

# Asylum

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THE RADICAL MENTAL HEALTH MAGAZINE

**TAXPAYERS  
DISABILITY**

**HOSTILE  
ENVIRONMENT**

**COMMUNITY  
AUSTERITY**

**GOVERNMENT  
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**SOLIDARITY  
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From  
*Grenfell Tower Tryptich*  
by Sanchita Islam



Ben Glass and Emily Cutler with the new Mental Health Resistance Network banner, unveiled at the Critical Voices Network Ireland conference in Cork, November 2018



## The radical mental health magazine

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Asylum, formerly the magazine for democratic psychiatry, was established in 1986 as a forum for free debate, open to anyone with an interest in psychiatry and mental health politics, practice and policy. We were inspired by the democratic psychiatry movement in Italy and continue to be influenced by radical mental health movements around the world, including the psychiatric survivor and Mad liberation movements. We welcome contributions from service users, ex-users or survivors; activists, family members 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. We are open to anyone who wants to help produce, develop and distribute the magazine, working in a spirit of equality and democracy. Please contact us if you would like 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. [editors@asylummagazine.org](mailto:editors@asylummagazine.org)

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## ***Every year at this time...***

# **A part-time homeless mental patient speaks out**

PHIL HUTCHINSON

Every year at this time there are TV news interviews with professionals and campaigners about the street homeless. There are always references to mental health issues, some complicated by an entrapping pattern of falling into drug/alcohol use and then dependency. By the time the intense cold begins many of the guys (it's predominantly men) will have temporary places to stay.

For many, inured to this existence, an adjustment to "living indoors" is not easy and requires a lot of support towards different possibilities if they aren't to retreat once again. But first of all the basic human needs of warmth, food, shelter and security must be met without the threat of them being taken away or the person moved on before being ready to do so .

Like war, the scenes are normalised by TV coverage. Another Politician stands in front of a camera in Westminster and delivers statistics to prove the government is tackling the problem. Trouble is, they've got the wrong problem.

The dominant neo-liberal economic ideology dictates that only the fittest survive. It leaves care and help to charitable groups and private companies which seek to cut costs in order to increase profits. As well as the elephant in the room called Brexit there is the monster God of the Free Market to which everything must bend and wring their hands in helplessness.

Are we really so powerless? I don't think so, but the increasing grip of neo-liberal policies have meant the diminishing of user mutual support and campaigning groups as well as alienation and thus further proneness to mental illness.

Perhaps it isn't such a surprise that the person most associated with Universal Credit is a graduate of Sandhurst Military Academy and that many of the men we see laying in excrement, vomit and urine on the streets of our cities are ex-service personnel.

Universal Credit has by design tied together the basic human needs of food and shelter with conditions that demand that a person lives in a permanent state of harassment and anxiety. This in itself impacts on supportive close relationships. People are pushed down and down and made to feel they are wrong and must be controlled. In this Universal Credit succeeds admirably. Any space to grow at one's own pace and in the ways one can is closed off by prescribed work plans formulated by a work coach. This may end in a life of permanent insecurity, forever having your benefits readjusted to low rate wages from temporary agency jobs or seeking to obtain "fit notes". We know that mentally vulnerable people are being sent to prison or kept in prison cells in

emergencies, as a result of the failure of vastly under-resourced appropriate services. The police themselves are talking about real social breakdown.

The ideological bent of the Universal Credit system is to provide a cheap, intimidated (pliant, flexible) labour pool. The coercion and control of vulnerable cheap labour is a hallmark of authoritarian and oppressive regimes. The British establishment has its own ways of attempting similar exploitation with the caveat that it's helping people. The reduction of income when people are switched to Universal Credit is also meant to reduce State spending. It means that people are in fact practically consigned to the lowest economic class without much chance of escape. Combine this with the attrition put up by neo-liberal government to comprehensive health and social care, education and housing.

This is why people now direct their energies to holding what they have or opting out altogether. It would be wrong in this context to attack people for their defensiveness and negativity.

Unless a light suddenly illuminates the minds of a majority of politicians in an elected government there will be no policies costed and implemented to provide a comprehensive network of safe havens with enough trained professionals. There will be no appropriate housing for the needs of people who have begun a journey back from the streets. There will be no support for them to use their undoubted talents and abilities for the collective good.

We can't blame mental illnesses on neo-liberal economics but it does mitigate alternative approaches. An entirely different ideological approach is needed if we are to create holistic mental health care. There are flickers of light. Local Mayoral Authorities covering smaller areas but linking with national networks are now moving towards implementation of their first integrated social and health care frameworks. There is definitely a movement towards mental health being recognised as a very important part of the way forward.

Care in the Community in the last 35 years has seen numerous advancements in treatment and understanding of mental health and illness. These have often been instigated and campaigned for by people with direct experience. Professionals and people in the role of patients both suffer the consequences of the absence of an underpinning ideology and the investment required to protect us all.

Another year passes. There are more people living and dying on the streets. Survival of the Fittest. Who cares? We walk past.

We have neglected the need for safe havens. ■

# Prescription Abolition and the Politics of Mad Pride

*EMILY SHEERA CUTLER intriguingly suggests the underlying politics of Mad Pride is consistent with the demand to abolish prescriptions for psychiatric drugs.*



One of the most common objections to Mad Pride is that it is not helpful or beneficial to find pride in one's pain or suffering. I often hear: "I understand LGBTQ pride or Black pride because those identities don't inherently cause suffering apart from societal oppression. But pride in madness? Pride in something like depression? How can I be proud of something whose definition literally includes the experience of suffering?"

While madness does not inherently cause suffering for everyone, madness can be painful, and finding pride in pain is intensely difficult for many people. The idea of finding pride in pain, or accepting pain (physical or emotional) can be used against people in oppressive ways. Perhaps they have been denied access to pain medications or shamed from using substances to mitigate or "escape from" their suffering. So Mad Pride might seem impossible, if not threatening, to them.

It is for this reason that I wonder if Mad Pride is more about celebrating reactions to pain, not necessarily internal experiences of pain.

I think a great deal of psychiatric treatment revolves around the idea that emotional pain is an inevitable part of life that just needs to be tolerated or gotten through. The vast majority of mental health services do not attempt to change the circumstances or systemic factors in an individual's life that have driven them to experience pain, but rather, the individual's response to their pain. The overarching goal of conventional mental health treatment is to control a person's behavior – to ensure they don't react to the pain they feel in any sort of way that might be "dangerous" to themselves or others.

Our standard response to suicide, for example, is involuntary commitment. Most people don't expect locking someone up and depriving them of their bodily autonomy for 72 hours to reduce the amount of emotional pain they experience in any meaningful way. The goal is merely to restrict a person's body – to ensure that they cannot escape their pain by ending their life.

Another common mental health intervention, Dialectical Behavior Therapy, teaches us to "tolerate distress" and "radically accept" the circumstances that are driving us mad. It's about learning how to experience emotional pain without reacting. Without lashing out in anger or rage toward the system or individual(s) causing us pain, without failing to function in the workplace, without making others uncomfortable or being burdensome to those around us.

What if Mad Pride is about resisting the narrative that we should tolerate pain? What if it is about celebrating our right to take whatever action we choose to cope with, reduce, or react to pain?

That is what Mad Pride has come to mean to me personally. It is about the right to scream and cry out and lash out in rage and make plans to escape through suicide if it comes down to it. It is about the right to use drugs, alcohol, sex (and rock 'n' roll while we're at it) to cope with an oppressive, pain-inducing society. Because perhaps the satisfaction of having rebelled can at least give us some solace. It is about being (sometimes creatively, sometimes destructively) maladjusted to the world and letting those in power know just how *fucking crazy* they have driven us.

Maybe it doesn't sit well with many people (myself included) to be proud of feeling depressed. But could we take pride in the ways we might react to it? Could we take pride in our lack of functioning within an oppressive capitalist framework, or indulging in negative thinking in a world that shoves positivity down our throat, or our choices to cope through substances or self-harm?

I think Mad Pride can be about resisting and escaping pain just as much as it is about embracing it. In a society that tells us to "grin and bear it," to "man up," and that "what doesn't kill you makes you stronger," refusing to just "tolerate pain" is an act of rebellion. And I think *Asylum* readers will all agree that rebellion is something to take pride in.

For this reason, I see the philosophy and framework of prescription abolitionism as central to Mad Pride activism. Prescription abolitionism is the notion that all substances should be legal for all people (with the exception of antibiotics). Instead of a system in which people have to gain permission from a particular medical professional in order to access drugs they want or need, they would be free to access the substance(s) of their choice. Underlying the paradigm of prescription abolitionism is the idea that people should be the ultimate decision-makers over their own minds and bodies. People could still consult with physicians, pharmacists, biochemists, and other professionals (yes, including psychiatrists) about what options are available to address their particular needs or wants and what the potential risks and benefits of each substance might be. However, it would be the individual, not the professional, who makes the ultimate decision about what substances to consume or not.

If Mad Pride champions the right of each person to resist or react to pain in whatever way they choose, including the use of substances, then prescription abolitionism is not only complementary to, but a necessary component of, this paradigm. Rather than having to demonstrate that a particular drug is medically needed – a subjective designation dependent upon cultural context and the judgment of each individual clinician – Mad people should be able to act as the experts of their own needs and wants.

In our current paradigm of mental health care, psychiatric drugs are often prescribed in order to help people function better within society. They are not usually prescribed in order to reduce the amount of emotional pain a person is in but rather to increase a person's tolerance of that pain or decrease a person's ability to react to that pain. Many consumers and survivors report that antipsychotics do not eliminate their distressing voices but instead make them care less about those voices. For me personally, antidepressants did nothing to address the depths of depression and despair I felt in response to my life circumstances at the time; instead, they made me almost completely apathetic to my emotional pain. While I still felt intensely lonely and alienated, I did not cry as much, complain about it, or engage in self-harm.

In this sense, psychiatric drugs are often used as behavioral control. They are used to help people appear more "normal" or conform to standards of what "mentally healthy," functioning members of society look like. Or they are used to reduce feelings of discomfort in the friends, family members, co-workers, and mental health professionals of Mad people. In decreasing Mad people's external reactions to their pain, psychiatric drugs can aid those around them in not feeling so uncomfortable or having to witness that pain themselves. In our current framework, psychiatric drugs are also sometimes used

as chemical restraints in institutions – to violently force inmates into submission and compliance, i.e. not showing any outward signs of how much they are suffering.

On the other hand, access to drugs that are seen as hindering people's functioning or productivity is restricted. It is incredibly difficult, for example, to access benzodiazepines, as they can lead to a blissful or euphoric state resulting in "laziness." Drugs that allow people an escape from the everyday drudgery of life under capitalism are vilified and demonized. People are told that they should not become "dependent" or rely on these drugs in order to escape their pain, sadness, or ennui. People who are deemed dependent on or addicted to these drugs are often subjected to violence including criminalization and forced withdrawal. In this sense, lack of access to substances is used as behavioral control and coerced conformity to the societal ideal of pain tolerance.

