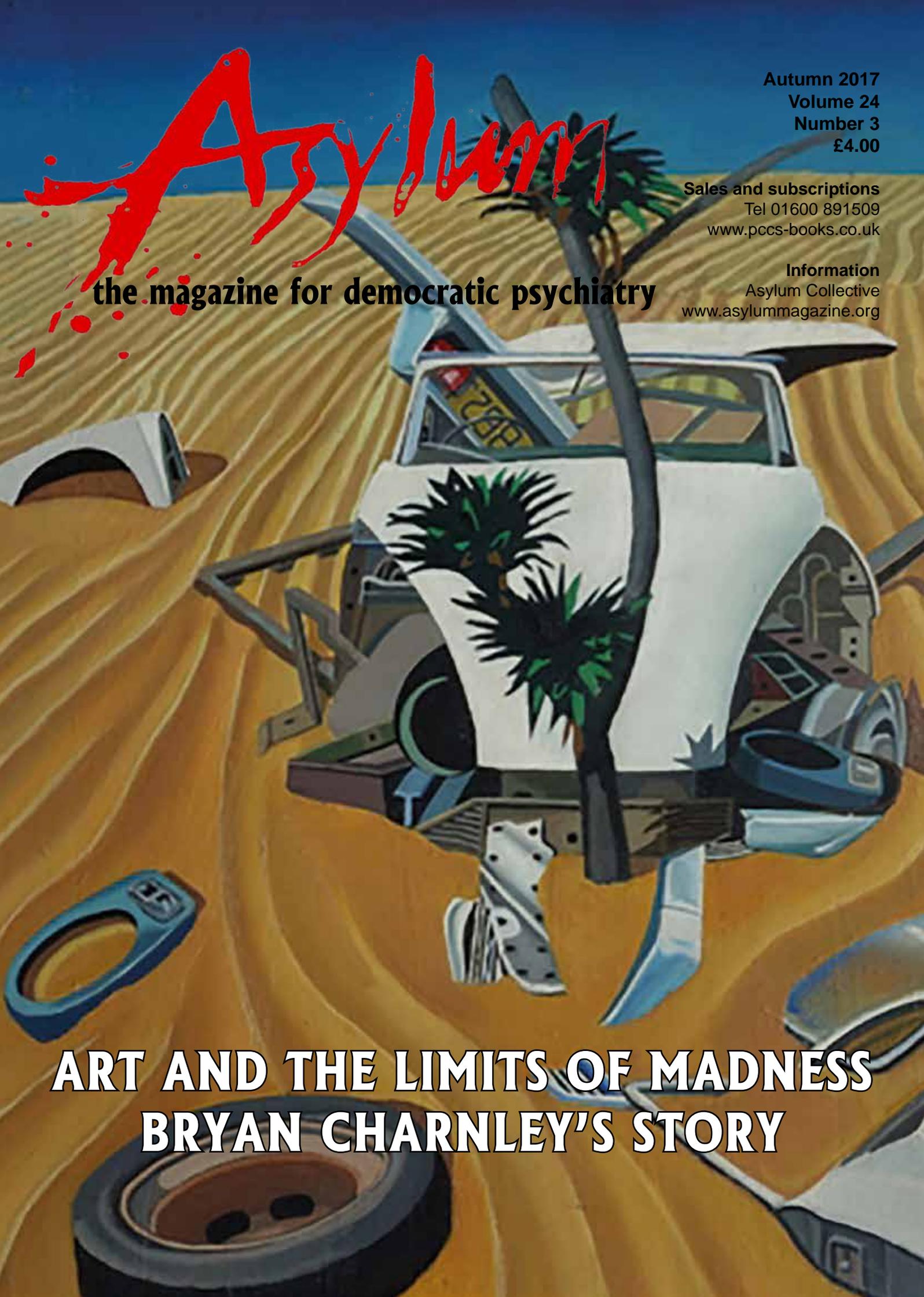


# Asylum



the magazine for democratic psychiatry

Autumn 2017  
Volume 24  
Number 3  
£4.00

Sales and subscriptions  
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**ART AND THE LIMITS OF MADNESS  
BRYAN CHARNLEY'S STORY**

## COMING SOON... THE BEST OF

# Asylum

In the light of our recent 30th anniversary, with PCCS books we are planning a collection of the 'Best of' *Asylum magazine*. Do you have any favourite articles, features, cartoons or stories from the first thirty years of the magazine? If so, let us know and we'll consider re-publishing them in this special collection.

This is part of a research project funded by the Wellcome Trust: *Crafting Psychiatric Contention: Asylum magazine (1986-2016)*. As far as we know, the Wellcome Trust Library in London is the only organisation that has a full back catalogue of the magazine available to researchers and the public. Helen Spandler will be exploring the first thirty years of the magazine. Nice job!

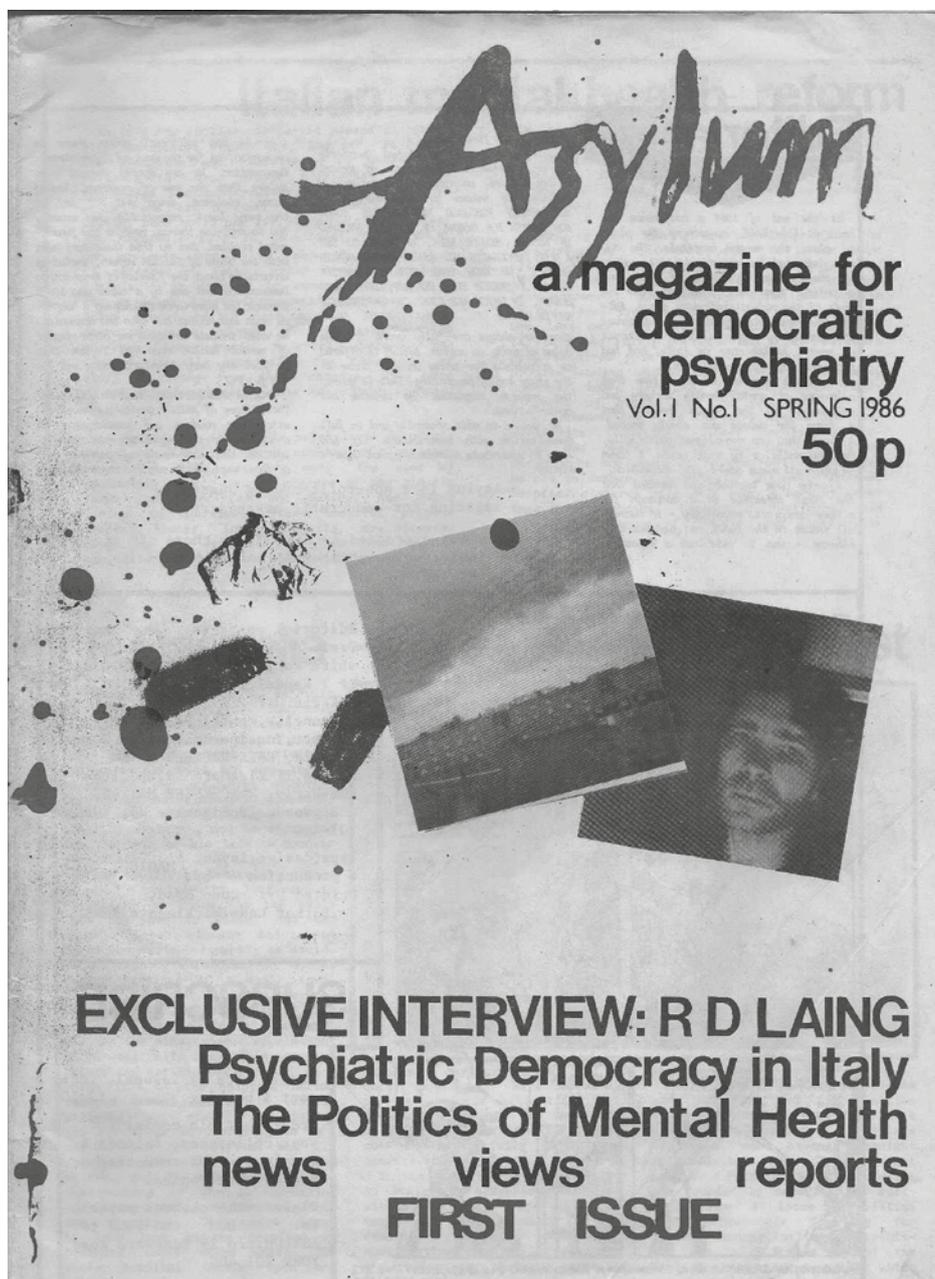
Please contact: [HSpandler@uclan.ac.uk](mailto:HSpandler@uclan.ac.uk) for suggestions and information.

### Early issues...

We are also starting to put early issues of the magazine available on our website.

<http://www.asylumonline.net/portfolio-category/archive/>

Big thanks to the lovely Pauline Sometimes for helping us with this project.





# The magazine for democratic psychiatry

Volume 24, Number 3, Autumn 2017

ISSN 0955 2030

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

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### Executive Editor

Phil Virden: [tigerpapers@btinternet.com](mailto:tigerpapers@btinternet.com)

### Managing Editor

Helen Spandler

### Creative Writing Editor

William Park

### Business Manager

Sam Taylor, PCCS Books

### Members of the Asylum Collective

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

### Administration & Distribution

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

### Subscriptions (see below for rates)

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Front cover image *Desert Car* by Bryan Charnley  
Back cover *Mad Pride Hull's Breaking Free* exhibition

*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.

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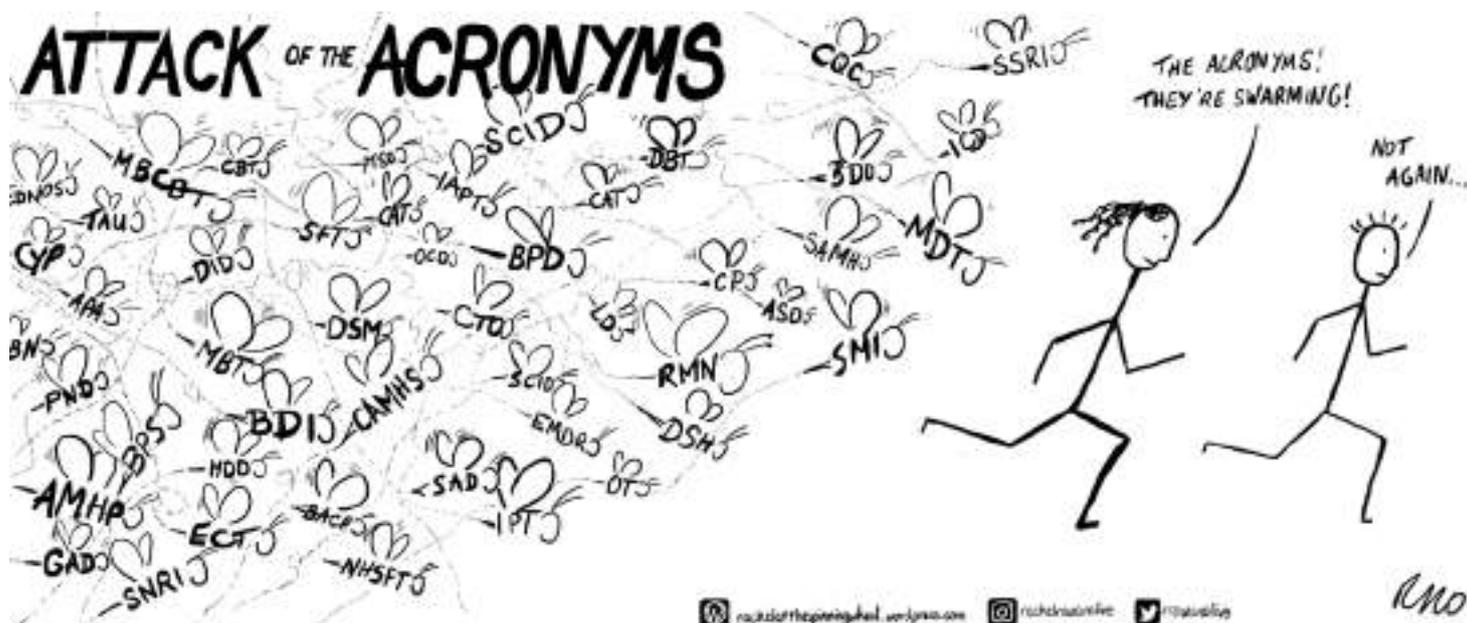
# Editorial

We hope you will find every bit of this edition interesting, but perhaps we should begin with some comments on the lead article. This concerns the remarkable artist, Bryan Charnley. Bryan suffered with mental health problems for many years, was diagnosed and treated for schizophrenia, decided to stop taking his meds, and finally took his own life. The article includes images and writings he produced while he stopped his meds and descended into his own nightmare world. Although some readers might find the story distressing, we have included it as the main feature because it raises a number of very difficult questions: for example, about people's rights to go mad, to take meds, or not take meds, and the right to pursue a dangerous path which might end in suicide.

