that have made me feel powerless, not just bodily, but also with respect to my relation to the world and this has tested my already confused ego's ability to deal with severely conflicting emotions. Even in situations where I may be receiving positive support, my relation with institutions appears as one of intimidation and alienation.

# SIGNIFIER

or putting a surfboard



When there is nothing I can do, or what I can do seems insignificant and dwarf-like it seems better to do something I can feel powerful about elsewhere. And so I write, and when I can't write, I walk.

Many of my voices come from experiences of engagement with those who vehemently defend the status quo and during my recent stressful experiences they had gained the upper hand, thus making it hard for me to retain my autonomy. Or at least that autonomy I have hitherto been permitted and that I have fought for, in the sense that it seems you are only permitted what you fight for, if you stop, that too is taken away.

You have to fight for the right for your emotions to party, and under section 44<sup>2</sup>, the right to wander freely has been taken away. This is what the philosopher Gilles Deleuze (Deleuze and Guattari 2004) means by taking a line of flight within psychosis. The gate is barred, you have to follow desire paths in another direction: create your own space (survivor movement); re-wire those paths that have been blocked (CBT); sublimate the hell out of it (art therapy); or if you are some of our more assimilated brethren, get a job (recovery as imposed by ATOS<sup>3</sup>).

To the extent that I have felt powerless, my psychosis has from time to time entered Delphic proportions, in the sense of Sophocles' tales of Oedipus, I cannot seem to escape the fatal and traumatic path laid out for me, each futile attempt to tread my own path turns out to have been preordained.

So I took up signifier surfing. A signifier relates to the sign by means of the signified, that is that which we have in mind when we are referring to something in the real world. The sign is most often a word and is only understood by the way it relates to another word. On its own a sign is arbitrary.

According to Lacan, the psychotic makes connections between signifiers, S1, S1, S1 (Lacan 1993; Lacan and Miller 1998). S/He links up these signifiers by lateral thinking, what would be called apophenia in psychiatry, when the sign gets separated from its meaning. It is the experience of seeing meaningful patterns or connections in

# SURFING

## to the S1, S1, S1 waves

random or meaningless data. When this happens to me I start surfing the signs and the structure of language becomes a surfboard for the waves of my emotions. A bush means someone is upset and liable to scapegoat, a bird's tweet will suggest superficial gossip, the delivery man's banter to the baker will be about the coming of the obeah man (and he's coming to get you cross, hot and cross, unless you are forcibly sacrificed)<sup>4</sup>. But the obeah man has no power over you if you own your labour, emotions, decisions and truth. He only applies his voodoo to the alienated believers, those with faith in the Protestant Ethic. Gather the multitude.

At the moment I encounter a difficulty in my emotional environment that refuses my ability to express my emotions in an Enlightenment approved understanding, a form of rationality based on a denial of the emotions (the passions, demons, obstacles, Satans, complexes, knots). This inability often stems from trauma and failed learning or development with regard to linguistic communication, emotional blocks as a result of say double binds, or shaming.

At such times I fall back on a past understanding of signs triggered by powerful emotions, and in doing so I become estranged from my body, that part of me which communicates my emotions to my cognition. The world around me then communicates with me directly, seemingly from the outside, via emotions that have lost any meaning with regard to what could be regarded as an interpersonal and consensual world view. In this sense I become alienated in my language. The words I hear as voices have no direct meaning with regard to what I am experiencing, but I am caught up in them. The shared discourse, the use of language as a form of communication by which we try to understand each other and reality, is no longer immediately available to me. The Other becomes as a vampire noumenon<sup>5</sup> and the Symbolic its blood-sucking Law (Land, Mackay, and Brassier 2011) and Brassier 2011.

And so I surf the signifiers, trying to find some emotional purchase, until I find a break that allows me to reach the calm waters and sink down into the waves, and return to some sense of shared meaning.

This means that in a hostile environment either vacating the area to a place of safety to allow my body to do its own thing and finally relax, or by breaking the signifier chain. Or finally and most successfully, find someone who will recognise what you are feeling, and empathise with you rather than enslave you. Help you name that sign, that emotion, put a meaning to the feeling. A significant Other to support, guide and befriend you. Recognise you as who you can become and not trap you as they want you to be; someone who can be-in-the-world with you rather than over you.

In his book 'Nomad Codes', Erik Davis talks of 'bardo'; "the insubstantial in between state [the Tibetans claim] that confronts the soul after death, when the contents of

the mind return to seduce and terrify the ego's disorientated after-image as it reverberates into rebirth". He then adds the following as an idea of the last minutes of electrical activity after death, when, perhaps, our life flashes before our eyes;

"the traditional teachings of bardo navigation may come in handy despite the basic reality of brain death: even if we are riding the last wave of flatline, it pays to know how to surf." (Davis 2010, 347-348)

When the Real insists on returning to one constantly, denying one's emotional autonomy, in the form of soul murder as Schreber called it, when one's life becomes one interminable wave to flatline, what can one do but surf on the shores of the heart of darkness?

### Notes

1. The panopticon was a type of building designed by the utilitarian philosopher Jeremy Bentham. It consisted of a tower surrounded by back-lit cells that allowed the observer in the tower to see all of those in the cells. It was supposed to be a blueprint for prisons, schools, factories and other regimes that required a particular kind of productivity. Foucault argued that as the beauty of it was that those in the cells had no idea whether they were being observed from the tower. It meant that it was not necessary for someone to be there permanently, just the idea that someone might be was enough.

2. Section 44 refers to the Criminal Justice and Public Order Act (1994), Section 44 of the Mental Health Act (2007) and Section 44 of the Terrorism Bill (2000). In my madness it refers to the i-Ching number 44: Kou (Coming to Meet)..

3. ATOS: the UK's leading occupational health (OH) service provider of medical staff for the Employment and Support Allowance assessment which is receiving continued criticism for not being fit for purpose.

4. 'Coming of the Obeah Man' Mad Professor – Science and The Witchdoctor (Dub Me Crazy Pt. 9), Ariwa, ARILP 045

5. The noumenon is the idea of the transcendent, that which cannot be known as it lies outside our subjective phenomenological experience.

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# THE ITCH

## Philip Thomas

his soul itched as he walked up regent street towards Portland Place. it had been itching for several weeks but today it was worse than ever. he stopped for a moment and pretended to look in a shop window. he scratched his head, but his soul wasn't there, and it only made the itching worse. Then he remembered he didn't even believe in the soul, let alone know where it was.

The itch had begun a few weeks earlier, on his way back from a meeting in Hawaii. He'd been asked to give a confidential paper summarising the outcome of thirty year's scientific research into the cause of schizophrenia. The results had drawn a blank, and on the plane home he felt the slightest prickling sensation somewhere deep inside. he thought he had imagined it, so he tried to ignore it, but it grew, and this morning, *this morning* of all mornings, with John Humphrys and the *today programme* waiting, it was almost unbearable.

he scratched again. nothing happened.

'morning Professor.'

'good morning, reg.'

'what is it this time, *all in the mind*, *Desert Island Discs*?'

'the *today programme*.'

'have a seat over there and help yourself to a coffee.' The receptionist picked up the phone and after a short conversation turned to the Professor.

'someone will be down in a minute.'

he sat, sipped his coffee, and waited. it was beginning to drive him crazy. he wondered what might have caused it. Then he had a bright idea, the new scanner at work. he would pop his head in later that morning when he arrived back at work. he smiled as he imagined his brain lighting up like a Christmas tree.

in the studio they checked his voice-level while someone read the 8.30 news summary.

'you've done this before?' asked Humphrys.

'Aye, a few times.'

'so you know what to expect?'

'Aye,' he shrugged.

The 'on Air' sign came on.

'schizophrenia is a devastating illness affecting about one per cent of the population. The government has set up a think tank to investigate the state of scientific knowledge about the condition, and with me here in the studio is Professor Angus, director of The Institute of Clinical Neuroscience, at the Maudsley Hospital here in London. Professor Angus, you'll be chairing the think tank. why is it necessary?'

'well John, as you said, schizophrenia's a devastating condition. it's the forgotten illness. sufferers used to be locked away in asylums, but now thanks to better drugs we can get them out of hospital into the community. but you see the problem is that schizophrenia is a chronic condition.'

'Are the drugs expensive?'

'no, not at all.'

'do they cure it?'

'well, yes, sort of, but people have to stay on them for many years.'

'so it doesn't cure them?'

Angus scratched his head. until then he'd forgotten about the itch. 'well yes it does, but...'

'but if as you say the drugs cure the condition, why do people need to stay on them so many years?'

'Ah well, that's why we need more research funding. you see we need more research to answer that question. That's why the government set up the think tank, so we can make recommendations about where the money should be spent.'

'but any neutral would say that it sounds like you've already decided that more research is necessary.'

'oh no, John. it's just that we've made great strides over the last thirty years in understanding the biology of the condition, but there are still things we don't know.'

Angus's head erupted with a glorious bouquet of itching, of many different scents and shades of colour.

'is that really the case, Professor? i don't know how much money has been spent on researching the cause of schizophrenia, but over the years it must be billions, here, America, elsewhere, and now you're telling me we still can't cure it?'

Tendrils of doubt tightened the professor's throat, and his mind blossomed with shame, heavy red blooms of it. 'well, strictly speaking that's not true, John, you see...'

'but with respect, Professor, you must think our listeners are stupid. here you are having spent billions on research, and you still don't know what the cause is, and you can't cure it, and now you're asking the government for even more money. i mean schizophrenia's been around for a hundred years, and you're no further on.'