In a prescription abolitionist framework, we could move away from the use and restriction of drugs to increase pain tolerance and conformity and toward the use of drugs as resistance to and rebellion against pain. Rather than a psychiatrist or medical professional looking for drugs to fix their patients, to restore their patients to functioning – to help them "grin and bear" their pain like everyone else – Mad people would have the chance to seek drugs that fit their particular needs as individuals. Maybe they want to consume a drug like a benzodiazepine or an opioid that might allow them to escape their pain and enter a blissful or euphoric state. Or maybe they want to take a drug like Ritalin or Adderall that might allow them to have some quality time focusing on a creative or academic pursuit despite their pain. Or maybe, antidepressants or antipsychotics fit their needs and improve their quality of life. But in the prescription abolitionist framework, it is Mad people who get to decide if those drugs suit their own needs, rather than a psychiatrist deciding that is what their patients need to be "normal".

In my opinion, the act of feeling pain, and not tolerating it or hiding it like everyone says we should, but taking matters into our own hands and choosing to react to, resist, or escape from pain is worthy of celebrating. For so many people, pain and suffering are horrible, dehumanizing experiences. Rebelling against those experiences through yelling, screaming, crying, negative thinking, self-harm, or drug use can be an incredibly satisfying way of taking back some of our power, or at least enjoying a modicum of consolation. It's time for Mad autonomy and Mad resistance to pain. ■

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# SHEDDING THE SAFE COAT OF PROFESSIONALISM

*CAROLINE VON TAYSEN recalls how being involved in the Hearing Voices Movement profoundly influenced her practice and identity as a clinical psychologist.*



## **From academic theory to triological practice**

I joined the German Hearing Voices Network “Netzwerk Stimmenhören e.V.” right after my university studies at the Free University in Berlin. Parallel to mainstream nature-sciences-oriented lectures, there were also some different classes. The critical psychologists integrated Marxist ideas, questioning the positions of power that psychologists and psychiatrists usually claim and promoting alternatives to hierarchically structured institutions. They also stressed the negative influences of capitalist logic on individual agency and psychological well-being. The Social Constructivists claimed the non-existence of objective truths and argued that everyone creates their own subjective realities, instead. While usually believed to be given by God or nature, social values and norms are actually constructed by societies themselves. These norms and values exclude those who don't ‘fit in’ and thus have to be challenged and changed.

I was (and still am) an enthusiastic follower of these ideas and looked forward to putting them into practice. I knew that psychotic experience was a phenomenon and not a dysfunction and that pharmacotherapy was one of the tools used for repression. But my ideas were very simple: the poor victims of the oppressive psychiatric system needed to be rescued! I was going to position myself on the side of the psychiatry survivors and fight for their rights.

In this first phase of searching for my professional identity, I found out about the Netzwerk Stimmenhören

e.V. (NeSt). A self-help booklet informed me about the triologue groups that took place every two weeks. I was intrigued. Meeting up regularly with people who hear voices and their relatives and friends, as well as professionals sounded great.

## **First of all, as ‘Caroline’**

I remember my first visits to the triologue group. I was actually quite intimidated by what was going on and realized how little I knew. What surprised me most was how diverse the people in the group were. So far, I was only used to the fairly homogeneous political groups at the university. Here were people from all kinds of professional and social backgrounds. They were different ages and presented all sorts of opinions.

I was very impressed by the respect people showed each other. The primary rule of the group says that everybody is an expert on their own experiences and that everybody's stories and opinions are to be accepted without judgment. This both inspired and confused me. Some of my very politically correct opinions started to crumble away. There were voice-hearing people who talked about having good experiences with antipsychotic drugs, and some who actually liked going into a psychiatric hospital because it gave them a sense of protection. How could that be? There were also those who insisted on being called “ill”, and some did not at all agree with the idea that their voices could be meaningful in any way.

Unlike other groups, nobody asked for general positions or theories. When I mentioned some generalized theory during the group, I was asked to please talk about myself and was told that my personal experiences are far more valuable than any theories. Oh, was I embarrassed! But I felt accepted into the group; I felt like I was first of all looked at as a human being, as Caroline, and then also as a psychologist. I got as much space and time as I needed to settle into the NeSt and find my place there.

This mutual care of everybody's limits was something new for me. It has been, and still is, a healing experience.

## **Who empowers who?**

Another primary rule of the NeSt has formed me: one of the methods to better deal with problematic voices is to be the boss in one's own house, to take control of and responsibility for one's own actions, and not give in to what the voices dictate.

As a student, I had learned about the concept of

empowerment. This was all about giving power to the psychiatry users and liberating them from their roles as victims.

Now I realized what an arrogant and even absurd way of thinking this was. I had never before asked a person whether s\*he wanted to be liberated by me, or actually be liberated at all. I started to learn that it was a contradiction in itself to condescendingly give someone else power.

Today I believe that it is important to differentiate between two different levels: the sociopolitical and the private/individual. They contradict each other, in a way, because they follow two different kinds of logic. At the political level I think it is essential to criticize hierarchical structures, to assess which groups in society are structurally stigmatized and disadvantaged, to support self-organization, and to make the government listen to our demands. At the individual level this doesn't work, however, because it would lead to a new kind of paternalism or prejudice. Here, we have to accept the diversity of human beings.

In the existing system of privileged and less privileged people, it is logical that the influence of the "powerful" rises when they "help" the "weak." This attitude implies that "they" need to be helped because "they" can't help themselves, and thus cements the structurally given victimhood. Still today I find it a struggle only to help when asked to do so.

### ***Do we forge our own destinies?***

The individualistic glasses that we are taught to put on in our professions are another possible trap. It is especially dangerous when combined with the attitude that 'everyone can make it, if they only try hard enough'.

Psychotherapy, for example, assumes that it is possible to change 'hindering' cognitive, emotional and behavioural patterns into more 'successful' ones just by having a one-to-one relationship with a therapist. Social, political and economic factors as major influences on people's lives are mostly dismissed. The aim is usually to learn how to function (again) as a part of the capitalist society. The British psychologist David Smail described this very well in his book *Power, Interest and Psychology. Elements of a social materialist understanding of distress*:

[...] psychology has over the past century invented and sustained a magical theology in which it seems that people may choose *themselves* and shape their future by eradicating their past. Tragedy may be averted by no more, essentially, than wishing that things might be otherwise, and reality is reduced to a set of stories that may be manipulated to result in happy endings. The only thing that people are called upon to *do* to realise their dreams is to *consume*, and psychology has been fundamental to the creation of the perfect consumer. [...]

The strength and integrity of the subject

is determined not (as therapeutic psychology would have us believe) by efforts of free will, but by the adequacy or otherwise of the environment (including, crucially, the public societal structures) in which it is located.

I would like to clarify this statement using myself as an example: About 15 years ago, I went through a five year long therapy as part of my own Body Psychotherapy training. During this time I experienced periods of not really holding things together very well any more. I spent these days at home in my safe bed, hoping the crisis would pass soon. All kinds of fears, dark imaginations and feelings of dissolving myself came up, and sometimes I wasn't sure if I was going to get out of it all again safely. I knew a few things, though. In the event that it got too bad, I could still call my best friend who lived in the same house and worked in a crisis intervention centre. I was safe financially and workwise and so had enough time to plunge myself into my inner journeys without having to worry about these issues. My friends and the Hearing Voices Network were on my side.

Besides, the crises took place within a therapeutic process. I was able to make sense of those dark inner worlds by connecting them with parts of my biography and thus they lost their scariness and became controllable. I also had a therapist who didn't see the aim of her work as adjusting me to the capitalist reality. Instead, she supported me in engaging with it in a critical and self-determined way. How lucky can you get? I basically had the best possible conditions to do psychotherapy.

I hope it becomes clear how it is presumptuous and hurtful to demand this 'successful' therapeutic engagement from all people – and to accuse them of a lack of motivation if the success doesn't take place! Most people are not as privileged as I am. Financial worries, everlasting pressure to perform, (self-) stigmatization, social isolation, and a support system based on pathologizing certain human coping strategies are the opposite of helpful resources in a crisis. I think it is a lot more helpful to explicitly acknowledge that these circumstances disempower and are situated outside of people's spheres of influence.

### ***Taking Off The Safe Coat of Professionalism***

While visiting conferences, workshops, and meetings within the hearing-voices movement, I have realized that the majority of us professionals continue to hold on to our power, even though we talk about abolishing hierarchies. We continue to use academic language and we continue to talk about our clients instead of talking about ourselves. Years of professional training have taught us that scientific theories are far more valid than personal stories. We have internalized this 'truth' more deeply than we would like to admit to ourselves – and, to be honest, it is also advantageous for us to hold on to



power: we are the ones in control; we are the ones who don't need help but who give it to others.

It is so easy to hide behind the safe coat of professionalism while telling others to disclose their most personal stories. And still, how much could we gain from taking that coat off, having a good look at ourselves – as I did in the triologue group in Berlin – and making our own weak points a little more visible?

Thanks to the NeSt, I was able to gain new insights into my own relationship with different realities and unusual perceptions. I realized that there are very good reasons why I chose to work in this field, that there are connections to my own life story. In some ways I feel

quite close to the phenomena, while in other ways they make me scared and insecure.

It definitely encouraged me to take a closer look at my own unquestioned beliefs and my own oddities.

There are no distinct black or white categories of 'normal' or 'abnormal' beliefs or perceptions. We live in a whole spectrum of different shades of perceiving the worlds in and around us. We all move within certain ranges of the spectrum, depending on all kinds of different influences. It is so normal to be different. ■

*Caroline von Taysen is a clinical psychologist and a member of the Hearing Voices Movement in Germany*

## A HISTORY OF SURVIVOR ACTION: THE BREAKTHROUGH YEARS

*The veteran survivor activist, PETER CAMPBELL, reflects on survivor activism in the 1980s*

The 1980s saw a notable expansion of action by survivors. It was not the beginning – there was certainly significant action in the 1970s and two groups were important: the *Scottish Union of Mental Patients* (SUMP) and the *Mental Patients Union* (MPU). But these groups had faded by the end of the decade, so much so that many activists in the 1980s knew little or nothing about them. Even so, they were precursors of the independent action groups of the 1980s, had some links with them, and shared many of their concerns.

