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the magazine for democratic psychiatry

**THIRTY YEARS
PROGRESS OR STAGNATION?**



The magazine for democratic psychiatry

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

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INTRODUCTION - THIRTY YEARS – PROGRESS OR STAGNATION?

This issue is devoted to contributions which reflect on the changes (or not) that we have witnessed during the last thirty years; they also consider what is to be done. Included are a range of local views, and we especially welcome interesting appraisals from Italy, Australia and Greece.

During the lifetime of *Asylum* magazine, the mental health systems of many nations have moved from relying on the big old mental hospitals to relying mainly on a kind of 'care in the community'. To some extent this responded to the thoroughgoing critique of mental health care posed by 'anti-psychiatry' during the 1960s and 70s.

All the same, nowhere in the world is there an official mental health system which will allow that anyone's very worrying emotional distress and irrationality is largely a result of emotional and psychological trauma, which in turn is usually driven by something pathological in the social relations. And so, thirty years after the switch to 'care in the community', and fifty or sixty years after anti-psychiatry, the official response still has no idea that 'clients' could be helped by genuine solidarity and encouragement. There is no coherent official theory of cause or remedy. Never mind: everybody must blindly believe in the failed medical model, and 'clients' must be grateful for their medication.

Dr Tim Kendall

National Clinical Director for Mental Health (NHS England)

Back in 1985 Tim Kendall was a junior psychiatrist under the wing of Prof. Alec Jenner, one of a group of various professionals, patients and ex-patients who met monthly at Alec and Barbara's home outside Sheffield to discuss starting a new mental health magazine. It was Tim who suggested the name, as an ironic nod to the psychiatric profession's first journal.

*The group soon agreed to remain a loose, non-hierarchical collective – an affinity group – and that *Asylum* magazine would provide an outlet for anyone who took an interest in the field, whatever their psychiatric or academic standing – or lack of standing. Of course, this attracted a number of mental health professionals who passionately disagreed with the conventional wisdom. However, it was even more contentious amongst most professionals and academics that some psychiatric patients and ex-patients fully participated in planning, producing and contributing to the magazine, and that patients and ex-patients were more than welcome to express anything they liked in its pages – including any of their bad experiences of psychiatry.*

Meanwhile, Tim continued to practice psychiatry, and went on to set up and direct the Centre for Psychotherapeutic Studies at the University of Sheffield. From 2001 until this March, he was Director at the National Collaborating Centre for Mental Health, Royal College of Psychiatrists, where he carried out systematic reviews and developed national guidelines and quality standards in mental health and social care for the National Institute for Health and Care Excellence (NICE). He is also Medical Director (Research) and Consultant Psychiatrist for Homeless People, Sheffield Health & Social Care NHS Foundation Trust (from 2003), and Visiting Professor at University College, London (since 2010). Now he has been appointed to the top job: National Clinical Director for Mental Health (NHS England). Well done, bruv!

Tim says:

Without a doubt, the biggest change in the mental health services during the last thirty years is the interest now taken in the views of service-users.

During its early years, *Asylum* magazine was viewed by the psychiatric profession as scandalous. The idea of spending much time listening to patients – let alone listening to their views on mental disorder or psychiatry – was anathema. In those days, a doctor was considered very remiss in his duties if he ever 'got too close' to his patients. But nowadays every psychiatrist likes to boast about his close friendship with a service-user!

Most of the credit for this huge shift in attitude must go to the survivors and service-users movement. And *Asylum* Magazine has played no small part in that movement.

As for the future, of course the whole of the NHS and social services are under great pressure, but it now looks certain that at last the politicians have realised that wider financial savings can be made by bringing the mental health services up to parity with those for physical health. I believe we will soon see significant increases in funding, as well as increased attention given to the views of service-users.

Many congratulations to the *Asylum* collective for bringing the magazine to its thirtieth birthday, and may it live to see many more!

THIRTY YEARS OF DEMOCRATIC PSYCHIATRY DOWN THE DRAIN... or... the struggle continues?

Phil Hutchinson

The history of *Asylum* magazine is inextricably linked with the move from custody to community for mental health services in the UK.

Ironically, today many people would dearly love the option of being able to unconditionally access a physical refuge, a safe haven. For although the Mental Health Act's powers of compulsory detention remain in force, psychiatrists under economic pressure now try *not* to use them, so as to keep people out of hospital.

Many people who would once have been habitués of locked wards are now locked up 'at Her Majesty's pleasure', and – as with the old asylums – many end their own lives in desperation, uncared for, and certainly not understood.

For many years there has been a democratic conversation, even an institutionalised democratic conversation, but as ever, it seems, very little if any democratic conversation between the holders of economic power and their subjects. (Who? Us?)

A Freedom of Information Act request in early-2016 found that 59 Mental Health Foundation trusts in England and Wales had an average reduction in income of 2% compared to the previous financial year. And this was on top of previous cuts. There is no real surprise in this. The initial plan to close 'the bins', taken by the Health Minister, Enoch Powell in the early 1960s, was in the true Tory tradition: purely to cut public spending drastically. It was a popular and easy choice to make: 'What a waste of money, spending on those useless people.'

The quality of mental health services may have improved since 1960, but in terms of financing and the level of provision, the ruling political class has always treated it as a low priority. Do the math: cancer, tick; mental health...?

In 1986, unpleasant though it all was, I was referred to a social worker, a day centre, a community hostel, a consultant psychiatrist, and admission to an acute ward. There was also an after-care plan, and my life was eventually transformed. In 2015, when I expressed frequent suicidal feelings to a social worker, I was questioned as to why it would be justifiable for me to be referred to x or y service, given the financial costs and the pressure on 'numbers'. I found this an impossible position to be put in. Was there

an invisible entity presiding over allocation of resources according to need, wearing a hat labelled 'Mental Health Budget Allocation'? Was it an outtake from Joseph Heller's *Catch 22*?

Nowadays we also live in the era of 'The Recovery Model', whereby all service clients are required to have planned ways into voluntary work. Undoubtedly being occupied in work, making social contact, improves the quality of our lives. But can this be, by any chance, anything to do with the dictates of our old friends, a Tory Government, especially manifested in Iain Duncan Smith's Department of Work and Pensions mission to get people into work, so as to 're-balance the economy' towards low-waged, insecure jobs and increased profits??

The collateral damage to this policy – benefit sanctions, reliance on food banks, debts, lost homes, and even lost lives is well enough known. And yet the psychiatric profession and the mental health services seem to have bought into that one. Or maybe they've been bought off.

At the outset of 'Care in the Community' there was a creative, democratic discussion whereby 'users' or 'survivors' challenged the status quo of consultants, pharmaceutical companies, etc. There were hopes that there could be different and better ways of understanding and working with people afflicted by mental illness – that services would be more efficient, which is to say, more cost effective!

One of the prominent patients' groups of the late-1980s was Survivors Speak Out, which had a membership category of 'allies'. This acknowledged that strength came from unity of purpose between 'client' and professional.

It's that unity of purpose between service users and providers which we must strive for and establish if we are to successfully gain genuine 'parity of esteem' with other health sectors, backed by commensurate funding.

Do we need a National Mental Health Service distinct from the NHS, and with its own separate and more democratic governance and budget? ■

Phil Hutchinson has tried very hard to be normal, with predictably unhappy results. He wants a job in the steel industry and £13 to send a bottle of rum to his son in North Wales.

THIRTY YEARS SPEAKING OUT

The many voices of survivors

Andrew Roberts
for the *Survivors History Group*

The birth of *Asylum*, the magazine for democratic psychiatry coincided with what Peter Campbell has called 'the breakthrough' for survivors (*Asylum* Summer 1986, pages 8–9). This was when powerful agencies recognised our movement and its organisations, and new networking organisations formed. It was planned to close the old asylums in England and Wales and, if the new *Asylum* arrived as the hospital magazine for community care, it was a magazine that was not only read by the inmates (outmates?) but willing to consider publishing our contributions.

Many survivor voices that spoke and sang during those thirty years were heard in *Asylum*. Anne Plumb has indexed *Asylum* articles from 1986 to 2010 written by or of special interest to survivors. (Go to <http://studymore.org.uk/mpu.htm#Asylumbox>) You can compare that list to the history outlined here from the survivors history timeline (<http://studymore.org.uk/mpu.htm>)

In July 1985, Mind ran a World Federation for Mental Health conference in Brighton. Survivor representatives were invited from Scotland, Holland, Denmark, and the USA, but not from England! However, the Campaign Against Psychiatric Oppression (CAPO) sold literature outside, and survivors from other countries negotiated their entry to the conference. A revolution started as British, European and American survivors took over sessions and worked out a declaration on 'self and citizen advocacy'.

That autumn, Mind's annual conference was devoted to the English users' movement. *Survivors Speak Out* started in January 1986, and in November 1986 the *National Schizophrenia Fellowship* launched the *National Voices Forum* (from about 2007, this became the *National Perceptions Forum*). In December 1987, Mind employed Jan Wallcraft to start what became *MindLink*. The *United Kingdom Advocacy Network* (UKAN) began in 1991, and



Tam Graham at the Survivors Speak Out stall at the November 1988 Mind Conference. The cover of the *Asylum* Winter 1988 edition is displayed on the wall. Tam was a Glasgow pioneer of the survivor movement. In 1984, he and others made the first survivor presentation at a Mind Conference when they presented an alternative mental health policy for Scotland – one designed by the recipients and called 'Life after Mental Illness'.

in 1993 its chair, Edna Conlan, was made an MBE in the Queen's birthday honours.

Anne Plumb points out that the different networks meant that users with different perspectives could find a group they liked, and through that, work with other groups. A combined 'survivor' movement (with hardly a professional assistant in sight) was ready to engage with government in the 1990s.

Engaging meant conflict as well as cooperation. In 1992 Christopher Clunis murdered Jonathan Zito, and Ben Silcock climbed into the lion's den at London Zoo. Both events attracted dramatic media coverage of the policy of community care. A long battle over community treatment orders began between survivors and government. On the cooperative side, in 1992 there was a *Service User Group* to the *Mental Health Task Force*, formed to help build new community services; this had representatives from *Survivors Speak Out*, the *United Kingdom Advocacy Network* and *MindLink*. Regional conferences and trainers events in 1994 led to guidelines for service user charters and advocacy.

What is now called *Depression UK* started in 1973. The *Manic Depressive Fellowship*, formed in 1983, became *MDF The Bipolar Organisation*, in 2005. In 1987, *Stichting Weerklank* (Foundation Resonance), a collaboration between voice-hearers and supportive professionals, was formed in Utrecht, Holland. *Hearing Voices UK* was formed in Manchester in 1988. In 1989, Louise Pembroke, Education Officer of *Survivors Speak Out*, organised a conference of survivors 'looking at self-harm', and in 1991 an eating distress conference. Publications followed these conferences. (See <http://studymore.org.uk/7.htm#Pembroke>) The *National Self Harm Network* was formed in 1995. *Emergence* was formed in 2009 by merging *Borderline UK* and *Personality Plus*.

Survivors' voices were heard in rhythm and song. Without funding, Frank Bangay of CAPO organised events and magazines throughout the 1980s, leading to the funded *Survivors Poetry*, in 1991. This now has a regular electronic poetry magazine, *Poetry Express*. (Available from <http://www.survivorspoetry.org/>)

Survivor research is, as it sounds, research by survivors from a survivor view-point. In the late-1990s, Diana Rose and Alison Faulkner turned survivor views into formal research by using research methods learnt in universities. Diana's approach was called *User Focused Monitoring*, whilst Alison's was *Strategies for Living*. One evaluated existing services, the other sought creative new approaches. In 2003 the *Survivor Researcher Network* began work on a book, published six years later as *This is Survivor Research*. 2009 also saw a *Handbook of Service User Involvement in Mental Health Research*, and a seminar series at the British Library which led, in 2013, to the book *Mental Health Service Users in Research: Critical Sociological Perspectives*. Seminars in Birmingham in 2010 included research in Northern Ireland and Scotland, and celebrated the tenth anniversary of the Midlands' *Suresearch* network of users in research and education. (<http://suresearch.org.uk/>)

Having a Voice was founded in Manchester in 1990, with Tony Riley and Altaf Ramtoola as paid workers. Its projects included AWAAZ, for Asian users, and a Jewish

user group. In 2001, Hanif Bobat from AWAAZ published user-led research showing the mental health benefits from attending a mosque. Associated with *Having a Voice* was the *Manchester Users Support Group*, which still continues as *Manchester Users Network*. (<http://www.manchesterusersnetwork.org.uk/>)

Deaths of friends and relatives made activists of many black people. In 1981, Richard 'Cartoon' Campbell's death in Ashford Remand Centre led to the formation of *Inquest* (on deaths in custody), and in 1991 the death of Orville Blackwood in Broadmoor led to the *Orville Blackwood Community Campaign* 'in memory of all those who have not survived psychiatry.' A multi-cultural society provided energy and innovation. *Tower Hamlets African & Caribbean Mental Health Organisation* argued that, 'We must go back and reclaim our past so we can move forward. Health is found through history as identity is restored.' SIMBA (Share In Maudsley Black Action) took Bob Marley's advice that 'none but ourselves can free our minds', and confronted hospital management with poetry and song, accompanied by their cubs (children).

Community Health Councils in England and Wales often provided a base and resources for local groups. Their abolition in 2003 changed the landscape, as statutory requirements for user consultation and a new structure came into being.