'what i'm trying to say, John, is...'

'Are you alright?'

'I'm fine, i've just got a wee itch.'

'have a glass of water.'

'is there anything in it?'

'what do you mean?'

'no drugs, chemicals.'

'not as far as i know.'

'it's just that i hate chemicals. They have a weird effect on me.'

'look, it's just ordinary bb C water. now stop playing for time.'

The itch overwhelms him, impossible to resist. he grasps the glass and gulps a draught back. water spills down his Paisley tie. he must scratch and, as he stands to face his audience, scratch he does.

'okay, you're absolutely right, John. it's all a load of bollocks, this biological basis for schizophrenia. i should know. i've been in it up to my neck with the drug companies for thirty years. it's a load of complete and utter baloney. we know just about everything there is to know about fuck all that's relevant to the poor folk who suffer from schizophrenia, whatever it is. After all i've got to pay the bills, put the kids through college. it's all about keeping ageing old goats like me in a job until i can draw my pension and buy a cottage on skye, where i can return to my roots and knit a shawl for the wee wifey. i've got to be seen to believe in it, otherwise they'd all accuse me of fraud.'

'Professor Angus, thank you.'

## Philip Thomas: IN THE WRITER'S CHAIR

### WHO ARE YOUR MENTAL HEALTH HEROES AND HEROINES?

Louise Pembroke and Peter Campbell for their tireless and principled activism over the best part of thirty years. Lou for her powerful dance videos, and Peter for his equally powerful poetry. Marius Romme and Sandra Escher for challenging the conventional wisdom (surely shome mishtake?) about madness. Loren Mosher for his down-to-earth American pragmatism in sorting out Ronnie Laing's brilliant ideas (Kingsley Hall) and, through Soteria, making it work in practice.

### ROOM 101 OF MENTAL HEALTH – WHO OR WHAT?

Schizophrenia, what else? Oh yes, and other ways of categorising madness that replace the person with theories. A hundred years or more of biological research into psychosis and distress that, with one or two notable exceptions (Alzheimer's being one), has failed to deliver any significant lasting improvements in the lives of people who suffer.

### SUGGEST A COCKTAIL OF DRUGS FOR THE PRIME MINISTER.

I can't. To answer this implies that there is something 'wrong' with him that requires some sort of pharmacological correction. The incumbent is an arrogant, self-serving prepuce, intent on dividing the country geographically (North/South), economically (poor/rich) and morally (have and have more/have not).

### WHAT DIAGNOSIS WOULD YOU LIKE TO ADD TO DSM FIVE? BE AS CREATIVE AS YOU LIKE!

I'd scrap the lot.

### IN THE PSYCHIATRISTS CHAIR – WHO WOULD BE THE PSYCHIATRIST (PAST OR CURRENT) AND WHO WOULD BE INTERVIEWED?

It would have to be Ronnie Laing interviewing Emil Kraepelin. I'd love to see Ronnie questioning Emil about his deep admiration for that stalwart of the German right, Kaiser Willhelm. (Yes, towards the end of his life, Emil wrote a paper about his admiration for Kaiser Bill.) On second thoughts, knowing how right-wing Kraepelin's views appear to have been, from some of his later writings, it might be even more fun to have David Cooper interviewing him.

For more than twenty years **Philip Thomas** worked as a consultant psychiatrist in Manchester, North Wales and Bradford. He has always held the strong belief that we can understand distress if we take into account culture and history (both individual and group). In 1999, he became a founder member and co-chair of the Critical Psychiatry Network. Although he left clinical work eight years ago, he continues to write about critical psychiatry, madness and culture. Until recently, he was Chair of Sharing Voices Bradford, a community development project working with Bradford's diverse communities in the wide field of distress and madness. He likes to relax by smearing lard on the cats' boils.

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**Asylum** magazine is a forum for free debate, open to anyone with an interest in psychiatry or mental health.

we especially welcome contributions from service users or ex-users (or survivors), carers, and frontline psychiatric or mental health workers (anonymously, if you wish).

The magazine is not-for-profit and run by a collective of unpaid volunteers. Asylum Collective is open to anyone who wants to help produce and develop the magazine, working in a spirit of equality.

Please contact us (admin@asylumonline.net) if you want to help.



**EUROPEAN NETWORK OF (EX-)USERS  
AND SURVIVORS OF PSYCHIATRY**

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**FOR IMMEDIATE RELEASE**

**CZECH REPUBLIC MUST STOP CAGING HUMAN BEINGS**



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February 22, 2012 – Prague, Czech Republic

The caging of human beings is a gross violation of international human rights law. yet it continues to be acceptable 'treatment' for psychiatric patients in the Czech r epublic.

The european network of (ex-) users and survivors of Psychiatry (enus P) has learned of the recent suicide of a woman in a caged bed at Dobřany psychiatric clinic near Plzeň.

According to reports in the Czech press, the 51-year-old woman hanged herself in the cage on the morning of January 20, 2012. she had been locked inside just hours earlier after being reported "restless". s taff noted she had a history of self-harm. A security camera above the cage transmitted continuous images to the nurses' station, but no one intervened as the woman took her life. A police report ruled out foul play. but local activist and enus P d eputy board member michal Caletka said the woman's death exposethe extreme abuse and neglect being endured by people inside Czech mental hospitals:

"s he made a hole in the netting big enough to shove her head in there... o bviously nobody was watching her and as usual, nobody is responsible for it. i don't know how long it takes to prepare a hole like that and suffocate oneself, but, i believe, long enough to notice on the camera..."

Caletka, himself a survivor of psychiatric caging, said distressed people are typically heavily drugged, tied to beds and kept in solitary confinement. Contact with staff is kept minimal. There is no public oversight.

"it is a quite common practice to lock everyone up and overmedicate [them]...The patients are left there on their own most of the day. w ho cares?"

At least five other people have met "unexpected, unnatural and violent" deaths while being restrained in cages

in Czech psychiatric wards in recent years, according to enus P's research. In 2006, 30-year-old Vera Musilová was found dead in a cage in Prague's Bohnice hospital after she choked on her own faeces. She had been caged continuously for two months, and was naked, dehydrated, and dirty, with her head shaven. A recent Court of Appeal judgment held that the hospital didn't owe the woman's mother an apology for her daughter's treatment.

#### LIVES THAT DON'T MATTER

Net cages and other restraints remain legal and in use in psychiatric 'care' across the Czech Republic despite heavy criticism from the international human rights community. The European Commission, the United Nations, the Council of Europe and psychiatric survivors have all condemned these barbaric responses to people in crisis. Author J K Rowling called for the banning of caging, declaring the practice "torture".

Despite promises to end caging around the time of EU accession in 2004, the Czech Republic openly shuns its international law duties when it comes to psychiatric patients. The country has ratified multiple UN human rights treaties prohibiting torture. These include the Convention on the Rights of Person with Disabilities (CRPD). The CRPD, designed to protect the rights of people in psychiatric settings, states:

"No one shall be subjected to torture or cruel, inhuman or degrading treatment or punishment."

enus P is aware that these rights are being mocked and betrayed daily inside psychiatric settings in the Czech Republic and elsewhere. After the death at Dobřany, prominent psychiatrists, including the head of Protective Treatment at Prague's Bohnice hospital Jiří Švarc, pronounced the cages "one of the mildest forms of restraint". They say that staff will resort to more severe techniques if caging is banned. Michal Caletka responds:

"We're horrified this is the only way that mental health professionals know how to respond to people in distress: different kinds of torture and punishment. Many people turn to the mental health system because they want help with a serious crisis in their lives. All they get is a whole new layer of abuse and suffering."

#### A CALL FOR ACTION

The use of caged beds violates every aspect of human rights and dignity; it is grotesque, degrading, and torturous. The damage to the human person resulting from this act of torture cannot be estimated.

enus P is extremely concerned about the gross violations of human rights and dignity now taking place in Czech psychiatric wards. As Human Rights Commissioner Thomas Hammarberg said last year: "There is an atmosphere of impunity surrounding these violations."

We urge the international community to take action by sending messages to the Czech Ministry of Health.

#### SAMPLE MESSAGE

I am shocked and outraged by the recent death of a woman locked in a caged bed at Dobřany psychiatric clinic near Píseň.

I demand that the Czech government immediately bans and removes all caged (metal and netted) beds in psychiatric hospitals and any other treatment settings in the Czech Republic.

I demand that the Czech government immediately bans all violent, forced and non-consensual psychiatric procedures, which are a replacement for real care. These procedures include bed strapping, solitary confinement, and drugging, detention and institutionalisation against a person's will. None of these practices are acceptable alternatives. They are human rights violations according to the UN Special Rapporteur for Torture and the UN Committee on the Convention on the Rights of Persons with Disabilities. They must stop.

Signed,

Country:

**Please send your message to: Czech Ministry of Health**

**E Mail [mzcr@mzcr.cz](mailto:mzcr@mzcr.cz) PO Box 81, Palacký ul. 375/4.128 01 Prague 2, Czech Republic**

**Source: <http://praguemonitor.com/2012/01/26/pr%C3%A1vo-mental-hospital-patient-strangles-herself-caged-bed>**

About the European Network of (Ex-) Users and Survivors of Psychiatry  
 Euro PeAn ne Twor K of (eX-)users And sur vivors of Psy Chi ATry (enus P) is the only independent network of mental health service users and survivors of psychiatry at a European level. Our members are regional, national and local organisations and individuals from 39 countries united in the fight for human rights and self-determination. In addition to maintaining a Europe-wide support network, enus P has campaigned for the last nineteen years to end discriminatory and abusive treatment of users and survivors of psychiatry and advance accessible alternatives in the community. Our efforts help to expose coercive psychiatric treatment as a major human rights violation which must be dealt with through changes to public law and policy. We are consultants to the European Commission, the United Nations and other major public and non-profit bodies.

