Asylum

the magazine for democratic psychiatry

ASYLUM CONFERENCE - ACTION TO REACTION & MORE

Mad Pride (Hull)

MadPride

◆ Mad Pride is about getting people talking about madness in creative ways.

◆ We want to talk about how mad our world really is, about all the inequality and injustice, greed and violence, and how all this madness so often makes us unwell.

◆ We want to challenge the tyranny of normality, and to celebrate diversity, and difference.

◆ With art, music, and storytelling, we want to help people share their highs and lows, their breakdowns and breakthroughs, their struggles and successes.

◆ We want to bring people together so we can help one another better navigate all this madness and build together a more beautiful world.

xxx

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

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

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

Front and back cover images from Mad Pride Hull

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

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

Editorial

This issue consists mainly of material offered at our public event in June 2017 – *Asylum: Action to Reaction*. We include most of the main presentations, some of the workshops, and some reactions as well – both positive and more critical.

We take criticism very seriously. Within the bounds of civility, *Asylum* is a completely open forum for debate. So please let us know your thoughts on any matter, or suggest what you would like us to cover.

In the meantime, among our plans for future topics (issues or part-issues) is to explore the question of companion animals and mental health. If you are interested in contributing, on this or any other topic, get in touch!

P.S. Please bear with us while our website is being redesigned and updated. We hope to include more content soon...

… and a Merry Christmas to all our readers!

Asylum: Action to Reaction

Milan Buddha Ghosh

Not just an event, but inspired and warmed by survivors' humanity and courage. It came out in the workshop on the *Diagnostic and Statistical Manual (DSM)*, and throughout *Asylum*'s Action & Reaction conference, that there were clear differences in strategy when seeking to change society for the better.

My thoughts are this. We don't need total agreement – no social movement for progressive change ever has had total agreement. What they did have were: conviction-passion, clear intellectual analyses of oppression, how to de-stigmatise, how to reclaim new healthy, politically active identities, and how to build allies and allied organisations.

I offer this reminder because there were obviously arguments about the efficacy of mental healthcare, including psychotropic drugs, which clearly had helped people during a manic or suicidal crisis. My point is that we don't need to argue, we need simply to give different choices to people – informed choice and informed consent to any treatment, for us as humans rather than patients. ('Patient' means long-suffering)

Victor Hugo once said: "There is nothing so powerful as an idea whose time has come." Indeed.

We are all trying to build an alliance of organisations in order to get our agenda as patients, service-users, survivors, thrivers even(!)

Freedom will happen. This I know but yet cannot prove. No matter how horrible heart-breaking stigma is, the deaths from psychiatric abuse, medication/poly-pharmacy, restraint, forced injections, the barbarity of ECT, the ruined, zombified lives, fried brains, the crushed self-esteem, the rape on wards and suicides on wards – all because 'we' are mad, bad and dangerous to know. A lie! We are good people trying to get help. Many of us have recovered and thrive and enjoy life. I do.

You can all go beyond any barrier to personal or socio-political freedom. A proof is that most slavery ended, apartheid ended, raw Victorian brutish, British capitalism ended. Yes, these are not complete revolutions/changes but along with the feminists and gay movements, etc. they are still worthwhile.

If we cannot hold that idea of freedom and non-stigmatisation clearly in our mind-hearts as ENTIRELY possible, then we might as well continue to argue like children – which we sometimes do, let's face it – and give up and go home go to bed, depressed. Ah but depression in bed is not compassion.

We are intelligent enough to use mind creative, not mind reactive, to get enough agreement between ourselves, and with Mind, UKAN SUN Wales user network, etc., all user and campaigning groups but LED by us survivor-led organisations. How about thriver-led?

For this, we need to think and be like Mandela or Gandhi, to continually go beyond our own doubts and cynicisms of disappointments about our own human real ability, to be good enough campaigners, who will never give up in the struggle for freedom and human rights in mental health advocacy and care.

I will never give up. Will you? How do you feel if you give up? Bad and nowt has changed, only a change to cynical despair.

''Tis better to light a candle in the darkness than to curse the darkness.'' – a freedom-fighter in the Anti-Apartheid struggle.

Alignment of enough agreement, but not necessarily total agreement, is what's needed, a unity with all users groups UK-wide, UKAN and non-survivor campaigning groups as allies.

Please don't miss this massive opportunity for overcoming your own doubts as a campaigner, creating new friends, and being healthier-happier – good enough agreement, in an alliance in the future so we will have a mental health parliamentary bill with genuinely democratic user-led psychiatry.

Other countries have banned ECT and modern forms of psychosurgery, poly-pharmacy that is lethal, and have made wards much more open, user-led even, user run.

WE CAN CHANGE. We can run things! BUT it requires openness to the barriers that are here, tightly defined and Strategy of Alignment of Wholes: as individuals, and groups that will make informed choices/freedoms, and consent and thus real therapeutic-ness. We are imperfect messes-in-progress, Good Enough, not victims, geddit?

Be Positive. Be Strong. Thrive. And make the world a better place, so that aliens if they spied on us might say, "By golly these humans really have learnt to look after each other and the planet. They have far more Applied Intelligence than us! Let's not invade! Let's ask 'em for help! I'd love to direct the next wholesome, intergalactic peace movie, not alien invasion!"

Yeah I'm bonkers and proud of it. Humour saves the day, and maybe the world.

POWA, ah say POWER to the mad people! Anything is possible. ■

Milan Buddha Ghosh is former Chair of UKAN, and Advisor to National Mind, in order to include ethnic minorities and users/survivors in Mind's structures.

WHAT IS TO BE DONE?

Roy Bard

In 1835, having recently managed to extricate himself from the asylums to which his family had had him committed after he became involved with a religious sect, John Perceval, son of British Prime Minister Spencer Perceval, published an account of his incarceration. This contained some themes which would be argued by anti-psychiatrists, 130 years later.
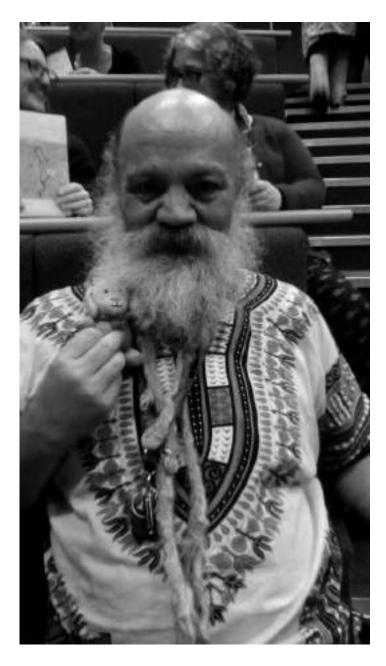
In her book, *Inconvenient People*,[1] Sarah Wise notes that:

"Mr Perceval believed that patients were best placed to inform their carers of the nature of their problem, and instead of ridiculing the seeming nonsense of the patient's speech, what was required was a sympathetic attempt to unravel the source of the distress. This task was best undertaken by those who knew the patient well - family, old friends or general physicians of long acquaintance. It was no task to be given to a money-minded, vainglorious stranger. A lunatic was an individual, with an individual cause of his or her own illness, and required an individually tailored attempt at cure. 'Many persons confined as lunatics are only so because they are not understood, and continue so because they do not understand themselves', Mr Perceval wrote."

Powerful words from a survivor who sought to understand his own experiences, and to understand the brutality of the asylums and those who ran and profited from them. What John Perceval said is in accordance with the belief of many survivors today: we cannot expect help or a cure from the psychiatric and pharmaceutical industries which have grown around our mental distress, but rather through working together with other survivors to understand ourselves and each other, and to learn to relate in new and different ways.

However, it is also worth noting that John Perceval's experience was affected by his class and privilege, and that those from less advantaged conditions were treated much more harshly, and had fewer and less effective safeguards available to them. Their voices were also far less likely to be heard. Indeed, Perceval's book was first published anonymously and received little attention - it only found a wider audience when it was published under his own name.

More than 180 years later, this is an issue we still need to ponder: How do we ensure that the voices of those who are suffering the most are heard - and especially in the current climate? We are told that one in four experience a mental health issue, and everyone is encouraged to talk about mental health, albeit mainly in relation to how we can better be incorporated into work. But this is precisely when automation threatens many jobs, when the welfare system and services are being dismantled before our very eyes, and ever-increasing numbers of those who experience severe and enduring mental distress are being made more isolated and lonely. All this is a result of the neoliberal ideology, while, as a cynical electoral ploy, Theresa May talks of 'the burning injustice of mental illness'.[2]

As survivor activist Robert Dellar noted, shortly before his death last year: "OK, so one in four people might have experienced mental illness of some kind. We need to remember that one in four hundred are suffering really badly, and their lives are at risk... but they're getting abandoned."[3]

Foucault noted that "Institutions of knowledge, of foresight and care, such as medicine, help to support the political power. It's also obvious, even to the point of scandal, in certain cases related to psychiatry."[4]

Recent headlines have drawn attention to the continued racial- and gender- inequalities inherent to modern psychiatry. Detentions under the Mental Health Act continue to rise with "black and minority ethnic communities disproportionately affected", and yet the recently announced official review is to be headed by a powerful white male. Meanwhile, women are increasingly likely to find themselves diagnosed as 'having a personality disorder', and refused psychiatric services. As a survivor recently noted on Twitter, the PD diagnosis "is at core a punitive pathologisation of women, interdependence & emotion generally."

At the same time, psychiatrists continue to be drawn mainly from the class that enjoys the most privilege and power, and this is reflected in their practice, where they are more likely to show empathy and provide less punitive 'assistance' to those from a similar class background. From its inception, Psychiatry sought to paint mental distress as a medical problem. Doctors continue to deny the impact of emotional trauma, such as wars or very adverse childhood experiences, which in modern times is increasingly identified by less partisan observers as the main contributory factor.

It seems unlikely that Psychiatry can ever unlearn its allegedly medical-scientific roots. This is why many of us have lost faith in the psychiatric profession, with its completely unproven medical model. We want systemic change, an end to the inequality inherent to capitalism, and new ways of relating to each other, in which there will be empathy, compassion and a meeting of needs rather than greed - ways of living where trauma and ecological degradation are not inherent and persistent features. The seeds of such a change will not come from psychiatry, but only from new ways of being together. And it is most likely that the voices of survivors and service-users will be central to starting that change.

We need to start experimenting with new ways of coming together, and to identify and encourage survivor-led initiatives which break the isolation of the abandoned. We need to start documenting new initiatives which seek to identify new ways of coping with distress. For example, the Madlove Asylum project,[5] The Kindfulness coffee club in Liverpool,[6] and the Streets Kitchens springing up in our cities.[7]

We should share and expand on these projects. We also need platforms that allow us to hear and learn from those whose experiences and voices are more marginalised than our own, and to learn to become allies with them. ▪

1. Wise, S (2013) *Inconvenient People: Lunacy, liberty and the mad-doctors in Victorian England.* Vintage Books.

2. www.gov.uk/government/news/prime-minister-unveils-plans-to-transform-mental-health-support

3. www.vice.com/en_uk/article/7bxqxa/mad-pride-remembering-the-uks-mental- health-pride-movement

4. *The Chomsky-Foucault Debate: On human nature.* The New Press (2006)

5. www.madlove.org.uk/

6. www.facebook.com/KindfulnessCC/

7. streetskitchen.co.uk/

WHEN THE MAD RESEARCH THE MAD
Transforming narratives into solidarity and action

SUE PHILLIPS, PENNY STAFFORD & SHIRLEY ANNE COLLIE

We were all absolutely delighted to be invited to present at *Asylum*'s *Action and Reaction* conference this year. And when we heard Bob Dylan was in town we knew we had to attend.

We are members of CAPS Independent Advocacy, and have all completed the Mad People's History and Identity (MPHI) course at Queen Margaret University, Edinburgh. Now we are involved in evaluating the course by using participatory action research (PAR). We identify as survivors, activists, mad people.