Mary Nettle was appointed a Mental Health Commissioner for England and Wales in 1997. In New Zealand, Mary O'Hagan was appointed a Mental Health Commissioner in 2001. These ex-patients had a supervisory role over the compulsory detention and treatment of other patients. Mary Nettle wrote about 'visiting psychiatric units to ensure the rights of patients... are observed.'

Interacting with power brought innovation and change at Bethlem (Bedlam) Hospital's 750th anniversary in 1997. Collaboration included *Bethlem Gallery* 'for artists who have experienced mental health problems' and *Beyond Bedlam: Poems written out of Mental Distress*. Creative conflict included *Reclaim Bedlam* protesters disrupting the official celebrations. Peter Campbell (2008) spoke of '300 years of oppression' at Bethlem. Peter Beresford commented (1998) that 'if we are to take charge of our future, then we must also regain control of our past.' *Reclaim Bedlam* led to *Mad Pride's* spectacular new perception of cultural and musical protest against being absorbed by establishment consultation, research, and publishing. Their idea of celebrating mad culture spread across the internet. *Mad Pride* events, often publicised by the USA based *Mindfreedom.org*, took place, and still take place, in the UK, Canada, Ireland, the USA and Italy.

The most extensive survey of the user movement in England was published as *On Our Own Terms*, in July 2003. *The Survivors History Group* was formed in London in 2005, Scotland blazed a trail with *Oor Mad History* in 2010, and Canada with *Mad Matters: A Critical Reader in Canadian Mad Studies*, in 2013.

But the inter-relating networks of survivors that saw us through the 1990s went on to run into hard times, and by 2016 they have nearly all disappeared. In their place we have NSUN, formed in 2007 as *National Survivor User*

Network. Amongst its many services to the movement are an electronic newsletter and a website that keeps survivors well informed about one another's activities. (<http://www.nsun.org.uk/>)

In 2006, cooperation between people with physical disabilities and survivors led to the United Nations adopting a Convention on the Rights of Persons with Disabilities. In 2009, in Kampala, Uganda, this was the focus of discussion for the *World Network of Users and Survivors of Psychiatry*. This meeting sought to build links with what has become the *Pan African Network of People with Psychosocial Disabilities*. Debate continues about what it means to link mental distress and physical disability, and many papers on this subject have recently been published with the title *Madness, Distress and the Politics of Disablement* (2015)

In 2010, the relaunch of *Asylum Magazine* was accompanied by a coalition government which announced 'radical welfare reforms'. These were described by survivor journalist Clare Allan as 'a cynical attack on people with mental health problems.' (*The Guardian* 6 July, 2010). Harsh tests were introduced so as to drastically reduce welfare. Half of all those on benefits because of illness had mental health problems. The cuts hurt, and so did the rhetoric which portrayed claimants as scroungers.

Mad Pride revived in a Hackney cafe, and out of its agitation the *Mental Health Resistance Network* was born. This won a major legal victory in December 2013 when the Court of Appeal ruled that the benefits tests discriminate against people with mental health problems. The voices of survival continue! ■



Dina Ibrahim, a survivor of asylums in the Sudan and London, sold *Asylum magazine* (Volume 17, no. 1) March 2010 - hot off the press - on 19 March, at the Survivors History conference held at Kingsley Hall in the East End of London. 'A Pageant of Survivor History: mental patients in poetry, story and song, from the 18th to 21st century.' *Asylum magazine* was re-launched in the hall where Gandhi stayed in 1931 and Mary Barnes painted in 1966.

Andrew Roberts has suffered from periods of suicidal depression since the 1950s. He was a member of the *Mental Patients' Union* in the 1970s, and with Peter Campbell is now working on a book on survivors' history from 1800 to the present. This will be published by Palgrave. You can join *The Survivors History Group* mailing list by writing to: studymore@studymore.org.uk

From Psychiatric Abuse to Psychiatric Neglect?

Helen Spandler

When *Asylum* magazine was launched, in 1986, I was immersed in what was dubbed ‘anti-psychiatry’ literature. I didn’t get involved in *Asylum* until a few years later, but I was already a reluctant observer of the mental health system.

My dad had been in the local psychiatric hospital, and was out of work due to ongoing mental health problems. His death was not, I believe, unrelated to psychiatry. The diabetes and stroke he suffered are known to be related to certain psychiatric medications, and his physical complaints were routinely dismissed as part of his mental health problems. My brother has been periodically immersed in the psychiatric system for nearly 30 years – more than a dozen admissions, mostly under section, including locked wards and a Community Treatment Order. I’ve suffered myself, alongside family and friends, over the years. During this time I have tried to be a good ally, advocate, mental health worker, teacher and researcher.

So what’s changed in all these years? I still believe in alternative approaches to madness and distress, but I want to focus on some ‘inconvenient truths’ to anti-psychiatry politics today. After all, openly discussing contentious issues was always the vision for *Asylum* magazine. No-one embodied this spirit more than our co-founder, the late Alec Jenner.

When *Asylum* started, followers of ‘anti-psychiatry’ and the emerging user/survivor movement were, quite understandably, highlighting psychiatric abuses. However, critics like Peter Sedgwick warned us that radicals over-emphasised psychiatric *abuse* at the expense of psychiatric *use*. I think he had a point and I’ll explain why.

There is nothing more exciting to a young radical than challenging the latest oppressor and identifying with its victims. It’s a good instinct, even if it’s often oversimplified (note recent scuffles over transphobia). Whilst psychiatric survivors have never been a fashionable oppressed group, psychiatry itself has been an easy target: at the sharp end, labelling people as ‘mad’ or ‘mentally ill’, locking them up against their will, and giving them drugs and electric shocks. In this context, stories of resistance are understandably appealing – faking normality; hospital break-outs; and other forms of psychiatric refusal.

Although these stories are seductive, it’s possible we’re entering a new phase of psychiatric resistance in the UK. This relates to a wider shift – from psychiatric abuse to psychiatric neglect. I am not suggesting that psychiatric abuses are no longer important. Nor that it has to be either/or, i.e., choosing between challenging psychiatric abuse *or* challenging neglect. We need to do both. However, I think the shift is important to understand where to focus our energies. In order to change the future we need to see the present clearly.

Despite fears of the ever increasing ‘psychiatrisation’ of everyday life, contrary to popular opinion it is not that easy to get psychiatrised these days. In the UK, at least, we are a far cry from the ‘Don’t mention you hear voices or you’ll get locked up’ scenario, immortalised in the classic Rosenhan et al. study *Being Sane in Insane Places*. It’s true we have witnessed an expansion of psychiatric categorisation and increasing medicalisation and individualisation of complex human problems. That argument is well rehearsed.

Yet psychiatric classification doesn’t automatically result in psychiatric or psychological support or intervention (other than medication, which is increasingly administered by your GP and managed by the individual concerned). Unfortunately, in order to receive mental health services (or welfare support), psychiatric classification is necessary, but it is certainly not sufficient. This is especially the case in a mental health system which is under-funded, understaffed and inflexible.

It’s true that rates of compulsory detention and treatment are on the rise. This is very worrying. But it needs to be seen in a broader context. Currently, it’s actually very difficult to get a bed in a psychiatric unit, certainly as a ‘voluntary’ patient. Sometimes mental health workers feel that the only way to ensure services will provide emergency accommodation is to use the Mental Health Act. Similarly, it can be difficult even to get an appointment with a psychiatrist, or be eligible for mental health services, and it’s increasingly hard to access mental health services. That is, unless you pay privately or you’re considered an imminent and serious risk to yourself or others.

Community Treatment Orders (CTOs) are often seen as coercing the *individual* to comply with treatment

– which, of course, they are. However, there is some evidence they are being used to coerce *services* to provide support. In the current system, where workers have to provide written ‘justification’ for providing ongoing support, these sorts of measures may be increasingly used to plug gaps in services. After prolonged resistance to the introduction of CTOs, it would be a bizarre irony if their strategic use became a new form of resistance.

This reminds me of debates about Assertive Outreach Teams in the 1990’s. Due to worries about people being harassed by mental health workers, many dubbed them ‘Aggressive Outreach Teams’. Now you’re unlikely to find a mental health worker, let alone be visited by one! All this means that rather than resistance taking the form of ‘faking normality’ (for example, to be discharged from psychiatric hospital), we are now faced with the perverse situation where people may have to exaggerate their madness (and emphasise their dangerousness) in order to access or retain services. This is very worrying.

The 1970s and 80s were marked by the setting up of Patients’ Unions and Councils in psychiatric hospitals, often to advocate for release or to protest against detention and treatments. Now, many user groups find themselves fighting to keep psychiatric wards open and even demanding admissions and treatment. Whilst this isn’t new – user groups sometimes fought to keep the older mental hospitals open too – it is becoming an increasingly bitter irony. Some argue these user groups are backward, parochial, and perhaps suffering from ‘false consciousness’. Yet, without any genuine alternatives to the prevailing mental health system, especially when in crisis, perhaps it’s not surprising that some user groups seem to demand more psychiatry, not less.

The current user/survivor movement is divided on these issues. Put crudely, some believe in psychiatric abolition and see any dents in psychiatric provision as a step forward in the struggle for liberation. Others demand more and/or better psychiatric services. Most agree that we want better support, more understanding and real alternatives. Indeed the user/survivor movement has consistently *demand*ed alternatives. There are a number of promising developments in this regard in the UK, including Soteria and various survivor led initiatives. However, they usually rely on the tireless and dedicated efforts of a few, and remain elusive for the majority.

It’s easy to say, ‘We just need to listen to users and survivors’. However, with such diversity of views and experiences, it’s no good just listening to those we agree with. It means listening deeply – to those who want to abolish psychiatry, *as well as* those who want to preserve

and improve it. Ultimately, I suspect, they’re not so far apart.

Thirty years ago we were debating post-asylum care. What would community care look like? Would it be adequate? What can we learn from the Italian experience in ‘democratic psychiatry’? Perhaps we have now entered a phase of post-community care. If the asylum era was synonymous with psychiatric abuse, will the recovery era become synonymous with psychiatric neglect? Certainly ‘recovery’ is increasingly used as a justification *not* to provide support and services.

Maybe, just maybe, this isn’t such a bad thing. Perhaps, like the title of Liz Sayce’s book, it’s part of a progression ‘from psychiatric patient to citizen’. After all, people like Franco Basaglia argued that community facilities were merely a transitional step in progress to full equality and liberation. Maybe it will force us, as a society, to truly embrace madness and distress. Maybe users and survivors will be free to develop their own support systems – away from psychiatry and the state. Hopefully we will see a proliferation of genuine ‘alternatives’.

Rather than being hived off into mental health service ghettos, maybe madness will be ‘mainstreamed’ – like most things these days. Perhaps this is the ideal culmination of the neo-liberal project. Or maybe it’s the real meaning of ‘market madness’ – each to their own, with no collective responsibility for those in need. Hands on hearts, can we say we’d do a better job than the ‘psy’ professionals we so readily condemn? Do we, as individuals, families and communities, have the necessary resources, capacity and humanity?

I have no easy answers. I do know that being with people experiencing extreme altered states, psychosis or suicidal thoughts, is essential – but never, ever easy. It can be exhausting, stressful, and sometimes terrifying. I don’t think this can simply be reduced to ‘stigma’ or ‘sanism’. Rather, it’s about negotiating the complexities and vagaries of being human. Over the years, I’ve seen lots of grandstanding and radical posturing, but (with some notable exceptions) insufficient attention to the challenges of this task.

One thing seems clear. Thirty years on we still need forums like *Asylum* magazine to discuss these issues – as openly and honestly as we can. ■

Helen Spandler has been a member of the Asylum Magazine collective for more than twenty years. She works at the University of Central Lancashire.

Educate agitate organise!

Mick Mckeown

Building upon an earlier piece in *Asylum* which argued for trade unions to organise for reciprocal alliances with survivor movements, this article makes connections between matters of democracy in the workplace and the wider society. Thinking about this creates possibilities for considering a new workplace democracy in public services which would bring together the voices of patients, public and workers in decisions about how to organise care. Ultimately, the forms of deliberation and dialogue required to make progress in establishing and strengthening such alliances have much in common with the best characteristics of alternative forms of care such as Open Dialogue, therapeutic communities and Soteria.

Trade unions in and of communities

The interval now commemorated by *Asylum* in this anniversary issue more or less spans my own career in mental health services and trade union activism. These have been turbulent times for UK trade unions, and especially recently when we have witnessed savage cuts to the NHS and wider welfare state. *Asylum* was launched in the year following the crushing defeat for the miners after a year-long strike. For many commentators this heralded the beginning of the end for union power, and was arguably the reason the government provoked the dispute in the first place. The political and economic hegemony we now know as neo-liberalism was forged in these times, as Thatcher and Reagan favoured privatisation and the market, as they tried to 'roll back' the state.

Nowadays, trade unions find themselves in a period of crisis, with falling membership and reduced influence. Arguably, the shift in the balance of power between employers and unions is detrimental to both the wider democracy and the economy. Unions have been trying to renew themselves by simultaneously aiming to recruit more members and deepen social ties between their members. Looking to strengthen internal relationships, whilst very important, can only be part of the task ahead. A parallel objective is to reinvent closer ties with the community – looking outside the workplace and considering non-workplace issues around which to build solidarity.