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# WHY DO DOCTORS STILL PRESCRIBE NEUROLEPTICS?

**Bruce G Charlton MD**

it is usually said – and i have said it myself – that the invention of neuroleptics was one of the major therapeutic breakthroughs of the twentieth century. but i now believe that this opinion is due for revision, indeed reversal. neuroleptics have achieved their powerful therapeutic effects at too great a cost, and this is a cost which is intrinsic to their effect. The cost is the many millions of formerly psychotic patients who are or who have been made socially docile but emotionally blunted, demotivated, chronically neuroleptic-dependent and who suffer significantly increased mortality rates. Consequently, as a matter of some urgency, neuroleptic prescriptions should be curtailed to the point that they are used only as a last resort.

## Behavioural suppression in medicine

Psychiatrists, especially those working in hospitals, have a frequent need for interventions to calm and control behaviour – either for the safety of the patient or of society. less frequently, the same applies for other medical personnel dealing with agitation, for example, due to delirium or dementia. broadly speaking, there are two pharmacological methods of suppressing agitated behaviour: with sedatives or with neuroleptics.

for many decades, prior to the discovery of neuroleptics, sedation was the standard method of calming and controlling psychiatric patients, and sedation remained the only method where neuroleptics were not available (e.g. in the old eastern bloc and in underdeveloped countries).

The therapeutic benefits of sedation should not be underestimated. In the first place sedation can usually be achieved safely and without sinister side effects; and an improved quality of sleep helps patients feel and function better. sedation may also be potentially ‘curative’ where sleep disturbance has been so severe and prolonged as to lead to delirium, which (arguably) may be the case for some psychotic patients, such as those with mania.

but clearly, except in the short term, sedation is far from an ideal method of suppressing agitation. The discovery of neuroleptics offered something qualitatively new in terms of behavioural control: the possibility of powerfully calming a patient without (necessarily) making them sleepy. in practice, sedative neuroleptics (such as chlorpromazine or thioridazine), or a combination of a sedative (such as lorazepam or promethazine) with a less-sedating neuroleptic such as haloperidol or droperidol, were often used to combine both forms of behavioural suppression.

## The Parkinsonian core-effect of neuroleptics

The emotion-blunting and demotivating Parkinsonian core-effect of neuroleptics has been missed by most observers. This failure relates to a blind spot concerning the nature of Parkinsonism.

Parkinsonism is not just a motor disorder. Although abnormal movements (or an inability to move) are its

most obvious feature, Parkinsonism is also a profoundly ‘psychiatric’ illness in the sense that emotional-blunting and consequent demotivation are major subjective aspects. All this is exquisitely described in oliver sack’s famous book *awakenings*, as well as being clinically apparent to the empathic observer.

emotional blunting is demotivating because drive comes from the ability subjectively to experience in the here-and-now the anticipated pleasure deriving from cognitively modelled future accomplishments. An individual who is emotionally blunted thereby lacks current emotional rewards for planned future activity, including future social interactions; hence he ‘cannot be bothered’.

hence, demotivation is simply the undesired other-side-of-the-coin from the desired therapeutic effect of neuroleptics: neuroleptic ‘tranquillization’ is precisely this state of indifference. The ‘therapeutic’ effect of neuroleptics derives from indifference towards negative stimuli – such as fear-inducing mental contents (e.g., delusions or hallucinations) – whilst the inability to experience pleasure from activities usually found enjoyable (anhedonia) and lack of drive are predictable consequences of exactly this same state of indifference in relation to the positive things of life.

so, Parkinsonism is not a ‘side-effect’ of neuroleptics. neither is it avoidable. instead, Parkinsonism is the core therapeutic effect of neuroleptics. This is reflected in the name, which refers to an agent which ‘seizes’ the nervous system and holds it constant, ie., blunted or indifferent. demotivation should be regarded as inextricable from the neuroleptic form of tranquillization. And the so-called ‘negative symptoms’ of schizophrenia are, in most instances, simply an inevitable consequence of neuroleptic treatment.

by this account, the so-called ‘atypical’ neuroleptics (risperidone, olanzapine, quetiapine etc.) are merely weaker Parkinsonism-inducing agents. The behaviour-controlling effect of ‘atypicals’ derives from inducing a somewhat milder form of Parkinsonism, combined with strong sedation. however, clozapine is an exception. because it is not a neuroleptic, it does not induce Parkinsonism, and therefore (presumably) gets its behaviour-controlling therapeutic effect from sedation. The supposed benefit from clozapine of ‘treating’ the ‘negative symptoms of schizophrenia’ – such as de-motivation, lack of drive, asocial behaviour, etc., – is therefore that, not being a neuroleptic, clozapine does not itself cause those negative symptoms.

## What next?

whatever the historical explanation for the wholesale misinterpretation of neuroleptic actions, recent high profile papers in the *new england Journal of medicine* and *Jama* have highlighted serious problems with neuroleptics as a class (whether traditional or atypical), and the tide of opinion now seems to be turning against them.

in particular the so-called ‘atypical neuroleptics’ which now take up 90% of the us market, and are increasingly being prescribed to children, seem to offer few advantages over the traditional agents while being highly toxic and associated with significantly increased mortality from metabolic and a variety of other causes. new data has added weight to the idea that usage of neuroleptics should now be severely restricted.

Indeed, it looks as if after some fifty years’ widespread

prescribing there is going to be a massive re-evaluation and re-interpretation of these drugs, with a reversal of their evaluation as 'a great therapeutic breakthrough'. it now seems distinctly possible that for half a century the creation of millions of asocial, neuroleptic-dependent but docile Parkinsonian patients has been misinterpreted as a 'cure' for schizophrenia. This wholesale re-interpretation represents an unprecedented disaster for the self-image and public reputation not just of psychiatry but of the whole medical profession.

Perhaps the main useful lesson from the emergence of the 'atypical' neuroleptics is that psychiatrists did not need to make all of their agitated and psychotic patients Parkinsonian in order to suppress their unwanted behaviour. 'Atypicals' are only weakly neuroleptic but highly sedative. This implies that, in most instances, sedation is probably sufficient for behavioural control. In the immediate term, it therefore seems plausible that already-existing, cheap, sedative drugs (such as benzodiazepines or antihistamines) offer realistic hope of being safer, equally effective and subjectively less unpleasant substitutes for neuroleptics for many (if not all) patients.

i would argue that this should happen sooner rather than later. if we apply the test of choosing what treatment we would prefer for ourselves or our relatives with acute agitation or psychosis, knowing what we now know about neuroleptics, i think that many people (perhaps especially psychiatric professionals) would now wish to avoid neuroleptics except as a last resort. few would be happy to wait a decade or so for the accumulations of a mass of randomized trial data – which may never emerge, since such trials would lack a commercial incentive – before making the choice of less

dangerous and unpleasant drugs.

but there is no hiding the fact that if neuroleptics were indeed to be replaced by sedatives then this would seem like stepping back half a century. it would mean acknowledging that psychiatry has been living in a chronic delusional state. And this may suggest that the same could apply to other branches of medicine. since such a wholesale cognitive and organizational reappraisal is unlikely, perhaps the most realistic way that the desired change in practice would be accomplished would not be by an explicit 'return' to the old drugs but by the introduction of a novel (and patentable) class of sedatives marketed as having some kind of more or less plausibly 'new' therapeutic role.

such a new class of tacit sedatives would enable the medical profession to continue its narrative of 'building upon past progress', and retain its self-respect – albeit at the price of cognitive evasiveness. but, if such developments were to lead to a major cut-back in neuroleptic prescriptions, then this absence of intellectual honesty would be a small price to pay.

The full article and references are to be found at:  
Charlton bg: why are doctors still prescribing neuroleptics?  
QJm 2006; 99: 417-20.

**Bruce Charlton** is reader in evolutionary psychiatry, school of Biology and psychology, university of newcastle upon tyne. he was recently sacked as editor of a medical publication for an article the establishment disapproved of. Go to his website, [www.hedweb.com/bgcharlton/](http://www.hedweb.com/bgcharlton/), and you will find his interesting and thought-provoking e-book: Psychiatry and the human Condition.

# COGNITIVE BEHAVIOURAL THERAPY ON TRIAL

*Fred Ruddick*

*Since 2008, NHS staff have been forced to implement and patients to accept CBT as the 'preferred therapy' in primary mental health care. But, as opposed to the 'one-size-fits-all' proposed in the recent initiative 'Improving Access to Psychological Therapies' (IAPT), is there any real evidence that CBT is better than other methods?*

## The Charge

**“You can have any therapy you want, so long as it's CBT”**

Henry Ford, founder of the Motor Company, is famously said to have once declared: “The customer can have a car any colour he wants, so long as it's black.”

This sentiment is now worryingly echoed in the Department of Health's 'Implementation Plan for Improving Access to Psychological Therapy' (IAPT, DOH, 2008). This plan is based upon the National Institute for Health and Clinical Excellence (NICE) dictat that primary mental health services should, almost without exception, offer only CBT for depression and anxiety-related problems (DOH, 2008, p. 8).



