Asylum

the magazine for democratic psychiatry

PSYCHIATRIC DRUGS TRIGGER VIOLENCE?
SEEKING ASYLUM, MAD LOVE
AND MORE ...

Send letters, comments & submissions (incl. articles, art work, poetry, images, etc.) to: editors@asylumonline.net
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Asylum magazine is a forum for free debate, open to anyone with an interest in psychiatry or mental health. w e 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.

EDITORIAL

Phil Virden

So far this year, each issue of the magazine took a particular theme. We hope you found them interesting. We apologise to anyone who has sent in a contribution not on one of those themes, and not had much of an acknowledgement. This issue catches up on some of the backlog of material we have on a variety of topics, and we hope soon to publish more.

Because hardly anyone seems aware of the problem – and even fewer are bothered by it – and since it affects the mental and physical wellbeing and behaviour of so many patients all over the world, perhaps the most important material we have ever published in *Asylum* is the information on genetics, psychiatric drugs and 'side-effects' which has been provided by Catherine Clarke (See *Asylum* 17.2 and 17.3). When I say 'hardly anyone' and 'even fewer', I mean (in the UK, at least) everyone from policy makers (e.g., NICE), psychiatrists, doctors and mental health workers in general, to Joe Public and the human guinea-pigs who are the patients. In this issue we publish another article from Catherine, this time concerning research which indicates genetic differences within the population for the propensity of the neuroleptic drugs to cause a patient to become violent. You can probably imagine the implications of this – especially, it seems, for certain sections of the BME population.

But we think you will find the other articles in this issue just as interesting. The editors certainly did. It's a good mix of topics, and mainly provided by people who are (or were) on the receiving end of the mental health and psychiatric services. While much of it is critical, it also seems to emanate a lot of spirit and optimism. So it's kind of bad news but also really good news … at least amongst these contributors.

2 POEMS by BEN GRAY

Little Shadow Puppet

Dance, little shadow puppet
You can never dance too long
Never stop, little shadow puppet
You may disappear before the dawn
Take care, little mannequin
The shop curtain is coming down
Do not fear, shadow puppet
The drummer will beat on
You never know, ragged puppet
When your dance is done
Just a patchwork of frayed stitches
A broken, absurd bundle
Silence spreads the shadows thin.

The Frozen Sky

Frost warped woods
Shattered and burning
Torn dark ice
Hollow black trees
Graves as empty
As trapped
Unfulfilled prayers
Filled only

Only with the bleak
Bleak cackle of ravens

Withered branches
Stretch empty prayers
Towards the heavens
As thin as time leeched fingers

About the poems and author

Little Shadow Puppet describes the feeling of being made invisible, silenced and little more than a puppet in modern society and the mental healthcare system. The poem tries to communicate the feeling of being made to dance like a puppet to a tune that is not your own, that suppresses individuality, creativity, freedom of expression and real dialogue between people. The shadow puppet is also a metaphor and can easily be pictured in the imagination. The poem suggests that the experience of hearing voices or being labelled with 'mental illness' can make people feel like 'a shadow of your former self'. The shadow is also a metaphor or image for the dark and perhaps destructive experience of hearing voices that other people cannot or will refuse to hear. The poem was inspired by Wayang Kulit, a theatre of the shadow puppet from Indonesia.

The Frozen Sky tries to communicate the metaphysical and spiritual aspects of human existence, which are often forgotten in modern society and dismissed by traditional psychiatry. People labelled with 'mental illness' can feel frozen out of society and their spirituality or beliefs fractured like ice, so fracturing and breaking the self. Their prayers or hopes, raised to the heavens like the branches of a tree, can seem to be empty and left unfulfilled.

Dr. Ben Gray is a voice-hearer, academic and researcher who has published several poems. He recently wrote an article for *Asylum*: Psychiatry and Oppression (Winter 2011). He lives in Wivenhoe, a small coastal town that was once a fishing village and thriving port, but is now better known for its community of artists, writers and academics. He is currently a service user expert at Rethink Mental Illness. btgray@hotmail.com

PUBLICATION OF THE NEW EDITION OF THE PSYCHIATRIC BIBLE

REACTIONS TO DSM-5

According to the leading body which represents Britain's clinical psychologists, there is no scientific evidence that psychiatric diagnoses such as schizophrenia and bipolar disorder are valid or useful.

in a groundbreaking move that has already prompted a fierce backlash from psychiatrists, the British Psychological society's Division of Clinical Psychology (DCP) issued a statement declaring that, given the lack of evidence, it is time for a 'paradigm shift' in how mental health issues are understood. This questions psychiatry's predominantly biomedical model of mental distress – the idea that people with mental health problems are suffering from illnesses that are treatable by doctors using drugs.

The DCP said its decision to speak out 'reflects fundamental concerns about the development, personal impact and core assumptions of the diagnosis systems' used by psychiatry. Dr Lucy Johnstone, a consultant clinical psychologist who helped draw up the DCP's statement, said it was unhelpful to see mental health issues as illnesses with biological causes. 'on the contrary, there is now overwhelming evidence that people break down as a result of a complex mix of social and psychological circumstances – bereavement and loss, poverty and discrimination, trauma and abuse.'

The DCP's provocative statement was timed to come out just before the publication date for *DSM-5*. This is the fifth edition – the first for two decades – of the American Psychiatry Association's *Diagnostic and Statistical Manual of Mental Disorders*. *DSM* has long been attacked for expanding the range of mental health issues classified as disorders. For example, *DSM-5* classifies manifestations of grief, temper tantrums and worrying about physical ill-health as (respectively) the mental illnesses of major depressive disorder, disruptive mood dysregulation disorder, and somatic symptom disorder. some of the omissions are just as controversial as the inclusions: 'Asperger's disorder' will not appear in the new manual, and instead its symptoms will come under the newly added 'autism spectrum disorder'.

DSM is generally known as 'the world bible for mental health diagnosis'. in the uK, an alternative manual is mainly recommended: *The International Classification of Diseases* (*ICD*), published by the World Health organisation. However, *DSM* is still very influential – and very controversial.

oliver James trained as a clinical psychologist. in an article in *The Observer*, he welcomed the DCP speaking out against psychiatric diagnosis, and stressed the need to move away from a biomedical model of mental distress to one that examined societal and personal factors: 'We need fundamental changes in how our society is organised to give parents the best chance of meeting the needs of children and to prevent the amount of adult adversity.'

But Professor sir simon Wessely, a member of the Royal College of Psychiatrists, and chair of psychological medicine at King's College London, said it was wrong to suggest psychiatry was focused only on the biological causes of mental distress. in an accompanying article, he defended the need to create classification systems for mental disorder: 'A classification system is like a map, and just as any map is only provisional, ready to be changed as the landscape changes, so does classification.'

Psychiatrists under fire in mental health battle. *The Observer.* 12 May, 2013.

More harM than gooD
dSm-5 and exclusively biological psychiatry must be completely rethought

Western psychiatry is in crisis. The direction taken by the new *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) has received ample criticism. Moreover, disagreeing with the American Psychiatric Association, the us national institute of Mental Health (niMH), the world's largest research institute, has announced they will no longer fund projects based exclusively on *DSM* categories. unfortunately, while Mental Health Europe considers the niMH decision to be the right one, by focusing almost entirely on neuroscience and on so-called disorders of the brain, the niMH is missing out on the critical importance to psychiatric practice and research of user experiences.

Mental Health Europe is extremely concerned that the publication of *DSM-5* represents another step in the increasing dominance of a wholly biological approach to mental health problems, supported by the enormous machinery of science, technology and economic interests. What is more, one of the visible consequences of this approach is the relative downgrading of psychological and social interventions, which support personal and social recovery. Moreover, psychological and social interventions are becoming dependent on the biological model, instead of responding to the needs and aspirations of mental health service users. obviously, this contradicts the social and human rights perspective of the un Convention on the Rights of Persons with Disabilities (un CRPD), now ratified by the European Union and by more than one hundred countries worldwide.

Furthermore, Mental Health Europe is alarmed that *DSM-5* includes many diagnostic categories with questionable reliability. These increasingly medicalise normal reactions, such as grief or shyness: a label of psychiatric illness would be imposed on people who would fare much better without

one. Consequently, *DSM-5* could also lead to unnecessary and potentially harmful treatment, especially considering the relative ease with which potent psychotropic drugs are prescribed.

For these reasons, Mental Health Europe denounces the exclusive use of biomedical approaches in the new *DSM*. While science can be very useful for mental health and well-being, the simplistic and imposed application of partially explored, reductionist science can also impede understanding of the human condition and encroach on basic human rights.

There are many tried and tested psychosocial approaches to treating and supporting people with mental health problems. These are neglected by the powerful political and commercial interests which dominate Western psychiatry. over the next few months, Mental Health Europe will be giving prominence to some of these through our newsletter and website, so that service users and their families can make informed judgements. Articles, research and conference summaries will be published. These will include models which combine medical with other approaches, as well as models which are not at all medically based.

in light of these points, Mental Health Europe also calls on the World Health organisation to take account of these widespread concerns in the forthcoming revision of its own *International Classification of Diseases*. When it classifies mental health problems and assesses the effectiveness of interventions, we ask it to give much more weight to service user experience and psychosocial approaches.

Mental health problems are not black and white. They can be fleeting or permanent, stem from a multitude of causes, and, depending on the individual person, respond to different interventions. The biomedical approach in the DsM-5 *is thus restrictive and harmful, and should definitely be rethought.* Karina Huberman, Acting Director of MHE. Brussels, May 17, 2013

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BooK REViEW
TWo PLEAs FoR sAniTy   in JuDGinG insAniTy
Dwight Garner

the book of w oe: the DsM and the unmaking of psychiatry by Gary Greenberg. 403 pages. Blue Rider Press. $28.95.

saving normal: an insider's revolt against out-of-control psychiatric diagnosis, DsM-5, big Pharma, and the medicalization of ordinary life by Allen Frances. 314 pages. Harper Collins. £18.99.

The new edition of *The Diagnostic and Statistical Manual of Mental Disorders* was published in May. This revision of the so-called bible of psychiatry, known as *DSM-5*, is available at a hardcover price of $189.

Before its publication, there were pre-emptive strikes against it in the form of new books by Gary Greenberg and Dr. Allen Frances. Like anti-missile systems, these volumes propose to knock the forthcoming Manual out of the sky.

The arrival of a new *DSM* is always an awkward moment for psychiatry. it is a rewriting of the rules of engagement with the human mind, and a tacit admission of past errors, errors that have caused irreparable harm. For example, homosexuality was listed as a mental disorder until 1973.

if you think disputes over a new edition are merely a matter for eggheads, you should reconsider. As Dr. Frances notes, *DSM* holds vast sway over human lives, dictating:

… who is considered well and who is sick; what treatment is offered; who pays for it; who gets disability benefits; who is eligible for mental health, school, vocational, and other services; who gets to be hired for a job, can adopt a child, or pilot a plane, or qualifies for life insurance; whether a murderer is a criminal or a mental patient; what should be the damages awarded in lawsuits; and much, much more.

Both authors argue that the manual and its authors, the

American Psychiatric Association, wield their power arbitrarily and often unwisely. They encourage the diagnosis of too many bogus mental illnesses in patients (Binge Eating Disorder, for example) and too much medication to treat them.

Greenberg goes further in his assertions: psychiatry itself is suspect. We know so little about the human mind. For bodily diseases, there are actual tests. For mental diseases, not so much. Psychiatrists are forced to deal with symptoms, which are often misleading.

'A doctor who diagnosed strep entirely on the basis of symptoms was practicing bad medicine,' he comments, 'while a doctor who diagnosed depression only on the basis of symptoms was practicing standard psychiatry.' He argues that psychiatry needs to become more humble, not more certain and aggressive.

Mr. Greenberg is a practising psychotherapist, the author of books including *Manufacturing Depression* (2010), and a contributor to *Mother Jones*, and other magazines. His current book grew out of an article he wrote for *Wired* magazine.

Dr. Frances, who is also among the major characters in Greenberg's book, is the former chairman of the Psychiatry and Behavioral science Department at the Duke university school of Medicine. He was also the chairman of the task force that put together the previous version of the *DSM*. He is a man who, Greenberg writes, 'has spent the last four years waging a scorched-earth campaign against his successors.'

Greenberg is the fresher and funnier writer. He doesn't merely mock the way that the American Psychiatric Association bends its findings to be sensitive to the needs of clinicians or patients. He delivers this arrow: 'if Galileo had been sensitive to the needs of priests, we might still think that the sun moves around the earth.'

yet his book is also repetitive and overlong.

Accurately enough, Dr. Frances calls his book '… part mea culpa, part j'accuse, part cri de coeur.' He delves more deeply into the history of mental illness, makes his

arguments crisply and has good personal stories to tell. He's articulate and learned. But his book also feels pokey and padded – 75 pages of good material attempting to fill a much larger sack.

Both have three essential targets. The first is diagnostic inflation: the way we are turning normal people, especially normal children, into mental patients. The second is the American Psychiatric Association, which neither writer trusts to possess naming-rights to psychological pain, in part because of its financial stake in new editions of the manual.

Finally, there is *DSM-5* itself, for which both authors offer a critique based on what they know of it thus far. At least narratively, Greenberg has the upper hand here because he was among the lower-level therapists – in the APA's terminology, 'collaborative investigators' – who agreed to supply data in field trials to help undergird the book's conclusions. Greenberg witnessed the disarray up close.

A central argument against the latest edition of *DSM* is that it gave clinicians too much discretion and leads to a diagnostic epidemic. The problem with the latest manual, in Frances's view, is that by adding more neuroscience it attempts to make 'psychiatric diagnosis more precise by quantifying disorders with numbers'.

But as Greenberg shows over and over again, the neuroscience isn't really there yet. He thinks the manual, in its every iteration, is nothing more than 'a compendium of expert opinions masquerading as scientific truths, a book whose credibility surpasses its integrity, whose usefulness is primarily commercial.' He compares it to a book of poorly written short stories.

Greenberg is a more cynical fellow than Frances, who declares: 'My nightmare scenario is that some people will do a selective reading and draw the completely incorrect and unintended conclusion that i am against psychiatric diagnosis and treatment.' yet Greenberg, like Dr. Frances, is basically in loyal opposition to much of the way psychiatry is practised.

Each of these books is depressing to read – they should come with a strawberry milkshake and a side order of Zoloft. Each author spies a kind of bad faith at the centre of the psychiatric world, and each argues for more honesty, less certainty and more close and extended observation of patients, who can't be reduced to numbers by their psychiatrists.

Frances writes, 'i like eccentricity, and eccentrics.' Like Greenberg, he's in favour of not medicating, and thus muffling, all the off-beat pain and beauty out of existence.

