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EDITORIAL

Phil Virden (Executive Editor)

Four of the last five issues were given over to one particular theme or another, and they were usually put together by a group of people who wanted to highlight a particular aspect of psychiatry or their response to it. This means we have accumulated a fair number of contributions from readers on a whole array of topics, some of which we can now publish. Thanks for contributing. Please continue to do so! And apologies if we could not find space to print your particular contribution – we may be able to do so in a future edition.

So this edition looks more like a magazine usually looks, in the sense of a mix of different topics and viewpoints. Because they were crowded out by all the 'special editions', several chunks of news items take up some of the space. It seemed to us that readers would be interested in various newsworthy developments over the last year or so.

If there has been one particular worry everyone shared recently, it is probably 'the cuts'. As soon as they were

mooted, and then brought in, many people predicted the short-sighted effects of indiscriminately cutting budgets for mental healthcare. In the past year or so the evidence has started to come in about exactly how much damage is being done. And it seems that the psychiatric and mental health services are visibly and significantly deteriorating. As predicted, this is proving a false economy because – if they won't just crawl away and die – the pieces of desperate or distressed people's lives still have to be picked up.

On the other hand, there was often not much to say for psychiatry and mental healthcare even before the cuts. We publish a number of pieces that address the various ways in which psychiatry and mental health care always did fail, anyway. But don't be downhearted, there are even more articles here that shine a ray or two of sunny hope. I won't spoil it for you by telling you which bits I mean.

Dip in and you might be surprised!

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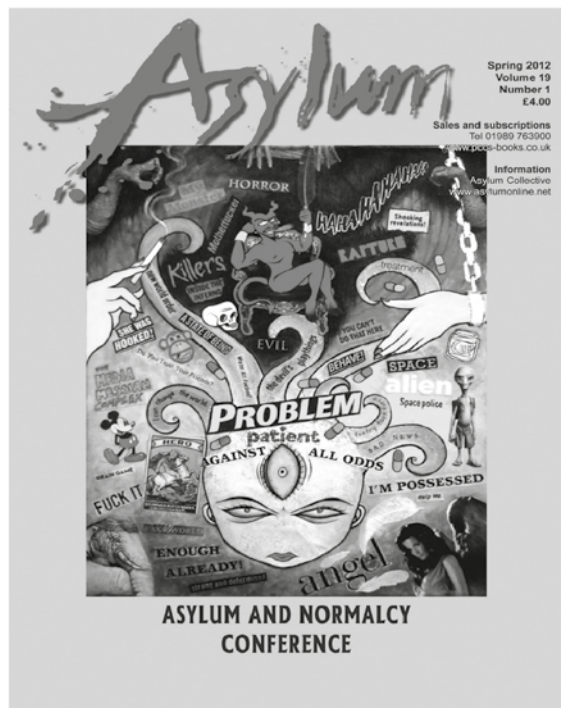
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ASYLUM AND NORMALCY CONFERENCE

EUROPE VOTES FOR CLINICAL TRIALS TRANSPARENCY



It will soon be European law that drug clinical trials are publicly registered and the results reported. On 2nd April 2014, MEPs voted by a huge majority to adopt the Clinical Trials Regulation: 547 votes in favour and only 17 against.

This is fantastic. It will mean that in future researchers will know about trials as they are happening and will be able to scrutinise results as soon as trials end. This is due to the efforts of people all over Europe – including many patients who took part in clinical trials – who have pressed their MEPs to ensure transparency in the future.

The new Clinical Trials Regulation says that information from Clinical Study Reports of trials should not generally be considered commercially confidential and will:

- 1: require that all drug trials in Europe are notified on the publicly accessible EU Clinical Trials Register before they begin;
- 2: require that a summary of the results from these trials is published on the register within a year of the trial's end;
- 3: require that a summary understandable to a lay person of what was found in the trial is published on the register;
- 4: where they are produced, require Clinical Study Reports (detailed documents normally produced for regulatory processes) are made publicly available;
- 5: establish a new publicly accessible EU Clinical Trials Register, to be set up and run by the European Medicines Agency;
- 6: require that all trials used in support of an application to run a new clinical trial are registered or have published results;
- 7: impose financial penalties on anyone running a clinical trial who does not adhere to these new laws.

Congratulations to Glenis Willmott MEP, who led the negotiations on the Regulation, and fought for transparency to be at the heart of the new law. Following this positive vote in the European Parliament, the Regulation now has to be formally adopted by Council and published in the Official Journal. At the earliest, it is expected to come into effect in mid-2016, and then all EU member states will adopt the laws into their own statutes. The European Medicines Agency can now start building the new publicly accessible online clinical trial database.

Now we want to see recognition and use of the contribution that thousands of patients have made in the trials that have already been conducted.

Here are some comments – welcoming, but also cautionary:

Dr Ben Goldacre, author of *Bad Pharma* and co-founder of AllTrials said:

This is an excellent small step forward after some really good work by MEPs. But the new EU legislation is only concerned with new trials. It does not address the far bigger problem, that we still don't have full reporting for all trials on the medicines we are using right now, today, medicines which we will continue to use for the foreseeable future. Doctors and patients simply cannot make informed decisions about which treatment is best, when the evidence on the treatments they are using is still being routinely and legally withheld. We need all trials on all uses of all currently prescribed treatments to be made available, and urgently. There is no excuse for industry inflicting ongoing harm on patients, and on their own reputation, by continuing to campaign against this position. They should join their more ethical colleagues, and sign up to the AllTrials.net pledge.

Sile Lane, Director of Campaigns for Sense About Science, co-founding organisation of the AllTrials campaign, says:

Huge congratulations are due to the people all over Europe, including many patients who took part in clinical trials, who have pressed their MEPs to set the future straight in this way. Now we want to see recognition and use of the contribution that hundreds of thousands of people have made in trials that have already been conducted but never published results. We have to make their efforts count.

Richard Stephens, patient and clinical trial participant, says:

The new legislation is good news for patients in the future. But as a patient now, I know that I am being given treatments and medicines based on research that has not been made public. I hope that all funders and sponsors of research will publish the results of their research over the past twenty years, so that we can evaluate it in the same way that we will evaluate the research of the future. As a trial participant myself, I would ask everyone who has joined a trial anywhere in Europe to ask when and where the results will be made openly available, and I would ask every European ethics committee to make sure that open and accessible publication of results is made a requirement before researchers are allowed to conduct experiments on patients.

Professor Carl Heneghan, Director of the Centre for Evidence-Based Medicine, Oxford, co-founding organisation of the AllTrials campaign, commented:

The success of the EU clinical trials regulation vote

is one step towards guaranteeing novel treatments are based on all of the available evidence. Th[is] regulation ... ensures that new trials are registered, and their results will be published in a timely manner. For patients, this means future treatments are likely to be effective and safe. However, there is a need to carry on with the campaign, in that clinical trials done on medicines in current practice pre-date this regulation; and much of the evidence base for these treatments is simply missing or incomplete, which is unacceptable.

Dr Trish Groves, Deputy-Editor of the *BMJ*, co-founding organisation of the AllTrials campaign, says:

Having methods and results of all drug trials in the public domain is a big advance and discussions have already started about the practicalities, upsides, and what some may see as potential downsides of sharing this information. It is time for medical educators, investigators, funders, sponsors, ethics committees, and most importantly, trial participants, to prepare for an era of much greater openness.

Dr Virginia Barbour, Editorial Director of *PLOS Medicine*, co-founding organisation of the AllTrials campaign:

With this vote, the European Parliament is demonstrating leadership in legislating for the reporting and registering of new trials, and this will be closely watched by legislators worldwide. This is a critical move, but the next step has to be further legislation to mandate full availability of all human trials, past and future.

Dr Richard Lehman, GP says:

As a general practitioner trying to advise patients on the best treatment to achieve the outcomes they want, I need complete information about harms and benefits. The legislation before the European parliament is a welcome step towards making this possible in the future. But at present, half the information we need to inform choices about treatments remains hidden. There are moves afoot by some manufacturers to release full data about trials of treatments already in use, but this legislation represents a lost opportunity for making this mandatory. As a result, patients and health professionals will continue to work with only part of the information they need and are entitled to have.

Dr David Tovey, Editor-in-Chief, *Cochrane Library*, co-founding organisation of the AllTrials campaign:

Evidence informed healthcare decision-making is one of the best ways to improve health. However, for the evidence to be the best quality, most trusted and most up-to-date, we need all clinical trials data to be made available to the researchers reviewing it. For Europe to sign up to a register and commit to reporting results it is a great step forward. Yet there are currently many medicines in use where all trial data hasn't been made available, and without it we risk using ineffective and potentially harmful treatments and medications on the very people we want to help.

Two Way Mirror

Keren Hill

She is sunlight
 She smiles, she laughs
 She's bright and warm
 She takes care of everything
 Everyone
 She hides the storm
 Her rays shine through

She is the beach
 A million little particles
 That shift and turn
 And move away underfoot
 Every minute the landscape changes
 Dunes and reeds waving, bending
 Not breaking

She is silence
 She is the pause between chords
 And the tightness of strings
 The discordant guitar, untuned
 Unplayed
 Her scars shine bright
 Scream look at me

This is him coming in the night
 This bruise is saying his grip
 Was tight
 This hammer will smash
 It will clear a way through
 Walls and doors
 And make a hole to be crept out of

 Silently, in the dead of night

She needs the sunshine
 Her shield of iron
 And cleansing spring rain.

DUAL PSYCHE

Scott Michael



The second hand slowly dragged its way around the clock, like a son carrying his father's corpse down a flight of stairs. Beaker screamed, as he usually did before he received his medication. Unusually, this time he was standing up, rather than being subdued on the floor by three hefty blokes.

I was used to the screaming. Beaker had done it every day for a week. I felt for him. He said he had a vague recollection of distorted faces and rough hands propelling him down stairs, which explained his bruised face.

The thought of returning to that state was less appealing than the fish and chips the canteen served us every Friday. I had got used to people passing through the ward, where life was in a constant state of flux. Little events happened to interrupt the controlled normality of a locked ward, strict times for certain events, doors locked, possessions taken away, but mostly all of us were treated like moody adolescents who had received a bad school report and had our XBoxes taken away for not reaching society's ideal. Third rate citizens, lower than Romanian immigrants.

Life in general was bad outside, but when you're stuck on a ward under a Mental Health Act section, with a duration only to be decided by a consultant psychiatrist and his team, inside at night it felt like a glimpse of eternal damnation.

Mornings were usually brighter. I woke up early and had the ward to myself. The nurses would make coffee, telling me it had caffeine in it, when I knew it didn't. They often used to tell people 'white lies' to stop them complaining about the smallest things that they couldn't have. Anyway, who would want to give caffeine to someone experiencing a manic episode, when their brain was creating its own version of nuclear power?

So I gave thanks and sought refuge in the smoking room. Normally you could hear the sound of the pigeons roosting sleepily nearby. Their gentle cooing soothed me after a restless night of broken sleep, often interrupted by the sounds of crying from the guy in the room next door. He often paced up and down, muttering to himself. This was normally a daytime feature of the ward, but the guy couldn't sleep at all, and his medication wasn't having any effect.

I exhaled smoke and put all last night behind me.

Everyone had their own routines. New admissions were normally exhausted so they often missed breakfast. The hatch opened and the nursing assistants served cereals and

toast, and I took them into a lonely curved room with a bay overlooking the seaside, noticing for the first time that a little sign displayed the room's length in cubits. I would have to check in my Bible for exactly how long that is, as I had a bit of mist between the eyes and it had been years since I had thought in cubits.

The nursing shift changed and I watched TV, wondering about when was my next appointment with the consultant. The nurses couldn't say. It was tempting to lose my temper due to the sheer ineptitude of the whole situation, where one team controlled my life to such a degree that it left me in a constant state of anxiety as to when I was to be discharged.

I approached the friendliest of the nurses and asked her if there was anything that could help with my anxiety. But, as if she was talking to a little blonde-haired child with a squint asking for a pint of milk, she said I would have to wait. There was little to do but return to my bedroom, look out at the sea and listen to Beaker screaming for alcohol again. I didn't feel much disappointment for myself, only for Beaker, poor guy, who sounded so tormented. As I looked up the length of a cubit, I prayed for his quick recovery. I was surprised a cubit was only 45 centimetres. No wonder the figures in the room were so big, I thought.

My phone rang. That would be my parents. They phoned every day I had spent on the ward, and I never answered it. They were the ones who sectioned me in the first place. I didn't think I would ever speak to them again after being discharged. A week of sleepless nights, and suddenly I was insane. 'Never trust a family of Doctors with a grudge' is my motto, even if they are your own. Forget that.

So with a gentle hope I walked into the consultant's room and meekly answered his questions. He discharged me and gave me some sleeping tablets.



PSYCHIATRY & THE PROFESSIONAL DUTY OF (S)CARE

Matthew Connolly

Professional Duty of Care (PDoC) is designed to ensure safety and well-being, and to prevent cruelty and injustice. However, considered in relation to psychiatry, this duty of care may not be as democratic as one would like to assume. By drawing on concepts developed within critical theory, and by introducing a unique alternative, this article aims briefly to address certain very important ethical concerns.

First of all, since this has implications for how their respective objects¹ are exploited, it is important to differentiate between psychiatry and the physical sciences. With reference to Ian Hacking's (1998) work on 'natural' and 'human kinds', a physical (natural) ailment (such as diabetes or a broken leg) is impartial since it exists pre-discursively. This means that it can be handled without any interpretation on behalf of the practitioner: it just is.

However, on the contrary, any psychiatric (human) ailment – such as a broken heart (otherwise known as depression) – *does not exist* beyond the limitations of discourse, particularly metaphor.² In which case it warrants an interpretive stance (often based on a 'qualified opinion'), and this necessarily implies a relationship of social power.

So, physicians of the natural world are able to enforce their duty of care and take subsequent actions based on an empirical knowledge of the objective body. But physicians of the human world – psychiatrists – cannot help but base their decisions on socially constructed representations of the subjective mind. In accordance with such representations, those deemed 'mentality ill' or 'at risk of suicide' – behaviours which, of course, are considered undesirable – can be legally detained, often against their will, for the purposes of 'appropriate treatment'.