There were only a handful of survivor groups active in the first half of the 1980s. One group was the *Campaign Against Psychiatric Oppression* (CAPO), originally the Campaign for the Protection of the Rights of "Mental Patients" in "Therapy" (PROMPT) which had links with the MPU. PROMPT/CAPO had a fully developed manifesto. They argued that psychiatry was a means of social control, a weapon of the capitalist system against the working class. PROMPT/CAPO were a comparatively small group but they punched above their weight. They had the distinction of being condemned in the House of Lords by Lord Mottistone. The death of a key member critically impacted on CAPO's effectiveness in the second half of the decade, and by the end of it they were a shadow of what they had been. But in the first half of the 1980s they carried the torch of survivor action at a time when there were few other groups.

Another group which was active in the first half of the 1980s but had faded by the end of the decade was the *British Network for Alternatives to Psychiatry*. Despite its name, the focus of British Network was on the South of England. Like CAPO it held meetings in London. It was a "mixed" group, having survivor and non-survivor members who were mostly radical mental health workers. This

sometimes created problems as some survivor members felt that non-survivors dominated the group and this led to disagreements which limited the group's effectiveness. The British Network, which had always been something of a talking shop, declined as the number of other groups expanded and was eventually displaced by newer, more dynamic groups.

1985 and 1986 were significant years for survivor action. Some people have seen these years as the true beginning of "user involvement". In 1985 the *World Federation for Mental Health* held an international conference in Brighton to discuss Mental Health Charter 2000. Survivors from England and Wales were not invited. CAPO went anyway and set up a stall on the fringes of the event. Invited in at the behest of international survivor participants, they were involved in developing an alternative charter. Some of the mental health workers who noticed the comparative absence of survivors sought funding for a meeting of survivor activists after the forthcoming Mind Conference. It was from this meeting that *Survivors Speak Out* eventually emerged the following year.

The annual Mind conference in the autumn of 1985 was the first large conference where a decent number of survivors were significantly involved. Groups running workshops included: CAPO, British Network, Contact (Chesterfield). Camden Mental Health Consortium (London). The Education and Action Group of Link/GAMH (Glasgow) also participated. They had been trailblazers and did a presentation at the previous year's conference. Although it is dangerous to place too much emphasis on the significance of one conference, this event did show that the contribution of survivor action groups was starting to be recognised.

*Survivors Speak Out* (SSO) was founded in January 1986. It was a networking group and had a membership of individual survivors. Groups could affiliate. SSO also had an ally membership (non-survivors) but, when its constitution was voted through, allies were deprived of a vote at AGMs. SSO's major aim in the 1980s was to bring survivors together, to put forward the possibilities for action and encourage the formation of independent groups. In 1987 it organised a weekend conference at Edale for 100 survivors (it included a few allies) where a Charter of Needs and Demands was unanimously endorsed. SSO was soon followed by two networking groups within important voluntary organisations: *Mindlink* within *Mind* and *Voices Forum* within the *National Schizophrenia Fellowship* (NSF). These became important and long-lasting groups but did not have the independence of SSO.

Another important group was *Nottingham Advocacy Group* (NAG), preceded by *Nottingham Patients Council Support Group* (NPCSG). NAG established group and individual advocacy projects and was unusual at the time in having paid workers and decent funding. It was influenced and supported by survivor advocates in the Netherlands and became a model for people trying to establish advocacy projects elsewhere in the UK. NAG, alongside SSO, did a good deal of travelling around the country, speaking at meetings about survivor action. They were the key survivor groups in the second half of the 1980s.

Survivors were enthusiastic about advocacy which did not feature in most mental health services in the 1980s. Many saw it as a useful weapon to counter the power imbalances in the system. But advocacy was not championed by everybody. Some mental health workers were very sceptical and some organisations held back. *Mind* was slow to support advocacy and the *NSF* were very cautious, perhaps because they felt advocates were rivals to relatives. Therefore, survivor activists were left to take the lead and much of the innovation and campaigning around advocacy came from survivor groups.

A major concern for survivor activists was the Mental Health Act. They were very critical of services based on compulsion. Although they could have differing ideas about amending the Act, activists were almost unanimously opposed to any extension of compulsory powers. In the mid-1980s the *Royal College of Psychiatry* proposed the addition to the Act of powers to compulsorily treat people in the community. Survivor activists campaigned against this. In the autumn of 1987 a march was organised between Marble Arch and the Royal College to oppose their proposals and remember those who had died under psychiatry. Fifty or sixty survivors and their allies took part. The Royal College's proposals were eventually blocked. Although it is impossible to know the precise impact of survivor action on this issue, it is clear that a number of psychiatrists were taken aback by their "clients" speaking out with such vehemence.

The 1980s were a pioneering time. Most groups were small. There was not much funding available. Many activists had to learn new skills as they went along: chairing meetings, writing minutes, doing mail-outs, teaching, public speaking. The struggle was to speak and act for yourself to achieve positive change (self-advocacy in 1980s terminology). Basic issues like language could be contentious. Survivors had to fight against being called "the mentally-ill", "schizophrenics" or "anorexics". Those who argued that "there is no such thing as mental illness" were accused by some of discounting people's distress. Survivor activists usually began their presentations with a section arguing why listening to them was justified. The right to self-define was widely asserted but not always respected.

The response to survivor action was varied. There were good allies around. Some groups, like *Survivors Speak Out* and *Camden Mental Health Consortium*, definitely benefited from the involvement of allies in their early days. Nevertheless, as the decade wore on, the trend was towards survivor-only groups with allies supporting from the outside. But not everyone was supportive of action. Many mental health workers were sceptical or even obstructive. Some found it difficult to cope in meetings with survivor activists who were not acting as their clients, were articulate but also angry and emotional. The argument that activists were not "real users" was often put forward as a reason why they should not be listened to. Representativeness was used in a similar way. It seemed that the mental health establishment could accommodate atomised users/consumers but were much more uneasy when it came to survivor activists organising collectively and developing a coherent analysis.

Even so, progress was made. By the end of the decade there were about fifty survivor groups in existence. They were the backbone of survivor action. Although consultation was not absolutely necessary as it became in the 1990s, survivors were involved in areas of the mental health system where they had never been before. Most groups were involved in the planning and monitoring of services and the establishment seemed happiest seeing them taking part in this activity. Survivor activists also started to train and educate mental health workers like Approved Social Workers and mental health nurses.

However, it became clear that it was difficult to achieve positive change. Some people dismissed survivor activists because they were "mentally-ill". The more radical demands – for 24-hour non-medical crisis houses, against over-medication and the use of ECT – were pushed to one side. The achievement of the 1980s was to be there in numbers and speaking out. Survivor activists had broken through. It remained to be seen whether they would have a real impact. ■

*Peter Campbell is a member of the Survivors History Group. He was a founder member of Survivors Speak Out.*

# An interview with Richard Wilkinson and Kate Pickett

This is an extract from an interview with Richard Wilkinson and Kate Pickett, conducted shortly after the publication of their latest book, *The Inner Level*. The interview was conducted by JONATHAN GADSBY, of the Critical Mental Health Nurses' Network.

Kate and Richard's book, *The Spirit Level*, published in 2009, was a significant addition to research about inequality, and is undoubtedly known by many readers of *Asylum*. It provided evidence that inequality (rather than just poverty) is strongly correlated with many problems in society, including health problems. Their new book, *The Inner Level*, updates that work and provides a new and more interpersonal focus. Jonathan caught up with them both at their office in York University.

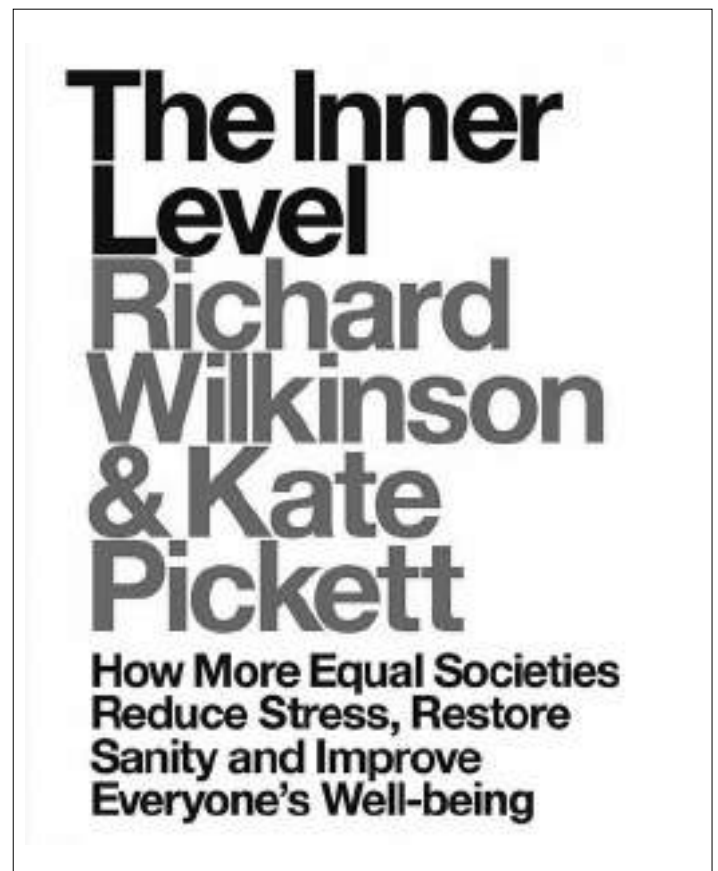
**Jonathan:** Who do you most want to read *The Inner Level*?

**Kate:** When we wrote *The Spirit Level*, what we were showing was the effects on whole populations of inequality. The prevalence of different things in a population. That is quite an abstract idea. It has policy implications, but it is not always easy for people to see what it means for them in their lives. But it is actually affecting individual people's feelings and thoughts and behaviours, so we wanted to tease that out and help people see how what is most important to them in their lives and relationships – that intimate world – is affected by structural things.

We wanted to write it for an audience who wouldn't necessarily think they were interested in politics, sociology, economics, policy but are interested in their own life and well-being and that of their family and friends.

**Jonathan:** Do you think that your first book changed the debate about the importance of poverty versus the importance of inequality?

**Richard:** It is hard to tell whether we were just the beneficiaries of the rising interest in inequality post-financial crash, with Occupy... or whether we helped create that interest in inequality. For me, Tony Blair thought that inequality didn't matter – perhaps it mattered in the 1930s when so many people were living in awful squalor, but now the bottom 20% of people in society had accommodation, flat screen televisions etc.... But we are drawing attention to the social effects of inequality. We often say that there is a naive view of inequality, that it only matters if it creates poverty, but we are trying to show that it affects us in all kinds of ways



much more deeply – psychologically – I sometimes say that inequality is a social relationship between superiority and inferiority.

