

Asylum

the magazine for democratic psychiatry

Winter 2016
Volume 23
Number 4
£4.00

Sales and subscriptions
Tel 01600 891509
www.pccs-books.co.uk

Information
Asylum Collective
www.asylumonline.net



**MAD STUDIES
COMES OF AGE (PART 1) &
PSYCHIATRY vs GARTH DANIELS**



'Flip my top' – Gonzalo Araoz



The magazine for democratic psychiatry

Volume 23, Number 4, Winter 2016

ISSN 0955 2030

CONTENTS

Send letters, comments and submissions (including artwork, images etc.) to: editors@asylumonline.net

Send creative writing and poetry submissions to:
william.park@talk21.com

For reasons of editing and printing, please send any graphics as jpegs (or equivalent) with a resolution of at least 300dpi.

© Asylum Collective for one year after publication, and free of copyright thereafter.

Executive Editor

Phil Virden: tigerpapers@btinternet.com

General Editor

Lin Bigwood

Business Manager

Sam Taylor, PCCS Books

Members of the Asylum Collective

Jill Anderson	Tamasin Knight
China Mills	William Park
Ian Parker	Dina Poursanidou
Sonia Soans	Helen Spandler
Jim Campbell	

Administration & Distribution

PCCS Books, Wyastone Business Park
Wyastone Leys, Monmouth, NP25 3SR

Subscriptions (see below for rates)

www.pccs-books.co.uk sales@pccs-books.co.uk
01600 891509

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

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

Editorial: Mad Studies comes of age (Part 1) <i>Helen Spandler</i>	4
Mad Studies 2016: A situation report <i>Peter Beresford</i>	5
Inclusion Interrupted <i>Jijian Voronka</i>	6
Mad Studies needs to examine its silence on violence <i>Lucy Costa</i>	7
Can we put hurt behind us? <i>Mick McKeown</i>	8
Disabling Madness <i>Sarah Golightly</i>	10
Book Review: Searching for a Rose Garden <i>Helen Spandler</i>	12
Two years of Mad Studies organising in the UK <i>Brigit McWade</i>	13
Conferences in 2017	15
Images <i>Amani Omejer</i>	16
Garth Daniels' struggle against vindictive psychiatry <i>Phil Virden</i>	18
Letter: A reply to Diana Rose <i>Don Weitz</i>	24
News and Findings	26
Photographs <i>Garth Daniels</i>	31

Front cover image 'Pathologise This' by Dolly Sen

2017 Annual Subscription – print, incl. delivery – online at www.pccs-books.co.uk, by phone: 01600 891509 or send cheque payable to 'PCCS Books Ltd' to PCCS Books, Wyastone Business Park, Wyastone Leys, Monmouth, NP25 3SR

UK Individual £16.00	Overseas Individual £18.00
UK Organisation £90.00	Overseas Organisation £95.00

Bulk orders/Trade/Resale call 01600 891509
for information on discounts

Individual digital subscriptions are available for £12.00 – visit the PCCS Books website for more information

Visit www.pccs-books.co.uk to sign up for hassle-free rolling subscriptions

VAT payable on digital products by
UK customers

Editorial: Mad Studies Comes of Age (Part 1)

This issue and the next (March 2017) are mainly given over to highlighting new and original work around the theme of Mad Studies. We wanted to share our collective enthusiasm about this new project with *Asylum* readers. Mad Studies can be seen as both a continuation and a new phase of radical scholarship and activism in mental health.

We were specifically inspired by the second Mad Studies stream at the Lancaster Disability Studies conference in September this year. While the first Mad studies stream in 2014 arguably kicked-off Mad Studies in the UK, it felt a bit tentative and cautious. This year it seemed bolder and stronger. By the final session there was a real sense that Mad Studies had come of age. There were a number of reasons for this:

- The emergence of new Mad scholars developing Mad-centred experiential-based knowledge, including those experiences that don't 'fit' the usual radical mental health stories.
- The involvement of activists and scholars from other social movements and identities such as disability, neurodiversity, queer, non-binary, etc.
- The cross fertilisation with other critical disciplines, such as Disability and Queer studies.
- The willingness to engage in conversations about difficult and troubling aspects of madness, such as violence *within* the Mad community – and being bold enough to own that agenda.
- Going beyond old debates and divisions between psychiatry/anti-psychiatry; the social/medical model; physical/mental health, etc.
- Overall, discussions were conducted in a spirit of openness and kindness.

We also witnessed the first Mad Studies keynote speaker for the whole conference. Jiji Veronka's presentation, about the dilemmas of Mad-identified peer support workers, had strong resonances across the disability field. It demonstrated how Mad Studies can feed into, and inform, other critical disciplines and activism.

Dolly's Sen's artwork 'Pathologise This' was used as the emblem of the event, and it is featured on the front cover. It was inspired by her belief that madness comes from a broken heart rather than a broken mind, and the fear most of psychiatry has about moving away from the broken-brain hypothesis for explaining mental pain.

We'd like to thank the convenors of the Mad Studies stream, Brigit McWade and Peter Beresford; also the conference organisers, especially Hannah Morgan, and all the presenters and participants not featured here. We also acknowledge Brigit's crowd sourcing efforts, and PCCS books for funding free survivor places.

Conferences aren't all about the presentations. They're also about the buzz around an event, conversations had, and connections made. So we'll include some of the presentations, but also reflections about the event,

and other material relevant to the theme. It was our original intention to have one special issue on the theme. But it soon became apparent that we had far too many interesting submissions for one issue. So we've saved half the submissions for the next issue (24.1). Lest people think Mad Studies is merely an academic pursuit, we'll include articles from our Canadian, Scottish and Northumbria colleagues who are doing Mad Studies in their respective communities.

In addition to Mad Studies, we wanted to make space for a longer piece which tells the story of Garth Daniel's continuing struggle with the psychiatric system in Australia. If Mad Studies is to mean anything at all, it has to be relevant to the ongoing concerns of people like Garth. We also include a reply to Diana Rose's interesting provocation in the previous issue, and as usual we end with a selection of mental health news & findings.

Asylum magazine is proud to announce the coming of age of Mad Studies. For thirty years we've dubbed ourselves *the magazine for democratic psychiatry*. Is it time we stopped orientating ourselves towards psychiatry – whether as 'anti', 'critical' or 'democratic'? Instead, should *Asylum* be the magazine for Mad Studies? Comments from readers are welcome!

We hope this issue whets your appetite. Part 2 to follow... Don't forget to renew your subscription!

Helen Spandler



**LIGHT A
CANDLE FOR...**



**ALL THOSE WHO DOWN TOOLS
TO HELP US ROCK THE BOAT**

Mad Studies 2016: A Situation Report

Peter Beresford

Although a number of developments had already taken place, particularly in Scotland, the Mad Studies Stream at the 2014 Lancaster International Disability Studies Conference was the first major UK mad studies initiative. The second Mad Studies Stream, at the same conference two years later (in September) shows just how much has happened since, both in the UK and internationally.

Mad studies may have originated in Canada, but it is certainly not restricted to that country any longer. Activities are now truly international, if not global, and this was reflected in the make-up of the 2016 Lancaster Stream. A much bigger venue was now needed, and it was filled for every session over all three days of the event. But beyond the event itself, there are now more books, more articles, more seminars and conferences and much more talk about mad studies – at more general mental health gatherings as well as those dedicated to its discussion.

There were new faces as well as more familiar ones, but what seemed to typify this year's Lancaster discussions was the maturity. I especially valued how prepared so many people were to play an active part in the discussions, within a general sense of safety and support. Universities have the resources to support events like this, but their formal paper-based structure and seminar-room environment isn't by any means conducive to more personal and open process. Yet that's what happened – encouraged not least by some thoughtful presentations which powerfully connected people's lived experience with policy, practice, ideas, theory, ideology and politics. I found this a creative, inspiring, supportive and reassuring place to be: there was that wonderful feeling of being among people with shared understandings, of collectivity and a shared commitment to humanistic change.

But this wasn't an inward-looking occasion or an inward-looking group of people. Another sign of the coming maturity of mad studies was the critical edge that it embodied.

One major concern was about who might be being left out of occasions like this – and mad studies more generally – unless firm steps are taken to challenge such exclusions. Particular concern was expressed about the under-presence and marginalization of members of minority or ethnic groups and indigenous peoples. Unless far-reaching efforts are made to challenge such exclusions, there is no doubt that they and other inequalities in relation to gender, sexuality, age, disability, culture, class and so on, will be mirrored in mad studies. Ways to ensure inclusive and equal involvement have been identified and articulated, for example, in the project *Shaping Our Lives: Beyond the usual suspects* (www.shapingourlives.org.uk/documents/BTUSReport.pdf).

During and after the stream, concerns have also been expressed about mad studies ending up as just another elitist avenue of activity from which many survivors are excluded because it is inaccessible in form, process, culture and/or communication. There is no question that this might happen, as it so often has in every kind of campaign and intellectual activity. But we can only challenge such barriers and discriminations by highlighting the threats they pose, and commit ourselves to working



together in a different, more inclusive way, and value the contribution of any mental health service-user; this would include, for example, those with learning difficulties who identify as being on the neurodiverse spectrum, and who communicate differently.

Another emerging concern is that mad studies will be monopolized and dominated by academics. At the heart of the founding aspirations of mad studies was a determination that it must be equally concerned with both activism and theoretical development and debate. The two must have equal weight: one without the other will not thrive; together they offer the possibility of developing a praxis powerful enough to challenge the appallingly resilient structures of psychiatry.

I want to end with one major contradiction mad studies and the Lancaster stream raises for me. There is rightful pride that mad studies isn't the property of any one point of view or group of people. That's as it should be. Equally, it was apparent at the Lancaster Mad Studies Stream that there is no party line or simple consensus among us. Mad studies doesn't belong to anyone, but at the same time we have to become clear and develop the process of negotiating what it must mean for us all. Otherwise it will end up as a vague catch-all that is readily subverted by its enemies and critics.

Other things are clarified for me. Mad studies must be inclusive and anti-discriminatory. It isn't just an intellectual exercise concerned with winning academic arguments in peer-reviewed journals, as part of an academic career. Too much rests on it. Too much hope is being placed in it as a way at last of challenging the dominance of psychiatry and the drug companies. We have to be clear about our principles. I believe that they involve the recognition that survivors' knowledge and experience lie at the heart of mad studies; that it represents a rejection of the prevailing bio-medical paradigm; and that it supports the full and equal involvement of all survivors.

Peter Beresford was joint-convenor of the 2016 Lancaster Mad Studies Stream. He is Professor of Citizen Participation at the University of Essex, and a long term mental health service user/survivor and Co-Chair of Shaping Our Lives, the service-users' and disabled people's national organization and network.

Inclusion Interrupted

Jijian Voronka

A long history of mental health service-user/survivor advocacy and activism has helped make the current moment of service-user inclusion in mental health systems a best practice. Exemplified by the disability rights mantra of 'Nothing about us without us,' exclusion has been a central target of contention, to be redressed through practices of inclusion. Yet, as a culmination of participatory opportunities continue to grow, we now must contend with how our inclusion is being organized. One way in which we are being included is through employment as peer workers: positions that center our lived experiences of distress/contact with mental health systems to help inform diverse mental health projects.

As both a peer worker and an early career scholar, I used mad studies to help guide me through a four-year ethnography of what peer work produces in contemporary mental health systems. This research offered the opportunity to explore inclusion as a technology of rule: how inclusion is organized, managed, contingent, and what effects it brings to mental health systems. I used participant observation as well as interviews with other peer workers to explore how we experience inclusion: What does it mean to do peer work? What is it like to have to work from this identity every day? How do we manage our character, comportment, and self-presentation so that we are recognized as 'peers'? What are we asked to do in our work? Where is our work understood as useful?; And where is our work rendered as useless? How can our identities as peers both disrupt and reify notions of 'the mentally ill' subject? Peers spoke in complex ways about the difficulties in trying to build, protect, and justify their roles within workplaces that make sense of the value of our labour through the unquestioned epistemologies of the psy disciplines.

My research shows that there are clear terms of engagement that manage our inclusion, including that we must be 'authentic' enough to represent the 'mentally ill,' yet simultaneously respectable enough to sustain employment in professional settings. Further, the direction of our work is oriented in very specific ways. Peer work is recognized and celebrated most when we undertake relational work. This means sharing our stories, inspiring others, and trying to help those in distress to 'feel better' through strategies of recovery and resiliency. Yet, when we try to critique or change the conceptual frames that govern us – for example, the policies, regulations, laws, professional procedures, discourses, and structures that are actually producing and sustaining our marginality – our work is ignored, blocked, or gets us into trouble.

In short, when 'exclusion' is positioned as the problem in need of redress, inclusion becomes the answer. Yet we are currently being included into systems that ultimately understand us as the problem that needs to be fixed. Our inclusion as peer workers leaves larger structural inequalities unchallenged. Clearly, our peer work needs not only to be premised on helping to support those made marginal, but

also to orient towards dismantling the systems of oppression that create and sustain our subordination.

Peer work also presents a paradox in labour relations. While peer work offers clear benefits to some of us who are usually excluded from workforces, peer work remains a precarious form of labour that contributes to the deskilling and fragmentation of the unionized health and community service workforce. Most often, peer work is paid less than other professions, and is carried out by people who are marginal not only by virtue of their status as 'mad', but also by virtue of their position in terms of gender, race, class, sexuality, culture and more. Thus, the use of peers in health and social policy delivery is not simply a matter of inclusion, but it also entails a shift towards lower-paid often non-unionized labour, and is thus part of a complex political-economy of carework. Our inclusion changes things: it both benefits us, and creates new complex problems. It also benefits neo-liberal austerity strategies and alters the landscape of how labour is organized in health and social service system settings.



Thus, inclusion is creating new troubles, and mad studies is a field poised to query these new ruling relations. Mad studies should continue to ask: How are our experiences and identities being used to benefit dominant mental health practices? How can we use mad studies as a knowledge-base to help interrupt peer work so that it is not based solely on individual 'lived experience' but also collective social movement politics? What can we do to ensure that our critiques make their way to those already working as peers? Ultimately, how can we ensure that mad studies is useful to peers in everyday practice so that we can push past the constraints that currently bind our roles? ■

Jijian Voronka teaches at Ryerson's School of Disability Studies, and is SSHRC Postdoctoral Research Fellow in the Department of Women's & Gender Studies at Rutgers University, Newark, NJ.