Taken together, these efforts at rebuilding union strength and influence are known in union jargon as 'organising'. The ways and means by which unions might forge alliances with community interest groups and other social movements has been referred to as 'reciprocal community unionism'. The skills needed to undertake this mission are intensely relational, building first on personal connections and friendships to develop the solidarity needed to eventually

cooperate to tackle important issues or identity-based concerns. The context of mental health is complicated by the potential for union activists to fail to fully appreciate the criticisms survivors make of services, and by implication, their members. Arguably, unions have had more success, and put more of their energy, into inward-facing renewal programmes. Along with the fact that many union activists have little time to spend on organising away from the immediate demands of local bargaining and negotiation, or serving members caught up in discipline and grievance, this has impeded the full realisation of goals of community-union organising. That said, there are some excellent examples that buck this trend and show how reciprocal organising in communities can bear fruit.

Notably, under the umbrella of UK Citizens, diverse alliances have formed to leading successful living-wage campaigns. In terms of union-led initiatives, there are Unite's community branches, with significant involvement



of disability and mental health activists. In my home town of Liverpool, this coalesces around The Casa Pub and Community Resource Centre, which was established by ex-dockers following a protracted and ultimately unsuccessful dispute against casualization and job-losses. This represents an interesting re-connection with more traditional union-community cultures, based around dock communities that no longer really exist, although the solidarity bred there persists in other forms. Unite also produce a very good, critically-inclined mental health magazine for nursing members. Unison are about to embark on a national mental health campaign. My Unison branch, located mainly in a mental health Trust, links with a local radical mental health group, ReVision. This relationship involves supporting public meetings organised to raise awareness about critical mental health issues. Recently, this has involved making a small financial contribution to a mental health Arts Festival with organising input by ReVision and hosted by FACT, a local cinema and arts centre. Mental health activists chose a series of films for a programme of screenings and debates, at which members of the public debated with practitioners and survivors. Conceptual artist The Vacuum Cleaner created an alternative Madlove space, which anyone could hang out in or book for meetings, and numerous other artistic endeavours and spontaneous events occurred in the course of this three month festival.

We have also collaborated on a funding application to the Edge Fund for radical action (www.edgefund.org.uk/) to undertake a joint union and survivor project framed by

creative writing. ReVision members host a regular critical reading group which meets to discuss seminal radical mental health texts. Joint activism has resulted in solidarity efforts to resist the closure of community mental health services in the Save Our Sanity campaign, and collaboration with the radical Social Work Action Network on the production of their Charter for Mental Health. (www.socialworkfuture.org/attachments/article/172/SWAN%20Mental%20Health%20Charter.pdf)

Beyond the obvious value of working creatively together, we hope that such collaborations begin to dismantle negative stereotypes and open up discussions about points of consensus and contention, working towards developing a politics that can sustain solidarity in a context framed more typically by division. Thus, at the Film Festival it became apparent that practitioner staff and people who have been patients in services were able to have different types of conversations in this setting, with staff freer to engage in criticisms of the services they work in.

Democracy and dialogue

If we can conceive of democratically organised alliances between trade union and survivor activists in the community, why not directly in the workplace? From workers' cooperatives to the original post-revolution Russian soviets, to kibbutzim and industrial democracy in large factory settings, different,

albeit imperfect, democratic forms have occurred throughout history. At least rhetorically, employers in modern healthcare workplaces claim to value the voices of both service users and employees. And yet positive examples of user involvement and employer-union partnerships co-exist with oppressive managerialism and neo-liberal cost cutting. Interestingly, following notable service failures, strategic momentum in the NHS has been building for more distributed and democratic forms of leadership. If this were fully implemented it would flatten hierarchies and re-calibrate power relations.

It is not beyond our imagination to consider possibilities for deeper democratisation in the NHS – and specifically mental health services – properly inclusive of public, patient and worker interests. In the mental health setting, such a state of affairs would be highly compatible with the explicit democracy promised by new ways of working such as Open Dialogue, although it would also face the same set of hazards of dilution and incorporation that lurk in the shadows of innovation and change.

Democracy for all

Where is the democracy we seek? It won't just fall into our laps. We have to make it for ourselves. The forces that would impede progressive democratisation are powerful and have all the appearance of omnipotence and omnipresence. Furthermore, the public at large has been fed the lie that our current representative democracy is the most superior form. At the same time this legitimates the concentration of power and control into the hands of unelected rich and powerful elites. However, we could make hay while the powerful are not looking by organising for change in the interstitial spaces of governance and institutions – including within our public services. The consumerism inspired by neo-liberalism can open up critical spaces for survivor voices to infiltrate, and the ongoing politicised attack on our workplaces could galvanise and make unionised and public opposition more effective.

Many of the barriers to success expose organising and democratic deficits, highlighting opportunities for more concerted organising to bring in more people. Unions have traditionally linked member and activist learning to organising and campaigning, hence the old labour movement slogan, recycled here: *Educate, agitate organise*. Radical elements in the survivor movement appreciate the value of learning, persuasion, and consciousness-raising. We all have recourse to democratised and relational processes of learning and community development, such as the critical pedagogy of Paulo Freire, which aimed to increase people's awareness of their own agency and power and to effect change.

To help us in this task we need alternative sources of knowledge and support. *Asylum* magazine has consistently provided this, and its thirty years of furnishing radical sustenance have roughly coincided with the time between first publication and the recent reissue of Peter Sedgwick's famous book *Psychopolitics*. This seminal text effectively makes the case for building alliances, and closes with a plea for transformations in the social relations of both psychiatry and the wider world. In the meantime it has become clear that these emancipatory goals are ever more important and their realisation is, as it always was, in our hands. ■

Mick Mckeown is Reader in Democratic Mental Health at the University of Central Lancashire, and a long-time activist with Unison; he has a seat on Unison's national nursing committee.



Ramblings and Reservations

Tina Coldham

'It's amazing where times goes', and 'Time is a great healer'. Such platitudes are meaningless for some of us in certain contexts. I first became unwell in my teenage years, although I crashed big time when I was twenty-five. So I'm *not* celebrating an anniversary of slightly fewer years than *Asylum* magazine. Thank goodness for an outlet which doesn't sanction the survivor voice, unlike mainstream psychiatric services. What is less widely acknowledged by the mainstream is the way that survivors have led on initiatives, and in the face of indifference or cynicism from other parties.

Stigmata

When first flung into the bewilderment of severe mental health problems, in 1990, I needed help and support. The sense of shame was overwhelming. But since then I've learnt to embrace my identity as a lunatic, and have made a living out of training, researching, being a consultant, and turning my hand to projects that need a survivor voice, whilst also allowing myself space when regularly unwell. I am 'out' about my mental health, although in some circumstances still chary about who I tell, and how, since ignorance prevails and I don't always feel strong enough to overcome it.

Things in this regard are getting better, but only slowly. And it has not been mainstream services which have led the way – they spend more time feeling sorry for themselves as the poor medical relation who has to engage in funding battles. It has been survivors who have tackled this issue, often by using social media to challenge prejudices. The *Attitudes to Mental Illness* survey, in 2011, found 43% of the respondents saying they would feel uncomfortable talking to their employer about their mental health. Clearly, there is a long way to go to counter mainstream ignorance and prejudice about mental health problems.

The world of work

I've always had a strong work ethic. I grew up in a working class household and saw my parents make ends meet by dirty or poorly paid work, and growing vegetables on the allotment to help the household budget. Ironically, when I couldn't carry on working in my chosen job due to physical health problems, as a teenager I ended up working for the Department of Employment. Yes, I confess my sins as a gatekeeper turned poacher. I was retired on medical grounds

many years ago because administrating a broken system had driven me mad. There is no way I could work there now. All these years later I find it very difficult to view the stories of disabled people struggling to negotiate a clumsy welfare system that is being cut dramatically, to such an extent that people are committing suicide. A civilised society doesn't do this to vulnerable people. Why is it left to broken people to come together to plead for understanding on behalf of others? Groups like DPAC, the mental health resistance network, expose the everyday struggles that claimants endure. I am lucky that I can provide for myself, but the spectre of claiming benefits, as I once had to, also hangs over me.

Talking therapies

When I crashed big time and was referred to mental health services, I was given an appointment within a month or so. Pretty good timing, by today's standards. I was assessed by a senior psychologist. This seemed obvious to me at the time, but today psychology services are only 'tertiary' in my locality, and have been for some time. Once he is out of options, you need to be referred to them by your psychiatrist. So nowadays you are first of all assessed by a community psychiatric nurse, and if warranted by him or her, you might get some input from a psychiatrist's assessment. But what the service then offers is very limited: the day services have been shut down, personal budgets are rare, and anti-depressant prescriptions are always on the rise.

After assessment from the psychologist, I was given the choice of monthly psychotherapy or admission to a day hospital. I chose the latter, and spent a year in the hospital being encouraged to explore my condition and learn techniques to manage it. After popping 5mg Valium tablets regularly throughout the day, and still feeling incredibly anxious, I was amazed that I stopped shaking at my first session on relaxation. The ever-present tremor had been alleviated by mind over matter, when even a nasty old addictive drug had failed.

This set me on a path to new understandings about my mental health. Now I think how naïve I was as a new service-user, and how important it was to be given treatment options. The fact that I was given an up-front choice of psychotherapeutic treatment is astounding by today's standards. The only option now is to go private, although even then I doubt I would be so luxuriously advantaged.

In fact, in 2011, when I needed to talk to a skilled counsellor, I didn't bicker about going the futile NHS route. Straightaway I went private, seeing someone I had connected to in the NHS but who ran their own consultancy. I dictated the time and pace of my 'confessions', and we worked in partnership to control my sessions and clear out some hideous demons. Nowadays, the mainstream mental health services do not provide adequate psychological assistance to people with enduring problems. Six 20-minute CBT phone sessions just don't cut it.

Self help/peer support

I remember how it was in the mid-1990s, when I had 'recovered', felt depressed again, and saw the psychiatrist yet again, and all that was offered was more of the same or try a new medication. I remember thinking 'Is this all there is?'

But in the waiting room I did see a flyer for a community mental health development project which was starting up self help groups. I went from making a simple enquiry to being the one to start a group, and then carrying on as a facilitator to that group for eight years. My activism stems from this, as does my deeper understanding of mental health issues and the challenges that people face in life.

'Self help' wasn't new then, and indeed it came from other health areas, but it was very difficult to get the local GPs and mental health services to take it on board as an open offer to help struggling people. It was seen as amateur and even dangerous – as the lunatics all coming together in one place! Nowadays, 'peer support' is seen by mainstream services as the latest 'good thing'. Because the system has let them down, survivors have lent support to their peers in hospitals and through tricky times. They fill the gap when there are no activities on wards due to understaffing, which leads to chronic boredom and increased stress. Services have caught onto this as a great way to save on staff costs by encouraging this 'volunteering'. Or if they pay survivors, then it's a token low wage, much less than having to employ expensive OTs. This exploitation of the good will that survivors put in is a cynical move by mental health trusts to make it look as if they actively employ people with mental health problems. Peer support is a necessary part of people's ability to carry on living, having understanding and acceptance from like-minded folk. It should not be cheap labour and a replacement for a properly resourced mental health system.

The above is just the ramblings of a mad woman. They say retrospection is the only precise science. Certainly psychiatry is wanting as a science. In all this time, I've not seen any cures come forward, or any

decisive tests for so-called mental illness. Arguably, things have degenerated during my time as a service-user. There is now less official help and support, but thankfully the survivor spirit has never diminished.

When I think back, I often recall David Bowie's music as a soundtrack to my life. I am rather taken with his final album, *Black Star*. The refrain in 'Girl Loves Me' feels appropriate when paraphrasing the thoughts I share with you, and about time ticking by. Altogether now – 'Where the fuck did Monday go?' ■

Tina Coldham first started using mental health services in 1990, and is still a practicing depressive. She became a user activist through setting up self-help groups, and also being part of a local successful campaigning user group. This led to wider involvement and work but which still feels like banging her head against a brick wall at times.

Stop Press!

Next year we will be hosting a 1 day event to celebrate over thirty years of ASYLUM magazine.

It will be very low cost, with special rates for Asylum subscribers!

**University of Manchester – Wednesday,
28 June, 2017.**

The theme for the day will be 'Action and Reaction'. The title evokes a range of possible meanings, including the kind of political action we need to defend our rights and build better services, the struggle against reactionary attacks on mental health provision, and responses to what *Asylum* has been doing so far.

Please get in touch if you would like to contribute or participate.

Watch out for details on PCCS Books
or Asylum websites
or e-mail:

asylumconference2017@gmail.com

ECT and the Fish Pond

William Park

In 1986 I was in my early twenties. I had started to write poetry that would later be published in journals, and at the end of the decade I received a Gregory Award. In January 1986 I wrote 'Unit Four', in which I imagined/anticipated my psychiatric nurse training which that year would begin at Whittingham Hospital, on the outskirts of Preston.

In the Spring of '86, two of my poems were published in *The Rialto*, issue 5: 'Winter Dream' and 'The Colouring Wood'. *The Rialto* is still going and highly respected, having now reached issue 86! I finished the year's poetry writing in December with 'Fade-Out', in which I imagined an orphan figure lost in the snow, with 'a hollow moon/and the mean drip/of money into nothing.' 'The wind is an ache tonight, the trees are indifferent.'