**Kate:** Put alongside things like Thomas Piketty's analysis of the causes of inequality, the crisis, and other things that were going on – I think it was a key part in opening up that conversation leading to a wide acceptance that inequality itself is damaging. However, the book has been much more influential in some spheres than in others. The role of inequality is much more accepted at international level – by the UN, the World Bank, the International Monetary Fund and by the World Economic Forum, who last year said it was the number one problem facing sustainable development in the world this decade... The arena in which we have had the least effect has been national level politics, because of the government we have had since 2010.

**Jonathan:** Would you say *The Inner level* is a hopeful book?

**Richard:** I think anything that gives you more understanding of a problem increases grounds for optimism. If it is giving understanding at the societal level on individual problems I think that is very strong grounds for optimism.

**Kate:** We do spend some time towards the end of the book talking about possible solutions, and that is hopeful. We feel that the zeitgeist is right for this book – the timing. It was right for *The Spirit Level* because of the global financial crisis. The timing is right for this one because of an epidemic of mental health problems, distress, discomfort and psychological distress being exceptionally high in this country.

**Richard:** I think there is also a growing recognition of the inadequacies of many forms of treatment of mental illness. There are books coming out all the time about the inadequacies of drug therapy treatment. Inevitably, very high rates of mental health issues leads people to want to think about context and not just about them as individual failings.

**Kate:** Danny Dorling has recently published a book called *Peak Inequality* and he thinks that in the UK we have reached peak income inequality and that things can only get better. I'm not so sure... but I think there are a huge number of people around the world, from different perspectives, who are now convinced that we have to have system change. A growing movement including people from all walks of life and academic disciplines – I think we will look back on this period of history as when the neoliberal journey came to an end.

We should also say that young people give us hope. In the ways that they seem to be thinking and voting and acting, compared to our generation, the younger generation are progressive in their thinking, they are less racist, less homophobic, and less misogynistic, less for Brexit. So that's hope the future.

**Jonathan:** It was striking in the book that the main thing you ask for is more democracy – 'democratisation of the economy'. Is this an anti-capitalist book?

**Richard:** It depends what you mean by capitalism. I don't think we would suggest that there is no role for the market... It is a question of how much one modifies the market... we think that capitalism needs very major modifications particularly in the antisocial incentives it gives to business. I do think that to deal with the environmental problems that we are facing business has to change fundamentally. While you have shareholders who are demanding high profits and maximisation of profits I don't think you can reach sustainability.

**Kate:** I would say this is an anti-business as usual book... 'Business as usual' starts to look stupid, actually...

**Jonathan:** What would the economic democracy you describe look like within a mental health service? For

staff and for service-users?

**Richard:** The staff as a whole would be choosing the people at the top and they would be answerable. Within companies with more democratic structures more information flows and this is part of the reason for their success.

**Kate:** When the National Health Service was founded it was a radical idea, with radical aims and values. Yet it was staffed with an incredible hierarchy. The hierarchy of employment within the NHS has always been staggeringly steep, with doctors at the top and cleaners at the bottom, and everybody treating each other rather horribly in-between. But... when we think about team care for anybody with a complex health condition, whether it's physical or mental, the number of people that are involved – the number of skills that need to be brought to bear – why on earth should we value any one of those skills more than another? In terms of pay and prestige? I think we need a radical rethinking of contributions in teams.

**Richard:** Endless structures alienate people from what are the real social purposes of their roles. That means they don't get feelings of purpose and self-worth.

**Jonathan:** Is there a danger that what you describe as a 'correlation' (between inequality and various outcomes for individual health and societal problems) could be interpreted as saying that the stratification occurs because of people's ill-health, because of their lack of confidence, their psychological make-up or lack of social skills... that what we see is a sorting of society based on the very things that you're noticing.

**Richard:** In order to counter that I say, okay, the common view is that the hierarchy is simply a sorting of people available, the less able go down and the resilient go up. But we could do this with hair colour. All the grey hairs in this room, all the light haired, all the dark haired on that side... But that sorting won't change the hair colour of anyone in the room! And yet, in *The Spirit Level*, we showed that some of these problems were 10 times as common in more unequal societies, so it can't be just a sorting process. And on that basis we argue that it is substantially a response to social differentiation, to inequality itself. ■

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*The Inner Level* (Penguin Books, 2018) is available to buy in high street bookshops, or why not try [hive.co.uk](http://hive.co.uk), a tax-paying UK online bookstore that also supports a tax-paying local bookshop of your choice.

# Turn Up The Volume on Women's Mental Health



Statue: *Der Ruf* in Berlin

A new project launched by **WISH** is the only national, user-led charity that works with women with mental health needs in hospitals, prisons and the community.

Women's voices in the mental health system have been silenced for too long. There are fundamental problems within the system that mean these services, and other similar services for women, only touch the surface of support rather than look at a woman's individual needs. This means women are often wrongly placed in certain services, with the mental health system repeatedly failing them through lack of early intervention, lack of appropriate care and support, and through stigmatisation.

Though gender is rarely discussed as an important topic when it comes to mental health campaigning, we have to understand the experience of people who identify

as women or non-binary in the context of a world where we are far from achieving equality. This influences, perhaps in part subconsciously, how we treat women both within the mental health and criminal justice system.

As the role of women is often still expected to be one centred around sitting quietly and looking pretty, women are judged by a different value system to men, including being more harshly judged when it comes to the secure psychiatric and criminal justice system.

We recently launched our latest project, the **Women's Mental Health Network**, which is a partnership of voluntary organisations working across sectors, to provide a user-led, campaigning platform to give women with mental health needs a voice, and drive forward change.

The Network's focus is to improve women's experience of using statutory services in a range of settings, such as hospitals, prisons, drugs and alcohol, housing, and social services, by influencing them to become more gender-specific as a way to address this inequality that currently exists within the system.

Over a decade ago, the Corston Report (2007) emphasised the importance of this gender-specific, needs-led work to address the multiple needs of vulnerable women. Yet in 2010, less than a third of NHS Trusts reported steps to include gender issues in assessment and care planning, and just a third of Trusts said that they provide gender-specific services. And in July 2018, the London Assembly Police and Crime Committee produced a report highlighting similar issues to those first raised in the Corston report, and expressed concern that not enough changes had been made since that report came out in 2007.

Not only is the Women's Mental Health Network vital in getting these much-needed gender-specific services implemented, but it also addresses the stigmatisation women face due to being labelled and boxed into a particular service that doesn't meet their needs. But both Wish and the Women's Mental Health Network look more holistically and see how a woman's life experiences and mental health can interlink, with estimates of 53% of women who have mental health problems also having experienced abuse. A woman in poverty will also be more likely to face poor mental health, with estimates that 29% of women in poverty experience a common mental health disorder, compared to 16% of women not in poverty. That's



why our Network partners have specialist knowledge for different areas of the sector, including People First, which is a campaigning and self-advocacy organisation run by and for people with learning difficulties, and St. Mungo's, a charity and housing association supporting people who are homeless or at risk of homelessness.

Ultimately the Women's Mental Health Network works to **turn up the volume** on women's mental health, and we want to put the voices of the women the Network strives to help at the centre of our work. That's why we're inviting readers of Asylum to tell us what is important to you when it comes to mental health and other statutory services, as part of our current consultation.

We're asking you to identify the top three issues within service provision that need to change, and we will then be developing user-led campaigns to improve these issues. This will be done to drive forward the provision of gender-specific statutory services; and then we will take these campaigns forward at a national level.

To fill out our questionnaire, go to [womensmentalhealthnetwork.com/consultation](http://womensmentalhealthnetwork.com/consultation) and help us ensure that the voices of women will finally be heard in the mental health system. ■

**Deadline: 14th Jan 2019**  
**WISH**

# DISTRESS NOT ILLNESS: A NEW PARADIGM

NEIL CATON

What would a mental health system look like if it moved away from medicalising distress to primarily looking at psycho-social explanations and solutions? I often wonder how it might have helped me navigate what has been a long journey through sadness or depression and several episodes of psychosis.

I remember when I first sought help when I was at university. I was severely depressed, socially isolated and actively suicidal. The professionals I looked to – counsellors and a university chaplain – all encouraged me to see my distress as just that, distress. At the time, I was very attached to medical interpretations of misery and I was convinced I was defective in some way and needed fixing. I felt reassured by this notion. I took the societal narrative of 'mental illness' as self-evident. Given how different I felt from others, and how extreme my distress was, I thought I must be amongst their number.

In retrospect, I think I was actively participating in

a denial of myself and this prevented my recovery. The parts of myself I was uncomfortable with, which caused me so much emotional pain, were neatly sewed up in the label of a 'mental illness' and this stopped me truly accepting the fact that, to some extent, I would always struggle with these parts of myself. The strong societal narrative that some people are mentally ill legitimised my denial because I was more comfortable with the idea that my distress related to personal flaws that could be fixed.

I slipped into psychosis as a way of coping with my low mood. I had a number of grandiose ideas that I was a re-incarnation of famous historical figures such as the Buddha, Saint Peter and Martin Luther King and that I had saved humanity from going to hell. This is when I attracted the attention of the mental health system. I have to say that they did actually help pick me up after this. They helped my parents support me, gave me the



Image by Jill Anderson

space from my stresses to recover, and my depression went from severe to mild. However, they also told me that I was mentally ill, something my support system at university had encouraged me to think twice about.

Although I did make a lot of progress within the mental health system, I still struggled to accept myself. I blamed the parts of myself I didn't like on the 'mentally ill' part of me. Most significantly, I struggled with being an introvert and believed I should be a social butterfly. It took me many years on my recovery journey – which included a lengthy psychotic episode – in order to learn this lesson. I needed to accept who I was, not who I thought I should be. Undoubtedly the mental health system colluded with this in diagnosing me as mentally ill. It told me that I was ill and therefore I logically deduced I could be cured. This meant I thought that the parts of myself I didn't like could be overcome, rather than accepted, valued and loved. In other words, I thought I could become the person I thought I should have been to begin with.

It was a revelation when I discovered that the medical model was actively contested by psychosocial interpretations of distress. I always felt that being bullied at school was a significant life trauma, but labelling myself as mentally ill was more problematic. It stopped me making sense of the things that had happened to me, which would have helped me accept myself, it kept me frozen in the trauma of being bullied throughout my schooling.

I remember being in a therapy group when I was at university surrounded by others who also thought their

distress meant they were mentally ill. The counsellor would periodically encourage us to question this, but it fell on deaf ears. I remember clinging to that idea myself too. My friends knew I was struggling but didn't seem to understand how excruciatingly miserable I was. I felt the only way I could possibly bring this home to them was through the idea I was mentally ill. I felt that this was the only possible explanation for my distress.

Whilst I regret labelling myself as mentally ill and the years I've lost to its effects, at the same time, I understand the eighteen-year-old me who did this. The emotions I felt were extremely painful and I felt I needed answers. I was unable to think clearly and see what I needed to do to recover. Instead I spent ages scrutinising what I needed to do, losing all perspective. I also empathise with me in my early twenties when these feelings just wouldn't lift. I needed a logical way to explain to my friends and family what I was going through as they didn't seem to understand.