This makes such treatment a kind of punishment. However, a Professional Duty of Care also operates in a more insidious way as a form of 'governmentality', that is, as a component to a set of 'techniques and procedures for directing human behaviour', (Foucault, 1997: 81), and it can also be recognised as what Rose and Miller (1992) identify as 'political rationalities' and 'programmes of government'. From this perspective, a PDoC appears less as a healthcare intervention and more as a governmental regime – one that happens to be embodied within discourses of morality and consent.

Furthermore, since government is effectively a 'problematizing activity' (Rose & Miller, 1992: 181), a PDoC functions to suppress the apparent threats to the social order posed by mental illness, disorder, deviance and so on.

These discourses are translated into authoritative inscriptions such as a code of ethics, assessment procedures, clinical guidelines, and negligence laws. These then serve to

articulate and reify what is going on, so that it can be used to initiate action. And all this even before the person is apprehended!

In which case, it is no surprise that vulnerable people, who suffer from real distress and really do need emotional support, are reluctant to find help or even to speak out about their situation. Access to any health service is intimidating enough without the added fear of stigma, mental health diagnosis and incarceration.

Nevertheless, some resistance to all this may be found in the form of the Samaritans, a charitable set-up that has no obligation to comply with the State. Through that organisation people are able to confide anonymously in someone who is not a professional and therefore will not offer any determent or advice – thus implying no duty of care.

Does this sound inhumane? Perhaps, if considered from the perspective of government. But from the perspective of the individual, this is genuine democracy, with judgements about care based on transparency and self-determination. After all, who is anybody to decide 'what is best for the client'? (The same can be said for other non-governmental organisations (NGOs) or informal support networks, such as Rape Crisis, LifeLine and Women's Aid, to give just a few examples.)

The motivation for this article stems from my own experiences as both a service user and volunteer for Samaritans, and so I focus particularly on the Samaritans.

Countless calls are made every second by people, who, like me, felt they had nowhere else to turn. They can find solace in the fact that a person who has no prior theories or axes to grind (unlike members of the psy-professions) will not impose any particular ideology on the person involved but will simply listen. But more significantly, making that phone call does not carry the threat of any unwanted repercussions upon the caller's personal liberty.

To conclude, although it seems very reasonable in theory, in practice the professional duty of (s)care is both obstructive and undemocratic. It gives psychiatrists a powerful technique with which to enforce social norms. And it incites a milieu of self-regulation.

The presence of a third-party organisation may offer a solution to the problem of how to help people in distress. Yet despite being established for more than sixty years, the

1. The objects of a science may be material or conceptual.

2. I would like to thank Geoff Bunn for providing this comprehensive yet accessible way of thinking about natural and human kinds. See also Danziger (2002) for a more detailed account on the role of metaphor.

Samaritans often seem to be misunderstood by the general public, and they seem practically unheard of within the professions. Volunteers and sponsors in the Samaritans work tirelessly to try and change this perspective.

However, this invisibility or neglect of the work of the Samaritans seems to be more a question of professional politics than of utility. The service offered by the Samaritans is purposefully overlooked on psychiatric wards. This is usually said to be because of the Samaritan's 'too liberal' approach to matters of suicide and mental illness. One hears officials responding with words such as: 'I don't want my patients knowing about this [the Samaritans] because they might get the wrong idea'.³

But this begs two vital questions: What exactly is this 'wrong idea'? and, Is the official approach necessarily the best for the person?

Samaritans are available 24/7 to listen and offer emotional support for those in distress. No subject is taboo and you

3. This quote stems from a personal communication with a ward manager when attempting to arrange an information session on the work of Samaritans.

will be treated in a manner that is non-judgemental and fully confidential. For more information or ways to contact the service, visit: www.samaritans.org.

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Matthew Connolly is a PhD student at the Research Institute of Health & Social Change at Manchester Metropolitan University. His research aims to develop a post-humanist approach to psychology by studying how the concept is performed, by using actor-network theory and studies of governmentality.

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REVIEW

Our Encounters with Suicide

Edited by Alec Grant, Judith Haire, Fran Biley & Brendan Stone.

PCCS Books, Ross-on-Wye, 2013

www.pccs-books.co.uk

This is a well-constructed book with five main sections: Witnessing Suicide; Living in the Wake of Suicide; Thinking Suicide; Surviving Suicide; Defending Suicide. There are Appendices: on the Maytree Sanctuary for the Suicidal, and on Useful Links and Contacts. The contributors' biographies are full and informative. After each personal story there are usually 'Learning/Discussion Points', a thoughtful and educational addition for readers.

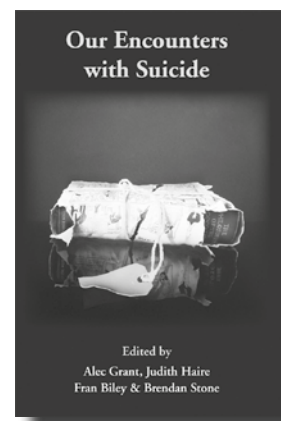
The first narrative is by a train driver, Karl Davis, who witnessed a suicide. But most of these personal narratives describe attempted suicide and survival, or they are stories of friends or relatives who ended their lives.

Ruth Kilner tells us that her suicide attempts remind her that she is *alive*: 'It reminds me I have the choice to be here or not, and that in itself is liberating.' In his piece, Sid Prise says: 'It can be a hard decision to live, but it's the only decision that allows other decisions, better choices and better possibilities for the future.' Nevertheless, in the anonymous piece, 'Suicide – my Story', feeling suicidal is defined as 'feeling without hope'.

In his chapter, Michael Skinner touches on the well-known reaction that despite feeling hopeless one should simply 'move on', 'get over it', and tap into that self-will and positive determination which are exactly what are missing when a person is in a state of depression. But he says that eventually he 'found a new support system of caring and loving friends ... I also eat right, exercise, meditate, and take time to relax and express creativity.'

The reader is also brought sharply and uncomfortably near to the moments when people ended their lives. This often left me with a feeling of unresolved enigma, as well as sadness. I feel there are no easy answers, no prescriptive solutions. The great variety of these narratives show the individuality and uniqueness of each person's journey.

Although the mind and its motivations in its most complex or darkest hour will often remain a mystery, this book gifts us with the opportunity of coming close to people's experiences of despair, intensity, confusion, or revelation.



THE CAUSE & A POSSIBLE CURE FOR SCHIZOPHRENIA

Alfred A Barrios

In my book, *Understanding Hypnosis: Theory, Scope and Potential*, I offer an explanation for the cause of schizophrenia that derives from my theory of hypnosis. Based on this explanation, I also present a possible cure for schizophrenia by means of hypnosis.

I would like to begin with a brief overview of my theory of hypnosis (Barrios, 2001), focusing especially on how the theory explains hypnotic phenomena such as hallucinations and delusions.

I define hypnosis as a state of heightened belief produced by a series of suggestions to which there is a positive response. The belief factor (that is, belief in what the hypnotist is suggesting) increases with each positive response. And I define belief as concentration on a thought to the exclusion of anything that would contradict it. Thus, in a state of heightened belief, any sensory or cognitive stimuli that might contradict the suggestion given by the hypnotist are automatically blocked off. This highly focused state of mind is then capable of amplifying images to the point of their becoming hallucinations, and amplifying thoughts to where they can become delusions.

All hallucinations and delusions can be explained in a very similar way: an image or thought can become highly amplified as a result of the blocking of any contradictory thoughts or stimuli. Blocking can be accomplished in a number of different ways. As pointed out in my theory explaining the behavioral and therapeutic effects of the hallucinogens (Barrios, 1965), this 'blocking' results from the inhibitory aspects of those drugs. In the case of schizophrenics, the 'blocking' is due to the hyper-suggestible state (heightened state of belief) they are in. The psychotic breakdown occurs when, not realizing that they are self-induced, these individuals begin to think that the hallucinations and strange thoughts or voices come from an outside source. They believe that they have no control over what is happening, and what's worse, they believe that this will become permanent. And because of the heightened state of belief they are in, it *may* become more or less permanent. As I pointed out in my theory of hypnosis, in the state of heightened belief, higher-order conditioning can be exponentially enhanced, thereby allowing this belief to become permanently entrenched.

This explanation of schizophrenic psychotic breakdowns is supported by the fact that there have been many cases of psychotic breakdowns by people taking hallucinogenic drugs. Just as in the case of schizophrenics not realizing that the hallucinations they are experiencing are self-induced, people who have drug-induced breakdowns also think that their condition is due to 'outside forces' over which they 'have no control'; and what's worse, they believe that this state will

be permanent. As I said above, due to the state of heightened belief, this belief can actually become permanently entrenched.

The following excerpt from my book, *Understanding Hypnosis* (2009), expands further:

One may wonder if something very similar to this frightening state of uncontrolled hyper-suggestibility [occurring in some cases of people taking hallucinogenic drugs] isn't at the bottom of non-drug induced psychotic breakdowns. One question that would need to be answered here of course is what could have led to this state of uncontrolled hyper-suggestibility, hyper-responsiveness, in the first place? We know that a certain percentage of the population is highly suggestible to begin with. (Could this be because some individuals have a higher concentration of hallucinogenic-type chemicals in their bloodstream than others? If so, this would fit in with the idea that schizophrenia is caused by 'a chemical imbalance'.) Is it possible that a state of high stress or anxiety or certain negative thinking could cause this suggestibility to get out of control? And if uncontrolled heightened suggestibility does play a part leading to psychoses, such as schizophrenia, could a form of controlled hyper-suggestibility (such as hypnosis) be used to somehow reverse the psychosis; i.e., cure the psychosis? Could it be used to reverse the belief that the psychotic symptoms would be permanent? We know that hypnosis can be used to remove the causes of any precipitating high stress, anxiety or negative thinking. There are some interesting possibilities here.

(See the studies below by Abrams, 1963 and 1964, and Biddle, 1967, on the successful use of hypnosis in the treatment of psychoses.)

One of the most spectacular hypnotherapy cases I worked on was that of someone diagnosed paranoid schizophrenic whom I cured in one three-hour session, by making use of the hypnotic state of heightened belief to reverse the negative thinking, i.e., the negative beliefs underlying her paranoia. The following excerpt from my book *Towards Greater Freedom and Happiness* (1985) describes the case. (Note that I often refer to my hypnosis techniques as SPC or Self-Programmed Control techniques.):

Maria, a woman in her late-thirties, was brought to me by her sister, out of desperation. The woman had been suffering from paranoid schizophrenia for the past three years and was getting worse. Her primary symptom was the delusion that people were 'out to get her'. She had also recently shown signs of being homicidal – having so scared her husband with very real threats on his life that he had moved out.

As with many psychotics, Maria had been put on a drug treatment program and sent home, even though not cured. The drugs had only served to mask the symptoms, and little had been done about getting rid of the root cause of her problem. When I saw her, she had stopped taking the drugs, without approval.

One advantage I had was the fact that I had cured her 27-year-old nephew of heroin addiction – in a total of only three sessions, incidentally. The all important belief

or prestige factor was thus quite high from the beginning.

The first half of the three-hour session was devoted to getting some idea of the root causes of her problem. It wasn't too long before I saw that she had deep-seated feelings of inferiority, and as a result she felt that no one could possibly love her.

Judging from her background, I could see why she might have thought this. Coming from a minority background, from an early age she had been conditioned to think of herself as inferior. Her subsequent life experiences only served to add to this low self-image. She had been a heroin addict for a good part of her life, and had resorted to prostitution as well as dealing heroin to support her habit. This had resulted in her spending five years in prison, so she was an ex-con as well. The breakdown had been triggered by a younger sister who, in a fit of anger, one day threw all this in her face.

How did I cure her in just one session? Using the SPC Pendulum technique (p. 34) I had her go into a state of heightened belief or increased responsiveness to words. Once she was in this state, I was able to convince her that she was indeed capable of being loved. I pointed out all her good points (something that I was able to ascertain in the first half of the session) and assured her that her family, and especially her husband, did love her. Others before me had tried to convince her of this but to no avail: the words had gone in one ear and out the other. But in this state of increased responsiveness to words, I was now more able to get through.

Within a week, every one of her symptoms – hallucinations, delusions, etc. – were gone. She had gotten back with her husband and was happily looking forward to a trip to San Francisco with him. Six months later when I called to see how she was doing, her sister informed me that she continued to be fine and free of symptoms.

The most amazing thing about this case was that I had been able to cure this woman of paranoid schizophrenia in just one three-hour session. Such a feat is considered so extraordinary that I hesitated mentioning it lest I be labeled a charlatan by my fellow professionals, since paranoid schizophrenia is a most difficult mental illness to cure. It usually takes years, and many are never cured. So to say that I cured such a case in one session is almost like someone claiming to have cured a case of cancer by 'the laying on of hands'.

I have included this example here because I want the reader to see the real potential of an approach that allows the power of the word to really get through. This is not to say, of course, that all such problems can be cleared up in just one SPC session. But still, it should take a lot less time and be more effective than any of the standard approaches.

A POSSIBLE EXPLANATION AND CURE FOR BIPOLAR DISORDER?

Could it be that bipolar disorder (formerly known as 'manic-depressive disorder') can be similarly explained? If cognitive stimuli can be amplified to cause psychotic delusions

or hallucinations when someone is in a state of hyper-suggestibility, a state of hyper-responsiveness, why not the possibility of manic or depressive thoughts or behavior also being magnified in a similar uncontrolled hyper-responsive state that leads to a state of hyper-mania or hyper-depression? If so, one also can see the possibility of employing hypnosis to help regain control and tone down or reverse such hyper states, as well as to banish any underlying negative states of mind that add to the problem.

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Alfred A Barrios, B.S. (Caltech), Ph.D. (UCLA), is the inventor of the Stress Control Biofeedback Card.