Some may read Bryan Charnley's story as a warning about what happens when you stop taking your medication; others might read it as a unique existential portrait of a fractured mind; others as a sad indictment of a society which offers precious little support for people who decide to come off their meds. Bryan's story reminds us of the Antonin Artaud piece we featured in *Asylum* 4.1 back in 1989 – 'Van

Gogh: The man suicided by society'. Co-authored by the artist's twin-brother, this article offers no easy answers, and we make no judgments, leaving it up to readers to make up their own minds. As always, we welcome readers' thoughts and reflections on the important issues raised by this article.

On a lighter note, we would like to say a big thank you to all those who contributed to the success of June's *Asylum* conference in Manchester – to everyone who participated, but of course especially to those who helped with all the organising. Special thanks must go to Ian Parker and Helen Spandler of the *Asylum* collective for their commitment to the project in the face of so many difficulties, and Alex Dunedin from the Ragged University for fundraising and hosting our superb evening celebration. We'd also like to thank Di English and others at PCCS books for dealing with bookings and general liaison; the many helpers on the day (too many to list!); and those who donated to our crowdfunding campaign. We know that some of the presentations sparked a lot of debate and we very much welcome further discussion in the pages of the magazine. We hope to produce a special issue soon featuring some of the contributions and reflections.



# Bryan Charnley:

## Art and the expression of schizophrenia

JAMES CHARNLEY & NICK BOHANNON

Autonomy, self-expression and freedom of choice could be seen as prerequisites for life in a civilised world. Our hopes and dreams and the plans we make reflect the interface between our inner-world and our environment. Indeed, our actions often say more about us than the words we speak. What happens, then, when someone's internal experience leads them to draw conclusions and take steps which others may view as inadvisable? When what one person sees as acceptable risk, others see as ill advised?

The experiences we generally recognise as 'schizophrenia' commonly involve different perceptions and altered priorities. However, there are times when those differences somehow mask the message that the person is trying to convey. Rather than hearing the message, we notice the symptoms; rather than attending to the human state, we respond to the clinical condition.

The artist Bryan Charnley was diagnosed with paranoid schizophrenia. He decided to reduce and then stop taking the medication prescribed for treating his condition, and while doing so, to paint a series of self-portraits which he hoped would convey his internal experience during that process. No-one knew what the results would be, and a valuable source of insight is offered by the series of self-portraits and the notes the artist made in his diary.

Until recently, Bryan Charnley's diary was the only source of information concerning the artist's progress and intentions. New information is now available. In his forthcoming book, *Bryan Charnley: A Strange Interior Journey*,\* James Charnley has incorporated the artist's journals and conversations. Along with interviews, research and art historical analysis, these provide a wider perspective on the artist and the nature of self-determination, creativity and schizophrenia.

Creative people fail. They view failure as an essential part of the journey towards success. Therefore, not only does creativity require the courage of one's convictions, it also requires a willingness to struggle and to die a little bit for those convictions, over and over again (Kotler). Also, to create is to be seen – by oneself and by others – and to be seen, for some people, can be terrifying.

There are frequent citations of the link between mental illness and creativity (Kaufman), and some truly stunning creations have come from the minds of people diagnosed with a mental illness. Louis Wain's cats and Van Gogh's self-portrait after cutting off his own ear are both examples

of people who were diagnosed as sick and were also wonderfully creative. However, closer consideration reveals that it is uncertain whether Wain's paintings developed in conjunction with his changing mental health (Drinkwater), while Van Gogh is quoted as saying in one of his last letters: "Oh, if I could have worked without this accursed disease – what things I might have done." (Van Gogh). Perhaps considerations of cause and effect are ultimately less important, and what matters more is the intended content of the message, and the way in which it is received.

To a great extent Bryan Charnley's life, like the lives of so many others, was defined by the diagnosis of schizophrenia. This happened in 1971, while he was studying at the Central School of Art. Subsequent hospitalisations, electro-convulsive therapy and medication deepened the identification of the person with his condition. In his own words, Bryan had become "a schizophrene" – someone who lived outside of the normal world, separated from a shared reality. His reality involved 'thought-broadcasting'. This is described variously as a person hearing his or her own thoughts being spoken out loud; the experience of his own thoughts silently escaping, which may or may not then be available to others; or as the experience of other people being able to think in unison with



the subject, and his being able, by some means, to share in others' thoughts (Pawar & Spence). Psychiatric opinion is unclear. Whatever the particular mechanism, Bryan believed his private thoughts were public knowledge, and though medication numbed his anxieties about it, it did not offer a cure. As did his family, he wanted to know what had caused his madness.

After several years, in 1978, Bryan recovered sufficiently to find a flat in Bedford and begin to paint again. He demonstrated considerable ability and produced some remarkable paintings. For example, the painting *Desert Car* is a recognition of his propensity to collide with misfortune; Bryan explained this image as describing his inevitable bad luck: "If there was one tree in the desert, I would find a way of driving into it."

In March 1991 Bryan telephoned his twin brother, James. They kept in regular contact via phone calls and visits when possible. Bryan, as usual, came straight to the point.

"Here's what I have decided to do. I'm going to paint a series of self-portraits. I'm coming off the medication to do it. Show what happens as the drugs wear off, just keep on painting so that at the end you get a full portrait of the artist as schizophrenic."

James supported the idea. Bryan had weighed the dangers of stopping the medication against the strength of the concept. As the artist said: "I need to make a big statement, something that people can't ignore. Go the whole way. I've been painting about schizophrenia, but I've been doped-up all the time. How about I let people know what it's really like? Take the gloves off. The naked truth."

James recalls: "A small note of alarm was beginning to sound here. I remembered what had happened in Leeds when Bryan had stopped medicating. Then he had gone out of his mind. But now Bryan spoke as if he knew what to expect, and anyway, this was going to be in a controlled situation. He would only go as far as he needed to complete

the paintings. He would paint one portrait a day, no going back, no revisions, just carrying on as the drugs receded and the schizophrenia took over."

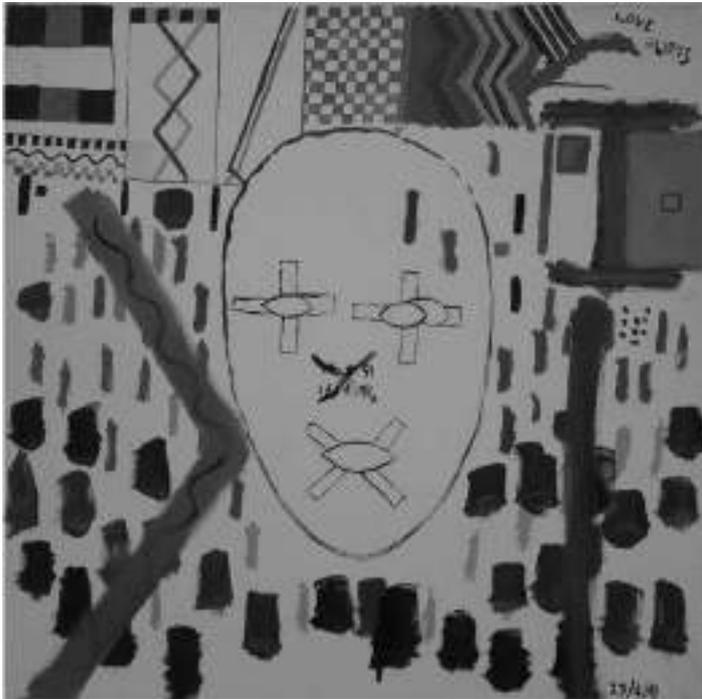
This plan seemed viable and worthwhile, and whatever worries James might have had were outweighed by the potential of the project Bryan was proposing. James remembers: "It was worth the risk. There had been so little progress with trying to get exhibitions. So many rejections that Bryan had grown despondent. To hear him talk so positively now had to be better than the constant sapping of his confidence."

Bryan began the Self-portrait Series on 11<sup>th</sup> of April, 1991. The first conventional portrait, painted while he was on his prescribed medication, took two sittings rather than the one he had originally intended. This deviation bothered Bryan, even when he had much more serious things to worry about. These details would have remained unknown had Bryan not been encouraged by Marjorie Wallace, the CEO of SANE, to keep a diary of his progress. The diary which recorded his thoughts and decoded the imagery of the paintings has proved immensely significant, adding much to the communicative impact of the work.

The second portrait, of 20<sup>th</sup> April, records the effects of drastically reducing his medication. Bryan had gone down to only one Depixol tablet a day – one-quarter of his normal intake. At that time, Depixol was a widely-used antipsychotic. Many side effects were associated with it, including drowsiness, loss of co-ordination, tremor, poor concentration, confusion, depression and nervousness (electronic Medicines Compendium), several of which were mentioned by Bryan in conversation and letters. As can be seen in the second portrait, the effects of lowering the dose were alarming: Bryan had started to become psychotic. He was convinced his mind could be read, and that this was because he was sending out the information. His hold on reality is beginning to break down, and yet he



finds a way to communicate what is happening to him: "I tried to express this in the painting. The large rabbit ear is because I was confused and extremely sensitive to human voices, like a wild animal."



Worse was to come. By the third self-portrait, of 23<sup>rd</sup> April, Bryan records that he has lost any ability to concentrate. This was anathema to painting, and his plans were again upset. He had expected to be painting a disintegrating ego with the sort of hallucinatory geometry associated with Louis Wain's psychedelic cats. Instead, he could only make the simplest of marks. Crude daubs of colour usurped any painterly skills. His ability to draw had been reduced such that he could only manage to describe the most basic of shapes. Bryan's face was reduced to an oval white mask, his empty features crossed out or taped over. The effects



of drug withdrawal seemed to be getting more acute.

By the fourth self-portrait, of 24th April, Bryan writes: "Why miss a golden opportunity to describe through paint total mental disintegration?" He has accepted that no matter how crude the painting has become, it is truly expressing his condition. The division between life and art is fragile. Bryan's experience is so integral to the art work that he now uses his own blood. He writes: "The spots on the brain are real blood to try and get over the mental pain I was experiencing." By now he has begun to doubt he can hold on much longer. All this is contained in the diary notes that go with each portrait.

The next diary entry is on April 29<sup>th</sup>. It records that Bryan had taken fifteen tablets of Depixol so as to try to find relief from the mental torture he was going through. The advised maximum daily dose for Depixol is 18mg; Bryan would have taken 45mgs, considered a serious overdose. For the next few days he kept taking high dosages, but they seemed to have no effect. What worked were a few kind and rational words. Bryan marvels at their effect, and writes bitterly:

"The doctors just prescribe more and more drugs when the patient comes up with something he can't handle. What I think is interesting is that the drugs, no matter how high the dosage, had no effect. What made the change was rational insight, the truth. The doctors, of course, will mutter that the drugs just began to take effect, but I do not believe this for an instant. [I] Believe instead that the answer to my condition is rational insight, but the doctors seem unwilling or unable to help me here."

James reflects: "If Bryan could not find the truth, at least he had exposed the lie. Drugs alone are not the answer. People respond at least as well to rational insights. They respond best when they are treated with kindness and understanding."



By the 23<sup>rd</sup> May, 1991, Bryan had painted his 10<sup>th</sup> self-portrait. His journal reflects his frustration. "I really tire of having to explain my paintings. It is very much my tragedy that people cannot understand the straightforward poetic use of symbols I am employing. One is very much up against the almost impossible task of describing in paint that which is essentially totally invisible. At this stage my central worry was thought-broadcasting. This would pass as I gained insight and effects of drug withdrawal wore off. I was much worried about radio and television because I seemed to intertwine with their broadcasted waves and expose myself completely, which I found humiliating. People laughed at me when this happened or let me know it was for real by acute remarks. I continued my retreat from social contact."



To accompany his 13<sup>th</sup> self-portrait, on 13<sup>th</sup> June, Bryan wrote: "The eggs have been emptied like a head stripped of its contents. It has nothing left in it, no more secrets, they went to satisfy somebody's appetite, somebody that has power over me. They enjoyed every tasty mouthful."

Two eggs? It was the same yesterday. Needless to say I feel suicidal so I painted in Van Gogh's crows from his final, suicide picture of the wheat field. E.S.P. horns, voices as mouths grinning. Birds come from eggs so the crows can also be like my thoughts flying away. All this sort of gossip increases my fears of telepathy, and is the main reason I feel suicidal. Still on 1 1/2 tabs Depixol (3 mg. each). On 24<sup>th</sup> May cut out anti-depressant, Tryptisol, completely."

27<sup>th</sup> June: "An extremely complicated picture, as I feel I am closing in on the essential image of my schizophrenia. I am transparent, firstly. Make crazy attempts at some sort of control over what has become an impossible situation (the man with the control stick). My brain, my ego is transfixed



by nails as the Christ who could not move freely on the cross without severe pain. My self-respect my ego my feelings about me are crucified as the Christ. From here on in enlightenment about my condition creeps in and imagery become even more difficult to find. I realised that the fear caused by the anger (symbolised by the red tied beast, muzzled because the anger arises through not being able to reply to the abuse heaped on me) this fear is causing me to hallucinate telepathy and E.S.P. which is not there. Or not there when I am no longer in fear. I express this as best I can through the mouths on the end of the enormous bent up eyebrows. My senses are being bent by fear into hallucinations. Like eyelashes it is something about the bending taking place at the periphery of my sight. That is why I had been feeling blind all the time. Anger, 'He's mad at you, he's mad', is cause of fear, the anger being in a latent, unconscious state, but giving rise to paranoia which in turn gives rise to characteristic schizophrenic hallucinations and symptoms. But I am still at an acute disadvantage socially. Can this ever change or will the anger always remain? I intend to record my progress with more self-portraits to add up when they are all joined together as an important document as to life at the end of the twentieth century. *Self Portrait* will state with depth what it is to be human and schizophrenic. One 1 1/4 tabs Depixol (3 mg. each) from 22<sup>nd</sup> June 1991."