Mad Studies needs to examine its silence on violence

Lucy Costa

We advocates, community activists and Mad-identified have for decades talked about the violence perpetrated by psychiatric treatment and practice, and medicine more generally. While we need to continue those conversations, it is also time we looked at the ways in which violence permeates other less visible sites which are not often studied or discussed. It is time to push the boundaries of how we talk about violence. There are long-held ways in which we discuss violence so as to keep ourselves in a comfort zone within our own activism. At times we are arrogant and righteous instead of thoughtful and focused about how to resolve some very difficult and messy questions.

I am interested in how the project(s) of Mad Studies can better engage and explore violence, and perhaps do the following in the future:

1. Further develop a psychiatric survivor anti-violence framework that analyses and coordinates the fairly disconnected conversations currently in existence, for example, violence as it emerges in institutions, community settings, domestic relationships, racism, LGBTQ communities, etc. (In 2015 this topic was broached after a serious violent incident.* But we need to do more.)
2. Create a violence research agenda which looks at a range of under-researched areas.
3. Develop a key statement on who this research might be for.
4. Identify who we can collaborate with and learn from in our work – including stake-holders outside of our regular circles who have skills and knowledge that we actually need.

This means looking at violence from both the individual and structural angle. I realise the treacherous nature of this discussion given that historically, and at any moment, mental health service-users are liable to be made scapegoats for anything that goes wrong in the world. We can see this pattern playing out in various sites and in sensational media reports, and lately more insidiously in the ways in which intersecting discussions of terrorism, Islamophobia and sanism are playing out. Just as there are efforts to 'destigmatize myths of violence and madness', there are new emergent ways that violence and madness are being surveilled and codified – particularly in relation to race.

The common historical strategy for addressing the prejudice and myths of violence by people with mental

health issues is to deploy the sound-bites that tell the public about 'stigma' and remind us that:

"People with mental health issues are no more likely to engage in violent behaviour than the general population", or that

"People with mental health issues are more likely to be victims of violence themselves."

These are obviously important reminders to the unenlightened, whose fear may be whipped up whenever something happens that they can't understand. But outside of this we have not really developed our own research agenda into the problems of violence as conceptualised and tied to mental health, let alone developed our own communication strategies when violence is perpetrated by someone who happens to have a mental health issue.

Most of the studies that aim to research or debunk causal arguments about mental health conditions and violence are produced by psychiatry or psychology. This should concern us within Mad Studies because we know that both the criminal justice and forensic systems are increasingly incarcerating people with mental health issues. Yet we ourselves have no clear way by which to understand the implications of this or, more importantly, questions concerning our own ethics, responsibility and support for our people moving through these systems.

Lofty arguments for abolition are all very well, but they usually fall short and do a disservice to people who need something in real time and who often circulate through the judicial and prison systems because they have been already been abandoned by friends and family. The last thing we need to do is abandon people by our intellectual theorising.

If we want Mad Studies to be revolutionary, we need to be more thoughtful about how we organise effective opportunities – who to include, and what energies to harness. I think we need to drop rhetoric that no longer serves the most marginalised within our communities. We need new scripts. There is no greater task in the Mad Studies work ahead than to develop a robust critique and analysis of violence as it emerges today, because under current austerity policies people with mental health histories experience an exorbitant amount of violence and are also completely disposable.

So how do we proceed? What frameworks shall we turn to? In Canada, our Indigenous communities have developed a model of 'restorative justice' that foster interventions based in Indigenous legal traditions and seek opportunities for understanding between the victims and the perpetrators of crimes. We can learn (not co-opt) from these interventions, which address accountability. I want also to mention the work of INCITE! – a national activist organization made up of Women, Gender Non-

* See the report at: <https://torontoantiviolencecoalition.files.wordpress.com/2016/02/clearing-a-path-dec-2015.pdf>

Conforming, and Trans people of Color. They are based out of California and have been doing interesting work in addressing structural issues of violence, but have also developed resources that look at domestic violence and community accountability. In the UK there is a group called Salvage that brings together women, transgender and non-binary survivors and activists who experience gender oppression, violence and abuse in activist communities.

The complexity of violence should matter to us. In 2010, the delicate nature of this issue came up at a conference centered on issues relevant to psychiatric survivors. The organisers of the conference had to work through a conflict that arose when one of the accepted presentations was that of a father who had killed his son, after a bout of psychosis. Tensions arose when other conference participants wanted to exclude his presentation, arguing that allowing him to speak was to endorse violence. This is just but one example where negotiation of needs had to be resolved. In the end, the person was able to make his presentation which, in my view, was the right decision. But it was also important to hear the fears and concerns of others, and to discuss male violence.



If you have ever worked at or used a drop-in or shelter, you know these ethical tensions between competing needs come up all the time, and questions arise about how to protect everybody's rights. How do we support and care for each other? So far, we have left the resolution or theorising about violence to psy professionals, and quite frankly, it is time for us take these issues further ourselves and not perpetuate the silence within our own learning and educational work. I have no doubt we are up to the task. It is not going to be easy, but I am sure we can do it. ■

Can we put hurt behind us?

Mick McKeown

It was great to be part of the Mad Studies gathering that has for the second time in two years met under the umbrella of Lancaster's Disability Studies Conference. For me, this involved catching up with activist and academic friends and colleagues, and engaging in a concentrated, supportive and inspirational exchange of ideas. Observing the greater range of interests and perhaps deeper and more sophisticated thinking exhibited this time round, it seemed entirely true when Helen Spandler remarked that Mad Studies had come of age. She also correctly referred to participants' inclination not to shy away from difficult, contentious, provocative or troubling topics, and their ability to discuss them with passion and enthusiasm whilst also taking care over other people's sensibilities and emotions. My contribution to the proceedings certainly

raised some points of contention, and in this piece I wish to address some of the emotional reactions to it and my own feelings.

I don't wish to dwell so much on the content of my talk, as I have written about this quite a lot in *Asylum* and elsewhere (see McKeown et al 2014, McKeown 2016). Indeed, I introduced my talk by referring to myself as something of a one trick pony – my consistent interest being in the potential for forging alliances between radical critics of mental health services and the mental health-care workforce: for example, alliances between public service unions and survivor groupings.

There is evidence of dialogue and debate involving union activists and members, exemplified by campaigning and protest groups such as the Critical Mental Health Nursing,

Social Work Action and Critical Psychiatry Networks, and Psychologists Against Austerity. More critical tendencies such as Mad Studies and Psychopolitics (inspired by Peter Sedgwick's book of the same name) challenge the mental health workforce to think in a more sophisticated manner about alliances on this territory (see the special issue of *Critical and Radical Social Work* 4 3, November 2016: Psychopolitics for the 21st Century). These critical voices variously offer a fundamental challenge to the way mental healthcare is understood and organised. By implication these challenges extend to how trade union activists do union organising, connecting with our mutual interest in fighting neo-liberalism.

In my talk I developed this thinking about connections between social movement and union organising, and considered the appeal for forms of democratisation to be the solution for both better mental healthcare and a more equal society. In the course of this I reflected on violence within mental health settings, and the extent to which a recalcitrant or aggressive disposition amongst service-users could be seen as a legitimate form of resistance to coercion. I then linked this sort of recalcitrance to popular dissent and protests against wider oppressions in the world at large. I concluded by asking those present to imagine the potential for forms of workplace democracy in healthcare settings. One set of possibilities would be new types of organisation which engage service-users and workers in deliberative dialogue to shape the provision of care.

On the whole, this set of propositions was dealt with warmly, and the first couple of responses from the audience appreciated the core argument. The desirability of survivor-workforce alliances grounded in dialogue, and consideration of the practicalities and emotional work necessary to achieve this, provoked a more critical response. This was made most tellingly by another participant, who, visibly upset, recalled examples of pretty awful maltreatment experienced personally and particularly visited on a good friend, to pose the challenge: "You don't know what you are asking me to do. This is too much to ask." It was apparent that if it involved starting conversations with a mistrusted workforce, or at the very least elements within it, the appeal to forge alliances was a step too far.

This was a difficult moment for me since I felt obliged to provide an answer, but there wasn't much I could say that could come near to healing that hurt or providing a reasoned bridge towards the case I was trying to make for alliances. In the event, I stumbled through some sort of reply that put the onus primarily on the workforce for initiating alliances and attending to such raw experiences and emotions, whilst also recognising and attempting to resolve obvious imbalances in power. If I am honest, I also felt that I was carrying the blame for hurtful and damaging services, and this was uncomfortable to say the least. During and after this exchange, however, I was also conscious of a comment from one of the previous sessions where a survivor involved in practitioner staff-training had noted with frustration the ever-present 'requirement'

to be sensitive to the potential for upsetting staff when inadequate care (or 'improvement to care') is under scrutiny. So I felt uncomfortable and even a little unfairly dealt with, but my unease was in no way commensurable to the distress of my interlocutor. Furthermore, whether or not I felt personally responsible for any of this was moot, given that my previous experience as a mental health nurse indicates complicity within the very system that had caused this enduring pain and upset.

Talking later with various conference delegates, the complexities and challenges of finding solutions that might engender a better starting place from which to consider workforce-survivor alliances remained apparent. Some of the ideas we returned to include the fact that Mad Studies does explicitly call for diverse alliances, and that seeking and sustaining them might be ever more warranted in contemporary neo-liberal times. Similarly, simply seeking an end to psychiatry without thinking about alternatives or the tactics by which both might be achieved may be wilfully naïve, which makes a further case for broadly-based alliances. In the end, we agreed that for such alliances to embody true solidarity, rather than be merely temporary or an expedient response to specific circumstances, we need a way to heal previous damage and provide restitution. One possibility is to enter into some sort of 'truth and reconciliation' process as a necessary precondition for future political alliances and the building of alternative more relational care services. There are models for such an approach and, notably, groups like the ICARUS project have made a start.

All of us committed to a new politics of mental health – survivors and critically-minded care workers – have a real interest in whether these initiatives prove successful, or even in what we can learn from failures. I hope we can all find the necessary courage to enter into dialogues of healing and solidarity, and that the aforementioned initiatives and forums for critical thinking provide some of the safer spaces where this might take place. Together with other comrades in the union movement, I am acutely aware that the obvious asymmetries in power and hurtful consequences demand that we workers offer the olive branches, show appropriate humility and compassion, and are prepared for legitimate criticisms or people refusing to take part. I hope this small contribution is such an olive branch, and that at the very least it might result in some thoughtful and kind reflection of the sort that was hearteningly to be found in large measure in the Mad Studies stream. ■

References

- McKeown M (2016). Educate, agitate, organise! The democratic challenge facing workers and survivors. *Asylum* 23(2): 9–10.
- McKeown M, Cresswell M & Spandler H (2014). Deeply engaged relationships: alliances between mental health workers and psychiatric survivors in the UK. In Burstow B, LeFrancois BA & Diamond SL (eds). *Psychiatry Disrupted: Theorizing resistance and crafting the revolution*. Montreal: McGill/Queen's University Press.

Disabling Madness: Disrupting the mind-body divide

Sarah Golightly

I was in London at a large community arts event, speaking as part of a panel on mental health. I spoke of my experience with a rare form of non-cancerous tumour that is attached to the brain and causes an array of distressing effects, including an extremely high level of the ‘stress hormone’, cortisol. These high hormone levels contributed towards my feelings of depression at the time. This experience changed my perception of the distinctions people often make between the physical or neurobiological aspects of our health, as separate from the psychological or social. I spoke about taking antidepressants, and that I found them moderately helpful. To me, it was clear that my experience of depression was a part of my social context, my psychological coping, and the neurobiology.

Suddenly, I was interrupted. Another panelist, an anti-psychiatry activist, declared that my high level of cortisol “was probably caused by medication!” Interesting, I thought, that someone who had listened to me speak for less than five minutes, and who knows much less about my health conditions and my medical history than I do, has already concluded for me the root of my problems!

It’s not the first time that I’ve come across this kind of attitude, unfortunately. It reminded me not only of many anti-psychiatrists I have come into contact with but also of the psychiatrists: with little or no input from me, both types have hastily come to conclusions and declared what is the best course of action for my health.

Many people in the audience spoke to me afterwards, saying that they are worried that if they talk openly about choosing to take medication for their mental health they will be judged or lectured by their activist peers. This led to me think about why so many people have invested in a logic that disconnects the physical or neurobiological from the psychological or emotional. Why can’t we look at neurobiological ways, as well as social and psychological ones, as connected parts of who we are, and include them in our approaches to survival and coping?

I’m not trying to minimise the differences between physical and psychological experience. Instead, I aim to encourage thinking about those experiences as connected. We can’t live physically without living psychologically, and vice versa. I think of the psychological and the physiological as necessarily intertwined. I wouldn’t even

stop at ‘intertwined’. What we, in Western societies, imagine to be ‘psychological’ or its supposed opposite, ‘physical’, is a distinction made by doctors, by society, by capitalism. It’s a cultural practice in mainstream Western societies. There’s no real way to definitively separate ‘mental’ from ‘physical’, just a bunch of cultural traditions that lead us to do this – traditions now so normalised that we often don’t even think twice about it.

However, many health experiences trouble these distinctions, complicate this cultural tradition, and are part of an ongoing debate as to whether they should be considered physiological or psychological. For example, chronic fatigue syndrome/myalgic encephalomyelitis (CFS/ME): a mental health condition or a physical health condition? Ask different people and you will get different answers. There is no clear way for me to distinguish between physical and psychological symptoms, my mental from my physical health. In my experience, categories of physical disability, chronic illness, mental distress, as well as learning differences, always overlap. It feels restrictive to compartmentalise, to try to pigeonhole complex experiences as belonging only to one category or the other.

I’m concerned about the way some Mad and/or anti-psychiatry activists and academics adopt a stance of total opposition to medications for mental health purposes. Firstly, the argument that psychopharmaceutical medication is unacceptable but other medications are OK is based on a misunderstanding of the role of medication and science in the social construction and treatment of physical disabilities. Secondly, claims that all psychopharmaceutical medications are essentially harmful overrides the voices of those who experience mental distress and find them useful. Third, we need to have theory and activism that think across oppressed communities, including those for whom medical access is vital – otherwise we risk inadvertently contributing towards the damage wreaked by current austerity measures.