Some Useful Phrases

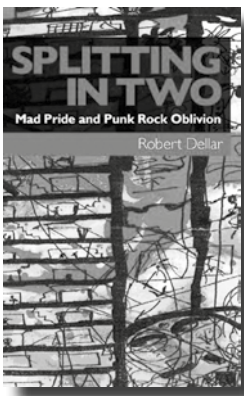
RACHEL STARBUCK

Although fear is clutching her airway
and clawing at her stomach, she fights.
She screams courageously at the nightmare faces that
taunt her.
She is 'responding'.

In the TV room she hides silently in a corner.
The chair envelops her body as she stares in awe
at the dust which is dancing in a shard of sunlight.
She is 'facially flat'.

Then at food time,
the sloppy mockery of shepherds pie
tempts memories,
of moist chunks of steak in flaky pastry.
And she picks and she sighs.
She has a 'poor appetite'.

The bite of the first cut yanks her,
gasping, to present time.
For four glorious seconds she feels alive.
And it is taken from her.
She is a 'self harmer'



REVIEW

Splitting in Two: Mad Pride and Punk Rock Oblivion

by Robert Dellar

Is Robert Dellar mad?

In the article 'A brief history of Mad Pride, London' (*Asylum* 18:1), Hugh Mulhall states, as a fact, that he is not. He writes that 'perhaps (it is) an issue for those who seek autonomy'. (page 10).

In this book Dellar strongly asserts otherwise. If Dellar interprets himself as 'mad' then no one has the right to state otherwise. But obviously this doesn't mean you can't disagree with him. This is the difference between saying: 'Robert Dellar is not mad', and: 'I don't believe that Robert Dellar is mad'.

However, Dellar and Mulhall do agree that the origin of Mad Pride was the question: if Gay Pride, why not Mad Pride? Also the people responsible – the 'guilty parties', as Rage Against the Machine might say – were Simon Barnett, Mark Roberts and Dellar.

I have no hesitation in recommending this book both as a set of entertaining and occasionally scary personal reminiscences, and as a contribution to the theoretical debate about advocacy and user involvement. You don't have to be a fan of punk rock, but it helps. If you are not taken aback and offended by some things in the book then you are taking Anarchism too seriously.

Dellar has worked for mental health charities since 1987, particularly various Mind branches in London, helping to pioneer advocacy and survivor-led projects. His long-term interests are madness, left wing politics and punk rock, and this is reflected in the book. His interests led him – along with others – to form Mad Pride, and to write the book *Mad Pride: A Celebration of Mad Culture*.

Dellar is not modest about his own contributions but he is very honest about his own experiences with, for example, squatting, alcohol and illegal drugs. We learn a lot about him during the course of the book.

Given that Dellar's views are controversial, and contrast starkly with much expressed in *Asylum* 18:1, I won't concentrate on the autobiographical elements in this review but instead on some of the ideas the book provokes. This can be seen as a contribution to the Hegelian dialectical process that is one of the three aspirations behind the title: *Splitting in Two*. (The others are the song by Alternative TV and RD Laing's book, *The Divided Self*.)

Dellar is not frightened of offending people. For instance, he calls Mind conference delegates from outside London 'bumpkins', and Mind management committee members a 'cartel of do-gooders'. He strongly supports the social basis of mental distress and suggests a swear-box for anyone who uses the phrase 'mental illness'.

I think he is right to say that funding concentrates wrongly on the most acute stages of a mental crisis, rather than supporting people in the community so that hospitalisation doesn't become inevitable. The present funding priorities make it easier to have an acute condition rather than a chronic

one. This is also an advantage for middle-class white people with a diagnosis of bipolar disorder (manic depression) rather than black and ethnic minority people with a diagnosis of schizophrenia.

His views on the user movement are clearly expressed. He says there is a history of ill-intentioned individuals working in bad faith, getting paid or getting management positions – although he accepts that things have improved. He contrasts this with his approach which is to spy on dodgy professionals until he catches them out.

As Advocacy Co-ordinator at City and Hackney Mind, Dellar set up an advocacy project which was one of the first of its kind in the UK. He established it quickly, using policies from Mind in Tower Hamlets and more radical ideas from Holland and Nottingham. He gives a vivid account of PICU, the intensive care unit in Hackney which has now been shut down. So as to share ideas and problems with other workers, he set up the North East London Advocacy Network. This mutated into the Greater London Advocacy Network led by 'a suit in informal clothes' who campaigned for advocacy 'standards'. Dellar's view is that this led to the danger of advocacy becoming another professional tier, like nursing and social work, and that such an advocate would collude with workers against the patients. In fact, this is what happened: patients did perceive that advocates were not on their side.

Not only is the book vivid on the differentials of social power between users and professionals, it is even more so on the differentials between psychiatrists and other workers. He acknowledges, correctly, that most nurses genuinely try to help. He traces the power of the psychiatrists back to the drug companies, and ultimately to capitalism. He explains clearly the role of the drug companies in expanding the market for their products. However, he does also acknowledge that psychiatric drugs can be helpful.

The battle over Community Treatment Orders (CTOs) is trenchantly portrayed, particularly the demo outside the SANE offices in 1999. He says that this was an unprecedented show of strength from the grassroots mental health survivor movement. Dellar says that the desire to keep up the pressure was the reason behind getting Mad Pride going.

Some service users may be happy to be fluffy, but Mad Pride responded to a gap in the market for something more ostentatiously spiky and rebellious. This chimes with Mad Pride's early shows which featured punk rock acts. (The first show was in London on 20 June 1999, at The Foundry.) The book gives a detailed account of the early Mad Pride events: some were brilliant, some shambolic, and some were brilliant and shambolic at the same time.

This book makes a contribution to the debate about the relationship between creativity and madness and refers, for instance, to band members being on day release from hospital to play gigs.

The last chapter provides an assessment of Mad Pride. For a short time the movement really thought it could change the world. Ultimately, it was just a group of people who made a lot of noise. He admits that they had a gratuitously intense time for themselves.

Dellar believes that Mad Pride sold out by co-operating with clinicians like Dr Rufus May. This is perhaps his most controversial claim. Obviously it is up to the reader to decide.

Jeremy Spandler

TAKE CARE WHEN YOU SPILL THE BEANS

**The challenge of balancing helping
professionals' need for greater understanding
with exposing the client in written work**

**Julia Young
(Humanistic Counsellor)**

Do those of us working in the helping/therapeutic professions ever wonder what our clients think and feel when we commit their experiences to the page? In those very professions that pride themselves on valuing clients, and which emphasise the importance of enabling them to find their 'true selves', we counsellors and psychotherapists must acknowledge that there is a lot of secrecy and blurring of boundaries when it comes to writing about clients.

What about the assignments we undertake to complete our qualifications, for example, where client-related material is often used to explore aspects of the client-counselor/therapist relationship and process?

Hopefully, we gain permission to write about our clients and act in line with recommended guidelines, such as the British Association for Counselling & Psychotherapy (BACP) Ethical Framework (2002). This states that the rights of participants in research need to be carefully considered and protected. It adds that research must not adversely affect clients.

For example, I note that, concerned by how revelations of our process might affect them, my own tendency when writing assignments was to choose clients I thought would not ask to see what I had written. And I know supervisors who have struggled with this issue, too.

I recall my dissertation, where the issue of revealing my client in such depth left me with a feeling of disingenuousness. I knew that if she read what I had written she would have struggled with the concepts I used, and with my interpretation of our relationship.

We tell ourselves confidentiality and anonymity ensure our clients are not identifiable from the text. But that only ensures they are not identifiable to others, whereas the client will know only too well who he or she is, should they read the assignment or article.

Throughout my degree course I struggled with what I was being invited to write about my clients. I wanted to honour our work together, whilst also honouring my tutors' understanding of what I needed to learn. Over time I became increasingly concerned that the latter was driving the process, and for this reason I even handed in a dissertation that I knew was short of what was required. When my tutor discussed this with me we came to an agreement about how my written work could be managed should my client ask to see it. Yet I know my work was affected by my concerns.

* * *

Hence my reason for writing this article and wishing to ask the question regarding what is and what is not appropriate for us therapists to commit to print about our clients. It relates to my own experiences of pain and distress when my own therapist decided to write about me.

I was shocked when she handed me a typewritten copy of her article. The language she used looked foreign to me, and it seemed that our relationship caused her strain and powerful unpleasant feelings.

I also suddenly saw my all-too-human struggle as something far worse than I imagined, and dove back into the depths of my despair to try and understand my 'illness'.

Now, looking back at that time, I feel betrayed and 'labelled' because my therapist's article left me questioning my sanity and desperately trying to understand a language that was so far removed from my own. Whilst genuinely believing that my therapist meant no harm, my attempts to debunk that legacy continue to this day. Even this very article is a product of my wish to be mindful of, and highlight, the dilemmas inherent in written work that exposes others (in this case my therapist). Sadly, she is no longer with

us, yet I doubt I would have written this article were she alive, being concerned that doing so could cause her distress.

* * *

When reading published articles, therapy professionals (including me) are interested to know how peers do their work. Yet I wonder how mindful the authors of these articles are of the potential for harm in revealing aspects of their clients to the public. I recognise the valuable insights we can gain, yet for me the end will never justify the means. Looking back to my own distress following the article written about me by my therapist, I feel that my family, friends and work could have been very badly affected by the consequences of what had been written. At the time, it took all my strength and courage to try and understand and hold my own counsel whilst I worked through what had taken place.

Furthermore, in my view, there is a likelihood that serious misunderstandings and confusion will be experienced by clients. On the one hand, therapists try to appeal to the professional audience when they write articles, whilst on the other, they wish to maintain intact the therapeutic alliance with their clients. Language is bound to be a key factor in misunderstandings and confusions. For example, I am trained as a humanistic counselor. Whilst I am aware of many other professionals' use of diagnostic labels, and the availability of *DSM* classifications for our clients' behaviours, thoughts and feelings, I did not train to look at mental distress in that way. So all the diagnostic, *DSM*-derived language jars and seems quite foreign to me. But what about the clients, for whom such highly technical language bears no resemblance whatsoever to their everyday way of communicating? Even when the therapeutic process seems to be fulfilling for both client and therapist, some conclusions I have seen published in articles have left me wondering what clients might have felt about going public on such a private and privileged relationship.

James Horley wrote a beautiful article on his concerns regarding the impact of using psycho-diagnostic labels, which some professionals assign to clients and which leave them believing that they are 'born bad', 'damaged', 'dangerous', etc. In his view, that approach can limit a person's ability to find a more successful identity (Horley, 2011). Do we counsellors and therapists become so blinkered by our theoretical approach and our wish to publish it to a wider audience that the needs of our clients are drowned out? This seems to me to be an issue which deserves much more

serious consideration than appears to be happening at present. Otherwise, we run the risk of simply becoming the abusers we are working with our clients to vanquish.

For example, when I contacted the contributors and editor of a book in which my experiences had been included, highlighting the impact on me of the published material, the response was that I had given my informed consent for the material to be used. Yet I wonder if it is actually possible to give 'informed consent' when the language used in a written piece may be outside of one's understanding. It certainly took me some time to get to grips with what was being said about me in the publication. And whilst I continue to disagree with some of the conclusions, I am also still unsure about some of the terminology used.

The other issue regarding 'informed consent' is that I did not want to disappoint my therapist since I sensed that the article was important to her.

On the other hand, one might ask how we are to learn to carry out counselling or psychotherapy if the possible risks to clients preclude writing about them. I have no easy answers. Yet I feel that much of my best learning has occurred through reading about theories and approaches where clients' personal details are mainly absent, or where therapists employ cases and stories about fictitious clients so as to highlight the issues.

John McLeod points out the dilemma which some helping professionals may experience:

As a therapist, the practitioner has a duty to act in the service of the well-being of the client. As a researcher, the practitioner has a duty to collect data and make a contribution to knowledge and understanding. Much of the time, these roles may complement and enhance each other. On some occasions, however, they may be in conflict. (2008, p.174)

I believe that therapeutic duty must always take priority over the duty to contribute to knowledge and understanding.

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THE NATIONAL RESEARCH ETHICS COMMITTEE & MH SERVICE-USER RESEARCHERS

Jane Clewes

Thrilled to be given the opportunity to undertake a small research study as part of my Masters in Clinical Research coursework, I wanted to take advantage of the updates to national policy and have a service user on the research team. I wanted to investigate something which looked into the concept of Expert by Experience in the mental health services. Given the topic, it would be incongruous not to have an expert by experience helping to run the study. I knew from the progress made by initiatives such as Involve (2011) that it was now the norm to have service users involved in mental health research.

I found that probably the most usual involvement of service users was as advisors about the design of the research method, with a view to how participants will engage and respond. But there was no reason why service users could not be involved in all stages of the research. Books on the subject showed me how research studies had been successfully undertaken when led by service-users – particularly ‘action research’ (e.g. Allam et al, 2004, Morrow et al, 2012). In 2011 it certainly seemed to be the norm to undertake studies in partnership with service users. I wanted their involvement throughout all of the stages of the study, and with equal say and power.

I started to put together a research team. Initially I discussed my ideas for the composition of the study's questions and research team with the staff on the local user group. They were happy to support me with the study, as well as have input into the design. They helped by advertising for a service-user co-researcher for my study. Meanwhile, I gathered two mentors for the research steering group – one academic from the local NHS research and development department, and one clinician who also had teaching and academic roles in the local mental health secondary NHS services.

Due to the limitations of time for my course requirements, both (a) appointment and training of the service-user co-researcher, and (b) submission of the research proposal to the National Research Ethics Committee (NREC) went forward in parallel. The service-user co-researcher would need to undergo the usual mandatory training, character references, Disclosure and Barring Service checks, etc., and this took time. A date was set for the NREC to consider the proposal.

I attended the Ethics Committee meeting, expecting a rubber stamp for what was a very soft, qualitative, low-risk

protocol. In retrospect, I should have taken the service-user co-researcher with me. This could have demonstrated their obvious capabilities and showed that they were not going to get upset and relapse, not going to upset participants when they interviewed them, not going to breach confidentiality, were not unintelligent and unable to carry out an interview, not unable to deal with upset participants, and not be unable to engage in critical debate.