Thirty years later, I am back at Whittingham every week. I tutor Creative Writing at the Therapeutic Resource Centre, and have done so for the past two years. The last few buildings of the old Victorian 'mental asylum', as it was known, were demolished this year. Now residential



properties have just been completed for people to move in. Housing was rumoured as one possibility for the land back in the 1980s!

In the 1990s a forensic unit was built in the grounds of Whittingham, and called Guild Lodge. This is where I tutor. Or, rather, I like to call what I do 'facilitating' or 'inspiring', as opposed to simply 'instruct' as implied by the word 'tutor'.

I didn't continue as a nurse. I wanted to build on my love of writing, and so I left training two-and-a-half years later, with just months left to complete, vowing to tutor and achieve my Gregory Award. Back then, nurse training was very practical and there were no links to a University. Amongst the four practical assessments as part of the training, was the 'teaching' assessment, and I presented a piece on electroconvulsive therapy (ECT). This treatment was given regularly to patients at Whittingham. I hated it, and was suspicious of it because no-one knew how it worked! But I loved presenting information on a subject, and this confirmed my decision on my future career.

With respect to nursing, 'caring' for patients wasn't emphasized; rather what was required was 'containment' and 'observation'. Nurses certainly weren't supposed to talk on equal terms with 'deluded' patients, since that would be 'encouraging the delusions'...!

Over these past thirty years I've remained true to my inner spirit, forging my own individual path. I think this is the best thing to encourage others to do. But first, we



need to encourage ourselves – one eye on the source of inner inspiration, the other on practical considerations. I've been a part-time tutor for more than twenty years, in many community settings. I have an MA in the creative arts and poetry, and also a PGCE. But I remained true to my calling to be a writer and a tutor before I got those qualifications.

Things certainly come round full circle. A big 'mental health inpatient hospital' was recently built and is now open on the outskirts of Blackpool. I don't want to agonise over the provision or lack of community care, which was being talked about back in the 1980s as the much-needed answer to mental health problems. In any manner that would truly help people to enrich their lives, it simply hasn't happened. But my 'politics' is much more about starting from the individual: the first thing to nurture is oneself, then one's immediate environment.

Every week I hear jackdaws coasting over the trees around the grounds of Whittingham, just as I did thirty years ago. I never learned to drive, and I couldn't afford a car anyway, so I still catch a bus. The bus shelter here is a shell. The old hospital wards, toxic with age and asbestos, are flattened. The fish pond remains, but with a metal fence and a sign warning about deep water.

I have a sense, an intuition, that has helped me in my work and collaboration with people. I once warned a charge nurse about a patient being likely to try to commit



suicide. But, back then, my warning was brushed aside. 'If she wants to kill herself, there's nothing we can do to stop her,' was the charge nurse's reply. A week later, the patient ended her life in the fish pond. Now, before I go to my creative writing session, I take the other direction for a while. I walk towards the fish pond and remember her. ■

William Park is our creative writing editor.



Photos by William Park: Whittingham Hospital site, before demolition.

Small acts of rebellion

Linda Gask

The two quite contrasting uses of the word 'asylum' have always perplexed me. On the one hand, a place of safety or shelter where a person is treated with humanity, and on the other, an inhumane institution to which a person was 'committed'. The large Victorian asylums may have gone, but mental health services still reflect the ambiguity of that word.

I look back now on my early years of training in psychiatry, at the start of the 1980's, as a time of hope. Around us, Thatcher was beginning to disassemble the National Health Service; but there was a sense of moving forward – at least in the small corner of South Manchester that was the psychiatric unit attached to Withington hospital. This was one of the early departments attached to a general hospital, and it was relatively easy to get access to the many different medical services all on the same site. We heard about the changes going on in Trieste. Some of our teachers had even visited the place. We hosted fascinating speakers from round the world. On most wards there was a morning ward meeting every day, and in some wards we even ran group therapy sessions. I am sure there are others reading this who will remember the time they spent there differently, and I would be the first to admit it was a very long way from perfect. But we witnessed the asylums closing down, and colleagues beginning to develop community mental health services. Perhaps we were naive, given the cuts in funding that were already taking place, we saw only progress in the road ahead.

So when I began work as a Senior Lecturer in Psychiatry in 1992, in a huge asylum where I took responsibility for an acute ward, and only 40 miles from where I had trained, I soon learned how difficult life was going to be – both for me and for those I was trying to care for. The fabric of the place didn't come as too much of shock to me. I had visited asylums both to visit a family member and in my training. And I already realized how simply moving the building and staff from one place to another didn't change attitudes. In my first consultant post I had met a charge nurse who told me he was disciplined for a small act of rebellion: he had changed the date on the front of his shiny new '1990' diary to '1960', so as to reflect the practices in the hospital. I also heard about their experiences from those attending meetings at the local Mind office, so I concluded that he was probably right – although sometimes 1890 wouldn't have been much of an exaggeration. There was resistance from my colleagues when I complained that people were not having a physical examination on admission, even though many of them had multiple physical illnesses. 'We've always done that once a year' was the reply - the annual practice in the 'asylum', which they had simply continued in the new hospital.

The asylum in which I found myself in 1992 was closing, but very slowly. Staff from the back wards were

being moved into new positions 'in the community' and in the newer unit attached to the general hospital. They took their prejudicial attitudes and behaviour with them. Every day felt like a battle. There were existing practices to fight, such as the predecessor's 'blacklist' of people who were not to be admitted at any cost; and then there was the new management (the 'trust') which courted public opinion by being seen to close the asylum, but at the same time showed little concern for the future welfare of the very people they were supposed to be helping – patients and service-users. Looking back, it is not difficult to see how the popular movement to close the large mental hospital to create more humane community care was hijacked in order to cut costs. When the asylums closed the money didn't go into better community services. It flowed straight to acute health care.

More than 30 years have passed since I began to train in psychiatry. I would like to be able to say that the hopes I had for mental health care, as a young psychiatrist, have been fulfilled. But too many have not. And it isn't always about money, although the shocking dis-investment during the last few years has compounded the problem. In England, the organizational split into 'mental' and 'acute' health care trusts was a disaster for the integration of physical and mental health care. And this was just at the point when there was increasing recognition that people with a severe mental illness die 20 years earlier than the rest of the population. Now the units at district general hospital are being closed, and we are moving back to single-site mental hospital care. At a meeting I once suggested that a proposed new unit, miles from where people actually lived, might have a farm too, and my comments were almost taken seriously. But mostly we now have vast virtual asylums in the community. The 'inmates' suffer not only from insufficient care and the constant imperative of 'recovery' but are even denied their basic needs. Once again the government has highjacked a positive message – the association between satisfying work and good mental health – by turning employment, at all costs, into its desired outcome.

The stories of what has happened to the most vulnerable people within the system, many of them now in privately-run units miles from their homes, echo the ways in which people used to be treated in the asylums. People with mental illness and learning disabilities are still treated as less deserving of care. We don't know how many hundreds died from negligence in the old asylums, but we do know that during the last decade very many have died while under mental health care. And yet few people, except for the families who are supporting them, seem to ask 'why?' Services continue to distinguish between those who 'probably deserve care' and those who do not. This

distinguishes people with diagnoses such as psychosis, dementia or acutely suicidal from those with 'personality disorder', 'substance use' and all those with 'depression' who unfortunately cannot benefit from the panacea that is Improving Access to Psychological Therapies. In mental healthcare, moral judgments are never very far away, and all around us now there are echoes of the Victorian division between the deserving and undeserving poor, not least in how we ration mental health provision.

I suffered from episodes of severe depression throughout my adult life, and some were precipitated by problems at work. I was considered 'difficult' because I complained about the shortcomings of the system. I refused to wear a corporate name badge 'for security reasons'. As I saw it, if I visited the wards often enough people should know me – and I always introduced myself to those who didn't. I always avoided attending Control and Restraint training, too. I ran a clinic out of hours for those who couldn't attend during working hours, much to the annoyance of management who told me it was 'a security risk'. I was protected from some of the controlling behavior of 'management', and punishment for my own small acts of rebellion, by being a university employee. If I hadn't been, I would never have lasted as long as I did. But while acknowledging I wasn't always emotionally strong enough to confront it, I still feel guilty for not having done more to challenge some of the things that went on

around me. The NHS has a poor record of supporting the mental health of those who work for it, although I know I have been very fortunate in the care I received.

Erving Goffman described how the total institution had power not only over its inmates but those who worked within it. When I worked in the asylum, I felt that power very strongly. But I still feel it now. I regularly hear respected mental health professionals boldly justifying detrimental decisions taken by managers – because they feel powerless to challenge them. I see instances of professional groups divided rather than finding ways of working together in true partnership with those who use and rely on the mental health services. I still hear how the bad behaviour of some workers goes unchallenged – I suspect because of the fear of disturbing the flow of life in the virtual asylum. I have seen people whom I admired in my younger days slowly get burnt-out by the system.

Yet I am pleased to know many others who stand up for what is right and still share my hopes of a better future. Every day there are small acts of rebellion – but we have to get better at working together to start a revolution. ■

Linda Gask is Emerita Professor of Primary Care Psychiatry at the University of Manchester, and a retired consultant psychiatrist. Her latest book is The Other Side of Silence: A psychiatrist's memoir of depression.

OLIVE'S STORY

&

THE PHOENIX OF HOPE

Margaret Turner & Olive Bucknall

'All your rocks are jewels.'
(Charlotte Joko Beck)

I first met Olive at the Soteria Network Open Meeting at the Centre for Community Mental Health in Birmingham, in July 2007. In the morning, after a range of illuminating presentations, there had been time for sharing experiences and a discussion. But all I remember of the afternoon is that a woman in her eighties, called Olive Bucknall, held the audience's rapt attention as she told us how her son's suffering needed to be known so that others need not be submitted to similar anguish. Immediately afterwards, I wrote how the meeting had been 'inspiring, moving and essentially a bearer of renewed hope.'

Now ninety-five, Olive's aspiration is as keen as ever. She says, 'Terry's voice was taken away and I'm acting as his voice. His would have been the same line of thinking.' What happened to Terry, caught up in the mental health system from the age of eighteen until his death at sixty-five, was tragic and shocking. But if his story can be heard and learnt from, and if more humane approaches become better

known and more widely practised, then his suffering will not have been in vain.

Terry's Story

At the age of eighteen, Terry Bucknall was a young man full of promise. He was an apprentice electrical engineer, an RAF cadet, and an accomplished driver. As far as his family were aware, his childhood had been happy and untroubled, and he was well prepared to embark on adult life. But then misfortune struck, in the form of a carelessly driven car which sent Terry's three-wheeler into a triple somersault and wrote it off. Terry declined the offer of being taken to hospital. This was unremarkable since he had always made light of his injuries and resisted medical attention. Yet what happened shortly after this accident, and the chain of responses that followed, changed, destroyed and ultimately ended his life.

After walking away apparently unscathed from the wreckage of his car, just weeks later Terry told his parents that he had a problem he needed to see the doctor about. He didn't reveal what kind of a problem, and so it came as something of a surprise when he reported back that the doctor had advised him to have two weeks rest in the psychiatric hospital.

With no prior knowledge of psychiatry, his parents assented. Olive now bitterly regrets that decision: 'Looking back, and through experience, we felt we made a wrong decision in allowing him to go there, but we always thought the doctor's advice would be right. How wrong we were!'

For rather than emerging the better for rest and care, Terry had entered a world where he was labelled 'schizophrenic'

and, without his informed consent, he was subjected to an array of powerful treatments – drugs, ECT, insulin.

Olive never understood why she was told that her son had ‘the worst kind of schizophrenia’, nor did she know what the original problem was that Terry had presented to the doctor. Only much later did she discover the psychological trauma at the source of Terry’s suffering, which had probably been reactivated by the accident. Tragically, Terry was never helped with that trauma.

The number of drugs Terry was made to take, over the many years that followed, was excessive and ‘quite unbelievable!’ He was given thirty-three sessions of ECT, which Olive later discovered were administered by inadequately trained staff using poorly maintained machines. Consequently, Terry suffered great red burns on both sides of his head. Equally horrifying was Terry’s abject state of helplessness, lying on a grey mattress on the floor after insulin coma therapy. Indeed, this was so distressing to Olive that she collapsed, only to wake up later in hospital, drugged-up. Again, for Olive as for Terry, no-one reached out in sympathy and understanding. Instead she was bullied into signing consent to ECT – even though she was not subject to the Mental Health Act. This resulted in her losing every memory of her schooldays.

During his years in hospital, Terry’s unhappiness became so excruciating that he tried to kill himself six times – although Olive was unaware of this until she obtained Terry’s notes. One of Terry’s fellow patients, someone who had become a friend, did finally manage to take his own life, despite being under maximum observation. He had absconded from the hospital but had been found and brought back in.

For a long time Olive had no idea what had happened to Terry to bring him to the state he was in. Neither the doctors nor the care co-ordinator seemed to want to talk to the family or listen to them, although there was much that Olive wanted to ask or explain. Terry wrote in notebooks which he locked away, and made tape recordings which he then destroyed, burying one in the allotments and throwing another in the river. It was not until she came across a letter from Terry to his uncle that Olive began to wonder what could have befallen him. He had written: ‘They tell me I’m in here because of what happened at school!’ Olive kept this to herself however, never dreaming of the truth that was to emerge later.