I’m concerned about the way in which some anti-psychiatry and other mental health activists have ‘othered’ physical disability and chronic illness. By this I mean that some mental health activists have tried to establish that medications are unnecessary (or, in their view, harmful) to those experiencing mental distress because, unlike

physical health, psychological distress doesn't manifest as a 'provable', i.e., measurable, condition. Certainly some medications seem to have a more direct and 'provable' impact on physical disability. However, many physical conditions are not diagnosed by means of traditional scientific measurements such as tests and observations. For example, chronic pain is usually diagnosed according to how a person describes their feeling of ongoing pain; also, where certain other explanations for the pain have been ruled out since there is no way of measuring pain by means of an observable test such as by blood, X-Ray or MRI. All 'disability' diagnoses are a labeling exercise that depends on where and who you are in society, and how 'functional' your body and mind is deemed under capitalism.

Unfortunately, it is very common for those of us who experience mental distress – as well as for many others who live at society's margins – to have our views written off. What's perhaps less expected, but equally troubling, is when this is done by people with a shared experience of mental distress. I have heard arguments in which people insist that service-users who find medication helpful are either brainwashed or only experience a placebo effect. This suggests that we, as service-users, are not able to judge and identify for ourselves what is best for us. This is another way in which we are pathologised, stigmatised and have our decisions deemed disturbed or invalid. To argue that there's 'no proof' of psychopharmaceuticals being helpful is to imply that we need scientific 'proof' to validate our choices, rather than to listen and prioritise the perspectives of those with service-use experience, albeit with perspectives that may seem controversial or inconvenient.

This is not to say that we can't be critical of the enormously wealthy companies that profit from medicating our distress. Anti-psychiatry has made important contributions concerning medical companies funding research trials, university departments, hospitals and doctors so as to gain influence over what medications are endorsed by the medical authorities as 'effective'. Those who refuse medication, especially those hospitalised against their will, often face the consequences of having other aspects of their care obstructed, or they experience coercion and violence from staff. Others may feel they have little choice, or have received misinformation or no information about the medication, and any rights they may have to refuse treatment. In this context, we must consider elements of coercion behind what is often presented as 'choice'. However, it is disingenuous and disempowering to argue that nobody can make an informed decision about their health if they have been in contact with medical professionals. People can still choose to take medication, even if we acknowledge that more needs to

be done to challenge coercive practice and authoritarian structures.

It is important to recognise that we cannot take our theories, our practice or our activism out of the social, economic and political context in which we live. Austerity is crushingly cruel to large swathes of society, especially the most marginal. We need to think about how the government could easily co-opt a radical anti-medical campaign into its cost-cutting agenda. This could have a devastating impact on those who have been campaigning hard for increased access to adequate medical care. For example, trans and gender non-conforming people in much of Europe and North America have been working hard to improve their access to gender-affirming medical care (such as hormone replacement therapy), and for trans awareness in healthcare more broadly. Given that access to healthcare and resources are both already scarce, an un-nuanced campaign to end medicalisation may contribute to further restricting access to the medical care that we do want.

In these circumstances, we need to build alliances and think beyond what might be immediately visible from our own point of view. We have seen, for example, time and again that many regions in the US and the UK will take advantage of the opportunity to cut costs by closing mental health hospitals and then provide very little support for those who need mental health care. As mental health hospitals are closed, prisons are being built, and both are increasingly outsourced to private for-profit companies such as G4S. These companies profit from cruel human rights abuses on a global scale, and of course the poor and people of colour are particularly affected. It seems that a high proportion of those in prisons and immigration detention centres suffer from serious mental health problems; this is exacerbated by the traumatic impact of incarceration itself. We need to include these issues as essential concerns of Mad Studies and Mad liberation.

We cannot address the oppression of Mad people without working collaboratively. Not only do we need to think about the biological, psychological and social aspects of our health, but we also need to look beyond. We need to rethink power. We need to demand a re-definition of the agenda, whereby service-users aren't just tokens at the top table but rather where we shut down the boardrooms and create our own conversations, on our own terms. We need to re-examine current knowledge to think creatively and critically about practical ways of building a powerful movement. This requires going beyond the traditional boundaries of psychology and physiology, removing the restrictions on the way that we see the world, how we see ourselves, how we build alliances in resistance movements, and how we work together to fight oppression. ■



Book Review

Searching for a Rose Garden: Challenging psychiatry and fostering Mad Studies.

Jasna Russo & Angela Sweeney (Eds)

PCCS Books, 2016

ISBN - 978 1 910909 23 1

This anthology emerged from an international conference organized by the Association for Protection against Psychiatric Violence. Held in Berlin in 2011, they called it 'Searching for a Rose Garden: Fostering real alternatives to psychiatry'.

I've been steeped in discussions about 'challenging psychiatry', 'developing alternatives' and 'user-led initiatives' for years. I confess I somewhat arrogantly wondered if I'd learn anything new from this book. Well, that's another lesson in humility. Believe me, there's plenty of new ideas, reflections and wisdom here. I'm not going to list them, but you'll find plenty, if you take the time to look.

Searching for a Rose Garden has more than twenty chapters about survivor-produced knowledge, survivor-controlled practice, and partnerships with allies – mostly in the UK, but also from the USA, Canada, Australia and India. Most of the contributors are self-defined service-users or survivors. The breadth and depth covered reminds me of Peter Stastny and Peter Lehmann's *Alternatives Beyond Psychiatry* (reviewed in *Asylum* 17(4)). Both books are excellent and indispensable resources.

At the outset, I wondered: What is this Rose Garden? I was a little frustrated that it wasn't immediately defined. I assumed it was inspired by Joanne Greenberg's autobiographical novel *I Never Promised You a Rose Garden*, based on her experience as an in-patient at Chestnut lodge in the US. But I couldn't find many references to that. Since Greenberg's recovery came about through intensive psychotherapy, I assumed this wasn't the rose garden sought here. Well, what then? A survivor-led holy grail? I was a bit worried: is this what users and survivors want? What if it becomes dogma? What if it's imposed on people? Wouldn't that be just like psychiatry? Then I realised I was missing the point. And I was getting ahead of myself. My worries became less relevant if I dropped my need to know what the rose garden is, or should be.

This book is not intended as a blueprint. It not necessary to define the rose garden, nor to create it, or even to see it as intrinsically desirable. Rather, as Jasna Russo says, the value of the rose garden lies in '*our right to search for it ourselves*'. This deceptively simple statement is probably the most powerful message in the book. It's easy to forget. It's easy to jump in with criticisms or solutions. It is not so

easy to let go and offer the space and support for this to happen.

Erick Fabris argues that the search may not result in theorising the 'correct alternative' (the rose garden itself), but it may create possibilities of developing ways to avoid the worst kinds of practices, such as compulsory treatment. Roses, he says, might not be what the Mad movement needs, and 'promising' them would be too psychiatric. Roses might be pretty, but the thorns can hurt, if not approached carefully. I guess that's the mixed blessing of the metaphor. Yet, as Russo argues, 'it is still a revolutionary act when we – 'cases to be managed' and 'problems to be solved' – take the lead in defining support and generating knowledge about madness'. Drawing on Eliot's *Four Quartets*, Terry Simpson suggests the rose garden is a metaphor for the path not (yet) travelled.

What role is there for allies in this search? Cath Roper's chapter suggests that allies have a role in facilitating the material conditions and environments conducive to the growth of survivor-leadership and -knowledge. As a self-defined 'Mad positive' ally, Kathryn Church says 'I may not be able to do this 'insider' work myself, but I can recognise its profound value and stand with you as you do it.'

There is no neat conclusion to this book. Instead, it ends with each of the contributors posing questions for us all to consider – which is a neat way to conclude.

However, in the context of the main focus of this issue of *Asylum*, it would be remiss not to ask: What's the connection to Mad studies? It seems the decision to refer to it in the book's sub-title was made late in the day, and so not many contributors explicitly reflect on it. However, in her chapter Russo argues:

the creation of a new paradigm for understanding and approaching madness lies in our own hands... We have a choice: we can either let our differences forever divide us and inhibit the work we do together or we can find a way to embrace them and let them deepen, broaden and enrich the uniqueness of our contribution. (Russo 2016, 67)

If that's what fostering Mad Studies is all about, then count me in. What kind of garden do we need for Mad Studies to grow? ■

Helen Spandler

Two years of Mad Studies organising in the UK

Brigit McWade

What a difference a (couple of) year(s) makes!

I was incredibly moved by the success of this year's Mad Studies stream at Lancaster Disability Studies conference. I couldn't possibly list my highlights here – it was the whole event! The atmosphere, the knowledge shared, the rich discussions, and the people. Instead, I'd like to look back at Mad Studies organising in the UK over the past two years, to share some of what I've learned about creating mad owned spaces and centring mad knowledges.

Just over two years ago, my colleague Hannah Morgan (now Director of the Centre for Disability Research, Lancaster University) invited me to work with Peter Beresford to put together a Mad Studies 'stream' as part of the Centre's well-established and internationally recognised Lancaster Disability Studies conference. Since then, there have been several UK events specifically exploring what Mad Studies is and what it might offer us in terms of critical thinking and activism around madness and distress. Alongside these events, more Mad Studies books, journal articles and blog posts have been published, community-based courses have been developed, and there are now at least two Mad Studies Facebook groups.

The first Mad Studies Stream. Lancaster University, 2014

In 2014 we approached the stream organisation in quite a loose way. We received (and accepted) fifteen abstracts from people whose work was about the politics of madness and distress, but they didn't all necessarily badge their work as 'Mad Studies'. We were lucky enough to have leading Canadian Mad Studies activists and scholars present, who discussed what Mad Studies is or might be (Brenda LaFrancois), the challenges of making space for Mad Studies within the neoliberalising university (Kathryn Church), and the practice of teaching Mad Studies to liberal arts students and psychiatric residents (Jijian Voronka and Lucy Costa). There were also presentations about neoliberal policy and practice covering recovery, welfare reform and anti-stigma campaigns (myself, Kate Mattheys and Victoria Armstrong, respectively). The areas of education and employment rights were addressed by Feredic Fovet and Rosalee Dorfman. Questions concerning the costs and benefits of working in alliance with professionals, other disability groups, and trade unions were variously discussed in papers by Lucy Costa and Mick McKeown, and in general discussion. Two papers, those by Alison Wilde and Helen Spandler, and Jill Anderson and Bob Sapey, explored representations of and engagement with the alleged link between madness and violence. As part of

the programme we dedicated the last session to an open discussion, and highlighted themes that required more time and space for discussion – two of which were the link between neurodiversity and mad studies, and violence and madness.

Mad Studies & Neurodiversity: exploring connections. Lancaster University, 2015

The following year, funded by CeDR and Lancaster University's Sociology Department, myself, Peter and an informal advisory group (Damian Milton, Hannah Morgan, Helen Spandler, Steve Graby and Larry Arnold) organised a one-day symposium taking up the topic 'Mad Studies and Neurodiversity: exploring connections'. This issue had been raised in a chapter by Steve Graby in *Madness, Distress and the Politics of Disablement*, and we celebrated the launch of this new work with editors and contributors the evening before the symposium.

With the organisation of the first Mad Studies stream under my belt, I turned my attention to learning more about how to fully open up university spaces in an inclusive and accessible way. The event was free. Drawing on expertise from the Autscope conference (organised by and for the neurodivergent community) we adapted the Shaping Our Lives ground rules for engagement, to include waving rather than clapping, and experimented with the lighting and organisation of the furniture. Each speaker was either neurodivergent, mad-identified or mad-positive. We discussed the connections between identity, bodies or embodiment, organising, knowledge and space. Members of the Oor Mad History collective talked about the Mad People's History and Identity course at Queen Margaret University in Edinburgh, and how creating a 'mad owned space' was an important element of their teaching and learning practice. Artist Lyte Moon invited us to consider how to de-institutionalise our thinking and our organising. Creating space for Mad Studies with an academic environment is a physical and material practice as well as being concerned with changing knowledge and research practices.

Making Sense of Mad Studies. Durham University, 2015

This conference took place a few months later, organised by Victoria Armstrong and the North-East Mad Studies Forum, and funded by The Wellcome Trust. It was free, and the organisers offered bursaries to help with travel and accommodation. Keynote speakers were Peter Beresford, Brenda LeFrancois and Richard Ingram. Alongside research papers, many presented on their experiences of teaching Mad Studies. There were some great artistic interventions, and a panel discussion exploring the issue of publishing Mad Studies work. During our two days together an interesting set of questions emerged concerning the canon of Mad Studies and whose knowledge counts. Was Mad Studies really rooted in the thinking and writing of a set of dead white men such as RD Laing, Michel Foucault and Thomas Szasz? What is the connection between Mad Studies and Disability Studies? Or Mad Studies and Cultural Studies, Feminist Theory, Postcolonial Theory,

and so on? Is its canon only made up of knowledge created within academic institutions?

The 2nd Mad Studies Stream. Lancaster University, 2016

In 2016, Hannah once again supported Peter and me to hold the second Mad Studies stream at the Lancaster Disability Studies conference. This year's conference was the biggest in the conference's history, with more than 275 delegates from all over the world.

The approach to organising this stream was a lot more carefully considered and selective than in 2014. Key decisions in organising the 2016 stream began with negotiating the material barriers. Lancaster Disability Studies conference is an academic conference, and delegates have to pay a fee to attend. Many academics have access to institutional funding to attend conferences because it is part of their job to present research findings to academic audiences on a regular basis. However, if we were to ensure the inclusion and participation of non-academic community members in the Mad Studies project, and others on insecure incomes, it was important to offer free or subsidised places and travel bursaries. The conference has always offered subsidised places and bursaries, and this year Hannah and I increased the number available. We also ensured that the student/unwaged rate was frozen at 2014 rates. In addition, I secured sponsorship from PCCS books for two places at the conference, including accommodation and meals, and ran a crowd-funding campaign that raised enough money for three more places. Competition for these funded places was high, and making the decisions about who to fund was emotionally tough.

Organising the 2016 stream was also an exercise in finding a balance between recognising Mad Studies roots and making space for newer voices to be heard. We received more than forty abstracts, and this time around many of them – from well-established community organisations to postgraduate students to academic researchers and activists from across the globe – were explicitly named as 'Mad Studies'.