It is with this in mind that I embark on a mission to increase awareness that intense emotional pain, which often gets called mental illness, is part of life. Whilst some people experience this more than others, I think the remedy lies in finding ways to be kind and empathic with the parts of ourselves that causes us pain. ■

*Neil is a trustee of the International Society for Psychological and Social Approaches to Psychosis (UK)*  
[www.ispsuk.org](http://www.ispsuk.org)

***Anxiety*** is fear.  
***Anxiety*** is exhaustion.  
***Anxiety*** is irrational.  
***Anxiety*** is real.

BY DONNA PARRY

Anxiety feels as though you are in the middle of the ocean, alone, in the cold dark night in a rowboat. The rowboat is old, wooden and weathered. There are a few cracks in the rowboat where the water trickles in and begins to fill the bottom of the boat. You look frantically to your left and your right, desperately searching for someone to see these cracks to help save you. You see another boat in the distance and wave them down; they wave back, turn on you and row away. Then you remember that the boat looks okay on the outside. There is no one.

You look up to find the sky is overcast. No stars or glimmers of hope tonight. You lean over the edge of the boat; there is nothing down there to help you. Deep, dark, nothingness and the sheer terror of the unknown. You are panicked. Your senses are heightened; your heart is thrumming quickly in your chest, you think you are going to vomit and your throat burns as it constricts. You can see, feel, and sense the water pouring through the cracks trying to drown you.

You cast around the boat for something to empty the water: there is nothing. There is nothing that can help you. You frantically cup the water with your hands and throw it back out of the boat. If you do this quickly enough, you can stay afloat. You can survive. You're a ball of nervous energy; this is fight or flight. The energy is part of you so



it has nowhere to go, there is no escape: it's bouncing off your insides and reverberating around you. You try to calm yourself, to reason that you can survive if you keep on top of the water. But the water is ever threatening to creep higher and overwhelm you. To survive is hard and it is exhausting.

A crash of thunder rocks your already fragile boat. The sky is becoming stormy and starts to swirl. The bob of the ocean turns into angry waves. Your boat begins to violently rock back and forth, the water is spilling over the sides now. You can't empty the water anymore; it is hopeless. It spills over your legs and makes its way up your torso. Your heart is terrified, so it climbs up into your throat and pounds against your esophagus trying to escape the water, to break free of your body, screaming for help. Your hands are sweaty, but they're cold. You can feel your heartbeat there too, right in the tips of your fingers. You can feel it in your neck, behind your eyes, at the side of your head. You gulp at the cold night air looking for relief, but the air is cold and harsh and brings you no comfort. You can't seem to breathe enough of it in at once so you gulp harder, bringing you less comfort, causing you to gulp harder. Your chest is restricted; it's stuck in an ever-tightening vice. Your head begins to throb and you're already certain you're drowning, your body is suffocating because there is no air, you can't breathe, this must be what drowning feels like. The water continues to rise; it's neck deep now. You take a last panicked gulp and you're beyond terrified, desperately kicking and grabbing, screaming and crying. Then it's over. But there is no relief, just fear, because you know that your boat will sink again. ■



# Mental health activism and research in Poland: notes from a visit.

In June 2018, China Mills (a member of Asylum's editorial collective) was invited by Anna Witeska-Młynarczyk, an anthropologist working at the University of Warsaw, interested in child and youth psychiatry, to visit Poland to learn about mental health activism and practice in Warsaw.<sup>1</sup>

Three years ago Anna had contacted China to ask if she could translate an article she'd written on psychiatric drugs and children into Polish, for an anthology she was editing titled "Antropologia psychiatrii dzieci i młodzieży. Wybór tekstów" (Anthropology of child and youth psychiatry. Selected works). China of course said 'yes please', and they've been in touch ever since. The book was published recently in October 2018. Now, China's work, and other interesting articles written by British, Canadian and American academics can be read in Polish.

China and Anna have co-written this piece for Asylum about the trip and from now on will refer to themselves as 'we'.

China arrived in Warsaw on a burning hot day just at the end of a week-long occupation of Poland's Parliament by parents of disabled adults protesting the meagre federal support they receive to care for their family members. This disability activism in Poland was strikingly similar to recent and continuing anti-austerity activism by disabled people's groups in the UK, who have highlighted the mental health impacts of welfare reform and its links to suicide (see Asylum issues 25.3 and 24.2). The occupation of the Polish parliament lasted 40 days. The central aim was to increase the monthly allowance. Still, the action was aiming at larger issue, such as: the social visibility of the problem, the dignity and the worthy life of disabled people and their carers, as well as the support of disabled adults when their parents are not anymore able to act as carers.

During the trip we met with Jakub Tercz and Andrzej Kapusta who run the Open Seminars on Philosophy and Psychiatry Foundation. Their activism aims at integrating the research community in the humanities, social sciences, psychiatrists, therapists, people experiencing mental distress and all citizens, making a change in social awareness, working towards a more open, reflexive and inclusive society. Jakub, who is based in Warsaw, introduced us to the Fountain House and organized a meeting with the Section of the Polish Psychiatric Association. The people we met there have also been actively engaged in the yellow ribbon campaign which took place for the second time this year. Here people marched through the streets of Warsaw with yellow ribbons attached to their coats, holding banners that read: "I am myself. I am not my illness", "I am free", "The illness is not my choice".

In Warsaw, we spent a lovely morning at the Warsaw Fountain House, a space where people who self-identify as psychosocially disabled and/or who experience distress, can come and go as they please, accessing various kinds of support (including delicious food made



1. The visit was financed through a grant awarded to Anna by the National Science Centre.

by those who use the space), for example, support with employment. We wondered how you could ever sum up in words or try to measure what it means to someone to simply know there's always somewhere they can go where they will be welcome (even if they never do return). To say thank you, we brought a pile of Asylum magazines for their library.

Running late because of closed roads blocked by the escort of governmental limousines, we also attended an open meeting of the Community-based Psychiatry and Rehabilitation Section of the Polish Psychiatric Association, Warsaw Branch. Sat in a circle in a room filled with paintings and half full coffee mugs, we talked with mental health users and psychiatrists about the growing patient movement in Poland. People said they didn't feel this is (yet) a survivor movement as such but instead is a loose grouping of users and professionals who are campaigning to end stigma, to advocate for specific solutions (like including in the system of care the former patients who would work as "therapists through experience"), to respect patients' dignity and their right to self-determination.

Eventually, we also ran two more academic events at Anna's work place – the Institute of Ethnology and Cultural Anthropology, University of Warsaw. One of them was a workshop on "Children, youth and mental

health: themes, methods, ethics". We talked about the ethics of working with and doing research with young people who have diagnoses and / or have experienced distress or alternative realities. Anna talked about her research on ADHD in Poland and the way diagnosis is a social process. Part of her research involved speaking with children about mental health, and she found that sometimes children could be as discriminatory and sanist in relation to madness as adults (we felt this shows how strongly and tightly anti-madness is woven into our ways of thinking and how society is organised).

Eventually, what I (Anna) enjoyed the most was the presence of China. When I close my eyes and recall, what comes to my mind immediately is a long train ride (Lublin-Warsaw), a walk in what used be a Jewish quarter in Warsaw, an Indian restaurant in Lublin... and our conversations, which build me up in innumerable ways. It was a great pleasure to meet a person whose texts I enjoy reading, to share her presence with others, and to be able to talk about the reality that surrounds us and different states of mind, in a manner that is full of respect and non-judgemental, from a standpoint that is impressively wide-ranging. Last but not least, ever since, on my bedside cabinet, there lie three issues of Asylum magazine which I from time to time look into while sipping my morning coffee. ■

# ON THE NEED FOR DIALOGUE

OWEN SPALDING

I recently wrote a blog on my website about the culture of abusive practices in inpatient mental health services, and how those working within these settings had a responsibility to call out these issues. It was, in part, a reflection of my own role as a mental health nurse within the NHS and the sort of issues I see on a day-to-day basis, as well as an exploration of what acute care could be like if done properly.

I was deeply humbled by the breadth of responses that I received, from professionals, activists, but also users and survivors of psychiatry. The discussion ranged from conservative suggestions of change from within services, to more radical ideas based on direct action and resistance to bring about new ways of thinking and doing things. What united these different voices and rallying cries was a fervent political hunger, a recognition and understanding

that things could not go on in the way that they were, and a desire to do something about it. It was striking to see so many people, from across all sides of the mental health political spectrum, talking in a way that appeared to show a deep sense of solidarity, however imperfect.

Was this something new? Or was this just a tokenistic "oh dearism" from professionals like myself, whilst maintaining the status quo that had so long oppressed and subjugated the people we are supposedly helping? Would it actually have any meaningful, tangible effects on the lives of those experiencing mental distress?

I am not surprised that some users and survivors of psychiatry are deeply suspicious of any idea of solidarity between themselves and professionals, given our history of co-opting radical ideas from within the survivor movement for our own political ends. I refer to the

recovery movement here particularly. This is a movement that had its roots in a principled demand for support from the state in order for people with mental distress to be able to live independently on equal terms with the rest of society, manipulated by those in power to engender ideas of rugged individualism, and as a justification for withdrawal of services and welfare provision. There is also the very real issue of what Peter Beresford calls “consultation fatigue”, where service-user engagement with mainstream mental health services becomes nothing more than a tick-box exercise, another hashtag on Twitter, or an abuse of experiential knowledge to legitimate business as usual, with little or no change to policy or practice.

As the user-led mental health group Recovery In The Bin so aptly put it recently:

*“After years of service user involvement and experts by experience, are services listening? Is an emotional response to survivor testimony in a situation removed from clinical practice making a difference at the point of delivery on the frontline?”*

This is deeply worrying for me too. Talking the talk may make us look like well meaning and compassionate mental health workers, but what are we actually doing to effect meaningful change for those suffering with mental distress? Sure, we might be able to do some good in our work environments, but what about those who have been abused and traumatised by the very services that we provide? What about those who do not identify with mental health services for fear of having their experiences silenced or pathologised? Don't we have an obligation to them, too? Or is it all just lip service?

The dialogue between users and survivors of psychiatry and providers of psychiatry has often operated within or at the edges of mainstream mental health services. This in itself is a barrier to any meaningful communication. David Webb has described the “unmentionable giant gorilla” of coercion and compulsion remaining firmly in the room, stifling any discussion on an equal footing. Juergen Habermas also writes extensively about the conflict between the system and the lifeworld, in which the lifeworld (our interactions with society and the world at large) is manipulated by institutional authority to fit the goals of the professional and administrative sphere. There is no place where this phenomenon is more acute than in the boardroom of a mental health trust whose policies are driven by neoliberal notions of performance, targets, and managerialism. Is there not a better space, a space derived on more equal terms, where this dialogue can begin?