I really was amazed that there still existed – and in such exulted positions of authority – clinicians who stereotyped and patronised the mentally ill. Not to mention that they quite obviously hadn't even heard of the concept of service-user involvement in research. And the irony of it all was: the service user co-researcher was in excellent health at the time whereas I was still only just emerging from a moderate to severe depressive episode!

If you are thinking of doing a research study which involves service users with a history of mental health problems, before submitting your proposed protocol I suggest that you have a conversation with the NREC who are going to consider it. Then you can work on allaying their concerns before they put a stop to your plans. Take with you the reasons why you want service users on the research team. Arm yourself with lots of evidence showing how it has been done successfully before. Show them all the current schemes and organisations and resources which support this type of activity. Reassure them that you know what you are doing.

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THE SURVIVOR'S MANIFESTO

Thirty years of flexible working combined with welfare reform and 5 million working people on minimum wage, and a tsunami of human tragedy appears to be heading our way. Thousands of families are about to end up in the grey economy, living off the books to survive, and outside society's norms and protections. This deregulation of working life is a deregulation of our states of mind, a legacy of mental illness in the making. When we live and work in toxic environments we get sick, and whatever the philosophers amongst us might think about the mind-body split, it's likely that mental health problems will soon be appearing at venues near you.

In this recessionary context, suggesting that dealing with mental health requires sorting out your politics might look like avoidance or ideological pedantry on a par with punching kittens. I like animals, but surviving the current regime of employment relations and public policy involves keeping our political wits about us and working out which side we're on.

Workplaces have taken a perverse turn, and I mean that in its Freudian sense. We live in a society where receiving chemotherapy means you're fit for work, and millions of people work in zombie organisations, shuffling like the un-dead from one bit of paper to the next, a substitute for a productive life. This is a sadistically superficial age, where the therapists put in charge of the Psychological Wellbeing of an increasingly distressed nation work under Dickensian workhouse conditions, high-fiving the therapists sitting next to them in an IAPT call centre when someone doesn't answer the phone.

Political debates during conference season like to split rich and poor, working people and unemployed, left from right. The reality is that we have millions of working poor, part-timers, zero-hours, agency workers, interns and the unwaged, all mixed up in that love bundle called 'the world of work'. As these social fault lines break down, mental illness becomes the number one cause of absence, making it our best-kept occupational dirty secret. As humans, we do like a bit of splitting, and those of us who audaciously stumble into precarious states of mind from 9 to 5 are subject to a game of psychic ping

pong where organisational problems get projected into the individuals within them. In polite terms, we could call it psychic recycling but actually it's dump and run – easier to refer someone to occupational health than take the issue of corporate psychopathy to the next board meeting.

One of the implications of this temptation to split off vulnerability into the vulnerable is that mental health becomes an issue of social justice, a wet dream for those of us on the left and of a workplace-campaigning persuasion. So it is with some surprise that in some sections of the left the debate about whether workplace mental health is a legitimate concern has taken such a brutal turn. Recently some of the work I do under the title *Surviving Work* got caught up in a pretty tatty part of this 'debate'. I quote an unnamed union functionary:

'This "Surviving Work" stuff has just popped up again... Let me re-state the key issue again. Work-related stress is a hazard created by employers ... [the trade union] does not support the idea that individual members of staff can or should be 'given the resilience' to deal with poor working conditions created by the employer.'

At which point, com, being right actually means being wrong. Any workplace organisation – whether it's a union or a business – becomes perverse when it says it's politically incorrect to help the people around us. That is paranoid insistence on being certain about the rights and wrongs of a late-capitalist macroeconomic system which we live in – and in the process it totally misses the point. Being right is not sufficient to right the workplace wrongs.

I'm not only bringing this up because that attack hurt my feelings. The left has always had an ambivalent relationship with the individual, particularly at work. Sometimes we put ideology above humanity, in part for the practical reasons that it is much quicker, cleaner and takes less rainy Tuesday night meetings to agree to anything. By splitting the good and the bad between right and left, political and personal, we get to be 'right', and together, and can live in the warm glow of being 'in the union'. But the problem is that in this union are real

people with complex lives and plenty of scope for well-meaning activists who want to make things better.

Mental health problems are some of the few matters that you can truly describe as being democratic, as disrespecting sectarian and ideological boundaries. Being left wing in no way protects you from losing your mind, and although research shows the importance of building up your social capital and joining a union, you could argue that it could increase the chances. People who protest are vulnerable to attack but they are also often unable to square what they believe with how they actually feel.

Within left-wing organisations we are encouraged to suck it up or spit it out, and the suggestion that there might be a progressive approach to mental health at work can be met with a harsh political wrist-slapping. Much of the left's response to mental illness is based on a fantasy that we can somehow gang up against human frailty and legislate it away. There's no question that having rights is essential to navigate work, but to deny the needs of the individual within the organisation strips away the important stuff of why anyone would join a union in the first place. This is hardly the warm hug of solidarity.

Part of the problem with politics is about what's happened to policy. It's not just embarrassing that the United Nations thinks that the bedroom tax denies human rights, it should terrify us to know that our government has overlooked human beings when designing its social policy. Although poor people's bodies might still be inconveniently cluttering up NHS corridors, they have become zombies, grieving the capacity to make choices about how to survive and live within the law. This is terrorising and criminalising the poor, where low wages and benefit cuts mean that the only way is to rent out that 'spare' room for cash. Ten years in prison for benefit fraud. We can only hope they reintroduce sending people to Australia for stealing bread.

One of the reasons for what is going on is that public policy exists in a parallel universe, crafted by tribes of brilliant young things from the political class. It would be mean and envious of me to say this is entirely due to the fact that the people designing it don't have to live it. Nor am I suggesting that we don't need reports and seminars in W1 to help politically ignorant folk get a decent education. But why does the policy work if it doesn't actually make any difference to whether things ever get better?

One of the problems with the current policy apartheid is that it has become a substitute for actually doing something. For a mental health policy to work, it has to help people recover from mental illness and also protect the rest from falling off a psychic cliff without the safety gear. This means reorienting policy to go through the blood-and-guts process of creating a progressive and mass mental health service. We must judge mental health policies and services according to whether they are socially useful, delivering what we want, not just a whether they tick the policy gonk boxes or go down well with NESTA.

'Caring about the individual' doesn't make you right wing but it does raise a question about how we go about the business of building better mental health in the recession. We need places where people can talk and listen, confidentially and with respect, and then together we need to try to figure out what can be done. This used to be the point of left-wing activism and education, the basis of human emancipation in all its gorgeousness.

What this requires is the capacity of organisations and policy makers to listen and engage with us ordinary folk, the real experts in surviving work. While remembering that the only thing that holds us together in any 'union' is that we can bear the discomfort of not being right or wrong, just being human.

You can sign the Survivors' Manifesto here <http://survivingwork.org/sign-up/>

About Surviving Work

This year we set up the Surviving Work Library, a free and anonymous library of podcasts and tips from users. Our aim is to use the profound-lite mix of social media and blogging to think about mental health and psychoanalytic ideas, using ordinary language. Our authors, who talk about how they survive work, are anonymous and ordinary (that's a Freudian compliment). Over time we hope to build up a large catalogue of user-driven content so as to raise awareness and knowledge about mental health and work. We also hope that people will enjoy it.

Please tell people about the Surviving Work Library. Send the link to your friends, tell the people you work with about it, put it on your websites and tweet about it. If you wanted us to come over for tea and a chat and do some recordings with you or the people that you work with, then please simply contact us: info@survivingwork.org.



THE MANIFESTO OF A NONCOMPLIANT MENTAL PATIENT

Aubrey Ellen Shomo

I see it everywhere: *People with mental illness need medication.* It sounds reasonable.

Today, there are even political organizations that seek to make it easy to force a person to take it.

It's easy to look at another person and assume things like that. It's human. After all, it's compassionate to help someone who isn't able to ask for help, right? They'll thank you in the long run, won't they?

No one asks why their child, or sibling or friend refuses to take their meds. Why bother? It's an illness. It's meaningless. The doctors say so. They know these things.

Have you ever questioned the logic of the phrase 'She wouldn't be refusing medication if she wasn't ill'?

I am a noncompliant mental patient. I have been for years. I beg you. Ask why.

Look into my eyes and see me. Try to understand where I'm coming from. Even a crazy person has a human will.

I am someone's sibling, someone's child, and someone's friend. I could be yours.

I've been told more times than I can count that I won't make it without medication. I've been told that I have a chemical imbalance. My brain's broken. I need it.

If I refuse, it's the side effects. They can treat them with more medication. If it isn't that, I lack insight. I don't know I'm sick.

Why would I possibly want to stop? How could I wish to do so? Let me ask you: Have you ever taken these drugs?

They call it anti-psychotic medication. It sounds good enough, but did you know these drugs are also called major tranquilizers?

They speak of side effects, but do you know what it feels like to have them? Can you read that on the label? On my label?

What's that? You learned all about this in medical school?

Can you learn what it is to be in love from reading a medical description? Heart rate, neurotransmitters, behavior patterns. Three criteria out of five.

Can human experience be described in such simple terms? I bet you don't think yours can. Why, then, do you insist on describing mine?

I know how major tranquilizers feel. I've had to find out.

They change a person. The vigor of human experience fades to shades of gray. Life becomes dull, boring, long. Creativity slips into nothingness. The very human spirit

is dulled. You can go from the rapture of being alive to wondering if you even exist.

They will make you calm. They will make you behave. They might even help with your problems, but they can dampen what really matters – what makes you alive.

They majorly tranquilize.

'She prefers her mania – her madness. It's a symptom of the disease.'

How can you say what matters to me? Is that your right?

For this broken mind of mine, I have been locked up. I have been threatened. I have been restrained. I have suffered at the hands of a system I'm told is helping me.

And they wonder why I don't trust them. How could I be hesitant, even bitter?

'She's paranoid. She won't take her medication.'

They might be right, but all I ever wanted is to make my own choices. I've only wanted to scream, 'What about how I feel!'

I am a noncompliant mental patient. Hear my voice.

A cancer patient can refuse chemotherapy. A religious person can choose to trust God over penicillin. A doctor would call both irrational, but acquiesce. All I ask is the same right.

'She'll decompensate without it. It's the only thing keeping her even remotely sane.'

I stopped all my medication twice. I was hoping once would be enough.

The first time, I failed. I lost it. They were right: I went crazy. I was strongly encouraged to take my meds. It was a fight I knew I would not win.

'Patient has been compliant – though hostile.'

A façade of normalcy regained. High functioning. Working, going to school, socializing. All the things you're supposed to do. All so hollow. The spark was gone.

'The medication is effective.'

But the drugs felt the same. So, I stopped again. Lots of people do.

'Compliance is a major problem in the treatment of mental illness.'

I was told that I'd need medication forever. The facts spoke clearly. I was mentally ill. As long as I took my medication, I would be fine. Without it, I was doomed. Why did I want to stop?

I told them how it feels, but it didn't matter. I told them I would recover through force of will alone.

'Patient is grandiose.'

So, I told them I didn't believe I was sick.

'Patient lacks insight.'

In truth, I was terrified. I believed I was insane, I had failed before, and I wasn't sure I could pull it off on my own. After all, the facts were clear – no one does.

But I did.

Later I learned that many have. No one talks about *them*.

John Nash never took medication again – it was key in his recovery. They left that out of the movie.

There are many others who were told no one recovers – told that they would be ill forever – but who proved them wrong.

I am a noncompliant mental patient, yet no one would try to hand me a pill today.

To get here, I had to ignore good medical advice. I had to have poor insight and bad judgment. Without it, I would

never have achieved what I have in life.

So, now when I hear about family members who *should have* made sure their relatives were taking the medication, or courts that *should have* forced it, I think to myself about doctors who *should have* listened.

I often think about people who may have succeeded in stopping their medication, if only they had the necessary support instead of assurances of failure. I wonder how many more I should be able to name.

I wonder why so few people speak of the validity of the desire to not be medicated. Even a crazy person has a human will.

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'Welcome' to the Asylum

JACKIE JOSEPH

Please don't bring your smarts beyond the foyer
(they're as welcome as a modicum of pride);
attitudes of any kind will only earn disdain,

perception will be labelled paranoia,
incredulity will not be justified
and a lack of trust will just prove you're insane.

Your wish for someone caring you can speak
with
(not another head f# for god's sake)
will show you have no faith in your own mind,

will prove you haven't mastered being lonely
and, lest you think your shrink's some sort of
flake,
will show that you're the one who can't unwind.

Your admission and your clearly being ill
(as though you might be here if you were not)
burden both society and state;

when you can't swallow one more bitter pill
our therapeutic chats will turn to rot,
and here you'll stay until you're used to hate.

Hospitality

RICHARD-YVES SITOSKI

sedated to the hilt
we hover
about the grounds

threatening
as wasps
in October

bumping
absently
against a window



ON A MISSION FROM GOD

Notes on the anti-psychiatric experience of the homeless shelter 'The Cure'

Giuseppe Bucalo

Many of those volunteering, managing or working in facilities for the homeless seriously think they are on a mission from God. And they believe this without acknowledging that many of those they strive to look after also imagine they are on such a mission.

I am not speaking of the presumption of holiness often believed to accompany the condition of extreme poverty. I have doubts about the innate goodness of the poor, as well as the sanctity of the Good Samaritans who donate all kinds of goods to food distributions. I refer to the fact that many of those who crowd into the shelters feel that they are literally messengers of truths, revealed or self-revealed. With no intention of offending all the volunteers who 'feel that God is in their hearts', many of those they try to help out experience, see, attend and are guided every day by all sorts of deities.

The paradox is that those who give their services to the poor often recognise sanctity and sanity in the priests and the church hierarchy but not in those Dharma Bums (as Jack Kerouac might call them). Yet we should be able to recognise the divine in those lives, too.

The Catholic Church's Caritas centres should be a natural refuge for these wandering apostles of the truth. They should certainly find care, food and warmth there, but also be listened to and be able to share their messages and their missions. There, it should be clear that our fulfilment as human beings is not measured by what we can do or have but what we can be. There, it should be clear that the call of God turns your life upside down and makes you throw off material security, friends, family, possessions and the usual ways of thinking – makes you different from what you once were. There, the Franciscan message should be well known: not so much (or only) that poverty is the main path to God, but that the only kind of help every human being really needs is whatever helps him to realise himself and his truth.