Eventually, when he was living in a mental health care home, and not long before he became very ill, Terry visited his mother much earlier in the morning than usual. Somehow Olive was moved to touch him gently on the arm and ask ‘What happened at school?’ And he replied: ‘A teacher raped me.’ Those were his exact shocking words, but when she asked for more information, he said ‘Don’t torture me about school!’

Olive immediately looked for help for her son, but when she questioned the care co-ordinator his riposte was: ‘Let sleeping dogs lie or you’ll open a can of worms.’ Olive believes the staff knew of his traumatic experience all along, yet they did absolutely nothing to help him address it.

This revelation, and any chance of healing, came too late. A ‘massive, aggressive squamous cancer’ on Terry’s face, apparently unnoticed for too long, progressed inexorably. When he had lost so much weight that he could barely stand, his family suggested he be moved to the

hospice. There, on 5th March 2011, aged sixty-five, Terry died. And Olive, by now a widow, had lost ‘a wonderful son, much loved by all the family.’

The Issues

‘Mum, they’ve killed my soul – I’ve got psychiatric angina.’ Terry Bucknall.

The most fundamental error, and one that still pervades psychiatry, is to respond to a person’s acute distress, which will have been caused by a very traumatic experience, by giving them a psychiatric diagnosis and medical treatment. Whereas Olive was referred for counselling to an organisation dedicated to those who had suffered from abuse, Terry was never given this opportunity, although ‘it would have done him a world of good.’ A traumatised person should not be consigned to a medical institution. Rather, if need be, given sanctuary where they can receive compassion and understanding.

It’s essential to look at the whole person, to treat body and mind together. Little attention seems to have been paid to the physical effects of Terry’s accident, but even more importantly his physical care as a psychiatric patient was so neglected that a cancer advanced on his face without anyone noticing. Psychiatric drug ‘treatments’ can be an abuse in themselves, and as in Terry’s case, given deliberately to block distress instead of to heal the person. Heavy, prolonged, enforced application of medication hurts and changes people, taking away joy and initiative, sometimes to the point of prompting suicide. In Olive’s view, Terry’s ‘schizophrenia’ was caused by the hospital, its treatment of him, the drugs and shock treatment used.

ECT has long been known to be harmful. It is worse if the charge through the head is continually raised to such a point as to cause a visible seizure. Olive undertook much research and has campaigned vigorously against its continuation. She is dismayed that a new £46 million hospital is to have an ECT suite!

Anyone receiving psychiatric care, and their families, should be treated compassionately rather than punitively. Olive gained access to Terry’s medical notes. They were a horrifying revelation. She read: ‘If this lad comes back, we’ll throw the book at him... give him ECTs and insulin.’ Olive herself was described pejoratively. The care co-ordinator had written of her: ‘wracking tears... tirade... anger... not in the here-and-now.’

Family members should be involved from the outset. They have much to offer towards the construction of a narrative, developing understanding and giving love and support.

Olive’s hopes

First of all Olive wants the horror and tragedy of Terry’s story to be known so that the compound mistakes that were made are learnt from and not repeated.

She has a very positive hope too: that alternative, humane approaches based on compassion, being alongside, finding meanings, can become better known and turned into a reality. In her quest, Olive heard about and was much inspired by the work of the late Loren Mosher and his creation of the Soteria House in California in the 1970s-80s. Since then she has devoted much effort to promoting Soteria Network UK, its vision and endeavours for the 21st century. ■

SOTERIA BRIGHTON

Origins and activities

Dominic Pearson & Katy Baboulene

Unsurprisingly, criticism during the 1960s of unjust and unhelpful psychiatric ‘treatment’ met with resistance. Fifty years later, the technological advances orthodox psychiatry promised have not been delivered. Rather than ask what has happened to a person, the search for what is wrong with them continues. Long-term neuroleptic medication is still the default treatment for those who experience acute psychological distress. For those experiencing what is referred to as psychosis, our services still largely operate by focussing on what to prescribe – they avoid the question of whether anti-psychotic medication is required at all.

The Soteria Brighton Group is neither anti-medication nor anti-psychiatry. We find those terms unhelpful since too often they are labels employed by those wanting to distract everyone from legitimate criticisms of orthodox psychiatry.

Yet it seems that all too often some of the fundamental tenets of humanity and humane healing are lost in the cacophony of orthodox psychiatry’s technical smoke-and-mirrors. ‘Why ask distressed individuals what they think would be best for them when the professional experts are well-trained and knowledgeable?’ ‘Why listen to the richness of meaning in what someone has to say? Just find out whether or not there are indications of a psychotic disorder.’ ‘Why would you want to be with someone when we have all these sophisticated ways of treating the illness?’

As silly as these questions may sound, this is the attitude that Soteria finds itself opposing. We believe that the provision of services for people diagnosed with a psychosis is at best limited, and at worst, damaging. We

prioritise *being with* distressed individuals, rather than *doing to* them.

‘Soteria’ is a Greek word meaning deliverance, preservation, safety and salvation. It was adopted on the basis that the distress of the residents of Soteria House need not be enduring. We are pleased to see that gradual progress is being made in line with this ethos. Alternative ways of understanding and responding to ‘psychosis’ seem to be developing. The medical model of psychological distress that used to dominate care and therapy is beginning to lose its absolute grip, and in some places the provision of both grassroots and institutional services is beginning to reflect this shift.

Bound together by a commitment to a more humane understanding and approach to ‘psychosis’, the Soteria Brighton Group is made up of individuals with lived experience, carers and professionals. We began four years ago, inspired by the work of Loren Mosher and his colleagues, who set up the first Soteria House. This was established in California in the 1970s, and it was open to people who would otherwise probably have been diagnosed with ‘schizophrenia’. The aim was to see whether residents could come through their experiences with minimal medication but high levels of interpersonal support. Soteria emphasises the provision of a safe, supportive environment in which individuals are able to go through their experiences free of invasive interventions.

In 2007, in a review of all the controlled trials assessing the efficacy of Soteria, it was concluded that ‘the Soteria paradigm yields equal, and in certain specific areas better, results in the treatment of people diagnosed with first or second episode schizophrenia spectrum disorders (achieving this with less medication) when compared with conventional, medication-based approaches.’ This is important evidence! People who receive care by way of the Soteria approach are afforded the opportunity to find meaning in their experience, and to integrate this experience into their lives. Often they are able to live free of long-term medication. By contrast, most distressed people who rely on the conventional mental health services find that the meaning of their experience is ignored. Furthermore, any individual who is given a psychosis diagnosis is told that that kind of experience is most likely to happen again. And so they are prescribed long-term medication. This is despite emerging research which shows that long-term medication does more harm than good.

Of course, Soteria Brighton does not deny that there are people who experience ‘psychosis’ more than once. What we reject is the idea that these experiences are indicative of ‘disorder’, and that repeating those

experiences is inevitable and in itself evidence of 'disorder'.

The long-term aim of Soteria Brighton is to achieve a Soteria house in our community. However, a house based on the original model would not be cheap, and at the moment our group consists of people who volunteer their time and resources. The cost is comparable to traditional psychiatric beds, but due to shorter in-patient stays and fewer return visits, overall we are more cost-effective.

Because of the financial magnitude of our project we decided to provide other services in the meantime. Several of our members are pursuing the possibility of a Soteria café and a group to help people manage medication.

We hold bi-monthly Soteria In The Pub (SIP) events to raise awareness of views alternative to orthodox psychiatry. We began with Bob Whitaker in debate with a local psychiatrist, and have continued with guest speakers. To name a few, we would like to thank Joanna Moncrieff, James Davies, Bob Johnson, Dave Harper, Open Dialogue UK, and Lucy Johnstone.

At the end of one SIP event, a member of Soteria Brighton commented: 'If this event changes one person's life then it has been worthwhile...' Following this, someone who had been attending SIP events volunteered their story.

'I have never been very forthcoming about my 'lived experience', but I want you to know that SIP has made a vast difference to me. I have shared my story with friends and therapists but not beyond these circles, so this wider sharing with you is testament to the impact of SIP & Soteria on me, and my attitude towards myself.

Last February, after a psychotic episode and two suicide attempts which I chose not to go through with, I found myself in hospital, under a section. I came out after a week, full of drugs and not having talked to anyone about what happened, other than during formal assessments. As an out-patient I asked, several times, about speaking to someone on a one-to-one basis, in order for me to gain some understanding of what I had been through and to avoid going there again. I will always remember the look on one nurse's face – slightly perplexed, confused, as if no-one had ever asked that question before. Why would I want something like that? I was offered six group sessions, which did not address any of my issues. The unsaid message was "Keep taking the tablets, come back in six weeks and we will see how you are doing". I was left with no understanding of what had happened, why it might have happened and how I could help myself other than by ensuring I took my medication...

...I was pretty desperate about gaining some knowledge about psychosis. This is where I was very

fortunate. I had met a member of Soteria Brighton previously, and we shared a friend who told me about the SIP event: "What to do in a crisis". This was the beginning of my education. It was the first time I heard about the side-effects of the drugs I was on, and their toxicity on various systems within the body, what psychosis is and the various ways in which it can present itself, who to talk to and where to go if things got bad. There was someone on the panel talking about her experiences, and this gave me hope of being able to live with this/come through it...

...SIP allowed me anonymity when I desperately needed it, initially, when I wanted answers but didn't want to 'expose myself' as someone who had "a mental illness". I was ashamed and embarrassed to speak about what had happened to me. I wanted to see if I could be accepted as "normal", and I didn't want to have to define myself in relation to my mental health. I didn't have to explain who I was as I came through the door to the SIP event...

...For my therapy I need an intellectual approach, I need to understand the various theories concerning my "condition" and I need to learn a different language to talk about my experiences. SIP gave me these...

...I have always believed, maybe naively, that when something bad happens to us, then something good will come out of it. GPs, psychiatrists, mental health nurses all tell me how quickly I have "recovered" from what has happened to me. I am not going to say that this is all down to SIP since I have been lucky enough to have other support. But SIP has played a major part in getting me to where I am now, and I hope my story has explained ways in which it has truly helped me. I go to see my GP next week to discuss whether I can stop taking my medication completely. Without SIP I doubt I would have had the confidence to discuss with him the idea of reducing or ending medication.'

We believe that if offering an alternative to orthodox psychiatry can bring positive change for one person, then more alternatives hereon in can only bring about more positive changes for others. ■

TRIESTE BEFORE & AFTER

Reflections on the Italian psychiatric reforms

Daniel Magalhães Goulart

Introduction

Situated towards the end of a narrow strip of Italian territory lying between the Adriatic Sea and Slovenia, Trieste is deeply influenced by Latin, Slavic, Jewish and German cultures. Part of the Austrian Empire for almost 400 years, the city was annexed to Italy soon after the end of the First World War, and became a symbol of Fascist power. In the main square, Mussolini announced his anti-Jewish racial laws, in 1938, and during the German invasion the only concentration camp on Italian soil was in Trieste. About 3000 Jews, south Slavs and anti-fascists were killed at the camp. Another major symbol of violence and oppression in the region was the Trieste asylum – l'ospedale psichiatrico cittadino – which opened in 1908.

And so Trieste is a city of historical disputes, struggles and oppression. But on the other hand, it has also been an inspiring centre for the arts, resistance and political engagement. And it was from the core of one of its most conservative social forces – psychiatry and the asylum – that one of the great mental health movements of 20th century emerged, led by Dr Franco Basaglia.

Franco Basaglia and *Psichiatria Democratica*

Influenced by existentialist philosophy and critics of psychiatry such as Ervin Goffman and Michel Foucault, Franco Basaglia (1924–1980) became famous for his actions as a coordinator at the mental hospital in Gorizia, from 1961. He began by refusing to strap patients to their beds, or to have them put into isolation cells. A national debate about psychiatric theory and practice developed out of Basaglia's initiative, leading to innovative ideas about therapeutic community. Gradually, he began to get powerful support from some users and their families, as well as concerned workers, intellectuals and artists.

In August 1971 Basaglia was made the manager of Trieste asylum. Immediately, he followed the path taken at Gorizia, but more radically. He started to dismantle the asylum, replacing it with a network of alternative community services. (MHD, Trieste) This process of de-institutionalization reversed the historical relationship between psychiatry, its institutions, and the patients. The main proposals in the program of *Psichiatria Democratica* (PD) had been established by 1973.

In 1977, alongside the Radical Party, *Psichiatria Democratica* collected three-quarters of a million signatures on a petition to change mental health law and prohibit sending people to psychiatric hospitals. The growing movement put pressure on the government to

start to dismantle the asylums across the whole country. In May 1978, this policy was enacted as Law 180.

Despite different reforming experiences across Europe after World War II, such as in France and in Britain, Italy was the only country to radically shift the axis of mental health provision from the psychiatric hospital to the community, and to gradually abolish all psychiatric hospitals, as well as historical practices such as physical restraint and electroshock therapy. This reform could not be directly linked to any previously consolidated practices or knowledge, and so there were, and still are, very difficult challenges. (MHD, Trieste) Moreover, since 1978, the challenges changed significantly as soon as the critical movement turned into public policy. As Tarabochia (p. 116) puts it: "Any reform risks becoming part of the very system it is trying to reform." It was in this light, with a critical kind of curiosity, that I visited Trieste in August 2015.

My visit

I was in Trieste for two weeks in August 2015, and I had a chance to see several services and talk to users and workers in the Trieste mental health system. Although I was sometimes with a Brazilian colleague who currently works there as a researcher, most of the time I went to those services and talked to whoever was there by simply introducing myself in my very basic Italian, without any previous contact, appointments or the mediation of someone else.