The course came from Oor Mad History, a community history project about the service user movement in the Lothians, which was facilitated by CAPS. The people involved were inspired by the Mad People's History course taught by David Reville at Ryerson University, Toronto. After a lot of time and a few false starts, we finally met Elaine Ballantyne, a lecturer at QMU, who identifies as Mad Positive. The course was funded initially by NHS Lothian and ran from 2014-2016. Most of the lecturers and all the students had experience of mental distress and using services. Some students went on to develop and deliver a five-session community course which we called Mad Matters.

Mad People's History & Identity was short-listed for the *Glasgow Herald* Higher Education awards, 2016

Why research MPHI?
We were initially funded for three years by NHS Lothian, which enabled us to successfully run the university course from 2014-2016. It was agreed to take a year out to review our achievement and secure further funding to develop Mad Studies, both in the university and beyond.

Feedback from students included "Made me feel not alone", "Gave me answers to questions I'd never had before", and "Helped me connect with my anger".

There was a general feeling of a sense of community, with some people stating the course had changed their lives! We wanted to better understand the motivations, experiences and impact of being involved in Mad Studies on mad-identified students. A MPHI course lecturer, who identifies as Mad + and as an ally of mad-identified people, and who had also been part of the original steering group,

invited all the QMU students to work on a participatory action research proposal with her so as to explore the experiences and impacts of the course on students. The lecturer is also using the PAR research for her PhD.

> "It was important to us for the research to be in keeping with the course by developing people's skills and building on a newfound sense of community. We wanted to break down the gap between researchers and those being researched, just as the course aimed to blur the lines between lecturers and students, and we thought it vital to bring the message of the course to people in other parts of the university."

The research Group comprised a QMU Lecturer, a CAPS Oor Mad History worker, a Mad-identified postgraduate research student, and four Mad-identified students. They began to meet regularly in the Spring of 2016. The student members of the group were invited to attend a two-day training course for community-based PAR at the Durham University Centre for Social Justice and Community Action. This was to ensure the survivor members of the research group have the knowledge and skills to take a leading role in the development and delivery of the research project.

What is PAR?

Participatory:
• Collaboration through participation
• Empowerment of participants

Action:
• Change – real life experiences
• Evidence, in terms of different outcomes

Research:
• New knowledge
• Documented learning

Research aims were agreed as:
1. To understand the motivations, experiences and impacts of being involved in a mad studies project on mad-identified students.

2. To develop a deeper understanding of mad studies as a critical pedagogy, and its contribution to promoting mad identity, generating mad knowledge and facilitating mad activism from mad studies student perspectives.

3. To ascertain the contribution of PAR to understanding the connections between engaging in mad studies, mad activism and emancipation, from mad studies student perspectives.

Research questions as developed by the PAR group were:
1. What motivates mad-identified people to be part of a mad studies course?

2. What narratives do mad-identified students construct around their own mad history and mad identity?

3. What are the experiences and impacts on mad-identified students of being part of a mad studies course?

4. What can Participatory Action Research contribute to understanding the relationship between the engagement in a mad studies project, activism and the facilitation of emancipation?

Research methods:
An analysis of documentary evidence already available would inform further data collection and student anonymised application forms which included questions about their motivation and reasons for applying for the course, as well as details of previous experiences. Student (survivor) members of the research group would take part in interviews about their own experiences of being course graduates, and would also interview other students. Interviews were filmed and completed using a semi-structured interview schedule.

The research group met together to work on the analysis of the interview material and to develop a framework of key themes before inviting interviewees back to the university to review the film of their interview and to comment on our analytical framework, so as to ensure it coincided with their own experiences and understanding. It was hoped the fieldwork and analysis stage and other outcomes of the PAR would be completed by October 2017.

As part of the QMU course, students were asked to bring a photo which expressed their experiences of madness, which also incorporated that week's topic. They were invited to write an optional photovoice assignment of a thousand words describing their experiences of madness, which earned 20 credits. The research group organised an exhibition of some of these images and narratives which took place at the University during March 2017. A short film is being made to help raise awareness and disseminate information and outcomes from the research.

Students' Photovoice Assignment at Exhibition

Penny's story

Dialectical Behavioural Therapy: Effective treatment for BPD or a "Stepford Wives therapy" Programme? (aka, the Anti-Psychiatry Movement: Irrational Hostility or Common Sense).

The image I have chosen to write my 'photovoice' assessment around is one from the 1970's film *The Stepford Wives.* This is a Hollywood movie about how the wives in the community of Stepford, during the heyday of feminism, were eerily transformed into ultra-compliant, twee, very feminine, 'wouldn't say boo to a goose' robots. This was because their husbands were fed up with their wives being influenced by feminism and no longer wanting to be the pretty little wife at home to wait on them hand and foot, have their tea on the table and waiting for them in bed wearing a sexy negligée.
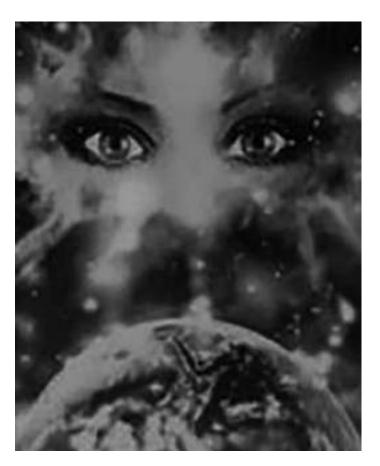

This is the image that came to mind when I first read Marsha Linehan's *Skills Training Manual*, in which she first described how to deliver dialectical behaviour therapy (DBT). In the UK, DBT is now the most widely offered type of talking therapy for people diagnosed with borderline personality disorder (BPD).

Shirley's story

In 2013, I was referred to the Barony Project in Edinburgh, where I was told about MPHI. I was delighted when I successfully applied for the 2015 course. My credentials were my own lived experiences of mental distress. I was also grieving for my son whom I lost in 2012.

The course gave me great purpose not only for myself but also in my son's memory. I have attended conferences in Durham, Cork and Manchester. I have also been involved in several projects including: Conversations for Change, Stories of Changing Lives at a local psychiatric hospital, and helping organise and facilitate a Mad Studies community course.

All of this has been very valuable and has inspired me

to help others and continue with mental health activism. I feel more knowledgeable and resourceful in moving forwards.

Presentation done and dusted (phew) we had time for questions and comments.

Some people said they wouldn't use the word 'mad' to self-identify, which is something that came up regularly amongst students on our course. We also discussed replacing Recovery college courses with Mad Studies community courses, thereby replacing a neoliberalist approach with a collective lived experience one.

Several people asked why they had never heard of Mad Studies, which we have taken on board and were discussing just recently. We hope soon to be able to look at ways of publicising what we do. We already have a community course template which has been successful in Edinburgh, and we are happy to pass it on as shared knowledge.

Funding was discussed, and we explained how in Scotland mental health advocacy is a legal right and hence more likely to be funded. We are also fortunate in the Lothians to have an excellent relationship with the NHS purse-holder.

It's still early days for the outcomes of the PAR research. However, one major and exciting outcome is we have now been given five years more funding from NHS Lothian!

Thank you, *Asylum magazine*, for inviting us to take part at your Action and Reaction conference. We had a ball and hope to catch up again with you all soon. ▪

Creative responses to mental distress

RUFUS MAY, ANNE-MARIE MCKENZIE & APOSTOLIA FOTOGLOU

I (Rufus) met Anne-Marie in my work as an inpatient psychologist. She felt emotionally numb and suicidal, and consistently had voices telling her to kill herself. Medication was not really having any noticeable effect on this distressing experience. Anne-Marie and the team supporting her decided to gradually reduce her medication, and try focussing more on psychological and social approaches to her problems.

Anne-Marie wrote some poetry about her situation, which she showed Rufus:

I'm feeling like shit
I feel as though I'm in an endless pit
Will it ever change

I'm struggling to get through the day
It doesn't help with what the voices say
Will it ever change

I just think it would be better if I was dead
Then I wouldn't have these thoughts in my head
Will it ever change

I wish I didn't have 2 endure this torture
EUPD has no cure
Will it ever change
Will I always want 2 die
Will I ever be able 2 cry
Will it ever change

Will I always be detached from everyone and everything
Will I always feel like I'm just existing
Will it ever change

After listening to her poem I was moved by how powerless Anne-Marie felt as well as the power of her poetry to convey how she was feeling. During our work together we looked at writings about post-traumatic stress reactions, accounts of emotional blocking, and writings about living with aggressive voices. I also shared my feeling that all psychiatric diagnoses were limited constructs – including the one she had been given: Emotionally Unstable Personality Disorder. Anne-Marie said she too did not think this label was very useful to describe her situation. I suggested to her that if she could work in new ways with some of her emotions she may feel a shift in her numbness and the intensity of her voices.

Anne-Marie told me about her life, giving several accounts of abusive relationships during her childhood, and also how court systems had added further layers of trauma.

We then looked at the possibility that the voices which urged her to kill herself were parts of her suffering in relation to the abuse and powerlessness she had experienced, and that perhaps Anne-Marie's suffering had been ignored and the voices had lost faith in life.

We worked on this in two ways. Firstly, it felt important for Anne-Marie to experience her pain by being listened to. I asked her to write a letter to her abusers – which she did not need to send – to let each one know how she felt about what they had done to her. We did some drama work with this letter, including reading it out loud at the *Asylum* conference, along with the poem above. This was done with the support of assistant psychologist Apostolia Fotoglou. The aim was to give Anne-Marie the experience of the community hearing and acknowledging the painful experiences she had been through – something that up to then did not seem to have happened. This work is especially influenced by the idea of truth and reconciliation: that healing and reconciliation is made possible when members of the community bear witness to the painful and harmful events a person has been through.

Anne-Marie's letter:
To Grandad,
You hurt me a lot and have caused me to have mental health problems.

I hate you so much for what you did. I was too young to understand what you was doing was wrong. You took away my childhood beliefs at such a young age by telling me Father Christmas and Easter bunny wasn't real.

You have totally ruined my life to the point I just want to die. I can't remember everything that you did, but I have started to remember some things and no little girl should go through that.

You were supposed to love me and protect me, instead you used me for your own pleasure. What you did was so fucking wrong.

I'm glad you're dead now at least you won't be able to destroy someone else's life.

You made out that you was such a good person to everyone else when really behind closed doors you were a monster. I know that you had it hard in the prisoner of war camp, but it still doesn't excuse what you did. There are no excuses, what you did was vile.

I wish I could have confronted you and asked you why. I nearly did once but then Irene walked in so I never.

I will never be able to understand how you can do that to a child, or anyone for that matter. I've tried to think from the abuser (you) and that's why I made excuses up for why you did it. I know deep down that I shouldn't have done it but it was my way of coping at the time.

I should be very angry with you but the truth is I don't feel anything.

I think that it is better that you're dead so I don't have to see you as that used to be a constant reminder of what you did.

You used to always tell me I was special and it was our secret. Then when I got older and realized it wasn't happening to my friends and kind of knew it was wrong you told me if I told anyone I would get taken away from my mum and dad. I believed you. So I didn't tell anyone and had to carry that secret around with me.

You used to spoil me with sweets and toys, and as I got older you used to bribe me. If I did what you wanted you would buy me sweets or give me money. Basically you used me for what you wanted.

I'm going to go now as another memory has just come in my head. What you did was sick and now I'm left dealing with it.

Anne-Marie

Alongside this work, Anne-Marie did some role playing of standing-up to her voices, by using 'box-ercise'. She wore boxing gloves and I wore boxing pads. I would say the kinds of things the voices would say: "Kill yourself", "Hang yourself ", and "You are better off dead." In response she would punch my pads and say things like "I want to live" and "I choose life".

We would practice this repetitively several times each week, and in her mind Anne-Marie would carry on saying this kind of thing back to her voices.

We also presented the 'box-ercise' at the *Asylum* conference. Gradually, Anne Marie started to believe more in the idea of living, and gradually her voices started to diminish in intensity and frequency.

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Reflections on 'Creative responses to mental distress'

Angela Sweeney and Sarah Carr

First of all, we'd like to acknowledge the importance of having this presentation at the Asylum 30th Anniversary Conference. It is vital to explore hearing voices in a non-psychiatrised way, and with creative, non-pharmaceutical responses determined with the voice-hearer. There is no doubt that many in the audience found the presentation powerful and resonant. In practice, many voice-hearers would benefit hugely from the approach demonstrated by Rufus, Anne-Marie and Apostolia.