These authors' dual piece of intellectual skywriting might be: Keep Life Weird.

A version of this review appeared in *The New York Times*, May 2, 2013.

NEUROLEPTIC DRUGS & PATIENT VIOLENCE

Catherine Clarke SRN, SCM, MSSCH, MBChA
& Jan Evans MCSP, Grad Dip Phys

In Asylum 17.2 *and* 17.3 (2010) *we published two articles by Catherine Clarke. These are perhaps the most important articles we ever published. They concerned the known genetic basis to the ill-effects of psychotropic medication, and NICE's failure to recommend testing for the possible ill-effects of different psychiatric drugs on different patients, or even to acknowledge that the problem exists.*

This article explores research which reveals another officially unacknowledged ill-effect of medication. It came to us with full references which had to be removed for reasons of space. The original (fully referenced) version of this article is available free from: cclarke@post.com

Introduction

In this article we address the fact that the treatment for Severe Mental Illness (SMI) is neuroleptic medication and that this has certain undesirable consequences.

It is established that there is an increased risk of violence perpetrated by people with a mental health diagnosis. A greater risk of violent behaviour (27.6%) has been found for patients who commit substance abuse, compared to non-abusers (8.5%). For patients with schizophrenia, 13.2% committed at least one violent offence, compared with 5.3% of the general population.

Violence is reported in response to command hallucinations: in one study, 48% committed harmful or dangerous actions. This increased to 63% in medium-secure units and it was significantly higher for the forensic population (at 83%).

People classified as SMI (i.e. schizophrenia or bipolar disorder) often commit violent incidents *following* a diagnosis of SMI, even though they do not consume alcohol or street drugs, nor have a past history of violence or command hallucinations to harm others.

Our purpose is to provide an explanation of how neuroleptic medications are also a potential cause of violence. We take a physiological perspective concerning pharmacogenetic variants and the disruption of neurotransmitters. In Part 1 we discuss what is known about neuroleptics and neurotransmitters; in Part 2, the neuroleptic disruption of neurotransmitters.

1: Neuroleptics and Neurotransmitters

Patient Violence

This is an important issue. In three acute psychiatric units in Australia, 58 % of reported incidents were seriously violent. In an attempt to address psychiatric violence in the UK, the National Institute for Health and Clinical Excellence* (NICE) published a full clinical guideline: *Violence. The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments.* Although this addresses many issues, it omits the following potential causes of violence:

- Neuroleptic medications: due to neuroleptic disruption of neurotransmitter circuits such as dopamine, serotonin, norepinephrine/noradrenaline and acetylcholine.
- Pharmacogenetics: the issue of inefficient neuroleptic metabolising.

Adverse Effects on Behaviour of Neuroleptics

Neuroleptic toxic adverse reactions are related to behavioural changes such as akathisia, with symptoms of extreme, involuntary internal physical and emotional restlessness, including restlessness, agitation and irritability.

Akathisia was formally recognised in the late 1970s, and is known to be a predisposing factor to violence. When there is an existing precondition, and patients are agitated or irritable, they are less able to cope with perceived disrespect and are more prone to respond violently – any perceived untoward disrespectful attitudes or verbal communications can trigger violence.

A marked increase of violence occurs with patients prescribed moderately high doses of haloperidol, and with Asian patients clozapine played a role in causing aggression and disruptive behaviour. One study reports that 'the newer antipsychotics did not reduce violence more than perphenazine': both the older 'typical' and the newer 'atypical' neuroleptics are associated with adverse behavioural reactions

Toxic Behavioural Effects for Typical Neuroleptics

Typical Neuroleptics	Adverse Reactions Related to Violence
Clopixol	Agitation and akathisia
Haloperidol	Restlessness, agitation and violence
Stelazine	Restlessness
Sulpiride	Restlessness and akathisia

* Now The National Institute for Health and Care Excellence

The Toxic Behavioural Effects for Atypical Neuroleptics:

Atypical Neuroleptics	Adverse Reactions Related to Violence
Abilify	Restlessness, agitation and akathisia
Amisulpride	Agitation
Clozaril	Akathisia and agitation
Olanzapine	Restlessness and agitation
Palperidone/Invega	Akathisia and aggression
Quetiapine	Akathisia and irritability
Risperidone	Agitation
Sertindole	Akathisia
Zotepine	Akathisia

Observations in prisons also associate neuroleptic treatment with increases in aggressive behaviour. Inmates were better able to control their aggression until prescribed neuroleptics, after which the aggression rate almost tripled.

Adverse Effects on Behaviour of Neuroleptic Withdrawal

There is also the issue of violence experienced during withdrawal. Irritability and agitation are reported in association with neuroleptic withdrawal, and a direct reference links akathisia following the withdrawal of a depot in an in-patient setting. Irritability, agitation and akathisia need to be recognised as reactions to neuroleptic withdrawal.

In order to prevent violence in association with akathisia and withdrawal, this process needs to be undertaken by a professional or lay person who understands the potential problems and can therefore guard against unwittingly appearing at all antagonistic to the patient.

Neurotransmitter Functioning and Behaviour

Human behaviour is fundamentally determined by neurotransmitter functioning. 'A rich literature exists to support the notion that monoamine (i.e. serotonin, dopamine, and norepinephrine) neurotransmitter functioning is related to human aggressive behaviour.'

Dopamine, serotonin and all other neurotransmitter circuits are interdependent, and a disturbance in one results in an imbalance in all, thereby disrupting normal functioning. Jackson's First Law of Biopsychiatry states: 'For every action, there is an unequal and frequently unpredictable reaction.'

Chronic neuroleptic treatment causes unpredictable behavioural reactions due to dysregulation and disruptions between dopamine, serotonin and acetylcholine neurotransmitters.

Neuroleptics and Serotonin Disruption

Some neuroleptics which affect serotonin receptors are known as 'serotomimetics': some block the receptors and some make them more active. 'There are 14 different types of serotonin receptors that may be targeted by neuroleptics, with risperidone, clozapine, olanzapine, quetiapine and clopixol especially affecting the serotonin 5-HT2 receptor.'

Changes in mental status occur in Serotonin Syndrome, caused by neuroleptic drugs due to serotonin toxicity.

Animal research indicates that serotonin disruption is associated with increased violence. Reduced levels of a specific serotonin metabolite (5-HIAA) in cerebrospinal fluid is linked with increased aggression in both dogs and male rhesus macaques, and low concentrations of 5-HIAA in different cultures are consistently reported to be associated with impulsive destructive behaviours, aggression and violence.

Since 'Impulsive violence is closely linked to serotonergic function and to several brain regions, and since impulsivity is also linked with both low and high serotonin levels, it is difficult to know which of these changes plays the most important role in treatment-emergent violence.'

The reciprocal interaction between the dopaminergic and serotonergic systems that are disturbed by either dopaminergic blockers or serotonergic enhancers leads to the disruption of homeostasis. Although the serotonin system and its interactions with other neurotransmitters are complex and full information is difficult to find, there are research papers which clearly show that serotonin and aggression are related.

Neuroleptic Serotonin Disruption-Associated Adverse Toxic Behavioural Effects

Akathisia	Irritability
Suicidality	Violence
Arson	Aggression
Violent Crime	Self Destructiveness
Impulsive Acts	Agitation
Hostility	Violent Suicide
Argumentativeness	

Neuroleptics and Noradrenaline/Norepinephrine Disruption

Neuroleptics affect the norepinephrine neurotransmitter; akathisia induction with haloperidol is known to be associated with increased noradrenaline turnover.

Neuroleptics and Acetylcholine Disruption

An important function of the acetylcholine neurotransmitter is the control of psychological defence mechanisms, including fight or flight responses. Such responses are impulsive and naturally include aggression or violence.

In varying degrees, all neuroleptic drugs have anticholinergic properties. This means that they block and cause disruption to the acetylcholine neurotransmitters. The body compensates and responds by making and releasing more acetylcholine.

Acetylcholine Disruption and Increased Violence

In animals, aggressive responses such as defensive rage and violence are linked with excessive acetylcholine, and a relative acetylcholine increase is associated with neuroleptic drugs due to the disruption of the dopamine-acetylcholine equilibrium.

Since excessive acetylcholine is linked with aggression and violence in animals, it is likely that neuroleptic-induced acetylcholine abundance triggers aggression and violence in humans:

Neuroleptic → Disrupted dopamine-acetylcholine equilibrium → Relative acetylcholine increase → Aggression/Violence

Neuroleptic Malignant Syndrome and Organophosphate Exposure

Neuroleptic Malignant Syndrome (NMS) is an adverse effect of neuroleptics and potentially fatal condition, with a mortality rate of up to 76%. Symptoms of NMS include aggression, agitation and violence. New research associates NMS with elevated acetylcholine.

Organophosphate chemicals form the basis of many insecticides, herbicides and nerve gases. They block the action of the body's acetylcholinesterase enzyme, which breaks down acetylcholine so it may be processed and recycled. If the action of this enzyme is blocked, excessive acetylcholine accumulates in the nervous system.

Prolonged and repeated exposure to organophosphates results in Chronic Organophosphate-Induced Neuropsychiatric Disorder (COPIND), e.g. the chronic organophosphate poisoning (OP) found in farmers who handle pesticides. COPIND behavioural symptom changes include: hostility, anger, aggression and violence. Since OP results in excessive acetylcholine, which is linked with aggression and violence in animals, the behavioural changes in COPIND are highly likely caused by excessive acetylcholine.

The link between Neuroleptic Malignant Syndrome and Organophosphate Poisoning

The symptoms of NMS and OP are similar. In both NMS and OP the replication of symptoms is due to autonomic instability, and this stems from disruption of the acetylcholine circuits and transmitters of the autonomic nervous system which are involved with vital involuntary functions. Autonomic instability includes profuse sweating, high blood pressure, low blood pressure, respiratory distress, drooling, urinary or faecal incontinence, and either increased or decreased heart rate.

The Symptom Similarities of NMS and OP

Neuroleptic Malignant Syndrome	Organophosphate Poisoning
Autonomic nervous system disturbance	Autonomic instability
Aggression, agitation and violence	Aggression
Muscle rigidity	Paralysis, dystonia, cranial nerve palsy and polyneuropathy
Muscle breakdown	Weak respiratory and limb muscles
Coma, alterations of consciousness	Loss of consciousness
Confusion	Dementia, psychosis, anxiety, depression
Fever	Seizures

Conclusion: Organophosphates, Neuroleptics and Violence

Organophosphate poisoning results in over-stimulated acetylcholine neuro-circuits and systems. The action of neuroleptics is similar. It is generally accepted that organophosphate poisoning results in behavioural changes, including violence.

Despite research demonstrating that neuroleptics are associated with disrupted acetylcholine, it is not yet generally accepted that neuroleptics are a potential cause of violence.

Antipsychotic (neuroleptic) drugs have strong anticholinergic properties. Long-term use causes behavioural changes which replicate the behavioural changes occurring in chronic organophosphate poisoning :

'This adaptation [to psychiatric drugs] replicates the effect of organophosphate poisoning whether by nerve gas, by insecticide, or by anti-Alzheimers pharmaceuticals, by over stimulating acetylcholine circuits of the brain.'

Increased Prescribing of Neuroleptics

There has been a distinct increase in neuroleptic medications,

prescribed as part of treatment for mental health issues.

In the UK between 1998 and 2010, neuroleptic drug prescriptions increased by an average of 5.1% every year. Over twelve years, this is a total increase of 60%.

The data for the number of neuroleptic prescriptions in inpatient settings is not made available ('due to confidentiality'). So the actual total increase of neuroleptic prescriptions in the UK is unknown. However, in England, the approximate number of neuroleptic and depot (injection) prescriptions for outpatients in 2008 was 7.0 million, in 2009: 7.3 m, in 2010: 7.6 m, and in 2011: 7.9 m.

Increased Prescribing as a Risk for Increased Violence

As outlined above, neuroleptics are a possible cause of violence. With ever-increased prescribing of neuroleptic medications, it is reasonable to expect an increased amount of violent behaviour amongst those with a severe mental health diagnosis.

Since neuroleptic prescriptions are increasing by at least 300,000 per year in the UK, it seems likely that the rise in violence for neuroleptic-treated patients will also escalate, whether in the community or in acute wards, secure units, prisons or outpatient units.

2: Neuroleptics and Pharmacogenetics

Introduction

Pharmacogenetics is the science of how drugs are broken down and used, i.e. metabolised in the body (mainly in the liver) by the genetically diverse cytochrome P450 (CYP450) enzyme system and other drug-metabolising systems. There are many CYP450 variants that affect the therapeutic efficacy or inefficacy of medications.

People who are Extensive Metabolisers are efficient metabolisers, whereby side effects do not build up. Poor Metabolisers are inefficient metabolisers that have no metabolising activity whatsoever; this means that drug toxicities do build up and cause side effects. Intermediate Metabolisers have approximately 50% drug metabolising capacity and produce lesser side effects than Poor Metabolisers. Ultra Rapid Metabolisers/Hyperinducers have higher than normal rates of drug metabolism and: 'For prodrugs Ultra Metabolisers may also be at increased risk of drug-induced side effects due to increased exposure to active drug metabolites.'

Neuroleptic drugs are metabolised through CYP450 enzymes, e.g. CYP450 1A2, 2D6 and 2C19. For metabolisation, a single neuroleptic can necessitate a combination of CYP450 enzymes.

All serious mental illness (SMI) patients who are Poor and/or Intermediate Metabolisers of neuroleptics, as well as Ultra Metabolisers of neuroleptic prodrugs (activated by metabolic processes of the body, e.g. paliperidone, the active metabolite of risperidone) inevitably suffer neurological and behavioural changes due to the toxicity they incur from the body's inability to metabolise neuroleptics efficiently. Polypharmacy (the use of multiple medications) – which is quite normal – compounds these toxicities.

CYP450 1A2 Metabolising Pathway and Neuroleptics

The CYP450 1A2 enzyme pathway has many variants. It metabolises olanzapine and haloperidol and is the major metabolising enzyme for clozapine.

CYP1A2*1C and *1D Poor Metabolisers have been associated with increased clozapine exposure and adverse reactions. CYP1A2*1K is also a Poor Metaboliser genotype.

In one study, Asian patients prescribed clozapine manifested aggression and disruptive behaviour; improvement followed discontinuation of clozapine. The genotype of the Asian patients in the study is unknown. However, since 25% of Asians have the CYP1A2*1C Poor Metaboliser genotype, it is possible these patients were either CYP1A2*1C, *1D or *1K, or a combination of those Poor Metaboliser genotypes.