In fact, that was my first strong impression: in Trieste, the services and the social spaces involved in mental health care are conceived as places of socialization, and not strictly a stage for professionals to make their interventions. This is a huge difference from closed-doors institutions, queues of users waiting to be seen by the doctor, and all the sharp questioning: "Who are you?" "What sort of information are you looking for?" Instead, I found houses with open doors and people chatting in the garden, in the rooms and along the corridors, sometimes with mental healthcare workers, sometimes without them.

Certainly, this did not mean that there are no crises, no distress or acute suffering. Nevertheless, I could see that those houses and gardens were somehow closer to the usually abstract notion of 'community', with a flexible and living flux of people and communication. Up to a certain point – which I will clarify later – I could see that professional interventions in those contexts are not such hierarchical, top-to-bottom processes, but more a dialogue and collective practice, where difference is more tolerated

and technical knowledge is not manifested as arrogance. In this manner, I was invited to take part in home visits, staff meetings, informal chats, and group sessions with users.

Those features are indeed part of the ideal of the Community Mental Health Centres, which are considered the main device for reforming mental health processes in Trieste. The doors open onto the street, and there are multidisciplinary teams which work in a therapeutic domestic-style environment. There is provision for day and night care, family meetings, team meetings, home visits, leisure and daily life support, among other activities.

The population of Trieste is about 200,000, and the main features of the mental health network are:

- four community mental health centres, open 24/7, and each with 6–8 beds;
- one small unit at the General Hospital, with 6 emergency beds;
- A rehabilitation and residential support service – 12 group-homes with a total of 60 beds;
- two day centres, which include training programs and workshops;
- thirteen accredited social co-operatives;
- family and users' associations, clubs and recovery homes. (Mezzina)

The outcomes of this organization, through the years, are quite impressive. Trieste has the lowest ratio of people under involuntary treatment in Italy; there is no use of electroconvulsive therapy (ECT), including at the hospital unit; no users are 'treated' in forensic hospitals; and the suicide ratio has fallen 50% in the last twenty years. (Mezzina)

Yet it seems to me that some of the contradictions of this process, and the emergence of new forms of institutionalization are very significant. One remarkable aspect of the current Trieste mental health network is the clearly more powerful role that psychiatrists have, compared to other mental health workers. For instance, unlike some other countries, only psychiatrists have ever been made managers of the community mental health centres and coordinators of the Trieste Mental Health Department.

Moreover, amongst the activities of the community mental health centres, the central role of medication is striking. Barcola Mental Health Centre is symbolically important: it was the first one opened by Basaglia. And excessive medication was a major concern for *Psichiatria Democratica*, a main part of the struggle in the early days. So it is surprising to enter the centre at Barcola and realize that the first door after the reception desk is the pharmacy, and that every user attending activities in the service must take medication at least once a day. Medication was also central to the home visits that I witnessed. Regardless of any conversations the mental health workers were having with the users, at a certain point they would bring out a blue bag full of tablets and administer the prescribed drugs.

What is at stake here is not simply a technical issue, i.e., whether or not the medications work as they are supposed to. What concerns me is how medicalisation – in

this case via psychiatry – is socially configured in current institutions embedded in historical, political and subjective relationships. To assume that medicating every user is natural, together with the centrality of psychiatry, still seems to answer an oppressive political and social mandate: that we must all depend on scientifically legitimized experts to provide particular products so as to fix certain problems. Instead of being concentrated in the old mental hospitals, medicating psychiatry now permeates the whole of the users' lives. This is an important expression of how the capitalist logic of consumption and passivity, as represented by the pharmaceutical industry and the psychiatric experts, still plays a major role within a progressive movement that initially had tried to subvert it.

It is important to say that this medicalization of every problem is not limited to mental health provision. It is an urgent global issue: it expresses the way we currently face all the problems in our lives.

As with any social and political movement, what is most interesting is not its history but the current challenges in the Trieste mental health system – what is yet to be achieved. And if this story is still a source of inspiration, it is precisely due to the contradictions that it has been able to expose, which inevitably still persist. The memory of combating some specific forms of psychiatric institutionalization during the 1960s and 1970s should help us keep a critical eye on present forms of institutionalization. We should not support practices, in the form of new social techniques, which run counter to our ideals.

As Basaglia pointed out, contradictions should not be viewed as evidence for the inevitability of oppression, but rather as a call for more action and change:

...[T]he important thing is that we have shown that the impossible becomes possible. Ten, fifteen, twenty years ago, it was unthinkable that an asylum could be dismantled. Asylums could become closed, and more closed than before – I do not know – but, in any account, we have shown that the mad can be assisted in another way, and this evidence is basic. I do not believe that the fact that an action can become general means that one has won. The important thing is something else: Now one knows what can be done.

(Franco Basaglia, Brazilian Conferences, 1979) ■

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Daniel Magalhães Goulart graduated as a psychologist from the University of São Paulo, Brazil, and was a Masters and PhD student in Education, University of Brasília (CAPES). He is a member of the Discourse Unit, Manchester, Lecturer at the University Centre of Brasília, and an activist and researcher in mental healthcare.

IS PSYCHIATRY REALLY BETTER NOW?

A view from Australia

Deidre Oliver

Then

In 1969 I trained as a psychiatric nurse at the biggest, most 'modern' mental hospital in the state. Coming from a middle class and educated background, with no 'mental' skeletons in the closet, I had virtually no experience of psychiatry whatsoever.

Of course I'd heard and read stories about lunatic asylums, including Hannah Green's *I Never Promised You a Rose Garden*, but I'd never even met anyone who was mentally ill. Green's book had a profound influence on me, and along with a recommendation from a friend, it steered me towards the unknown world of psychiatry.

And that was a revelation.

But at that time it wasn't nearly as bad as the 'snake pits' in the novels. There were no straitjackets, shackles, chains or padded rooms, and the patients weren't raving, filthy, dangerous lunatics. On the whole, they were rather nice, ordinary people – troubled, but basically just like me.

I found a 'them and us' attitude but, thanks to Hannah Green, I didn't see it that way. My approach was vindicated when, because of my background in the theatre, I was asked to run a musical production in a unit designated as a rehabilitation unit for young schizophrenics. The charge nurse was a musician who had found music helpful for his charges in the past, and now he wanted to extend this into a theatrical project. Remember, these were the days where there was no money for anything other than basic and very ordinary care.

This project became a *cause célèbre* in the hospital. It lasted six months. During that time, not one of the young patients had a psychotic episode. Everyone worked diligently, we produced a great show, and I met some of the most talented, courageous young people I've ever known. I learned from them that you CAN talk to 'mad' people, that they did all have a story to tell, that 'madness' was not all-embracing and permanent, and that you could get involved in their lives and not catch anything. We used drugs, though very carefully, and the use of ECT was in decline.

I went on to work in crisis intervention and psychotherapy, and later started the first official home visiting service. Before this there was no official outpatient support, though the need was obvious. And so, on their

own initiative, many nurses used their own cars to visit discharged patients, or if there was a need they would see people out of working hours. There were few specialist therapists – psychologists, occupational therapists and social workers were thin on the ground.

The thing is, in a system with extraordinarily limited funds, with a background of institutional apathy and oppression, all the same there was at that time a sense of hope, that the lights were about to come on.

I left in 1975 and had no more contact with psychiatry for twenty-five years. In the meantime I had raised my kids and lived a busy and fulfilled life, first in the theatre and then as a sculptor, novelist, and screen and TV writer.

Now

Early in 2000, I had a burgeoning sculpture career, my first novel had been accepted by a publisher, and a screenplay series was accepted by a producer. I was very excited but the pressure made me anxious and stressed. A friend suggested Prozac: no side effects and very good for stress, he said. As a former nurse who accepted the validity of psychotropic drugs, I thought: why not?

Bad idea. Within two weeks I had a suicidal reaction to the Prozac, and at the age of fifty-seven entered the life of an electroshocked and drugged-up psychiatric patient. This continued for the next thirteen years.

I witnessed today's psychiatry from the inside. Gone was the feeling of 'the lights coming on'. All the officials seemed to believe that the lights were on – that they'd now got it right, and everything was as it should be. The old mental hospitals with their institutionalization were gone, the stigma was gone, everything that needed doing was now done. Mental illness was now 'a chemical imbalance', so you didn't need talk to patients any more. If they get upset, it's because their 'balance' is out, so you top them up with medication. If the patient at all disagrees or protests or resists having the drugs or ECT, well, they're just wrong. It's all scientific now, and if the doctors say it won't kill the patient, they're right – even if it does.

Whereas staff used to mix with the patients in the sitting rooms, the grounds and the dining areas, if it is not forbidden it certainly now seems to be discouraged.

Nurses spend most of their shifts in the office, only coming out, often reluctantly, when asked. They don't seem to understand that many people, demoralised and discouraged by the very fact that they are in a hospital at all, cannot ask for help. Back then, staff would find out if the patients needed anything by sitting next to them and asking.

There is very little space in today's public hospital wards. Psychiatric units are often attached to old hospitals in urban settings where space is minimal. The wards are over-crowded and dingy, often without access to the open air. The old mental hospitals, institutions though they were, had open spaces and gardens.

As used to be the case, people made aggressive by toxic drugs or alcohol are mixed in with others who are distressed and disturbed. But back then the extra space and less pressure on beds allowed patients to be moved to more appropriate accommodation quite quickly, thereby averting the potential for violence. Today's units seem more under pressure, and there seems to be much more aggression and violence.

During the six years when I worked in acute admission units I never once saw shackles being used, seclusion was rare and usually brief, and I never saw a patient assaulted by a member of staff. As a patient between 2000 and 2013, there were only a few occasions when I spent days in public hospital wards. However, neglect was common, and it was almost routine for staff to be rude, insulting and threatening to patients, and to assault them. One young woman, quiet and afraid, told me that for the three days she'd been a patient no member of staff had spoken to her, except to tell her to take the medication. Shackles are now used as a matter of routine, and seclusion is used as a threat to control people.

Whilst offering nicer accommodation and a quieter atmosphere, probably because the patients are more carefully selected, the private hospitals offer no more support than their public equivalents.

In none of the hospitals I saw during my recent thirteen years experience of psychiatry was there any more space given over to pursuits such as craft, music, etc., than there had been in the old days. Auxilliary therapies such as art, music, craft, and exercise were absent unless initiated by the patients. The public system has no money, space or time, and the private system is more concerned with profits than with providing expensive therapies. In the old days there was a limited occupational therapy program. There was no evidence of such a thing in any hospital I was admitted to in the years 2000–2013.

Since I was an academic high achiever in the early-1970s, I was asked to speak at an International Congress on nursing education. I rubbished it – which was exactly

what my superiors wanted me to do. They were working towards improvements and more respect for psychiatric nursing, which was then very low on the totem pole. Subsequently, psychiatric nursing was elevated to a university degree.

Sadly, while respect for nurses had obviously improved, their knowledge is no better than when I left in 1975. It seems that the drugs revolution which suppressed understanding people as a major strand in psychiatry, extends to nurses as well. They can talk endlessly about the benefits of ECT and drugs, but have never heard of Carl Rogers, Transactional Analysis or REBT. Their understanding of Freud was limited to sniggering about the Oedipal Complex, and they knew nothing about Jung or Adler. I don't expect nurses to know the theories and details behind all these important thinkers, but they should have heard of them. Thirty years on, nurses' ignorance is staggering.

I'm not saying that nothing bad happened in the old days. They did. I knew a few sadistic doctors: one purposely scarred a young girl 'to teach her a lesson', while another nearly killed an eighteen-year-old girl by excessive treatment. I witnessed ECT being used as punishment, and some attendants sacked for brutality. Many nurses obviously spent their time minding a desk until they qualified for a pension. But has psychiatry improved? NO.

Right now a group of Australian doctors are punishing a patient with ECT. People are being drugged against their will more often, and with higher doses than we ever used. People who used to recover between episodes of illness now do not. More young people diagnosed with schizophrenia are committing suicide. This always happened, *but surely it should be better now, not worse.*

When I fell under the psychiatric bus, I needed the sort of care offered by our team at the 'bad old loony bin' – not what I got from today's aggressive, smug, lazy and ill-informed attendants.

In psychiatry today, there is no hopefulness, no search for something better. Only apathy, self-righteousness and the arrogance that they have got it right.

NO THEY HAVEN'T. ■

Deidre Oliver is a happy granny living in Melbourne. She plays tennis, writes and sculpts. She trained as a mental health nurse and also survived psychiatry, and is a sometime psychiatric advocate. She campaigns against ECT, and among other activities, works with Speak out Against Psychiatry and Mindfreedom.

MENTAL HEALTH CARE IN GREECE

The reform that never happened

Eugenie Georgaca

When there has been an intense economic crisis since 2009, any account of the current state of Greek mental health and mental health care is bound to be gloomy. What makes the picture even gloomier is that the intensified suffering caused by economic hardship and shrinking mental health services only serves to exacerbate the failings of an already dysfunctional and ineffective mental health care system.

Until the mid-1980s, the old-style of asylum psychiatry was in full force in Greece, and the only kind of mental health care. Under pressure from the European Union, and with European funding, deinstitutionalization began at that time. In the following decades European money was poured into the country to facilitate what is commonly known as 'the psychiatric reform'. This was to consist of closing nine psychiatric hospitals that pretty much exclusively catered for more severe mental health problems, and establishing a mental health service network to provide community-based comprehensive mental health care for everyone else. The reform was slow and disjointed; there were repeated warnings from the European Union, and increased monitoring of its implementation.