However, as female members of the audience, with a particular perspective, we want to flag up something very important. In the auditorium were a large proportion of service-users and survivors, many of whom will hear or have heard exactly the voices Rufus spoke when re-enacting the psychologically and physically powerful therapeutic sessions he had with Anne-Marie. This is something we felt wasn't adequately considered, given that the presentation and performance constituted the conference's opening keynote address, attended by all the delegates.

For an audience which included many survivors, we did not feel it was entirely appropriate to go into the level of detail that Rufus revealed, as a practitioner – particularly in the context of a conference, which in and of itself can be stressful, and where a delegate may feel trapped and unable to leave the room, or very self-conscious if they do so.

We would like to point out that the presentation also introduced a gendered power dynamic, which for some female survivors would have been resonant of trauma, or problematic gendered relationships with male practitioners. We think the presentation would have worked equally well, and would have made as much sense, if the therapeutic session with the voices re-enactment had not been performed on stage. Doing so was potentially highly triggering and therefore damaging for those in the audience – and in fact it was experienced as such by some of us.

Our suggestion for the future would be to present something like this as a workshop which people elect to attend, rather than a presentation before the whole conference, which people attend automatically. We also feel it would help if the presentation was described in advance information and on printed conference materials (especially the programme) so that people can make a fully-informed decision about whether or not to attend. In isolation, a warning at the beginning of a keynote presentation may not be an appropriate solution since it can be difficult or embarrassing to leave a room at the start of a presentation: effectively, that tells everyone present about your personal struggles.

Ultimately, we feel that if there is the potential for a presentation to be triggering, and even if just one person in an audience is significantly distressed, then there is a demonstrated need to reflect on what constitutes appropriate content for an opening, keynote presentation. ▪

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A reply *from Rufus May*

Thanks for giving your perspective which helps us to look into adapting how we do similar things in the future. We are very keen to try and make presentations on sensitive subjects like abuse and voice hearing as respectful and mindful of power dynamics as possible.

The presentation was designed collaboratively with Anne Marie, Lia and myself. As the title of the presentation was 'Creative Approaches to Distress', we had wanted to show how poetry and letter-writing might be helpful in restoring a sense of voice, and being heard, after experiences of oppression (and in overwhelming times).

In relation to the role-play, we wanted to show a way to support someone who experiences constant and overpowering voices urging suicide. The idea is that by one person role-playing the voice, in response the voice-hearer can practise being assertive and self-compassionate. The aim is that they can then build on this role-play, and learn to set boundaries with their voices, on an ongoing basis. Where distraction and dialoguing are not effective, many people have found these kinds of role-play helpful.

In the hearing voices movement we are keen to demonstrate what voice-hearing is like, to demystify the experience and make it easier to talk about and empathise with. Many people have told us how they feel they are more understanding and empathic after seeing these kinds of role-plays. And people who hear voices have said they feel it helps to acknowledge what they have to go through, alone.

I was aware the presentation could be triggering, and I tried to let the audience know this, and for people to be prepared to leave if they found it overwhelming. On reflection, I realise that it may be difficult to leave an auditorium, because of the nature of the seating. I did also invite people to approach me at the event – or afterwards, as you have done – to give me feedback on the presentation. One person at the event said she had valued the presentation but decided to leave when it became too overwhelming, and she was grateful that she had been given a forewarning.

In the Bradford Hearing Voices group, we often use role-playing to respond to challenging voices, and I have also done similar role-plays at other conferences. Up till now, I haven't had any voice-hearers complain about saying aloud what voices say in a role-play. I appreciate, though, that we put a lot of powerful content into a short space of time. I had not done this before, so I am reflecting on what you say, and want to learn from it.

In future I will discuss the content with the organisers of events much more, and try to negotiate more time for this kind of presentation – possibly putting it into a workshop format, which people can choose to go to or not, instead of make the presentation to a whole conference. I will also think more about the space and seating arrangements.

This conversation reminds me that I am interested in gatherings where there is more time for dialogue and listening to personal experiences. I am thinking that traditional academic conferences, which are set-up with didactic lectures and workshops (which the recent *Asylum* conference seemed to emulate) do not enable the space-sharing that we need so as to really think and learn how to relate to each other in helpful ways. Maybe the manner in which we organise meet-ups, and might create gentler, interactive and democratic spaces, can be discussed more in the planning for the next gathering... ▪

Keeping the FUN in DYSFUNCTIONAL

Yasmin Dewan

When I was asked to give a talk on Therapeutic Support at the recent *Asylum* conference, when compiling my notes I was of course immediately drawn to considering my role as a psychotherapist. In particular, I considered the specific benefits of my approach to therapy, focusing on client life issues and the co-creation of certain holistic solutions.

Invariably, though, as always seems to happen when asking my intuition for guidance, another more interesting answer came to me.

During these globally trying times, maybe we need to look for support in another way? If we're not able to access external mental health resources directly, for whatever reason, perhaps the answer lies in each of us securing a very different type of support? One that works for us individually, in a more bespoke kind of way? After all, we are all very different, with very different needs.

Despite these different needs, however, we are, all of us, I'm afraid, set up to be emotionally dysfunctional.

Guided by our role models – this includes what we learn from our parents and society in general – we are taught to repress and distort our own emotional process. We are trained from a very early age to be emotionally dishonest.

Back in 1990, my younger brother was diagnosed with paranoid schizophrenia, and I know from personal experience the lengths to which my own family members have gone in attempts to keep themselves emotionally safe, and how this has manifested in various forms of illness. So much so, that 25+ years later, there is a metal plaque in the family home which takes pride of place in recognition of this fact. It says: ***This family knows how to put the fun in dysfunctional!*** Most families are indeed just that – quite dysfunctional. Our job is to simply make the most of it!

Now this isn't to discount the need for therapy – how could it be when that now represents my entire working life's purpose? No, what I'm talking about is finding a way for people to learn how to take greater personal responsibility for their own healing, by re-empowering ourselves so that we're not at the mercy of our doctors or the drug companies!

I am totally convinced that nearly all our life problems today stem from unmet needs during childhood – be it experiencing harrowing health, money misery or rotten relationships, they will all have their roots based and firmly entwined with the messages or so-called injunctions fed to us by our caretakers.

Modern civilisations – both Eastern and Western – are only one or two generations away from believing that children were property. This goes hand-in-hand with the other ridiculous notion that women are also property! I distinctly remember in my early years, while training to be an accountant, coming across the words, 'wife' and 'chattel' in the same sentence when it came to the administration of tax law and the legal aspects of drafting up a will! I still can't believe I even saw that.

The idea that children have rights, when it comes to individuality and dignity, is relatively new in modern society. The predominant and underlying belief, manifested in their treatment, has been that children are an extension of, and the tools to be used by, their parents. Is it then any wonder that children swallow whole whatever is fed to them while growing up?

When she talks of people "stamping out a child's exuberance" (in her book, *The Drama of the Gifted Child*), Alice Miller offers a telling insight into the basic beliefs that underlie some attitudes. In other words, you have to crush the child's spirit in order to control them!

Other idiomatic statements, such as "children should be seen and not heard" and "spare the rod and spoil the child", also do very little to help matters.

It is only in recent history that our society has even recognised child abuse as a crime instead of it being the inherent right of a parent! The concept of healthy parenting as a skill to be learned, rather than what happens automatically simply because you've given birth, is still very new in our society.

Any society that does not respect and honour individual human dignity is one that does not meet the essential needs of its members. In their very essence, patriarchal systems that demean and degrade women and children are totally dysfunctional.

The way we form core relationships with our own self, with life, and with other people, is based on the messages we take on board during our early years. Reactions we receive during childhood will either help or hinder our adult years. We have no training or initiation ceremonies, no fully approved programmes to help us let go of our old internal programming so that we can learn how to BE, to have a healthy relationship with ourselves before being able to have a fulfilling one with another person. We build upon the foundation of the dysfunctional past, and so we experience the same in the future. And so the cultural hot potato is formed, passed on from one oblivious generation to the next, forever more, until and unless someone is brave enough to attempt to break the cycle.

As adults, if we don't look to change we simply react to the programming of our childhood. To say that our childhood emotional wounds do not affect our adult lives, both personally and professionally, is ridiculous. To think that our early programming has no bearing on the support we're in search of today is denial to an extreme.

Responding to the needs of our 'inner child' lies at the very heart of therapeutic healing and support. When we react out of fear, insecurity and dysfunctional belief systems, it brings about all manner of distress, emotional heartache and mental upheaval. Just look at some of our world leaders today for the perfect example of inner child needs being ignored, now being left to go on the rampage!

It is only through each of us taking responsibility for the care of our own inner child that we can learn to heal ourselves of any pain we feel today, be it physical, mental or emotional. Learning to respect the little kid who lives inside each of us, to discover its desires and to love it unconditionally, so that the early wounds can be kissed better – this must be seen as fundamental, at both an individual and global level.

So, depending on how you wish to define Therapeutic Support, maybe in the absence of anything else being available 'out there', this internal resource is really all we do have when it comes to our own healing?

No time like the present – let's get started! ▪

RETHINKING PSYCHIATRY

CRITICAL PSYCHIATRY NETWORK

SUMAN FERNANDO

As the name suggests, Critical Psychiatry Network (CPN) is a hub for psychiatrists in the UK to share critical views on the psychiatric system. My association with CPN began in about 2008, with the Transcultural Psychiatry Society (TCPS). This was a multidisciplinary association which I think was the main critical voice in the 1980s and 1990s. It was critical of both psychology and psychiatry, and the mental health system in general, mainly from the viewpoint of 'race' and culture. This article reflects my personal take on critical psychiatry and related matters.

Psychiatry and clinical psychology – the main 'psy disciplines' – tend to underpin how our mental health services function in the UK. These developed within Western culture during the 18th century, from the study of what was viewed simply as 'madness'. Studies were undertaken by scholars and medical doctors – not by the people given the label 'madness' – and they appeared on the back of an asylum movement which locked-up people when for various reasons they were not wanted in society, and often when they were deemed insane. Then, after World War II, there was a degree of de-institutionalisation and community care. However, this was complicated by the advent of powerful new psychotropic drugs, the 'chemical cosh', and the lucrative drug trade – the 'medication revolution' of the 1950s–1970s. This resulted in today's drug-based system of bio-medical psychiatry.

But if we look closely at the history of psychiatry – not just the official texts but also at back-stories of what really went on, politically – almost from its beginnings there have been voices critical of psychiatry, and even efforts at fundamental reform, some coming from unexpected quarters. Critical psychiatry is not new; and it keeps going in its present form for a variety of reasons, mainly to do with power. I shall illustrate this point with some stories – real ones, not fake news!

* * *

I recall when the Association of Psychiatrists was to be converted into a Royal College, in 1971. The meeting called to approve this arrangement was unexpectedly (at least to me) faced with a revolt. A group of youngish psychiatrists from the Maudsley opposed the proposition as it stood, and criticised the way psychiatry was structured, saying this was a chance to reform. What they proposed was that the new College should be very different to the other medical Royal Colleges, should be multi-disciplinary, should not have exams for membership but some sort of entrance qualification that showed an interest in the welfare of mental patients, and that a medical formulation of the project should not dominate.

This revolt of the young against the old guard appeared to be developing into a majority of the fairly small attendance, and likely to carry the day. Tempers ran high, and then the chair of the meeting intervened. This was Professor Martin Roth, who was already appointed as the first president of the College. He gave an impassioned personal assurance that once the royal charter was granted – only possible if the motion to approve the way the College was structured was passed – and once the College was a legal entity, he would make sure that it was re-structured in the way proposed by these critics. The revolt collapsed, the College got its royal label, the psychiatric establishment bought expensive premises in Mayfair which outdid all the other medical colleges, and then proceeded to set up its medically-oriented exams. The leader of the incipient revolt moved up the career ladder very quickly, while the other dissenters were bought-off or side-lined in various ways. And Professor Roth got his knighthood.