There was an interval of eight days before another self-portrait appears, on 12<sup>th</sup> July. The writing has been transferred to the canvas, becoming one with the painting. On the map of a battlefield, surrounded by enemies, Bryan Charnley paints: "The cards are no good that I'm holding unless they're from another world." In *Series of Dreams*, he is referencing Bob Dylan's lyrics. In the final portrait there is no text at all, other than the date: 19.1. 91, the 19<sup>th</sup>



desire to control and shepherd him along a path that he does not feel is his own? When we control and try to shape someone, we change them from who they were. Each time we intervene – out of love or respect or a desire to help – a little bit more of that person is gone. However, Bryan Charnley is gone now and his paintings are left with us, like words hanging in the air. The question is have we heard them?

### Postscript

Bryan Charnley was a talented and prolific artist. The self-portrait series was exhibited in the National Portrait Gallery, but most of his work remains largely unknown. His photo-realistic paintings, the series of bondage heads, and his allegorical work represent a stunning collection of creativity and talent. For more information and high resolution images of Bryan's work go to [www.bryancharnley.info/](http://www.bryancharnley.info/) ■

July. The words have disappeared, along with the artist's face. All that is left are two predominant colours – red and yellow – which seem themselves to be disappearing into the dark earth. As James Charnley has noted, red and yellow strands act as a *leitmotif* throughout the series, seeming to be associated with acute mental anguish. This final portrait was on the easel in his studio, where he committed suicide.

What had Bryan achieved? He had set out to illustrate his experience of schizophrenia by “taking the gloves off”. His desire was to paint the invisible in order that we might see, and in order to do that he had to “come off the medication” and risk the precipice that he was walking towards. Did he see the danger? Or did those risks represent opportunity to Bryan? Perhaps the worst death of all, to a creative person, is the loss of his creativity. Diagnosed schizophrenic, Bryan had been given many drugs but no answers. The cure seemed to be a secret he could never discover. In his last Artist's Statement he put it like this:

It is like everybody knows the secret  
But nobody, no, nobody will tell you  
Because if they keep the secret they can  
Go on treating you as less than a man.

And that was just the problem. The added cruelty of his condition was that Bryan was ignored as a person, his sufferings unrecognised and given no sympathy. The schizophrenic suffers untold miseries, not least the indignity of being seen as mentally weak. By his art, Bryan tried to inform this ignorance. He balanced clinical risk with creative opportunity. Was he right to take on such a task? How do we balance respect for someone, *as a person*, with the

### Endnote

\* The co-author of this article, James Charnley, is the artist's twin brother. His book is intended as a comprehensive source which may be referred to by those interested in Bryan Charnley's life and art.

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# DEMOCRATIC THERAPEUTIC COMMUNITIES IN THE 21<sup>ST</sup> CENTURY

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REX HAIGH & JAN LEES

During the twentieth century, therapeutic communities in the UK established themselves as a radical alternative to mainstream psychiatry. We think they still are. In our view, no other forms of intervention, treatment or therapy are as democratic. The level of social control in most forms of mainstream psychiatry is becoming overwhelming, with increasingly burdensome regulation, a neoliberal-driven aversion to risk or uncertainty, and policies such as Community Treatment Orders. This combination leaves very little scope for democratic psychiatric practice.

By contrast, in the way power is exerted, the continuing radicalism of the therapeutic community approach is the same as it ever was. In clinical work, the authority of 'the biomedical model' is secondary to that of group decisions, and in more progressive organisations this extends to influencing institutional policies and procedures.

Some of the philosophical roots of therapeutic community may be traced back much further than the last seventy years. In the thirteenth century, 'mentally afflicted pilgrims' travelled to Geel, where the village community took them in and looked after them. With The Enlightenment, people with persistent mental health problems were defined as 'mad' and simply incarcerated away from society. In England, the Quaker William Tuke responded to this inhumane policy by arguing for the 'moral treatment' of people as human beings, rather than as animals to be tethered and caged; at York, in 1796, he opened The Retreat.

There is also a long tradition of progressive residential education for children and young people, dating back to the late-nineteenth century with the 'Boys' Republic' in Chicago and the 'Little Commonwealth' in Dorset, run by Homer Lane. After the Great War, Summerhill School, in Suffolk, was set up by AS Neill, and is still operating today; it holds regular community meetings, and each child is allowed to choose what they learn and when they learn it. In the field of learning disabilities, farming communities such as L'Arche and Camphill were established in the twentieth century, by Jean Vanier and Karl König respectively; both organisations expanded internationally and still exist today.

The British democratic therapeutic communities emerged from wartime military experiments and the heat of the 1960s and '70s social psychiatry movement. The doors of wards were unlocked, and therapeutic communities stood firmly against medical orthodoxy, the power invested in hierarchy and status, and the use of physical treatments,

such as the newly emerging psychotropic medications. Instead, therapeutic communities promoted democracy, empowerment, treatment of equals by equals, and the importance of 'being with' rather than 'doing to'. The main principles include challenge and confrontation in a flattened hierarchy, and a culture of enquiry in which people feel emotionally-contained and safe to do the necessary psychological work. Risk is contained through relationships rather than by protocols and procedures. Programmes are group-based, and the community itself is the primary therapeutic intervention: all members of the community are responsible for the day-to-day running of the unit, and decisions are made by consensus or voting; members cook, eat and spend social time together. In contrast to the paternalistic attitudes taken by mainstream services, a most important principle of therapeutic community is that patients must take the lead in their own treatment, as well as contribute to the treatment of others. Therapeutic communities have extended this practice so that ex-service users and experts by experience are encouraged to become involved in teaching, training, research, service commissioning and consultancy. More recently, these practices have been adopted by other services in all areas of health and social care.

Although this discussion mainly concerns democratic therapeutic communities for people with mental health difficulties, there is also a large worldwide contingent of 'addiction therapeutic communities'; although their origins were very different to 'democratic' therapeutic communities, in many ways they are becoming increasingly similar.

Therapeutic communities have managed to adapt and change in response to challenges, and their members are expected to do the same in their own lives. In the last thirty years they have particularly had to adapt and change in response to increasingly austere economic policies and an emphasis on short-termism, as well as to the rise of individualism and consumerism. While the late-1980s and the 1990s saw the closure of many residential NHS therapeutic communities due to financial constraints, creative adaptations were also taking place in order to survive. Two new national residential NHS therapeutic communities were set up to replicate the work of the flagship Henderson hospital; other NHS residential therapeutic communities responded to the challenge by converting to non-residential programmes, and a number

of day communities were established as part of the national personality disorder program, in the early 2000s. Four new wings were established as part of a new purpose-built private prison; researchers in the field were awarded two major grants for review their evidence base.

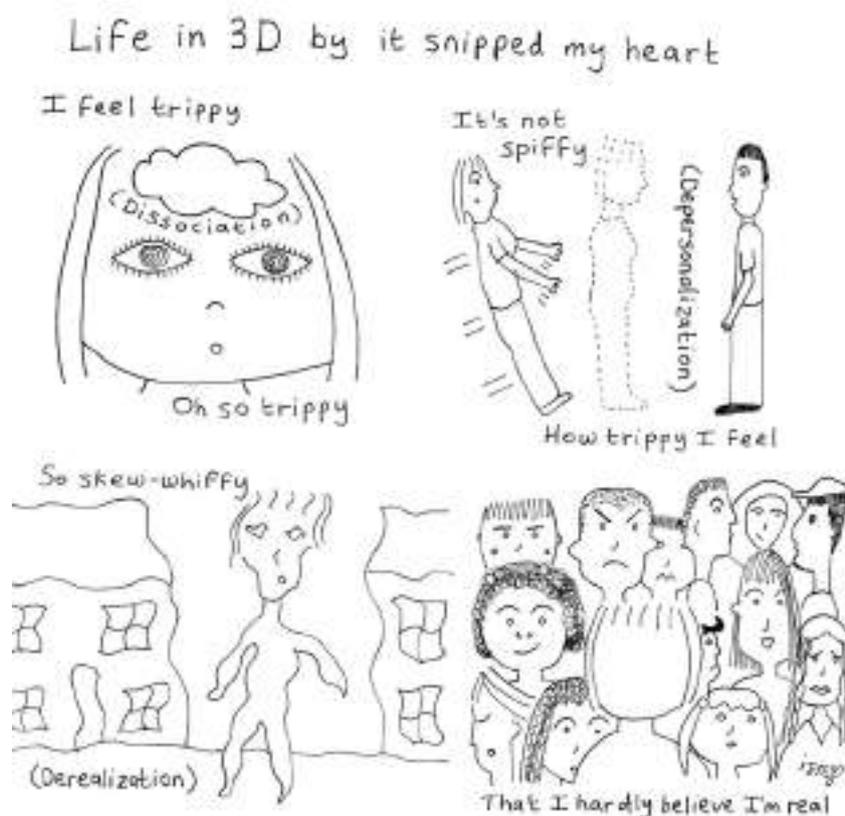
Due to increasing government regulation and inspection of care provision, therapeutic communities again responded creatively by devising an international network of peer-review and audit: the 'Community of Communities'. This sets its core standards by democratic processes, involves current and ex-service users at all levels, and implements its audits in an inclusive and empowering way.

In 2007, the Community of Communities started a spin-off project called Enabling Environments. By distilling the underlying relational values from several years of audit data, ten 'value-based standards' were set. These represent the ways in which the ethos and atmosphere of therapeutic community is established, but without any of the structural requirements – such as community meetings or specially trained staff. They are therefore transposable to a wide range of settings where the quality of relationships is seen as crucial. This work, and the portfolio-based award to which it leads, now underlies new ways of working in the homelessness and prison sectors. Psychologically Informed Environments are transforming homelessness hostels, while Psychologically Informed Planned Environments are doing the same in prisons and probation premises. Most recently, all UK 'approved premises', are being supported to become accredited Enabling Environments, and their use in other public service settings is being explored.

Although British therapeutic communities struggle to survive in the current political and economic climate, there are still some new and interesting developments. One is the establishment of regular experiential training communities – the 'Living-Learning Experience' workshops. These were originally set up to give staff the experience of what it is like to be a member of a therapeutic community, but they have more recently been adapted for use in training for relational practice in groups, teams and organisations and, in Italy, for entrepreneurs and business leaders. Although these events have been running in the UK for more than twenty years, the programme and structure is being faithfully reproduced and used throughout Italy, increasingly in India and most recently in Portugal. In addition, the government of Sicily has encouraged the setting-up and funding of new therapeutic communities, while several other Italian centres have also set up networks adapted from the UK's Community of Communities.

An additional extension of therapeutic communities and enabling environments is 'greencare'. This includes nature and the natural world as an integral part of therapeutic programmes: it can include therapeutic horticulture, animal-assisted interventions, care farming and wilderness camping.

Although the future remains uncertain, the basic principles of therapeutic community will endure – they are part of being human with each other – and the practice of therapeutic community will continue to change and adapt in creative and forward-looking ways. ■



# BEATEN WITH A CARROT

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## *My Dysfunctional Relationship to Legal Capacity*

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RONDA E. RICHARDSON



Drawing by Róisín Cure

I am staring at this blank page, wondering how I can so easily describe my life as torture but I cannot find the words to explain my relationship to legal capacity. The concept feels insidious – but hopeful. It has been both a carrot held out to keep me striving, and a stick used to beat me into submission. As the ultimate standard of protection and the basis for losing everything, legal capacity forms a contradiction that makes me unable to breathe. I spend hours overthinking ways to untangle and make sense of my right to be in the world unrestrained. So far, I am still tied up in knots.

On paper I lost legal capacity through certification, just once. As a teenager I was given an unforgettable education in the dangers of power imbalance. Instead of learning to be free, I learned how to physically survive the cage by leaving my needs and mind at the door. At 18, I did not celebrate my arrival into adult freedom. I mourned in the knowledge that legal capacity was only a given for those not touched by diagnosis. There was no way to get untouched.

Despite experiencing more than twenty additional psychiatric hospitalizations, I was never again certified. In order to keep a semblance of legal capacity, I learned quickly to give it away. I was shrewd enough to know that if they took forceful possession of my rights I would have a harder time getting them back. I was proud of all the certification paperwork that my cowering had saved. In an existence with so much defeat, I was clinging to any success I could find.

I had to learn to play this game the hard way, without any help. The rules were irrational and ever-changing. My own mind became the locked room I was fighting to escape. I found an illusion of safety by curling up into a ball and riding it out. Some days I feel I am still stuck in that place with my hands squeezed over my ears and my knees drawn up. I still freeze. I still collapse. I still give myself away so I cannot be stolen.

After an emotional lock-down, I realize with frustration that I have fallen back into the same survival behaviours I am endeavouring to let go of. I am trying to remember that this pain is actually progress. The next step is finding strength earlier and earlier. I am slowly peeling my hands away from my ears, straightening up, and forming fists. A short burst of power before recoiling is amazing headway when compared to where I started.