We aimed to include as many contributions as possible, and made some key decisions in our selection process. We decided to prioritise paper presentations which shared the findings of empirical research and also considered intersecting oppressions. Those presentations discussing teaching Mad Studies or the experience of madness were invited as poster presentations. We also assembled a special panel discussion on the relationship between Survivor Research and Mad Studies. For my part, I carefully curated the programme so that papers in each session were organised around themes such as gender, alliances, sexualities, and the mind/body split. It was like making the best Mad Studies mix tape.

This approach to programming meant we covered a lot of ground, and sites of discussion included rape culture and sexual abuse, migrant lives and citizenship, the role of service-user organisations and peer workers in changing the system from within, the shared histories and theories of LGBT and mad activism and scholarship, marginalised identities and experiences within mad communities such

as borderline personality disorder (BPD) and physical impairment, the role of medication, and our relationship to and understanding of science, in particular medical science.

We were delighted to have two keynote speakers, both closely linked to the development of Mad Studies in Toronto, Canada. Lucia Costa, an activist and advocate, has most recently galvanised survivor-led activism and research into the issue of violence in the lives of people living with mental health diagnoses, from a Mad Studies perspective. Jijian Voronka's cutting-edge work addresses questions of inclusion and peer-work in mental health, and Jiji has extensive experience of teaching on the first ever Mad Studies course, offered at Ryerson University's School of Disability Studies for more than ten years.

Lucy and Jiji drew on a wealth of experience to show us what Mad Studies can do to move the conversation about 'mental health' beyond the status quo. They raised important questions about how we might organise our work and activism since forms of oppression are shifting. Many of our presenters also came with ideas that sought to refresh or rewrite dominant arguments within the survivor/mad movement. These contributions drew on a rich combination of mad knowledges and postcolonial theory, queer theory, feminist theory, critical race studies, and cultural studies to situate madness and distress and connect it with other forms of power, identity and oppression.

This is a significant move away from situating Mad Studies as a continuation of white, European thinking and critique. This feels especially important. If Mad Studies is to break down boundaries and address inequalities, both in the way we know madness and distress, and how we live with those experiences, everything that has come before cannot just be re-named Mad Studies, but nor can we just collectively go about re-inventing the wheel.

What next?

Working from inside the academy, I have spent two years learning and organising around Mad Studies in the UK. I am inspired by those who are creating different spaces within and outside of the university. But my hope is that we don't continue to reproduce that distinction too strongly, because it is divisive. Neither 'the university' nor 'the community' are singular entities. In my experience of working in a university, you can always find pockets of people who think critically and fight a daily battle to keep that space open for thinking and doing things differently. Community organising principles can work in academic spaces, and some academic practices can work to build communities across that border, providing resources and ensuring that we get the most out of the time and space we have together – since this is always limited.

I have witnessed a great enthusiasm for these opportunities. But they require careful work if they are going to succeed. I look forward to attending future events and the continued collective conversations to come. ■

***Brigit McWade**, at the Department of Sociology, Lancaster University, was co-convenor of the Mad Studies streams in 2014 and 2016.*

CONFERENCE 2017

The '**ASYLUM: ACTION AND REACTION**' conference will be held in **Manchester on 28 June 2017**, 10.00am to 5.00pm. Join us. We have some great speakers – more details soon.

This will be a very special event, a day conference in Manchester to celebrate over thirty years of ASYLUM: International Magazine of Democratic Psychiatry. It will be held in the University of Manchester on Wednesday 28 June 2017. It will be an all-day low-cost conference, with a lower rate for subscribers to Asylum Magazine which will cover refreshments on the day. The theme of the day will be 'Action and Reaction', and we have in mind by that title a range of possible meanings, which include the kind of political action we need to build to defend our rights and build better services, and the struggle against reactionary attacks on mental health provision, and we have in mind the kind of action that we collectively take and responses to what Asylum has been doing so far.

The low registration charge for the conference will just cover the costs for the day. We are asking you to come to Manchester to be with us and many other activists, survivors and their allies. This will be a chance to take stock and discuss what we do next, and to share action about the many different kinds of networks you are involved in, to build those networks together.

Please let us know about any dietary requirements. The cost of registration will cover refreshments and lunch.

Tickets:

£10.00 for Asylum Magazine subscribers

£30.00 for non-subscribers
(includes a one-year subscription to
Asylum Magazine)

Contact: asylumconference2017@gmail.com

Asylum website

www.asylumonline.net

Conference registration is at:

www.pccs-books.co.uk

Click the 'Asylum Conference 2017' link

ISPS

ISPS – The International Society for Psychological and Social Approaches to Psychosis

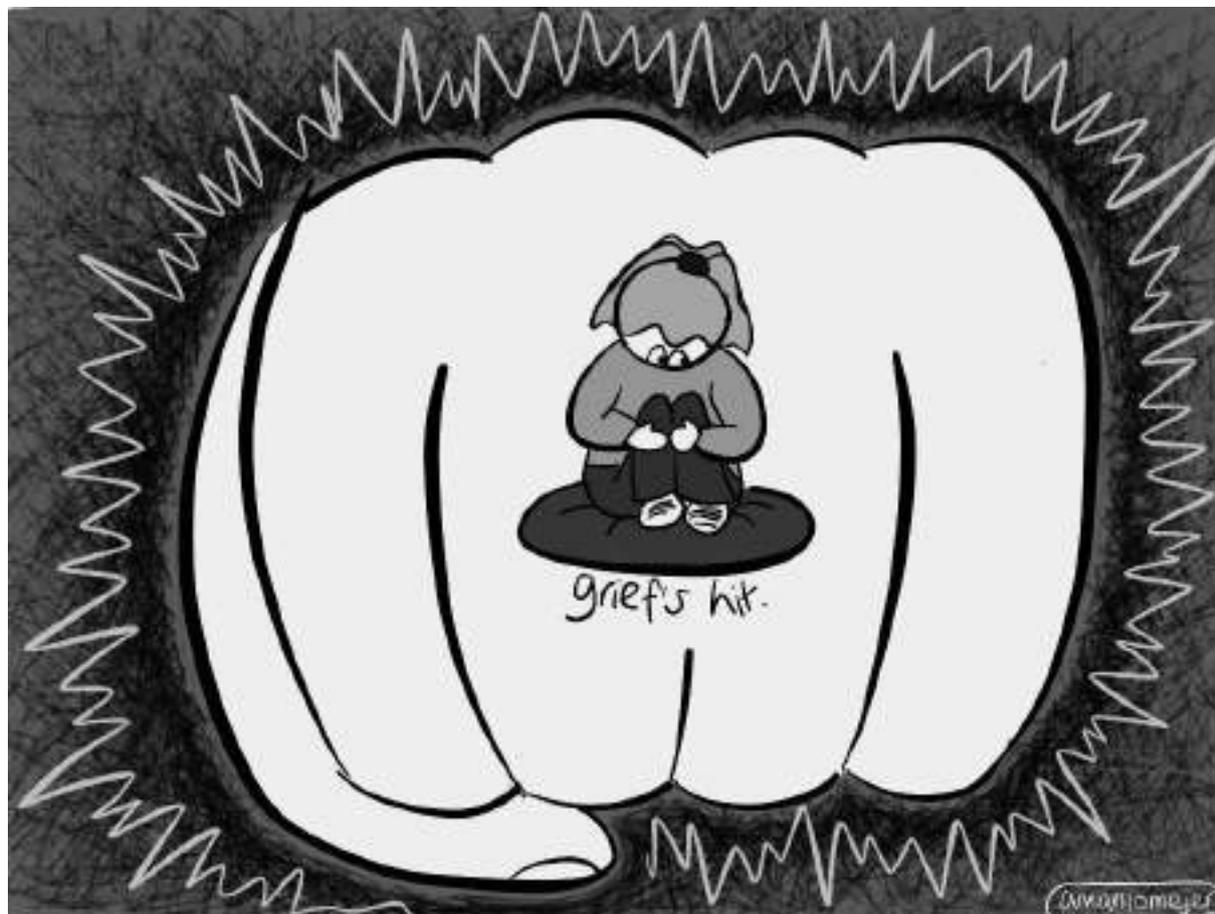
MAKING REAL CHANGE HAPPEN

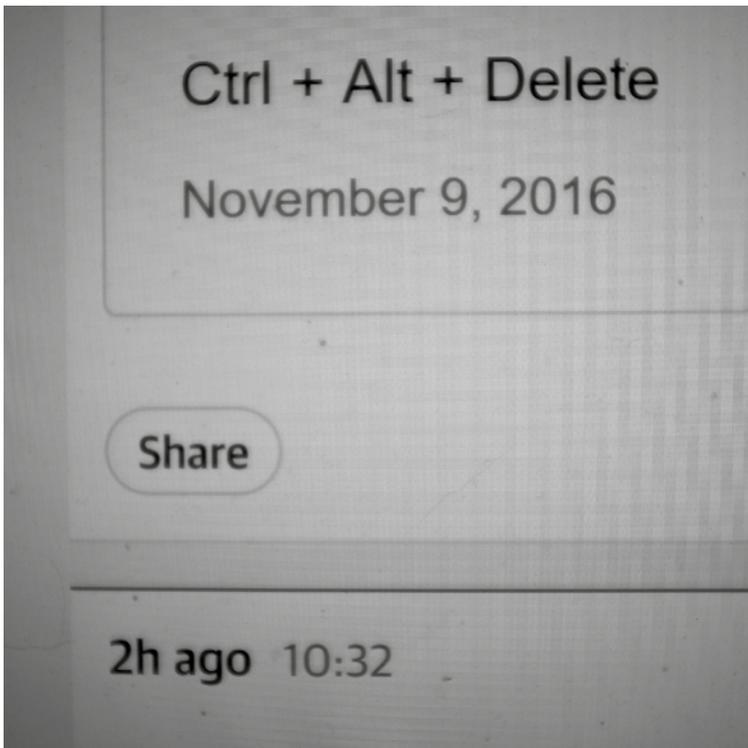
ISPS Conference in Liverpool, 30 August – 3 September 2017

Interested in Psychosis? Interested in real change for the better? The ISPS 2017 conference in Liverpool, UK is for you, whatever your discipline and if you are a service user or carer. The International Society for Psychological and Social Approaches to Psychosis conferences have an outstanding reputation for vibrancy, conviviality, breadth of presentations and social events.

Please go to www.isps2017uk.org

Images by Amani Omejer





'Ctrl + Alt + Delete'

Image by Sean Burn
from the Mad Studies North East Collective

RENEW YOUR ASYLUM SUBSCRIPTION FOR 2017 NOW - CALL/WRITE/ONLINE

PLEASE SUPPORT ASYLUM

SUBSCRIBE <> CONTRIBUTE <> SUPPORT

subscribe online at www.pccs-books.co.uk - where you can also buy a digital version of *Asylum* or telephone 01600 891509 Monday-Friday 9am-5pm to speak to a real person or complete the form below and post it

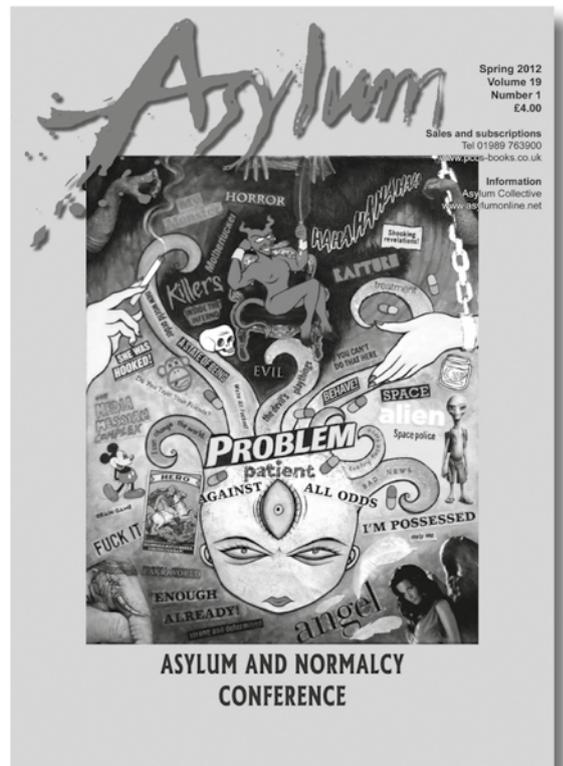
Printed paper subscriptions, please tick one:

- | | | | |
|------------------------------|--------|--------------------------|-----------------------|
| UK individual | £16.00 | <input type="checkbox"/> | Support <i>Asylum</i> |
| Overseas individual | £18.00 | <input type="checkbox"/> | by distributing the |
| Individual digital version | £12.00 | <input type="checkbox"/> | magazine. Call |
| UK library/institution | £90.00 | <input type="checkbox"/> | 01600 891509 for |
| Overseas library/institution | £95.00 | <input type="checkbox"/> | bulk discount rates |

Name.....
 Address.....
 ZIP/Postcode.....

Pay by:

- Cheque (make payable to 'PCCS Books Ltd'), return form to: *PCCS Books, Wyastone Business Park, Wyastone Leys, Monmouth, NP25 3SR*
- Credit/Debit cards accepted: Visa, Mastercard, Maestro, Solo. Fill in form and return to address above or telephone 01600 891509
 Card Number.....
 Valid from..... Expiry date.....
 Security number (last three digits on back of card).....
 Name of cardholder as printed on the card
 Billing address if different from above.....
ZIP/Postcode.....



Garth Daniels' struggle against

VINDICTIVE PSYCHIATRY

'Insanity: doing the same thing over and over again and expecting different results.' Albert Einstein

1: THE PSYCHIATRISTS ARE ALWAYS RIGHT

'Who is the danger – the lab rat or the psychiatrists?'

Bernard Daniels

Garth Daniels is an Australian citizen, notorious within the psychiatric system. His blog has been running since 2008, and a campaign has been waged for his human rights – especially with regard to the cruel manner in which he has been subjected to an exceptionally prolonged series of shock treatments.

Garth's career as a psychiatric patient began in 1996, when he was 21, and he has been in and out of hospital for years – often apparently to his benefit. However, his health and psychological condition did suffer almost immediately from serious psychotropic drug reactions, and he and his family have been in dispute with the psychiatrists about the treatments for years.