Instead, what happens is that we look after the physical needs of those who knock on the doors of the shelters or who are found at the train stations, and we delegate to psychological or spiritual experts the question of 'the cure' of their 'delusional' ideas: these are believed to be due to individuals' unproductive and anti-social choices, and to the difficulties of their social inclusion.

Rather than helping such people with their missions, we try to convince them to give them up. This kind of help is thought to be what is needed: 'help' that is not asked for and

is often imposed on people because 'common sense' says that is the right and humane thing to do.

It is not uncommon to see intervention projects in the field of extreme poverty being advertised as 'innovative' because they offer the possibility of access to psychiatric care for those who have often escaped from the clutches of the mental health services: lacking stable family and social references, these unattached human beings are no longer traceable and controllable by officialdom. The innovation introduced by these projects is the transformation of the shelters and their workers or volunteers into guarantors of 'psychiatric care'. And in the 'most advanced' practices, mental health workers go out onto the streets 'to provide care' which is not asked for. This might seem legitimate: to bring people back into the community and persuade them to accept their need for care.

As it stands, some shelters do not welcome anyone thought to be suffering from a psychiatric disorder while others expel people because they do not follow the rules of the shelter. Others, as a condition of eligibility, impose mental health treatments on people who come to them – they say that everyone who comes to them must begin a stable relationship with the community mental health services. In accordance with their own pet theories, they don't recognise the scandal of trying to force involuntary treatment on those who are the least likely to change their attitudes and behaviour.

So it is no coincidence that increasing numbers shy away from those shelters. They wander about and find refuge in more and more inaccessible physical and mental spaces.

Many years ago I was a young social work student who fully believed in the principles of social inclusion and rehabilitation. Along with the asylum where I was on work placement, Messina railway station became the place for testing my good intentions and for deconstructing all the professional knowledge steadily being passed on to me. The station became a kind of antivirus to the standard ideas and practices of 'professional development and training'.

At the station I happened to bump into Giovanni. He was travelling without a ticket, following the signs left by God. He felt he had to lie down on the floor in a crucified-like position, so as to accept and take on himself all the sins of the world. He told me he had often been 'rescued' by people of good will and taken out of the station (or to the psychiatric hospital), and how that had prevented him from achieving

his mission and so being able to feel good and at peace with himself.

I also happened to meet a homeless man who was lying peacefully at the station entrance, after being politely asked to leave the premises, that locus of acceptable civil society. He asked me what made me in such a hurry, and what I was doing with my life. A young social worker is proud of what he does, and with enthusiasm I told him. And so as to highlight all my disappointment with those who were still lazing about rather than acting to change the world, I defiantly asked: 'And you? What are you doing here?'

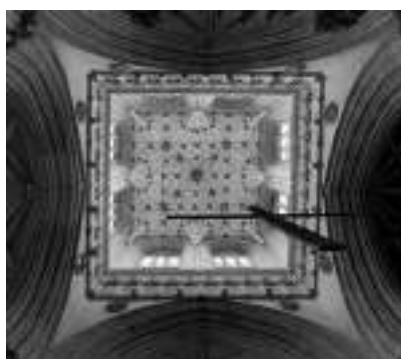
'I observe you,' he said.

This was his task and his mission.

* * *

During my years of self-education, I was impressed by a young man in a documentary about Poona, an Indian village where the guru Osho had his headquarters. In answer to the same question: 'What are you doing here?' he said with revolutionary simplicity: 'This planet has no heart. I am here to be the heart of the planet.'

Who we become depends on our encounters and experiences. Our perspective changes if we let our experiences enter into us. To use an image from RD Laing, it is possible that the entire formation is off course, not the one plane that leaves the formation.



Sometimes changing one's viewpoint is all it takes to see how unnecessary, violent and harmful our 'help' really is. All you have to do is lie down on the floor with Giovanni and feel his peace, and then feel pulled up and taken away. But you can't make that sort of a rebellion without being considered insane or ungrateful.

What I learned is that everyone knows what makes them feel good, and the help they need is to be able to realise what they wish for.

So I learned that this planet needs everyone, even people who are inactive, who refrain from doing things, who observe us and act as a mirror. Just as there is a need for factory workers, farmers and all sorts of other ways of being, we need people who explore all possible worlds, and who can speak about them and affect reality.

But what we do *not* need is a so-called science (psychiatry) and people (psychiatrists) who claim the right to define what are acceptable ideas and activities, and what are not. Saying they are due to a mental illness can destroy the sense and meaning of the experiences of other people, thereby forcing them into loneliness and exclusion, herding them into institutions or into their own bodies, or forcing them into exile in train stations.

* * *

All this may seem to make sense and even be poetic, but I can sense the irritation of all the pragmatists and professional helpers. I heard their objections for years – I know them by heart. For example, I know that the world I describe is partial and that there are many people who are invaded by presences that are much less 'divine', who behave in ways that hardly fit into social or family life, or with

the rights of those who live near them, or who do not seem to want to communicate with anyone, and who are put at risk by rejecting any form of approach or help. People and behaviours that hardly make sense to us – but for that very reason we cannot define as incomprehensible.

In reality 'helpers' do nothing but show the limits to our understanding, acceptance, openness and participation. It is we helpers who ask psychiatry to help the deviant thinkers and actors, not they who need such 'help'. We should be honest about it, and simply allow that this unasked for 'help' is an understandable human error, rather than a horror and a crime against others' humanity and our own.

Professional pragmatists are not accustomed to being confronted with a reality that makes facts follow political and philosophical analysis: that is, to 'getting their hands dirty' by accepting a direct confrontation with all the human and social contradictions, and always experimenting with new strategies to overcome them.

I call this 'the impossible project' because it consists in making possible the mission of becoming who we really are, refusing simply to be what we are supposed to be. My ten-year experience with the homeless started from rejecting what civil society expects from us.

At best, the usual reception centres are asked to provide shelter and relief to people in need. But behind this program there is often another agenda: (1) please

remove from view (from the streets and railway stations) these disturbing presences, and (2) make sure they become integrated into society, i.e., that they behave according to the unwritten rules of decency. No one can define scientifically what is allowed, but everyone knows when something exceeds what is socially permissible. And that is when society asks us to intervene – not to understand or even question the motives of the social offence, but simply to reinstate the *status quo ante*.

This is especially true for those who do not seem particularly concerned by their poverty, and who give greater weight to their inner vicissitudes rather than to material matters such as eating, bathing, shelter ...

These are the people who we are not able to 'objectify' or 'flatten' into a material need that we can answer, and so feel that we have fulfilled our mission of helping; people we cannot 'contain' within our rules of acceptable behaviour, which we pass off as 'education', and which meet the requirements or philosophy of the social workers. People who, in my view, instead of being defined and treated as 'disturbed' and 'disturbing', could be perceived as an opportunity and a stimulus for change and ongoing experimentation.

* * *

'The Cure' was established ten years ago as a low-threshold reception facility. It is open 24/7 to anyone who, for any reason, is homeless or unsupported by family or society. The idea is to offer refuge to people from the streets without making moral judgments about how they became homeless, and without judging the normality or abnormality of their reasons and choices. For us, what unifies those who have lost their home due to losing a job and those who left their homes because they are inhabited by spirits, is the lack

of housing. We try to support both kinds of people in the search for a home that is as close as possible to what they would wish.

Instead of simply thinking someone is foolish for leaving home 'because it is haunted', we get involved with his vision of things, and learn to consider that, even for the unemployed, 'having a life' does not necessarily coincide with 'having a home'. When offering a job or a house to a homeless person, how many of us ask: 'Would I take it?'

Hoping to make our support closer to what is really necessary, we are gradually evolving a practice increasingly attentive to everything that is needed.

First, the person signs a contract for accommodation. When this is done, an estimated time of support is agreed, depending on what the person intends to do. Among the possibilities is what we call 'the right to laziness'. People can ask (and receive) hospitality without proposing any concrete goals, except that of having some quiet time or thinking about picking up the pieces of their fragmented lives.

Having internalised the ideology of other reception centres, and hoping to meet our expectations, it happens that many guests like to display willingness to work and become independent. These aspirations crash miserably at the first job opportunities not taken, causing the resolution of the agreement with an invitation for the future to take direct responsibility for their own needs.

Users have only to agree to:

- (1) respect the space and privacy of the other guests
- (2) not bring in weapons, drugs or alcohol (for drugs and alcohol there is an informal rider which reads: 'if not circulating in your body'; this confirms the idea that, if not incompatible with social life, personal and voluntary use of a substance does not preclude acceptance in the centre.)
- (3) not use threats or violence against other guests or workers.

The Association tends to interpret violence as the outcome of a relationship. Hence, a guest will be expelled if he is violent to another guest (and sometimes so will the one who seems to be the victim). But when violence is committed against the centre or the staff, there is normally a self-critical reflection on the context, and this has rarely led to expulsions. In our view, it is unfair to view a failed relationship as the personal failure of a guest. So when there is such an issue between the person and the centre, the person in charge of the case duly apologises for any unilateral ending of support by the Association. In this way, we resist stigmatising as 'difficult users' people who, in our experience, we consider only intolerant to the often unfair rules of reception facilities.

The guest agreement has a blank section where we indicate the exceptions and permissions notwithstanding the usual regulations, as agreed in the beginning or during the reception.

If, for example, for organisational reasons, the shower is being fixed at 6.00 pm, the person may be authorised to take a shower at another time, without failing to fulfil guest

obligations. The addition of exceptions on one or more points in the regulations naturally causes changes in the general rules and thereby adapts the rules to the people who are actually at the centre at a given time. This is what we mean by the phrase borrowed from a song by Jovanotti, which has become the political slogan of the association: 'The rules do not exist; only the exceptions do'.

Over the years we have been accused of being libertine and unregulated. But, simply and realistically, we redefine different rules at different times and according to the presence of different guests. This ensures that the rules are useful to our social life, and not vice versa. Certainly, this makes for more work, but when we do this at the meeting with all the guests, the shared regulating strength of our policies is recognised by everybody and it is really worth it.

Between the times when we change the organisation's rules we try to provide flexibility through the recognition of individualised exceptions. This sometimes causes much criticism of the management by the guests, when they are accused of making special distinctions and not treating everyone equally. Actually, we do not believe that everyone is equal, but that everyone must have equal opportunities. Treating everyone equally is neither fair nor equitable, it is just a way of imposing the majority's ideas on the few.

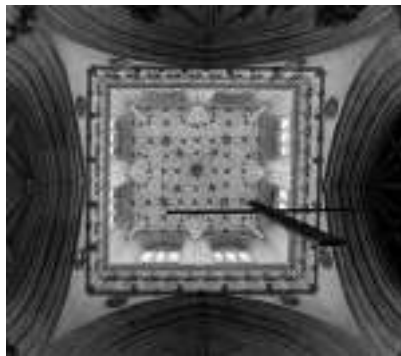
In fact, our goal is to treat everyone unequally, to ensure that everyone is equally happy to be helped in the way that they want.

I do not think adults need to be 'educated', as is assumed in many other facilities. One can simply relate to adults, and decide whether or not to share their goals and whether you can or want to help them achieve them. Our goal is not to review the solutions that the other person finds for himself, but to choose to support it or not, even if and when we don't agree with them. We usually help others whether we share their objectives or not, provided that their choices do not hurt anybody other than themselves.

These notes on the model of 'The Cure' explain why it is a refuge for many 'vagabonds' who escape the attentions of the social and psychiatric services. Our disengaged guests are the motor to change the internal structure and regulations used by many guests whose mental health is not jeopardised by the institutions, but are guilty of social maladjustment.

At 'The Cure', people find a refuge in which they are not forced into involuntary treatment, are not reported to the psychiatric services, and are defended from the intrusiveness of psychiatric workers (who are not permitted access to the facility). We support people who can live their experiences and communicate them freely without being forced to live either with families who can hardly stand them or psychiatric facilities which just serve to contain them. People who, if they want, can freely choose to seek treatment or stop it if they don't find it beneficial. People who are free, and therefore responsible. If they want it, people are helped to find accommodation and work, and to leave the psychiatric circuit.

I always thought that people are processed in the normal



reception centres with the object of their re-insertion into the community from which they had already been expelled. If we pull them in without changing their path at all, nor, as far as possible, change the rules of the community, we only expose them to failure and to what they have already experienced.

* * *

At the beginning of this adventure at The Cure, we hosted a barefoot wandering mystic who owned nothing, called Sandro. Refractory to every rule, he chose us as a refuge while he paused for reflection. I was contacted by his brother during one of these stopovers. He urged me to seize the moment and get Sandro put into psychiatric care, so that he could be returned to a normal life. Given that Sandro did not think he needed that kind of help, I called his brother to a meeting. Their conversation was enlightening. Concerned about Sandro's choice of life, his wanderings and begging and lack of a future, the brother insisted on hospitalisation. But Sandro had shared the Neocatechumenal experience with his brother, and taken it to its extreme. He reassured his brother, and said that in fact he too was worried – that his brother had a serious spiritual problem and had lost the right path. Here were two different choices or lifestyles, each with equal validity.

When I think of the impossible as a project, I think of the exploration of the unconventional and non-ordinary ways of being and thinking. I think of Sandro who had abandoned his worldly life, and who continues to inspire us in our daily lives. I think of the story that he told me of the encounter with his brother.

The two of them had a vegetable garden. Sandro thought that cultivating it was wrong because God would make sure that it would be fruitful, that it was sufficient to have faith. The brother disagreed, and would go and work in the field, complaining about Sandro's attitude.

This created a serious conflict between them until Sandro proposed to split the field. One half was cultivated by his brother when and how he wanted. Sandro assigned the other half to the grace of God, and he believed he would receive its fruits. At harvest-time Sandro picked many well-formed but tiny cauliflowers, but his brother's cauliflowers

had come up big and beautiful. However, at the market no-one bought the big cauliflowers. They preferred the small fruits of Sandro's plot since they were easier to use in the kitchen.