Significantly, that document offers no guidance on how to manage the existing workforce of dedicated primary care therapists already trained in approaches other than CBT. They have developed many years of expertise and most of them very much believe in their practice. In fact, their passionate belief is recognised as very influential in promoting positive change in clients lives (Wampold, 2001). What happens to those therapists now? Converting them to CBT is one option. Or perhaps they will be marginalised from primary care work because they don't believe in the CBT mantra – they will become the proverbial square pegs in round holes, surplus to requirements.

Client autonomy, and the associated choices that go along with this ethical principle, also seem to have been paternalistically overlooked by this IAPT agenda. Rephrased, Ford's words find a modern echo: 'Primary care clients can have their therapy from any psychological approach they want, so long as it's CBT'.

It might be argued that the strength of psychological

approaches to therapy lies in the range or variety available – not all clients are able to engage with one specific type of therapy. Against that, it could be suggested that clients don't always know what they want from primary care mental health services, and to offer that therapy with the most extensive portfolio of good quality randomised controlled trials (RCTs) is the only legitimate course of action in an evidence-sensitive NHS. But the danger is that therapies which emphasise other aspects of human nature – such as emotional life – are discarded for a therapy that appears to have a more scientific- and technique-driven ethos, irrespective of the client's needs.

### **Political Influences and Medical Allegiance**

Under this IAPT initiative, therapy which was primarily delivered in the interests of the client also seems to have now taken on a strong political thrust not directly associated with enhancing the well-being of individuals or families. In relation to financial targets, CBT could become almost wholly accountable to a government concerned with keeping people off incapacity benefits and reducing the numbers of those already claiming. The political pressure to provide positive results therefore becomes a central consideration for service managers in primary care. They will be expected to come up with the goods. It also appears that in terms of pre- and post-treatment outcome data there will be a focus on symptom-reduction in depression and anxiety disorders, rather than more substantial therapeutic change.

Therapists in primary care services will be familiar with self-report predictive devices such as the PHQ-9 depression and GAD-7 anxiety scales which are used to facilitate the recognition and diagnosis of those common mental disorders. These scales were developed with an educational grant from Pfizer, one of the world's leading pharmaceutical companies. They form a key strand of baseline and outcome measurement for many primary care teams. But these tools are simplistic in the extreme. They focus entirely on negative symptoms and pander to a pathological perspective of psychological experience. Practitioners who have employed these scales will recognise that scoring is often at odds with the actual presentation of the client in therapy. The more cynical might even suggest that they are actually target-driven management tools that will no doubt produce outcomes to confirm that the huge amount of government investment has worked. Therefore we must be cautious: a simple measure of symptom reduction does not automatically equate with longstanding recovery.

Another interesting perspective is the closer alignment of CBT with the medical or biological view of mental health problems, and with the practice of labelling clients according to the psychiatric bible, The *Diagnostic and Statistical Manual (DSM)*. Normalisation and avoidance of stigmatising common mental health problems in primary care seems to have been lost as a concept, at the expense of diagnosis. This seems to be in order that specific outcome

measures can be applied to feed the government's thirst for statistical evidence, in turn to show that taxes are well spent. At the least, this infusion of CBT with political aspirations and an ever-growing harmonisation with medical constructions of anxiety and depression raises questions about whose goals are served by IAPT and CBT.

### **The New Miracle Cure**

History is full of examples heralding a new era in the treatment and care of people experiencing mental distress (e.g. psychoanalysis and the phenothiazines). CBT is supported by a veritable mountain of randomised controlled trials. It is the latest therapy to promise a major breakthrough: if it lives up to its billing, it will impact on the treatment of a wide range of mental health problems. CBT researchers have spent much energy and time accumulating supportive data, and to this extent they have become The Champions of Therapeutic Research. In fact, it is hard to find a condition or problem for which CBT is not recommended by some researcher or other, and publications shining a light on its possible shortcomings are few and far between.

However, there are sufficient doubts that CBT is such a wonderful panacea.

1. Some studies cast a shadow over the requirement for the cognitive elements of CBT. For example, when treating depression, Jacobson et al (1996) separated out the cognitive and behavioural elements. Some clients received only the behavioural elements of CBT whilst others received both behavioural and cognitive elements combined. Both permutations showed equivalent results at the end of therapy, and at follow-up, two years later. Hayes et al (2004) suggest that, after analysis of the sub-components of CB treatment, the indications are that the cognitive interventions provided little added value to therapy. Also, when examining studies of depression and anxiety disorders, Worrell and Longmore (2007) claim: '... A comprehensive review of component studies finds little evidence that specific cognitive interventions significantly increase the effectiveness of the therapy.' In conclusion, they claim that there is a substantial body of research showing that cognitive interventions are not a necessary component of therapy. These findings suggest that the importance of working cognitively as opposed to behaviourally is less important. Yet, once you've taken the cognitive out of CBT you're basically left simply with behaviour therapy.
2. In relation to depression and anxiety, it has not been unequivocally proven that CBT works better than other therapies – only that there is more quantitative research to back up the claims of success. Indeed, Butler et al (2006) reviewed CBT meta-analyses for unipolar depression and concluded that it was comparable, but not better than, antidepressant medication or the other evidence-based psychological therapies. In the arena of major mental health challenges such as schizophrenia, despite

recommendations by NICE, the evidence for CBT over alternative interventions remains an area requiring attention. Lynch et al (2009) pooled data from published trails of CBT in schizophrenia, major depression and bipolar disorder. They conclude that CBT is ‘... no better than non-specific control interventions in the treatment of schizophrenia, and does not reduce relapse rates. It is effective in major depression, but the size of the effect is small in treatment studies.’ And in relation to bipolar disorder, ‘... on present evidence, CBT is not an effective treatment strategy for relapse prevention.’

3. Again, despite a massive roll-out of CBT training programmes, there is no guarantee that practitioners comply with the standard form of delivery in their day-to-day practice with clients. This poses a challenge to the claims that the CBT offered in research trials is the same as that delivered in real life.
4. In a world dominated by science, it may be impossible for other forms of therapeutic orientation ever to compete with more behavioural type therapies because they don't lend themselves to randomised controlled trials in the same way. Humanistic and psychoanalytic therapies, for example, have underlying core principles and methods of treatment that focus more on the inner experience of the mind that are not so easily accessible to measurement. Does this mean they are less successful, or simply that it's harder to prove in a manner acceptable to the scientific community, NICE and the UK Government?
5. ‘The belief of the practitioner in the approach to therapy’ is postulated as one significant factor in a successful therapeutic outcome, and no doubt this will bolster the CBT practitioners’ faith in all the supportive research papers. CBT has a clear structure and well-described techniques which, in turn, give therapists confidence and direction regarding how to proceed with clients. This then begs the question: has the success of CBT been gained in part by the therapists’ confident delivery and the creation of a climate in which success is expected? Could it be that the placebo effect is at work here in just the same way as it is in any other therapy when therapists have a strong belief in their cause?
6. CBT is often claimed effective in relation to symptom-reduction. This makes it a natural bedfellow with psychiatry. However, Ben Goldacre (2009) warns against making a premature judgement that any success is attributable to the therapy in question. He outlines the well-known statistical notion ‘regression to the mean’. This is the phenomenon whereby conditions or states at their extremes are likely to settle back down regardless of the specific treatment provided. Clients (and researchers) may therefore make the mistaken assumption that what they did when their symptoms were worst (e.g. they participated in CB therapy) must be have been a significant factor in their recovery.

## The Verdict

The success of IAPT and CBT are now inextricably linked. Primary mental health care services are a fundamental force engaged in facing the challenges of a UK economy caught up in the recession and mounting job losses. Depression- and anxiety-related problems are likely to increase, and effective interventions are vital. The case for offering more than CBT in primary care is gathering pace. However, so is the danger that the myriad of fledgling practitioners currently navigating the IAPT training initiatives may end up delivering a form of CBT that is overly rigid and too time restricted. Humane and effective therapeutic relationships rely on more than those operational sequences favoured by those predisposed to a form of therapy which compulsively aligns itself with quantitative scientific thinking. This argument is supported by an analysis of five retrospective studies of CBT where clients consistently responded that their relationship with the therapist was more helpful than the CB techniques employed (Keijsers et al, 2000). Supposing themselves ‘more scientific and pragmatic’, reductionist ideologies such as CBT are in danger of sacrificing the therapeutic relationship for a view of the mind as machine.

Primary mental health care services may also have a case to answer in relation to ‘therapeutic cleansing’, whereby therapists with many years of experience and an allegiance to another established therapeutic approach are driven into the arms of CBT because of the steamroller of service directives. It could be argued that, as much as devaluing their therapeutic orientation, this devalues them as individuals. Non-compliance with such government-driven directives is not really an option. Surely it would make more sense to retain the diversity, and hence the strength of any team delivering IAPT, by embracing the knowledge, qualities and experience of existing practitioners, and add to them, rather than render some therapists into second-class citizens?

Proof of the superiority of one form of therapy over another remains elusive. The difference in outcome between individual therapists is reported as more significant than that between different kinds of therapy. A single technique is not the panacea for all ills. NICE ought to break away from the church of RCTs, and once more value and embrace diversity in primary care therapeutic practice. CBT is currently central to government policy. This impairs therapeutic independence. The paymasters will expect results in exchange for funding and a reduction of the 1 million people in the UK with mental health problems who currently receive incapacity benefit or who are unemployed. Despite the CBT dominated IAPT initiative which began operation in late 2008, these figures remain largely unchanged. The government certainly won't want this number to grow, so how will CBT respond to the gauntlet thrown before it?