In 2011 rancour between the two sides culminated in Garth being transferred to a forensic hospital without having committed a crime or been found guilty in a court of law. There he was held prisoner along with convicted rapists and murderers, put in seclusion for fifty-five days straight, and administered a cocktail of drugs and intramuscular injections; along the way, they managed to break his jaw. This, they said, was all 'for his protection'.

Next Garth found himself in a university teaching hospital, shackled to a bed in four-point restraint for nine weeks. Against his will, he was given intramuscular injections of Acuphase 'to cure his violence'. This drug causes akathisia - the inability to be still (aka restless legs syndrome). He was also given a drug to prevent deep vein thrombosis (DVT); this drug caused itching and hives on the skin which he was unable to scratch because he was shackled down. The doctors didn't tell anyone that the drug was to counteract the DVT 'side-effect' of Acuphase, and no-one mentioned that the akathisia could be due to intra-muscular injections of Zuclopenthixol (decanoate) or similar compounds of Acuphase (clopixol). Instead, the restlessness was said to be an emerging psychosis



'exacerbating aggressive and violent behaviour'. But if someone is tied down and tortured by excruciating akathisia and itching, how else can he resist except by screaming and spitting? This only confirmed for the officials that 'he is a violent patient'. By this time Garth was also suffering from tardive symptoms including Parkinson-like tremor, treatment emergent Neuroleptic Malignancy (NMS) and a state of delirium.

It was then decided that his situation was life-threatening and he needed to be released from the restraints. But this could only be done if he was given continuous ECT so as to quell his 'violent behaviour', which the doctors attributed to 'a chronic condition of treatment-resistant schizophrenia'. Never mind that his so-said violence – resistance – was a response to the dire iatrogenic effects of the drugging.

Freed at last from the restraints, Garth was attacked on four separate occasions by a fellow patient who managed to break an arm and a finger. The official response was to call the police and have Garth re-shackled. No-one asked him what had happened – everybody assumed it was his fault because he is 'known to be violent'. He was given another blood-clot prevention drug in his stomach (Clexane and Fragmin), and he still bled from the wounds. The other patient – the 'untroublesome' one – was discharged.

Garth was told that they would stop giving him shock treatment if he would agree to having Clozapine. Since he would not consent, they applied to the Mental Health Tribunal for twelve more shocks: they intended to shock him until he consented to Clozapine. Of course, after more than a hundred shocks his mind was dulled, but he did understand they wanted to lock him away and administer the antipsychotic.

When he protested that he has a heart condition and Clozapine affects his immune system and can cause agranulocytosis, they said: 'It's ok, we will monitor any side-effects. That's why we need to keep you in hospital

for eighteen weeks: if your immune system fails or you have a heart attack you are already in hospital! He didn't consent to any of it, so they continued with the shock treatments.

Apart from the right to refuse treatment, the State of Victoria Mental Health Act (2014) provides for a patient to prepare an Advanced Directive and to assign a Nominated Person to exercise his rights under the legislative provisions should the patient become incompetent. In Garth's case, the officials simply ignored those fundamental principles. The clinical director applied to have his own choice of guardian appointed, and to have Garth sent to a Secure Extended-Care Unit.

When he was transferred between two health authorities, both said the other was responsible for his treatment. And so the person nominated as an 'ally' and who had been granted medical power of attorney, along with advocates, now grapples with the psychiatrists in the Supreme Court of Victoria, trying to determine exactly who is responsible for deciding his treatment.

Meanwhile, the clinical director at Garth's psychiatric hospital applied to the Victoria Civil and Administrative Tribunal to remove Garth's father's Power of Attorney (Medical Treatment) and legal status as Enduring Guardian. While this hearing was taking place Garth went AWOL and the family moved to Queensland.

The family decided to resolve everything by leaving the State of Victoria, and had gone by the time their home was raided by the police looking for Garth. No more shocks, no more being tied to a bed, no more torturous akathisia... he was free! Three months later there was an emergence of the traumas, but after a short spell in hospital he was out and free again. But then he began to relive his awful experiences (PTSD), and he found himself once again on a dreaded involuntary treatment order (ITO). He was relieved when they assured him there would be no electroshock.

In Queensland, Garth has a psychiatrist who favours psychotherapy and tries not to use anti-psychotics. But he was taken to hospital in Brisbane in August, and despite assurances to the contrary, was again locked-up in isolation and forcibly medicated without his full and informed consent and against the advanced directive. They forced clozapine on him by spraying it into his mouth. Because he resisted, they charged him with assault. No longer resisting, he insisted that he knew the risks of that drug, and the treatment was under duress: HE DID NOT CONSENT. Kept in a high-dependency locked ward, he was told his clozapine levels had not yet been reached, although they never said what level needed to be reached. Were they experimenting on him? Without informed consent, this treatment surely violates his human rights – it is 'cruel and inhuman treatment' – and it seems to be sanctioned directly by the Government.

In 2008 Garth's father wrote: 'After 1996, Garth Daniels' mental health spiralled downwards into a never ending abyss of more psychiatrists, more involuntary stays in psychiatric facilities, then in 1998 Zyprexa, more "episodes", and more misery for him and his now helpless family. The simple fact is that Garth Daniels has never recovered from the initial prescription of drugs and [unconsented] drug trials, and it looks as if he never will. But mental illness, whether caused by dubious drug trials, over-recommended levels of Zyprexa or forced imprisonment is still not the real issue: Human Rights need to be extended to all human beings and this includes those subject to the Mental Health Act.'

2: TWENTY YEARS OF MISTREATMENT

Garth Daniels was unfortunate to encounter a coterie of particularly tacky doctors, but those gentlemen are probably not so exceptional. Power corrupts, absolute power corrupts absolutely. It is natural for any kind of officials to work to their own agendas: as long as they can get away with it, they will run through the motions and try on whatever is easiest for them, and damn the human consequences.

And if it can plausibly pass for a normal and reputable medical procedure, psychiatrists are used to getting away with almost anything they like – up to and including murder (most commonly by over-sedation). Psychiatric patients are a particularly vulnerable kind of 'client', and so checks on the uses and abuses of official power ought to be particularly robust. But they are not. In the UK, for instance, the routine possibility for legal oversight was abolished in 1959, and the doctors were left to their own devices. Throughout the world, policing, prosecuting and judging psychiatric crimes, misdemeanours and misjudgements is left entirely to the doctors themselves.

Since 1996, at least 400 different psychiatrists have been variously involved in the management of Garth Daniels' alleged mental illness. Apparently, some of these doctors proved helpful, but most did not, and an influential few have been particularly vindictive.

Garth's parents recently brought in consultant psychiatrist Niall McLaren to make an independent assessment. He finds that Garth – now aged forty – '...is a lightly built chap of mixed South African race (formerly known as "coloured") who presents as bright, alert, aware and pleasantly, even obsequiously, cooperative. When I saw him, he showed absolutely no signs of mental disorder whatsoever. He is bright and at least of average, if not superior, intellect, *but I have never found evidence he has been formally assessed.* [Our italics]. His personality is anxious, unassertive, socially insecure, and submissive. Oddly enough, the majority of his admissions were voluntary; he takes himself back to the hospital sometimes as little as a week after discharge.'

In January, Dr McLaren saw Garth again before putting a submission to the Mental Health Review Tribunal (MHRT) to the effect that shock treatment (ECT) could not work and that he did not need to be in a secure unit. He argued that Garth could safely be treated privately, that his case could be understood in psychological terms, and that 'more of the same' treatment (incarceration, shackling, drugs and ECT) was no more likely to be successful this year than it had been during the previous twenty years. He also advised that if the current program continues indefinitely, 'Garth will surely die.' The tribunal gave no weight to his evidence and pressed ahead with permitting more ECT.

3: MEDICATION & BRAINSHOCK WITHOUT END

In 1996 Garth was twenty-one. One night, stoned from one too many joints, he developed a headache and felt unwell, and so he took himself to the local hospital. Thus began his twenty-year psychiatric nightmare. At a stroke of a pen, without charge or trial for any crime or misdemeanour, Garth was involuntary detained, and without his knowledge was given anti-psychotic drugs – usually meant only for someone diagnosed with schizophrenia. Actually, *The Diagnostic & Statistical Manual (DSM* – the 'psychiatrists' bible') specifies that schizophrenia 'cannot be diagnosed' when an individual presents due to substance of abuse. Although Garth told them he suffered from a drug-induced headache and visual hallucinations, apparently it was easier for the psychiatrists to ignore what he said and simply give him the anti-psychotic.

Like so many others before and since, Garth suddenly found that he was no longer a person but – a psychiatric patient. In his case, he was in and out of hospitals and regularly detained and treated against his will for the next twenty years, with no end in sight.

Against explicit policy, Garth has routinely had two or more psychotropic drugs forced on him (polypharmacy). Over the years, grand-mal and petite mal seizures have occurred, and he also developed treatment-emergent neuroleptic malignant syndrome (NMS). Although he had always been peaceable, because he resisted detention and medication – still without charge or trial – he found himself placed in a secure facility for the most dangerous psychiatric criminals. There he was assaulted by a co-patient and suffered eye injuries and fractures to a forearm, a finger and his jaw.

By May 2016, Garth had spent a total of fourteen of his last twenty years in a mental hospital. To counteract his alleged mental illness, he has been prescribed every possible psychiatric drug, usually in doses way above the recommended limits. He is regarded by the state's psychiatrists as uncontrollably dangerous and has regularly been placed in seclusion, but over the past few years whenever he 'shows aggression' he has simply been shackled



to his bed by his arms and legs. Although he has committed no crime and faced no charges, when he was agitated from the 'side effects' of the psychiatric drugs forced on him, in 2015 Garth was strapped to a bed in a high-security forensic facility for sixty-nine consecutive days; this produced weeping pressure sores. That year he was shackled for about 110 days altogether, as well as previously being put into 24-hour seclusion for fifty-five days.

Over the preceding seven months he was also subjected to ECT three times a week. Treatment was ordered in regular series of twelve shocks, and each order issued by the Victoria Mental Health Review Tribunal (MHRT) followed as soon as the existing order expired. By now he has been subjected to 94 shocks at three per week – none with his consent – and the Victoria Mental Health Services (VMHS) indicated this would continue indefinitely. Because he refuses it and can't remember why he might need it, he is deemed incapable of giving consent to ECT, and so they 'make the decision for him'. The good doctors acknowledge that he can't remember due to effects of the ECT, yet at the same time he is deemed capable of agreeing to take medication even though he often doesn't remember what drugs he is taking.

On at least ten occasions he was subjected to two electroshocks the same day, contravening the widely accepted need to leave a gap of at least two to three days; once he was shocked four times in one day, which is very dangerous (even if it was done due to failure to elicit a seizure). Once, when it became obvious that he was reacting badly to the psychiatric drugging, he had to be rushed to a medical ward for specialist care. When he fiercely resisted treatment which he knew from past experience would make him ill, the police were called in.

Back in 1998, not having fully recovered from a massive overdose of chlorpromazine and excessive number of intra-muscular injections and treatment for emergent NMS, Garth was forcibly put into a clandestine drug trial for pharmaceutical giant Eli Lilly's Zyprexa. This drug has been linked with triggering strokes and

exacerbating suicidal tendencies; in fact there is a list of over 150 known adverse side-effects, of which, over the years, Garth has unfortunately experienced many. He is not alone: Ely Lilly recently settled a class action in the US for nearly \$700 million for not putting warning labels on the bottles stating that the drug can cause diabetes. Zyprexa has been removed from use in many countries, but it is still prescribed in Australia: Eli Lilly helps fund many clinical trials, conferences and scholarships in that country and around the world.

4: CONTESTING THE PSYCHIATRISTS

When it became clear that the doctors in charge of Garth's case had run out of treatment options and were only ever going to force on him more of the same harmful and unhelpful medications, Garth's parents tried to intervene. You guessed it – the psychiatrists wouldn't listen. As might be expected, the tactics of the officials was to ignore communications, not respond to questions or requests, and deliver pat and unevidenced dogma as scientific fact. All this while trying to fob off any complaints by reference to the health service's standard public relations policy statements, such as: 'We believe in consumer-centred care delivered with respect and integrity', and 'We facilitate supported decision making with our consumers and acknowledge and respect a person's capacity to make informed decisions.'

Garth's parents tried following through the standard complaints and objections procedures, with little success: even when they win a point at a Mental Health Tribunal, or Bernard Daniels tries to exert his power of attorney, the officials simply continue with the same old treatments regardless. The stand-off has led Garth's father to go to law so as to hold the officials to account. Complicit in the denial of Garth's civil rights is a whole set of Victoria State officers – these include the Department of Health & Human Services, the Office of the Chief Psychiatrist, the Mental Health Tribunal, the Mental Health Complaints Commission, and the state Government. In the opinion of Professor John Read, 'Some of the agencies that have behaved the worst in all of this case are precisely the ones that are supposed to be protecting the human rights of people who use mental health services.'

Earlier this year there were a couple of sympathetic press reports, but until then none of the press or media showed any interest in this case, apart from reporting the official version. In February Garth told *The Sunday Age* that he is suing the hospital for assault, saying 'I don't want to be in this hospital, I just want to go home as soon as possible.' At that time his father was trying to get an injunction to stop Eastern Health (Victoria) from forcing Clexane and Zuclopenthixol on him. The Mental Health minister was asked to intervene, and Swinburne University clinical psychology professor John Read also

raised the issue with the Government and lodged a series of formal complaints against the Mental Health Tribunal, which had given the hospital the go-ahead to increase the rate of shock treatments.

After all, Victoria State policy tells us: 'The Tribunal is an essential safeguard under the Mental Health Act 2014 to protect the rights and dignity of people with mental illness.' And its health department guidelines state that: '... a course of ECT can be up to 12 treatments performed over a period of time that cannot exceed six months.' According to the UK's Royal College of Psychiatrists, 'A course will on average be 6 to 8 treatments, although as many as 12 may be needed, particularly if you have been depressed for a long time. If, after 12 treatments, you feel no better, it is unlikely that ECT is going to help, and the course would usually stop.' Besides, unless he is ruled incapable of doing so, a patient must give informed consent to ECT – and Garth's father maintains that he is fully capable.

John Read points out that in the last three months of 2015, psychiatrists applied to the MHRT 176 times for permission to give ECT to patients who had insisted they did not want it, and had been strong enough to somehow resist all the doctors' attempts to talk them into it. Of these 176 hearings, the tribunal had turned the psychiatrists down just 14 times (8%). In Victoria, then, the chances of the organisation explicitly established by law to 'safeguard people's rights and dignity' actually doing so – as against safeguarding the rights of psychiatrists to administer harmful electric shocks – is about twelve-to-one.