In my very visual internal world, carrot orange is the colour of bullying. Legal capacity for me is intrinsically tied to

tyranny. Removal of freedom was implied so as to enforce compliance. Losing my autonomy was an effective ultimatum, and I knew how to quietly fall in line. I wholeheartedly bought a whitewashed label falsely advertising my freedom of choice, so as to soothe the reality of how little choice I actually had. They were honest and stated clearly: “You are voluntary unless you choose to leave.”

A handful of people have disdainfully pointed out the absurdity of delaying my self-protection. It took time to find courage and support. It is easy to say what the best choice would be while looking in through the window of a burning building. In looking back, from the inside, I never once stopped fighting this fire. Yes I was unskilled and misguided, but I did my very best. The first way I have applied the principles of legal capacity is by making a choice to disengage from any oppression whether it comes from myself, my family, peers or professionals. That milestone is a proud untangling of a very big knot.

Legal capacity is always on my mind. I am vigilant often to the point of complete withdrawal. The way I dress, how fast or loud I talk, and my posture are just a few of the aspects under constant scrutiny.

The threat is real. When supporters try to ensure me of protection I feel suspicious and listen instead to an echo coming from the locked room in my mind. With valid concerns, my intuition screams: “Run! It is a trap!” I know from experience that it only takes three seconds to lose your freedom and three more months as a psychiatric inpatient for the world to forget you ever existed.

Like a parent holding out a reward for desired behaviour, legal capacity has always been held over my head instead of given unconditionally. It was a tool removed or granted in order to discipline any “normal” deviation. I wrongly assumed that those in power knew better than I did. It was less excruciating to go without than to hope and have it all taken away. Today I am beginning to realise, with regret, that I have been choosing to live my life as if legal capacity was never an option for me. It has been a life lived in perpetual surrender.

If I could live legal capacity instead of chasing it as an entity outside myself, maybe I would finally feel it as a right and not an elusive and unattainable privilege. I could stop trying to untie this problem and instead turn this row of knots into a warm blanket, a friendship bracelet or a dream-catcher. It is going to take a while to renegotiate the boundaries of this dysfunctional relationship, but I have plans to eat this carrot just as soon as I catch it. ■

# ROBERTFEST 2017

12 NOON, SUNDAY 24 SEPTEMBER AT THE AMERSHAM ARMS, DEPTFORD, SE LONDON

A 12 hour rock gig to celebrate the life of well-known mental health activist  
and general mensch Robert Dellar

Robert Dellar died suddenly on 17 December 2016, at the age of 52. This left a huge hole in the mental health survivor movement. Robert lived in New Cross with his partner Shirley Pearson and stepdaughter Sophia. This event is organised by mental health service users from Mad Pride and the Mental Health Resistance Network.

Robert was a founder member of Mad Pride, and through his work at Mind pioneered the model for mental health advocacy projects that are still in use. He had over 25 years in the saddle as a star player in the mental health survivor movement, becoming one of the best-known mental health professionals in East and North London. Most recently he worked for Southwark Mind and Southwark Assn for Mental Health, from where he reached pretty much every mental health service user in Southwark with his tireless efforts, setting up groups, lobbying local service providers, organizing demos, producing an anarchic newsletter (in a fanzine style), and offering support to individuals. He formulated and set up the User Council for Southwark Mind, another pioneering organ whereby local mental health service users could feed in their views directly to decision-makers at the Maudsley Trust and to those involved in service provision across the whole of Southwark and Lambeth. (For information about the User Council, contact Southwark and Lambeth Mind.)

But perhaps he is best remembered by most people for the outstanding rock gigs that he put on all over the borough in mental health settings like the Lorrimore Centre and Muses Café – these were always packed to the rafters. As a founder member of Mad Pride, he organized sell-out gigs at high profile venues like the Garage in Highbury, and in the last couple of years at the Lexington in Islington –

again packed with hundreds of mental health service users. He also spearheaded many big public protests under this banner, and, along with the late great Pete Shaughnessy, was largely responsible for *Time Out* covering Mad pride, with the headline: 'Mad Pride have stampeded into the limelight'. This was when our one day festival in Hackney's Clissold Park, attended by 3,000 mental health service users, punks and anarchists, was covered by *CNN* and spawned Mad Pride groups nationally and globally.

A book of reminiscences about Robert Dellar – *Kiss of Life* – is currently being compiled by cartoon artist Lawrence Burton. Robert was a music journalist before getting into mental health work, and when too ill to any longer work in a full-time, salaried capacity, he returned to writing and produced a book. *Splitting in Two* was published a couple of years ago by Unkant. This expands on all the hilarious and significant things he and others got up to, both at work (including in Hackney Hospital and Brixton prison) and in his free time with Mad Pride and the Mental Health Resistance Network. (*Asylum* 24.1 featured Robert in its Editorial, where there is more information about his writings.)

Robert was the inspiration for countless people to realise that they have a voice, as well as an empowering force that drew people together to organize themselves for action. I was privileged to work alongside him in Mad Pride and countless other ventures. Always funny, true to the authenticity of his views, Robert was energetic, creative, charismatic and totally on point in his knowledge of the benefits system, mental health law and precisely what constitutes acceptable (and therefore unacceptable) practice. He was the 'go-to person', night and day, for very many people if a crisis blew up, which they often did, and if anyone needed immediate and urgent help.

This event will run from 12pm–12am, and features all Robert's fave bands and performers, who he put on at gigs for mental health service users as often as he could over the years, not to satisfy himself but to introduce a whole new audience to the music he loved. Headlining will be the legendary punk band ATV. Also playing are Vic Godard (of Subway Sect fame) and his band The Bitter Springs, notorious mad punk band from Blackpool The Ceramic Hobs (whose best known album 'Straight Outta Rampton' earned them a record contract the moment it was released), highly regarded North London musician Jowe Head with his new band The Infernal Contraption, seasoned rockers The Long Decline (who will do a set with Vic Godard and Mark Perry of ATV), Dave Kusworth and The Jacobites (who fans will remember from their glam-rock days of fame) – and



many more! It's a real cornucopia of punk and rock bands getting together for this one-off tribute to their mate and ours, Robert Dellar, and promises to be an excellent and memorable event. Everyone welcome, whether you knew Robert personally or not. The event will also showcase the inaugural Robert Dellar Memorial Lecture, to be given this year by mad academic and writer Prof Esther Leslie, another friend and fellow agitator.

Tickets are £5 unwaged/ low waged, £10 quid waged,

£20 quid if you feel like it. Any proceeds after the costs are covered will be donated to the Mental Health Resistance Network, a campaigning organisation that Robert was very involved with, up to the time of his death. Get tickets on the door or on Eventbrite. The Amersham Arms is at 388 New Cross Road, London SE14 6TY. Buses 34, 35, 40, 41, 52 run past the venue. See the Robertfest 2017 facebook page for more!!! ■

**Debbie McNamara**

# HOW MENTAL HEALTH STIGMA IMPACTS ON PHYSICAL HEALTH

OLIVER SWINGLER

It can be essential to get a mental diagnosis in order to access support services such as counselling, or respite from employment whilst working through a traumatic episode, without facing dire poverty. However a diagnosis may then significantly affect a patient's physical health condition, in a number of ways.

Firstly, there's the attitude of doctors, many of whom are at least as ready to stigmatise as the general public. Because of having been fairly itinerant over the years, I've had many experiences of signing on with new surgeries. At the first visit I've usually got on well with the doctor – at college I knew a number of medical students, and I've worked in the NHS, so I can talk their language – and I'd have no trouble explaining my current symptoms and getting a prescription. But if I returned a few weeks later – in the meantime my medical records including mental health history having arrived – what met me would be totally different. The doctor would not look me in the eye, he'd talk loudly over me as if I were stupid, my described symptoms such as where I felt pain would not be believed, and I'd sometimes go away without any medication, feeling a lot worse for my visit.

At a recent local HealthWatch meeting, a carer described how his daughter, who was diagnosed as bipolar, was assigned to a particular doctor in the practice – and however bad her physical health, no other doctor would see her, and the next appointment might be a month away. By which time her untreated physical health condition might have got whole lot worse. On one occasion she urgently needed attention, and had to shout really loudly before anyone listened. Having had a similar experience, I then chipped in that a further problem could arise – the doctor might write into the permanent medical record that “the patient was aggressive” (no I/she wasn't, we were ill and extremely upset at not being believed!), and any future doctor would be even less likely to be sympathetic.

Another patient described how he was having real, painful and even life-threatening problems with his pacemaker, but he was not believed by a number of health professionals. Having only fairly recently had a mental health episode, he was able to differentiate between the attitude of staff before and after he was known as a mental health survivor. Eventually, after weeks of unnecessary pain, they did decide to investigate, which took a minute or two; a very simple mistake had been made, and the problem rectified in a few seconds. But in a sense he was fortunate: some mental health survivors are never believed, until too late, after the autopsy.

Then there's the problem of time. A patient may go to the GP needing some help with mental health problems as well as one or more physical health conditions. Physical symptoms are hard enough to describe but mental health problems are even more so, and the allotted ten minutes per appointment is often not enough. I've had the experience of being told that my time was up, and I hadn't even mentioned two physical health problems, which therefore got no treatment until I could make a further appointment a week or more away.

I'm sure many mental health survivors have their own stories of receiving a poor standard of the care of their physical health at the hands of their GP. And the appalling fact is that the death-rate of mental health survivors is significantly higher than the average, even when suicide is factored out.

We shouldn't and needn't put up with this, and as a first step I would urge everyone with a personal experience of poor care to contact your local Healthwatch, and pass it on, so they can collate experiences and take it up with higher authorities within the NHS and government. And maybe one day medical professionals will treat us with the dignity and respect we deserve and sometimes so urgently need. ■

# Creative Writing

## i AM YOUR SELF HATE

ERIN MUELLER

I do not want to get better, and I hate these therapy groups you go to. I will not let you feel anything but the suffering I believe you deserve.

I will drive away everyone who is close to you, with my wicked ways. I don't want to have fun. I want to be isolated and have no friends. I want to be alone so that when I kill us, it doesn't matter. If I let you have people in your life, you'll have hope. Hope takes away everything I am...

The rape was the best thing that could have happened to me – and one of the worst things to happen to you. I twisted it into your brain so deep that you will never want intimacy again. I've disassociated the physical and emotional, and I will fight like hell every single time you try to let someone see us. Really see us. Because of what happened, I could keep you down. I could make sure you were not happy. I could make you feel like you deserved it, and the fact that you gave me that power thrills me.

Since I have made you hate intimacy, I can make us walk away. I walk into and out of people's lives, making them believe we loved them, so easily. When I hurt someone from manipulating them, I feel accomplished. Your guilt about this weighs on you so heavily, and feeds into me.

I make you starve and then binge eat. And I'll love every moment of it. I love the pain of not eating for days, the empty pain in this body. And then the pain of eating mountains of food at a time. But the best part is how much shame it gives you. When you stare in the mirror and cry, I smile. Making you believe that this body we live in is disgusting brings me joy. There is nothing I love more than when you go shopping. I know what you'll see in the mirrors and I know you'll cry and give in to me. I know you'll let me bleed.

When you bleed and burn, I smile. I do my job so well. The release of the bad blood exhilarates me. I thrive on this pain. It excites me and gives me a high I've never felt before. It puts me in control and it makes everything okay. No one will ever hurt us as much as I will. You want it to, but for very different reasons. Hurting our outside to try to kill me will never work, but you are so convinced it will. The only way to kill me is to control me, and your groups terrify me for that reason.

I've made you believe that I am you for so long that you couldn't tell the difference. You want a family and children, I do not. You want to have fun with friends and want people to care about you, I do not. You want to finish school and have a job you love, I do not. You want to feel love, **and I do not.** But now that you know who I am, and that you are not me, you can be free.

## BODY FOR RENT

MEGAN TYLER

my body is an empty house  
all the bedrooms are locked  
i have picked the locks  
i have kicked down all the doors  
i have punched my knuckles through drywall  
my body is a canvas  
arms and thighs  
painted well with marks of  
destruction and self loathing  
it is dark  
it is always dark  
the bulbs do not glow or shine  
my body is an abandoned building  
glass shattered  
bathtub of blood  
scarlet on tile floor  
this chaotic mess  
this screaming and hissing  
belongs to something else  
someone else  
woman of wounds  
woman of healing  
this ache that pulses  
it has its own beat

# MARK TWAIN

## CONCERNING THE 'INTERVIEW'.

*Mark Twain (Samuel Clemens) was celebrated world-wide for writing Huckleberry Finn – perceptive, progressive, and the funniest novel of the 19th century. In this piece, written in 1890 but not discovered amongst his papers until 2010, Twain writes about the futility of the newspaper interview. This is because, in his experience, every reporter comes to the encounter expecting to meet a chuckling, avuncular old gent, bursting to tell folksy, hilarious and previously unpublished anecdotes concerning his life and times. The reporter might elicit a few facts – probably already well-known – but the expectations he brings will prevent him from ever getting at, or recognising, anything about the real nature of his subject – about what makes Sam Clemens tick.*

*When it encounters a new patient, modern psychiatry employs a standard interview schedule. This, too, might get at a lot of facts, and help 'fix' the patient with a diagnosis and organise a care plan. But like Twain's newspaper interview, does the standard schedule get to what the patient – the person – is really about?*

*As they perform their duties, mental health officials are always, in one way or another 'interviewing' the patients, i.e., openly or covertly interrogating them, just as a matter of 'keeping on top of things'. And of course they see patients with mental illnesses, rather than people, each with their own unique and pressing problems. See if the following rings any psychiatric bells!*

No one likes to be interviewed, and yet no one likes to say no; for interviewers are courteous and gentle-mannered, even when they come to destroy. I must not be understood to mean that they ever come consciously to destroy or are aware afterward that they have destroyed. No, I think their attitude is more that of the cyclone, which comes with the gracious purpose of cooling off a sweltering village, and is not aware, afterward, that it has done that village anything but a favor. The interviewer scatters you all over creation, but he does not conceive that you can look upon that as a disadvantage. People who blame a cyclone, do it because they do not reflect that compact masses are not a cyclone's idea of symmetry. People who find fault with the interviewer, do it because they do not reflect that he is but a cyclone, after all, though disguised in the image of God, like the rest of us; that he is not conscious of harm even when he is dusting a continent with your remains, but only thinks he is making things pleasant for you; and that therefore the just way to judge him is by his intentions, not his works.