In addition, 15–20% of Asians are Poor Metabolisers for CYP2C19, and 2% are Poor Metabolisers for CYP2D6. CYP2C19 and CYP2D6 metabolise clozapine as well as CYP1A2; any of these combinations are possible and could have predisposed the subjects to disruptive behaviour.

CYP450 2D6 Metabolising Pathway and Neuroleptics

75% of all psychotropic drugs (including neuroleptics) are metabolised via CYP450 2D6. This is a highly variable enzyme with a significant percentage of the population being Poor, Intermediate or Ultra Metabolisers. It is also linked with a poor therapeutic response and adverse reactions.

Violence in relation to serotonin toxicity/akathisia has been linked with pharmacogenetic CYP450 2D6 drug metabolising variants.

Pharmacogenetics with respect to Ethnic and Black Populations

For the CYP450 2D6 pathway, due to genetic variation there is higher incidence of Poor Metaboliser and Ultra Metaboliser status amongst Black populations, compared with White and Asian populations. 'The prevalence of poor metabolizers in Black populations has been estimated from 0–19%, compared with consistent reports of Poor Metabolizer status in Caucasians (5–10%) and Asians (0–2%).'

Recalling that 75% of neuroleptic medications are metabolised via CYP450 2D6, the following table shows the variation of metabolising ability in black/ethnic populations for CYP450 2D6.

	Poor Metabolisers	Ultra Metabolisers
South Africans	18.8%	
Nigerians	8.6–8.3%	
Ghanaians	6%	
African – American	3.9%	2.4%
Zimbabwean	2%	
Tanzanian	2%	
American Black	1.9%	
Ethiopians	1.8%	29%

29% of Ethiopians and 2.4% of North African Americans are Ultra Metabolisers via the CYP450 2D6 pathway. Furthermore, 10–20% of Africans are Poor Metabolisers and 5% are Ultra Metabolisers via CYP450 2C19.

Many prescription medications can lead to 'serious mental change'. Since, statistically, Black populations have greater difficulty metabolising general and psychotropic medications (and cannabis) via the CYP450 pathways, this factor could contribute to BME groups living in the UK who are more likely to be diagnosed with a mental mealth problem and admitted to hospital.

Psychiatric Intensive Care Units and Over-representation of Black Populations

There is a clear over-representation of Black ethnic patients in the UK's psychiatric intensive care units (PICU). One study found that, compared with 25.6% of total hospital admissions and 20.9% of the local catchment area population aged 16–65, 55% of PICU admissions were from ethnic minorities.

Typical PICU patients are male, younger, single, unemployed, suffering from schizophrenia or mania, from a Black Caribbean or African background, legally detained, and with a forensic history. The most common reason for admission is for aggression management.

UK Mental Health Act Detentions and Over-representation of Black Populations

When considering detention under the Mental Health Act, there is also a disproportionately large representation of Black, Minority and Ethnic (BME) origin.

Between 2007/8 and 2008/9, the proportion of Black and Black British people legally detained rose by 9.7%; compared to a 0.3% rise for the overall number of people detained, there was also a rise of 9% in the number of Asian or Asian British and mixed-race people detained for treatment. 31.8% of all psychiatric inpatients spent some time detained during that year. But for Black/Black British inpatients the proportion was 53.9%, for mixed-race inpatients it was almost 50%, and for Asian/Asian British inpatients it was 40%.

UK Community Treatment Orders and Black Populations

Community Treatment Orders are enforced in the UK when patients have received mental health treatment (i.e. neuroleptics) and have a history of violence. Unsurprisingly, BME groups have more Community Treatment Orders than White populations.

There is a possible relationship for psychiatric inpatients between compulsory detention, disturbed behaviour, depot medication and being Black, which is not satisfactorily explained by diagnosis alone.

The higher incidence of mental health problems in Black populations may well be due to the higher incidence of Poor, Intermediate and Ultra Metabolisers, and associated problems with the metabolising of medications.

Summary

- Due to neurotransmitter disruption, neuroleptics can be a cause of violence.
- Violence must be considered not simply as an indication of how schizophrenia or bipolar illness can get worse, but as an adverse effect of neuroleptic treatment.
- People who are inefficient metabolisers are likely to suffer more severe adverse effects, and more likely to become violent or aggressive.
- BME populations have a higher incidence of inefficient metabolisers, and as such a higher incidence of violence leading to PICU admissions and Mental Health Act detentions.
- However, whatever their ethnicity, if individuals are Poor and Intermediate Metabolisers or Ultra Rapid Metabolisers for prodrugs, the impact of neuroleptics in triggering akathisia, aggression or irritability can increase the propensity to violence.

Conclusions

There is a bigger incidence of violence in people with a severe mental health diagnosis than in the general population. Those suffering a severe mental disorder are invariably treated with neuroleptic medication. But, since neuroleptic medications disrupt neurotransmitter functions, this can itself cause violence. The withdrawal of neuroleptic medication is also problematic, due to the disruption of neurotransmitters associated with violence.

Pharmacogenetic research indicates that many patients are unable to metabolise neuroleptic medication, fully or at all, and that this inability can result in further disruption of neurotransmitter functioning, with an increased likelihood of violence.

The inability to metabolise neuroleptic medication is particularly prevalent in BME populations. As a consequence, this population will tend to commit violence

more often. This is confirmed by an over-representation of BME individuals on psychiatric intensive care units (where a common reason for admission is aggression), and by the use of Mental Health Act detentions and Community Treatment Orders.

With the trend towards increased prescribing of neuroleptic medications, increased levels of violence can be anticipated for the future.

However, it is possible to ameliorate the greater propensity to violence amongst patients diagnosed with a severe mental illness. First, by ensuring that pharmacogenetics is fully recognised as a significant factor. Second, by adopting genotype testing for the ability of each individual to metabolise proposed neuroleptic medication. Without such testing, much of the responsibility for the patients' violence can be laid at the door of psychiatrists and the pharmaceutical companies.

dIAIOguE & dEbATE IN PRESTON
William Park

successfully described the narratives of people who, for one reason or another, have been alienated. i also mentioned The Tidal Model originated by Phil Barker and Poppy Buchanan-Barker. They emphasise the importance of people's values and the strengths of the natural community.

On November 27th 2012, I hosted the first Preston public mental health debate in association with *Asylum* magazine. This was held in the heart of Preston's city centre, in the conference suite at the Council for Voluntary services (Guild Hall Arcade). Photographer sebastian Kozbial of 'sebo photography' took pictures of the event, and a small selection accompanies this piece.

My concept for these occasional events is to have an ongoing dialogue with the public around 'mental health' issues, starting with presentations from key speakers and followed by a debate exploring themes and problems surrounding mental health work and 'treatment'. i am aiming for a gradual shift in perception so that we can come together as a community and realize that, in terms of living our lives and encountering problems and difficulties, we are all essentially the same. The more we label people as 'other' we set up divisions and find it more problematic to unite together as a community.

I was happy that the venue was filled to capacity, and a good representation of the community attended.

i introduced the evening, referring to Tony Parker's writings from the 1970s onwards, as i felt he has

Dina Poursanidou spoke about the pressures on mental health services, highlighting Manchester since that's where she is currently a service user researcher. sonia soans raised the importance of recognising the cultural connections linked to issues surrounding mental health, and called for more understanding of people's alternative experiences and visions. Helen Spandler identified 'madness' in general terms as involving behaviours that we don't understand, which challenge and often frighten us. She hoped that by airing our experiences we could find more deeply human responses.

The debate in the second hour brought to light a cluster of different dilemmas and questions, including: the language used in discussions around mental health problems; the fear of difference; pressures on the mental health system; community support; what does 'recovery' mean?; cultural understandings of 'visions' and 'voices'; the role of the voluntary sector; idealism vs. reality; time and resources for prevention rather than 'cure'; and recognition that there are no 'easy answers'.

in summer 2013 there will be a second debate, at the same venue, to continue the discussions with more speakers, including Tamasin Knight of the Asylum Collective.

Photos on this page by Sebastian Kozbial (Sebo photography)

FEAR & LOATHING IN THE CON DEM NATION

Michelle Brown

Like poor Alice, we have tumbled into a looking-glass world. As the century embarks on the difficult teenage years, as the future looks bleaker than ever before for almost everyone, a coterie of dead-eyed, grinning (and crucially: rich) sociopaths literally laugh in the faces of the poor as they rob them. This is a familiar hobby for their leader, a man who spent his formative years as a member of that notorious gang of (k)nobs, the Bullingdon Club – cruising around in Bentleys, laughing at beggars while burning £50 notes in front of them. Our leaders strike me as the sort of men who would enjoy pulling the wings off flies. And they are overwhelmingly men. In fact, overwhelmingly white, male millionaires. This is something I find so outrageous I am daily astonished that people are not out in the streets going: 'Wait a minute!'

Against this dystopian background, policies and press alike become more and more poisonous, bad and mad. One gem among multitudes came from *The Daily Mail*. Hysterically, it accused a man of being 'workshy' when he was so scared of being found fit for work that he cut off his own foot and cooked it so that it couldn't be reattached. This name-calling was followed by some egregious crowing that the man in question had STILL gone on to be found fit for work. This was cheered on by a luminously intelligent comment: 'This shows how easy it is to get benefits'. (Which leads one to believe that the commenter had not really understood the article.) The man had not been 'clearly desperately mentally ill', but 'workshy'. Such are the depths we have sunk to in our populist disgust, abjection and total lack of empathy for the poor, sick, disabled and vulnerable.

In fact, the only time the press applies the lexicon of mental illness soothingly and with concern is with regard to The Market. The Market is 'depressed', 'in crisis', 'in need of reassurance', or 'crashing'. In law, corporations are classed as 'people'. The Market is seen as a sensitive flower that needs constant 'incentives' and 'reassurance' lest it fall into catastrophic depression. Meanwhile, actual breathing mentally ill people are left to rot in penury and be treated as scum – increasingly, to the point of being physically attacked.

In this shameful context, a new conversation about mental health urgently needs to be had – a political conversation.

Mad and bad policy, bad and mad media, a total vertiginous reversal of what matters most. The appeasement of The Market (which is equally worshipped and feared) with endless sacrifices, as if it is some vengeful, never-sated pagan god, whilst enacting policies which directly affect and in one way or another impoverish, oppress, discriminate against, demonise or otherwise harm nearly all actual HUMANS. Is it any wonder actual humans go mad? Or is our distress a completely natural and understandable response to a world and a polity which is becoming inexplicable, psychotic, monstrous, openly evil, and obscenely, avidly greedy, and (if we are compassionate thinking beings) beyond our comprehension? Any examination of what is happening to millions of people in our country right now makes it self-evident that mental distress is inevitable. It would be strange if people were not depressed. And so any diagnosis of 'mental illness', and individualised treatment (usually in the form of medication), runs the risk of medicalising inequality.

Image by Clara Lieu: www.claralieu.com

Let's take a tour around those affected by this government's austerity measures. Let's illuminate why so many are unhappy, frightened, and in despair. The sick and disabled are, quite literally, being hounded. The despised Work Capability Assessments, administered by the reviled Atos, are based on tick-boxes and targets. They have been condemned by doctors. They are based on assumptions, guesses and lies. They are humiliating. They deny all dignity and humanity.

For example, depressed people can be found 'fit to work' because they present themselves in a clean state. To prevent the loss of our income, to prevent being forced to look for work that we are not able to do and which is brutally scarce anyway, they will take their pound of flesh: we must demean ourselves by turning up filthy, stinking and babbling. It may be apocryphal, but the sentiment is all too real, when a Whitehall mandarin is reputed to have said: 'If we want them to tap dance, they'll tap dance, they'll tap dance.'

The unemployed must endure indignity and slur ad infinitum, despite there being so few jobs that a recent vacancy at Costa Coffee attracted 1,700 applicants. Voluntary work is essential, laudable and altruistic, and Cameron's Big Society rhetoric applauds it. Yet the workfare programme has resulted in the ludicrous situation whereby doing voluntary work can be used against people so as to find them 'fit for work' or – even more ridiculous – forcibly removing them from their voluntary work and putting them into a shelf-stacking placement. Never mind that with volunteering, unlike with paid work, you can choose your own hours and stop if you need to. Never mind that the charitable sector is already stretched to breaking point because of the cuts, and relies on volunteers. Never mind that volunteering has tangible benefits both for society and the volunteer, particularly for the self-esteem and sense of purpose it can give to those who are unable to engage in paid work. No, if we don't want to be packed off to Poundland, we must hide and lie about the good that we do. Again, who is really mad here?

The cuts are disastrous for women. Benefit cuts are bound to hit women the hardest, since we shoulder most of the caring responsibilities and make up most of the under-protected, part-time workforce. Women's refuges are shutting almost daily, even as the incidence of domestic violence rapidly rises – in response, no doubt, to poverty and frustration. Changes to benefits and legal aid mean that abused women and children will be unable to afford to escape, or to have their abusers prosecuted. Some commentators reckon that the cuts amount to state-sponsored discrimination against at least half of the population.

As students, we are not immune. An average undergraduate degree now costs in the region of £26,000, while rents are rocketing for shoddy, damp and often unsafe student houses. Our education is increasingly run along neo-liberal lines, meaning that research modules are cut and business and management degrees proliferate.

At Lancaster, there have been some notable successes in mental health provision for students. A long-term campaign to improve the counselling service, both in terms of availability and context of sessions (some sessions were being held in open spaces where people could see in) has resulted so far in 25 more sessions a week being added, with a report on longer term solutions promised by the Head of Student Wellbeing. And this year, a new student-run group has started up: LU Open Eyes, Open Mind. As a sufferer of chronic depression and anxiety, this development fills me with hope.

Image by Clara Lieu: www.claralieu.com

On early showings, there is great enthusiasm for Open Eyes, Open Mind, and a feeling that this is something that's needed. But I believe we need to go even further. We need to stop medicalising inequality. We need to refute the idea that mental illness is some kind of personal defect, something in us that needs to be fixed. We need to say: There is nothing wrong with us. What is so glaringly wrong is outside of us, deeply embedded in the vagaries and cruelties of modern industrial capitalism, a wounded beast more dangerous than ever in its desperate death throes. We need to say: Is it any wonder we are mad, when our incomes, our prospects, our very souls are being attacked from all sides? When dissent risks incurring police brutality or a criminal record? When every day our characters are assassinated in the media?

Depressives, agoraphobics, schizophrenics of the world unite!

We have nothing to lose but our demons!

www.radicaluniversity.wordpress.com/

The Royal College of Psychiatric Patients
By Jo McFarlane

They met once a lunar month
in the hospital board room.

The manically elated
dictated the agenda

and the obsessive compulsives
went through the minutes
of the previous month's meeting
with a fine tooth comb.