I do not believe in God, but I think that the faith and passion of Sandro shows it is possible to find ways to live with each other, and to learn from each other apparently irrational ways that we do not understand until they reach their completion. We should learn to respect these differences.

Meanwhile, the logic of psychiatry simply makes for an irreversible rupture within ourselves and between us and others. We are there at the time of the fracture between Sandro and his brother, witnesses of a separation that we must make possible, in order to recognise everyone's right to exist without condemning others.

This is what I call 'anti-psychiatry'. Where there is psychiatry, people are not possible.

Giuseppe Bucalo is founder of the Committee for Antipsychiatric Action, and President of the Penelope Association, and of the Coordination of Social Solidarity. He has written the following:

Dietro ogni scemo c'è un villaggio. Itinerari per fare a meno della psichiatria. Sicilia Punto L, Ragusa, 1993 (Behind every fool there's a village: Routes to take without psychiatry)

La malattia mentale non esiste. Antipsichiatria: prime istruzioni d'uso. Nautilus, Torino, 1996 (Mental illness does not exist: Antipsychiatry – first instructions for use)

Malati di niente. Manuale minimo di sopravvivenza psichiatrica. Calusca Grafton, Milano, 1996. (Sick of nothing: Minimum manual for psychiatric survival)

Dizionario Antipsichiatrico. Esplorazioni e viaggi per fare a meno della psichiatria Sicilia Punto L, Ragusa 1997 (Antipsychiatric Dictionary: Explorations and journeys to make without psychiatry)

Sentire le voci. Guida all'ascolto. Sicilia Punto L, Ragusa, 1998 (Hearing voices: Listening guide)



**Mad Love
writes:**

Dear all our lovely Madlove people,

Please send us a quick email answering this:

If you could create your own asylum, what would it look like?

What objects, activities, tastes, smells, colours, etc., would you have, and why?

Playful, serious, impossible, radical, gentle, tiny, massive ... all ideas are wanted. Answers can be very long or super short!

We will be using your answers to develop and promote the project, so please let us know how you would like to be credited (name, diagnosis, location, job ... or completely or partially anonymous ... whatever you are comfortable with ...)

We look forward to reading your responses!

<engage@madlove.org.uk>

NEWS & COMMENTS

MENTAL ILLNESS COSTS UK £70 BILLION A YEAR

The OECD has added up the costs of healthcare, benefits and lost productivity, and finds that the yearly cost of mental illness to the UK is £70 billion – 4.5% of GDP. Its report, ‘Mental Health and Work: United Kingdom’, says that mental illness is the main reason the UK has the highest concentration of disability benefits claimants in the developed world.

In the UK the employment rate for people with mental health problems is 17% lower than for other countries. Compared with all the other OECD members, including the USA, they are almost twice as likely to be poor, and they are more likely to fall into poverty. Each year up to 370,000 Britons (1% of the working-age population) move onto disability benefits; mental illness accounts for 40% of new claimants.

Mark Peterson of the OECD warns that ‘ignoring these facts would be a major error, an economic error as well as social.’ A key message in the report is that employment has a positive effect on mental health and treatment for mental illness. The report praises the UK for having one of the more innovative attitudes towards mental health treatment and employment. However, while there has been good recent progress on policy, the system for administering mental health care and employment is not well joined-up, and this hampers treatment outcomes.

The report also urges the UK to improve early identification and action for those at an early phase of mental health problems. ‘Helping people to keep their jobs is far easier than helping people find new jobs,’ Peterson added. Presently, return-to-work support in the UK only starts after employees have been off work for nine months or a year. To tackle this, so as to help get them back to work quicker, the Government has announced it will launch a ‘Health and Work Service’ to offer voluntary medical assessments and treatment plans to employees after just four weeks.

[Hickman, A (2014) Mental illness costs £70bn per year, says OECD report, *HR Magazine*, 11 Feb.]

CARE & THE CUTS

False economies

Mental health accounts for 23% of the disease burden in England but receives only 13% of the NHS budget. MH trust budgets for 2013–14 fell by 2.3% from 2011–12, and trusts have been asked to save almost 20% more than general hospitals from next year’s budgets.

But a report by Rethink Mental Illness and the London School of Economics finds that cuts to MH care are a false economy: fairly quickly they cause greater costs. Since 2010 the cuts have meant fewer people accessing early intervention treatments, such as a talking therapy. More cases of psychosis (usually diagnosed as schizophrenia) now end up in hospital rather than being treated in the community.

Community MH teams support patients to prevent their health deteriorating to crisis point. But 54% of the psychosis budget was spent on in-patient care rather than on preventive community services, and whereas referrals

to community MH teams rose by 13% during the year, their budgets did not increase at all.

And yet on average, it costs the NHS £13 a day to support someone with psychosis in the community, compared with the average daily cost of £350 for someone in hospital. The report reckons the NHS saves £989 every time someone is treated with cognitive behavioural therapy (CBT) rather than going in to a hospital. At least £50m a year could be saved by shifting the focus towards family therapy, CBT and peer support.

Lack of beds forces more patients out of area

Meanwhile, MH trusts are trying to cope with cuts of more than 1,700 beds in the last two years. The critical lack of beds is increasingly forcing trusts to send patients for treatment in other NHS facilities, sometimes hundreds of miles away. Data from 30 of England’s 58 MH trusts shows that the number of patients having to travel for emergency treatment has more than doubled in two years: from 1,301 in 2011–12 to 3,024 in 2013–14.

Earlier this year, despite not being deaf, a patient was put into a deaf unit. Understandably, she found this very stressful. An investigation found this had happened because there were no female beds available *anywhere* in the country. The trust says it has changed its procedures and this should never happen again.

When a bed couldn’t be found closer to home, another patient who suffered from bipolar disorder was taken 200 miles in the middle of the night, from York to a hospital in London. This patient said that although the treatment was good, the move was very disorientating and had made her anxious, and had cut her off from her family and friends. Other patients have been forced to make even longer journeys.

Data from 23 MH trusts shows that the costs of sending patients out of area almost doubled from £21.1m in 2011–12 to £38.3m in 2013–14. The increasing shortage of local beds is despite the numbers being admitted to hospital for MH problems falling slightly from 167,285 in 2011–12 to 166,654 in 2012–13.

Kent and Sussex are among the worst-affected by bed shortages. In Kent 334 patients were sent out of the county last year at a cost of £5m, compared with only 20 people in 2011–12, at £141,000. One Kent patient complained she was made to sleep on a mattress on the floor. The trust said there was unprecedented demand for beds last year. In Sussex, the number of patients sent out of area increased from 28 in 2011–12 to 227 last year.

One London MH trust was reprimanded by the Care Quality Commission (CQC) for using seclusion units as bedrooms. It had also started to move patients out of beds and into bed-and-breakfast accommodation. The trust said the patients were fit to be discharged from hospital but had accommodation problems – but it admitted that B&B was not ideal. Figures show that 132 patients were sent to B&Bs last year.

The chief executive of the Sussex Partnership NHS Foundation Trust said that rising demand for MH services and cuts to community services by councils were creating problems.

Mental health services are a barometer of how the system

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is operating and if you remove some of the lower levels of support that people rely on to maintain their lives, it's not surprising that they'll present in crisis. We are seeing people coming to hospital who are much, much iller when they arrive so we have higher numbers of detained patients but, much more than that, we're seeing people have to stay in hospital for longer.

Marjorie Wallace of SANE said: 'This situation is a result of the longstanding agenda to reduce the number of psychiatric beds, the most expensive element of care. But this is a false economy – leading to misery for many who struggle to access the treatment they need and undermining their chances for recovery.'

Karen Wolton, of the Mental Health Lawyers Association, commented:

We've noticed a sharp increase in the last year with inappropriate admissions for out-of-area beds. We've had people admitted from where they live in Margate to Weston-Super-Mare, which is a trip of 225 miles.

We've had people overdosing in order to obtain a bed. They've told us that they deliberately overdosed because that's the only way to get a bed.

We've also had people who are inappropriately discharged after long spells in psychiatric hospitals; they're being discharged to bed and breakfast accommodation.

Rise in MH detentions

It looks like the cuts might also be causing an increase in detentions under the Mental Health Act. Last year was the highest number ever: more than 50,000. According to the NHS regulator, the Care Quality Commission (CQC), the number of people in England being detained under the Mental Health Act rose by 12% in the past five years. CQC also criticised the use of blanket bans on activities such as the use of internet and phones, and access to outdoor space. Inspectors found one or more such rule in three-quarters of all wards, and said this was 'unacceptable'. It also criticised the practice – seen sometimes – of putting patients in police custody when there were actually health facilities available when crises developed.

Inadequate staffing levels and poor access to GP care were also highlighted as problems in psychiatric units.

[Stephens, P (2014) Mental health cuts cost the NHS millions, charity says, *BBC News* 10 April. Buchanan, M (2014) Mental health patients forced to travel miles for care, *BBC News* 6 May. Trigg, N (2014) Mental Health Act detentions up 12%, *BBC News* 28 Jan.]

CHILDREN'S MENTAL HEALTH CARE GETTING WORSE

A child a day locked in police cells under MHA

Very likely due to the cuts in both MH and social services, it looks like children's care is not getting any better. In England and Wales, nearly 8,000 people with serious mental health problems were held 'under section' in a police cell during the year ending March, 2013. In each of the last three years this has included more than 300 children. According to data released under the Freedom of Information laws, there were 385 child detentions for 2011, 317 for 2012, and 305 detentions of under-18s in the first 11 months of 2013. Some were held for lengthy periods, including 17-year-olds detained for more than 24

hours, 15-year-olds for between 8 and 15 hours, and a 10-year-old in Gwent.

Under the Mental Health Act, police have the power to take anyone to a 'place of safety' if they suspect they are mentally disturbed and could be a danger to themselves or others, for assessment by a doctor. Detention may only last up to 72 hours. 'A place of safety' is supposed to mean a hospital, care home or any other suitable place (such as an adolescent psychiatric unit or a children's home) but 'in exceptional circumstances' it may also be a police station.

Of course, the circumstances in these cases are in fact rarely anything more 'exceptional' than the lack of an available bed, or poor organisation or collaboration between the various psychiatric and social services.

Why many troubled children are banged up

People who suffer a mental health crisis in a public place – and are detained under the Mental Health Act – should be taken to a 'place of safety' to have their needs assessed. This could be a specialist mental health hospital or an emergency department at a general hospital. However, in 2012/13, 580 children in England were detained by the police under Section 136 of the Mental Health Act, and of those, 45% were taken into police custody.

The Care Quality Commission (CQC) says it is worried about the routine use of police cells. Many troubled children are forced into police custody because, in England, 35% of NHS 'places of safety' ban children. Of 161 facilities, including hospitals, half will not admit anyone under the age of seventeen. Care minister Norman Lamb said the situation is 'unacceptable' and that it was 'imperative' that people under eighteen were treated in an environment suitable for their age.

Talking about such children, Lucie Russell, from the charity Young Minds, told the BBC: 'What they're going to feel is, "I'm a prisoner, I've done something terribly wrong. So the fact that I'm distressed and traumatised and confused and frightened must mean that it's my fault because I've been locked up." Being surrounded by four walls in a police cell for anyone is a traumatic experience.'

Children let down by Welsh MH Service

Amidst accusations that the problem is ignored by ministers, the number of children in Wales waiting more than 14 weeks for psychiatric services soared from 199 to 736 in the twelve months to January 2014. Problems with mental health services in Wales were highlighted in a report last year, and problems with the child and adolescent mental health service (CAMHS) were raised in a report last December, despite some progress being recognised since a previous study in 2009. The joint review by Health Inspectorate Wales and the Wales Audit Office said that children are being put at risk because of inappropriate admissions to adult mental health wards.

However, despite a pledge of £250,000 extra funding – yet to be delivered – Welsh Lib Dem leader Kirsty Williams said: 'Sadly the Welsh Labour Government is determined to bury its head in the sand and ignore the catalogue of concerns and warnings that young people in Wales are being put at risk. This complacency is astounding and the Government should hang its head in shame.'

50% rise over six years for ADHD drugs

Over the last six years, there has been a 50% rise in England in the use of drugs for Attention Deficit Hyperactivity

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Disorder (ADHD). According to the CQC, NHS prescriptions for methylphenidate drugs, including Ritalin, rose from 420,000 in 2007 to 657,000 last year. It warned health workers to 'carefully monitor' their use as they have the potential to be 'abused'.

Methylphenidate is a psycho-stimulant and these drugs are one of a number linked to the 'smart-drug' craze where students take medication to help them focus.

The CQC reported the number of prescriptions for both children and adults for such medications rose by 11% between 2011 and 2012. Professor Tim Kendall, a psychiatrist at NICE said: 'I think it's a real trend ... too big to be ignored.'

Private prescribing also rose during the period, up from just under 2,000 in 2007 to just under 5,000 last year. But since these are a small fraction of the NHS prescriptions, the belief is that the rise has been driven by an increase in the number of ADHD diagnoses.

The CQC said: 'As in previous years, we believe that this reflects increased diagnosis of, and prescribing for, the treatment of ADHD. We are also aware of the possibility that methylphenidate could be diverted and abused, and for this reason we recommend that its use should be monitored carefully.'

Asked if there are any dangers to people who take methylphenidate drugs over a long period, Prof Kendall said:

In children, without doubt. If you take Ritalin for a year, it's likely to reduce your growth by about three-quarters of an inch. I think there's also increasing evidence that it precipitates self-harming behaviour in children, and in the long term we have absolutely no evidence that the use of Ritalin reduces the long-term problems associated with ADHD. Having said that, if you've got a kid with severe ADHD, it's very difficult to treat them psychologically without using Ritalin as well.

[Under 16s 'refused access to mental health safe havens', *BBC News*, 16 April 2014. More children waiting longer for mental health services, *BBC News*, 2 April 2014. Beckford, N (2014) Hundreds of children 'detained in police cells', *BBC Radio 4*, 26 Jan. Sectioned children sent to police cells. *Metro*, 4 Feb 2014. Use of ADHD drugs 'increases by 50% in six years', *BBC News* 13 August 2013.]