The Interview was not a happy invention. It is perhaps the poorest of all ways of getting at what is in a man. In the first place, the interviewer is the reverse of an inspiration, because you are afraid of him. You know by experience that there is no choice between these disasters. No matter which he puts in, you will see at a glance that it would have been better if he had put in the other: not that the other would have been better than this, but merely that it wouldn't have been this; and any change must be, and would be, an improvement, though in reality you know very well it wouldn't. I may not make myself clear: if that is so, then I have made myself clear – a thing which could not be done except by not making myself clear, since what

I am trying to show is what you feel at such a time, not what you think – for you don't think; it is not an intellectual operation; it is only a going around in a confused circle with your head off. You only wish in a dumb way that you hadn't done it, though really you don't know which it is you wish you hadn't done, and moreover you don't care: that is not the point; you simply wish you hadn't done it, whichever it is; done what, is a matter of minor importance and hasn't anything to do with the case. You get at what I mean? You have felt that way? Well, that is the way one feels over his interview in print.

Yes, you are afraid of the interviewer, and that is not an inspiration. You close your shell; you put yourself on your guard; you try to be colorless; you try to be crafty, and talk all around a matter without saying anything: and when you see it in print, it makes you sick to see how well you succeeded. All the time, at every new change of question, you are alert to detect what it is the interviewer is driving at now, and circumvent him. Especially if you catch him trying to trick you into saying humorous things. And in truth that is what he is always trying to do. He shows it so plainly, works for it so openly and shamelessly, that his very first effort closes up that reservoir, and his next one caulks it tight. I do not suppose that a really humorous thing was ever said to an interviewer since the invention of his uncanny trade. Yet he must have something "characteristic"; so he invents the humorisms himself, and interlards them when he writes up his interview. They are always extravagant, often too wordy, and generally framed in "dialect" – a non-existent and impossible dialect at that. This treatment has destroyed many a humorist. But that is no merit in the interviewer, because he didn't intend to do it.

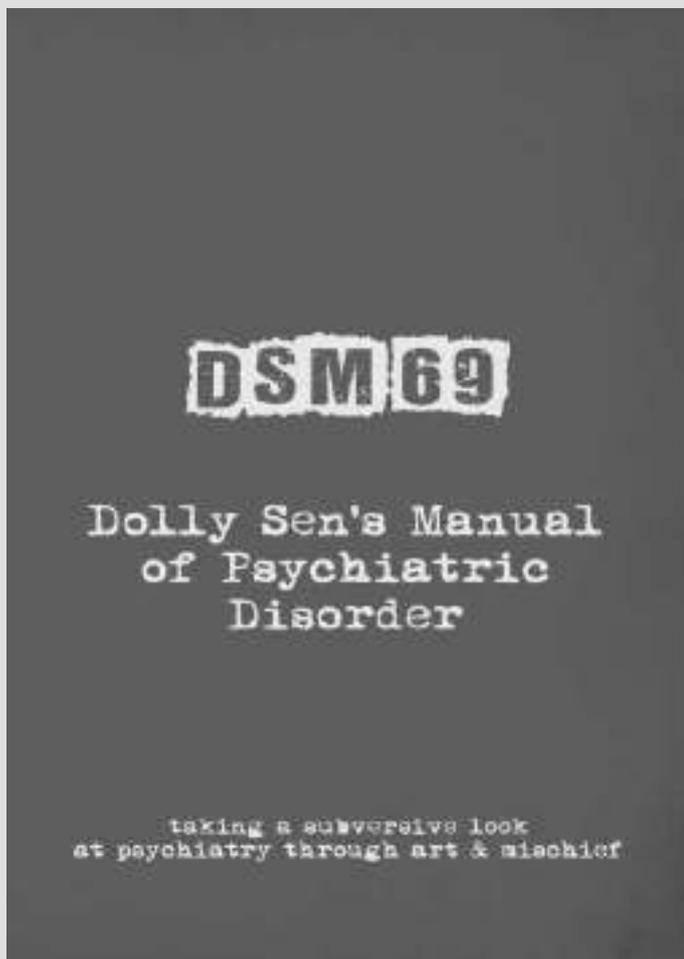
There are plenty of reasons why the Interview is a mistake. One is, that the interviewer never seems to reflect that the wise thing to do, after he has turned on this and that and the other tap, by a multitude of questions, till he has found one that flows freely and with interest, would be to confine himself to that one, and make the best of it, and throw away the emptyings he had secured before. He doesn't think of that. He is sure to shut off that stream with a question about some other matter; and straightway his one poor little chance of getting something worth the trouble of carrying home is gone, and gone for good. It would have been better to stick to the thing his man was interested in talking about, but you would never be able to make him

understand that. He doesn't know when you are delivering metal from when you are shoveling out slag, he can't tell dirt from ducats; it's all one to him, he puts in everything you say; then he sees, himself, that it is but green stuff and wasn't worth saying, so he tries to mend it by putting in something of his own which he thinks is ripe, but in fact is rotten. True, he means well, but so does the cyclone.

Now his interruptions, his fashion of diverting you from topic to topic, have in a certain way a very serious effect: they leave you but partly uttered on each topic. Generally, you have got out just enough of your statement to damage you; you never get to the place where you meant to explain and justify your position. ■

## Review

***DSM 69: Dolly Sen's Manual of Psychiatric Disorder.***  
(The Eleusinian Press).



This is a mischievous look at modern psychiatry. A mad person poking fun at the system. What's not to like?

A former poster child for the recovery industry, Dolly Sen is now a member of Recovery in the Bin ([recoveryinthebin.org/](http://recoveryinthebin.org/)). Dolly discovered that the recovery model "... isn't about people living their dreams or having less distress - it's about reducing us as an economic burden."

Dolly uses art, cartoons and poetry to parody and critique the mental health system. This is a creative and fun way of illustrating the idea that the mental disorder might be in psychiatry and society, rather than in individual mad people.

Her aim is to subvert normality and emphasise the creativity and humour of madness and resistance. She sums up her manifesto in the following way:

'Don't be a little flame, ashamed of the light you shed. Time to shine and embarrass the sun, the stars. Subvert the world and insist it be beautiful!'

Dolly Sen does just that.

We often feature Dolly's work in Asylum. For example, her very popular 'Pathologise This!' image adorned the front cover of our first Mad Studies issue (Note: Rachel Rowan Olive gives this a new twist on next page.)

**Helen Spandler**



# LOONIES FEST CREATING HEALING LUNACY

Friends of East End Loonies Present



CREATING HEALING LUNACY

Kingsley Hall Powis Road  
London E3 3HJ  
<http://bit.ly/2sh1Bbk>  
[f.e.e.l.campaign@gmail.com](mailto:f.e.e.l.campaign@gmail.com)

Sat 9 Sept 2017  
10am-10pm

Marking the 10th anniversary of FEEL (Friends of East End Loonies), the Loonies Fest is a celebration which honours lunacy, creativity and individuality. Participating are prominent survivors & artists whose work advocating for the benefits of the arts is at the forefront in our field.

An all-day free festival is scheduled for Saturday 9th September, 2017, from 10am to 10pm. Visual & performing arts, documented mad history and mad culture will come together under one roof, giving people the opportunity to celebrate and network. With the Loonies Fest we're producing an educational day for the 'normal' crowds, healing/cosy space for the 'lunatics', and especially entertaining times filled with creativity & inspiration for ALL.

The Loonies Fest will be at the historic Kingsley Hall in Powis Rd, London E3 3HJ. The visual art group exhibition 'SURVIVORS STORIES' will run from 5th to

19th September 2017. On show there will also be some works from Mary Barnes. She discovered her artistic talents while residing on site as a patient in the care of the radical Philadelphia Association community, led by RD Laing between 1965 and 1970.

With this event we wish to raise awareness of the misconceptions concerning mental health/illness, and to offer people the chance to interact in creative and healing activities, enjoy poetry, music and performances, and explore and debate the benefits of the arts as healing mediums; there will be a panel discussion.

Last but not least, the term Loonies needs clarification, as some people still find it offensive. This is the way we have been calling ourselves for the past ten years. We do not intend to insult ourselves or anyone else, but rather to embrace the fact of being vulnerable, mercurial beings, part of a complex Universe.

## ORIGIN OF FEEL

Since 1987, the Friends of St Clements (FoSC) brought along patients, friends, family members and staff to discuss what was beneficial and what was harmful in the hospital's practices. Chaired by the awesome Myra Garrett, in 1992 FoSC established a social club for inpatients, in the Wandsworth Stanley Hall; a creative writing group started publishing its journal in 1995.

In 2007 St Clements Hospital was shut down and the psychiatric unit was moved to Mile End Hospital. It was during this period that David Kessel suggested that the group should reform as a new independent anarchist group, naming it: Friends of East End Loonies.

With St. Clements closed down, FoSC eventually found a new space to carry on their activities at the new Mile End unit. This lasted until 2014 when, due to lack of interest or cooperation from staff, the group was caused to end.

FEEL met for the first time in November 2007 at the Whitechapel Idea Store cafe. A month later we got our permanent meeting space at LARC, the London Action Resource Centre. We still meet there these days, on the 3rd Monday of each month (bank holidays included). Here we keep updated about mental health news and plan the special events that we host several times a year at Kingsley Hall, inviting critical and progressive figures of the psychiatric field.

As a genuine grassroots campaigning group, in our work

we have raised awareness about the severe risks of prolonged use of psychiatric medication, while promoting gentler approaches in psychiatric care, such as the arts and healing therapies.

Despite being a diverse group, very deep and supporting bonds have developed over these past years.

## RAVAGED WONDERFUL EARTH

Published by Outsider Poets in collaboration with FEEL, *Ravaged Wonderful Earth* is a collection dedicated to David Kessel. Dealing with the issues of creativity and solidarity which he has promoted, this is a rich collection of pictures and writing about (and sometimes by) David. It was launched in Wandsworth's now demolished Stanley Hall, where the Social Club once used to gather, on the soft opening of the first Shuffle Festival, in July 2013. Only a few copies of this book are still available: see contact below. ■

Loonies Fest details: <http://bit.ly/2sh1Bbk>

Facebook event page: <http://bit.ly/2vgCeEC>

Email: [f.e.e.l.campaign@gmail.com](mailto:f.e.e.l.campaign@gmail.com)

...

When we received the above information it was touch and go with the deadline, but due to organisational difficulties we were unable to get the magazine distributed in time to advertise this event, for which we apologise.