Despite having more research money poured into it than any other psychotherapy, and the unrelenting sense of

superiority given off by its practitioners, research comparing CBT with other therapeutic approaches is still a significant area for investigation. In the ongoing trial of CBT as the all-consuming evidence-based treatment of choice, it appears that the jury is still firmly out.

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# NEWS — COMMENTS — FINDINGS

## SECTIONED PATIENTS' DEATHS COVERED UP

At least 261 'sectioned' patients in England are known to have died during 2011. That's an average of five a week - compared to 189 deaths in prison and 31 in police custody in England and Wales.

Bereaved families have to rely on investigations carried out by the hospital trust which had been responsible for the patient's care. By contrast, all deaths occurring in police, prison or immigration custody are immediately subject to independent investigation by either the Independent Police Complaints Commission or the Prison and Probation Ombudsman. This independent body, coupled with a later inquest, means that those custodial deaths are investigated in compliance with the right to life guaranteed by Article 2 of the European Convention of Human Rights.

Historically, mental health deaths were excluded from this level of scrutiny. But a House of Lords ruling in 2008 declared that hospitals have a duty to reasonably protect detained psychiatric patients from taking their own lives. (The case involved the death of sectioned patient Carole Savage, in July 2004; she committed suicide after leaving hospital unnoticed.) This landmark ruling meant that investigations into unexpected deaths or when failures of care were suspected must comply with Article 2. The government has since insisted that, if the coroner deems it necessary, inquests can expand to fulfil this function.

But there is growing unease about what is actually happening. According to The Independent Advisory Panel on Deaths in Custody (IAPDC), many families still face big obstacles when they try to find out the truth from internal investigations. And lawyers argue that coroners vary greatly in the way they conduct such inquests. For example, deaths in prison and police custody automatically trigger a jury

inquest, whereas the coroner can decide whether one is needed for a mental health death.

Besides, legal aid is only granted "in exceptional circumstances", so legal representation is rare, especially with deaths categorised as 'natural causes'. This makes it very hard for families to challenge the independence of expert evidence, witnesses and the scope of the inquiry.

In the decade to 2010, 3,628 detained mental health patients died. This constituted 60% of all custodial deaths, and about three-quarters were classified as 'due to natural causes'.

Philip Leach, Professor of Human Rights at London Metropolitan University, and a member of IAPDC, says there is a "lack of understanding and complacency" among health officials regarding their duty to investigate deaths and learn lessons: "There is no doubt that a national, independent body would be the best way to ensure proper investigation of any death in the mental health sector where there is a possibility of hospital failures."

The IAPDC advises ministers, and it says that information about internal mental health investigations is scant and inconsistent. Lord Harris, chair of the Panel says: "It is striking that in mental health, institutions investigate themselves. This makes concerns about cover-ups very difficult to disprove ... There are too many instances of people dying prematurely of 'natural causes' in the mental health sector, which are not properly being analysed."

Deborah Coles, the Co-Director of campaign group Inquest, says: "The defensive and closed nature of the investigation process has resulted in a culture of secrecy and complacency over the shocking number of psychiatric deaths. They are not subject to robust public scrutiny and proper systems of accountability which could identify systemic failings that safeguard lives in the future."

A Department of Health spokesman says: "It is vital that the NHS learns from each suicide and strives to ensure it doesn't happen again. This is why all suicides in hospital will be investigated by the coroner at a public, independent inquest. This complies with Article 2 of the European Convention on Human Rights."

In October 2010, at the age of fifty-three, Jane Antoniou apparently took her own life while detained under the Mental Health Act at Northwick Park Hospital. A respected campaigner with a long history of serious mental illness, she was admitted to hospital following a suicide attempt and died nine days later. Her husband, Dr Michael Antoniou, has started legal proceedings against the NHS trust and the Department of Health for failing to carry out an independent investigation. The judicial review has been stayed until after the inquest this April.

In the meantime, a landmark Supreme Court ruling on 8th February 2012 means there is now the same duty to protect vulnerable "voluntary" mental health patients as all other detained persons. The case was brought by Gillian and Richard Rabone, whose depressed daughter Melanie, aged twenty-four, hanged herself in 2005. Against their wishes, she had been given home leave. A note in her file said she should be assessed for compulsory detention if she tried to leave psychiatric care.

An internal investigation by Pennine Care NHS Trust took two years. The report was "watered down" several times, and key witness statements omitted. The inquest lasted only half a day, and the only expert witness was the doctor who had let her go.

Her family said: "We heard nothing from the trust until we complained four months after Melanie died. We know now things had gone blatantly wrong, but no one told us anything, they were always trying to cover their backs. Knowing what we now know, we really regret not having a lawyer at the inquest. But all this made us even more determined. We'll never get Melanie back but at least now things will be better for people coming along behind."

N. Lakhani: "'Sectioned patients' deaths 'hide failures'", *The Independent*, 11 Feb, 2012.

#### **MORE MH DEATHS IN CUSTODY THAN OFFICIALLY ADMITTED**

The numbers dying in police custody after being forcibly restrained is much higher than officially stated. This is revealed by a joint investigation carried out by The Bureau of Investigative Journalism and *The Independent*. They found that cases are left off the list if the deceased was not formally arrested.

In the decade to 2009, the officially admitted number of "restraint-related" deaths is 16. But apparently the real figure is 86. In other words, most cases are not included in the publicised figures - including a landmark case that changed the way that officers are supposed to carry out

arrests. Cases were omitted because the person had not been officially arrested or detained. These hidden cases emerged after applications made under Freedom of Information legislation requesting the names of the people in the 16 restraint-related deaths identified by the IPCC.

Analysis of the figures then revealed the omission of eight high-profile cases from the list - including that of Roger Sylvester, who died after being handcuffed and held down by up to six officers for 20 minutes. This case led to a review of techniques by the Metropolitan Police, resulting in changes in training.

The Sylvester case is significant because it led to changes about how police are supposed to arrest suspects and detain the mentally ill. According to guidelines from the Association of Chief Police Officers, any force must be "lawful, proportionate and necessary".

Inquest is an organisation which takes up cases of deaths in custody. Its chief executive, Deborah Coles, said it was "absolutely astonishing" that some of the cases were not described as "restraint-related" deaths. "I think there are some very serious concerns about the IPCC and I don't think it's fulfilling its purpose as a robust independent watchdog for the public and indeed bereaved families to have confidence in."

The IPCC's research found that 333 people died in police custody between 1998-99 and 2008-9, including the unpublicised figure of 86 who died after being restrained. That figure included 16 of the most controversial cases classed as restraint-related.

However, only cases involving formal arrest or detention are included in the figures released to the media. The IPCC also lists people who have died following "police contact" but cannot say how many are restraint-related. It is planning a further study later this year. The organisation said: "How we collate data has no impact on the way in which we investigate a death. It ignores the fact that we independently investigate and all our investigations are heard before a Coroner, a jury, the family of the deceased and the public. To assert that the IPCC is not fulfilling its purpose as a sufficiently robust independent watchdog is a complete misunderstanding of what the IPCC does."

The IPCC said: "The IPCC is robust in its attempts to provide accurate statistics where police have restrained an individual. We are accountable to Parliament for the statistics we collate unlike pressure groups and charities that have less defined criteria. The data that the IPCC provides is completely transparent and is published on the website ... Three of the names you cite are included in this category and would therefore not appear in our deaths in custody study but would appear in our overall figures for deaths following police contact."

Not counted in the official statistics - the forgotten cases - include:

- Roger Sylvester, who died in 1999 after being handcuffed and held down by police officers. The

case led to a review of restraint training by the Metropolitan Police. The 30-year-old was detained after he was spotted naked outside his home. An inquest jury initially concluded his death was an "unlawful killing" caused by excessive force. After a challenge by the police, the ruling was quashed and replaced by an open verdict. The death was not included as one of the 16 restraint-related deaths in the IPCC report because of disputes over the evidence.

- Mr Freeman, "a schizophrenic", died in police custody in 2002. He was taken into custody at the request of his family, given a sedative and restrained by officers after he became agitated. A jury found he had died as a "result of restraint and excessive activity while suffering a psychotic episode".
- Mr Bosworth died in July 2008 while being restrained by police in his garden. A jury ruled he suffered a heart attack brought on by a combination of restraint, cocaine use and epilepsy. He was not included on the publicised list of 16 because he had not been detained under mental health legislation. But the IPCC did carry out an inquiry.

Amidst calls for fresh scrutiny of the way some of the most disturbed detainees are held by police officers, an expert told The Bureau of Investigative Journalism that restraint techniques used to deal with extremely aggressive people can substantially restrict their ability to breathe. Dr John Parkes, a restraint expert at Coventry University, said that those pinned down by police were likely to struggle more as they fought for air. "In the cases in our research, we have used no extreme force, but in some cases have restricted the subject's ability to breathe by up to 80 per cent ... That was done with very, very little force indeed."

The police continue to use restraint techniques that have been attributed to deaths stretching back nearly two decades. Guidelines do not bar any particular holds but only say that the use of force must be lawful, proportionate and necessary.