Now a story about an event a long time before, described in my book *Mental Health Worldwide: Culture, globalization and development* (2014). Soon after the French revolution, in the early 1790s, when the motto was Liberté, Egalité et Fraternité, the revolutionary Paris Commune sent Dr Philippe Pinel to work at the asylum at Bicêtre, near Paris. There he found an ex-patient in charge of things. This was Jean-Baptise Pussin, who had somehow become manager or director. Together with Madame Pussin (I think), Pinel and Pussin devised a humane method for care of the inmates. They abolished physical restraint, provided much better living conditions, and what we might call 'support'. Pinel later moved to Saltpetrie asylum and instituted the same humane conditions; in fact, a painting of the removal the chains from patients at Saltpetrie informs what most historians say about Pinel. For its time, and even today, Pinel's *Treatise on Insanity* was an extraordinary document. He described those suffering from insanity as very special people who had ways of seeing reality in ways not available to lesser mortals. He suggested they needed protection from society until they got over their afflictions – and that given time, they did. He called the caring acceptance they should have in an asylum 'traitement moral'; this is best understood as psychological support or treatment. Unfortunately, when this model was copied by Tuke, a Quaker layman, at the retreat at York, he called it 'moral treatment', and seemed to interpret it as teaching morality – what we may now call Victorian values. This was later criticised as only substituting the control of behaviour and thinking, a sort of mental coercion, for the previous bodily restraints.

I shall now speak of a political battle currently going on within psychiatry and mental health. This is immensely important to the Global South, which makes up most of world's population. Essentially, financed indirectly by Big Pharma (it is suspected), there is a drive to spread what are called evidence-based psychiatric services (i.e. medication) across the Third World. This is known as 'the Movement for Global Mental Health' (MGMH). There is now a contentious argument between 'cultural psychiatry' and mainstream psychiatry, the former seeing the imposition of the Western system on the Third World as neo-colonialism. One problem for the cultural psychiatry movement is that the World Health Organisation (WHO) has recently changed its policies, and now backs the MGMH approach of introducing 'evidence based treatments' from the West on a large scale, thereby pushing-out indigenous ways of helping people seen (in Western terms) as 'suffering from mental problems'. The back-story to WHO power-politics is important here. In the 1990s, WHO used to encourage and help Third World countries to develop mental health systems primarily by supporting locally developed ways of helping people – by supporting indigenous healers, religious organisations, community development, and so on. Then, in the late-1990s, WHO became short of money because the rich countries reduced or withdrew funding, and so it turned to the big international corporations for funds. This is why WHO has changed its approach.

* * *

Now back to the mental health services in the UK, and how I see it from a critical angle. I know there is often talk of abolishing psychiatry. In my view, this is not politically possible, just like that. The social and political forces ranged to keep the institution active are tied up with the powerful forces that keep the drug culture in the West going (and hence the economy), and our criminal justice system in place. I believe that instead we should work towards bringing about changes in psychiatry – hopefully fundamental changes.

Many critical psychiatrists agree that we need to work on changing the paradigm by which the mental health system is organised. That is to say, very much change the way of going about our business. And many feel we should discuss how to bring about changes in the current system while avoiding getting something equally bad or much worse, if too much is thrown out too soon. In 2012, a paper in the *British Journal of Psychiatry*, signed by several members of CPN, sets out quite well the road we need to take. It does not go far enough, but it does indicate a start.

Looking at the history of the mental health system, I suggest that totally removing the medical dimension may be foolhardy and even dangerous. But we very much need to move away from its dominance, and towards a socio-political and cultural approach. Dependence on diagnosis is something we need to move away from rapidly – perhaps by some carefully organised steps. There may be a place for banning some types of treatments (such as ECT), at least for a trial period, and this would also indicate the direction of travel. And certainly we need to reduce the use of medication.

A critical approach should aim at introducing incentives for professionals to work *with* users of services, rather than the current practice of encouraging them to work *against* users – for instance, by too easily resorting to sectioning. So perhaps there should be strong disincentives to sectioning, making the event rare, and with a view to soon abolishing it. Other drives should be about changing the approach to service delivery so that it becomes consumer-driven (i.e., the direction is indicated by the service user) rather than driven by symptom-reduction or outcomes measured by allegedly objective criteria. These are suggestions for a critical psychiatry to take up and pursue, for a start.

Between 2007 and 2012 I spent some time helping with some research and capacity-building in Sri Lanka, which was then emerging from civil war and natural disasters. There are a lot of lessons we can learn from some countries in the Third World where, on the whole, there is very little psychiatry and much more emphasis on enabling people's resilience and a reliance on community, religion and so on. Also, for those who want to turn to others outside the family for support and therapy, there is a plurality of systems available to choose from. Perhaps that is what we should have in our NHS, by backing user choice. What is lacking in many poor countries is the practical support (i.e. resources) for people to access sources of help, whether at healing centres, from astrologers, indigenous healers or the rudimentary psychiatric clinics – which I believe help, but only as a part of a pluralistic system from which people can chose.

* * *

Before ending, I will mention a few more interesting facts. This information cannot be found in the standard textbooks and is excluded from most histories written by Europeans for Europeans (what is called 'white knowledge').

The story of the very first mental hospitals does not strictly illustrate a critical psychiatry movement within Western psychiatry, but if medieval politics and wars had turned out a differently, they could well have led to a very different sort of psychiatry developing in Europe. These institutions were not developed in Western Europe, as most people might imagine, but in North Africa and Islamic Andalus (southern Spain). Very different approaches to problems of mental health were practised in the mãristãns of the Arabic Empire between the 10th and 14th centuries. The treatment at these hospitals is described as:

> '... a blissful union of science and religion.' Graham, TF *Medieval Minds Mental Health in the Middle Ages* (1967);

> also

> '... a sort of spiritual therapy ... involving music, dance and theatrical spectacles and readings of marvellous stories…'
> Foucault, M *The History of Madness* (2006)

There was also a kind of psychiatry developed in Tibetan Medicine, with

'... a complex interweaving of religion, mysticism, [Mahayana Buddhist] psychology and rational [Ayurvedic] medicine…and psychology involved with insanity [psychosis] is the same as that required for pursuing enlightenment. ... It all depends on whether it is accepted or not.' Clifford, T *Tibetan Buddhist Medicine and Psychiatry* (1984).

*   *   *

Finally, a word about reforming the mental health system via changes in the psy disciplines. There is a recent realisation of the need for a critical clinical psychology as well as a critical psychiatry. About two years ago students at UCL devised a Youtube film: *Why is My Curriculum White?* (youtube.com/watch?v=Dscx4h2l-Pk). Apparently, this has fostered study groups in some universities about the nature of curricula in philosophy and the social sciences – specifically concerning the failure to draw on knowledge from non-Western sources for university courses, and the exclusion from positions of influence of those who teach such knowledge.

The critique of clinical psychology suggests that there are many different psychologies to inform the lives and beliefs of people around the world – not just Western, medically-based clinical psychology. In non-Western cultures these approaches are mainly embedded in religions and philosophies. The current training of clinical psychologists may be far too Eurocentric, based as it is on 'white knowledge' that promotes racist thinking and culturally insensitive systems in mental health. This may well be one of the debates – the political battles – in the critical mental health field that is developing. ▪

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HELP!

MY DRUGS ALL SOUND LIKE HARRY POTTER SPELLS

Neoliberal Hard Times

Mick McKeown

At the *Asylum* conference I gave a short talk to introduce some ideas – actually, gut feelings – about neoliberalism, and resistance to it. Such ideas were taken up in more detail and depth by a number of the other presenters and participants, notably Rich Moth and Phil Thomas. Arguably, an engagement with neoliberalism in some way or another colours most contemporary critical debate on mental health. My intention in particular was to locate neoliberal politics as a provocation for activism, and to connect briefly with some ideas for how best to organise activism if it is to involve broadly-based alliances. I also wanted to weave in some connection to our conference mascot and his namesake, the dogged, world-weary troubadour and lyrical protester, Bob Dylan.

'Neoliberalism' denotes a particular way of organising the political-economy under the latest form of capitalism. This dominates the globe and is responsible for hugely detrimental inequalities, widespread misery and poor health outcomes. It involves a professed faith in free markets, and leads to privatisation, the retraction of public services and welfare, and wholesale deregulation across the economy. The consequences can be seen in the proliferation of precarious work, such as zero-hours contracts, where the bosses *sing while you slave but you just get bored*. Similarly, food banks proliferate as increasing numbers, including many of those who have a job, wonder if they can even feed themselves. At the same time, whilst the living standard of more or less everyone else stagnates or falls, there has been a massive concentration of wealth into the hands of the very few, the super-rich. In the UK, the richest 10% of the population holds 45% of all the wealth, whilst the poorest 50% can claim less than 9%. In this looking-glass world, where *money doesn't talk, it swears, it's hard not to ask yourself if it's you or them that's insane*.

There is some academic dispute over what neoliberalism actually is, and whether it indeed represents a substantial discontinuity from earlier forms of capitalism. However, most commentators trace its beginnings to the Thatcher-Reagan era, and the relish with which this duo rejected the post-war Keynesian consensus and adopted the radical 'free market' ideas of von Hayek. The fact that it was Pinochet's illegitimate Chilean regime that was the first to implement neoliberal policies on a national scale lends force to the repugnance felt by the political left: from the start, neoliberalism was opposed by the labour movement and other social activists. Notably, disability activism has been in the vanguard of recent campaigns.

It is somewhat astonishing that the dominance of neoliberalism was not substantially shaken by the 2007– 08 global banking crisis, which exposed the more obvious shortcomings. Indeed, the fact that the legitimacy of neoliberal ideas appeared to be fatally wounded and yet the system carried on, has drawn wryly comic attention. Nowadays, *everything's a little upside down, as a matter of fact, the wheels have stopped.* This is so much the case that neoliberalism is sometimes called 'zombie economics'. *The winds of change should be shaking the windows and rattling the walls*, yet neoliberal hegemony remains intact.

Neoliberalism is bad news for most people, but it is an especially awful prospect for some. For mental health service users, refusers and survivors, all of their cards have been marked in advance. Neoliberal austerity policies force the most disadvantaged to carry the can for the system's failings, and they represent a particularly vicious attack which resonates with the complacent Victorian prejudice against 'the undeserving poor'. Rates of mental distress and suicide have increased under austerity, and despite some contrary rhetoric, the recent response of the state seems so far inadequate, insensitive and uncaring. Those in distress may *feel to moan but, unlike before, discover that they'd just be one more person crying*.

Cuts to services coincide with assaults on incomes in a purposeful attempt to force people off benefits and into degraded forms of work. In England, fewer beds and overstretched community teams has led to several clearly negative effects on the mental health system. First, the scarcity of care provision means those requiring an inpatient stay are increasingly placed in an 'out of area' facility, which could be hundreds of miles from home. Second, nowadays more or less the only way to enter an inpatient unit is to be compulsorily admitted under a section of the Mental Health Act. Rates of compulsion have steadily increased since the last reform; ironically the 2007 Mental Health Act was supposedly designed to better reflect community care. Third, the overall squeeze on resources is adversely affecting the climate of care, with inadequate staffing levels, overuse of agency staff, insufficient beds, and countless other limitations on the service. Tendencies for coercive and restrictive practices are consequently exacerbated, and they become the norm rather than options of last resort.

Arguably, these conditions are inimical for all concerned, alienating for both patients and staff. The capacity for services to transcend the function of social control, so as to offer genuine care, support and a healing environment, is hugely constrained. This is unhealthy for staff as well, with large and growing numbers suffering from deteriorating health and high levels of sickness absence; stress and mental distress is a substantial component of this problem.

So, the most appropriate stance to take towards neoliberalism is advocated by Simon Springer. He says, simply and succinctly: "Fuck it!" For anyone offended by the expletive, Springer argues that neoliberalism and its effects are far and away more offensive.

Of course, all of this is complicated, arguably worsened, by over-reliance on the narrow, biomedical psychiatry, enmeshed as it is with the state's interest in controlling deviance. And you know that *there's no drug that'll do for the healin', and no liquor in the land to stop your brain from bleeding.*

Alternatives include recent thinking around trauma-informed care and democratised models of practice. Peter Sedgwick understood that more relational solutions are required, and that in this sense the transformation of psychiatry into a relational form could show the way for resisting neoliberalism and transforming the wider society.