The schizophrenics
carried every motion with wild gesticulation.

The depressives
never spoke, just sat and smoked.

As for the Waterline Personality Disorders,
they were struck off long ago
for being a bunch of quacks!

BIGOTS AMONGST THE ANTI-CAPITALISTS

Ronny

Asylum 19.3 (Autumn, 2012) made some important points about the role of capitalist ideology in the theory and delivery of mental health services. An issue just as close to my heart is the lack of mental health awareness amongst anti-capitalist activists.

A year ago, i took a call from a friend who was very upset about being chucked out of a squatted social centre in the early hours in the morning for 'acting weird and talking too much'. He told me he'd tried to get involved in the occupy movement, by turning up at camps with a sleeping bag and food to share. Each time he found it extremely difficult to fit in, despite the movement's claim to welcome everybody.

it's all very well for occupy activists to claim they represent '99% of society', but does this include the 1% with psychiatric labels of 'severe mental illness', or even the 25% who mainstream anti-stigma organisations claim 'will experience mental health issues at some point in their lives'?

As a teenager back in the late-1980s, i got involved in animal rights and socialist groups. it didn't take long to suss out that the corporations which test drugs on animals also offload defective and out-of-date ones onto the world's poorest populations, whilst squeezing every bit of productivity out of their workforces and making huge donations to political parties. social justice issues are inter-linked. The ideology we fight is the same: that individuals can be treated as units of production, and that profit and convenience come before their right to freedom and self-determination.

in all these overlapping movements, activists seek solidarity and community and have established standards and conventions. Tastes in music, clothes, intoxicating substances and even sexual habits are scrutinised by peers, and there is strong pressure to conform as 'acceptably alternative'. Activists, particularly in the peace and environmental movements, are also expected to be educated and articulate.

i've attended hundreds of protests, gatherings and camps over the years, and the level of bureaucracy and efficiency can be staggering, though hardly surprising considering that such events are dominated by middle-class graduates. Meetings are conducted to set agendas, and contributors are expected to be brief and to the point. Hand signals are often used to indicate agreement or disagreement, and participants are expected to pick these up almost instinctively. Ranting isn't allowed. A contributor is expected to be a clear communicator who understands activist jargon and is comfortable addressing groups.

so how do the distressed, angry and less-educated people get their points across? How does a person whose childhood was full of pain, abuse and rough-sleeping, who left school with no qualifications and a complete contempt for authority, fit in to this polite and ordered activist culture? How do the ranters, voice-hearers, hyperactive dreamers and completely emotionally-open people fit in?

sadly, at the moment, they aren't allowed to. i've frequently seen campaigners pushed out and treated with hostility because their behaviour and manner of speech are misunderstood, ridiculed and judged by the very people they most want to be accepted by. i've lost count of the number of politically-aware, experienced activists i've heard calling people 'nutter', 'weirdo' and 'not right in the head'.

Activists need to understand that by doing this they're judging and labelling people as deviant and different. They're putting up barriers to participation in our social justice movement that are as real as a flight of stairs or a shared meal full of meat. it's only by questioning and challenging these barriers that we can kick them down.

Experienced activists know that phone calls and emails are monitored, that 'radical' meeting places are likely to be bugged, and that it is foolish to talk about anything that can be interpreted as illegal in front of people you barely know. We have a healthy, shared awareness. yet, wider society considers this paranoid, not healthy. so: who draws the line between sensible and embarrassing paranoia?

Activists share a painful awareness about the worldwide extent of suffering. Without a lurch of sadness, i can't witness a child being shouted at by a teacher or a cow waiting to be herded into a lorry to have her throat slit. once you open your mind to the reality and scale of exploitation, it's very difficult to switch off your awareness. We all have different ways to express our feelings of outrage and confusion, but the state has chosen to give some of them labels, like 'oppositional defiance disorder'. Must activists do the same, with cruder labels?

i recall sitting in a mental health tribunal at which a psychiatrist stated that her patient's preoccupation with the suffering he saw everywhere was 'deluded and obsessional', and that his eagerness to express his views was 'a symptom of formal thought disorder'. it struck me that the only difference between the patient and the thousands of articulate, 'mentally ordered' activists i've met over the last few decades was one of behaviour. The patient would stand in a shopping centre so as to broadcast his views to strangers, whereas the activists attend structured protests and meetings.

i had no consoling answer for my friend on the phone. i could only agree that bigots exist everywhere, even in so-called inclusive protest movements. That conversation started me on a path of trying to reduce the number of bigots, and i hope that, through discussion and debate, other activists will recognise the seriousness of this issue and join me.

Ronny is a community mental health advocate, working in Derbyshire.

MAD LOVE

Asylum interviewed James, '*The Vacuum Cleaner*', about the exciting new 'Madlove' project:

What is the 'Madlove – A Designer Asylum' project about?

Madlove, like a lot of my work as an artist and activist, is about power, and who has a legitimate right to it. People who experience mental distress are often not really the driving force in shaping care. In fact, it's often referred to as something that is 'done to us'. So it's a project where mad people get to design our own spaces for experiencing mental ill health, and then it's opened as a physical environment that can hopefully pioneer what an asylum could be like. It will be an example of mutual care, a focus on who the real experts are (i.e. not mental health professionals and the industry), and about moving beyond the recovery model to what I call 'the discovery model'.

Why did you feel such a project was needed? Why did you develop the project?

I've spent a lot of time in acute mental health wards, in particular the City and Hackney Centre for Mental Health, which is notoriously unpleasant – under-resourced and badly designed – though it has improved a little in the last couple of years. Like many people who have been through these kinds of wards my experience wasn't something caring, but painful, distressing and degrading.

In 2011 my care team wanted to admit me again, tried to section me at home, etc. I was aware that I was very distressed, in an unbearable amount of pain, and that I needed help and support but really didn't want to be admitted to a ward. In 'a moment of madness' I decided to turn my council flat into my own hospital. I wrote my own mental health act and sectioned myself with it – I called the project 'Ship of Fools'. I invited artists and non-artists to come and share this time with me, in an attempt to experience this distress in a more positive and creative way. It was one of the most difficult yet wonderful things I've ever done, but a few months later I realised that I should share this with other people – that the Ship of Fools needed up-scaling and sharing, I guess that's where it comes from.

How are you going about developing the project?

I'm really inspired by the Mad Pride movement. It's such a brave and compassionate thing. But I worry about how sustainable it is (or was). I know all too well that supporting someone in acute distress is utterly draining. So the first thing that Hannah Hull (my collaborator and producer) and I are trying to get right is making it sustainable. That involves raising a lot of money so that we have the things we need and people can be paid a living wage for their involvement. This is taking a long time. In parallel, we're having a lot of conversations with people about the process of the project, what are the pitfalls to avoid, what examples to copy from, etc.

Once we have the financial resources we can get going on everything else. We'll be holding a weekender to bring people together as a big focus group to think about what it could be like, from there we'll hopefully be working with a broad range of people with and without mental health experiences to fully design and build the space.

It will then open for six weeks as a day-space – or that's the plan at least.

Mad Love – Statement of intent from Madlove.org.uk

WHAT IS MAD LOVE?

It ain't no bad thing to need a safe place to go mad. The problem is that a lot of psychiatric hospitals are more punishment than love … They need some Madlove.

Is it possible to go mad in a positive way? How would you create a safe place in which to do so? If you designed your own asylum, what would it look like?

Madlove is a new project by *The Vacuum Cleaner*, based on his personal experience of mental health hospitals, and his desire to find a positive space to experience mental distress … and enlightenment.

The project will bring together people with and without mental health experiences, mental health professionals and academics, artists and designers – and everyone else on the spectrum. Together we will attempt to create a unique space where mutual care blossoms, stigma and discrimination are actively challenged, divisions understood, and madness can be experienced in a less painful way.

The aim is to build the most crazy, bonkers, mental asylum we dare dream of: a desirable and playful space to 'go mad', countering the popular myth that mental illness is dangerous and scary. This temporary structure will be a reflexive and responsive space for exploring and redesigning madness.

Exactly how Madlove looks and functions will be collaboratively decided at a two-day design workshop. Thirty participants will explore what objects, sounds, smells, colours, shapes, food, facilities and activities we need to create safety around 'madness'.

We will design a programme of activities that will happen within the 'asylum' structure. These could include: drop-in sessions, free tea and biscuits, phone lines, family visits, supported food time, benefits support, service-user-led workshops on restraint for the police, debates between herbalists and psychopharmacologists, conceptual art therapy …

Madlove will then be built and opened, operating as a voluntary admission 'day hospital', over six weeks. Primarily

an experimental space, designed by and for the experience of madness, might this model be highly supportive and self-sustainable?

The wider public will be invited – mad or not – to participate in the six-week programme of events. Through Madlove, we can begin to understand the power relations between patient and staff, lived expert and academic expert, artist and audience, neuro-diverse and neuro-typical … and start making positive change.

This significant mutual aid project invites people to share knowledge, experience and openly support and inform each other. We need a wide range of skills to ensure the mutual support needed to make Madlove happen. Whether you are a set designer, a hospital architect, a horticulturalist, a sensory room specialist, a baker … We need you to help ensure the development of supportive relationships and a genuine legacy of Madlove.

If you identify with the need for this project, don't be shy – get in touch. Tell us your ideas or just put your name down and see what happens …

Image courtesy of The Vacuum Cleaner

www.madlove.org.uk
www.thevacuumcleaner.co.uk
twitter.com/vacuumcleaner
www.peoplelikeus.dj

OUT OF SIGHT

Notes on obstacles to community in a Philadelphia Association[1] 'community household'

meg kelly

'We propose,' said Hugh Crawford, 'merely not to silence the unspeakable'.[2]

i lived in The Grove, a Philadelphia Association 'community house', from october 2010 to March 2013. My aim is to raise publicly questions which i found were not welcomed at The Grove (or within the PA more widely) during the time i was living there. Although I have struggled to find the right tone in which to write this, the reflections that follow should be understood as exploratory and contingent. i hope to bring into view aspects of life in PA houses which may otherwise remain out of sight.

My suggestion is that life at The Grove might accurately be understood as subject to disciplinary structures aiming at a form of 'treatment'. The desired outcomes of this treatment would be, in order of importance: attendance at house meetings, not to behave in ways which were disturbing to others, and to replicate the accepted 'therapeutic' discourse of the house. in this view, the speech and actions of those of us living in the house were influenced, if not outright dictated, by the following structures:

house meetings

There were[3] four one-and-a-half-hour house meetings per week at The Grove: on Monday evenings, Wednesday and Thursday afternoons and Friday mornings. Aside from occasional individual meetings to draw up 'support plans',

these were the only times when the therapists were present in the house. Attendance was compulsory, and enforced through tremendous social-emotional pressure. Whilst originating with and encouraged by the two house therapists, this pressure was distributed throughout the group of those living in the house. At times kindly and politely, at times impatiently, covertly and overtly, we 'encouraged' each other to attend, genuinely believing that this was for the best. in retrospect, this 'encouragement' mainly contributed to a damaging tendency to see the times when the therapists were present as the most important times in the house. so effective was this combined pressure – from the therapists, from each other, from within ourselves – that among the feelings elicited by non-attendance were unbearable guilt and terror at being excluded.

It was also enormously difficult, at times impossibly so, for anyone to remain outside the meeting with another

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1. The Philadelphia Association (PA) is a training and membership organisation for psychotherapists, which also runs two 'community households', both in North London. Each has room for up to seven people. House therapists do not live there but attend the house meetings, three times a week at Freegrove and four times a week at The Grove.
2. Robin Cooper, 2004, p. 9.
3. I use the past tense as a recognition that my knowledge of The Grove is limited to the time I spent there.

member of the house when he or she was very distressed, perhaps most especially when the person's distress was to do with the meeting taking place. The house therapists often appeared to proceed on the basis that 'disturbing people are particularly in need of firm organisation',[4] and they strongly disapproved of anyone being outside the room. When the distressed person was also a danger to him or herself, this approach took on a distinctly punitive aspect. Rather than the meetings being placed at the service of the community, facilitating our muddling through with each other from day to day, we were forced to choose between 'the house' (those of us living there, and our solidarity with each other) and the meeting (the arena for our treatment).

hierarchical roles

Whereas an important aim of the early PA communities was to break down the binary structure of 'treater' (psychiatrist, psychotherapist) and 'treated' (patient, resident),[5] by the time i arrived at The Grove in 2010, this distinction was fundamental. no room was left for doubt as to who was managing the institution, and who was subject to it. For example, anyone enquiring about moving in would be put in touch with the house therapists, who would vet them before telling us that this person would be visiting. similarly, PA trainee-therapists wishing to do a placement at The Grove would arrange this with the house therapists, who would then inform us when the trainee would be coming. We were thus denied even the possibility of offering either visitors or trainees a genuine welcome, since we had not had the opportunity to invite them into our home in the first place.

Like other similar arrangements (such as our complete ignorance of the houses' finances), these were presented to us as 'protective', whilst simultaneously denying us any autonomy as a community. The relationship between house therapists and house residents, whatever else it may be and whatever particular forms it might take, was based in a stark imbalance of power.

house discourse

What with so much of our energy going into surviving the intensity of the meetings, not to mention the effort of coping with our own and each other's suffering outside of them, with the crash in self-confidence to which finding oneself allotted the part of 'house resident' could lead, and a generalised feeling of being dependent on the house for our survival, we residents were very vulnerable to indoctrination into particular patterns of thought and speech. using the accepted discourse of the house would make it much more likely that a person's comments would be engaged with and responded to in meetings, especially by the house therapists, whose opinions carried more emotional weight than anyone else's. outside the meetings, we tended to replicate the same patterns in our conversations, at times with humour, but too often in a way that replaced creativity with formulaic responses to, and understandings of, what each of us was going through.

There is space here to mention only one key feature of the discourse of the meetings: a repeated and repetitive emphasis on individual responsibility,[6] used in attempts to shame us into no longer expressing distress in ways which others

found unacceptable. This tended to justify angry outbursts towards a person whose behaviour had been disturbing, so that he or she could become aware of 'the effect you have on others'. Attention was thus diverted from efforts towards a necessary, painstaking understanding of what could be happening between us all so as to push someone into socially unacceptable ways of being. This protected the structures of the house from being called into question.

surveillance

Though dependent on the house meetings, the most potent form of surveillance at The Grove took place outside of them. We were constantly aware that anything any of us said or did in the presence of another, even in confidence, could potentially be 'brought to a meeting'. This meant that, if we wished to do so, we would have to explicitly agree with each other to keep a conversation private. Like prisoners or psychiatric inpatients, we were simultaneously subjected to intense scrutiny in our immediate surroundings and hidden from outside view. yet unlike the situation in a prison or hospital, we ourselves were the main conduits for this surveillance: entirely well-meaningly, we subjected *each other* to it.

isolation and psychiatry

The importance of disciplinary structures within The Grove, and its isolation from the rest of the PA, cleared the path for meshing with the disciplinary institutions of the society beyond – most pertinently with psychiatry. With the emotional resources of those of us living at The Grove most often stretched to the limit, it was not uncommon for someone in great distress to refer themselves (or be referred) to the local psychiatric crisis team, who would then visit the house. on a more day-to-day level, the majority of those living in the house were taking significant doses of psychiatric drugs, and house therapists would liaise with consultant psychiatrists and be involved in drawing up 'crisis plans' to go onto our psychiatric records. Thus psychiatry's methods of social control reached into the house itself, becoming part and parcel of its operation.