DEPRESSION IS SECOND MOST COMMON HEALTH RISK

Second only to back pain, depression is the most common cause of disability in the world, according to a World Health Organization (WHO) review. Clinical depression was compared with more than 200 other diseases and injuries as a cause of disability. The report in *PLOS Medicine* suggests that depression should be treated as a global public health priority since at the moment probably only a small proportion of those affected get diagnosed, and relatively few people have access to treatment.

Rates of depression tend to be lower in high-income countries and higher in low- and middle-income countries: they varied between the highest in Afghanistan and the lowest in Japan. Up to 2010, Algeria, Libya, Syria and Afghanistan fared worse for the cumulative number of years their citizens lived with the disability of depression, and parts of Africa and Eastern Europe did not do well.

Japan fared best, along with Australia and New Zealand. In the UK, depression ranks number three in terms of years lived with a disability. Everywhere public awareness tends to be low, and so do rates of successful treatment.

Around the world, about 5% of the population suffers from depression. The rates for both major depressive disorder and dysthymia (milder depression) have remained quite stable during the last twenty years. Women continue to suffer about twice as much as men. But it seems depression is becoming a young person's affliction: people aged 20 to 24 suffer most, closely followed by the generation immediately senior to them; rates dwindle from age 50, and decrease sharply for those over 60.

[Ferrari, AJ et al (2013) Burden of Depressive Disorders by Country, Sex, Age and Year: Findings from the Global Burden of Disease Study 2010, *PLOS Medicine*, 5 Nov. Briggs, H (2013) Depression - 'Second biggest cause of disability in world', *BBC News*, 6 Nov. Rice-Oxley, M (2013) *Guardian* blog 8 Nov.]

THOUSANDS OF MH PATIENTS DIE EARLY

The charity Rethink Mental Illness says that thousands of people with mental health problems 'die needlessly' due to a failure to take seriously problems with their smoking, drinking and obesity. Rethink reckons that in England the number of avoidable deaths runs at 33,000 a year.

One in six people in the UK currently have a mental illness diagnosis. Excluding suicides, in England more than 100,000 deaths each year are officially classed as 'avoidable'. This is most often due to 'lifestyle decisions' including deaths from lung cancer that could have been prevented if people did not smoke, heart problems due to a lack of exercise, and a diet packed with salt and fatty food.

People with mental illnesses represent a large proportion of the avoidable deaths figures, but this is too often ignored. MH patients were less likely to be given support to help them stop smoking, despite 40% of cigarettes being smoked by people with a mental illness. Ignorance, poverty and lack of motivation often results in bad diet and lack of exercise; anti-psychotics often cause patients to become overweight, but often this is not monitored.

Last year Victoria Bleazard, associate director of campaigns at Rethink, criticised Health Secretary Jeremy Hunt for 'barely touching on mental health' when he announced plans to deal with avoidable deaths. She said there were 'systemic problems in the NHS' including doctors focusing on a patient's mental health problems but not dealing with physical health problems, and an attitude that 'smoking is the last treat they've got' so should not be tackled.

Prof Sue Bailey, president of the Royal College of Psychiatrists, described the figures as 'chilling'. She said:

The fact that people with serious mental illness [e.g. schizophrenia] die an average of 20 years earlier than the rest of the population is one of the biggest health scandals of our time, but it is being ignored. If this statistic applied to any other group of people, such as residents of a particular town, there would be a public outcry. This simply isn't happening for people with mental illness. Failure to address this issue amounts to a form of lethal discrimination which is costing lives.

[Gallagher, J (2013) Mentally ill are 'dying needlessly', *BBC News* 26 Sept.]

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BULLYING AFFECTS PEOPLE FOR DECADES

It is well known that being bullied in childhood carries a risk for later mental health problems. A recent study from Warwick University which followed more than 1,400 people between the ages of nine and twenty-six found bullying had long-term negative consequences for physical and mental health, job prospects and relationships. Now, as part of the British National Child Development Study, research from Kings College, London finds that people bullied during childhood run a greater risk of negative impacts on their physical and mental health even after more than forty years. The study, just published in the *American Journal of Psychiatry*, tracked nearly 8000 children born in 1958 from the age of seven until fifty.

Parents had been asked if their child had been exposed to bullying at ages seven and eleven. More than a quarter said they had been bullied occasionally and 15% bullied frequently – similar to the rates reported these days. Over the years, tests were then carried out to see if the ill effects of bullying persisted into adulthood. Subjects were tested for psychological distress and general health at the ages of 23 and 50, for psychiatric problems and cognitive functioning at 45, and for social relationships and well-being at 50.

People frequently bullied during childhood were almost twice as likely to suffer from depression at the age of 45, and were more likely to develop anxiety disorders and suicidal thoughts. Victims were more likely to have poorer physical and mental health and cognitive functioning at age 50, were more likely to have lower educational levels, and more likely to report a lower quality of life. Men were more likely to earn less or to be unemployed. Bullying also affected people's social development, with victims less likely to be in a relationship at the age of 50, or to have strong social support networks.

Forty years after exposure to frequent bullying the risk of poor health, and bad social and economic consequences was about 1.5 times the norm – similar to that faced by children raised in care. The harmful effects of bullying remained when other factors including childhood IQ, emotional and behavioural problems and parents' socioeconomic status were taken into account.

These findings support groups who argue that victims of bullying need long-term support.

[Child bullying victims still suffering at 50: study, BBC News 18 April 2014. Cooper, C (2014) Childhood bullying 'can lead to depression and unemployment in adulthood', The Independent 18 April.]

POVERTY SAPS MENTAL POWERS

Two separate studies published in *Science*, from India and the USA, show that poverty saps a person's ability to think. Previous research had shown a correlation between poverty and bad decision-making, but the cause was unclear.

Every year, sugar-cane farmers in India experience a period of increasing poverty tied to their debts before the crop is harvested and sold. From a sample, the same farmer was compared at different stages of the yearly cycle, and cognitive tests (IQ tests) found that mental acuity varied directly with the farmer's current income. The study aimed to rule out other confounding factors such as nutrition, health, physical exhaustion and family commitments, and also the influence of factors related to stress, but measured biomarkers such as blood pressure and heart rate.

To make sure the findings were not somehow unique to these Indian farmers, a control study was completed in the US. Using one group of wealthy people and one of poor people, the researchers triggered thoughts about their personal financial situations using easy and difficult hypothetical questions, and then got them to sit non-verbal tests. When it was the easy condition there was no difference in the performance of the rich or poor, but in the harder condition the performances of the poor dropped off a lot.

These studies conclude that by having more constant and extensive financial worries, poor people expend much more of their mental capacity on those concerns, so that less can be used for other tasks.

These results indicate that constant financial pressure is likely to initiate a downward spiral for the less fortunate, and suggest that more support needs to be given to those in poverty so as to help them with the tasks of daily life. It also suggests that the general perception of the mental abilities of the poor needs to change.

[Gould, J (2013) 'Poverty significantly saps our mental abilities say researchers' BBC News 30 Aug.]

TREAT ADHD WITH SUPPLEMENTS?

The common symptoms of Attention Deficit Hyperactivity Disorder (ADHD) include inattentiveness, concentration difficulties, hyperactivity and impulsiveness. Symptoms tend to be first noticed at an early age – ADHD is normally diagnosed between the ages of three and seven. It is estimated that 2% to 5% of school children and young people are affected, though less than half have it so severely as to seem to need medication.

However, ADHD seems to be life-long: one-in-twenty adults are diagnosed with ADHD. The condition is generally treated with central nervous system stimulants.

A small-scale study now suggests that micronutrients such as zinc, calcium and vitamins could improve brain functioning and thereby prove useful in treatment. As reported in *The British Journal of Psychiatry*, compared to a placebo group, ADHD adults given supplements for eight weeks had 'a modest improvement' in the usual symptoms. Eighty adults with ADHD were given either a dummy pill or supplements containing vitamin D, vitamin B12, folate, magnesium, ferritin, iron, calcium, zinc and copper. After eight weeks, those on supplements reported greater improvements in both their inattention and hyperactivity/impulsivity compared with those taking the placebo. The effects of vitamins and minerals (micronutrients) are more modest than medication but may be useful for some people, particularly those seeking alternative treatments. Professor Julia Rucklidge says: "This could open up treatment options for people with ADHD who may not tolerate medications, or do not respond to first-line treatments."

Meanwhile, a separate study in Sweden, published in *JAMA Psychiatry*, suggests that medication could save lives on the road. Research indicates that almost half of transport accidents involving men with ADHD could be avoided if they were taking medication for the condition.

The study used data from health registers to follow 17,000 people with ADHD over four years. It found that men with ADHD had a higher risk of being involved in serious transport accidents, compared with those without the condition. Accidents were lower among men with

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ADHD who were on medication than among ADHD men who did not take medication. It was estimated that 41% of transport accidents involving men with ADHD could have been avoided if they had received medication and carried on taking it during the course of the study. However, a similar effect was not found in women.

[Briggs, H (2014) Vitamins 'effective in treating ADHD symptoms' BBC News, 30 Jan.]

JURY OUT ON CBT FOR SCHIZOPHRENIA

The general view is that about 40% of patients diagnosed with schizophrenia benefit from taking antipsychotic medication. But the drugs do not work for the other 60%, and they can also cause appalling 'side-effects' such as type-2 diabetes and obesity. It is estimated that perhaps half of such patients end up not taking their drugs.

Cognitive behavioural therapy (CBT) is supposed to work by identifying an individual patient's problem – such as hearing voices, paranoid thinking or no longer going out of the house – and developing psychological ploys to deal with them. NICE recommends CBT for schizophrenia, but in the UK it is available to less than 10% of patients with that condition.

A small-scale study (74 subjects) recently published in *The Lancet* is typical of much of the research: it finds that using CBT for 'changing the way people think about and deal with schizophrenia is a moderately effective treatment' – especially for the many who refuse antipsychotic medication – and that '... offering CBT is better than just leaving such patients to languish'. They reckoned that CBT had 'a moderate effect, roughly similar to the effect size of antipsychotics', although they did not make a head-to-head study directly comparing the two therapies. CBT did reduce symptoms and it also improved personal and social function. When offered CBT, most patients were happy to try it. The study suggested that combining CBT with drugs was most effective.

This research chimes with the findings of a number of studies in recent years: the medical consensus is that CBT does benefit patients diagnosed with schizophrenia, to some extent. However, a recent meta-analysis looked again at 52 studies and found that in fact there is rarely rigorous proof of any statistically significant benefit. It seems that treatment only 'has a therapeutic effect on schizophrenic symptoms [delusions and hallucinations] in the "small" range. This reduces further when sources of bias, particularly masking, are controlled for.' In other words, studies are often biased by not employing the double-blind procedure whereby, when the research is ongoing and outcomes are compared, the researchers do not already know who received CBT and who didn't.

But there is no reason to imagine that CBT might ever prove particularly effective. First, psychosis (or 'schizophrenia') is precisely *defined* by the fact that people in such a state appear incoherent or cannot focus rationally on reality since they are pre-occupied with their wayward ideas and perceptions, and also have difficulty communicating or otherwise responding in a conventional, 'reasonable' or 'constructive' manner. Secondly, CBT refuses *in principle* to permit patients to 'dwell on' or explore their own biographies so as to reveal or recall events that might have been emotionally or psychologically traumatic: it only wants to persuade patients to adopt certain tricks to help them cope with the

'symptoms' – the effects of such trauma. Other talking therapies want patients to recognise and understand, so as to *get over* their emotional trauma: they encourage patients to discover and confront the causes of their terrors, thereby providing themselves with a better purchase on reality and possibilities for recovery, or at least a possible lessening of the symptoms.

[Gallagher, J (2014) Schizophrenia: Talking therapies moderately effective, BBC News 6 Feb. Morrison, AP et al (2014) Cognitive therapy for people with schizophrenia spectrum disorders not taking antipsychotic drugs: a single-blind randomised controlled trial, The Lancet, Feb 6. Jauhar, S et al (2014) Cognitive-behavioural therapy for the symptoms of schizophrenia: systematic review and meta-analysis with examination of potential bias, The British Journal of Psychiatry 204, 20-9.]

EXTENT OF SELF-HARM IN PRISONS

Research published in *The Lancet* looked at incidents of self-harm in all the prisons of England and Wales between 2004 and 2009. Nearly a quarter of female prisoners cut, scratch or poison themselves – women make up only 5% of the total prison population but account for half of all incidents of self-harm.

In each year there were 20,000 to 25,000 incidents. 5% to 6% of male prisoners and 20% to 24% of female prisoners deliberately harmed themselves. This compared with a 0.6% rate among the UK's general population.

The study found that repeated self-harming was common, and a small group of 102 women prisoner self-harmed more than 100 times a year.

Prisoners who self-harmed were found to be at 'substantially greater' risk of suicide than other inmates, particularly among men. Older male prisoners (aged 30 to 49) with a history of serious self-harm were most at risk.

The study also examined those at greatest risk of self-harm. For female prisoners, being younger than 20 years old, white, in a mixed local prison, or serving a life sentence were major factors. For male prisoners, those at risk tended to be young, white, in a high-security prison and either unsentenced or with a life sentence.

Dr Seena Fazel, joint study author from the Department of Psychiatry at the University of Oxford, said all prisoners who self-harm should be regarded as a risk. She called for 'better multi-agency collaboration, in which self-harm and suicide is everyone's concern, rather than being the sole preserve of healthcare staff.'

Andy Bell, deputy chief executive at the Centre for Mental Health, said it was well known that women in prison were more likely to have depression, anxiety and borderline personality disorder which, in turn, can make them extremely vulnerable. He added it was important to be aware of those at risk at an early stage:

Women should have access to mental health support and advice at every police station. It should start when they are arrested, particularly if there are signs of self-harming or poor mental health. We have to intervene early to stop the journey.