Historically, there have been few instances where users and survivors of psychiatry and workers have formed

alliances and entered into a dialogue on equal terms. It is likely that this is in no small part a result of our role in a system that has so long treated those experiencing mental distress as second-class citizens, with the forced treatment and violence that has come with it in the name of “care”. I want to make it clear that I do not want to minimise or make excuses for this. Nor am I suggesting that users and survivors have to forgive and forget. For some, the role that we have played will mean that it is too difficult or too traumatic to consider such a forum for discussion. For that, I am sorry. I hope one day we will have provided the safety for you to speak your truth.

I think however that a place remains for us to enter into dialogue in an environment that is co-delivered and reciprocal. The UK government continues to dismantle the welfare state in a climate of austerity, and mental health services continue to be stripped of their resources. The hostile environment is only getting more hostile. But this rollback of support provides an opportunity for workers and survivors to build alliances. To organise together and to enter into a relational space is to foster a deep sense of collaboration based on a critical understanding of each other's values, beliefs, and politics. There will be times where our aims and goals differ, and I am under no illusion that there may be conflict, disagreement, and anger, but this deliberative process is fundamental to dialogue. We must be able to provide a space to discuss the issues that are central to our differences, in order to shine a light on what unites us.

I am not suggesting that the relationship between worker and survivor within these spaces will be one of equilibrium. There are questions of power that cannot just be bracketed and left at the door. If we are to address these issues, we must ensure that the testimonies of survivors are centre stage. We are here to listen. We are here to give our support. We are here to commit to agitating, disrupting and to improving our practice at the point of delivery, and we are here to bring our voices together to make demands on the state to provide services and welfare provision that have long been undermined. By entering into dialogue, and by organising together at a grassroots level, we open up opportunities for political pressure and change.

There is great power in mutual aid and co-operation – I have long been drawn to the co-operative values of self-help, self-responsibility, democracy, equality, equity, solidarity, and the ethical values of honesty, openness, social responsibility and caring for others. It is our interdependency on one and other that makes us human. For us to move forward together, our shared humanity must be central to our dialogue. For this is what unites us. ■

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# Exploiting Our Good Souls

**SANCHITA ISLAM claims the exploitation of artists with mental health problems is insidious, but sadly all too common.**

There is a worrying trend of organisations jumping on the bandwagon of mental health; they arrange exhibitions and talks designed to raise mental health awareness and invite artists to participate in such events, but seldom have any money in the budget to pay them properly.

Art is a precarious profession and living with a mental health condition can be arduous. Being paid to work is a fundamental human right; yet why do organisations expect artists to work for nothing?

My former psychiatrist Dr T wrote to me about participating in an exhibition hosted by X Gallery in Belgium. I had never heard of them before. My relationship with Dr T was fractured; I had lost all my mental health support shortly after the birth of my second child in 2013. During a psychotic episode I criticised my mental health social worker and never received a suitable replacement. I was going through post-partum psychosis and I had a new-born and toddler to care for. To say that I am disillusioned with the mental health services would be an understatement, I wrote about my experiences in my book *Schizophrenics Can Be Good Mothers Too* written under the pseudonym Q S Lam.

In addition, Dr T had decided to stop being my psychiatrist because I was only partially in Belgium. I found out via email. In the past I only saw him once or twice a year. After losing him, someone I trusted, I never felt more isolated.

Although Dr T was no longer my psychiatrist we still had a working relationship starting in 2012. To date I had done one exhibition with their arts organisation, which was unpaid. I completed two 30-foot scrolls with patients and was paid for this work, although it was a nominal fee. I was asked to design a postcard for an exhibition of postcards created mainly by patients with mental health issues. The postcards were auctioned at a gallery in Brussels, the proceeds went back to the organisation; the artists didn't receive anything.

For a long time I was grateful to be included. But if you work for free isn't that a form of exploitation? These people work in mental health, they all get paid – the psychiatrists, the mental health social workers, and the cleaning staff – so why not the artists?

Sometimes I would forget that Dr T was no longer my doctor and I would still talk about my mental state during our meetings, in retrospect I wish I had stayed quiet. Perhaps it is not possible to be a former patient and work with mental health organisations: the lines are too blurred.

I asked Dr T if I would get a fee for participating in the exhibition, he said, 'No'. Dr T told me the gallery had money; well perhaps this was why they were rich. I wanted to trust Dr T; it's tough always feeling like an outsider. In the end I agreed.

During the meeting I told him about an idea for neon signs with mental health messages and Dr T told me he would relay it to X Gallery. It turned out that they were interested.

Dr T's colleague came to my studio to see my new work. At the time I was very ill. I found it strange that although he was a psychiatric nurse he seemed uneasy when I was psychotic. I always felt ashamed when I became unwell, as if I was expected to control my episodes.

At the opening of the exhibition in September 2017 I was picked up by the gallery staff, they were affable and professional. I was taken for lunch; performed a fifteen minute set of my music with accompanying visuals; showed two 30-foot scrolls; and my Grenfell Tower triptych. I also met all the board of directors at X Gallery. On the night I sold copies of my book of poems, *Dented*. Then we spoke about the neon sign, we discussed the text and shook hands on the deal. There was even a group photo with all the gallery directors. I was excited.

A few weeks later, after I had completed designs for the sign, I received a terse message from the gallery saying that the neon sign was not happening. The bubble burst, I was shocked. When I told Dr T he promptly intervened and the gallery relented. Eventually, I was paid a fee for the neon sign and the text read: *What Makes a Good Soul?* What had Dr T told them to make them backtrack? Without his intervention I am sure it would not have happened.



Neon installation sign, X Gallery, Sanchita Islam, 2017

The gallery later invited me to speak at their Symposium. The whole theme was mental health, I asked again if I would get a fee, or if they would cover some of my travel expenses. They declined. There was no car to pick me up and take me home. It was an hour's drive to the gallery and back. It seemed bitterly ironic that they were speaking about mental health, and yet not taking care of their speakers. When I requested taking my paintings back with me the same night, I was told they wanted to keep my work for longer.



Grenfell Tower Triptych, pen and ink on canvas paper, Sanchita Islam, 2017

There was no contract and nothing in writing: it made me acutely apprehensive. Surely securing the safe return of my work was the responsibility of Dr T and his organisation?

In June this year I travelled to Bangladesh to work with the Rohingya refugees as a volunteer, I promised the women that I would share their harrowing stories with the world. I wrote to Dr T and Gallery X about my Rohingya work. Dr T praised the work but was not interested. The gallery was more equivocal.

For months I tried to get a meeting with Gallery X, I was also anxious to retrieve my work, which the gallery had exhibited for one year now. The day of the meeting came and a friend who was supposed to take me to the gallery didn't show up. I called the gallery and asked if I took a cab would they cover the fare? They didn't refuse. It cost 100 euros. I brought my guitar, amp, computer and the Rohingya work. The gallery representative was busy taking down an exhibition when I arrived, he told me the gallery was booked up for 2 years. I was incredulous, why waste my time? Had they just lured me to the gallery on false pretences to pick up my work so they didn't have to deal with it?

Two days later, I received an email saying the gallery would not cover the cab fare or showcase the Rohingya work. Dr T's organisation agreed to pay half of the cab fare, but then there was radio silence. I wrote back delineating all my grievances, but no one replied.

I felt duped, used, exploited and a fool for incurring costs to retrieve my work – albeit 50 euros – it was the principle.

Was I being used for their own ends? As long as it was expedient they showed my work and invited me to speak for free. Under the banner of mental health they held talks and exhibitions, but when it came to looking after the artists involved they fell short. Their behaviour made a mockery of their mental health campaigning. Was I supposed to feel grateful for their crumbs?

It's not the first time this has happened. Another organisation in Singapore invited me to exhibit, in the name of mental health and digital art. When I asked if



there was a fee, I was told there was not. Who actually benefits from such exhibitions? My work drew in the crowds, but they only sent an invitation a day before the exhibition so I couldn't even attend and if I had, I would have been out of pocket.

Galleries and mental health organisations that work with artists should pay them for any work they expect them to do and take into account their mental health needs. In retrospect I should have requested a written contract, stipulating a date for the safe return of my work and asked for a fee to exhibit and speak; if my demands were not met then I could have walked away. This whole experience has negatively impacted my mental health: a lesson learnt the hard way.

Since informing Dr T and Gallery X that I was writing this article they replied. Gallery X agreed to pay the rest of my cab fare and Dr T said he would speak to the gallery. Was it fear of being exposed that precipitated a response? Did they feel culpable? We will never know, but speaking out clearly is the way forward. ■

*Author's Note: All names except the artist have been changed.*

*Editor's Note: we have to admit that ASYLUM is not able to pay artists for their work. We do not make any money from the production of this magazine.*



# AHHHH, SLEEP...

MORRENE HAUSER

I hope I am not out of line or going to embarrass myself (yet again) by sending you this letter. You rarely answer me when I reach out to you for help, but I will try, and hopefully you will respond this time.

I am begging you, Sleep, to please read this letter to the end. Throw it away, burn it, rip it up when you are done. I'll leave that to you to decide.

I will try not to bother you after this letter, but I cannot promise. I have no pride where you are concerned, Sleep. None.

Please do not feel I am attacking you, but, Sleep, my friends tell me that you are sleeping with them.

"I slept with Sleep until 10:30 this morning!"

"Me and Sleep slept like a rock!"

"I took the most wonderful nap with Sleep today!"

Smirks on their faces, laughter in their voices as they look in to my eyes knowing of my obsession for you.

And, yes, a little voice in me says go to hell!

Go to hell.

But that doesn't last long.

I am a lover, not a fighter.

And a forgiver. Always a forgiver.

I awoke with another panic attack at 2:00 a.m. this morning, Sleep.

Whose bed are you in at this very moment? My heart pounds. My mind races.

When I find out whose bed you have slept in, I feel as though somebody has punched me in the stomach.

Sleep, the days on end where I have to go to bed at 6:00 p.m., 7:00 p.m. even on weekends because I know I need to get some rest before I wake up at 2:00 a.m., 3:00 a.m. and be awake for the rest of the day.

Thinking of you

Loving you

Longing for you

Ahhhh, Sleep...

The ruined weekends.

The ruined evenings.

Gritty, aching eyes, pounding headache, the mental and physical exhaustion that haunted my days while I tried to work and care for my babies when they were little. I learned to lay in bed awake for hours with eyes closed so at least they would not hurt.

Sleep, I am so very tired of disappointing my children because I am just too exhausted at times to do the things they want to do.

My kids would say, "Mom, you just don't want to spend time with me!"

"You don't care!"