Frequent recourse to psychiatry and emergency services not only allowed house therapists to limit their involvement to attendance at the four weekly meetings and the occasional phone call. It also stifled the necessity of a communal effort, of solidarity between those living at The Grove, other people we knew, the house therapists and the PA more widely, which could bring us together in times of crisis.[7] This struck me most forcibly when one of the house therapists attempted to help the police find a member of the house who had fled a hospital section, although fully aware of the great danger a psychiatric ward would pose for her.[8] Where a *communal*, whole-hearted commitment to hospitality is absent, we all too quickly find ourselves (or abandon each other) back at the hospital.

4. Robin Cooper, 1989, p. 9.
5. See, for example, David Cooper 1972 [1971], pp. 58–60.

6. For an alternative approach, see David Smail's discussions of blame and responsibility in *Taking Care* (Chapter 4) and *Power, Interest and Psychology* (also Chapter 4).
7. For accounts of this kind of communal effort in the past, see the chapter on Portland Road (taken from Robin Cooper's unpublished PhD thesis) in Paul Gordon 2010, especially pp. 59–64, and Robin Cooper 2004, p. 8.
8. My point is not to blame the therapist in question for this decision, but to highlight the context which made it seem acceptable.

it is not only from the risk of being forcibly drugged, from hospital-induced suicide or from incarceration that we need refuge, but from the humiliation of being bullied into exposing our most private experiences and our most vulnerable states to the pathologising gaze of the psychiatric system. if the PA communities once offered such a refuge – as perhaps at times they did – they no longer do.[9] This is nothing short of a tragedy.

the possibility of community

The possibility of reciprocal, unselfish care and concern is hinted at by the ways in which those of us living in at The Grove managed to meet, most often despite the house meetings. From the start, i was astonished and moved by the patience and generosity the people in the house showed to each other, even when suffering greatly. i witnessed (and was involved in) bitter rows, panics, suspicions and jealousies, so this is certainly not to romanticise life in the house but to acknowledge that the solidarity we experienced, simply by virtue of feeling ourselves to be in the same boat, could be a potent force for human kindness.

To respond to someone's distress with attempts to treat them psychiatrically is to deny them their full humanity. it is also to blind ourselves to the *social* causes of our suffering, and to miss the point that to lessen the pain we experience we must together seek ways to alter the world which inflicts it in the first place. What we need is not group therapy, but genuine community and the possibility of political action (in the best sense). The very social ties which can seem so

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9. There is one recent incident I know of which fleetingly countered this statement.

frightening, and in need of such careful, therapist-supervised management, are potentially a source of great strength for a place like The Grove. To achieve this would require a shift from (understandably) terrified insularity towards openness, towards deinstitutionalisation, and from dependence on the idea of 'the expert' to undermining hierarchy. This would take courage, and would have profound – and political – implications not only for 'the houses', but also for the PA as a whole. By nurturing a community around its communities, the Philadelphia Association might just become radical once more.

There is much more to be said about these things, but unfortunately not the space.

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WE ARE ALL ASYLUM SEEKERS NOW

David Morgan

Like many in the '70s, I was seduced by that scene in the film of Ken Kesey's *One Flew Over the Cuckoo's Nest* where the native-American chief incarcerated for many years in an asylum tears a washbowl from its mountings and hurls it through the hospital wall, and then lopes his way to freedom.

The images of human beings being constrained by authority and institutionalised made me passionate about the need for revolutionary action to free the oppressed. In those days Ronnie Laing saw asylums as repressive institutions, and psychosis as more of a spiritual journey. Closing down the big old loony bins during Thatcher's Government was said to follow the theories of Italian psychiatrist Franco Basaglia (who was even quoted by the Minister for Health). Although questionable under that government, this seemed a good thing, and Care in the Community seemed progressive.

Of course, the true intention of that government's policies soon became clear, and my eyes were opened. It had nothing to do with putting people back into society. It was an excuse to close refuges, however positive or negative they may have been, so as to save money. The Community Care that was set up to contain patients was too often community neglect. This led to a great increase in suicides, and tragic cases of the unwell and dispossessed acting out their anxieties on others, sometimes with violent and fatal consequences.

Like ex-PR man Cameron's pre-election slogan, 'The Big Society', the real aim of the idea of 'Care in the Community' was a cynical one: to espouse charitable and community values as a cover for saving money at the expense of the most vulnerable.

When the old hospitals were closed, twenty years ago, there followed a lack of care for the mentally ill who were dumped into the care of the public. This was a public being driven to earn more money to shore up flagging mortgages, who had neither the time, mental space or training to manage such complex problems.

The plight of those dispossessed and vulnerable people continues, even more extensively. Under the present capitalist global economy, those in need of asylum (be it for psychological or economic reasons) have even greater problems today. It seems that the need for safe places, where the lost can get a sense of identity or belonging, has no place in an economy even more driven by market forces.

People who are unable to function as part of society due to psychological illness, or because they are dispossessed and outside our cultural norms, or cannot keep up with the need for economic striving, are not so different from the much maligned category of 'asylum seekers' – which in many quarters is now a term of abuse. As we all know, 'asylum' originally meant nothing other than a place of safety. Why then, does society now hate those who seek or need safety? Are they reviled because they make us aware of our own vulnerable position, our own struggles with life and death anxieties?

As with the destruction of the old mental hospitals, when the Berlin Wall was pulled down, and with it the repressive communist dictatorships which hid behind it, there were great hopes that removing the physical emblem of control and authority would bring greater freedoms. Perhaps it has in some respects, but its effect has also been to reduce choice and to demonise those with ideals other than the pursuit of profit. What profit can there ever be in providing asylum?
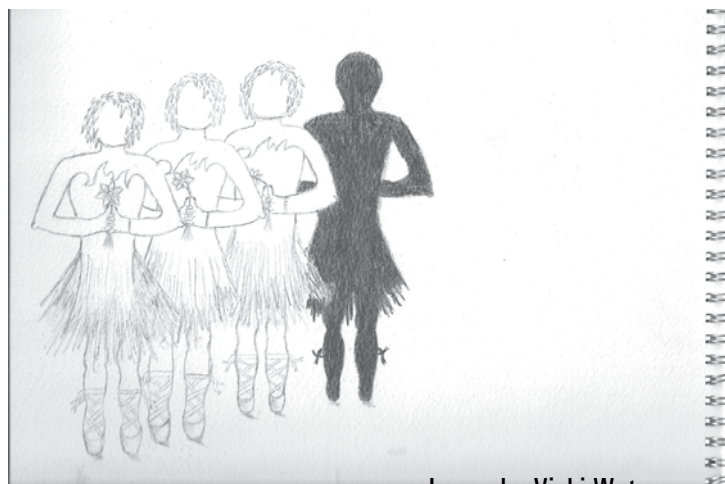
Image by Vicki Watson

In the newspapers we can see the worldwide effects of this relentless market-driven society. In India tens of thousands demonstrate against the ruling elite, in Israel they demonstrate for social justice, in China cyber critics blame their government for putting wealth creation above social welfare, and we also saw the Spring uprisings against the kleptocracies in Egypt, Tunisia and Syria. Even the rather pathetic riots in London disturbed our holidays.

As Pankaj Mishra said in *The Guardian*, all this anger is about one thing: 'extreme and seemingly insurmountable inequality' between 'the haves' (or what Bush calls 'the have-mores') and 'the have-nothings' in our society. In a market economy there is no asylum for the have-nots.

The most vulnerable victims of this inequality are children in trouble, the growing ranks of the aged and the physically and mentally ill. In India, Pankaj says, hundreds of thousands of farmers have committed suicide despite their society being more successful than ever before. And now, of course, in this country it is our turn. The educated and aspiring middle classes now have to worry about our futures (or our children's futures). Failure to get three starred-A's can feel like the beginning of sinking down through the social order all the

way to Gin Street. In other quarters, this sense of help-lessness leads to denouncing the corruption in politicians, businessmen and bankers. We have prosperity without equality, wealth without peace.

Lest I appear a hypocrite, I admit I benefited from increases in house prices , but like everyone else I also face an uncertain future in which the idea of meaningful professional work for my children, where they might help others, is becoming a scarcity because sickness is not a profitable business. I never thought I would attend a meeting in the NHS where the patients were described as products. But this has come to pass. Child psychotherapy is now beleaguered because 'time is money'. Colleagues are now being trained in quicker methods of treatment. NHS Direct – the five-minute phone refuge that amplified what the NHS could offer, and the excellent Sure Start are both being, or have already been, dismantled. And yet these offered refuge for the troubled and were in fact a pre-emptive strike on future more expensive interventions.

What I am saying is that we all need asylum and we all have hope of finding it both internally and externally. The truth is we are all asylum seekers. The longing for respite from life-and-death anxieties, whether generated in our internal world or all too apparent in crumbling external worlds, whether from socio-economic or political causes is, I believe, a fundamental human drive.

The number of bankers I have assessed (privately, of course!) who feel they have lost their souls to the machine they created is enormous. One man dreams he is being pursued by living-dead zombies and a taxi driver is helping him escape, but the taxi is very, very slow; he screams at the driver (presumably me, the analyst), to go quicker but he doesn't, keeping up the same plodding pace. This is a man who worked seven days a week, used cocaine and prostitutes and had panic attacks on Sunday nights. The panic attacks were the alarm of his soul.

From my perspective, achieving the capacity to bear uncertainty and the terrors of life depends on having safe places both outside and, of course, inside. My profession as a psychoanalyst, working at times with very disturbed and unhappy people, is mostly focused on trying to help restore or create (maybe for the first time) an internal capacity to bear uncertainty and loss without too many psychotic defences, such that very frightened and troublesome people can attain some feeling of respite from mental torture. In my view, this is a really important form of personal asylum. But I remain mindful of the fact that although my domain is that of mental torture, there is an external world of torture, too.

The conflict brought about in trying to work with people whose loss of identity and dispossession is both mental and societal was brought home to me very sharply when I worked with a group of refugees and asylum seekers in a hospital setting. Their awful helplessness was unbearable: they had lost all that they held dear. Family, dignity and home, was gone. I felt fat, middle-class and privileged.

The pressing concerns of the group members involved housing, clothing, food and other basics. But they had other needs too – more human, social, and hard to administer. They needed help and a feeling that others could retain a sense of them as human, even in the face of rape and torture. The sense of helplessness was on both sides: they who had experienced such loss and abuse, and me who felt torn about what resources were needed and could be used. I learnt a lot from that group.

I have always needed inspiration to keep my hope alive, and I often turn to writers like John Berger:

> The poverty of our century is unlike that of any other. It is not, as poverty was before, the result of natural scarcity, but of a set of priorities imposed upon the rest of the world by the rich. Consequently, the modern poor are not pitied, have no asylum, no way out, no representative ... but are written off as trash. The twentieth-century consumer economy has produced the first culture for which a beggar is a reminder of nothing.

How can those of us in the psychological professions hope to bring any internal asylum or respite from suffering to people in such extreme states of deprivation and trauma? I learnt very painfully and personally that there is a drive in me, which I think we witness constantly in all our hate-filled responses to people in need, to turn away and to reject. Having to take in and identify with the profound loss and terror of others is very demanding, and I think there is always a drive to push out the bad feelings by rejecting and demonising those who fill us with terror – thereby repeating for them all their experiences of rejection and cruelty. We all have to find our own ways of fighting the battle to keep hope and compassion alive, both for our work and ourselves. Reading and thinking with others sustains me. John Berger again:

> One of the fundamental reasons why so many doctors become cynical and disillusioned is precisely because when the abstract idealism has worn thin they are uncertain about the value of the actual lives of the patients they are treating. This is not because they are callous or personally inhuman it is because they live in and accept a society which is incapable of knowing what a human life is worth.

For 'doctors' let us read 'us all'. I believe it is only through fighting for a society which is truly committed to providing asylum for our most deprived, in all respects, social and mental, that we individually and collectively affirm the worth of human life. We let our care institutions crumble at our peril.

David Morgan is a consultant pychotherapist in London

A JOuRNEy ThROugh mAdNESS & bACk

How i became involved with *Asylum* magazine and what this has meant for me

Dina Poursanidou

how I became involved with *asylum* magazine

My first encounter with *Asylum* magazine was in the spring of 2010, when the magazine was re-launched after a three-year break. i was introduced to it by Helen spandler, a friend and colleague from the university of Central Lancashire, and a member of the editorial collective. And i have been reading *Asylum* religiously ever since.

in the autumn of 2011 Helen asked me whether i would be interested in being involved in the editorial collective, stressing the policy that 'the collective is open to anyone who wants to help produce and develop the magazine, working in a spirit of equality'. i was pleased to be asked and i have been a member of the collective for about a year.
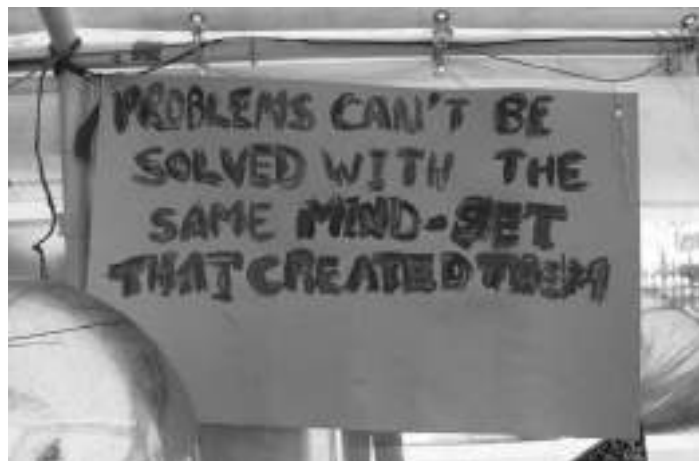
i feel that in order to communicate effectively how and why i became involved with *Asylum*, as well as what such involvement has meant for me, it is essential to locate my involvement with the magazine in the context of my life – and particularly in the context of my journey through mental illness (for want of a better word) and the mental health services during the period 2008–10.