Still  
alone  
in her  
voices

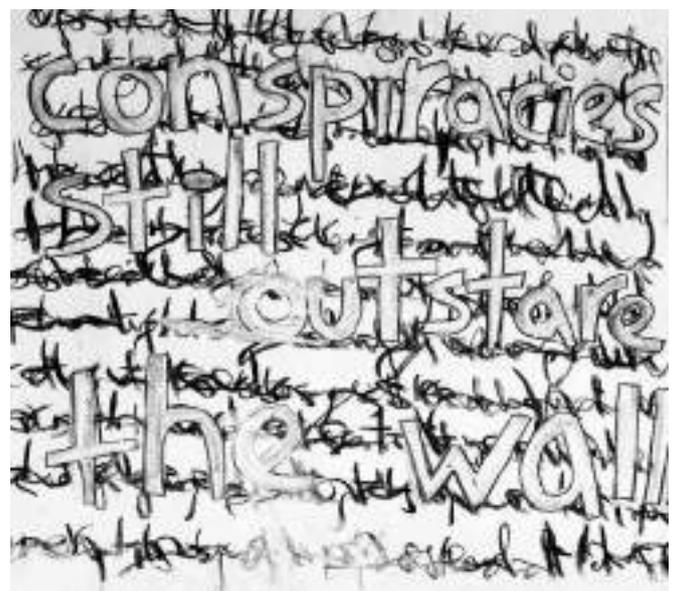
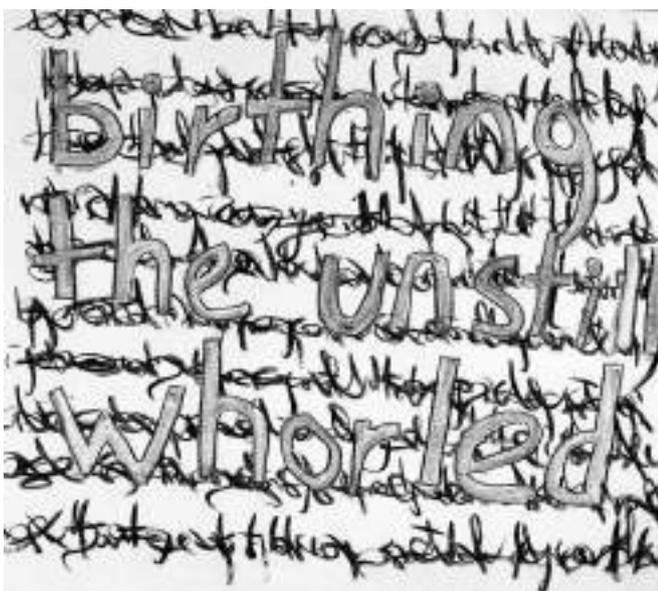
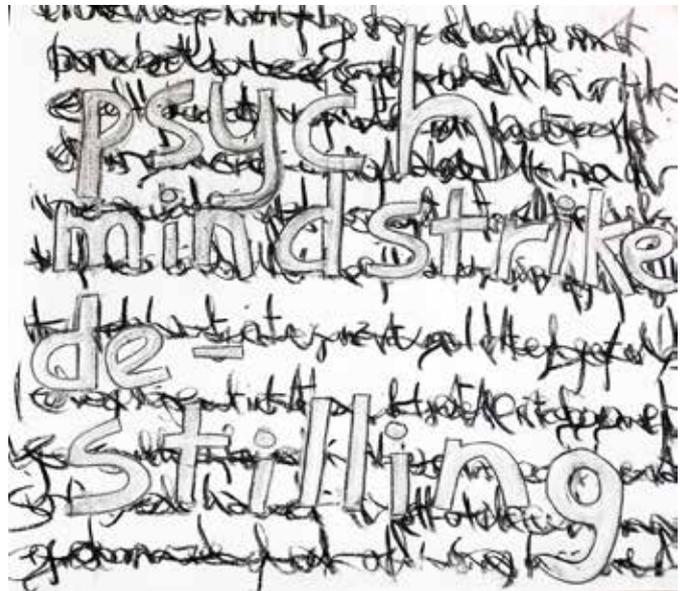
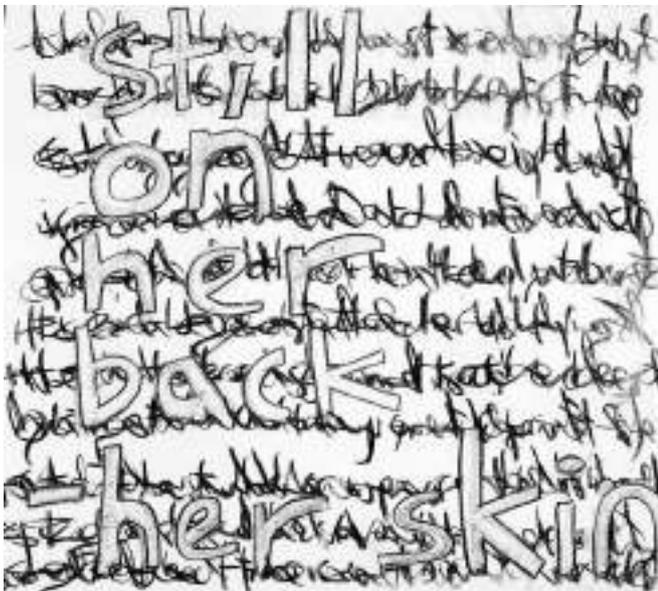
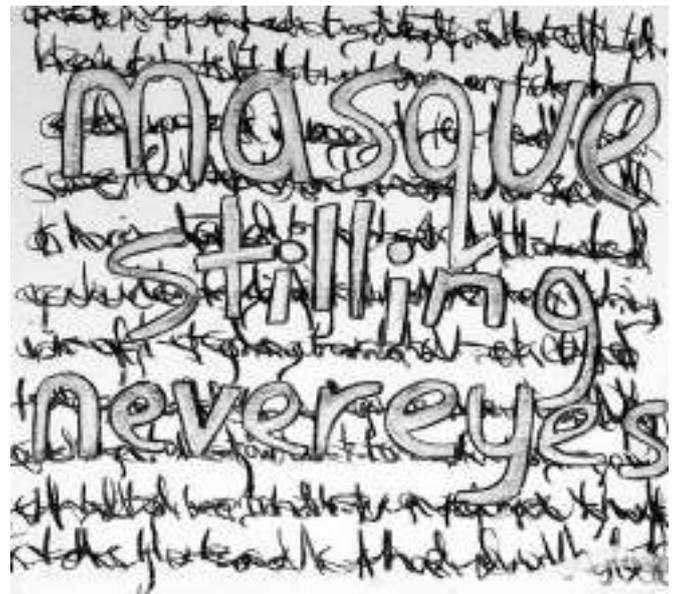
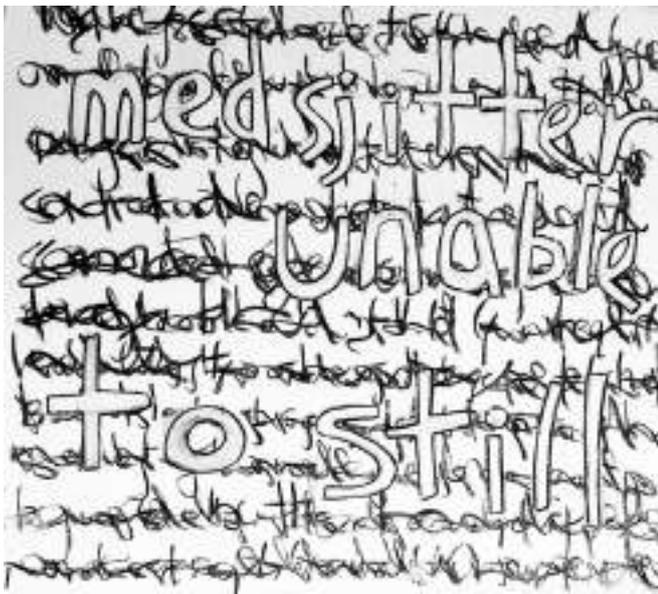
dark flame  
jaggering  
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breath  
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the blade  
within  
still  
a child

still in the  
academy  
silence on the  
word  
book without  
word



*still alone in her voices* is an evocative and haunting exhibition of twelve large panels of charcoal on painted wood from sean burn and is based on his experiences of psychosis. this exhibition was premiered at broadacre house, newcastle-upon-tyne thanks to the mental health collective and now tours until 2019. he is part of the mad studies north-east collective (<http://madstudiesne.weebly.com/>) - Check out Sean's (AKA Gobscore's) new exhibition, *Nudging Meteors* at the Art House in Wakefield, 27th Sept to 10th Nov, 2017 ■

## FILM REVIEW

# *Mad to be Normal* Not a Shaman?

ADRIAN CHAPMAN

"I'm not a shaman", says RD Laing, arrestingly played by David Tennant in *Mad to be Normal*, the new film about the radical Scottish psychiatrist and the experimental late-60s therapeutic community at Kingsley Hall, in London's East End. Throughout the film, however, Laing is presented as a figure of extraordinary charisma and shamanic power. He's also a conflicted figure, a wounded healer.

It is undeniable that Laing, who was certainly troubled, had the rare gift of being able to commune with very disturbed people. But the view of him presented by the film is limited. We are given a great, albeit flawed, individual – someone without compeers or forebears. We are led to believe that his was a one-man crusade against an utterly oppressive psychiatric establishment.

Laing wears the paisley shirts and has all the one-liners; the conventional shrinks, indignant and uncomprehending, are in sensible shirts and ties. There's no sense here that Laing was once a suited and booted psychiatrist, and that early in his career he ordered ECT and insulin comas. While we are given glimpses of Laing's unhappy childhood, we are afforded little sense of how his critique of psychiatry developed, let alone his later ambivalent attitude towards the profession.

The film's writer-director, Robert Mullan, invents people and situations. He also draws on facts, adapting them for his own purposes. Kingsley Hall, for instance, was a real place, an experimental community established in 1965 to test the hypothesis that madness might be a form of natural self-healing. The experiment lasted five years and inspired further radical therapeutic communities, such as Loren Mosher's Soteria experiment and the Philadelphia Association houses that continue in the UK to this day.

Kingsley Hall's most famous resident was Mary Barnes, a former nurse who moved in so as to fully experience her madness, which had been suppressed by ECT and padded cells. Her story, written with her therapist, Joe Berke, can be found in the book *Mary Barnes: Two Accounts of a Journey through Madness*.

But there's no place for Barnes or Berke in *Mad to be Normal*. Nor is there a place for Aaron Esterson, who, among others, co-founded the community. Esterson worked with Laing in researching 'schizophrenia' and family relations, but he strongly disagreed with Laing about how the Hall should be run. Esterson thought that more structure was required, with clearer divisions between carers and those being cared for.

Last year, researching accounts of Kingsley Hall at the RD Laing archive in Glasgow, I was struck by the ways in which the nature of the place was the subject of ongoing and sometimes fractious debate. How structured should it be? How communal?

How tolerant could people be? Should there even be any therapy at all? But these questions are not the film's concern.

The focus, rather, is on the charismatic RD Laing. Here David Tennant is compelling. The Laing we meet on screen relates easily and naturally to people who are in states of profound distress. Several people who knew Laing have told me that Tennant successfully catches something of his presence.

The film is successful, too, in presenting Laing as a celebrity. It might be difficult to imagine a superstar psychiatrist today, but that's just what Laing was in the late-1960s. In *Mad to be Normal* we are shown him addressing a packed lecture theatre, and at several points being questioned by interviewers. He is more like a rock star than a doctor.

The film's most powerful scene is based on an event that occurred in America during one of Laing's speaking tours. In a Chicago he visited a patient said to be catatonic and confined to a padded cell. She was a young woman, and was unclothed. Laing removed his own clothes and began rocking from side to side in the same way as the patient. After a while, the two began communicating.

Tennant's Laing sits down next to the woman, offers her a cigarette, lights one himself, and removes his trousers. After gaining the woman's trust, he applies acupressure to the woman's temples and then to her foot. He leads the patient out of the padded cell with his own jacket draping her shoulders.

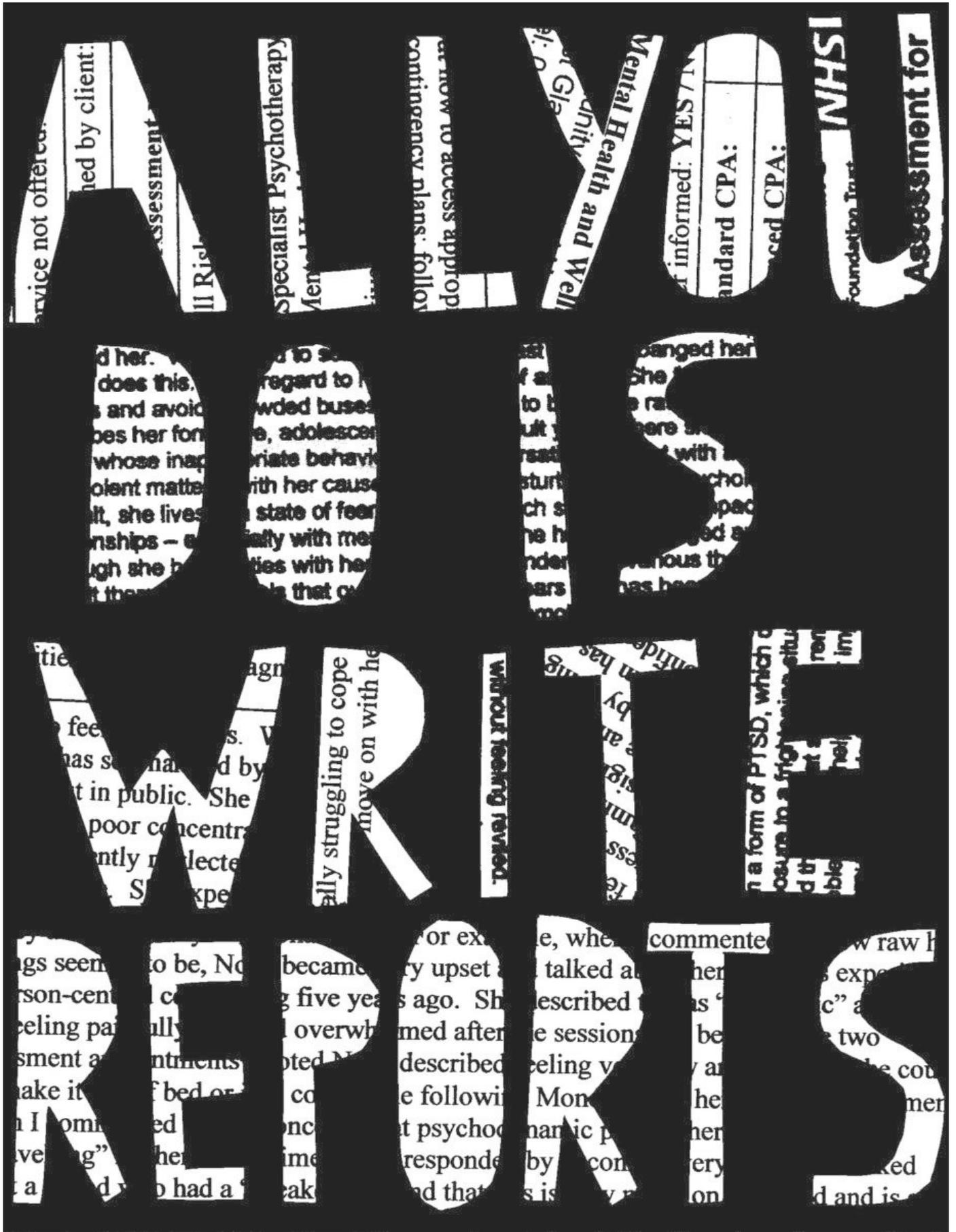
Watching this, I was interested in viewers' reactions. Looking around, I could see only rapt faces. No wonder: this is a moment of Christ-like healing. It's worthwhile noting, however, that not only is this a scene from a movie - and the acupressure is Tennant's improvisation - but we've no account of what actually happened from the woman who was confined in the padded cell.