Not true, my babies, not true I would say to myself all the while knowing they would not understand at their young age if I tried to explain.

The missed soccer games.

The missed parties.

The missed school events.

The activities that I did do with my babies all the while concentrating on putting one foot in front of the other.

You can do this I say to myself.

Adrenalin was my drug of choice to get me through those long, difficult days.

The guilt, the shame, the depression, the sadness over disappointing my little ones. I am so very sorry.

Guilt, guilt, guilt. The gift that keeps on giving.

Ahhhh, Sleep...

The one-night stands we have. I never know when you are coming, and that is the best! I wake up the next morning, and there you are, Lover, sleeping next to me. It would not be appropriate to write down on paper the pleasures we share in those moments.

The next morning I am endlessly happy! The sun shines brighter, the birds sing clearer, my obsession for you goes away!

But, Sleep, you cruel, fickle, heartless lover, the next night you again sleep with one of my friends. And when I find out who you had slept with, I am crushed. The depression and sleepless nights return in full force. Once again, I lay awake in bed wide awake

Thinking of you

Loving you

Longing for you

The sun does not shine, the birds no longer sing, my obsession for you continues.

Damn you, Sleep. Damn you

And, Sleep, you must have adored my pregnant body, Lover, because you slept with me night after night. And, oh, yes, the naps we would have!

Perhaps you have forgotten.

But, Lover, I have not.

But as soon as my babies were born, Sleep, you left me without a good-bye. Cruel, heartless, fickle Sleep.

Even when my baby girl was born still, you left me.

Thank you, Sleep, for at least staying in the hospital with me during that long, difficult birth.

Again, I am a lover, not a fighter.

And a forgiver. Always a forgiver.

So I forgave you yet again. Again and again and again...

Ahhhh, Sleep...

please come back to me.

I beg of you.

I will take one-night stands. I will take anything. Join me in the middle of the night, early morning after you have left another's bed.

I don't care, Sleep. I am that desperate for your love.

I have not slept with you in several weeks, Sleep. And I am very, very tired.

Ahhhh, Sleep...

I beg of you please come back to me.

Please come back. ■

# Creative Writing

## Stasis

Nothing moves.  
No thought or imagination.  
No bright dancing spirit inside me,  
nor any soulful human touching.  
Just the pale hiss of nothing in particular.  
There's a kind of peace here,  
all angst and trauma safely veiled  
behind a curtain of soft snow.  
And for that peace I keep taking the little white pills,  
day after day.  
But day after day they dull my spirit,  
still the song of my soul to a forgotten murmur.  
Nothing moves.  
All the bright green leaves have been painted grey,  
and someone stole the sun away,  
swapped its fierce splendour  
for a fluorescent lightbulb.  
A friend passes in the street.  
I say words, they say words,  
but nothing moves.  
They pass on,  
another ghost in the wilderness of the everyday.  
Life goes on, as it must,  
in stasis.

Andrew Baxter



## Bean Spiller

*What you are about to tell, no one can know. Since you will tell it anyway, you cannot order the sequence of the memories. You will write it quietly in the order it came.*

Three and a half years old, left alone, again, I walk confident by the houses in bare feet down the hill to the park. More of a baseball field, but I did not know that then. I sit on a bleacher, get a splinter in my thigh. Staring at the field before me, I feel an angel of the Lord beside me.

And he says, "God created the earth."

I look at the grass and up at the trees, the blue with white cloud puffs, the bend in the horizon. I don't have words for what I feel. Amazement, maybe. The trees strike me the most, something about each green leaf.

*Put that memory away! That did not happen! Just believe me that you are psychotic and you made it all up. You're not touched. You're not special.*

Rain on one side of the street. Sun on the other. A perfect divide down the middle. It is a sign. It is perfection.

*Do not say what happened at the other field, the one They told you never to go to. Be angry with God for what he has allowed.*

My first memory is of my death. I am two and a half, and a boy squirts his black squirt gun up my nose. As I fall I think his face evil. So rabid was he. And then, I only see dark. Black. In it, a glowing old man with big hands that holds an orb that is me. As he puts my soul back in my body, he says, "The first sound you will hear is your own voice." A gasping breath. My eyes open. Sky. And then it comes out, "What happened?" My grandmother is over me with smelling salts. She is crying and moving the smelling salts from one of my nostrils to the other.

*Do not tell the next part. Never write about us, including your sister, Chris.*

Sitting up from my death pose, I look over my shoulder to see my sister, Chris, five years my elder, walking out of the apartment across the grassy area that separated the buildings. She has a stuffed, green snake. A very long one. She is proud of her new acquisition, and somehow the coincidence is not lost on me.



*See, this is the thing. You do think your sister is evil. You've never written about her. Don't start or we will do something. Why are you tensing? Scared?*

Yes.

*Good.*

There are slugs on the sidewalk on a summer night. I hear crickets, see fireflies, feel heavy, hot air as I sit with a couple of neighborhood kids and my sister in front of our house. She leans in and so do we as she tells the story of a young girl ghost who hitches rides in cars and gets dropped off where she had once lived, before she died. She makes sure we understand that part. She makes sure we are afraid of the dead. She teaches us the song, "Never laugh when a hearse goes by or you might be the next to die."

*Remember the words.*

I am in the potty. My sister, Chris, knocks and says she wants in. An angel tells me not to let her. But I do. I open the door and she and the thug neighborhood boy laugh and stare. She swore. I trusted her. Now the Satan men will be able to watch me pee the rest of my life.

*Give us a break! No one will believe you. Joke's on you, sistah.*

The thug neighbor boy shows me his penis on the porch. I don't want to see it. I find myself in the bushes with who I thought was a nice boy but who says, show me yours and I will show you mine. Him I simply tell no. Perhaps that's the difference between naughty and nice.

*Horny?*

I was three.

*Angry?*

My sister, five years older than me, makes a haunted house in the shed and only later admits I was not feeling brains. It was spaghetti. Eventually, I fall asleep.

*Blame it on your mother. Blame it on your father.*

My father runs into the house he had to leave because he is "sick" and slaps my mother who is in the kitchen. On

the couch, watching TV, I see him come in. I see him go where he knows she is. I hear him yell, "You let my baby get sick!" (A sign from God I am in trouble.) I hear her yell, "Dick, no!" I hear the slap. I smile. My sister crouches by me and cries. My father runs out. I am three. I was three. All this, too young.

*Blame it on yourself.*

I'm four or five. Christ swoops past as I lie in my bed and says, "What do you want when I come?" I tell him chocolate milk and chocolate pop tarts. They don't make chocolate pop tarts anymore. I blame Satan.

*Stop. Now. You're adding to this. We told you no.*

Chris sends me a text and says I am evil. She says, "Own it." She is very angry at me, and I don't know why. I watch her sickness as it starts, intensifies, the way my father's did, the way mine did.... I hide from her now, at 54, and bar the door.

*You don't even know why she hates you? You moronic imp. Run while you can, sweetie.*

My sister sees demons in her smoke, in her photograph, and in lights. I would hold her tight, but she won't let me. I would hold her, anyway. If I could hold on, maybe I could push her and my demons away. Maybe I could keep her from wriggling out of my arms. Maybe I could save her, my father, my mother, and me. If onlys. Whys and whynots are tiresome.

*You can't love her. Don't even start with us. She's evil! You'll pay for this.*

I know. I always do. But, I don't know any more what the enemy is: innocence, knowledge, neglect, presence, time, what we see or what we fail to notice, what we do or don't, when we love and when, when we don't.

*All your spew is impressive. You are mocked despite your puny fists! And! We get the last word. We always do, mincemeat.*

**Carroll Ann Susco**

## Through the body

'She's not made of glass'  
they'd say to each other  
but I shattered,  
five times a day, when the white plates  
were placed in front of me,  
the droplets of oil  
hung as noxious as petroleum  
I saw my cells growing like tumours  
I felt them as yellow as pus,

I walked to flush the badness out  
I ran so darkness would not catch me  
and the cold,  
it reached in to squeeze my wasted heart  
and the wind was metal.

This cocoon body was empty  
I was my own sightless stare  
the blur of lights and numbers  
acid that burnt;

I searched my room for a needle and thread  
to sew my own mouth shut,

because the things we cannot say  
we say through the body,  
even the things we hide from ourselves,

I choked on a shame so strong I couldn't even swallow  
my own spit.

Some things can only be healed through the telling.

## Zoetrope

You came from your parents,  
already a bottle slugged  
and still you chugged one shot, two,  
whisky wine bitters, even Malibu.

Like a spinning top you spun  
from guest to guest  
from room to room,  
whirling dervish, glitter bomb,  
an astronaut, a bird that flew.

'I'm so happy!' you cried  
arms stretched wide  
with your Polaroid and its singular eye.  
Each blink a photograph,  
a fade from grey to bright,  
Zoetrope spirals,  
the film whorls into night

Staggering now, an evening gone bad, you said:  
'One day pictures will be all that I have'



*Through the Body & Zoetrope by Poppy Lingham*

# Psychiatry in France: Workers Strike Back.

*STAN MILLER reports on a recent strike of mental health workers protesting at the lack of decent psychiatric provision.*

The French president Emmanuel Macron and his Minister of Health, Agnès Buzin, are very clear about their priorities, and public health is not one of them. In 2019, the budget for healthcare will only increase by 0.002% (400 million euros) whereas inflation was 2.4% last year. Hospital deficit is somewhere between 1.2 and 1.5 billion euros and the directives from the ministry are clear: a balanced budget for hospitals no matter the cost. Therefore, personnel cuts and decreasing level of care. The psychiatric hospitals are among the hardest hit because their mission — to protect the weakest — is not in line with the government's neoliberal policies. To put it simply, the government is at the same time locking up a lot of people that it considers dangerous and not providing them with actual care, and putting a significant amount of people in the street who still need care. However, the employees of psychiatric hospitals are fighting back.

In 2018 a very impressive hunger strike, at Le Rouvray near Rouen, and strikes (like at Le Havre where the strikers occupied the roof of the building) culminated in victories. Management committed to hiring adequate staff numbers and providing more beds. The most recent of these movements is occurring at the Pinel Hospital in Amiens, Picardy.

In Pinel, 80% of the employees are on strike since June 15th, and have been camping out in tents in front of the hospital since then. According to management, the percentage of strikers is lower because some nurses are required to do mandatory work due to the nature of their work. All the different kinds of personnel are represented: clerical, nurses, cleaning, etc. The families of the patients are very supportive of the strike. The strike has made it to the national media in the past weeks. The main demand is an end to the attacks on public services and ensure that the staff have what they need to care for people. Now 25 patients are cared for frequently by only two nurses.