One technique is "prone restraint". This involves forcing a suspect face-down on the floor, cuffing his hands behind his back and then putting pressure on his torso, shoulders and neck. Following a spate of restraint deaths, stricter guidelines on the use of prone restraint in prisons were brought in during the mid-1990s. Prison service rules now state that "pressure should not be placed on the neck, especially around the angle of the jaw or windpipe. Pressure on the neck, particularly in the region below the angle of the jaw (carotid sinus) can disturb the nervous controls to the heart and lead to a sudden slowing or even stoppage of the heart."

A 2004 Metropolitan Police review recommended that prone restraint should be avoided or minimised. However, according to 2006 national guidelines, it is still not banned.

The charity Inquest believes there are "fundamental problems" in the effectiveness of police training in restraint. Deborah Coles says "My fear is ... that there is the ever-present risk of death and serious injury and that this is an issue that does require proper public and parliamentary attention as a matter of urgency."

The Met Commander responsible for self-defence and restraint at the Association of Chief Police Officers is Simon Pountain. He says: "Where an individual is violent and represents a danger to themselves and the public, the police are rightly expected to restrain them for their own safety and to protect other members of the public. Foremost in officers' minds is the safe resolution to volatile situations, not a medical diagnosis."

Angus Stickler et al: Rate of death in custody is higher than officials admit, *The Independent*, 31 Jan 2012.

Dan Bell: Restraint techniques that have an 'ever-present' risk of death, *The Independent*, 31 Jan 2012

#### **VIOLENCE AND MENTAL DISORDER - POPULAR MYTH & HARSH REALITY**

*The Lancet* recently published a systematic review and meta-analysis of worldwide research concerning violence perpetrated upon people with disabilities.

Most of the usable data came only from 'developed' countries where it was found that, on average, prevalence of any recent experience of violence was 24.3% for people with a mental illness. This shocking figure compared with the figures - bad enough - of 6.1% for those with intellectual impairment and 3.2% for those with non-specific impairments.

On the other hand, and contrary to popular belief, a number of studies have shown only a modest relation, at the most, between mental disorder and the perpetration of violence. For example, this 'modest relation' was shown by an intensive eight-year study involving more than 1000 patients with a mental disorder, carried out a few years ago by The MacArthur Foundation Research Network on Mental Health and the Law.

J. Monahan et al: Modest link between mental illness and violence, *The Lancet*, 349, 9047: 263, 25 January 1997.

M. A. Bellis et al: Prevalence and risk of violence against adults with disabilities: a systematic review and meta-analysis of observational studies, *The Lancet, Early Online Publication*, 28 February 2012.

#### **LIVING ALONE LINKED WITH DEPRESSION**

Many studies have shown that the elderly are more prone to depression and other mental health problems if they live on their own. New research finds the same pattern in adults of working age.

In a study of nearly 3,500 people aged thirty to sixty-five, researchers in Finland found that those living alone were significantly more likely than their peers to be prescribed an antidepressant. During the seven-year study, one quarter of the subjects living alone were prescribed an antidepressant, compared to just 16% of those who lived with spouses, family or roommates. It seems that, at any age, living alone may be considered a mental-health risk.

The results suggest that solo living may weaken social networks and produce "feelings of alienation from society" that could provoke depression. Those living alone were more cynical in their attitudes, and "... being cynical and living alone may predispose to hopelessness and negative feelings, ultimately leading to depression." On the other hand, of course, "... cynical people may also have ended up living alone because they are difficult to deal with."

Depression and feelings of isolation usually go hand in hand, and it's not always clear which comes first. "Being depressed certainly can cause you to not only feel, but also to become, more isolated ... You feel hopeless that you're ever going to be able to have relationships, but even at another level, you ... just don't feel like getting up and going out. You're under-motivated to take the various steps necessary to achieve social engagement."

So these findings only indicate an association, not cause and effect. The researchers acknowledge that this raises the hoary old chicken-or-egg question: does living alone lead people to become depressed or are the depression-prone more likely to live alone because of their temperament, preference or difficulties with relationships? Both explanations are plausible, and of course both may play a role in any given situation - a vicious cycle might set in.

At the start of the study each participant was interviewed about their health, living arrangements, work life and social background. 15% reported living alone and, of those, slightly more than 40% cited divorce or death of a spouse as a reason.

Overall, 17% of the participants had at least one antidepressant prescription during the period of the study. The odds of this were 81% higher among people who lived alone although, depending on the various factors the researchers included in their analysis, that figure could drop as low as 64%. For instance, much of the heightened risk of depression among women living alone was attributable to their tendency to have lower incomes, less education, and poorer housing conditions than their peers - all of which could independently make depression more likely. Similarly, for the men in the sample, social and psychological factors such as work-related stress, a lack of social support, and heavy alcohol use explained some of the association between depression and living alone.

But these kinds of factors only accounted for about half of the increased risk. This suggests that the fact of living alone does, in itself,

contribute to depression.

The study did have some gaps that could have skewed the results. For instance, researchers weren't able to differentiate between people who preferred to live alone and those for whom the arrangement was involuntary. Besides this, antidepressant prescriptions are an imperfect measure of rates of depression. Prescription data doesn't capture those who are depressed but haven't sought professional help. And because the authors had no data on diagnoses, it's possible some of the study participants were taking the drugs for one of the many conditions besides depression for which they're prescribed, such as chronic pain, migraines, and insomnia.

L. Pulkki-Raback et al: Living alone and antidepressant medication use: a prospective study in a working-age population, *BMC Public Health* 2012, 12: 236, (23 March 2012.)

A. Gardner: Living alone linked with depression in young and middle-aged adults, *Huffington Post* 03/23/2012.

#### RATES OF SEXUAL ABUSE OF CHILDREN

More enlightened observers of mental health are aware that there is often a clear and powerful connection between sexual abuse during childhood and serious mental disorder later in life. It seems obvious that abuse today - and especially hidden or denied abuse - is very likely to store up desperate emotional or mental troubles for tomorrow.

According to the latest police figures, during 2011 more than one third of all sex crimes were committed against children. Out of 54,982 sex offences in England and Wales, 23,097 were committed against children. And more than one fifth of those children were still in junior school. At the same time, fewer than 10% of reported child sex offences ended with a perpetrator being sentenced.

These statistics were obtained by the NSPCC in a freedom of information request. They cover crimes including rape, incest and child prostitution across all 43 police forces.

Most of the children (14,819) were aged between 11 and 17. This included 8,749 aged 13 to 15. There were 4,973 victims aged 10 or under, including 1,472 under six years old. Six times as many offences were committed against girls than boys (19,790 and 3,218 offences).

The head of the NSPCC's sexual abuse programme, Jon Brown, said: "When you have a situation where more than 60 children are being sexually abused every day, something is very wrong ... A concentrated effort has to be made if we are to start reducing this distressing level of offences, many of which are committed on extremely young and helpless children ..."

A government spokeswoman said: "The government is determined to protect children from sexual abuse and will continue to work across departments, law enforcement, agencies and charities in order to do so."

But these reported crimes are just the tip of the iceberg. Research commissioned by the NSPCC found that nearly one quarter of all the UK's young adults will have experienced some form of sexual abuse during childhood. However, most of this abuse is not divulged to anyone else at the time, let alone reported as a crime.

The researchers interviewed children aged 11 to 17, the parents of children under 11, and young adults (aged 18-24). Including both contact and non-contact abuse, they found that during childhood 24.1% of young adults had experienced sexual abuse by an adult or another child.

16.5% (one in six) of 11-17 year olds reported sexual abuse. Almost one in ten (9.4%) of that age-range reported sexual abuse during the past year. Girls between the ages of 15 and 17 reported the highest rates of sexual abuse during the preceding year.

As regards physical contact, one in nine (11.3%) of young adults experienced contact sexual abuse during childhood, whilst one in 20 (4.8%) 11-17 year olds experienced such abuse. Two-thirds (65.9%) of contact sexual abuse experienced by children was perpetrated by another child. Most was kept secret: four out of five (82.7%) children who experienced contact sexual abuse by another child did not tell anyone else about it. And one in three (34%) of those children who experienced contact sexual abuse by an adult did not tell anyone.

Sky News website, 4 April, 2012.

L. Radford, et al: *Child Abuse and Neglect in the UK Today*. London: NSPCC, 2011. See: NSPCC website, April, 2012.

#### **MIND CHIEF QUILTS WELFARE PANEL OVER NEW INCAPACITY TESTS**

By Spring 2014 the government plans to have reassessed 1.5 million people currently on incapacity benefit. In April 2012 the Chief Executive of Mind, Paul Farmer, resigned from the government's Welfare Panel because ministers refused to listen to his criticisms of the current fitness-to-work test. So as to advise and monitor its procedures, other major charities still sit on the Panel.

Farmer said the changes to the welfare system are "deeply flawed". But the employment minister said Farmer was asked to leave the Panel after Mind began legal action over the tests which determine if people are eligible for Employment Support Allowance (ESA). ESA became the new benefit on 31 March 2011 for all new claimants who are unable to work due to incapacity or illness.

The government is currently reassessing all those seeking to claim ESA, and says that of the first 141,000 reviewed, 37% were fit to work. But the unions involved say that the new test is designed purely to move people off benefits, "at whatever the cost". Farmer told the BBC that the 37% figure was "likely to be overstated", and that he had resigned because his concerns, as part of

the four-person advisory panel, were not being "appropriately listened to ... The test itself is not fit for purpose. It's extremely crude." In a radio interview, he cited an example of a severe schizophrenic whose symptoms are so bad that he's never been able to do any work and yet suddenly the new test found him fit for work. Happily, this decision was overturned at appeal.