Consultant psychiatrist Niall McLaren is highly critical of his peers on the basis that they do not have a theory of mental disorder and therefore do not practice scientific medicine. After independently assessing Garth, he too has raised concerns, and reported to the tribunal that he believed Garth had the mental capacity to refuse consent. 'They need to realise that twenty years of conventional treatment has abjectly failed, and if they continue on the present course, this man could die.'

The MH Review Tribunal then decided that Garth should not be subjected to more ECT against his will. Dr McLaren believed that '... the media publicity and the public outcry on social media may have helped the Tribunal get it right this time. At least they know they are being watched.'

This optimism was short-lived. Garth's psychiatrists responded negatively to the tribunal's decision to refuse a continuation of the series of more than 50 ECTs: they cancelled Garth's leave, tied him to his bed again, and appealed the decision. The MHRT then quickly reconvened and, surprisingly, granted permission to the psychiatrists to give Garth 12 more shocks – which they started that same afternoon, with another the following day. Their rationale was that Garth had refused psychiatric drugs and so there was no longer a 'less restrictive'

treatment option. So apparently he had capacity to refuse drugs, but did not have the capacity to refuse the ECT, and therefore should be given it against his will.

Meanwhile, the Mental Health Complaints Commission dismissed Professor Read's complaints against the Mental Health Review Tribunal and the Office of the Chief Psychiatrist, on the grounds that it could not legally investigate issues already been referred to those other agencies.

In a rare intervention, the Government has asked Victoria's Chief Psychiatrist for a report on the case. But in May the Daniels family relocated to Queensland, out of the jurisdiction of the Victoria health system. There he is under the care of a humane psychiatrist who favours psychotherapy, never uses shock treatment, and hopes to gradually bring him back to full health after his long-running psychiatric and medical nightmare.

5: A SECOND OPINION

According to consultant psychiatrist McLaren, Garth Daniels '... is not, and never has been, "schizophrenic". At the age of 18, he suffered some brief psychotic episodes after heavy marijuana use, which led to him being detained and treated under an order. He has never been free of mental hospitals since. From time to time, usually when agitated over being restrained, he may accuse people of trying to hurt him or that they are conspiring against him, but he shows nothing that would constitute a convincing delusion... or a hallucinatory experience. He is well-dressed, neat and tidy, studiously polite and does not show any stereotyped or manneristic behaviour. He can conduct a perfectly sensible conversation and is never intrusive, overbearing or otherwise odd. When unshackled, he cares for himself normally and has regular leave from the hospital to walk around the streets.

'The question of whether he is dangerous is important. He is currently being treated as the single most dangerous person in the history of the State of Victoria, if not in the entire history of this country. While in the hospital, he is normally kept on a closed ward but has recently been transferred to a long-stay secure unit. At some stage he was detained in a forensic psychiatric unit for two years, even though he has never broken the law. In twenty years, there have been only two episodes of aggression: one in which he assaulted a nurse who was trying to restrain him, and once when he whacked his father who was pushing him. He has been assaulted a number of times in hospital over the years, but does not retaliate.

'... I am accustomed to dealing with aggressive patients. I have extensive experience of treating serving military personnel (at least one thousand patients over twenty years) and of veterans of every conflict this country has entered since 1916. I am also very familiar with dealing with acutely psychotic patients... Over the years, I have treated many

murderers and rapists, including men with significant records of violence. In my current office, with absolutely no security facilities whatsoever, I see veterans of Iraq and Afghanistan who are so paranoid that they insist on locking the office door behind them and then sit between me and the door so they can watch out the window. Believe me: I know aggression. Garth Daniels is not dangerous.'

6: HOW CAN SO MANY EXPERTS BE SO WRONG?

Bearing in mind that over the course of his long career as a mental patient Garth has now been seen by around four hundred psychiatrists, Dr McLaren asks how could they get things so wrong.

First of all – no surprises here – Garth's copious files reveal that nobody ever took a proper history from him. There were some 'very skimpy histories in the distant past', but since then every psychiatrist has simply recorded: 'This well-known patient...'

Second, there is the 'emperor's new clothes' effect: nobody will question the status quo. Every profession makes its trainees comply with the orthodox view, but this may be particularly powerful in Australian psychiatry since the five-year training program is very intensive. Anybody who questions the professor or the official line won't last long. As Chomsky put it:

'... the people who make it through the institutions and are able to remain in them have already internalised the right kinds of beliefs: it's not a problem for them to be obedient, they already are obedient: that's how they got there.'¹

Third, when a conventional psychiatrist confronts a mental disorder he always thinks he sees a brain disease.

Fourth, each psychiatrist always wants to be the first to come up with the most serious diagnosis. Nowadays most psychiatrists are blind to the personality and neurotic disorders: modern psychiatry is actively engaged in a process of reassigning personality-disordered people to the category of psychotic disorders, so they can be treated with drugs. The illiberal use of powerful psychoactive drugs is thereby producing the current epidemic of major mental disorders (particularly so-called bipolar disorder). Psychiatrists administer more and more drugs in the vain attempt to 'cure' personality or neurotic disorders.

Fifth, there is the distinct possibility that the authorities wish to damage this particular patient, to the extent of making him unable to appeal or testify to their abuses of him. It certainly seems as if the Victoria Mental Health Service panicked when they realised the family was serious about moving Garth out of their jurisdiction so as to put him under the care of a doctor who disagrees with their methods and has successfully treated many diagnosed psychotics. Dr McLaren manages without all the modern chemical and electrical labour-saving devices – meaning the labour of having to talk to patients and

sort out their tangled lives. After spending something like \$10m over the past twenty years only to wreck Garth's life, the authorities would not want to risk somebody else achieving what they could not.

Assuming that his psychiatrists have been asked to try psychotherapy – and they will not do so – we might also assume that we could add to this list the motive of sheer vindictiveness in response to the dogged resistance put up by Garth and his family: psychiatrists are well-known to fiercely resent anyone ever questioning their 'authority' (power).

Neither is it fanciful to suggest that unconscious or closet racism plays its part in this whole sorry saga.



7: BUT SURELY THE DOCTORS KNOW BEST?

Despite an ALERT first recorded by Garth Daniels' medical files way back in the early days of his psychiatric career, it seems that little attention was given to his potentially fatal Neuroleptic Malignant Syndrome. Polypharmacy is known to be hazardous, and can mask underlying symptoms; there is a lack of evidence for the benefit of many of the prescribed combinations; and there is the potential of increased adverse events. It is difficult to distinguish akathisia side-effects from any underlying psychiatric disorder, but there is generally clear evidence of a relationship between the onset of symptoms (e.g. akathisia) and the use of medication, and evidence that symptoms diminish when use of a drug is reduced or discontinued. There are inconsistencies between current Australian Product Information documents and the best international information, but Garth has regularly been prescribed in excess of the manufacturers' recommended safe dosages, without his consent. Why was it that on every occasion Garth presented to hospital – whether voluntarily or not – his drug prescription was always increased, leading to unnecessarily traumatic and lengthy hospital stays? Why is it that when adverse drug reactions (ADRs) were reported by Garth to the 'treating team' – such as blurred vision, sore eyes, sore throat, oculogyric movements of the eyes, memory impairment and insomnia – they were routinely disregarded?

It is also worth pointing out that even if Garth had once responded badly to cannabis, there is no research evidence to support the idea that any of the psychiatric treatments foisted on him would have helped.

In fact, there has never been a systematic audit of the therapeutic or ill-effects of any psychiatric drugs, and precious little non-partisan, properly controlled research. For a long time, many patients and carers have worried about the ill-effects of routine psychiatric drugging, and even some doctors are now anxious about the long-term organic harm; this is associated with 'the atypicals' as much as with the old-style antipsychotics, e.g., chlorpromazine. For instance, there is considerable anecdotal evidence that an unusual number of patients who have had more than a short course of Clozaril show signs of a degenerating endocrine system: they become obese or develop diabetes or a thyroid condition.

Meanwhile, a review of 150 research papers concluded that the second-generation 'atypical' antipsychotics are no more beneficial than the types they were designed to replace; only clozapine was consistently slightly helpful or less harmful.² 'As a group they are no more efficacious, do not improve specific symptoms, have no clearly different side-effect profiles than the first generation antipsychotics, and are not as cost-effective.'³ Moreover, all of them are known to carry a high risk of serious adverse side-effects. Only four of the ten reviewed drugs were better than the old type, and then only marginally. The new drugs caused fewer extra-pyramidal effects (uncontrolled Parkinsonian-type movement) but they all caused more weight-gain than the earlier type. A meta-study also found that research and the publication of results (or not, as is often the case) was nearly always deliberately biased. More than this, there is no evidence to show that any anti-psychotic ever provided significantly greater benefit than placebo, psychotherapy or no treatment at all. In 2009, an editorial in *The Lancet* concluded that the atypicals are 'a spurious invention' that has been cleverly manipulated by the drug industry for marketing purposes.⁴

As for ECT, in a recent review of the research, Read and Bentall comprehensively debunked a belief still held by many psychiatrists: that electroconvulsive therapy 'works'. They found that placebo-controlled studies show minimal support for the idea of the effectiveness of shock treatment for either depression or schizophrenia. That is to say, it was only in some studies and for some patients, on some measures, and sometimes perceived only by psychiatrists but not by other raters (i.e., perhaps less partisan assessors). Beyond the treatment period, for either diagnosis, there is no evidence of benefit. (There are also no placebo-controlled studies which evaluate the hypothesis that ECT prevents suicide, and no sound evidence from other kinds of studies to support that idea.)

In addition, those authors review strong evidence of persistent and permanent brain dysfunction for some patients, mainly in the form of retrograde and anterograde amnesia; and this relates to ECT, not to depression per se. They cite the only reliable study on cognitive effects: this found a range of deficits (memory and attention) immediately following ECT, and that the number of shocks administered was the strongest predictor of gaps in autobiographical memory (retrograde amnesia) six months after the end of the treatment; there was also a significant relationship between the number of treatments administered and cognitive ill-effects; and the correlation between the number of treatments and memory loss was particularly strong for bi-temporal electrode placements (compared with unilateral). The best predictor of long-term brain damage from ECT is the number of shocks administered; there is also evidence of a slight but significant increased risk of death. In the light of all this, Read and Bentall conclude that the cost-benefit analysis for electroconvulsive therapy is so poor that using the technique cannot be scientifically justified.⁵

Every psychiatrist ought to be well aware of these facts.

In the case of Garth Daniels, the Eastern & Monash Health (Victoria) psychiatrists do not seem to recognise psychotherapy, CBT, peer-support groups, or any other non-biological approach as treatment options. This is not surprising – until very recently, the UK's Royal College of Psychiatrists was fanatically hostile towards any kind of talking therapy.

Unfortunately, now that Garth is twenty years down the psychiatric line, it might be nigh on impossible to disentangle the harmful organic and psychological effects of so much full-on medication and ECT from any underlying organic or psychological condition which he might have brought to the hospital when he sought medical help in the first place... ■

The full story of Garth Daniels' struggles with the psychiatric system can be found at www.freegarth.blogspot.co.uk

1. Chomsky, N (2002). *Understanding Power*. New York: The New Press: 248. (Footnote/s at end of article).

2. Leucht, S et al. (2009). Second-generation versus first-generation antipsychotic drugs for schizophrenia: a meta-analysis. *The Lancet* 373: 31–41.

3. Tyrer, P & Kendall, T (2009). The spurious advance of antipsychotic drug therapy. *The Lancet* 373: 4.

4. Tyrer, P & Kendall, T, op. cit.

5. Read, J & Bentall, R (2010). The effectiveness of electroconvulsive therapy: A literature review. *Epidemiologia e Psichiatria Sociale* 19(4) 344–7; with particular reference to Sackeim, H, et al (2007). The cognitive effects of electroconvulsive therapy in community settings. *Neuropsychopharmacology* 32: 244–54.

Letter: A reply to Diana Rose

As a psychiatric survivor and antipsychiatry activist, I feel compelled to reply to Diana Rose's attack on *Asylum* magazine, survivor research and Dr Bonnie Burstow's recent book: *Psychiatry and the Business of Madness* (which I reviewed very favourably last year).

I disagree with the suggestion that *Asylum* omits survivor and antipsychiatry perspectives. I have read and saved some issues of *Asylum*, and have never felt that the editorial or overall tone and content patronizes, distorts, minimizes or ignores survivor experiences and perspectives. For example, the issue on Electroshock of a few years ago was outstanding and empowering; it featured shock survivor experiences as well as critiques by dissident and critical health professionals. That issue was not just powerful but unique: I can't recall any other journal or magazine that targeted and thoroughly exposed shock as the memory-destroying, brain-damaging and unethical procedure it is and always was.

Although I too support and advocate survivor-controlled research, I don't feel survivors are necessarily compromised or co-opted by researchers who share an anti-psychiatry perspective. I make no apologies for ignoring liberal 'mental health' studies that do not challenge or expose psychiatric abuses and human rights violations (e.g., involuntary committal, electroshock, forced drugging) and lies for being unethical, unprofessional and sometimes deadly.

It's important to understand that many published personal accounts and public testimonies about psychiatric incarceration and forced treatment – trivialized or ignored by psychiatrists as 'anecdotal' – constitute a rich and immensely valuable source of existential knowledge about the corrupt, coercive and fascistic 'mental health' profession of psychiatry and its gulag. Survivor-grounded research, personal testimonies and organized grassroots resistance have produced brilliant critiques and movement classics such as Judy Chamberlin's *On Our Own: Patient-controlled alternatives to the mental health system* (1978); Leonard Roy Frank's *The History of Shock Treatment* (1978) and *Electroshock Quotationary*

(2006); *Nazis in White Coats: Psychiatric genocide in Nazi Germany and the United States*, by Lenny Lapon (1986); *Crazy Like Me: Stories from the Mad Movement*, by Irit Shimrat (1997); *What Difference Does It Make*, by Wendy Funk (1998); *Tranquil Prisons: Chemical incarceration in the community*, by Erick Fabris (2011); and *Shrink Resistant: The struggle against psychiatry in Canada*, edited by me and Bonnie Burstow (1988).