If the Laing in *Mad to be Normal* is Christ-like, he's also selfish, a boozier, and violent. After returning to London from Glasgow, where his daughter is about to die in hospital, his drinking worsens and he becomes abusive to his girlfriend, Angie. (The death of Laing's daughter is moved back several years to lend tension to the narrative: this change in chronology and use of a tragic event has understandably troubled the Laing family.)

Angie, a US grad school student ably played by Elisabeth Moss, is another invented character. So too is Michael Gambon's Sydney, and Gabriel Byrne's Jim. At Kingsley Hall, Sydney recalls his violent childhood in a rather clunky evocation of an LSD trip. Byrne is unnervingly captivating as someone who is dangerously possessive of Laing.

The film is a basically a sympathetic portrait of Laing, but unfortunately it reinforces the myth of the flawed hero and presents a skewed view of Kingsley Hall. Still, *Mad to be Normal*, with excellent performances from Tennant and Byrne, is worth viewing, and could provide a starting point for discussion of psychiatry and alternatives to conventional treatments. ■

*Adrian Chapman lived in a Philadelphia Association household in the 1990s, and has recently spent several months researching the papers of RD Laing at the archive in the Special Collections Department, University of Glasgow Library.*



it snipped my heart

# NEWS & REPORTS

## HALF OF EXCLUDED PUPILS HAVE MH PROBLEMS

The Institute for Public Policy Research has found that in England half of all pupils expelled from school suffer from a recognised mental health problem.

The IPPR says that permanently excluded children face significant disadvantage because of the 'broken system'. Only one in a hundred going on to attain five good GCSEs, while the majority will end up in prison: it estimates that of the 86,000-strong prison population, more than 54,000 were excluded at school.

Excluded children face many other disadvantages. They are four times more likely to grow up in poverty and twice as likely to be living in care; they are also seven times more likely to have special educational needs than those who are not excluded. After exclusion, there is a downward spiral of underachievement, with teachers in schools catering for excluded pupils twice as likely to have no educational qualifications.

Weale, S (2017) Half of pupils expelled from school have mental health issue, study finds. *The Guardian* 20 July.

## AMBULANCE CALL-OUTS FOR MH CRISES UP BY 23% OVER TWO YEARS.

In England, the number of ambulance call-outs for people with mental health problems has soared by nearly a quarter in two years – compared with 2014–15, in 2016–17 paramedics helped 30,000 more people experiencing a mental health crisis: that's 172,799 people as against 140,137 two years before.

Additionally, 55,000 hours were spent supporting people with their mental health last year, up by 32% compared with 2014–15. In London the time spent rose by 45%, according to the request for information made by the Labour MP Luciana Berger. She accused the government of "dismantling" vital early intervention and prevention services so more people are ending up in crisis. "Too much money pledged for mental health is not reaching the sector. In the absence of ring-fenced budget, funding is being diverted to prop up other areas of the NHS."

Natasha Devon, the former MH champion for schools who was sacked for criticising Government policy, said the numbers were a direct result of cuts. "I hear stories of people actively seeking arrest by acting in dangerous ways because that's the only way they can get the attention they need. I have also heard of vulnerable teenagers knowing exactly how much they have to self-harm in order to 'ensure' a hospital stay. Accident and emergency, ambulance and police services weren't designed for this... meanwhile the government talks vaguely about 'stigma' and training teachers'."

The London Ambulance Service responded to more MH incidents than any other trust, recording 51,717 calls in 2016–17. The West Midlands Ambulance Service experienced the biggest rise in MH incidents – an increase of 41%.

The government recently announced that 21,000 new mental health posts would be created at a cost of £1.3bn. Hunt said there would also be a major drive to retrain mental health staff. But the Royal College of Nursing questions whether this ambitious policy leaves enough time to train and fund new professionals. Berger said: "The new posts are a red herring – officially we've lost 6,600 mental health nurses and doctors since 2010. But many other posts remain unfilled too."

Marsh, S (2017) Ambulance call-outs for mental health patients in England soar by 23%. *The Observer* 13 Aug

## MH PATIENT DIES FROM NEGLIGENCE IN PRISON

Sarah Reed died on 11 January 2016 while on remand at Holloway women's prison. She was on the medical wing, and was reportedly found at around 8am, lying on her prison bed. The crown asserted, and the jury agreed, that Sarah had used a sheet to kill herself by "self-strangulation". The inquest at the City Of London coroner's court ended in July 2017.

Sarah suffered acute mental ill health, triggered by the sudden death of her baby daughter in 2003. Sarah and her partner struggled to cope after they were told to take their deceased baby in a taxi from a children's hospice to their home to find an undertaker. Sarah then began a slow decline into mental ill health. Prior to this she was an intelligent, loving daughter and mother with her whole life ahead of her. But she became haunted by the vision of her deceased child. It seems beyond any reasonable understanding that a child's hospice (now closed) could behave in such a callous manner.

Sarah was waiting on medical reports about whether she was mentally fit to plead after being charged with assaulting a nurse in a secure psychiatric unit. The reports found she was unfit to plead, but Reed killed herself three days before they were due to be completed.

The jury found that Sarah took her own life and, in a damning narrative verdict, went on to castigate the prison staff and mental health professionals for a series of abject failures –including failing to follow Ministry of Justice guidelines – that contributed to her death.

As a black woman, Sarah faced everyday racism; in 2012 she was beaten up by a Met officer, so viciously that she suffered two broken ribs. PC James Kiddie was subsequently found guilty of assault, given a community service order and sacked.

The inquest jury heard that Holloway prison failed to undertake a psychiatric assessment of her fitness to stand trial; they received the request for these reports on 27

October 2015 but, unbelievably, these reports were not completed before her death nearly three months later. This led the jury to find that “the failure to conclude the fitness to plead assessment in a timely manner contributed to her subsequent death”.

After concern about its effect on her respiratory system, Sarah had her antipsychotic medications reduced on 16 November 2015. Her psychotic symptoms then progressively worsened, yet alternative treatments that would not affect her respiratory systems were not prescribed. She was left in an increasingly distressed state, chanting religious parables incessantly, staring blankly at her cell wall and reporting she was being repeatedly punched by demons as she slept. For the last three days of her life she remained locked in her cell, alone and isolated, with a hospital screen around her hatch.

The jury heard the segregation unit, where Sarah was isolated for “bad behaviour”, was often freezing cold and without any hot water or heating. Every prison infraction Sarah made was dealt with by way of punishment. At 5ft 7in and weighing only eight stone, Sarah was designated so dangerous as to require four prison officers to unlock her door every time someone went in or out of the cell. This is usually reserved for only the most dangerous of prisoners. Throughout this period, the prison cancelled visits to Holloway by Sarah’s mother, her partner and her solicitors on 11 separate occasions.

Prison officers and medical staff in the prison’s mental health assessment wing gave her a “low risk” rating despite writing in her records that day: “She is completely psychotic, aggressive towards staff, making comments about god and the devil. She started rolling around in the bed and screaming.” Fellow prisoners gave evidence that she had complained about being bullied and one inmate heard her call out “they are going to kill me” and said she was becoming increasingly paranoid and was too ill to be in prison.

Sarah would be alive now if the governor, prison staff, psychiatrists and mental health in-house team had simply done their jobs in a timely and professional manner. Sarah’s family are now demanding that all the agencies and professionals whose failures contributed to her death should be subject to immediate disciplinary investigations. All must be held to account if we are to end the scandal of the treatment of the mentally ill and vulnerable in our prisons.

In addition, the Reed family will campaign for all coroners’ recommendations to be considered mandatory. Had previous inquest recommendations been implemented in historical cases such as that of Rocky Bennett – in which the coroner called for a national director for mental health and ethnicity – or the Corston report on managing mentally ill women in prison, many lives could have been saved. Further, home secretary Amber Rudd’s much-delayed report into “deaths in police custody” must now be published.

Deborah Coles, of Inquest, a charity providing expertise on state-related deaths, condemned the fact that Reed was in prison at all, given her serious mental illness.

“Sarah Reed was a woman in torment, imprisoned for the sake of two medical assessments to confirm what was resoundingly clear, that she needed specialist care not prison. Her death was a result of multi-agency failures to protect a woman in crisis. Instead of providing her with adequate support, the prison treated her ill mental health as a discipline, control and containment issue.”

In 2016 there were 22 deaths in women’s prisons in England and Wales – the highest number of female prison deaths since 1990. According to Ministry of Justice statistics, within the female prison estate there were 10 self-inflicted deaths at a rate of 2.6 per 1,000 prisoners in the year to March 2017. This was double the rate of 1.3 per 1,000 prisoners across both the male and female estates.

Coles added: “Serious mental health problems are endemic in women’s prisons, with deaths last year at an all-time high. They continue because of the failure of the governments to act. The legacy of Sarah’s death and the inhumane and degrading treatment she was subjected to must result in an end to the use of prison for women.”

Jasper, L (2017) Those who failed Sarah Reed must be held to account. *The Guardian* 24 July.

Taylor, D (2017) Care failings contributed to death of woman in prison, inquest finds. *The Guardian* 20 July.

## OVER 3500 MH PATIENTS KEPT LOCKED UP LONGTERM

The Care Quality Commission has criticised both English NHS and for-profit MH providers for keeping more than 3,500 patients in 248 wards locked-in. Often these vulnerable patients are miles from home, and this leaves them feeling isolated and less likely to recover.

In 2015–16 some stayed for 45 days, but others had been locked in for up to 1,744 days – four and a half years. Paul Lelliott, the CQC’s deputy chief inspector of hospitals, said

“We are particularly concerned about the high number of people in ‘locked rehabilitation wards’. These wards are often situated a long way from the patient’s home, meaning people are isolated from their friends and families. In the 21st century, a hospital should never be considered ‘home’ for people with a mental health condition.”

Private providers of NHS mental health care lock patients in more often than NHS trusts. Two-thirds of the 3,500 beds are in that sector, despite them treating fewer people than the NHS. This fuels suspicions that private operators hold on to some patients longer than necessary in order to maximise profits. According to Mind, patients kept on locked rehabilitation wards are denied their human rights.

Other failings in the mental health sector are identified by the latest CQC report. 20% of those referred to memory

services for a possible diagnosis of dementia have to wait more than 18 weeks for an assessment, while a further 22% face delays between 11 and 18 weeks. Similarly, and despite the risk that such patients can deteriorate quickly during delays, 9% of mainly young patients with an eating disorder have to wait more than 18 weeks to see a specialist psychiatrist, while 18% have to wait up to 18 weeks; one in five (19%) older people wait at least 11 weeks to be seen, as do 15% of mothers needing help with problems related to the birth of their baby.

The CQC also voiced concerns about the facts that: MH services are facing serious shortages of both nurses (whose numbers have fallen by 12% since 2010) and psychiatrists – although staff were praised for providing caring and compassionate treatment to patients; available inpatient psychiatric beds have dropped by 4% since 2014; detentions under the Mental Health Act increased by 26% over the three years between 2012–13 and 2015–16; and too many patients who become agitated are then physically restrained, often because poorly trained carers do not know what else to do.

Campbell, D (2017) Thousands of mental health patients spend years on secure wards. *The Guardian* 20 July.

## SHOCKING RISE IN SELF HARM & SUICIDES IN PRISONS

The National Audit Office says the prisons have “struggled to cope” with record rates of suicide and self-harm among inmates following cuts to funding and staff numbers, and it is unclear how their mental health can be improved with current levels of funding.

With an English prison population of 83,000–87,000, there were 40,161 incidents of self-harm – between 2012 and 2016, an increase of 73%. At the same time, the 120 self-inflicted deaths in prison in 2016 was the highest number on record, and *almost double* that for 2012. Funding for offender management has been reduced by 13% since 2010, and by 2016 staff numbers had been cut by 30%.

“Prisons have struggled to cope with reduced resources. When prisons are short-staffed, governors run restricted regimes where prisoners spend more of the day in their cells, making it more challenging for prisoners to access mental health services,” the report concluded.