Farmer reckons that, in fact, 50% of those deemed fit to work under the current test regime have appealed against the decision, and that 50% of those have been successful. So the figure for those deemed to fit to work is not really 37% but under 20%.

"The Work Capability Assessment really is letting people down ... This is costing huge amounts of money to the country, but more importantly it's causing huge amounts of distress to people with mental health problems ... If the process was more supportive and less terrifying for people, MIND would recognise that a lot of people with mental health problems do want to work ... But we would much prefer, especially given the current economic situation where there are not many jobs available for people, particularly those people with disabilities, that this process was slowed down, got right, so that people felt it was fair... The Work Capability Assessment really is letting people down ... so it's not right for me to be seen to be associated with it."

Employment minister Chris Grayling told the BBC he was informed the week before that Mind had begun legal proceedings against his department to try to stop the new testing process. This had come "very much out of the blue" and to his "surprise and disappointment". If the legal challenge was successful, he said, it would "bring to a grinding halt" reassessments of existing claims and assessment of new claims. And this would mean the government would have to give new claimants access to benefits "without conditions".

"Now Mind are, of course, entirely entitled to be involved in taking legal action against us," Grayling said. "But it's difficult to see how somebody can be chief executive of an organisation that's doing that and - at the same time - be advising our independent review on this whole process."

BBC radio interviews, 2nd April 2012

#### **\$1.1b FRAUD FINE FOR MAKERS OF RISPERDAL**

An Arkansas jury has decided that Johnson & Johnson misled doctors and patients about the risks of the antipsychotic drug Risperdal. The judge ruled that, by illegally marketing the drug between 2002 and 2006, the company must pay fines for 238,000 separate violations of the state's Medicaid fraud laws. Each violation carried a \$5,000 fine, pushing the total penalty to more than \$1.1 billion.

J&J is the second-biggest maker of health products in the USA. It was ruled to have hidden the risks of Risperdal and tricked Medicaid

regulators into paying more than they should have for the drug. This violated both Medicare fraud laws and Arkansas' own deceptive trade practices laws. This now makes three courtroom defeats in a row for the company, and will probably force it to settle in similar disputes pending in other states. Of course, J&J will now appeal the decision.

The total fine amounts to 11% of J&J's \$9.7 billion net income for 2011 (or 1.7% percent of its \$65.03 billion in revenue). J&J's shares fell on this news.

Risperdal's global sales peaked at \$4.5 billion in 2007 but declined when the drug went out of patent. According to the company's accounts, Risperdal generated \$3.4 billion in sales in 2008, or 5.4 percent of J&J's total revenues. Sales had fallen to \$527 million by 2010.

The US has been investigating the selling of Risperdal since 2004. Arkansas state officials argued that J&J deceptively marketed the drug as safer and better than competing medicines, and also that it failed properly to outline its risks. They said that, after being warned by

federal authorities to halt such sales, J&J had continued to sell Risperdal for "... unapproved uses, including various symptoms in children and the elderly ...".

J&J is contested by eleven different states, who say that it misled them about the safety and effectiveness of Risperdal. The company has now been ordered by judges to pay a total of more than \$1.6 billion in fines and penalties. The US Justice Department is also demanding that J&J pay about \$1.8 billion to resolve outstanding claims by federal regulators and some states.

It is not yet clear how much of this \$1.1 billion windfall will go toward reimbursing the Arkansas' Medicaid program for money it spent on Risperdal prescriptions. But officials say that the state faces a shortfall of almost \$400 million for Medicaid expenditures by 2014, and that it is likely that most of the fine will go to towards Medicaid.

'J&J Fined \$1.1 Billion for Misleading Doctors Over Risperdal', *San Francisco Chronicle*, April 12, 2012.

## The Dark Threads: A Psychiatric Survivor's Story

by Jean Davison

Accent Press, 2009.

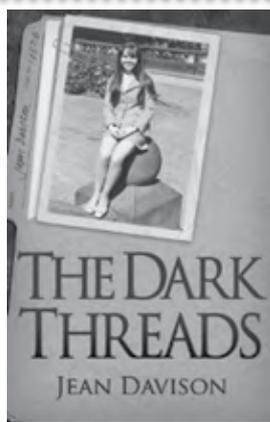
isbn: 9781906373597

reviewed by Pauline whelan

when i moved to west yorkshire in June 2011, one of the local architectural sights i was advised to visit was high royds Psychiatric hospital – an imposing victorian building on the edge of ilkley moor. in the same week that i received this recommendation, *the Dark threads* arrived for review at *asylum*. This book drew me into the grim and sinister world beyond the grand victorian façade, and provided insights into what happened at high royds before it became a popular film set.

*the Dark threads* is a beautifully told but intense and harrowing memoir of Jean davison's experiences of the psychiatric system in england in the 1960s and 70s. it is, as the back cover announces, 'the true story of how a bright teenager was transformed into a zombie thanks to a cocktail of drugs and electric shock treatment'. The book raises a number of critical issues for psychiatry and mental health practice, which are as crucial to address today as they were in the 60s and 70s.

Jean Davison first attended High Royds Hospital as a day patient in 1968. she was then recommended for full-time admission, and so began five years of medication and eCT, of re-admissions and repeat prescriptions. interspersed with her personal narrative are snippets of her psychiatric case notes. We read that she was first diagnosed as 'suffering from a schizophrenic type illness' on the grounds that she had doubts about religion, had introverted tendencies and was struggling with questions of morality. (The early psychiatric case notes also remark, clearly with no sense of critical self-reflection, that Jean suffered from 'a great lack of spontaneity'.)



The accounts of waiting around for routine electric shock treatments, drugged-up in dreary hallways, make grim reading. so do the accounts of psychiatric medications that caused more symptoms and distress than they could possibly have cured. The critical issues of psychiatric labeling, informed consent and psychiatric medication are made all the more vivid for being told through the very personal accounts of social alienation, drug-induced exhaustion, tremors, nightmares and an overwhelming

feeling of entrapment within a system that refused to listen to the people it claimed to treat.

A very sad kind of apathy and submission runs through the psychiatric system described in the book. This is exemplified by the nurse who insists Jean take her sleeping pills because the doctor has written it down in her notes, even though Jean's main problem at the time is clearly, thanks to the cocktail of other drugs prescribed, trying to stay awake. of course, the problems Jean writes about here are not unique to her case nor are they merely personality traits of particular offending characters. rather, as Jean points out, they are symptomatic of a system in need of change. There is are clear messages here, too, about ethics and accountability, and about speaking out, personally and collectively, against an oppressive status quo.

This narrative sparkles with davison's perceptive wit, and thankfully her story does not end at high royds. A wry, wonderful and important book, *the Dark threads* works both as a compelling memoir and as a general critique of psychiatry. it should be read by everyone involved in mental health services. high royds hospital may function as a successful film set now, but its history, like Davison's, is woven with dark threads.

# Drawn from Distress to Recovery

A Call for  
'Graphic Memoirs'

An undervalued feature of the recovery movement is the powerful narratives of those who have survived mental health problems and the psychiatric system.



Increasingly people in distress or recovery have turned to the graphic medium of comics to tell their sensitive stories, sometimes collaborating with friends or therapists, more often working alone on a personal diary or recollection.



While a few have emerged as published 'graphic memoirs', most never see the light of day, or at best, are only accessible as on-line web comics.



Going some way to correct this, we invite submissions for a compendium book of graphic short stories of personal journeys (or part of) to be published early 2013. The invitation goes out to everybody, past or present 'sufferer', regardless of artistic or literary expertise.

The editors appreciate that the form and dimensions of any proposed book are critical to those who create comics, so before committing, we ask for expressions of interest. This should be no more than a title and paragraph outlining your proposed story, plus a sample page of artwork submitted as a jpeg no bigger than 2MB.



As a rough guide, imagine the finished book is A4 format and in black & white. Your finished story or episode should be no more than ten pages long, but can be as short as a single page.

Provided it is indicative of your style or that of the person you will collaborate with, the sample artwork can be of anything and any dimension. It is not necessary to work up a sample of your proposed story.

Postal submissions will be accepted, but your outline must be typed, the artwork must be a photocopy, and a stamped self-addressed envelope must be included. Foreign language contributors will need to provide their own translations into English, and the page must read left to right.

The editors will respect full confidentiality should you wish your work to be included anonymously, but we need full contact details, even if you prefer to use a pseudonym. The editors cannot team up writers with artists, or visa versa.

Further Content Guidance: [www.brickbats.co.uk/index.php/callone](http://www.brickbats.co.uk/index.php/callone)

Editors: John Stuart Clark & Theodore Stickley



Deadline for Expressions: 31st July 2012

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**DATA PROTECTION:** The editors will retain entrants' personal data for use solely in conjunction with work on this project and will NOT make this available to other bodies.

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# UK JUDGEMENT ON PATIENT SUICIDES: A VICTORY FOR HUMAN RIGHTS?

**Helen Spandler and Dina Poursanidou**

There has been lots of press coverage in the last two years about suicides of psychiatric patients (especially patients who had absconded from hospital), and the associated dangers of patients being granted hospital leave whilst at risk of suicide.

One case in particular has resulted in a new court ruling. Back in 2005 a young woman killed herself after being granted two days leave by Stepping Hill Hospital. She had been voluntarily admitted following a number of suicide attempts. Claiming negligence, her parents took the hospital authorities to court. Initially it was ruled that the NHS Trust in question had no duty to protect the young woman's life since she was not officially detained under the Mental Health Act 1983. So they took their case to the Supreme Court.