By 2009, five of the psychiatric hospitals had closed down and the others had significantly diminished in size. A variety of community mental health services had also been developed, such as community mental health centres, day centres, rehabilitation units, mobile mental health units, accommodation and employment units. But this never made up a properly integrated mental health service network.

Amongst the most significant problems are the following:

- There is big discrepancy in the geographical distribution of services, whereby a few areas have a fully developed network while others have practically none, meaning that many people have to travel a fair distance to see a mental health professional or attend a service.
- There is no referral system and collaboration between services, which means that people may not have access to services they need and there is no responsibility for care, or continuity of care.
- There is still a significant lack of specialized services for children and adolescents, for older people, or for people with specific mental health difficulties.
- While establishing community services might have facilitated young professionals from non-medical professions entering the field, which could have been an impetus for a change in perspective, in practice this did not happen. Consequently, the mental health care system is still dominated by biomedical and reductive

understandings of mental health problems, and by the old institutionalized practices, simply extended into nicer looking community settings.

- Although Greece signed up to all the major declarations for the rights of people with mental health problems, the issue of rights has not really entered the agenda of the mental health services. It is telling that around 50% of all psychiatric hospitalization is by involuntary commitment, and the numbers are rising.
- Moreover, there are effectively no independent bodies to monitor and safeguard the rights of people who are in contact with the mental health service system.

And all this before the crisis...

Over the last thirty years there have been many discussions around the reasons that led to the creation of this misconceived and ineffective mental health care system. An argument rehearsed time and again is that 'the psychiatric reform' was imposed from outside (by the European Union) and did not grow from an internal process. There is a highly déjà vu feeling to this argument: we Greeks are always feeling that policies are imposed on us by 'the big powers', and thereby we take no responsibility for our own actions. It also begs the question of why such a demand did not grow within the country. Professional vested interests, social conservatism and a general inertia of the state might provide some of the answer, but in any case they are not complimentary. The way the community mental health service system was put together is indicative of the failure of the Greek state to develop organized sustainable services: it was due both to a lack of overall planning and monitoring and to cronyism and corruption.

In Greece, there never was a significant mental health movement to provide the impetus and support the sustained effort required to build a good community care system. Progressive voices and groupings had been evident in different historical periods. Examples of good community services could already be found in the 1950s, created and sustained as initiatives by progressive groups of professionals, but they were few and far between. From the 1970s, more radical anti-psychiatric groups appeared. The families of people with mental health problems, which in countries like Greece take the main share in care, started mobilizing during the 1990s, and in the last decade or so their national association has had an increasingly strong voice in mental health policy. Until recently, the user/survivor movement was akin to science fiction. Things did get moving in the last few years, with more self-help organizations forming, and even slowly networking. A few self-help groups for people with challenging mental health problems have been running for a few years. Playing a

crucial part in these developments have been radical organizations such as the Observatory for Rights in the Field of Mental Health, in Thessaloniki, the Coalition for Psychiatric Reform in Athens, and the Hellenic Hearing Voices Network. These have made sustained efforts over the last decades to raise public awareness on mental health issues, to promote patients' rights, to develop alternatives to psychiatric practices, and to support people with mental health problems by raising their profile and organizing.

So what were the effects of the last seven years of economic crisis?

Firstly, as is well documented both in Greece and in countries in similar situations, the mental health of the population has worsened. Economic hardship, unemployment or job instability, a decline in the quality of life, insecurity about the future, a sense of hopelessness and powerlessness, limited access to appropriate health and mental health care - all this combines to increase suffering, as is expressed variously by identifiable symptoms of psychopathology. Recent epidemiological studies show an overall increase both in psychosocial distress and in diagnosable disorders; these have increased for women, the unemployed, pensioners and people on a low income.

Secondly, as with every Greek public service, the mental health system is underfunded and shrinking. Staff are either laid-off or not replaced when they retire, and services are closed down due to lack of resources. Since Greece has committed to closing all the psychiatric hospitals, and given that insufficient community support alternatives are in place, people are in danger of being completely abandoned. Furthermore, the prospect for people with challenging mental health problems is already

pretty dire since the previously meagre social welfare system is under attack and families' resources strained. Many people are likely to end up in poverty or in private psychiatric inpatient facilities, the contemporary version of the old asylums.

Is there anything that can be done? In the last few years I have seen progressive professionals, who spent their working lives fighting for the closure of asylums and the development of a community based humane mental health care model, trying to cling on to existing services, hoping to prevent their closure and users being abandoned.

Others remind us that the mental health service system that is now shrinking is the one we always fought against, and the current crisis offers us the chance to build a different way of dealing with distress. These few radical voices call for us to turn 'the disaster' into an opportunity to build on the rubble of the crumbling system alternatives based on solidarity, respect and empowerment. Since I cannot find any other way out of giving up in despair, I try to cherish that idea. Such initiatives are indeed springing up. I just hope that they prove to be the foundations for a different way to encounter distress that can grow in time, and that they do not simply fill the gaps in the current system so as to allow it to re-emerge unscathed when the economic crisis is over. ■

Eugenie Georgaca is senior lecturer in clinical psychology at the School of Psychology of the Aristotle University of Thessaloniki, Greece. She teaches, researches and publishes in critical mental health. She is involved with the Observatory for Rights in the Field of Mental Health, and with the Hellenic Hearing Voices Network, and through them with the European radical mental health movement.

Challenging an Increasingly Maddening World: The timely emergence of Mad studies

Peter Beresford

Earlier this year, psychologist Richard Bentall took the BBC to task for what he described as 'an extreme biological approach to psychiatry' which he felt headlined their high-profile mental health season. What's perhaps especially interesting is the massive response Bentall got to his article on the Guardian website; with nearly 40,000 shares at the time of writing, and more than 700 comments (Bentall).

Well into the 21st century and it seems the dominant psychiatric narrative is still disproportionately bio-medical, however much it continues to be contested. If physical medicine in the late-20th century has had to develop new domains of public health, epidemiology and social medicine - all of which either highlight or take due account of social, cultural, environmental, demographic, economic and political relations - it sometimes seems as if prevailing psychiatric thinking can't get free of the positivism of the 19th century.

And despite the limitations of such psychiatry, which Bentall and other commentators, as well as service-users

and the service-user movement have long highlighted, if anything, the medical model seems to be on the ascendant. As mental health policy, services and support contract in the UK, for instance, the influence of psychiatry and psychiatric thinking seems to expand. This is reflected in more diagnostic categories listed by the latest handbook of psychiatry (*DSM-5*), their application to more and more people, and the interpretation of more and more social issues in individualized, bio-medical terms (from children's difficulties at school to the problems of older people and people with learning difficulties in institutions), and the application of psychotropic drugs as an increasingly routine response.

In countries such as ours, the increasing weight of 'medical' and individualised interpretations of madness and mental distress coincides with a shift to the political right, first associated with 'new right' ideology and more recently with neo-liberalism and the 'neo-cons'. Whether intentionally or not, this has encouraged an informal but powerful alliance between current psychiatry and ruling politics, both of which

underplay the social origins of human problems, and both of which emphasise deficiency, deviance and individual responsibility. All this reinforces negative stereotyping and stigma. This has resulted in a reactive focus on the consequences of reducing state support, particularly in relation to specialist mental health services, public services on which mental health service-users are likely to be particularly reliant, allied with unprecedented cuts and policing of welfare benefits, which are particularly targeted at mental health service-users.

But we now face even more fundamental issues, and it is important we address them – as well as moving beyond talk about ‘a crisis in mental health policy’, as if more of the same old policy and thinking will solve anything.

The first challenge we must make is the one made by Bentall and many other critics. So long as we see madness and distress as ‘only in people’s heads’ – a deficit of genes, biochemicals and personality – we are doomed to repeat the mistakes of the past. All this sort of thing tells us is about the differences between us. It takes us no further than the old combat adage that people’s breaking points may vary, but everyone breaks in the end. Once we look outside our heads, beyond ourselves, then we have to take account of the wider world and its impacts and interactions with us. This affects us objectively and subjectively: the world outside my head has an effect on what happens to me and how I live, and also on who I am and how I see myself.

Bentall writes that misery, adversity, poverty, insecurity, abuse, terrible relationships as a child and as an adult, can all contribute to madness and distress. But it seem to me that this world has become an increasingly hostile place for more and more of us. Most of us live in a world where the risks of experiencing any of these hardships seem to be growing rather than diminishing.

Too many factors seem to be coming together to create personal, social, political, identity, religious, ethnic, cultural and international conflicts. Underpinning it all is the unremitting ideological pressure towards neo-liberalism, which has been accelerating globally from the last quarter of the 20th century. Neoliberalism is committed to the deregulated free market, to the small state, and to individualism; this is associated with rapidly rising inequality and the concentration of political and economic power in fewer and fewer hands. The damaging effect of inequality within societies is charted in detail by studies like *The Spirit Level* (Wilkinson & Pickett). This graphically depicts the destructive effects of inequality for all involved – the advantaged as much as the disadvantaged. If that study highlights the problems for health and well-being created by rising inequality within any society, we see even greater extremes emerging between affluent nations and the rest. Material inequality engenders much other inequality, reducing opportunities and limiting lives, as well as encouraging discrimination and undermining democratic structures, and exacerbating conflict at personal and structural levels.

‘Globalization’ has kept down wages in the developing world, while attempts have to be made to restrict population movement towards the West. People desperately seeking to escape poverty are demonised as ‘economic migrants’. Over the same period, there has been a significant rise in religious and sectarian strife, tribalism, armed conflicts and terrorism. This has led to suffering and death on a massive

scale, as well as creating unprecedented pressures of famine, social and economic breakdown, population movements within borders, and many millions of refugees. All of this generates loss, disempowerment, conflict, trauma, family and community breakdown, disease and premature death, and, of course, extreme mental distress. Maddening politics creates the pressures which push more and more people into distress and madness.

At the same time, neo-liberal ideology works to reduce state intervention in support of the citizens, and it rejects large scale immigration, while international aid is restructured to align it more closely to the military and economic policies of the dominant nations rather than to assisting the most impoverished and disadvantaged.

Altogether, then, in the UK, in Western societies and particularly in the global South, the conditions for the creation and perpetuation of madness and distress are gaining ground, while the resources to support people who suffer from it are sharply cut back. In the UK this has taken the form of massive cuts in support services as well as a policy of a so-called ‘reform’ of welfare which particularly targets mental health service-users. At the same time, the dominant philosophy for support and ‘treatment’ is increasingly ‘medical’ and ‘bio-ethical’. But it has long been known that this approach has no science or evidence to support it, is not demonstrably effective and, so far as most service-users are concerned, is positively unhelpful.

The one bright star in the firmament is the emergence internationally of ‘mad studies’ (Le Francois et al, 2013). This project is vital for three inter-related reasons. First, building on previous survivor activism, it offers a radical challenge to traditional dominant psychiatric thinking, and is associated with a social approach to understanding and responding to people’s madness and distress. Second, it encourages alliances between different stakeholders with a shared commitment to survivor involvement and knowledge (Mad Studies Network). Finally, it seeks to combine theory and practice, analysis and activism, in taking forward a kind of Freirian ‘praxis’ based on liberatory ‘conscientization’ (Friere). The global significance of mad studies is also a reason why it is essential that it is developed in an inclusive way which challenges all forms of discrimination, notably racism.

If ever there was a time when a different response to madness and distress was needed then it is now – when the pressures driving us into difficulties are increasing at a global level, and the resources even to fund outmoded psychiatric approaches are increasingly threatened. At this critical moment, it is especially important to develop this kind of alternative vision rather than retreat to the failed prescriptions of the past. ■

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- Mad Studies Network madstudies2014.wordpress.com

The Mad Society of Canada [MADSoC]

A community of practice in the making

MADSoC emerged in November 2014, following the conference *After the Asylum: Legacies of Community Mental Health*, held in Vancouver. The conference showcased the culmination of multiple projects that had grown out of the five-year initiative *Open Doors/Closed Ranks: Locating Mental Health After the Asylum*. This was funded by the Canadian Institutes of Health Research, and led by historian Megan Davies (York University, Toronto), and involved academics and community-based members across the country. Its purpose was to excavate the history of psychiatric deinstitutionalization in Canada.

At the conference we celebrated the research site for *After the Asylum*, and also *History in Practice: Community-Informed Mental Health Curricula*. (Both are due to be launched this year on the History of Madness website: www.historyofmadness.ca) We also celebrated the historical documentary *The Inmates Are Running the Asylum: Stories from the MPA* (www.historyofmadness.ca/the-inmates-are-running-the-asylum). While the conference provided an opportunity to acknowledge important work, it was also a moment to reflect critically on what we have achieved, and to consider future directions.

A key theme throughout our work has been recognizing the continuing struggle to advocate for the rights of people diagnosed with a mental illness, as well as ensuring support in the community that is non-coercive and driven by people who have experienced mental distress. And so from across the country we brought in people who have been working on innovative, survivor-driven mental health programs, together with activists, mental health professionals, policy actors and academics. Everyone engaged in a series of presentations and dialogues.