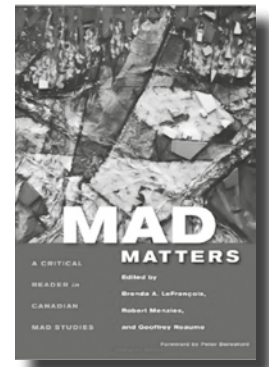
[Self-harm 'four times more likely' in female prisoners BBC News 16 Dec 2013.]

REVIEW

Mad Matters: A Critical Reader in Canadian Mad Studies

by Brenda A LeFrancois, Robert Menzies & Geoffrey Reaume (Eds)

Toronto: Canadian Scholars Press (2013)



This book travelled the Atlantic to arrive on my doorstep in a tightly bound package. The first thing I did was smell it, and the second was to read it. Like jumping into cold water, it made me lose my breath, it woke me up. I read it in four days, and my copy bears the stains of coffee and tears. This is the story that doesn't get told. This is Madness with a capital M.

In the Mad space of this book, Mad with a capital signifies a movement, a reclamation, a field of inquiry, a celebration. Yet this is a celebration always wary of the costs that go with it – how positive representations of disability and distress may also overlook the socio-economic production of madness, how society disables and drives people mad, a madness represented by psychiatry as 'biochemicals gone awry', a psychiatry that prescribes 'treatments' that do make people's biochemicals go awry (Gorman, Ch 19).

The space I occupied until recently, which invisibly bounded the things I could think and dream, was not a place where madness had been reclaimed. As someone not (yet) psychiatrized, my life bears the stain of psychiatrization. Psychiatry says it's in my genes, a secret code, but I'm not afraid of hearing the voices as much as I am of telling a psychiatrist that I hear them. Madness was heard in the background of my childhood like whispers, as psychiatry peeled off from our family the odd and the distressed, and said they were schizophrenic.

While *Mad Matters* (and the Mad Studies it advocates) is partly a conceptual challenge, it is one grounded and embodied in pain, in psychotropic scars still raw, unhealed; in brains swimming with chemicals, leaking; in memories lost from a 'therapy' that shocks. In the myriad disparate project of a Mad Studies that thinks madness otherwise, some themes emerge. Here Mad Studies is an 'interdisciplinary and multi-vocal praxis' that attempts to decentre psy-centred ways of being, whose rationale is the embodied realities of those 'whose lives have collided with the powers of institutional psychiatry' (Menzies, LeFrancois & Reaume, pp. 13–14); whose ways of knowing have been subjugated; on whose bodies the rawest forms of power intertwine. This is a project alert to the play of sameness and difference weaved throughout Mad ways of being, where consuming and surviving cannot be reconciled through hyphens and forward slashes (Burstow, Ch 5).

As a psychiatrist, Warne admits he can deny someone's personhood with a stroke of his pen: he has the forms for it in his desk (Ch 15). For Liegghio (Ch 8), this is violence

that denies personhood, that denies legitimacy to some people and some knowledge – an epistemic violence that interweaves with colonialism by stigmatising some people as less than human, as savage. But there is little 'post-' to this colonialism: today, experts concoct psychiatric and chemical 'solutions' to structurally embedded oppression and social violence on the brains and bodies of inner-city racialised, and increasingly psychiatrized, youth (Varonka, p. 316). Canada's indigenous and First Nations peoples are survivors of a school system that took children from families, forced them to speak English, cut through ties as long as time can remember and deeper than oceans. This dispossession is still felt today, and is diagnosed by psychiatry as 'a disease'. This is 'the imposition of the coloniser's methods for 'healing' their own consequences' (Tam, p. 295), the single story of distress as 'illness', a 'mental health literacy' to gloss over other ways of knowing, and to hide the State's role in injustice (White & Pike, Ch 17).

Here psychiatry, racism and colonialism (and a multitude of other oppressions) interweave not in a sum where one is added to the other, and not as discrete entities which only relate through analogy, but in a knot. This is to grapple with a space where, while psychiatry is always already racialised and colonial, it is not an even terrain but is experienced differently by different groups (Diamond, Ch 4). Claiming that all those who are psychiatrized are simultaneously colonised is to marginalise the realities of those populations who have experienced both colonisation and psychiatrization; this hides how forms of oppression are tethered and interwoven (Tam, Ch 20). Hence, the force-field of psychiatrization is not an even landscape: it is woven-through with the seams of other oppressions, tethered together, and those 'occupied' by psychiatry may live the memories of other occupations, or may themselves be occupiers – living the privileges of a settler in an occupied country now called Canada. For it depends how far back we can bear to begin this story of violence (Voronka, Ch 22). Here the traumatic colonial appropriation of land and the fracturing of the body politic entangles with the colonisation of minds, living on in memories borne on bodies, scars deep inside.

This book will make you angry, it will make you mad. Anger flows from one chapter to the next, an anger that is 'mad as hell' (Lee, p. 105), bleeding with the many kinds of violence at work within a system that can incarcerate someone against their will, in the name of a 'treatment' that has no evidence base; a system where 'treatment' disables

the brain and returns people to families they can't remember, their memories disappeared in the electricity: torture reconfigured as 'treatment' (Weitz, Ch 11). Grief flows too – just another 'disorder' the *DSM* can capture and categorise and tell us we need to take a pill for (Poole & Ward, Ch 6). But what about the grief for people lost to psychiatry, for those who didn't survive?

Wherever practised (on the streets, in schools, hidden away in hospitals) Mad Studies is entangled in a revolutionary project. While consensus of a post-psychiatric world does not exist, the idea that one is possible does: a world where 'nothing short of wholesale transformation – to our paradigms of thought, to reigning systems of knowledge and communication, and to the institutional structures that embody and sustain psychiatric relations of power – will suffice' (Menzies, LeFrancois & Reaume, p. 17). And yet there is painful awareness here that for those who live and resist psychiatrization day in, day out, alternatives must be offered, there must be hope.

Mad Studies is located in the then and the now (and the possibilities of the not yet), in enacting a historical memory-work that links resistance to psychiatrization to other historical struggles, and reminds us of something that psychiatry (with

its hegemonic clasp on our memories) has tried to help us to forget (sometimes through force, through chemicals and electricity). That is, that resistance to psychiatry has been around for a long time, longer than our memories, and it permeates the halls of asylums long torn down (see Menzies, LeFrancois & Reaume; and St-Amand & LeBlanc, Ch 2).

The book begins with an observation made in 1981 by the Toronto activist and survivor, Mel Starkman: 'An important new movement is sweeping through the Western world ... The "mad", the oppressed, the ex-inmates of society's asylums are coming together and speaking for themselves. The map of the world is dotted with newly formed groups struggling to decide ... whether 'the system' is reformable or whether they need to create an alternative community' (Starkman, p. 27). And now that map has many more dots, marking a multitude of struggles against psychiatrization gone global. For wherever psychiatry travels, as it expands and creeps across geographical borders into ever more domains of everyday life, resistance will meet it, head on, in protests, in courts, in local and global mobilisations, in pills hidden under tongues and flushed down toilets, in claims to rethinking what counts as knowledge, in projects such as Mad Studies, and in books like this one.

China Mills

ADVERTISEMENT

Psychiatry in Context: Experience, Meaning & Communities

Philip Thomas

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The contexts in which we all exist shape and give meaning to our lives for good or for bad. Research confirms how situations of adversity such as trauma, abuse, and racism can lead to psychosis. Philip Thomas argues that if we are to prioritise the role of values and ethics in mental health care we must engage actively with the contexts of people's lives, rather than focus on the endlessly fruitless search for the biological origins of distress and increasingly technological approaches to its management.

After careful examination of the problems of psychiatric diagnosis, treatments, scientific models of madness, and neuroscience, Thomas proposes that the opportunities we have through narrative, to talk about our experiences and the contexts in which they are embedded, play a vital role in the task of making sense of our lives, in health, when distressed, or when overwhelmed by psychosis.

Wise, accessible and humane critique of psychiatry, by a psychiatrist. Essential reading for all those concerned with the future of psychiatry.

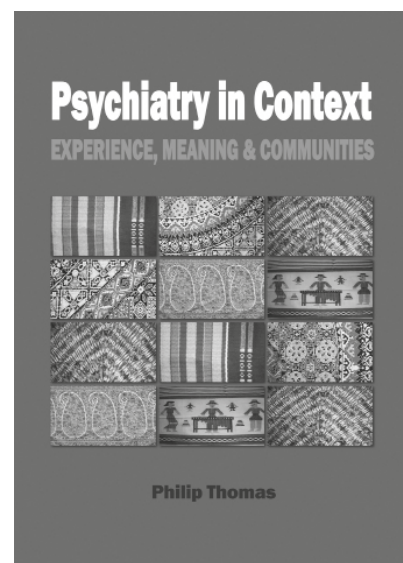
Jacqui Dillon, National Chair of the Hearing Voices Network, England

Using a powerful mix of historical and scientific evidence, together with illuminating stories, Philip Thomas starkly describes the darkness that has befallen the world of mental health, before showing us some ways back out to the light.

Professor John Read, University of Liverpool

A brilliant deconstruction of modern psychiatry, and a powerful manifesto – and blueprint – for change. And the writing sparkles with lucidity, making Psychiatry in Context an exceptional pleasure to read.

Robert Whitaker, author of *Anatomy of an Epidemic* and *Mad In America*



REVIEW

The Therapy Industry:

The Irresistible Rise of the Talking Cure, and Why It Doesn't Work

Paul Moloney

Pluto Press, London, 2013



It took a while for me to get there but this book became one of the most exciting I've read in recent years. The first part 'Evaluating Psychological Techniques' was initially a little slow. It travelled through the history of 'madness' from the 18th century, with the progress from hospitalisation and medicines up to the modern panacea, Cognitive Behaviour Therapy (CBT).

But then, from around Part I, Chapter 3, 'The CEO of Self', the central theme and message of the book begins to emerge: the startling suspicion that the self, as traditionally conceived (and as viewed in most of psychotherapy) is an illusion. If this is so, because individual suffering is more likely to be due to a whole range of pressures and disadvantages in the world – including social and economic – trying to 'fix' this internal self, so that we think and behave 'better', is an injustice to the suffering individuals.

In Chapter 5: 'I'm not ill, I'm hurt ...', the evidence for this suspicion emerges. 'Numerous community surveys have shown ... the prevalence ... of the most common mental disorders ... are associated with measures of relative poverty.' Essentially, 'impoverishment is soul sapping' and 'even privacy is linked closely with financial status'. (Think of the limited living spaces that the poorest have to share.)

By Part II: 'Therapy In Society' the author clarifies how the notion of 'self-esteem for everyone', has led educators to be all-encouraging to students whilst downplaying their own teaching expertise; this leads to 'therapeutic schooling'. I once experienced a trace of this in a tutoring role. My use of the phrase 'dead wood' – meaning to clear away superfluous words in creative writing – was perceived by my mentors as implying an attack on the precious feelings of the students, as potentially damaging as any inflicted upon a minority group! But, in the real world, as Moloney points out, it is realistic and useful guidance and practical qualifications that count. He brings us back to this fact: the biggest effect on academic performance is the social background and health of pupils.

So, the arguments in the book engaged me thoroughly. They got me thinking: the common question 'How do you feel?' assumes a locus of interest and involvement which might best be redirected to resolving some of the life practicalities for enabling a person to feel better. The same applies to education, and well-being: give someone the techniques and opportunities to meaningfully learn, compete, and develop – not simply vacuously praise people's efforts whatever their circumstances, in order to uphold and promote their 'esteem'.

Moloney also investigates the credibility of the UK Government's programme, 'Improving Access to Psychological Therapies' (IAPT). Amongst other criticisms, he points out that 'it is doubtful that any form of demoralization that can be solved by reading a set of self-help booklets ... can be all that serious to begin with.' He also reminds us that the new fad for 'mindfulness' in treatment is often applied whilst divorcing it from the cultural and ethical nuances and traditions of the original mindfulness teachings.

Towards the end of the book, David Smail's social-materialist psychology is highlighted. This recognises that the interactions between people, including within therapeutic and academic scenarios, are imbued with the dynamics of social power, and it's these dynamics which need rebalancing if people's needs and well-being are to improve.

As one of the conclusions of this book, it is suggested that emotional or psychological suffering is anguish rather than illness. If this is so, we would have to redefine the arena of suffering as one in which we all participate: we live in a world which conspires to create the conditions (some of them social and economic) which lead to suffering.

So, as a priority, let's try to investigate and improve this wider, holistic concern.

William Park



'Healing Goddess' by Tracy Needham



"Stood there, naked in my bathroom, ready for the final time to step into the clear warm water with a razor blade in my hand, I asked myself, 'is there nothing left, nothing at all, that I want?' ... No ... Nothing, was the answer.

"Em... ehh... that's weird... actually, there was something else... ehh... I could eat a Jammie-dodger biscuit!

"Not killing yourself, when that is all you want in life, is a skill. Not many people are likely to discover this, but they should know about it, just in case."

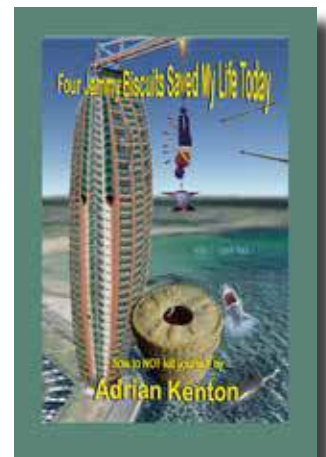
From age six to thirty-five, Adrian Kenton's history of abuse from his sister, mother and wife draws him to certain conclusions. Not least of his problems is how to live when all reasons for doing so are obliterated and mind, body and soul are intent on self-destruction.

A brutally candid account of isolated mentality at work under horrendous pressures. Just one experience that challenges the philosophical precepts underlying mental health treatment in the UK; exposing counter-productive strategies and stigmatising attitudes within health care and the wider society. It considers the predominant mental 'health' of an entire nation impacted by the harshest financial crisis, and its implications for the sanity of a disenfranchised global community - "Social, Political & Institutionalised Denial."

This book is for anyone afraid of the dark and for those left in it. The antidote? Biscuits.

Adrian Kenton

<http://www.4jammybiscuits.com>



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