Both Sedgwick and Springer advocate 'a politics of prefiguration' – modelling the world we would like to see in the course of bringing it into being. Sedgwick saw the need for broadly-based political alliances to work cooperatively and democratically for change. The Mad Studies movement also calls for alliances, and considers the characteristics of effective allies and the conditions for supporting alliances. Arguably, alliances between the mental health workforce and service user and survivor activists are warranted, but may need sophisticated grass-roots efforts to ensure that while solidarity is not perfect, inevitable turbulences in relationships and trust can be worked through. Amongst others, Helen Spandler and I have argued that creating the foundations for a more authentic solidarity could require processes of 'truth and reconciliation'. Within these processes we may realise *there's no success like failure, and that failure's no success at all.*

Ultimately, the mutual healing of past and present psychiatric hurts may bring closer together *all the rebels, luckless and outcasts, the aching whose wounds cannot be nursed, the countless confused, accused, misused, strung-out ones, and worse*. The sharing of personal stories and testimony has the potential to lead to recognition and appreciation of each others' experiences. This calls to mind the reading of *a book of poems where every one of them words rang true and glowed like burning coals, pouring off of every page like they were written in my soul, from me to you'.*

References: various Bob Dylan quotes throughout. ▪

You may have heard of Mansplaining. Well, how about Madsplaining?
Check this out by Ria Dylan & Rachel Rowan Olive…

Google — mansplaining

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mansplain
/man'spleɪn/ ◀

verb informal
gerund or present participle: **mansplaining**

(of a man) explain (something) to someone, typically a woman, in a manner regarded as condescending or patronizing.
"I'm listening to a guy mansplain economics to his wife"

Feedback

⌄ Translations and more definitions

Mansplaining - Wikipedia
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madsplain
/mad'spleɪn/ ◀

verb informal
gerund or present participle: Madsplaining

(of a normal) explain (something) to someone, typically a mental, in a manner regarded as condescending or patronizing.
"I'm listening to a guy professional madsplaining a mad persons life to them"

Feedback

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Can Clinical Psychology Ever Be Radical?

CRAIG NEWNES

Being critical takes many forms – from abstruse linguistic gymnastics by academic Marxist philosophers to simply telling a shop assistant that the shoes you bought yesterday were no good. For some 'critical psychology' embraces both elements, while for many, simply saying psychiatry is too much embedded in a medical discourse is as far as they go. A radical clinical psychology would perhaps involve something more strident, inviting an explicit political positioning of the profession and an acknowledgement that psychology forms only a small part of a wider struggle towards emancipation.

This article examines the state of clinical psychology and asks whether practising psychologists who are enmeshed in a history of compliance with the medical discourse are able to take a radical position. These practitioners also need to maintain their employment in a system where critique is barely tolerated and innovation limited to occasionally adding another type of therapeutic orthopaedics to the lexicon.

Compliance with the medical discourse

Medical discourse dominates the ordinary language of distress: people describe themselves and others as 'anxious' or 'depressed' rather than 'frightened' or 'miserable', 'manic' rather than 'inspired', and 'obese' rather than 'fat'. For professionals working in occupations allied to medicine, within an unavoidable public discourse, it has been suggested there are three possible positions: (a) compliance – where psychologists work as an adjunct to psychiatrists e.g., using formal assessments of various so-called disorders; (b) eclecticism – where psychologists offer various therapies without protesting about pharmacological treatments or the diagnostic terminology; and (c) radical opposition – the fight or flight option, where psychologists work alongside service recipients to advocate change to the diagnostic and medicalised praxis – or simply leave the profession. For most people, this last option is untenable, so they may prefer to work in the academy or in private practice – where, of course, diagnosis is the norm.

Compliant and eclectic positions pre-dominate. For example, since 1945 the Statement of Purpose of the *Journal of Clinical Psychology* says that it is …

> "…a monthly peer-reviewed medical journal covering psychological research, assessment, and practice... It covers research on psychopathology, psychodiagnostics, psychotherapy, psychological assessment and treatment matching, clinical outcomes, clinical health psychology, and behavioural medicine."

A review of recent issues shows nothing much has changed. Compliance with a medicalised praxis has a long history. In 1950 Eysenck wrote

> "…that a strong, respected and highly competent profession of psychiatry is essential for the growth and flourishing of clinical psychology appears obvious … The existence of well-trained, competent and friendly clinical psychologists can be of the utmost value to psychiatry."

An integral part of the capitalist project, the discipline of clinical psychology adds financial value to institutions, publishing companies and professional organizations. Simultaneously, clinical psychologists garner cultural and financial capital via research and their role in distinguishing the deserving from the undeserving poor. Radicalism can seem an impossible dream.

Psychology in the clinic

Nearly all formal interventions carried out by the human services produce 'wounds' of one type or another. The wounds include any action that removes a person from valued and normative settings and relationships. Many involve clinical psychologists – at the very least as bystanders. For example, a person might be rejected or excluded from a family, school, valued neighbourhood or activity 'for their own good'. Once placed elsewhere, a person might be quickly moved – often without explanation – thus losing any new relationships in the service setting, where the person is now isolated and congregated with other service-recipients who may only have in common the fact that their families and society finds them obnoxious, difficult to get on with, criminal or inscribed as disabled, disordered or disturbed. Once they are moved and inscribed, people will lack security and control. They will be marked, i.e., inscribed and re-inscribed by a terminology that distances them from normality and leads to confusion concerning what they need.

For example, it may be assumed that a lonely and frightened child 'needs drugs' rather than a safe place with caring others, or it might be taken for granted that a wheelchair-user experiences other physical difficulties. Confusion results simply from the nature of the obscure language used by the psy professionals. For example, schizophrenia, schizotypal and schizoid all have distinct definitions – if not construct validity – but their similarity is likely to lead to similarly labelled people being treated as if they all require the same intervention. In the context of ECT, this is particularly true for the term 'depression', where a range of potentially helpful and humane interventions are

replaced by electrocution of the inscribed person.

The vagaries of the benefits system mean that a further wound to the institutionalised is that they become poorer. Service recipients may also be blamed for 'resistance to treatment', subjected to humiliating case conferences, invaded without consent (e.g., by PRN medication), referred to other agencies without their consent, denied appropriate help, and administered harmful or useless 'treatments'. Beyond these legal interventions, they may be subjected to abuse within an institution. Invariably, they will be subject to the gaze – as are we all – although the gaze within mental health institutions is perhaps more pernicious.

Is a radical position possible?

Some possibilities suggest themselves for individual clinical psychologists. However, each depends on context, particularly on support from allies and employers. First then, any psychologist (or any member of a psy profession) who hopes to develop a more radical approach informed by critique should seek allies; frequently these will be service survivors and non-psychologists. It is advisable to think small. A great deal of effort is required to make quite minor inroads into the monolith that is modern Psy. For every article published from a radical perspective, there are thousands of reactionary papers repeating the tropes of illness and treatment.

Hard as it may seem when working with oppressed folk, clinical psychologists should be kind. If a patient or a colleague is exhausted, then the simple offer of child-minding or the gift of a CD is likely to cement ties better than so-called professional praxis (as well as running contrary to various professional practice guidelines). Psy professionals faced with the demand to make a diagnosis for the patient record might ask themselves what they would want on their headstone. It is likely that the professional would prefer 'inspired' over 'manic', and might ask the diagnosed person if they agree, and change the inscription accordingly. Again, this apparently simple manoeuvre is context-bound: a person losing a diagnosis may also lose much needed financial benefits.

Clinical psychologists should support advocacy and conduct the kind of research seen as important to service recipients, for example, how best to promote local advocacy campaigns. Here, learning how to write a press release is a good place to start. A particular area of research suggested by patient campaign groups is to investigate the impact of psychiatric compulsion – essentially a human rights agenda. For example: What are the longer-term effects of forced interventions and coercive treatments? How does coercion affect compliance? Is there an increase in non-compliance after patients have been coerced? Is there an increase in treatment-avoidance among people who have been coerced?

Acts of cohesion-building amongst allies might include: always responding to emails/letters/calls, encouraging mutual criticism, and speaking out from a position of knowledge – psy activists need to know their stuff. Importantly, they should practise what they preach. Published papers using the medical diagnostic terminology just won't do, however understandable the practice in terms of garnering cultural capital and prestige for the academy within the Research Excellence Framework.

I have suggested elsewhere that a truly radical approach might involve: developing shyness groups for people who are too assertive – bankers, chief executives, politicians, journalists, psy professionals, etc.; picketing leadership seminars, on the basis that they are ridiculous (can you imagine Genghis Khan, Marie Stopes or Henry Ford attending one?); and following employer guidelines exactly – thus attending all computer-update training and health-and-safety events: there won't any time left to see patients so there will be less chance of doing harm.

In the UK, it may be time to shift the demographic for entrants to the profession. Currently, more than 80% are white women in their twenties. The minimum age of entry to Clinical Psychology training should be thirty, with a hoped for concomitant increase in entrants with some experience of parenthood, relationship-breakdown, caring for a relative, etc. The preponderance of culturally White entrants might be changed by way of three-year trials where the intake is limited to speakers of, say, Mandarin or Urdu. The courses themselves should be designed by survivors and service users. Placements should be with the police, and organizations such as Soteria Bradford. All trainees should be familiar with the advocacy movement and resources such as the European Network of (ex)Users and Survivors of Psychiatry.

Finally – abandoning thinking small for the moment – it may be time to 'Imagine Manchester'. In recognition of broader social changes and the need to embrace a political discourse, some projects involving clinical psychologists have incorporated a wide range of allies when attempting community-based interventions with children and families. In September 1992, Imagine Chicago began with a design team consisting of educators, corporate and media executives, philanthropists, community organisers, youth developers, economists, religious leaders and social service providers; this was under the direction of Bliss Browne, a mother of three, Episcopal priest and former Division Head of the First National Bank of Chicago. By means of an 'appreciative enquiry' with distantiated youth and gang leaders in one of the most violent and rundown areas of the city, their aim was to create an environment that might enable young people to thrive rather than go on to a life of crime and incarceration. Some of the gang members were asked: "What kind of neighbourhood do you want your own kids to grow up in?" A quarter of a century on, many of the goals have been achieved and the project has expanded to embrace similar enterprises in other cities.

Perhaps Manchester's turn has come. ▪

NEOLIBERALISM & MENTAL HEALTH POLICY IN BRAZIL

Brazilian mental health policies, 2001–17: an overview and a call to (re)action

WILSON FRANCO & PAULO BEER

This is a brief overview of Brazilian mental health policies, beginning with the 'Paulo Delgado Law' of 2001, which provided legal support for establishing a communitarian, de-centered and psychosocial care policy. Since then, changes have mostly rowed back on this advance. A political and theoretical critical analysis follows the overview. This is mainly to try to understand how recent developments in mental health policy tie in with neoliberal notions and currents, thereby situating the Brazilian context within the wider picture – and the greater challenges facing all of us today.

From the 'Crack-land' to the 'Crak-cage'

The modern history of Brazilian mental health practice is quite different from that of Europe. In the 1960s, when Laing, Cooper, Oury, Tosquelles, Foucault, Deleuze and Basaglia were engaged in critical practice, in Brazil we were immersed in a dictatorial regime which censored group gatherings, public demonstrations and opposition to state institutionalized practices. This is why we had no established critique, practical or intellectual, until 1979.

The most repressive law in Brazil was known as AI-5, which stood for 'Institutional Act number 5'. As soon as this was repealed, various groups started discussing strategies for a change in public mental health policies, and a wide movement came together to bring attention to contemporary public mental health practices, and the urgent need for change. By 1989, a parliamentary deputy, Paulo Delgado, had proposed a law to implement radical reforms. After twelve years of negotiation, the law actually approved was but a dim shadow of the bill which had first been proposed. Nevertheless, from 2001 to 2014 there was a significant reduction in the number of psychiatric hospitals, psychiatric wings (only for short-term admissions) were introduced into General Hospitals, and a series of psychosocial, community services were introduced. Among the latter, the best known are the Psychosocial Attention Centres (CAPs): today, there are more than 2000 CAPs.