We decided to create a community of practice to ensure ongoing collaboration, resource-building and knowledge-sharing, and to sustain the relationships developed over the course of the *After the Asylum* projects and conference events. Marina Morrow (SFU) and Megan Davies successfully applied for a small grant to support the development of this community of practice. This has allowed us to continue the Canada-wide conversations between practitioners, academics and activists that had begun at the *After the Asylum* conference.

In a community of practice, people with shared concerns or passions learn how to improve or expand the scope of their practice through regular interactions



within the group. The concept originates in learning theory, where acquiring and sharing knowledge is a dynamic process. The focus of communities of practice is *tacit knowledge*: information that is difficult to codify or make explicit. Knowledge is transferred by sharing how we do things. Here, knowledge is distributed collectively, rather than held by individuals.

A community of practice provides support by helping you find others working on similar initiatives, finding out what success others have had, sharing resources, finding help with problem-solving, communication strategies, connecting with others, etc.

It is the intention of our new community of practice to connect people from many different areas: self-help, advocacy, practice, research, peer support, etc. The idea that connects us is to recognise the needs and support and build the capacity of those involved in psychiatric initiatives led or driven by survivors. It is our goal to create an inclusive community to serve the needs of its members and support their work, advocacy, activism, research, and other activities. In Canada, this is a unique community connecting people involved in different areas but with a common focus: mental health initiatives led and driven by psychiatric survivors.

By means of a small group who attended the *After the Asylum* conference and have a keen interest in seeing this community grow, we have completed our initial consultation and needs-assessment survey. Consulting with members, and from the results of the needs assessment, we find there is a strong need for us to support one another's work. We are currently exploring partnership opportunities to help our community grow, and hope to roll out a pilot by mid-2016. ■

For now you can find us on Twitter @MadSocietyCA. Also look for our Facebook page, or sign up for our newsletter: eepurl.com/bE7tx9. Or for more information contact Theresa: tmhchina@gmail.com

Speak Out Against Psychiatry

Cheryl Prax

I am proud to be a member of Speak Out Against Psychiatry (SOAP) which in July this year celebrates its fifth birthday. I think we have achieved a lot, considering we are a part-time, self-funded grassroots operation. Our core is a small band of dedicated activists who meet every fortnight at the Cock Tavern in Euston, London. But that is just the tip of the iceberg. The internet means we can connect with individuals and activist groups worldwide so as to coordinate activities, such as the Worldwide Electroshock Protest in 2015.

Our protests are designed to educate the authorities and the general public about the harm done by psychiatry. The first protest, in July 2011, was a glorious Speak Out outside the Royal College of Psychiatry, where many people, myself included, shared stories of the harm psychiatry had done to us. The video of this event can be found on our website. That video (and our other videos) was made by Sian Whitehead. I have become the stills photographer. Images can then be shared across the world via the internet.

One of my favourite protests was 'ECT Still Happens', held outside the 'Brains' exhibition at the Wellcome Collection, on the Euston Road. The public were eager for our leaflets and we ran out. Ironically, at the time of our protest the exhibition stopped showing the ECT films because people were passing out. At a later date they continued but the films were screened behind a warning curtain. Another favourite was the protest at Hyde Park's Speakers Corner last year, as people gathered to listen before we had even set up! The public were eager for information and asked many questions, and we met some really interesting people that day.



My proudest personal achievement was producing much of the material for the ECT edition of *Asylum* magazine, in Autumn 2014.

But we have so much more to do. The laws need to be changed so that people are not forced to have 'treatment' they do not want. My mind springs to the tragic case of Garth Daniels in Melbourne, Australia. Despite many interventions from his family, lawyers, humane psychiatrists and psychologists, from SOAP, the general public and even the United Nations, the administration of forced electroshock continues unabated – currently he has been shocked eighty-eight times. The power of psychiatry knows no bounds. Absolute power corrupts absolutely, and we must ensure their downfall.

- www.speakoutagainstpsychiatry.org/
- www.facebook.com/groups/speakoutagainstpsychiatry/
- Twitter @soapgroup.
- For Garth Daniel's story, told by Professor John Read, go to: www.madinamerica.com/2016/03/appealing-to-our-elected-representatives/



NEWS & FINDINGS

SURGE IN SUICIDES & SELF-HARM IN UK PRISONS

The UK has the highest prison population out of fifty European countries (after Russia and Turkey). For England and Wales there are 149.7 prisoners per 100,000 population, for Scotland 147.6; this compares with 118 for France and 81.4 for Germany.

The England and Wales prison population has remained relatively stable at 85,500 over the past year but the Ministry of Justice's safety in custody statistics confirm a growing tide of violence and despair. In the year ending in March there were six murders and 100 suicides in prisons – up from 79 in the previous year. These are the highest numbers for at least 25 years. The number of assaults also rose 27% to more than 20,500. One-in-ten prisoners (9,458) are also reported to have self-harmed during 2015, with a 25% rise in reported incidents to more than 32,000.

The six murders in prisons during the year follow four the previous year, and taken together this accounts for more prison murders than in the previous eight years.

Critics say the prisons are in meltdown because there is a failure to address problems with mental health, understaffing and rehabilitation; there has also been a huge influx of very potent 'legal highs' which is driving problems with psychosis and internal 'turf wars'.

Travis, A (2016). UK prison population is biggest in Western Europe. *The Guardian*. 8 March; Travis, A (2016). Murders and suicides in prisons in England and Wales hit 25-year high. *The Guardian*. 28 April.

MH SERVICES TURN AWAY 23% OF UNDER-18s

A report by Liberal thinktank CentreForum shows that mental healthcare providers refuse to treat 23% of all the under-18s referred to them by concerned parents, GPs, teachers and others. In the last two years the longest waiting times for users of child and adolescent mental health services have doubled, and some have to wait up to 2 ½ years.

The reasons given by providers include: services lack the capacity to deal with the problem, the child or young person has not been unwell for long enough, or their condition was not yet sufficiently serious. Some denied support to children and young people with anorexia if their body mass index (BMI) was not under a certain threshold. Others referred them to more generic support unless they had "enduring suicidal ideation" – to access specialist services they had to have expressed a desire to kill themselves more than once.

Analysis found that The North spends more on MH care for under-18s, while services have serious capacity problems in The South. Since April 2015 there were 26 days when no beds were available in the South-East and 52 days in the South-West.

Former mental health minister Norman Lamb chairs CentreForum's commission on child and adolescent mental health. He said, 'Intervening early can prevent a condition reaching crisis point. This is a scandal which has existed for too long... If we are to finally achieve equality between physical and mental health, as the government has argued for, these shortcomings must be addressed urgently.'

There is only patchy data available on the rates of mental ill-health among children and young people, but there are indications of a rise in mental health problems among under-18s during the last five years. One in ten young people aged between 5 and 16 have a mental health problem – across England, the equivalent of 720,000 children and young people, or three in every school class. £704m was spent on children and adolescent mental health services in 2012–13. This was about 6% of the total MH budget, and 0.7% of the NHS total. And under this government, services were again cut, the number of specialist doctors and nurses fell, and more children were placed on adult wards or forced to travel hundreds of miles just to get a bed.

A DoH spokesperson said the government was delivering on its commitments on young people's mental health. 'The full £1.4bn will be made available as promised over the next five years, funding the biggest transformation the sector has ever seen, with every local area in the country revolutionising their services. This includes £28m to continue the rollout of talking therapies for children, to expand capacity and help more children get the help they need before they get to a crisis point.'

Perraudin, F (2016). Mental health services turn away 23% of under-18s referred to them. *The Guardian*. 11 April.

MH SERVICES TOO OFTEN FAIL CHILDREN IN CARE

The Commons Education Committee has been told that in England almost half of children in care have a diagnosable mental health disorder. This compares with about one-in-ten of children not in care.

Despite this, children in care miss out on treatment too often. Provision for them is poor in many parts of England, and a significant number of local authorities fail to identify mental health issues when children enter care. These children are also often denied mental health care due to moving from placements too often, and in some areas they are turned away because their conditions are not deemed

severe enough to qualify for treatment. The MPs say that children in care should be given priority for mental health support. They also call for more mental health support for young people leaving care, who are more than five times more likely to attempt suicide than their peers.

A government spokesman said: 'Children in care have often lived through traumatic experiences, and it is vital they receive the support they need. That's why we are putting a record £1.4bn into children and young people's mental health, and investing in better links between these services and schools.'

Burns, J (2016) Children in care 'too often denied mental health treatment'. *BBC News*. 28 April.

UNKNOWN NUMBER OF UNDER-18s DIE IN MH CARE

Inquest, the charity for bereaved families, demands that the government investigate the way deaths of young people in mental health units are recorded. Research by Inquest suggests that in England at least nine young in-patients – but probably more – have died since 2010.

Health Minister Alistair Burt told BBC's *Panorama* that he didn't know the figure and is calling for further research. In a parliamentary answer last year, Mr Burt said there had been only one such death recorded by the Care Quality Commission. His predecessor, Norman Lamb, said there had been none.

Deborah Coles, director of Inquest said: 'My fear is there could be more deaths. Neither we nor the Department of Health knows.' Current reporting of deaths is confused and incomplete. The NHS puts nearly half of its young psychiatric patients in private units, and these are not subject to Freedom of Information requests. Besides this, the DoH cited the Care Quality Commission as collecting accurate data, but CQC is only notified of the deaths of young people who were sectioned (involuntary committal to hospital). Obviously, this omits the deaths of voluntary patients, who normally make up the great majority of psychiatric in-patients (for adults, over 80%).

Ms Coles calls for statutory notification and an independent investigation when a child dies in a mental health unit: 'How on earth can we learn if we don't know the true picture and circumstances? If a child dies in prison, an independent investigation follows automatically. There isn't that independent scrutiny given to these deaths. What's really shocking is how difficult it is to find the true picture of the number of children dying in psychiatric care.'

Marshall, P (2016) Mental health deaths under-reported, says charity. *BBC News*. 11 April 2016

GOVERNMENT AXES MH CHAMPION FOR SCHOOLS

Meanwhile, somewhat contradicting Cameron's touchy-feely New Year pledge to significantly improve mental health services, the government has just axed the job of Mental

Health Champion for Schools. The role was introduced only last August, with the appointment of Natasha Devon. Unfortunately, Devon seems to have made the mistake of taking the job seriously, and according to observers she had been 'a thorn in the flesh' of the Dept for Education. She had publicly criticised education policies, especially the relentless testing which starts as soon as children begin school and the huge amount of debt most students face when they leave college. And at the end of April she had the audacity to inform a headteachers' conference that '... Anxiety is the fastest growing illness in under-21s. These things are not a coincidence.'

Weale, S (2016) Role of outspoken mental health champion axed. *The Guardian*. 5 May.

GOVERNMENT RATS ON PROMISED MH FUNDS

Although mental health problems account for 28% of the total burden of disease, MH services get just 13% of the NHS budget. 'Parity of esteem' with physical health was promised in 2012 but research by NHS Providers and the Healthcare Financial Management Association finds that since then only 55% of the 32 mental health trusts in their survey reported any real-terms increase to their budgets. And only 25% said they expected NHS clinical commissioning groups (CCGs) to increase the value of their contracts for 2016–17, even though the 209 CCGs have seen an average 3.4% rise in their budgets.

Since 2014, the government has announced an extra £600m for adult MH services, £1.25bn from 2015 to 2020 for children and young people's MH services, and another £1bn in the 'taskforce' report published in February. The Cavendish Square Group, representing the chief executives of London's 10 MH providers, said that despite government pledges of extra spending the proportion of CCGs' budgets that went to their trusts reduced from 12% in 2014–15 to 11% in 2015–16.

Campbell, D (2016) NHS mental health funding is still lagging behind, says report. *The Guardian*. 9 May.

And finally, some better news?

The Government of Norway now requires all mental health services to offer users the option of medication-free treatment, and also to provide psychiatric wards that offer medication-free treatment and help for patients trying to reduce their meds. However, this does not apply if people are detained against their will. Which offers the officials a convenient 'get out' clause... One step forward...?

Newsletter. *International Society for Psychological and Social approaches to Psychosis*: www.isps.org

RHYTHMS

Jenny Johnson

Somewhere within that prime fear-of-annihilation –
 right inside that peculiar smell which accompanies
 certain psychoses –
 an artist exists.

Yet even though the Caribbean sister, the doctor, suggest
 re-polishing – or have led her to
 grand bowls of salvias and a tuned piano –
 it is another she needs: the one without questions or quests.

Standing just behind her –
 and listening to those chimings from her grandmother clock –
 he observes how her shammy does a dance on her looking glass ...

till a moment later, when he bends over her dresser;
 when he combs, combs her trailings of hair....

And here – for the artist – it is time for the borrowing of rhythms:
 time to compose a little; polish again.

The Ego

Scott Michael

The mind is set free, there is no
 Harm afflicted when your lecturer,
 Emotionless and detached without
 Energy or motion, sit listen to your
 Godless soul chatter and tell your
 Own truths and leave behind loss.

Anti-psychotic

Bruce E Saunders

I need a new drug
 One that comes to the point
 And sharpens the mind

If it stops on the roundabout
 Or it stops on the vein
 Or the artery or Life

It slows down the tempo of thought
 To the degree of nonsense which
 I cannot bear for it shows that I
 Have died in my head for you.

Apology: In the last issue, Debra June Williby-Walker's poem should have been entitled 'Enlightened', not 'Day Tripper Enlightened'.

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