I had my first major mental health crisis in 1991, when I was studying for a Master's degree in nottingham university. According to the official diagnosis, this was an episode of 'clinical depression and anxiety'. Following this crisis, i embarked on a long journey of self-discovery and healing which comprised, as vital components, having intensive psychoanalytic psychotherapy and completing a PhD on the experience of depression in young people.

My second major mental health crisis, this time a prolonged episode of 'treatment-resistant psychotic depression' (according to the official diagnosis), occurred between July 2008 and April 2010. This resulted in three-months detention 'under a section' in an acute psychiatric ward in Manchester in 2009, as well as a two-year period of unemployment. Following this second crisis, i returned to my research post at the university of Central Lancashire (where i had worked as a Research Fellow until the summer of 2008), and in the summer of 2010 i started working on a mental health advocacy project as a service-user researcher. so i have been using mental health services in Manchester since the summer of 2008. This included attending sTART, a mental health arts project, and having individual psychotherapy with an nHs clinical psychologist. Both were vital for my recovery.

It is important to draw special attention to the fact that I first encountered *Asylum magazine* in the spring of 2010. That was at a critical turning point in my journey through madness and back, so to speak, as it was the start of my getting better, the beginning of my recovery from a very serious and enduring mental health crisis.

it is also crucial to bear in mind that my mental health crisis between 2008 and 2010 had catastrophic consequences for every aspect of my life. First and foremost, as a result of my severe and persistent depression, for a couple of years i lost what had always been a vital source of self-esteem and recognition for me: my capacity to think creatively and excel intellectually or academically.

i could not think clearly, could not concentrate and retain information, could not process language, could not read and understand what i was reading, and could not be intellectually creative. My head was constantly heavy and cloudy due to the potent medication i was prescribed – especially when i was on copious amounts of it. i was off work for nearly two years, and so away from opportunities for intellectual stimulation for far too long. When detained in hospital, i was treated as somebody who lacks capacity and insight.

Characteristically, my care records covering the period of my detention (January–April 2009) portray me – amongst other things – as *'dishevelled, retarded, highly agitated, lethargic and far from mentally alert, incontinent and occasionally subjected to physical restraint'*. i guess all the above represented a huge blow to my confidence and a source of profound feelings of humiliation and shame, as well as a source of a deep sense of failure and unfairness or injustice. All these emotions were acutely disempowering.

in a nutshell, my mental health crisis back in 2008–2010, and in particular being sectioned in 2009, was a scarring and terrifying experience, whereby the very core of my existence was deeply shaken and all my certainties collapsed. This has meant that the struggle to regain my confidence and repair my life, a struggle that began slowly in the spring of 2010 and is still continuing, has been hugely challenging. it was at the start of that struggle that i encountered *Asylum magazine*, and it has been with me throughout my recovery journey.

what involvement with *asylum* has meant for me

- involvement with *Asylum* has afforded me a sense of community through contact with other mental health service users/psychiatric survivors and their allies, as well as through acquaintance with the psychiatric survivor movement at large and its rich collective knowledge and history. First and foremost, this sense of community has helped reduce the acute sense of loneliness brought about by the terror and disempowerment i experienced all the way through my mental health crisis (back in 2008–10), and the sectioning in particular.

- *Asylum* provided me with a safe space (forum) to tell the story of my struggle to recover from mental ill health, to freely express my views on mental health care, to be listened to and be taken seriously. *Asylum* has afforded me a space where i can be inspired and give voice to my resistance, rebellion and critical stance to the practices of

oppression and degradation of the self often used by modern biomedical psychiatry. Telling my story, articulating my views and being taken seriously has been really validating and empowering, as well as conducive to the cognitive and affective processing of my trauma. Whilst browsing the *Asylum magazine* website, under the section: History of Asylum, i read: *'Our central aim in encouraging those who felt hurt by the system was the hope that it would help them to express their views, which would also be discussed. So we tried to offer them "a proper place at the table". There they would be given as good a chance as is possible to be taken seriously.'*

- *Asylum* represents a space where i can safely value and honour madness and mad or psychiatric survivor knowledge as meaningful in the context of my life and other people's lives, without having to romanticise or idealise it. i feel rather uncomfortable with the tendency to romanticise and idealise madness and mad knowledge which appears to often characterise those calling themselves 'experts by experience' – for example, Mad Pride. i am suspicious of those who consider psychiatric survivor knowledge as 'special' – this reflects a presumed epistemological privilege for mental health service users; or those who equate madness with creative brilliance (where creativity is viewed as an inherent element of madness) and portray anyone with mental health problems as a struggling creative genius; or those who perceive madness as a blessing, and link madness (extreme states of consciousness) to mystical states and shamanism. The people i came across whilst sectioned in north Manchester hospital did not strike me, by any means, as poets or shamans, but rather as acutely distressed and unhappy people. i was one of them, of course ...

- *Asylum* has provided me with a space where it is acceptable to be profoundly ambivalent towards my latest mental health crisis, service use and recovery; where it is oK to be uncertain and not know when it comes to questions around how i feel about, and evaluate, my journey through madness and back. As i explained above, my mental health crisis back in 2008–10, and in particular my hospitalisation and sectioning in 2009, represent major biographical disruptions for me. They entailed huge losses, traumas and suffering, had catastrophic consequences for every aspect of my life, and left me feeling a great deal of bitterness and anger, as well as deep sadness and an acute sense of loss. At the same time, i recognise that my latest mental health crisis, and in particular my journey of recovery (including foremost my experience of therapy and my participation in the sTART mental health arts project) opened up opportunities for personal growth and transformation, affording me hope and new insights into the human condition. Hence, my feelings about, and evaluations of my journey through madness and back, are characterised by profound ambivalence. if madness is 'a dangerous gift' that users of psychiatric services need to embrace (as Mad Pride advocates), i am yet to embrace my own madness. Furthermore, I find the conceptualisation of 'recovery' in the current discourse rather simplistic and problematic – especially when recovery is romanticised and presented as just a linear journey of continuous and ever-increasing optimism that will inevitably lead to final acceptance of one's mental health crisis, and hence happiness. (i exaggerate a bit here.) My own recovery has been far from a linear process. Hope has incessantly alternated with bitterness, anger and grief. it has been a much more muddled journey. *Asylum* offers a space where muddle, ambivalence, uncertainty, and not knowing are tolerated and can be worked through.

- Last but not least, since my first encounter with *Asylum* i was drawn to the word itself – 'Asylum' – and to the phrase 'democratic psychiatry' (from the magazine's sub-heading). Both resonate deeply with me and carry a particular emotional weight since they derive from Greek, my mother tongue. 'Asylum' means sanctuary, safe refuge, and something that should not be violated. For example, in Greece there is 'university asylum' which forbids the police from forcibly entering any part of a university. university asylum was brutally violated by the army in a student uprising during the 1967–74 dictatorship, and this violation is now synonymous to tyranny in the memory of the Greek people. 'Democratic' means 'of the power of the people', which in my psyche is strongly linked to the long-standing struggles of my people to achieve freedom, including freedom of speech, political democracy, respect for human rights and justice for their country. i guess for me, because of all these powerful associations of the word with 'freedom', 'lack of coercion', 'justice', and 'respect for human rights' – the phrase 'democratic psychiatry' is a particularly powerful articulation of an ideal or a deep longing for humane and emancipating psychiatry. This would refrain from coercion and injustice, and have the potential to heal. This is an ideal that certainly stands in stark contrast to the reality of the wholly untherapeutic and unsafe psychiatric care which i experienced when sectioned, back in 2009. i imagine that to a very large extent this longing explains my involvement with *Asylum* and its mission and values.
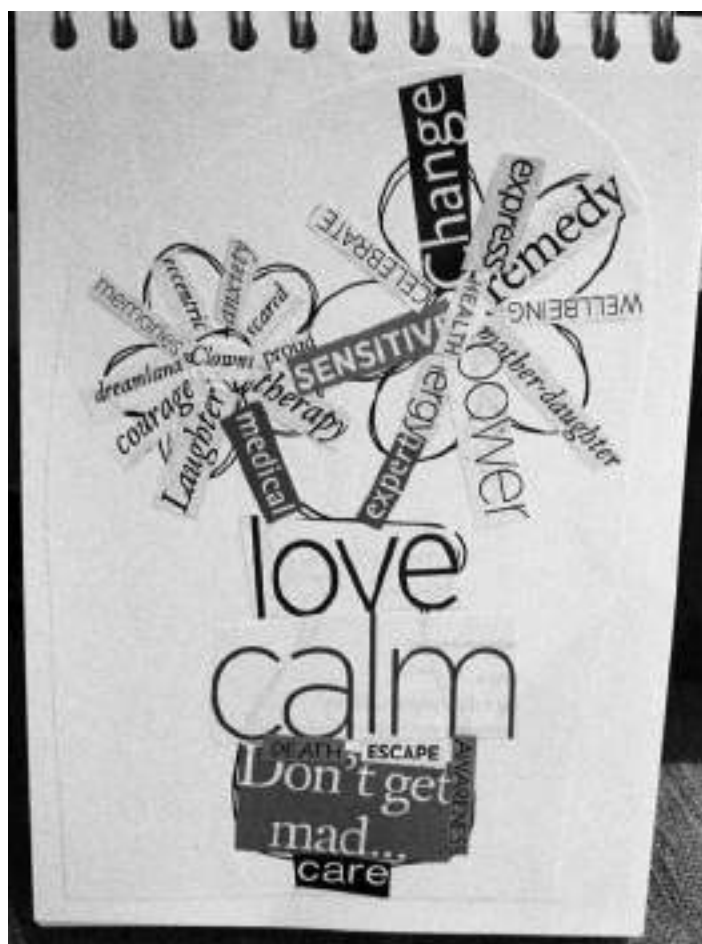

Image by Dina Poursanidou

PATIENTS TAKE CONTROL
A critical period in a day centre worker's life, and co-production in the era of the asylums

Mark Bertram

Introduction

The whole place was tranquil and the moon was full, casting a bright light among the shadows. i heard a rustling noise made by leaves being crumpled on the ground. i looked down and saw a naked person slithering through undergrowth – moving along slowly on the ground. i was very curious and stood still, watching. A pair of eyes beamed out from under the bushes. As our eyes met the person let out a howl. This was terrifying. The scream was so piercingly raw and intense that it made all the hairs on the back of my neck stand up. i was instantly paralysed by a deep natural fear. i couldn't move or think, and those few seconds felt like an eternity. I was petrified. It felt like something primordial was being unleashed, and i didn't have the capacity to be there. so, instinctively, i turned and ran out of the gates and continued running, running as fast as i could, until i was out of breath. That was my first lesson in just how wild asylum life could be.

i didn't have any professional training and relied on the staff to educate me about what was going on. it was mainly nurses who explained to me that the day centre had to be tightly controlled, so as to keep it safe. And having witnessed many highly charged events this made perfect sense to me at the time. Kitchen doors were locked, registers of who was in had to be kept, and some patients had to have staff accompany them and then be collected to go straight back to a locked ward. Above all i was told: you have to keep an eye on them at all times and never turn your back on certain ones. 'you just never know with some patients,' one of the nurses used to mutter.

The staff did their best to try and lighten things up with dances, occasional outings and giving patients sweets and cigarettes. At Christmas one of the staff would dress up as santa Claus and the patients were given presents. i remember at a Christmas party one of the nurses looked very happy, sipping her wine. When i asked her how she was she said: 'oh they are lovely aren't they, my little children.'

Despite the good intentions and benevolence of many staff, life for many patients had regressed to a totally primitive state of being, and it seemed like a hell on earth to me. Patients often attacked each other for a cigarette, and food was often snatched and quickly eaten. some patients seemed to have boundless energy and rushed around all day, while others were often laid out in the corridors or on the grass for hours. on my way to the day centre, i once walked past some stairs and a naked woman threw herself off the top and landed badly on concrete. i asked her if she was alright and she said: 'no, fuck off. i just want some unconsciousness. Leave me alone.' When I asked qualified staff what was going on they said: 'There are a lot of florid ones here. you will get used to it.'

When the day centre opened at 8.30, two nurses and another assistant like me would sit in an office to plan the day. By 9 o'clock patients were let off the wards and they would arrive. usually they immediately sat down and began to smoke, but others would wander up and down the three areas of the centre, manically darting their eyes left and right. some patients could be heard arriving from about 100 yards away because they were screaming loudly as they headed towards the centre. one used to repeat endlessly: 'she died, she died in Horton, my mum, she died.' By 10 the centre was usually packed with fifty or sixty patients, and it was my job to encourage people to join in an activity group. These groups were always the same, with a planner on the wall. Monday: bingo, Tuesday: skittles, Wednesday: try and do some art – and so on.

However, everyday there was always some sort of trouble. someone would start screaming or smashing something up, and staff had to rush over and try and calm things down because it could escalate quickly into a ripple effect. on a 'bad day' i saw some patients throwing chairs around and waving pool cues about because the energy in the centre had become uncontained and highly distressing. occasionally, there would be out-and-out fights, and these would need to be broken up. it really was like something out of *One Flew Over The Cuckoo's Nest.*

Institutional change

When news reached staff that the asylum was about to close down, many became very angry and upset. At meetings some staff would say: 'How can they expect these poor patients to live in the community? it's mad. What are we going to do? Doesn't the government realise the patients are safe here with us?' For some it felt like they had been betrayed. some had devoted their entire working lives caring for the patients in the asylum, and now they were being told that it's wrong, it's bad, close it down.

it got to the point where many staff started to resign or go off sick. i arrived at work early one morning, walked into the locker room and one of the nurses was drinking half a bottle of whiskey. she said: 'y ou never saw that.' And i said: 'What?' and she laughed and carried on necking the bottle. staff anxiety in the asylum seemed at its highest level, and within a few months, one by one, my staff team disappeared and i ended up on my own opening the centre. When i approached management there was a battle going on. There were two directorates: Elderly and Mental Health. The senior manager for Mental Health had resigned, so the Elderly directorate was trying to take over the entire site. The senior manager explained to me that there wasn't funding for additional staff, but i could collect the small budget for the centre myself.

Over the next few weeks I was like a fly buzzing around, trying to run the centre. opening up, doing the register, doing the groups, making the tea, collecting supplies, answering the phone, and dealing with the daily incidents as they happened. Quite quickly, i realised that i was becoming exhausted and slightly paranoid. But i was enjoying the challenge of keeping it open. i stopped going to the staff canteen and stayed at the centre all the time because the other staff seemed antagonistic and depressed – and some seemed very disturbed.

i decided to try a 'new group', where we sat in a large room in a circle seeing what would happen. A woman might walk around the group making duck noises and stripping off, another would make finger signals pointing into space, and our pianist (who was an accomplished concert performer) would spontaneously burst into a beautiful version of Moonlight sonata. When we got to make eye contact in the group everyone would let rip with hysterical laughter. Many patients told me they loved the new group and could we do more? As it evolved, we got into dancing and singing, and it would always end in torrents of laughter.