In the last few years, however, the political tide has turned, with less investment in welfare projects and an ever-greater focus on austerity or economic-focused measures which menace both the psychosocial services and the general national healthcare system (called Unified Health System, or SUS).

To illustrate this, we focus on a particular crucial situation in Brazil: recent actions instigated by the municipality of São Paulo with respect to the use of crack and a trafficking hotspot in the centre of the city, a place maliciously known as 'Crackland'.

Crackland had existed for many years, and it was subjected to much public attention and many interventions from both public administration and non-profit organizations, dating back at least as far as the turn of the millennium. The normal understanding is that Crackland is a dangerous place which has been hijacked by dealers, muggers and other malingerers, and the usual intervention by the public administrations (both city and state) has focused on law enforcement and incarceration. Not surprisingly, this has met with little, if any, success.

The last city administration, which ran from 2013 to 2016, tried something new: a taskforce comprising many different offices (Human Rights, Health, Social Services, Labour, etc.) which launched a program called "Open Arms". This tried to "fight crack" by transforming Crackland's relation to law, society and community. Yes Brazil, too, has a "war on drugs". Basically, the idea was to provide health support, to implement harm-reduction, and to provide minimal social security policies, such as sheltered labour opportunities, housing and food.

This program lasted a slim four years – that's how long a mayor runs a city in Brazil, and that's how long "Open Arms" lasted. In this period some interesting statistics were gathered: 73% employment rate in sheltered positions, 53% of the citizens reached got back in touch with their families, and more than 500 participants received housing opportunities. As for harm reduction: 67% reduced their use of crack, 54% reduced tobacco use, 51% reduced cocaine and 44% reduced alcohol use. 95% of the citizens reached by the program understood it as having had 'a positive' or 'a very positive' impact in the course of their life trajectories.

Of course, all was not a bed of roses, by any means. Drug trafficking continued, many apartments and lodges were taken apart and had their furnishings exchanged in the market for drugs, while drug harm-reduction policies were slower than they ought to be, given the dramatic nature of the problem. This and more. However, the "Open

Arms" project did pioneer a non-violent approach towards Crackland, and it was the first organized, multidisciplinary endeavor launched by the city administration.

Last year we had city elections in Brazil, and in São Paulo a right-wing challenger won in the first round, with more than 50% of the votes. He quickly dismantled the "Open Arms" project, and for the last couple of months he has been advancing a set of violent actions in order to demonstrate, as he says, that "Crackland is over." Among other confrontational initiatives, prominent are a series of strikes by the military, shutting down many small stores and houses, and blocking-off the area. In the background to this official action is a new health policy which proposes drug policies of abstinence and compulsory confinement: a witch-hunt – a crack-hunt.

The neoliberal agenda and its peculiarities

We find this development particularly startling. It seems to demonstrate a way of functioning that is quintessentially neoliberal. If we try to understand why this is happening at this exact moment in Crackland, there's an immediate official response that is "The Nova Luz" project. "Luz" is the name of Crackland's neighborhood, so this "New Luz" project consists of an entirely business-motivated plan, in which the São Paulo administration will expropriate the buildings that now house drug users and other poor citizens, and give them to private sector companies. These companies, in turn, intend to demolish the premises and build new ones, so as to revitalize the center of the city.

It's not possible to fully understand why this would be a neoliberal move, just by reading these facts, particularly when one considers that this kind of government intervention goes against what is known to be the neoliberal standard. However, neoliberalism is much more than a form of economic organization: it's a full-blast form of control that uses a cynical kind of rationalisation to regulate social life.

What we find particularly enigmatic is the cynical logic that permits neoliberal governments and companies to sustain a paradoxical discourse without ever harming their reputations or power. It is clear that ordinary members of the public who usually support neoliberal ideals – such as 'free competition' and 'merit-based policies' – have no idea what the neoliberals are really thinking. Instead, those ideals are usually claimed to defend authoritarian and violent measures that would make intellectuals like Hayek or Becker turn in their graves.

However, it's intriguing how those in power seem to have the skill to make contradictory claims and yet not lose the public's support. For example, with respect to Crackland, we hear our mayor João Doria saying that the most important thing is the drug users' health. That would be a great point of view, if it weren't for the fact that this line was used to justify a policy of extremely violent action against those same users. The mayor repeated exactly the same line some days later, on the coldest day of the year, when the police made an intervention that ended with setting fire to the users' tents and blankets.

Even if we were to rely only on the official discourse, there's a clear opposition of ideas. On the one hand, it's said that the most important thing is the users' health, and that the main goal is to take them all into treatment. On the other hand, there's an almost military justification, that the police actions are necessary to end drug trafficking, and this is important because trafficking is the root of all evil. However, conflict between the discourse and the facts shows that the incongruity between those lines is inescapable: firstly, it's clear that the main effects of those police actions is to harm the users but not the trafficking; secondly, the users themselves say they don't trust the government and that they don't want to be part of this treatment proposition. If this incongruence becomes a real problem, the official answer is simple: due to their drug abuse, the users are in no condition to decide by themselves; therefore, the mayor asks for the power to make compulsory hospitalizations.

Allegedly, the ideal of autonomy and self-consciousness is highly valued in what we've been trying to describe as the neoliberal ideology. For this has two main features: a free and independent subject who is able to make his own decisions and is entirely responsible for his actions. However, the official discourse shows that this ideal is not in fact taken seriously: when necessary, whatever the reason – and in this case, there are very clear economic interests – that autonomy may be entirely overlooked. In other words, cynical calculations enable paradoxical ideas to coexist without disturbing each other.

At this point it becomes clear that something strange has happened – especially if we consider that the previous administration successfully cut the consumption of drugs by employing a radically different policy. It is this cynical rationalisation which manages to assimilate the mental health movements' key principles into authoritarian public policies. Cynicism enables a government to take contradictory measures, to affirm and at the same time deny the same principles, without losing its credibility or power. And that's why, even when important struggles have been won, even when there's some kind of victory, a social movement must always be alert, must always be ready to (re-)act. ▪

POETRY and PROSE

BPD and *me*

Janette Byron

Two maladaptive people
Conceive a maladaptive child
To exist in a maladaptive world
With a maladaptive mind
She has maladaptive relationships
But mothers an adaptive child
Who with his adaptive mind
Lives within an adaptive time
Her maladaptive thoughts
Disrupt her maladaptive life
But with some adaptive features
She helps others understand hard times
Her maladaptive mind sees T's maladaptive features
And thinks without a maladaptive mind
She could save T's life
But two maladaptive minds
In a maladaptive relationship
Who desperately want to be adaptive
Aren't living in an adaptive time
So with her maladaptive mind
She thinks and thinks then sighs
Coz her maladaptive thoughts
Are distorted and NOT FINE

Funkiness

Shaun K Skårnes

A myriad mix of shame, anticipation, anxiety and lust pulsed through his pubescent brain, tapping his feet and shaking his head at the floor, the best dancer in the world, not saying anything, not looking at anyone, wondering why no one wants some of his sweet moves.

School discos for autistic kids: they're bloody quiet.

Song: The Fire Still Burns

Shaun K Skårnes

Broken
Battered
Dragged through the streets
The fire still burns

Stripped
Tortured
Placed on display
The fire still burns

Finished
Fatal
Chucked down to rest
The fire still burns

Ideas
Determined
Will to fight ignites
The fire now spreads

Aggression
Uprising
Stood for no longer
The Fire still burns

Dear Psychiatry   Jyl Anais ion

I ground down in my Self,
the one I thought
had gone the way of all things
when I paid for your stories,
to help make sense of my pain.

Those days I washed up on your shore,
I was trying to put myself back together
when your therapy rearranged me
and then your medicine destroyed me.

I paid for your philosophy.
I paid you to help me.
I paid you with my life.

You told me you could help,
that the pills would
and then you drained my life out
slowly, over the next sixteen years.
Well, I returned home to myself
unmedicated and
found an answer
I sought with you
all those years you called me sick,
when I was already whole.

The effects of your pills poured cement
over my self-authority, until
I pried off the heavy glass
layered between
access to a full range of emotions,
memory, my identity
without your permission.
Now, I am reclaiming ground.

I sat across from you in that
English racing green leather chair
with brass rivets, and said "No."
It sounded like silence
when that was all I could afford.

Your patients' best interests get in the way
of profits, when health is what you reap
instead of sow.
Now, your white coats and fancy medical degrees
are in my wake,
as I hit the ground and
run for my life,
because the only way back to myself is
away from you
and the cage you filled pill bottles with.

Incarceration through diagnostic code:
you MD
you DO
you PsyD.

You,
purveyors of poison for profit.

You who use Jupiter and his symbol
to represent the reward.
You decimated me
with chemical infused trojan horses.
Make no mistake
my womb doesn't wander.

Research this:

barely four months off your "medicine"
my life force flooded back with a vengeance
that transcends your diagnostic criteria
and control.

I surrendered to my own body's ability to heal itself,
grounded into
what you called fundamentally flawed,
said was wrong in as many ways
as you could fill your
textbooks
and history.

"Whatever you do,
don't stop taking your medication." you said

after the Prozac
and the Paxil
and the Buspar
after the Klonopin
and the Xanax
and the Brintellix
and the Trazadone
and the Zoloft
and the Protriptyline
and the Lamictal

After the Hydroxyzine
and the Cymbalta
and the Celexa.
all this time
you claimed to do no harm.

I backed up,
told you to back off.
I withdrew and
finally found the answer
on my own without you,
who were no solution.

Your kindness and good intentions
aren't enough
when you do harm,
Psychiatry.

TOLERATE THIS!

Ria Dylan

Recently, I tried to off myself. Before I could be discharged from hospital I had to see someone from the psychiatric liaison team. Here are some thoughts on their response to me.

Dear Psychiatric Liaison Dude,

You speak of "distress tolerance" as if this is not something I am doing all the time, as if it is a skill to engage during extreme moments, as if every moment isn't extreme. "Distress tolerance" begins from the moment I open my eyes in the morning, and it is exhausting and sometimes I am just too damn tired and lonely to tolerate any more, and I fuck up. I fuck up and you waltz in with your "Stop and Think", and you seem to genuinely believe you have something meaningful to offer me here. Amateur!

You speak to me as if I lack skills, as if my decision to end my life constitutes a skill deficit. I challenge you, Mr Super Skilled, I challenge you to live for five minutes with the distress that is my life. Five minutes, Mr Super Skilled, let's discover just how well you tolerate distress.

I am mostly silent in our interactions. You comment on my lack of engagement, but this is a set up. How can I engage with you? How can I be anything but silent? Don't mistake my silence for vacancy, my silence overflows with a critique of the ideology you are attempting to subject me to. My silence is resistance. I will not betray myself and my experience by accepting your shallow framework that tells me my pain is mere skill deficit.

I didn't try to kill myself because I lack skills, I tried to kill myself because I was overwhelmed with pain and exhausted by the constant application of skill required to negotiate each day in such a state. I was lonely from the isolation that inevitably accompanies such pain. Your suggestion that I "Stop and Think" is insulting and it hurts me. This is why I cannot engage. You are hurting me.

My silence is a consequence of the space you leave me, of the power you have taken as you hold the frame in this conversation, where I cannot exist in any meaningful way.

Dear Psychiatric Liaison Dude, had it occurred to you that perhaps, contrary to your suggestion, perhaps I tolerate too much distress? How would we even quantify this? How much distress should an optimum human be able to bear? When is it acceptable to say "This is too much, please help me hold this distress, I am only human and some things are too painful, too frightening to have to face alone." You imply that there is something faulty with my relationship to distress. Show me a healthy relationship to profound distress.

I wonder, Mr Psychiatric Liaison Dude, if there is something just a bit dangerous about your paradigm. I suspect this model you are trying to sell me is akin to switching off the smoke alarm while your house burns down. People are incredible – we come with in-built smoke alarms alerting us to danger, screaming at us when enough is enough. My feelings are my friends. Like human friends, I sometimes need space from them, but ultimately I need them. Distress is an indicator that something is really wrong. Not something we should learn to tolerate but something we need to respond to with kindness and compassion.