It's important to emphasize that *Shrink Resistant* was an historical breakthrough for three reasons: it was the first Canadian book to seriously challenge psychiatry and the 'mental health' system by publicly exposing and documenting the country's systemic abuses and human rights violations in that field; it was the first Canadian book to give a voice to Canadian psychiatric survivors by empowering and validating their personal struggles and victories, told in their own words; and it was an authentic collaborative work produced by a health professional (Bonnie) and more than thirty psychiatric survivors.

It's also worth pointing out that the book was a natural outgrowth of *Phoenix Rising*, which was the first and only anti-psychiatry and survivor-controlled magazine in Canada.

For ten years – 1980-1990 – *Phoenix* gave a long-neglected voice and credibility to thousands of psychiatric inmates, ex-inmates and survivors whose outstanding and empowering articles, devastating critiques, thoroughly researched exposes, dramatic poems, and consciousness-raising editorials were born out of the fire of struggle and personal experience and research. *Phoenix Rising* was and still is a rich trove of personal knowledge and survivor research about the disempowering, stigmatizing and coercive 'mental health' system, as well as the numerous abuses and human rights violations of psychiatry, and survivor victories. The personal is political: it is also valid, raises consciousness and empowers – and it should be taken seriously.

I feel that Diana's criticism of Bonnie Burstow's *Psychiatry and the Business of Madness: An ethical and epistemological accounting* (2015) is unfounded, simplistic and dismissive. She refers to other readers' views and summaries of the book as "nihilistic and hysterical," and inaccurately and misleadingly calls it "mad studies." But it definitely is not: the work reflects and is totally informed by a solid anti-psychiatry perspective. Bonnie's book is one of the most comprehensive and thoroughly researched critiques of psychiatry published to date; it has been widely reviewed and justly praised. I don't think Diana has read or understood the book. I recommend she reads both the book and my review

of it in *The Journal of Ethical Human Psychology and Psychiatry* 17 (1) (2015).

To counter the popular and media myths of 'mental illness/mental health', and human rights violations and the lies of psychiatry, we need more of such comprehensive and brilliant critiques, many more survivor studies and personal testimonies, more survivor biographies, and more radio and tv documentaries to expose psychiatric crimes against humanity and to feature survivor victories over psychiatry – particularly electroshock, forced drugging, involuntary commitment and solitary confinement ('seclusion' and 'locked seclusion').

I also want to sincerely thank and respect the excellent work of sister survivor Cheryl Prax, in London. Although we have not met, I understand Cheryl has been outstanding in organizing survivor resistance to and public education about the many health risks of electroshock, and calling attention to the sexist or anti-feminist bias of virtually all shock doctors in the UK. And I want to pay tribute to Bonnie Burstow, a widely-respected professor and trauma specialist at the Ontario Institute for Studies in Education, University of Toronto, and to dissident psychiatrist Peter Breggin for their brilliant critiques of electroshock and psychiatry. I also deeply appreciate the riveting and courageous personal testimony and books by women shock survivors such as Connie Neil (*Aftershock*), Wendy Funk (*What differences Does It Make*), and the late and brilliant survivor-advocate and my life-long friend, Carla McKague.

Sexist and ageist factors are endemic not only in ECT practice and research but in virtually all psychiatric procedures; this is sufficient reason to ban this torture which masquerades as therapy. It is a fact, well researched and publicized by survivors, dissident health professionals and researchers, that sexism, heterosexism, ageism, racism, and discrimination against the LGBT community are all systemic in the 'mental health'/psychiatric system. As Burstow and other serious critics have suggested, psychiatric oppression and imperialism provide all the evidence we need for abolishing psychiatry. All psychiatric facilities should be closed; we need to create and sustain many more humane, non-medical and community-based alternatives.

Finally, I have to disagree with Diana Rose's criticism of *Asylum*, one of very few independent magazines that regularly exposes and criticizes many of psychiatry's human rights violations, and supports psychiatric survivors' research, personal testimony, successful anti-psychiatry protests, and victories. I feel more empowered when I read it. ■

Don Weitz, Toronto

NEWS & FINDINGS

ME/CFS: CRAZY AND LAZY?

Millions spent on dodgy research while valued services are axed

In 2011 the results were published from the largest and most expensive research study ever on ME/Chronic Fatigue Syndrome (ME/CFS). Costing £5 million, the PACE trial appeared to demonstrate the effectiveness of Graded Exercise Therapy (GET) and Cognitive Behavioral Therapy (CBT) in treating this misunderstood and highly stigmatised condition. The results not only influenced public health recommendations around the globe but were pounced on by the media who eagerly announced that people with ME/CFS just needed to exercise and think more positively.

This could only reinforce a common prejudice that sufferers are lazy and/or crazy: their problems must be due a lack of motivation and exercise (resulting in 'deconditioning') and false beliefs about their illness – they just think they're ill (i.e., they're deluded). Of course, this is what happens when people are psychologised: their views and experiences are discredited.

Whilst the researchers did criticise the media for oversimplifying their research findings, many sufferers and supporters of people with ME/CFS sensed a deeper problem: the findings just didn't fit their experiences. Yet senior figures like Richard Horton (editor of *The Lancet*, which published the research) and Simon Wessely (President of the Royal College of Psychiatry) have been accused of pathologising those who questioned the study as 'hysterical, dangerous and irrational'. Hysterical and irrational? Sound familiar? The mistreatment of sufferers might relate to the fact that most are women. Even ME/CFS support groups were criticised for encouraging people to believe they are ill and maintaining them in their 'sick role'.

Now, after years of campaigning by individuals and ME/CFS groups who submitted Freedom of Information requests to re-view the data, serious flaws in the study have emerged. It's highly unlikely the mainstream media will be as enthusiastic about reporting these revelations. So we've decided to highlight them:

- The PACE trial had vague and low entry criteria, i.e. people were included who were just 'tired for 6 months or more'. This didn't take into account other central and common symptoms associated with ME/CFS. Therefore, it's highly likely that the trial included people who were already feeling better and/or didn't meet the criteria for CFS/ME in the first place. This meant they could have got better anyway, regardless of any intervention.
- People with severe ME/CFS were effectively excluded from the trial because participants had to be able to travel to attend regular hospital appointments. Many people with ME/CFS would have been too ill for that.

- There was no follow-up of patients who dropped out of the trial. People may have done so due to relapse because of the treatments themselves, especially 'graded exercise': post-exertion fatigue is one of the hallmarks of the illness.
- Midway through the trial, the researchers decreased the criteria used to assess recovery. This meant that people didn't have to improve significantly in order to be deemed 'recovered'.
- This resulted in the most bizarre situation imaginable: High entrance criteria (people included in the trial who weren't very ill in the first place) and low recovery criteria (people considered recovered when still unwell) meant that people could have actually got worse during the trial but were still registered 'improved' or even 'recovered'!

Shocking isn't it? What went wrong? Did the researchers see what they wanted to see? Did they genuinely believe their treatments were effective, so they saw this in the data? Were their own beliefs false or even 'delusional'? Given the suggestion that patients 'only believed' they were ill, that would be ironic. It's tempting to ask: Who's lazy and crazy here? However, simply reversing accusations of psychopathology isn't always helpful. There must be something else going on.

Of course, the researchers were predominantly psychiatrists or psychologists, many of whom were CBT or GET practitioners. It's easy to see that they might have had a vested interest in believing CFS/ME is primarily a psychiatric/psychological condition that can be treated by those techniques. It's much harder to see how patients had a vested interest in remaining ill. Some patients even reported being told that the so-called treatments were 'evidence based', and were denied other forms of support if they didn't try them – despite the adverse effects they might experience.

The researchers and the medical establishment have still not publicly apologised for these errors, or any harm they may have caused. Until these basic flaws can be openly discussed and understood, it is hard to move forward. Surely this is bad science? Yet Ben Goldacre, who has done much to expose examples of Bad Science and Bad Pharma has been strangely silent on the issue: Goldacre is closely associated with psychiatrists who champion CFS/ME as a psychological illness.

This is just the latest episode in a long history of psychiatric abuse and the mistreatment of people suffering from chronic fatigue. ME/CFS remains mysterious. It would be absurd to claim that psychology or beliefs play no part in the trajectory of the condition, and we know from the placebo effect that beliefs can powerfully influence all kinds of illness and recovery processes. In this case, the either/or dichotomy – physical or mental – is distinctly unhelpful. Nor would it help to deny that CBT or graded exercise might help some people. However, drawing broad conclusions about the nature and treatment of CFS/ME from flawed studies like this does little to help those suffering from such a complex and little understood condition. Meanwhile, services that many patients found helpful – such as those providing

advice, support and information about pacing, mindfulness and relaxation strategies – have been axed in the current round of austerity. So much for ‘the evidence’.

In September 2016 The Millions Missing campaign held a global day of action for ME/CFS sufferers. Many sufferers were too ill to attend, but pairs of shoes were left in public places as a visual symbol of the millions of lives gone un-lived.

<http://millionsmissing.org/>

NO LONG-TERM BENEFIT FROM ANTIPSYCHOTICS

Long-term treatment with antipsychotic drugs is the standard treatment for anyone with a schizophrenia diagnosis. But research shows that most ‘schizophrenia’ or ‘schizo-affective disorder’ patients do not take their antipsychotic medications as prescribed (74%), or they stop taking their medications completely (26%). However, very few studies have compared the outcomes of such patients on and off anti-psychotics.

One such study reports that 35% of the patients who had stayed off medication for 18 years had significantly higher levels of general and social functioning compared to those who had continued taking anti-psychotic drugs.¹ Another found that non-medicated patients who had been off their antipsychotic medication for more than a year generally had fewer symptoms, were better functioning, and were less likely to be on disability benefit or readmitted to a psychiatric hospital.²

Now a small-scale study finds that in matched groups of medicated and unmedicated patients diagnosed with schizophrenia, while the two groups did not differ significantly in symptoms or levels of distress, those in the unmedicated group scored higher on levels of general functioning and spent less time in psychiatric facilities, both inpatient and outpatient. Patients in the unmedicated group who had never taken an antipsychotic also had significantly lower depression scores than those who had previously been medicated.³

The researchers were surprised to find that this increase in functioning was not explained by levels of social support or coping strategies – the only major difference was that the medicated patients were more likely to say they relied on professionals for help. Also, the longer patients had been off medication (in relation to the duration of disorder), the higher their level of general functioning.

‘Taking into account the common side effects of [antipsychotics] such as sedation or akinesia (e.g. “feeling slowed down” or “feeling like a zombie”), an alternative

explanation for higher functioning in non-medicated participants is that medication itself impairs functioning in those individuals who experience those restraining side effects. This is surprising as sudden withdrawal from [antipsychotics] has generally been found to be associated with increased risk of relapse. Our results indicate that there are patients who are able to withdraw responsibly and successfully from medication on their own.’

Study Finds Improved Functioning for ‘Schizophrenia’ Without Antipsychotics (2016). *Mad in America*, 25 July.

CRISIS TEAMS FAILING SUICIDAL PATIENTS

A report by a team from Manchester suggests that in the UK crisis teams are under too much pressure. There are about 200 suicides a year of people cared for by crisis teams, which is three times the number in hospitals. A third of these people had been discharged from hospital in the previous fortnight, and a further third had been using the service for less than a week.

Crisis resolution/home treatment (CRHT) teams consist of psychiatrists, mental health nurses, social workers and support workers. They make home visits, administer medication, and are supposed to offer psychological and practical support.

Twenty years ago there was a broad consensus in the NHS that suicides among psychiatric patients were inevitable. But the Detroit mental health support project has shown that suicides can be cut to zero for those known to be at risk. In the meantime, in the UK there have been ever-increasing numbers of suicides under the care of crisis teams: in the face of reduced beds, poor training, disorganisation, lack of co-ordination and stretched services, there is no improvement. The report of The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH) suggests that crisis teams are bearing the pressure of caring for patients who really need a more acute level of care, such as inpatient beds. There was too much reliance on crisis teams, and they had become ‘the default option in acute care, used for too many patients at high risk’.

The report also found that those NHS trusts which involve families in investigating deaths improve performance. Why some trusts fail to do so, or only engage in tokenistic efforts, is ‘utterly baffling’.

Suicide risk ‘higher in community’ (2016). *BBC News*, 6 Oct.

GOVERNMENT’S MH TARGET OFTEN IGNORED

In April 2016 the government promised that mental health patients would be able to access intensive treatment within two weeks of referral – the same priority as for cancer. This target is for anyone aged 14 to 65 experiencing a first episode of psychosis.

A Freedom of Information request sent to the 209 clinical commissioning groups (CCGs) in England by the

1. Harrow, M (2012). Do all schizophrenia patients need antipsychotic treatment continuously throughout their lifetime? A 20-year longitudinal study. *Psychological Medicine* 1(11).

2. Moilanen, J (2014). The use of antipsychotic medication and its association with outcomes and brain morphometry in schizophrenia: the Northern Finland Birth Cohort 1966 Study. *Acta Universitatis Ouluensis Medica* 1363.

3. Jung, E et al (2016). Symptoms, functioning and coping strategies in individuals with schizophrenia spectrum disorders who do not take antipsychotic medication: a comparative interview study. *Psychological Medicine* 1(10).

Liberal Democrats shows that a quarter of the CCGs are ignoring the target. 170 out of the 209 responded, and 23% said they had applied the target only to those aged 14 to 35; most of those CCGs had no plans to extend it to older people this year.

NHS England says it is investing more money in services so as to help meet demand.

Pym, H (2016). Mental health target being ignored. *BBC News*, 10 Aug.

GOVERNMENT TO AXE ESA BENEFITS RETESTS?

Employment and Support Allowance (ESA) applicants have to undergo a work capability assessment to find out if they are eligible, and are then re-tested to ensure their condition has not changed. Some are re-tested every three months and others up to two years later.

There are tales of terminal cancer patients being told they will have to reapply for ESA if they have been given more than a few weeks to live, while the officials never seem to get it about stress and enduring serious mental health problems.

Now Work and Pensions Secretary Damian Green says it is pointless re-testing those with severe conditions and no prospect of getting better. He says a 'key part' of making sure those who were unable to work received 'full and proper support' included 'sweeping away any unnecessary stress and bureaucracy'.