One day a young man came into the office and said to me: 'My body is a metal robot, really an orca whale made of transmitters, and when the time is right i will reincarnate into President Kennedy.' i said: 'oK', and then he left. And then there was an outing to a local safari park. Eight patients came along, with a couple of nurses, and i drove the hospital van. We drove around and saw the lions and tigers, and then ate in the café. The killer whale show was scheduled for 2pm. We all sat down and the presenter announced that the killer whale – which was swimming around the tank – had come from America. Lots of people clapped and cheered. At that moment the young man poked me in the arm and said: 'see the time is now. i will reincarnate with the orca and transform into President Kennedy.' Then he jumped up and barged through about five rows of people in front of us,

knocking children over. He was frantic, and i tried to catch up with him. He hurled himself up the wall of the pool and tried to throw himself into the pool with the whale. Luckily i managed to hold his ankles before he could dive in. security quickly surrounded us, and i convinced them to let us go back to our van. As we drove back to the hospital i didn't know what to think, but the young man just laughed all the way back.

Over time I found it more and more difficult to cope. My hope and idealism was to face extreme tests. one day i could hear screaming in the toilet. i ran in and a man was on the floor with his legs wide open. He had urinated on the floor and was thrashing around and pulling at his genitals. i didn't know what to do. After a minute he got up, held his hand out, and walked out calmly chatting to someone i couldn't see. i followed him and asked what was going on. He said he had given birth and was taking his child for a walk. At the same time the phone had been ringing, and at the other end of the centre another person was screaming and pointing. i ran down and found that a patient had broken into the food cupboard and stuffed himself with bread. He couldn't breathe and his face was turning a strange colour. intuitively, i turned him around and whacked him on the back, and he coughed and spat out lumps of bread. He gasped and then started screaming: 'i am just one wee man, one wee man!' and then walked away, telling me to fuck off. i walked back up and closed the centre, asking everyone to leave.

breaking down

i went into a small side room, closed the door, and after a period of numbness i burst into tears, crying a lot. i knew i couldn't cope anymore, and i felt a very deep sense of failure. i was still hanging on to the notion that it was all my responsibility, i was the staff member, i am supposed to deal with things, but i couldn't control it all anymore. i didn't know what to do. All i could do was cry. it was my first job for six years, and I had messed up. I had come out of a therapeutic community myself (for drug addiction) and thought i was sorted, after all the therapy. i didn't open the centre in the afternoon despite the banging on the door and phone constantly going off. i just stayed in that room until dark, curled up in fear. And then i left the asylum. i didn't think i would ever go back. i felt totally lost and utterly defeated.

After a night's sleep i decided to go back and open up. By 10 o'clock there were about forty patients in, and i called a meeting in the main room. Everyone was seated in a circle apart from those who never sat – they paced around the circle of people. i said to everyone: 'i can't cope anymore, it's too much, there are people fighting, pissing all over the place, screaming, doing crazy shit, i am sorry i can't cope, i can't control it, i can't open the centre anymore.' There was a long silence. At that point i burst into tears. After a minute or so of sobbing, i just said: 'What is it you want, i don't know?' After that i just held my head in my hands and bent over. i had broken down in front of everyone, and i just continued to sob. All i felt was a deep pain inside, and the only thing i could hear amongst the silence was the sound of me crying. As a staff member i had totally blown it.

After a few minutes, i looked up and one of the patients looked at me, smiled and walked over and patted me on the

shoulder. it felt kind and reassuring. some patients burst into laughter and others fixed their eyes on me, but most smiled as i tried to recover. i was in bits and i just knew intuitively that i was in good company – these people knew about pain and suffering. A man suddenly burst into song with a beautiful Jamaican tune. After he had finished there was a long silence – unusually long for us. We just sat in silence and the sun shone through and reflected brightly off the wooden floor. It was the first time I had felt a sense of peace in that place. i let go and did nothing, just breathing and sitting.

Eventually i came into my thoughts – my feelings and tears had done their job. i wasn't afraid anymore, all the anxiety had gone. The silence felt golden and i felt safe with these people. Then one patient said: 'We don't want the kitchen locked, we want tea when we want.' Then another said: 'We want newspapers.' And another said: 'i can't read or write.' Another said: 'i don't want this shit group everyday, i want a new group.' Then many followed: 'i want a snack bar, i want money, i want music, i want food and dancing and singing …'

Patients take control

i stood up and took the group programme poster off the wall, ripped it up and threw it on the floor, and everyone laughed hysterically, including me. Then i said: 'if you help me run the place, we can keep it open.' so i then wrote up on a large piece of paper 'Responsibilities', and then a list of who would do what. Patients volunteered readily. Who would look after the kitchen, who would answer the phone, who would go to the stores and collect supplies, who would do the register, who would do what groups, who would tell others not to piss or shit on the floor, and who would go to the shop and buy newspapers? The list was quickly written up with names, and displayed outside the staff office.

next day we set about it, and it quickly worked. i gave the kitchen door keys to a patient to make the tea and look after the area. i taught another how to answer the phone in the staff office. I gave the register to another patient and showed him the list of names and how to do it. i gave money to another to go to the shop and buy newspapers. i rang the supplies department to tell them that i was sending a patient to collect our supplies. Then we sat in the main room and decided what groups people wanted. in what felt like a secret mini-democracy within the asylum walls, the new groups were quickly elected every day: for bingo, skittles, art and cookery. All the other group stuff was dumped, and all the locks were undone at all times. i totally gave up control, and it felt like a big relief.

Patients voted with their feet and the centre seemed to get very popular. And no trouble flared up – none at all. It felt safe, and people got on with the activities. The place was buzzing. The tea bar was run by a patient and was open everyday, the groups were run by patients, the register, the kitchen, everything. Everyone went about doing things with a smile. After a few weeks it felt like it was running smoothly and people continued to come up with new ideas, including: the creation of a work project on the site so people could earn money, a tutor to help people learn to read and write, a dance group, and a yoga teacher who taught us meditation. We even set up a sunbathing group, and i took a handful

of patients to the local pub after for a beer. i was long past obeying the old rules that didn't work for anyone. it felt like we had developed a trust between us all. it was beyond words.

However, one day a head nurse came in and said to me he had heard from some nursing staff that the centre was out of control. He was a big guy whose team did all the restraining, and i felt intimidated but held my ground. i said: 'Look around. it's good here and there has been no trouble.' He looked in the office and said: 'You have a patient in the staff office answering the phone, and patients down there in a group unsupervised, for starters. The kitchen's not locked and i hear you give patients money. What the hell is going on? stop all this or we will remove you!' i was worried but there was no way i was going to stop it all. it felt natural to me. But I was unqualified, so I did have my self-doubts.

Next day I opened up and everything flew into action as usual. After a little while the head nurse returned with three other nurses in tow and said: 'Close the centre. This is all against uKCC rules.' i said: 'i don't know these rules and i am not closing it.' He walked up six inches from my face and grabbed both my arms, slammed me against a wall and shouted: 'shut it!' i felt his full ferocity and saw it in his eyes. I then moved back, terrified, but I mustered enough courage to say: 'Fuck off. no.' He shook his head, looked at me and signaled to his colleagues. They started to walk away, and as they got to the door he shouted: 'you are insane!' There was silence in the room and the patients looked at me. i just sat down and thought: 'shit, what now?' But i knew deep down that what we had all created wasn't insane. some of the patients came over and reassured me, saying things like: 'He's nuts, that nurse.'

Next day I was summoned to the senior manager's office. she told me the deal: 'y ou shut it in the afternoons, but you can carry on in the mornings.' I couldn't figure this out, and disobeyed anyway. i was beyond caring whether i had a job, but i would do anything i could to preserve the space and activity in the centre. After another heavy meeting with the head nurses, and my ongoing refusal, they suddenly gave up and left me alone, and the centre simply carried on. i'm not sure why they let it go. subversion and refusal was all i had left, and it seemed to be a legitimate tactic to keep things going.

After a couple of months a woman appeared in the centre and said she was the senior manager for the mental health side. she asked if i could show her around. i did, and as she walked up and down, she seemed intrigued. Everyone was just getting on with activities. she then said: 'What did you do here? How is it like this? it's running itself, isn't it?' i said: 'i don't know. i just got to a point where i couldn't cope anymore and asked the patients to help me run the place.' she smiled at me and asked me if i wanted to be the manager. i laughed, and i couldn't answer for quite a while. Eventually, i just said: 'i don't think the centre needs a manager.'

Mark Bertram is a Trustee at Lambeth Mind
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NEWS & COMMENTS

INCREASE IN MENTAL HEALTH PATIENT SUICIDES

Mental health experts and charities have called for improvements to crisis care after new figures revealed that the number of suicides by mental health patients in England increased significantly in 2011.

Figures from by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCI), produced by the University of Manchester, found that the number of suicides among mental health patients in England climbed to 1,333 in 2011, an increase of 158 over 2010.

The increase is largely attributed to the current economic climate, and experts and charities have called for more to be done to support people with mental illness with debts, housing and employment issues.

The research team says safety efforts need to focus on patients receiving home treatment, where there has been a rise in suicide deaths in recent years. Combined with a fall in the number of inpatient suicides, there are now twice as many suicides under home treatment as in inpatient care.

Paul Farmer, chief executive of mental health charity Mind, added: 'The current economic climate, unemployment and benefits cuts are likely to be having an impact but we know too that people in a mental health crisis aren't always getting the help and support they need from the services there to support them. Mind's own research has shown that, in many parts of the country, crisis care teams are under-resourced, understaffed and overstretched.'

Source: *Mental Health Today*

WATCHDOGS SAY MENTALLY ILL HELD TOO LONG BY POLICE

Four 'watchdogs' in England and Wales say that too many mentally ill people are being held in police cells. A report from the bodies which cover police, prisons and care called for a rethink of how powers are used to detain people in a 'place of safety'. Some of those detained were as young as fourteen.

Under Section 136 of the 1983 Mental Health Act, the police can hold someone for their own protection and so that they can be medically assessed. Current guidance says that the police should take the mentally ill to a hospital or similar location in all but exceptional circumstances. But the report, from Her Majesty's Inspectorates of Constabulary and Prisons, the Care Quality Commission and the Healthcare Inspectorate Wales, says that detention in police cells has been far from exceptional.

Examples include officers called to deal with an elderly person with dementia walking outside alone, people who may be suicidal, or incidents in which someone is suffering from a psychotic episode leading to abnormal or dangerous behaviour. And during the year 2011–12, 9,000 people were detained in police custody under Section 136, while 16,000 were taken to a hospital.

In one case, a woman had broken her hand, and the police 'manhandled' it when they tried to restrain her while detaining her as a mental health patient under a Section 136 order. Instinctively, she lashed out in pain, and was consequently charged and convicted of assault.

The inspectors said that the statistics show that this is '... clearly not an exceptional use of the power'. Drusilla Sharpling, HM Inspectorate of Constabulary, commented: 'Their only "crime" is that they have mental disorders, but they are treated in many ways as if they are criminals. This deplorable situation cannot be allowed to continue.'

When the watchdogs looked closely at a sample of seventy cases, they found that 80% of those held in police cells had been detained in relation to fears either that they were suicidal or that they could harm themselves.

Inspectors said the legal disparity needed to be resolved between mental health detainees, who could be held for 72 hours, and most criminals, who must be charged or released after 24 hours. Otherwise, people detained in police custody under section 136 were subject to the same 'processes and procedures' as arrested criminals. The average stay in a cell was more than ten hours.

The most common reasons for police custody were that there was neither a bed nor staff available at a hospital or other healthcare facility. Other detainees were taken to cells because they were drunk, behaving violently, or known to have done so in the past.

The report said that many police officers had told inspectors they did not think that custody was the best place for those detained. DC Steve White, of Devon and Cornwall Police, said: 'It's a real Catch-22. More people have mental health problems than there are staff to deal with them. A lot of the time, the assessor says "This person isn't severe enough to be admitted", so we have to release them. But the patient still feels they want treatment and is determined to get help, so goes out and either commits a crime or goes and stands on the top of a cliff in a suicide attempt, as a cry for help to get the attention and treatment that they feel they need.' He said a lack of resources and funding meant police were becoming 'a last resort': 'We had a time when we did a lot of community projects to prevent crimes from happening, now we are really just fire-fighting.'

Policing organisations said it was important to ensure those detained were assessed quickly in a health-based setting, and proper training was vital. The Home Office said it was working on various measures, including a pilot of street triage services where mental health nurses accompany police to incidents. But mental health charity Sane accused the government of failing to fund psychiatric services, leaving police to 'pick up the pieces'.

www.bbc.co.uk/news/uk 20 June, 2013

MH NURSES GO ON POLICE PATROLS

The Home Secretary agrees that the police spend too much time dealing with people with mental health problems. So as to improve responses to mental health emergencies, street triage services have already been tried out in Cleveland and Leicestershire. Now there is to be a pilot scheme in four more English police areas – Derbyshire, Devon & Cornwall, North Yorkshire and Sussex. It is hoped that this will ensure that fewer people with mental

health problems are detained in the wrong environment. This will be funded by the Department of Health and backed by the Home Office.

It has been estimated that the police spend 15–25% of their time dealing with such situations. Policing and Criminal Justice Minister Damian Green said: 'All too often the police encounter vulnerable people with mental health issues who need immediate care or longer-term support which only the health service can provide. The rollout of these street triage pilots are a step forward in our ongoing work with the Department of Health and police to ensure people with mental health issues are dealt with by the right emergency service.'

www.bbc.co.uk/news/uk 27 June 2013

GOVERNMENT MAY BAN FACE-DOWN RESTRAINT

Ministers will consider a ban on the use of face-down restraint in English mental health hospitals after new figures that show nearly 40,000 incidents of physical restraint were recorded by mental health trusts in just one year. This resulted in at least 949 injuries to patients.

The charity Mind received answers from 51 mental health trusts. Northumberland, Tyne and Wear NHS Foundation Trust recorded 923 incidents of face-down restraint and Southern Health NHS Foundation Trust 810. There was also 'huge variation' between trusts in the use of all types of physical restraint. Surrey and Borders NHS Foundation Trust reported just 38 incidents over the year, but Tees, Esk and Wear Valleys NHS Foundation Trust reported 3,346.