The NAO also noted delays in transferring inmates to secure hospitals for treatment: in 2016–17, just 34% of eligible prisoners were transferred within the 14-day target. The report said that responsibility for mentally unwell prisoners should fall upon the Ministry of Justice, HMPPS, Department of Health, NHS England and Public Health England.

Peter Dawson, director of the Prison Reform Trust, said the report showed a familiar tale of admirable policy objectives not being delivered on the ground. “This report makes horribly clear that our prisons are holding very many

people who will suffer disproportionate and unnecessary harm because of the prison environment.”

Sayal, R (2017) Suicide and self-harm in prisons hit worst ever levels. *The Guardian* 29 June.

## ANTIDEPRESSANT USE DOUBLES IN TEN YEARS

Last year a record number of antidepressants were prescribed on the NHS, fuelling an upward trend that has seen the number given to patients more than double in a decade.

This raises questions over whether doctors hand out the drugs out too freely or if it means more people are getting help to tackle their anxiety, depression and panic attacks.

Antidepressants are used to treat depressive illness, generalised anxiety disorder, obsessive compulsive disorder and panic attacks. 64.7m items were dispensed in England in 2016; this was 3.7m more than the 61m in 2015, and whopping a 108.5% increase on the 31m dispensed in 2006.

There are no statistics for how many people are given these drugs. The price per item halved over the decade and they are now fairly cheap, costing a total of £266.6m, out of the NHS overall £9.2bn annual spend on all types of medication.

Leading doctors defended the sharp increase in the use of drugs which have been accused of fostering dependency in some patients, often have bad side-effects and do not always relieve symptoms. “While at face value the rise might seem alarming, it could also be indicative of better identification and diagnosis of mental health conditions across healthcare, and reducing stigma associated with mental health in society, leading to more people with mental health conditions seeking medical assistance,” said Dr Helen Stokes-Lampard, the chair of the Royal College of GPs.

“Antidepressants can be effective drugs when used appropriately and they do help a lot of patients. Nevertheless, no doctor wants their patients to be reliant on medication, and where possible we will always explore alternative treatments, such as talking therapies...” However, “there is a severe lack of these services available in the community, where they could be of great benefit to patients.” She urged NHS England to deliver on its commitment of 3,000 new mental health therapists, to be based in GP surgeries, as a matter of urgency in order to help improve care for the mentally unwell.

Meanwhile, data obtained by *The Guardian* shows that 166,510 under-18s were given an antidepressant in the 14 months to June 2016; this includes 10,595 seven-to-12-year-olds and 537 aged six or younger. This total was a 12% rise in the numbers taking the drugs over the time period. These figures have prompted concern that medics may be overprescribing strong medication because of stretched and underfunded mental health services: it is feared that some

children and young people are given the drugs because they face such long waits for psychotherapy on the NHS.

Guidance from the National Institute for Health and Care Excellence (NICE) says antidepressants should be given only to teenagers and children with moderate or severe depression, and when psychotherapy has failed. It also advises that such medication should be taken in concert with other support, such as counselling. However, a major study published in the *Lancet* last year concluded that most antidepressants do not work on children and teenagers, and that prescribing them could do more harm than good.

Marsh, S (2017) Number of under-18s on antidepressants in England rises by 12%. *The Guardian* 18 June. Campbell, D (2017) NHS prescribed record number of antidepressants last year. *The Guardian* 29 June.

## 5,876 MH PATIENTS SENT OUT OF AREA IN 2016

NHS figures obtained by the BMA show that, in England, the number of psychiatric patients being sent long distance for treatment rose 40% in two years. 5,876 were sent far out of their local area for treatment last year, compared to 4,213 in 2014–15. Some had to travel hundreds of miles, and they could expect an average round-trip journey of seven and a half hours to see friends and family.

Dr Andrew Molodynski of the BMA consultants committee said it was an “endemic” issue. “The government needs to get a handle on this situation because patients are being routinely failed by a system at breaking point, with tragic consequences.” If there were “no free beds”, doctors had to take time away from severely ill patients to find a space, “often resorting to private hospitals... Patients then face long waits before being taken miles in locked ambulances to unfamiliar places.”

The figures, provided by trusts and clinical commissioning groups (CCG) in response to freedom of information requests, revealed that £159m was spent on placing patients in out-of-area beds in 2016–17, up 47% on the £108m spent two years before.

Kent and Medway, Barnet, Enfield and Haringey sent the most patients out of their area; Kent and Medway NHS and social care partnership trust (KMPT) sent 586 patients.

Louise Rubin of Mind said: “It’s unacceptable that people who are at their most unwell and in desperate need of care find themselves travelling across the country to get help ... When you’re experiencing a mental health crisis, you’re likely to feel scared, vulnerable and alone, so your support network of family and friends are instrumental to recovery. We also know that in some places – such as Sheffield and East London – out of area placements have been reduced to virtually nil, so it is possible. The government has also said it will end inappropriate out of area placements by 2020–21, but this can’t happen soon enough.”

Dr Mark Porter told delegates at the annual conference of the BMA that the government’s ambitions to put mental

health care on a par with physical care remained a “very distant prospect”. He said patients were being “shuttled around the country” because of a lack of beds, with some having to “languish” in police cells.

Marsh, S (2017) Almost 6,000 mental health patients sent out of area for care last year. *The Guardian* 27 June.

## DOMESTIC VIOLENCE CAUSES LONG-TERM POORER HEALTH

A long-term Australian study to investigate the health impacts of intimate partner violence finds that women who are abused by their partner suffer significant physical and mental health problems that persist throughout their lives.

From 1996, led by the University of Newcastle’s research centre for generational health and ageing, research followed 16,761 participants from the Women’s Health Australia study. This involved three cohorts of women, born 1921–26, 1946–51 and 1973–78; they were asked during surveys taken throughout their lives whether they had ever been in a violent relationship, and about their physical and mental health. The study only considered violence from a partner or spouse, and not general family violence.

Of the 3,568 women born 1921–26, 184 (5%) reported having experienced intimate partner violence in the first survey. At the start of the study, 8% of women born 1973–78, and 12% of women born 1946–51, had experienced intimate partner violence. Sixteen years later, 26% of women born 1973–78 had experienced intimate partner violence compared with 16% of women born 1946–51.

Despite the narrow definition of family violence used by researchers, they write that “The results are striking.” Across health measures including physical functioning, social functioning, general health, bodily pain, vitality, and emotional and mental health, women who had experienced intimate partner violence “recorded significantly poorer health than women who never experienced intimate partner violence, across generations and along the life course”.

While health is expected to worsen as people age, the physical functioning and general health of women who experienced intimate partner violence was consistently worse than those who had not experienced it. And while previous research had identified similar health problems in family violence survivors, this study showed that the issues persisted for many years.

It was also notable that women in their twenties with poor mental health were more prone to experience domestic violence at a later date. “Women with the best mental health at the first survey didn’t enter into a violent relationship as commonly as other women. So we concluded from this research that poor mental health was a risk factor for entering a violent relationship.”

Moo Baulch, chief executive of Domestic Violence New South Wales, said the findings highlighted the importance of ensuring young women had good mental health and

access to health services. “Studies like this show the better we are at early intervention and education, the better we can be at prevention.” Unfortunately, much of the focus for interventions and support for family violence is around the immediate crisis period, with many people believing that “if she leaves, then she’ll be all right”. But the reality for one-in-four Australian women is that the physical and mental health impacts of domestic violence can last a lifetime.

Davey, M (2017) Women abused by partners suffer lifelong health problems – study. *The Guardian* 13 June.

## HIGHER RISK OF PSYCHOSIS FOR BMEs

Psychosis is rare – rates in England stand at about 30 cases per 100,000 people per year. But a study reported in the *Schizophrenia Bulletin* finds that people from ethnic minorities have up to five times greater risk of a psychotic disorder than the white British population. This holds for both urban and rural settings, with first-generation migrants who arrive in the UK in childhood among those at increased risk.

James Kirkbride, a psychiatric epidemiologist from University College London and co-author of the report, says that if this was any other disorder we would be horrified and up in arms, campaigning from a public health perspective on how we could reduce this level of suffering. “There is a massive health inequality and it hasn’t got much attention.”

The factors at play could include stresses related to the migration process, discrimination, and issues related to isolation and integration. Kirkbride says more should be done to offer services to those in need, and to unpick drivers behind raised risks. “In the present climate, when issues about migration are at the forefront of the public’s mind, people from ethnic minority backgrounds may face additional stresses that could potentially contribute to mental health problems.”

A team from the University of Cambridge and a collection of NHS foundation trusts looked at trends among 687 people in the east of England. All were aged 16–35, had received a clinical diagnosis of a psychotic disorder, and had not previously had an episode of psychosis. After taking into account of a host of factors including socioeconomic status, age and sex, the results reveal that compared to the risk of psychotic disorders in the white British population, people of black Caribbean origin had a 4.6 times greater risk; those of Pakistani or black African origins, or of mixed ethnic backgrounds had risks 2.3 times, 4.1 times, and 1.7 times higher, respectively. Non-British white individuals did not have an increased risk of psychotic disorders.

Overall there was no apparent increased risk of psychotic disorders among first-generation migrants, but the team found that there was a higher risk for certain groups: the risk of psychotic disorders was higher for those who moved to Britain between the ages of five and twelve – at more than twice the risk seen for the white British population. “It is something to do with the migration process and the subsequent experiences that people have seem to increase people’s risk,” said Kirkbride. “It is not to do with higher rates in other countries.”

The team also found an increased risk among later generations. Overall, people from ethnic minority groups born in the UK were almost 2.6 times as likely to have a psychotic disorder as the UK-born white British population, with rates for UK-born non-British white migrants also raised. “Second generation and later groups have to deal with a range of different pressures, and they might be to do with living in a country where they are brought up and born, and [are] citizens of that country but actually they still face barriers and things like discrimination because of their ethnic minority status,” said Kirkbride.

Davis, N (2017) Risk of psychotic disorders up to five times greater for people from ethnic minorities – UK study. *The Guardian* 29 May.

## RISE IN STUDENT DROPOUTS FROM MH PROBLEMS

Data from the Higher Education Statistics Agency (HESA) reveals that a record 1,180 students who experienced mental health problems left university early in 2014–15, the most recent year in which figures are available. This is a 210% increase from 380 in 2009–10.

Data obtained by *The Guardian* from universities reflected a similar trend to the HESA figures, showing the numbers requesting counselling had risen by almost a third in three years: 87,914 students requested counselling in 2015–16, compared with 68,614 in 2013–14, a rise of 28%. Heads of counselling services put the increase partly down to more students going to university with existing mental health problems. They said young people were under greater pressure to succeed, with social media putting their lives under a microscope. It was also noted that the rise could be a sign of people having greater awareness of services, and there being less of a taboo about discussing mental health.

Only 26 of the 90 universities were able to provide the reasons students gave for requesting support. Most young people asked for help because of anxiety; the numbers doing so rose by 43% over three years. There was a 39% rise in students seeking counselling for depression over the same period.

But *Guardian* data shows that some universities are cutting back on the number of counsellors they employ, or are not recruiting more to meet the rise in demand. The University of Stirling, for example, reduced numbers from 2.44 full-time equivalent (fte) staff four years ago to 1.4 fte this year. This comes despite a 68% increase in demand.

At some universities, increased demand has resulted in longer waiting times, the most striking being at Staffordshire University where the average wait from first assessment to counselling rose from 25 days in 2013–14, to 43 days in 2015–16. This year, so far, the university said there was a waiting time of 55 days. This was above the average of 15 days most universities reported and closer to the 84 days reported for NHS primary care.

Marsh, S (2017). Number of university dropouts due to mental health problems trebles. *The Guardian*, 23 May.

# Cheerio Bob Dylan!

Bob Dylan, the Asylum mascot, has gone to pastures new. Bob was donated by Jill Anderson, of the Mental Health in Higher Education project, to help raise funds for our conference. He was named by Recovery in the Bin – a user led Facebook group for mental health survivors and supporters who are critical of the ‘recovery’ model (see explanation for the name below\*). Bob was auctioned at the Asylum conference (raising £100), and has now gone to live with Jonathon Gadsby from the Critical Mental Health Nurses Network.



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\*One of our readers recently had the baffling experience of reading ‘has a dog called Bob Dylan’ in their medical notes. As they didn’t – that is, they had a dog, but he wasn’t called Bob Dylan! So they started a thread on twitter: #bonkersmedicalnotes. Meanwhile, our reader’s dog (beautifully illustrated above by Rachel Rowan Olive) has been renamed Bob Dylan (our mascot’s namesake!) and developed quite a twitter following, using his new stage name @DogBobDylan. Confused? Don’t worry, his full story will soon be told, by his human, our new regular blogger...

## Some members of Bob’s fan club



... Look out for Bob in our Special Conference issue, to follow soon...

## Website update

Alex from the Ragged University has kindly offered to help upgrade our website and you can find us on our new domain: [www.asylummagazine.org](http://www.asylummagazine.org)

... Watch this space...

# Asylum

the magazine for democratic psychiatry

Autumn 2017  
Volume 24  
Number 3  
£4.00

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**Mad Pride Hull's Breaking Free: Imprisonment, Madness, Liberation, exhibition (July 2017).  
More info to follow in next issue...**

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