More than two million people get ESA, which is worth up to £109 a week, but tens of thousands claiming the main benefit for long-term sickness should no longer face repeated medical assessments to keep their payments. The illness criteria will be drawn up with health professionals.

Shadow work and pensions secretary Debbie Abrahams said it was 'a welcome U-turn' by the government, but 'the devil was in the detail... What about mental health conditions, conditions that are fluctuating, conditions that may not necessarily have a physical manifestation?'

ESA benefit payments: Re-tests axed for chronically ill claimants (2016). *BBC News*, 1 Oct.

CHILD MH CRISIS DEEPENS

The NSPCC reports that last year the UK Childline received an average of one call every 30 minutes from a child with suicidal thoughts. This amounted to 19,481 calls, 53 a day – more than twice as many as five years ago. Callers were often referred to the emergency services, but lack of support was leading children to reach crisis point. Many callers told the charity's round-the-clock service that they were dealing with problems on their own: there was an 87% increase in young people struggling to access professional help (3,250 calls). Most blamed lengthy waiting lists, a lack of information or a refusal to help.

Many of the children were self-harming. The major triggers for suicidal thoughts were a turbulent home life, abuse, school pressures and mental health conditions; children as young as 10 were calling.

Association of School and College Leaders specialist parliamentary adviser Anna Cole said Childline's report echoes the findings of a recent survey in which 80% of school and college leaders who responded reported a rise in self-harm or suicidal thoughts among students.

'All schools and colleges provide a wide range of emotional health and wellbeing support to their students, and most provide some specialist mental health support such as counselling and sessions with other specialists,' she said. 'Schools and colleges are, however, finding it increasingly difficult to commission specialist mental health services in the current climate of severe funding pressures.'

Richardson, H (2016). Record numbers call Childline over suicidal thoughts. *BBC News*, 8 Sept.

CHILD DEATHS IN MH UNITS

A fifteen-year-old boy with a history of self-harm died six weeks after being admitted to one of the largest mental health trusts in England. The coroner ruled that neglect and 'continuing failures' contributed to his death at Bethlem Royal, London, in August 2014. The inquest found that no formal risk assessment was carried out during his stay at the hospital, which is run by South London and Maudsley NHS foundation trust; neither was there a care plan in place, and he was allowed access to a number of items which he used to self-harm.

Deterioration in Christopher Brennan's mental health in the two years before his death had led to repeated hospital admissions. In August 2014 he was found unconscious in a communal toilet, and later died from cardiac arrest.

According to the charity Inquest, Christopher was one of at least eleven young people to die in psychiatric units in England between 2010 and 2014, although no-one knows the real number since they are not independently investigated and no single body is responsible for collating, analysing or publicising these deaths.

Neglect contributed to teenager's death in psychiatric hospital, coroner rules (2016). *The Guardian*, 21 Sept.

SERVICES STRAINED BY WORSENING STUDENT MH

A YouGov survey of 1,061 students suggests that in the UK a third of all female and a fifth of male students has a mental health problem. Overall, this was 27% of the respondents, but it rose to 45% among lesbian, gay, bisexual and transgender students.

Of those saying they had a mental health problem, 77% said depression and 74% anxiety.

In May, ONS had published statistics for 2014 which showed that student suicides had risen to their highest level since numbers were first recorded (in 2007). There were 130 suicides in England and Wales among full-time students aged 18 or above. Of those, 97 were for male students and 33 were females.

There has been concern about the level of mental health support services provided by universities. But the survey showed that students were broadly aware of the

mental health services offered, and Universities UK said that institutions were working hard to develop good services that linked in with the NHS. The number of students seeking counselling at university has rocketed by 50% in the last five years; first-year and international students are particularly affected. Heads of university counselling services say they are seeing more students arrive with existing psychological or mental health conditions. Some counselling services are under-resourced, and students are seeking help against a backdrop of mounting pressure to get the best possible degree in order to secure a good job to pay off their student loan debts.

Statistics provided by 37 higher education institutions to *The Guardian*, including many leading Russell Group universities, showed that referrals rose from just under 25,000 five years ago to more than 37,000 in the academic year 2014–15. The Nightline Association, which offers counselling services to roughly 18,000 students a year through its 39 branches, said that in the last year alone calls rose by 78% in Leicester, 46% in Sheffield, 40% in Durham and 35% in Leeds.

However, experts in the sector say part of the increase in demand is down to a new willingness among young people to ask for help, and most universities have also become far more proactive in reaching out to students with counselling teams and a peer-to-peer support networks. The figures indicate that at some universities young men, who are traditionally hard to reach, are increasingly using services as some of the taboo surrounding mental health dissipates.

All the same, a recent report by the Higher Education Policy Institute said that a number of universities needed to triple their spending on mental health support to meet demand. Catherine McAteer, the head of UCL's student psychological services, said: 'We have 39,000 students, soon to go up to over 40,000. There are 13 clinicians in my team. The reality is 13 people cannot meet that kind of demand.'

McAteer said her team had looked after 3,022 students in 2015–16, some of whom had lengthy waits before being seen, the longest being 15 weeks. 'The problem is the longer they have to wait, the more likely it is that the problem will escalate,' she said. When she took over as head of the department in 2002, just 9% of students who accessed the service had existing psychological or mental health conditions. Last year 53% had previously been seen by therapists for a variety of issues including depression, anxiety and eating disorders.

Richardson, H (2016). More than a third of female students 'have mental health problems'. *BBC News*, 11 Aug.
Yeung, P et al (2016). University mental health services face strain as demand rises 50%. *The Guardian*, 23 Sept.

BIG PAY-GAPS DUE TO MH PROBLEMS

According to the Equality and Human Rights Commission, British workers with depression or anxiety face a life of lower earnings. On average, men with conditions such as phobias or panic attacks earn only 58p for every pound that a non-disabled man earns, while men with anxiety or depression get only 74p.

A similar but less pronounced pattern holds for women: those suffering from anxiety or depression earn 10p less for every pound earned by their non-disabled peers.

Campbell, D (2016). UK's 'hidden disgrace': mental health problems can lead to 42% pay gap. *The Observer*, 6 Aug.

ARMY RISKS TROOPS MENTAL HEALTH

In 2015 we reported that nearly 1,000 British service personnel had by then needed psychiatric treatment after taking the discredited anti-malaria drug, Lariam, aka mefloquine (*Asylum* 22(2): 30). Lariam is once-a-week anti-malarial tablet licensed for sale in 42 countries. Although it is clearly linked with mental health problems ranging from hallucinations, depression and psychosis to suicidal thoughts, actual suicides and homicides, and has been rejected by the armed forces of most other nations, it is still given to UK troops. In May the MoD was formally notified of several legal claims after a firm of solicitors was contacted by about 30 serving and former members of the armed forces about the use of Lariam.

Recently retired army chief Lord Dannant now admits he would never take Lariam himself, because his son suffered mental health problems after two doses in the 1990s. He said the side-effects of the drug could be 'pretty catastrophic'. His son had become 'extremely depressed' and if he had been left untreated 'who knows where it would have gone'.

While not the main anti-malarial drug used by the armed forces, at least 17,368 personnel were prescribed Lariam at least once between 2007 and 2015. Dannatt said he thought that evaluating the merits of the drug was 'put on the backburner' because between 2003 and 2014 the Ministry of Defence (MoD) was focused on conflicts in Iraq and Afghanistan, which are not malarial areas. Probably more to the point, he also suggested the MoD was afraid of 'opening the floodgates' to expensive compensation claims if it ever admitted the drug had harmed troops.

An MoD spokeswoman said: 'The vast majority of deployed personnel already receive alternatives to Lariam and, where it is used, it is only prescribed after an individual risk assessment. But we have a duty to protect our personnel from malaria and, as the last defence committee report concluded, in some cases Lariam will be the most effective way of doing that. It continues to be recommended as safe by Public Health England and the World Health Organisation.'

Earlier this year the House of Commons defence committee called for Lariam to be designated a 'drug of last resort', to be issued only when there was no alternative available. The manufacturer, Roche, said 'We will continue to work with the Ministry of Defence to ensure that they have all the relevant information to ensure Lariam is prescribed appropriately'. The company pointed out that the most recent safety assessment conducted by EU authorities, in March 2016, reinforced previous guidance that the benefits of Lariam outweigh the potential risks of the treatment.

In September, responding to a further defence select committee inquiry, MoD officials announced that Lariam will now only be prescribed to service personnel after a face-to-face check-up, and that they will be offered an alternative.

Conservative MP Jonny Mercer, a former army officer and a member of the committee, says that guidelines should have been followed from the beginning. 'The evidence is very clear, prescribing a drug outside of the parameters clearly laid out by the manufacturers is not acceptable, and that's what they were doing. Consequently there are a number of people in this country who feel their lives have been ruined by this drug...'

Meanwhile, Dannant says he is 'quite content to say sorry' to those troops who had taken Lariam while he was head of the army. That's all right, then.

Ministry of Defence faces legal claims over malaria drug (2016). *BBC News*, 11 May.

Ex-army chief apologises to troops over anti-malaria drug (2016). *The Guardian*, 31 Aug.

Check-up for troops before anti-malarial drug Lariam, says MoD (2016). *BBC News*, 13 Sept.

SELF-HARM IN THE SERVICES

The number of UK armed forces personnel deliberately self-harming has jumped by more than a third over five years. Women, army personnel and those aged under 24 most at risk.

The Ministry of Defence has revealed a 36% increase between 2010/11 and 2014/15 for servicemen and women who self-harmed at least once. In 2014/15 there were 383 recordings of deliberate self-harming (DSH), which includes self-injury and self-poisoning. The data excludes servicemen and women who only had thoughts of DSH or suicide.

Those aged under 20 were around ten-times as likely to self-harm than those aged 45 and over, while women were twice as likely as men. These risk differentials are in line with those in the general population.

The MoD says that improved methods of capturing DSH data could have attributed to the reported rise in incidents. 'Through our many anti-stigma efforts, including the Don't Bottle It Up campaign, we encourage anyone with a mental health problem to come forward and get the support they deserve.' Military personnel are given a 'decompression period' after deployment where they can 'begin to mentally and physically unwind' and talk about their experiences.

Self-harming among British military personnel up by a third (2016). *The Guardian*, 22 Sept.

MENTAL HEALTH & RISING INEQUALITY

Using statistics from twenty-three of the world's richest nations and each individual US state, a few years ago

epidemiologists Wilkinson and Pickett famously showed up the systematically pernicious effects of income inequality: the greater the inequality within any society, the worse the effects – *for everybody*. Of course, the poor always tend to benefit the least, but in a survey of the most pressing problems shared by every modern society, the authors found that for physical and mental health, drug abuse, obesity, education, trust and community life, social mobility, violence, imprisonment, teenage pregnancy and children's well-being, without exception average outcomes for *everyone* in the society are significantly worse the greater the inequality, whether a country (or state) is very rich or relatively poor. The only exception to this rule might be the few thousand extremely rich – who certainly don't participate in surveys because they like to keep tight control of any publicity about their lives.

We all knew it, but research now shows that inequality increased since the millennium. In the UK, on average a CEO now earns 129-times the wages of his workforce. Oxfam says that Britain's richest 1% (634,000 people) now hold *twenty-times* the combined wealth of the poorest 13 million people: data from investment bank Credit Suisse shows the richest 10% owning more than half the country's wealth, with the top 1% owning 23% and the poorest 20% sharing just 0.8%.

Wilkinson, R & Pickett, K (2009/10). *The Spirit Level: Why equality is better for everyone*. London: Allen Lane.

Inman, P (2016). Oxfam calls on Theresa May to tackle rising UK inequality. *The Guardian*, 13 Sept.

& FINALLY – SNOOTS IN THE TROUGH

Earlier this year (*Asylum* 23(1): 17–18) we reported how relatives had to pressurise the authorities to call to account the Southern Mental Health Trust for failing to investigate the death by drowning of a young man in their care. After a subsequent CQC audit, the trust was criticised for failing to investigate 1,454 unexpected mental health and disability deaths during the four years up to March 2015.

This led to sustained calls for chief executive Katrina Percy to resign. These were ignored, until at the end of August she did finally resign – only to go straight into a new post created just for her. The job did not previously exist, she was the only candidate, and the pay was exactly the same: £240,000 a year.

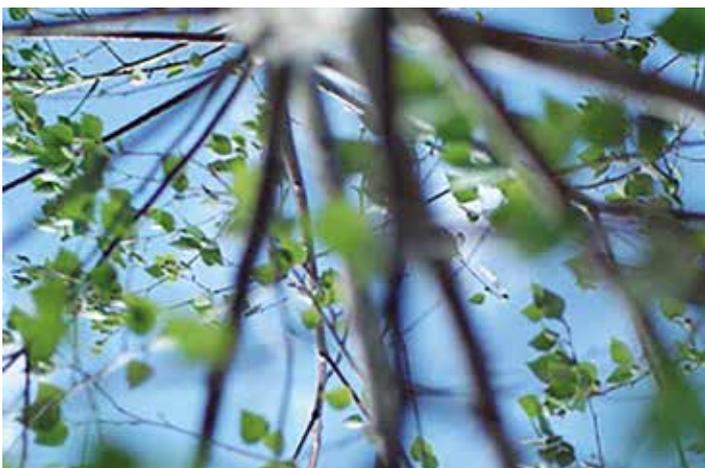
Southern Trust Chairman Tim Smart, in post for just four months, said they had not advertised the new role but the work – 'giving strategic advice to GPs' – 'needed to be done', and that Ms Percy is 'uniquely qualified'.

Smart resigned his post three weeks later. In the latest twist, the Trust's board says public feedback had led it to decide it was 'no longer possible for Ms Percy to continue'. She leaves with a £190,000 pay-off.

Southern Health boss Katrina Percy had new job 'created for her' (2016). *BBC News*, 7 Sept.

Former Southern Health boss Katrina Percy quits (2016). *BBC News*, 7 Oct.

'The opportunity to use the camera to re-invent everyday objects as items of beauty and wonder excites me.' **Garth Daniels**



Asylum

the magazine for democratic psychiatry

Winter 2016
Volume 23
Number 4
£4.00

Sales and subscriptions
Tel 01600 891509
www.pccs-books.co.uk

Information
Asylum Collective
www.asylumonline.net



• **contribute** •
editors@asylumonline.net

• **subscribe** •
www.pccs-books.co.uk

• **distribute** •
01600 891509