Seven years later, in February 2012, a judge in the Supreme Court ruled that psychiatric hospital staff must do more to protect patients from committing suicide. This decision is significant because previous case law drew a distinction between 'voluntary' mental health patients and those detained compulsorily under the Mental Health Act. Only compulsorily detained patients came under Article 2 of the European Convention on Human Rights, stipulating that 'right to life shall be protected by law'. Following this ruling of the Supreme Court, the NHS now has a duty to protect all psychiatric patients, both detained and voluntary, against the risk of suicide. This is likely to lead to an increased use of surveillance, observation, and preventing patients taking leave, etc.

This Supreme Court decision has been widely welcomed. By mental health organisations such as Mind, and leading Human Rights groups across Europe, it has been called a 'landmark victory' for voluntary psychiatric patients. At a time when Human Rights legislation is under fire from the UK Coalition Government, the ruling is thought to demonstrate its potential to protect the most vulnerable.

Those welcoming the ruling have a point, and we certainly wouldn't want to join the attacks on Human Rights laws. However, we feel rather more cautious about the implications of this recent ruling. Our argument is about the prevailing socio-political, economic and psychiatric context in which it will be interpreted and applied.

As we face increasing funding cuts to UK public services, with ensuing job losses, drastic restructuring of

services, as well as uncertain and disheartening employment conditions for staff, rulings such as these, whilst well-meaning and progressive in principle, may actually result in even more coercion than already exists within psychiatric services. That is, unless it is combined with a recognition of people's rights to truly therapeutic environments when in crisis.

The Care Quality Commission has already reported that psychiatric wards in England have become more security focused, imposing blanket rules, such as mobile phone bans, that are difficult to justify and which risk breaching other aspects of human rights law.<sup>1</sup> In the last few years we have also seen the use of the sectioning powers of the Mental Health Act and Community Treatment Orders rise beyond all expectations. Tony Zigmond, the Royal College of Psychiatrists' lead on mental health law, has also expressed concerns about the excessive use of compulsion and coercion.

Psychiatric in-patient care, whether 'voluntary' or not, needs to be genuinely safe and therapeutic, not just a way to administer drugs and manage behaviour. Unfortunately, psychiatric wards are notoriously unsafe and un-therapeutic environments. By way of illustration, a recent investigation by the BBC's Sunday Politics London revealed 'a shocking number of rapes and sexual assaults on in-patient wards in London's Mental Health Trusts'. In this context, some might consider it most ironic that in the Mental Health Act psychiatric hospitals are considered 'places of safety' for people in crisis.

There is actually little evidence about the protective effect of potentially coercive measures, such as surveillance and close observation.<sup>2</sup> In some of the wards in Bradford's Lynfield Mount Hospital, they decided to cut down on the use of routine formal observations in favour of increasing the availability of, and support for, staff to facilitate meaningful engagement and therapeutic activities for service users. Positive results and increased patient satisfaction were reported. Absconding rates almost halved, self-injury decreased and staff sickness and absence dropped.<sup>3</sup>

The Bradford approach has been called 'purposeful engagement rather than custodial ritual'. Unfortunately, it is 'custodial ritual' that appears to be the norm in psychiatric wards, as Dina's story (overleaf) illustrates.

## Endnotes

1. Samuel, M. (2010) 'CQC: Mental health services risk breaching patient rights', 27 October. ([www.communitycare.co.uk](http://www.communitycare.co.uk))
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3. Bowles, N and Dodds, P. (2002) 'The use of refocusing in acute psychiatric care' *Nursing Times*, 98, 22: 44 (Available on-line [www.nursingtimes.net/](http://www.nursingtimes.net/))

## DINA'S STORY: WHY I ABSCONDED FROM AN ACUTE WARD



in 2009 i was compulsorily detained under the mental health Act in an acute psychiatric ward in north manchester Hospital. I absconded twice within a week during my first month there - fairly soon after my admission - even though i was supposedly on close 1:1 observation, especially at night. This was because i was acutely suicidal when i was first admitted, and that was the reason for my sectioning.

Thinking back on the experience of 1:1 observation, i remember a quite imposing big woman sitting outside my single room for the entire night. She was constantly flicking through a magazine, and her job was only to prevent me from leaving my room. she would not engage with me in any other way. nobody introduced her to me or explained her role. in her act of watching me i did not experience any care or concern whatsoever for me and my distress. I guess I experienced her as a prison officer or a security guard. my bedroom was supposed to be my private space, and being watched by a complete stranger in such close proximity for the entire night felt quite exposing, threatening, intrusive and oppressive. This was bound to exacerbate the already heightened vulnerability and acute lack of a sense of security that my suicidal feelings had left with me.

Reflecting on this experience, I can relate to the idea of observation as a 'custodial ritual' rather than any kind of meaningful and 'purposeful engagement' (as discussed in the article above). very early on i sensed the complete lack of therapeutic care during my detention on the ward. staff rarely engaged meaningfully and therapeutically with the patients, if at all. Their interactions with the patients occurred mainly during the administration of medication - and the odd bingo night! when they were not administering medication, I remember the staff mainly sitting in the nurses' office and talking, eating and drinking coffee, or looking at a computer.

it appears from my case records that i was very agitated, acutely distressed and constantly knocking on the nurses' office door to tell the staff that I wanted to go home or that i wanted to go to the vending machine outside the ward. Apparently, the staff perceived me as 'intrusive': it seems that my acute distress and agitation was construed as an irritating, childish kind of intrusion by the people supposedly responsible for alleviating and containing my distress. As a result, i was sent to my room - 'to have a time out' - or, in a few instances, i was physically restrained. i now wonder whether the absence of staff's meaningful engagement with the patients was - at least partly - due to the staff's inability to tolerate acute mental distress, and their consequent need to defensively detach themselves from it.

nobody had explained to me what was meant by 'sectioning', or how long my sections were likely to last. by trial and error I just figured out that I could not even go to the hospital grounds without permission. i felt disorientated, powerless, endangered and terrified, to the extent that I became incontinent. That was the environment which i was desperate to abscond from.

even though i was on close observation, heavily medicated, very distressed and so disorientated that i did not really know where the hospital was in relation to familiar areas of manchester, i still managed to abscond. The hospital was in north manchester, and at the time i lived in south manchester - almost two hours away by public transport. i don't remember what happened the first time I absconded but apparently i managed to get the bus from the hospital to the city centre, and then to get home! The second time was at night and i remember it: quite late, i got into a taxi, paid £10 and was taken home. both times anything could have happened to me - i could have been run over by a car or i could have killed myself.

As far as i can remember, nobody on the ward asked me about my suicidal feelings, in any meaningful or therapeutic way: why had i wanted to take my life, what exactly i was feeling and thinking? i guess i was just asked whether i wanted to harm myself and a box was ticked. i wouldn't call this 'competent and meaningful risk assessment'.

\*

On reflection, I find the distinction between 'environmental/physical security' and 'relational security' on psychiatric wards really helpful.<sup>1</sup> measures currently used to enhance environmental or physical security in mental health wards include constructed features (e.g. fenced garden areas), alarm systems, formal observation systems (e.g. CCTV monitoring, scheduled staff observations), swipe-card systems for controlled access to wards, or locking wards. using the threat of compulsory detention for voluntary patients if they attempt to leave the hospital, or withholding patients' leave are also measures used allegedly 'to keep patients safe'.

however, genuine safety and security in mental health wards cannot be achieved merely through interventions targeting the dimension of physical or environmental security. An essential dimension of safety or security in mental health wards concerns relational security, which can create a sense of attachment and connection for staff and patients alike. relational security is thought to be enhanced through high staff-to-patient ratios, increased amounts of meaningful face-to-face contacts between staff and patients, achieving the right 'balance between intrusiveness and openness' and establishing clear relational boundaries on staff's part, as well as promoting understanding, trust, respect and therapeutic rapport between patients and staff.<sup>2</sup> it is also thought to be improved by staff being appropriately trained and aware of individual patients' histories and areas of vulnerability and risk, as well as involving patients in planning their own care.

i felt that this kind of relational security was totally absent from the ward i was detained on. i experienced a formal observation system established to enhance 'physical/environmental (i.e. external) security' on the ward but paradoxically this operated at the expense of my internal

security. i think this explains my profound experience of a lack of genuine safety and security on that ward, as well as my consequent absconding.

Physical/environmental security provisions cannot substitute for relational security. if there is more focus on increasing physical security and less on developing relational care and security in mental health wards, this is likely to lead to more compulsion, coercion and oppression. in turn, intensifying coercion is bound to undermine patients' senses of internal safety or security, and may well lead to higher rates of absconding, with all its associated dangers, as my story illustrates.

### Images

some silk scarves i painted during occupational Therapy art sessions when i was detained in hospital in 2009. The two hours of occupational Therapy per week was the only meaningful activity on offer. OT was an oasis of creativity

amidst the soul-destroying dullness of the acute ward. i remember feeling proud of myself for painting the scarves. i guess i was amazed i had managed to be so creative whilst being so severely depressed and demoralised, and on really heavy medication. i guess the art i was engaging in during those sessions reminded me of the possibility of another life, a life of freedom and joy away from the hospital where i was deprived of my liberty.

### Endnotes

1. Kennedy, h. g. (2002) 'Therapeutic uses of security: mapping forensic mental health services by stratifying risk', *advances in psychiatric treatment*, 8, pp. 433-43
2. department of health (2010) *Your guide to relational security – see , think , act .*



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