Health minister Norman Lamb told the BBC he was 'very interested' in banning face-down restraint. He has also ordered an investigation into the use of face-down restraint in Northumberland and Southampton.

A separate Mind survey questioned 375 frontline healthcare staff involved in physically restraining people with mental health problems. Almost a quarter (22%) had not had face-to-face training on physical restraint techniques in the last 12 months, and 42% said that, with hindsight, they felt that restraint had sometimes been used 'inappropriately'.

Mind chief executive Paul Farmer said: 'Physical restraint can be humiliating, dangerous and even life-threatening, and the huge variation in its use indicates that some trusts are using it too quickly. Face-down restraint, when a person is pinned face-down on the floor, is particularly dangerous, as well as extremely frightening to the person being restrained. It has no place in modern healthcare and its use must be ended.'

Deborah Coles, co-director of the campaigning group, Inquest said: 'Despite the plethora of restraint-related recommendations from inquests and inquiries into deaths, it is shocking that restraint is still relied upon at such disturbing levels.'

Kunal Dutta. *The Independent*, 19 June 2013

ABUSE OF WOMEN 'AN EPIDEMIC'

A report finds that more than one-third of women worldwide are victims of physical or sexual violence. The authors say this is a global health problem of epidemic proportions.

Of course abuse and the physical health effects are deplorable, but psychological trauma is also well known to be the cause of long-lasting emotional distress and mental turmoil – of what the mental health system calls 'mental illness'.

The great majority of women are attacked or abused by their husbands or boyfriends. The World Health Organization report finds that the attacks result in broken bones, bruises, pregnancy complications, and depression and other mental illnesses.

One of the authors of the report is Charlotte Watts, a health policy expert at the London School of Hygiene and Tropical Medicine. She says abuse is an everyday reality for many women. And the recent pictures of celebrity TV chef Nigella Lawson being grabbed by the throat by her husband, in public, illustrates that this can happen to any woman – not just to poor women, or women in a certain country.

The WHO report is co-authored by Watts and Claudia Garcia-Moreno. It finds that 42% of women who have been victims of physical or sexual violence by a partner have been injured as a result, while 38% of all women murder victims were killed by an intimate partner.

The report shows that violence against women is a root cause of a range of acute and chronic health problems. For example, women who suffer violence inflicted by their partners are 1.5 times more likely to get syphilis, chlamydia or gonorrhoea. And in some regions, including sub-Saharan Africa, they are 1.5 times more likely to become infected with HIV.

Reuters/*The Times*, 21 June, 2013

BIG PHARMA MOBILISES PATIENTS ON DATA TRANSPARENCY

A leaked memo has revealed that the pharmaceutical industry has 'mobilised' an army of patient groups to lobby against plans to force companies to publish secret results of drugs trials.

The industry has broadly resisted moves to share data from drugs trials more freely. Drugs companies publish only a fraction of their results and keep much of the information to themselves. For example, a recent review of medical research estimated that only half of all clinical trials were published in full, and that positive results were twice as likely to be published as negative ones.

If companies published all of their clinical trials data, independent scientists could reanalyse their results and check companies' claims about the safety and efficacy of drugs. Under proposals being thrashed out in Europe, drugs companies would be compelled to release all of their data, including results that show drugs do not work or cause dangerous side effects.

The latest strategy to resist this regulation was drawn up by two large trade groups, the Pharmaceutical Research and Manufacturers of America (PhRMA) and the European Federation of Pharmaceutical Industries and Associations (EFPIA). An email leaked by a drugs company employee and seen by *The Guardian* newspaper describes a four-pronged campaign that starts with 'mobilising patient groups to express concern about the risk to public health by non-scientific re-use of data'. This means using patient groups to help raise fears that if full results from drug trials are published, the information might be misinterpreted and cause a health scare.

Tim Reed, of Health Action International, raised concerns that some patient groups are in the pay of the pharmaceutical industry and will go into battle for them. In this sense he says, they are actually 'fronts for the pharmaceutical industry.

Source: *The Guardian*, 21 July 2013

MANY MENTAL HEALTH PATIENTS DON'T FOLLOW TREATMENT REGIME

A small-scale survey found that more than three-quarters of people with schizophrenia or bipolar disorder admit to sometimes not following treatment recommendations.

54% reported that they do this intentionally. Of this number, 63% were likely to take less medication than prescribed, and they specified side effects as the main reason.

The study also found that 29% of respondents were happy with not following their recommended treatment regimes. No surprise there!

Equally, it's probably no surprise that this study was funded by Janssen, a drug company! No chance of funding alternatives then?

Source: Gibson et al (2013) Understanding treatment non-adherence in schizophrenia and bipolar disorder: a survey of what service users do and why.

BMC Psychiatry 13, 153

AVATAR THERAPY HELPS SILENCE VOICES?

An avatar system that enables those diagnosed with schizophrenia to control the voice of their hallucinations is being developed by researchers at UCL. The computer-based system could provide quick and effective therapy that is far more successful than current pharmaceutical treatments, helping to reduce the frequency and severity of psychotic episodes.

An early pilot of this approach involved 16 patients and up to seven, 30 minute sessions of therapy. Nearly all the patients reported an improvement in the frequency and severity of the voices they hear. Three patients who had experienced 16, 13 or 3.5 years of auditory hallucinations completely stopped hearing voices. The avatar does not address the patients' delusions directly, but the study found that they do improve.

Professor Julian Leff (Emeritus Professor at UCL Mental Health Sciences) developed the therapy and leads the project. The team has now received a £1.3 million Translation Award from the Wellcome Trust to refine the system and conduct a bigger randomised study to evaluate this novel approach.

The first stage in the therapy is for the patient to create a computer-based avatar, by choosing the face and voice of the entity they believe is talking to them. The system then synchronises the avatar's lips with its speech, enabling a therapist to speak to the patient through the avatar in real time. The therapist encourages the patient to oppose the voice and gradually teaches them to take control of their hallucinations.

Prof Leff says: 'Even though patients interact with the avatar as though it was a real person, they know that it cannot harm them, as opposed to the voices, which often threaten to kill or harm them and their family. As a result the therapy helps patients gain the confidence and courage to confront the avatar, and their persecutor.

'We record every therapy session on MP3 so that the patient essentially has a therapist in their pocket which they can listen to at any time when harassed by the voices. We've found that this helps them to recognise that the voices originate within their own mind and reinforces their control over the hallucinations.'

The new study is led by Professor Thomas Craig of King's College London Institute of Psychiatry. It began enrolling patients in July, and the first results are expected towards the end of 2015. Prof Craig says:

'Auditory hallucinations are a very distressing experience that can be extremely difficult to treat successfully, blighting patients' lives for many years. I am delighted to be leading the group that will carry out a rigorous randomised study of this intriguing new therapy with 142 people who have experienced distressing voices for many years. The beauty of the therapy is its simplicity and brevity. Most other psychological therapies for these conditions are costly and take many months to deliver. If we show that this treatment is effective, we expect it could be widely available in the UK within just a couple of years as the basic technology is well developed and many mental health professionals already have the basic therapy skills that are needed to deliver it.'

It is reckoned that about 1% of the world's population 'has schizophrenia'. The most common symptoms are delusions (false beliefs) and auditory hallucinations (hearing voices). The condition often has a devastating effect, making it impossible to work and to sustain social relationships. Even with the most effective anti-psychotic medication, around one in four people with schizophrenia continue to suffer from persecutory auditory hallucinations, severely impairing their ability to concentrate.

Current guidelines from the National Institute for Health and Care Excellence (NICE) recommend that schizophrenia is treated using a combination of medication and talking therapies, such as cognitive behavioural therapy (CBT). However, in the UK fewer than one in ten patients with the diagnosis have access to this kind of psychological therapy.

Ted Bianco, Director of Technology Transfer and Acting Director of the Wellcome Trust, says: 'At a time when many companies have become wary about investing in drug discovery for mental health, we are delighted to be able to facilitate the evaluation of an alternative approach to treatment based on the fusion of a talking therapy with computer-assisted "training".

'In addition to the attraction that the intervention is not reliant on development of a new medication, the approach has the benefit of being directly testable in patients. Should the results of the trial prove encouraging, we expect there may be further applications of the basic strategy worth exploring in other areas of mental health.'

The Wellcome Trust has funded this project through its translational funding programme, which helps turn early-stage innovations into new health products by supporting researchers to advance an innovation to the point where it becomes attractive for further development by the medical industry or healthcare agencies.

Source: Avatar therapy helps silence voices in schizophrenia. UCL website. 29 May, 2013

ASYLUM QUIZ

In the last issue we launched a Quiz: 'What is democratic psychiatry?'

See a collection of readers' responses on our website: http://www.asylumonline.net/asylum-quiz/ & keep sending us your answers to: editors@asylumonline.net

A MAD DICTIONARY

Our Consumer Place is Australia's Mental Health Resource Centre, run entirely by people diagnosed with 'mental illness'. In July 2012 they launched a national competition inviting consumers – and anyone else interested – to contribute towards a collection of consumer-convoluted language that we could pull together as a dictionary.

Consumers were solicited to play with the twisted language of psychiatry. Back-to-front meanings, made-up words, acronyms redefined, re-created language and general comments on the State of Affairs in Mental Health Land were all encouraged.

In May 2013 they published the *Consumer's Guide/Mad Dictionary to Mental Health Language*. We've included some highlights below:

- **Case history** (noun): A register of personality assassination.

- **Case load** (noun): The number of consumers services can squeeze into a standard size suitcase.

- **Consumer participation** (verb): Various tokens: a small key that doesn't open anything, a magic fairy who has no tricks, a rock with two wobbly eyes that cannot see, a luscious lunch that makes you fat ... nothing that makes any real difference.

- **Lived experience** (adjective): 1. Does a psychiatrist not have lived experience of mental health services? Perhaps psychiatrists are not actually alive. Nice idea. 2. What other sort of experience is there? 3. Loony empiricism.

- **Obs/Observation** (in hospital): verb 1. One eye on us and other on the coroner's court. 2. The opposite of listening. 3. The well-considered and soothing practice of following, watching and making notes about people who are struggling with paranoia. 4. Spying. 5. Ogling whilst orbiting around the acute unit regularly. 6. Code for quick dash around the unit each hour and tick something.

- **Refusing treatment** (Colloquial): Attempting to negotiate with a mental health clinician.

- **It's just like** …: 'So, you've got diabetes? It's OK, it's just like having schizophrenia.'

The Recovery Steeplechase

The starter is ready and they're off!

Over the diagnosis fence quickly followed by the difficult medication obstacle and on towards the attitudes of the friends and family ditch. It's a big one this year.

Around the bend for the first time and on towards the psychiatric hospital steeple, now that's a huge one for all pundits.

The refusal of service jump looms now and once over this we head towards the huge pride & prejudice spread and then the discrimination wall, all in close proximity.

Safely on the other side the institutionalisation obstacle looms large and the riders go around the bend for the last time and aim towards the homeless jump and poverty hurdle.

The social oppression obstacle is second from last and as we turn into the straight, the field stretches out according to imposed function scales and are on their way over the shame ditch jump and on towards self-actualisation and the finish line.

All of us who dropped at a hurdle and broke a bone were, of course, shot in the head.

Source: Our Consumer Place
www.ourconsumerplace.com.au

We think MAD DICTIONARY *is a great idea and invite Asylum readers to send us other examples. Send your suggestions to: editors@asylumonline.net*

The *Ferguson Safety Smock* for suicidal inmates and patients

Feast your eyes on this amazing product: http://www.preventsuicide.com/index.htm
And for more information: http://www.preventsuicide.com/faq.htm

That's me on the right, first thing in the morning before a hairbrush and make-up, I've no idea who the hairy geezer beside me is [actually I'm told he's the CEO of the company].

Now I can't take this smock off when wearing it [looks very fetching] because it's made from incredibly strong fabric and apparently it's "not designed to prevent exhibitionism. It's for people who wish to be clothed, which is the majority of suicidal inmates".

Nah not me, personally I prefer to be naked when I'm suicidal.

Now please look at this additional product – the sani-belt for suicidal and self-destructive females: http://www.preventsuicide.com/products.htm
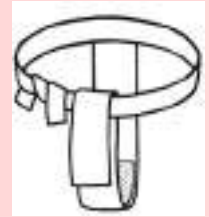
This does suggest that there are an extraordinary number of suicides as a result of using sanitary products as the method. I want to reassure readers that I have put this to the test under scientific conditions [I wore a white coat].

I placed two tampons up each nostril, and smothered my mouth with an Always Ultra [with wings]. I even had a medic on standby just in case of respiratory failure. The results of my scientific experiments were that suffocation by sanitary products is quite difficult to achieve. Maybe if you used a whole pack, I dunno …

"The use of Ferguson products has enhanced our safety standards. It has reduced malingering by 100%" Russ Ford, Senior Nursing Officer, Bermuda Dept. of Corrections.

Ah yes, he's absolutely right, of course wearing these smocks ensures there's no 'dramatic' self-harm, no fake suicidal behaviour. These products really do make the jobs of Samaritans and mental health services that much easier.

I am available for smock modelling. Please contact my agent for details of my fees.
Dr. Joanna, Dip. Loon.
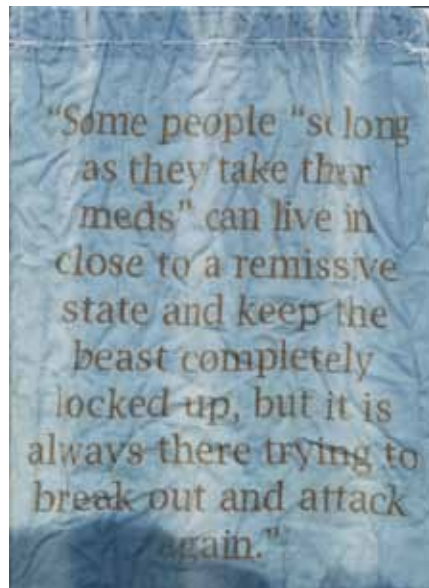
Antidepressant Prayer flags
By Caiti Berry

Having been prescribed and used various types of antidepressants myself for a good few years from age 17 this is something that has affected me personally. i gathered viewpoints through a global gumtree questionnaire then I printed them onto fine material and hand dyed them creating a set of flags. They purposefully were reminiscent of Buddhist prayer flags because they use the movement caused by wind to allow the prayers to be made, or be released as it were. somehow it just felt right to put these views out there, through some sort of release system and watch them flutter around outside – such happy things, with such strong emotions a part of them. This piece of art has not only helped me deal with my emotions regarding antidepressants but also those who contributed, and those who have viewed the piece whilst it was displayed in Manchester hospital.

Check out Caiti's blog at: http://ladycaiti.blogspot.co.uk/