Taken to its end point, "distress tolerance" is lethal. Why would you suggest I cut myself off from my own experience in this way, remove my subjective response to my environment? You are requiring that I tolerate the intolerable, tolerate it silently, tolerate it without bothering you or your colleagues. I suggest it is the mental health system, not its users, who need to learn some distress tolerance. It's not us who can't tolerate distress. I watch survivors tolerating unimaginable distress, kicking ass while our worlds crumble over and over, reaching out to support each other as our services and our access to money and safe housing are systematically removed. Reaching out while we are denigrated and ignored and disbelieved and swept aside because we are mad. It's you who are paid vast amounts to be secondary observers who cannot bear to allow any space for distress. ▪

NEWS & **REPORTS**

NEW LAW ON RESTRAINT

In the UK between 2000 and 2014, forty-six mental health patients died following restraint. A Home Affairs Committee has reported that black people and people on the autism spectrum or with a learning disability are more commonly restrained than others.

In 2010, at Bethlem Royal Hospital, Beckenham, 23-year-old Olaseni Lewis died soon after what an inquest called "disproportionate and unreasonable" restraint by eleven police officers who had been called in by staff. A misconduct investigation was dismissed in October.

Local MP Steve Reed (Labour) has tabled a bill to improve oversight over force used in mental health units. This has just been given initial approval in Parliament: The Mental Health Units (Use of Force) Bill, known as "Seni's Law", passed its second reading on Friday.

The bill would require mental health care providers to keep records about the use of force (including age, gender and ethnicity of those restrained) and any police involved to wear video cameras. It also calls for a clearly defined chain of accountability, with a senior named figure responsible for drafting a use-of-force policy and ensuring staff are trained to deliver it. A death would trigger an immediate independent investigation.

The bill now moves to the committee stage in the House of Commons for detailed scrutiny.

Gayle, D (2017) Olaseni Lewis's mother backs new restraint laws for mental health units. *The Guardian* 2 Oct.

ONE IN THREE SICK NOTES FOR MH

Sick notes are now officially known as fit notes (Of course. That makes sense.) An NHS report says that 12 million fit notes were issued by GPs across England over almost two-and-a-half years. Nearly a third were for psychiatric problems – ahead of musculoskeletal problems, they are the most common reason for people to take time off work.

The data discerned some diagnoses, and over the two years to March 2017 there was a 14% rise in notes for anxiety and stress. The report also reveals that fit notes for psychiatric problems were being issued for longer periods than other types of illness. For example, more than 20% of psychiatric fit notes were issued for more than 12 weeks, compared to only 3% of notes for diseases of the respiratory system.

Jed Boardman, from the Royal College of Psychiatrists, said not enough was being done to facilitate people returning to work. Also, the data "may underestimate the scale of the problem" as discrimination can mean those with mental health issues are out of the labour force completely. "Almost half of benefits claimants of Employment and Support Allowance in England are receiving payments as the result of mental and behavioural disorders."

Simon Stevens, chief executive of NHS England, said: "These figures explain why the NHS is now putting mental health front and centre, in what was recently independently described as 'the world's most ambitious effort to treat depression, anxiety and other common mental illnesses'."

Silver, K (2017) One in three 'sick notes' for mental health, says NHS. *BBC News* 1 Sept.

300,000 A YEAR LOSE THEIR JOBS DUE TO MH

A review commissioned by Theresa May finds that about 300,000 people with a long-term mental health problem lose their jobs each year. *Thriving at Work* reports the annual cost to the UK economy of poor mental health at up to £99bn, of which about £42bn is borne by employers.

The authors of the report are Mind's chief executive, Paul Farmer, and the mental health campaigner and a former HBOS chair, Dennis Stevenson. They were shocked to find that the number of people forced to stop work as a result of mental health problems was 50% higher than for those with physical health conditions.

"We think that the reasons… are a combination of a lack of support, lack of understanding within some workplaces and a lack of speedy access to mental health services."

They also found that about 15% of people at work have symptoms of an existing mental health condition, which illustrates the fact that given the right support they can thrive in employment.

Farmer and Stevenson want all employers to commit to six core mental health standards, including having a plan in place, increasing awareness among employees, stipulating line management responsibilities, and routinely monitoring staff's mental health and wellbeing.

Siddique, H (2017) Mental health problems are forcing thousands in UK out of work – report. *The Guardian* 26 Oct.

BIG RISE IN MH CALLS TO MET

Calls to the Metropolitan Police about mental health problems have increased by a third since 2012. Call-outs included to people involved in or suspected of crime, to people in crisis, as support to other emergency services, and for local council health assessments.

In London there were 115,000 calls with a mental health element in the 12 months to July 2017. This compares with 86,520 five years before, and averages 315 each day. 40,000 of the calls had a police unit assigned – or sent out – to them; of those, 13,000 related to MH hospitals, of which 4,000 had a unit assigned.

The CQC warns that the police are too often used as first resort, while police authorities threaten legal action over the lack of MH beds. The Met's Commander Richard Smith said that at some time or other one-in-four Londoners would experience "a diagnosable mental health condition"; this included the "large number of people" held in custody who would need an assessment and a care plan.

There was also a rise in the use of the emergency police power to take someone into a safe place when they are out in public – Section 136 of the Mental Health Act. Use of Section 136 has been increasing by about 10% a

year, and in London the numbers could double over the next ten years. The Met can take up to 400 people detained under section 136 to a place of safety each month.

Labour's police spokeswoman Louise Haigh MP says people on long waiting lists for mental health help were turning to the police – even committing petty crimes so as to get attention – as a service of last resort. "While facing a savage cut in numbers, the police are increasingly being asked to pick up the pieces of a scandalous lack of mental health provision."

Police calls for mental health issues up by a third. *BBC News* 29 Aug 2017.

SLIGHT FALL IN UK SUICIDE RATE

Last year Britain's suicide rate fell to its lowest level since 2011. Prevention work in England is credited for the drop. The annual rate fell in England and Wales but increased slightly in Scotland: the overall figure was down 202 (3.4%) to 5,688.

This was the third consecutive year in which suicide rates have fallen for the whole of the UK. Overall there were 10.1 suicides per 100,000 in 2016, compared with 10.6 in the previous 12 months.

The Office for National Statistics (ONS) said: "The recent decline in the suicide rate is likely to be due to the suicide prevention work in England by the government, the NHS, charities, the British Transport Police and others. The national suicide prevention strategy for England has included work to reduce the risk of suicide in high-risk groups. These include young and middle-aged men, people in the care of mental health services, and those in the criminal justice system."

Last year the suicide rate for males fell by 3.1% to 15.7 per 100,000, while the rate for females fell 9.4% to 4.8 per 100,000 (after hitting a 10-year high in 2015).

Since the early 1990s, males have committed about three-quarters of all suicides. Middle-aged men remain at greatest risk. According to the Samaritans, relationship breakdown can contribute to suicide risk; suicide is greatest among divorced men, who are almost three times more at risk than married men or those in a civil partnership.

Inequality is also major risk factor, with those among the most deprived 10% of society more than twice as likely to kill themselves than the least deprived 10%.

Suicide rates generally fell between 1981 and 2007 before rising again to hit a peak of 11.1 deaths per 100,000 in 2013, although that was still substantially lower than the rates in the 1980s and 90s.

The Samaritans are campaigning for every area to have an effective suicide plan; the government's latest progress report on preventing suicide in England, published in January, found that 95% of local authorities "have plans in place or in development". The chair of the Local Government Association's community wellbeing board said a commitment was needed to invest in local government to help tackle mental illness and prevent suicide.

The suicide rate in England dropped from 10.1 per 100,000 people in 2015 to 9.5 last year, a statistically significant decrease. In Wales it fell from 13.0 to 11.8, but in Scotland it rose from 14.0 to 15.0. The ONS says differences in Scotland's coroner system and the way suicides are certified and registered there make comparisons with the rest of Britain inappropriate.

Siddique, H (2017) Drop in suicide rate in Britain linked to prevention work in England. *The Guardian* 7 Sept.

24% OF 14-YEAR-OLD GIRLS FEEL DEPRESSED

Research funded by the Economic and Social Research Council and run jointly by University College London and the University of Liverpool prompts fresh questions about the effects of social media and school stress (e.g., academic demands, body image issues and bullying) on young people's mental health.

Based on the reports of more than 10,000 youngsters, it seems that nearly one-quarter of girls (24%) is clinically depressed by the time they turn 14; this compares with 9% of boys at that age. Across the UK, by the age of 14, about 166,000 girls and 67,000 boys of that age report depression. Symptoms include feeling miserable, tired and lonely and hating themselves. Being from a low-income family increases the risk, and ethnicity is potentially also a key factor.

Marc Bush, of Young Minds, says "We know that teenage girls face a huge range of pressures, including stress at school and the pressure created by social media... Difficult experiences in childhood – including bereavement, domestic violence or neglect – can also have a serious impact, often several years down the line."

The study also found that between the ages 3 and 11 small but growing proportions of boys and girls – up to around 10% – suffered from emotional problems such as feeling depressed and anxious, as reported by their parents. However, at age 14 significantly more girls disclosed that they were feeling depressed than were reported by parents – 24% compared with 18%. This suggests that parents underestimate the extent of, or fail to pick up on the signs of, depression among girls up to the age of 14 but overestimate how common the condition is among boys of that age.

14-year-old girls from the second lowest fifth of the population (based on family income) were most likely to be depressed (29.4%), while those from the highest quintile were the least likely (19.8%). 14-year-old girls from mixed race (28.6%) and white (25.2%) backgrounds were most likely to be depressed, with those from black African (9.7%) and Bangladeshi (15.4%) families the least likely.

Janet Davies, chief executive of the Royal College of Nursing, said a fall in the number of school nurses was making it harder to identify young people with mental health problems: "Demand for adolescent mental health services is reaching new heights but the NHS is failing young people."

Campbell, D (2017) One in four girls have depression by the time they hit 14, study reveals. *The Guardian* 20 Sept.

BIG RISE IN SELF-HARM AMONG YOUNG TEENAGE GIRLS

Self-harm by young teenage girls increased 68% between 2011 and 2014. According to research reported in the *British Medical Journal*, this was partly due to 'extreme obsession' with social media, compared to boys. Analysis of GP data suggests that dissatisfaction over physical appearance among young teenage girls was a big factor driving self-harm, and there is a growing trend for teens to encourage each other to self-harm by sharing videos and pictures of the practice online. In 2011, 45.9 girls per 10,000 harmed themselves, and by 2014 this had increased to 77 per 10,000. Across everyone aged 10–19, girls had a roughly three times higher chance of self-harming than boys. Approximately 80% per cent of incidents were self-poisoning,

Previous research has found that children who self-harm are seventeen times more likely to go on to commit suicide compared to children who do not, and nine times more likely to die unnaturally (which could mean suicide, but also incidents such as fatal drug overdoses). In England, the suicide rate for females aged 10–29 rose from 2.7 per 100,000 in 2012 to 3.2 per 100,000 in 2015.

An NSPCC spokesman said self-harm is often "an expression of a deeper problem", meaning early intervention for children reporting it is vital. "Last year we held more than 15,000 counselling sessions about self harm, and many young people who talked about suicidal feelings also mentioned self-harm."

Health Minister Jackie Doyle-Price said: "It's worrying to see the number of young people who self-harm and experience suicidal feelings is increasing. I want every young person to be able to seek and access help when they need it. That's why we have made the national suicide prevention strategy address self-harm as an issue in its own right for the first time, backed by a record £1.4billion investment in young people's mental health care, and we're working with schools to provide mental health first aid training, so that all children can get the support they need."

According to Young Minds, 10% of all children (aged 5–16) suffer from a diagnosable mental health disorder; over the last 10 years there was a 68% rise in the number of young people (aged 10–19) admitted to hospital because of self harm – three in every classroom; in the UK, 80,000 children and young people suffer from severe depression; 50% of adults with mental health problems were diagnosed in childhood; and 95% of young people in prison have a mental health disorder.

Bodkin, H (2017) 'Heartbreaking' 68% rise in self-harm among young teenage girls. *The Telegraph* 18 Oct.

40% OF CAMHS STILL FAILING

According to England's health service regulator, the Care Quality Commission (CQC), some children needing mental health care are forced to wait up to 18 months for treatment, and in one case A young person was forced to wait as long as 493 days for treatment and 610 days for family therapy. Elsewhere, services have been setting their own targets for how quickly children should be seen, which varied wildly depending on a postcode lottery. In one part of the country, a child might be seen within 35 days, but could have a wait of 18 weeks in another area.

Overall, four in 10 psychiatric services for young people are deemed 'failing'.

NHS England's mental health director, Claire Murdoch, says the health service was now making progress addressing the waiting times, but there had been "years of underinvestment" in young people's mental health services. She says there had been a 15% increase in funding, far outstripping the overall rise in mental health spending, which meant three-quarters of young people with eating disorders needing urgent care were now provided with that care within a week.

Elgot, J (2017) UK children who need mental health services face 'postcode lottery'. *The Guardian* 27 Oct.

BIG RISE IN STUDENT MH PROBLEMS & SUICIDES

A study by the Institute of Public Policy Research finds that almost five times as many students as ten years ago have disclosed a mental health condition to their university: in 2015–16, it was more than 15,000 UK-based first-year students (3,000 for 2006).

There was a larger rise in disclosure of mental health conditions among female students. Until 2010, the rate of male and female students reporting mental health issues was about the same, at about 0.5%. By 2015 it had risen to 2.5% of female students and 1.4% of male students. And the researchers suggest that due to imperfect data collection the actual number of mental health disclosures is likely to be higher.

The report also notes that official statistics show that the number of student suicides almost doubled between 2007 and 2015 – from 75 to 134, the most ever recorded. Besides this, 1,180 students with mental health problems dropped out of university in 2015; this was also a record, 210% up on 2010.

IPPR senior research fellow Craig Thorley said: "The extent of support is currently too varied, and many university services are overwhelmed by the level of demand."

The survey of UK higher education received 58 responses: 94% experienced a rise in demand for counselling services in the past five years; 61% reported a rise in demand of more than 25%; and only 29% had an explicit strategy on student mental health and wellbeing.

At some universities one in four students is using or waiting to use counselling services. Some institutions report dramatic increases: at Leeds there has been a 50% increase in demand during the past five years, with an 18% rise in the past 12 months alone; Birmingham estimated a 5–6% annual increase in demand throughout the last 10 years; Dundee reported an increase in demand of about 70% over eight years.

Marsh, S (2017) Suicide is at record level among students at UK universities, study finds. *The Guardian* 2 Sept;

Burns, J (2017) 'Sharp rise' in student mental illness tests universities. *BBC News* 4 Sept.

MH SERVICES & STAFF UNDER INCREASED PRESSURE

The number of NHS mental health staff who have had to take sick leave due to their own mental health issues increased by 22% in the past five years. From freedom of information requests, the BBC found that those taking long-term leave of a month or more rose from 7,580 in 2012/13 to 9,285 in 2016/17. (58 out of 81 UK mental health authorities provided this information.)

A Royal College of Nursing spokesman said: "Mental health staff face unique challenges. The pressure to make the right decision and provide care for extremely vulnerable people against a backdrop of staff shortages, can take its toll on their health and wellbeing… More than 40,000 mental health staff are assaulted every year, and too often violence is seen as 'part of the job' by employers and the authorities."

Meanwhile, the Royal College of Psychiatrists says there are not enough NHS psychiatrists in some parts of the UK and more should be recruited. In Scotland, there are 10 consultant psychiatrists per 100,000 people, across England and in Northern Ireland 8, and in Wales only 6. While London and North-East England have more than 11 psychiatrists per 100,000 people, the South-West has only 6 and Yorkshire and East Anglia only 5.

Over the past five years there was a 1.7% increase in psychiatry consultants in England; especially considering increases in the population, this does not compare well with the 20.2% increase across the NHS for other kinds of consultants.

NHS England recently announced there would be 570 extra consultant psychiatrists by 2020–21, and the Welsh government says it is committed to improving its mental health services. But the RCPsychs says one reason the mental health services are under increasing pressure is because too few medical students specialise in psychiatry and not enough are becoming consultants.

Psychiatric care is postcode lottery, say medical experts. *BBC News* 11 Sept 2017;

Greenwood G (2017) Mental health staff on long-term stress leave up 22%. *BBC News* 22 Sept.

BIG RISE IN ATTACKS ON MH STAFF

Attacks on mental health staff increased by more than 25% from 2013 to 2016. Under the Freedom of Information Act, BBC's *5 live Investigates* accessed data from nearly two-thirds of the UK's mental health trusts. This revealed that the number of assaults on staff rose from 33,620 to 42,692. (It is unclear whether this would translate to more than 60,000 for all the UK's trusts.)

Last year, attacks included a healthcare assistant who was stabbed to death and a worker who had part of a thumb bitten off. In England the number of assaults was up by more than a third, while the number recorded in Scotland, Wales and Northern Ireland showed little or no overall rise. There were also more than 17,000 assaults by patients on other patients in the UK last year.

One nurse who was seriously injured was off work for weeks and suffers from flashbacks and panic attacks. She no longer works with mental health patients. She said: "People are now much more unwell when they come into units, there's a shortage of beds and staff are stressed… It's a powder keg. It just needs the slightest thing to happen."

Unison recently surveyed more than 1,000 mental health staff working in a range of roles with children and adults in hospitals, secure units and in the community across the UK. Its report, *Struggling to Cope*, finds 42% of responders saying they had been victims of violence in the last year. Nearly a third said levels of violence had risen in the last year, and most blamed the increase on staff shortages and overuse of agency staff. Staff shortages meant fewer people were around to deal with rising numbers of patients with complex needs. This has led to an increase in violence and a working environment that makes it increasingly difficult to keep staff.

The Department of Health said it was "completely unacceptable" for NHS staff to face violence or aggression at work. "All incidents should be reported, and we expect the NHS to work with the police to seek the strongest possible action." It maintained £11.6bn had been invested last year, and that 21,000 new posts would be created by 2021.

Robinson, B & Grant, P (2017) Assaults on mental health staff up 25% in four years. *BBC News* 8 Oct.

ECT STILL USED MAINLY FOR WOMEN & THE OLD

A study which looked at data from a group of English NHS trusts between 2011 and 2015 found that two-thirds of the recipients of ECT were women while, 56% were people aged over 60. This chimes with findings from the annual dataset release by the Royal College of Psychiatrists which shows that for 2016–17, 67% of patients receiving acute courses of ECT were female, as were 74% of those receiving ECT to prevent relapses ('maintenance ECT'); the mean age of patients was 61 for acute ECT, and 66 for maintenance ECT.

Shock doctors say they favour ECT because antidepressants are associated with side-effects in the elderly, 'whereas ECT is very safe'.

The author of the study, John Read, professor of clinical psychology at the University of East London, says these findings are "…remarkably consistent over a long period of time and in almost every country where it has been studied… That ECT is more commonly used among women and older individuals is of concern… Nobody talks about it, or tries to explain it, or wonders why that might be." ECT does not tackle the social issues behind why more women than men appear to have depression, and "[ECT] is part of over-medicalising of human distress."

Davis, N (2017) Electroconvulsive therapy mostly used on women and older people, says study. *The Guardian* 20 Oct.

EPILEPSY & BIPOLAR DRUG SCANDAL

Sodium valproate – marketed as Depakine or Epilim – is used to treat epilepsy, migraine and the manic phase of bipolar disorder. But it has been controversial for decades.

This year a big class action finally got under way against the manufacturers, Sanofi. This is to represent an association of 2,000 French women who took Depakine during pregnancy, only to give birth to seriously damaged children. Sanofi also faces about twenty individual lawsuits. The French pharmaceutical giant is accused of failing to inform pregnant women about the probability of birth defects – a foetus exposed to the drug faces a high risk of physical birth defects or developing autism or learning difficulties. In another law suit last year it had to pay out a total of more than £10m to a number of French complainants. The company had known about the risks since the early 1970s.

In the UK, the drug is marketed as Epilim, Episenta or Epival. It is known to carry a 10% risk of serious physical abnormalities – spina bifida occurs twenty times more frequently in foetuses exposed to the medication – as well as defects of the heart and genital organs; there is also a 40% risk of serious neurological problems – autism, low IQ and learning disabilities. In France at least 14,000 pregnant women took Depakine between 2007 and 2014.

At last, the European Medicines Agency has begun a risk assessment of the drug. Campaigners at a public hearing said that up to 20,000 children in the UK may have been harmed, and warnings to young women who might become pregnant that sodium valproate could cause birth defects and developmental problems in their babies could have been made public more than forty years before they were finally advertised on the packets in the UK, just last year.

Catherine Cox from the Fetal Anti-Convulsant Syndrome Association said: "These warnings could have and should have been given in 1974. However, there was a deliberate decision not to publish them." Regulators knew about the risks when they were considering licensing sodium valproate. At the time, health professionals had been warned in a letter: "This compound has been shown to be teratogenic in animals, meaning it could harm the human foetus." But documents from 1973 show that the Committee on Safety of Medicines thought that telling patients "could give rise to fruitless anxiety", and therefore the warning should "…not (go) on the package inserts, so that there would be no danger of patients themselves seeing it".

In January 2015, the UK Government warned that unborn children exposed to valproate were "at a high risk of serious development disorders". However, the medication only began carrying a warning on its packaging in July 2016. According to the Epilepsy Society survey, one in every six women who use the drug are still unaware of the risks, even after a "toolkit" was produced last year for doctors and patients by the Medicines and Healthcare Products Regulatory Agency (which replaced the Committee on the Safety of Medicines). Clare Pelham of the Epilepsy Society said a recent survey of 2,000 young women with the condition found that 68% did not know about it – a slight increase on the 64% from the year before, when the toolkit had only just been introduced. She called on the inquiry to make warnings to women mandatory rather than voluntary, and to require GPs to regularly review any woman on the drug, face to face.

France's Sanofi faces class action suit over epilepsy drug (2016) *Medical Press* Dec 13.

Minelle, B (2017) Epilepsy drug valproate behind thousands of severe birth defects, says French study *Sky News* 20 April.

Harrison, S (2017) Epilepsy drug raises risk of birth defects, but women were not told, survey finds. *The Telegraph* 24 Sept.

Triggle, N (2017) We've had no help – epilepsy drug victims *The Guardian* 26 Sept. Boseley, S (2017) Birth defect risks of sodium valproate 'known 40 years ago' *The Guardian* 26 Sept

AWAY IN A MANGER, NO CRIB FOR A BED
I HAVE BEEN SECTIONED AND THERE'S NOWHERE
TO LAY MY SWEET HEAD
THE STARS IN THE BRIGHT SKY LOOK DOWN
ON A BED CRISIS
OH DEARIE ME, NOTHING RHYMES WITH CRISIS

D. SEN 2014

Breaking Free

Mad Pride Hull is a small grassroots group using art to get people talking about madness in creative ways, challenging the tyranny of normality and celebrating diversity. We run a weekly art space called 'Inside-Out' and a mutual aid support group inspired by the Icarus Project's zine *Friends Make the Best Medicine*.

We have also received funding to run around forty artist-facilitated workshops with different community groups and organisations across Hull, and to put on a week of activities in September that culminated in a small carnival on Saturday 16th September. During the week we had a performance by Lucy Aphramor (the Naked Dietitian), a kindful-eating workshop, a film-showing of Crazywise, a secular meditation session, and a foraging walk.

This July we launched two exhibitions of artwork that has emerged out of our workshops. One was called *Breaking Free: Imprisonment, Madness, Liberation*. This was launched on Bastille Day, when Parisians stormed the Bastille and released the political prisoners and those imprisoned because they were mad. The sister exhibition was called *Don't Put Me In A Box*, and it explored the different things that can make us feel labelled, judged, restricted and trapped.

Through everything we do we try to ask questions like "What is normal?", "What does it mean to be sane in a mad world?" and "In what ways can our strange and difficult experiences be a gift to our society and world?"

We are a relatively new group and are really keen to connect up with and learn from any other groups out there doing similar things. So please do get in contact with us – we would love to hear from you!