It is interesting to note that while 2000 beds were closed at the hospital, 2000 spots were opened in local prisons. The short staffing also has an impact on consultations. Frequently, to get a first free psychiatric consultation, one has to wait a year, if not more, and then you only get one every three months. One of the consequences is that private clinics are opening just in front of the hospital so that those who can afford it can receive proper care.

The traditional unions – CGT, FO and SUD – support the movement but it is led by a general assembly of all the striking workers. The general assembly has created several groups to manage the Facebook and Twitter accounts, and one for the local and national press. On October 5th, the CFDT union which did not take part in the strike demanded to be included in the negotiations: the workers and their representatives walked out by saying that only the people who strike can be represented in the negotiations. Finally the CFDT stepped out discretely... The strikers also created links with other hospitals and workplaces. One million euros has already been allotted to the hospital due to the strike by the regional health board (ARS): now is the time to discuss how this million is going to be used. ■



# NEWS & REPORTS

## SUICIDES IN MH UNITS: RECENT FIGURES

Data collected from England's NHS trusts by the Care Quality Commission (CQC) shows that from 2010 to 2016, 224 patients in mental health units died of self-inflicted injuries: 134 men and 90 women. All had been compulsorily detained and were deemed a risk to themselves or others. Over the seven years, nine young women and girls aged under 20 died by their own hands in mental health units, compared with four young men. This trend is at odds with men's much higher risk of suicide generally, and has led to claims that NHS care for women with mental health issues is "not fit for purpose".

Campbell, D (2018) More than 200 suicides recorded at mental health units over seven years *The Guardian* 14 Aug.

## UNIVERSITY FAILS TO HELP SUICIDAL STUDENT

Student mental health is increasingly in the news. Bristol University has seen ten sudden deaths amongst students since October 2016. Twenty-year-old Natasha Abraham, a second year physics student, died in April. Two months earlier, she had emailed a university manager saying: "I wanted to tell you that the past few days have been really hard. I have been having suicidal thoughts and to a certain degree attempted it." There appeared to have been no direct contact with student wellbeing services, according to her family. They also expressed concerns about the limited contact between Natasha and her personal tutor, and questioned whether sufficient allowances had been made when it became clear that she was struggling with her academic work.

Morris, S (2018) Bristol University did not help suicidal student before she died, coroner hears. *The Guardian* 22 Aug.

## NEW MINISTER FOR SUICIDE PREVENTION

Suicide rates have been gradually falling, but every year 4,500 people in England still take their own lives. This summer an online petition calling for a minister for suicide prevention received 400,000 signatures, and in October – as ministers and officials from more than fifty countries assembled in London for a summit on World Mental Health Day – health minister Jackie Doyle-Price was appointed Minister for Suicide Prevention. The government also promised more mental health support in schools, and pledged £1.8m to the Samaritans to keep their free helpline going for the next four years.

World Mental Health Day: PM appoints suicide prevention minister (2018) *BBC News* Oct 10.

## YOUNG PEOPLE'S MH WORSENS OVER 20 YEARS

Drawing on 36 national surveys and the experiences of 140,830 young people, a study in *Psychological Medicine* finds that between 1995 and 2014, in England the proportion of 4–24 year-olds with a mental health condition rose six-fold: from 0.8% to 4.8%. Recently there have been significant increases in the number of children and young adults reporting anxiety and depression, and also in self-harm – resulting in long waiting lists. This study suggests that the increase could be due, in part, to young people becoming more willing to acknowledge mental health issues and to seek treatment.

Campbell, D (2018) Mental health issues in young people up sixfold in England since 1995 *The Guardian* 11 Sep.

## BIG RISE IN OVERDOSES AMONGST YOUNG PEOPLE

An NHS-funded study finds the number of children, teenagers and young adults in England who were poisoned by painkillers jumped fivefold between 1998 and 2014. Two-thirds (66.5%) of the incidents were intentional, and those who poisoned themselves were up to 32 times more likely to die by suicide in the 10 years after their overdose.

The findings are based on the medical records of 40,333 self-poisonings among 31,509 children and young people (aged 10–25). The study also found: a three-to-fourfold increase in the numbers poisoned by antidepressants; a trebling in those who needed medical treatment after taking too much aspirin or anti-inflammatory drugs, such as ibuprofen; and a threefold rise in women poisoned by paracetamol. Young women were more likely than their male peers to experience distress in a way that prompted them to self-harm.

Campbell, D (2018) Sharp rise in young people overdosing on painkillers and antidepressants. *The Guardian* 11 Sep.

## 80% OF GIRLS HAVE SERIOUS MH PROBLEMS AFTER SEXUAL ASSAULT

New research finds that four out of five teenage girls who have been sexually assaulted suffer from serious mental health problems – anxiety, depression, post-traumatic stress disorder and other conditions – four to five months after the assault. This confirms that victims of abuse in childhood are likely to develop mental health issues that may persist into adulthood and last a lifetime.

Previous research by Agenda, which campaigns on the risks faced by girls and women, found that more than half of women struggling with a mental health problem had experienced some kind of abuse, and that experiencing both abuse and poverty was associated with the poorest outcomes.

Campbell, D (2018) 80% of teenage girls suffer serious mental illness after sexual assault. *The Observer* 22 Jul.

## **BIG CUTS IN MH BEDS, NURSES & SHRINKS SINCE 2009**

In 2012 the Health and Social Care Act said there must be “parity of esteem” between physical and mental health. Yet the number of hospital beds for people with acute mental health conditions (where a consultant psychiatrist is oversees treatment), has fallen by almost 30% in England since 2009. Patients can be sent hundreds of miles from home to access inpatient care.

New NHS figures show that the number of beds for those with some of the most serious conditions (e.g., psychosis, serious depression leading to suicidal feelings, and eating disorders) fell from 26,448 in 2009 to 18,082 in the first quarter of 2018. Over those nine years, the data also shows a significant drop in the number of NHS mental health nurses – from 46,155 to 39,358 – and in the number of doctors in specialist psychiatry training – from 3,187 in 2009 to 2,588 in early 2018.

Helm, T & Campbell, D (2018) Number of NHS beds for mental health patients slumps by 30% *The Guardian* 21 Jul.

## **MH STAFF CRISIS WORSENS**

In July last year, as part of an ambitious plan to treat an extra million patients a year and provide 24/7 care, health secretary Jeremy Hunt promised 21,000 more nurses, therapists and psychiatrists in the mental health workforce by 2021.

This looks like pie in the sky. According to the Department of Health and Social Care (DHSC), in the year June 2017–May 2018, NHS England lost 23,686 MH staff. This is one-in-eight of the sector’s workforce, and at the end of June one-in-ten MH posts were unfilled. The clampdown on NHS pay since 2010 has hit staffing levels, and Brexit will probably make things worse. Official figures show that understaffing across the NHS as a whole is the worst it has ever been: a record 107,743 vacancies includes a shortfall of 11,576 doctors and 41,722 nurses.

Campbell, D (2018) NHS mental health crisis worsens as 2,000 staff quit per month. *The Observer* 15 Sep.

## **USE OF TASERS ON MH PATIENTS**

Since April 2017, the police have to monitor their use of stun guns. They have to keep data on the outcomes of use, as well as the ethnicity and age of the individual targeted, and whether they were perceived to be suffering from mental ill-health. However, only 28 of the UK’s police forces – about half – responded properly to a recent freedom of information (FoI) request. This revealed 96 occasions, in just over a year, where mental health patients (some under eighteen) had a taser drawn, aimed or fired at them in a mental health care setting. Liberal spokesman Norman Lamb said such information should be publicly available, commenting that it was “extraordinary” that so few forces had responded to the FoI request.

Marsh, S (2018) Police used stun guns on mentally ill patients 96 times in a year. *The Guardian* Oct 1.

## **RISE IN POLICE CUSTODY DEATHS**

The police are often the first point of contact for people with critical mental health issues or addictions. Deaths in police custody are at their highest level for a decade. According to the official watchdog, the Independent Office for Police Conduct (IOPC), while 14 people died in or after detention in the year ending March 2017, 23 died in the year to March 2018. Police, experts and campaigners all agree that austerity and a crisis in the mental health service have driven the figure up.

There were other unwanted records last year. The number of deaths after the use of force or restraint increased, and this included a disproportionate and record number of people from BME communities: while there were 3 out of 11 such deaths in 2015–16, in 2016–17 there were 5 out of 15.

Dodd, V (2018) Police custody deaths hit 10-year high, with experts citing austerity. *The Guardian* 25 Jul.

## **COGNITIVE & MH EFFECTS OF AIR POLLUTION**

95% of the world’s population breathes polluted air, and each year it causes 7 million premature deaths. Harm to people’s mental abilities is not so well known, but now, by testing language and arithmetic skills, a big Chinese study finds that on average the impact of high levels of toxic air “is equivalent to having lost a year of education”. The effect is worse for older people (especially those over 64), for men, and for those with who have had less access to education. Air pollution was also found to have a short-term impact on intelligence.

Other research has found that toxic air is linked to “extremely high mortality” in people with mental disorders, linked it to increased mental disorder in children, and found those living near busy roads had an increased risk of dementia. Road traffic is the biggest contributor to air pollution in residential areas.

Carrington, D & Kuo, L (2018) Air pollution causes ‘huge’ reduction in intelligence, study reveals. *The Guardian* 27 Aug.

## **DISUSED HEALTH CENTRE TO MAKE WAY FOR MENTAL HEALTH HUB**

A disused health centre will be transformed into vital housing and a “crisis café” for people with mental health issues, under new plans unveiled by Haringey Council.

Cabinet gave the thumbs up to proposals to buy Canning Crescent Health Centre in Wood Green and repurpose the building into a multi-use mental health hub, with 21 sheltered housing units and a crisis café – a dedicated space for people with mental health needs to drop in for support. Clarendon Recovery College will also be relocated to the site.

# SUMMIT ON GLOBAL MENTAL HEALTH SPARKS CRITICAL RESPONSE FROM SERVICE-USERS AND RIGHTS-GROUPS

Mental health service-users, rights-groups and professionals advised caution before implementing a 'scaling up' of mental health care globally.

On October 9<sup>th</sup> and 10<sup>th</sup>, 2018, World Mental Health Day, the UK government hosted a Global Mental Health Ministerial Summit with the intention of laying out a course of action to implement mental health policies globally. In the same week, The Lancet Commission on Global Mental Health and Sustainable Development published a report outlining a proposal for "scaling up" mental health care globally. In response, a coalition of mental health activists and service-users have organized an open letter detailing their concerns with the summit and report.

The open letter raised several concerns with the positioning of the UK summit and calls on the organizers and leaders of the event to reflect on issues of discrimination and human rights abuses in mental health treatment in their home countries before recreating these systems abroad. The signatories raised the issue of representation and participation:

"Significantly, there has been little or no involvement of organisations led by mental health service users, survivors and persons with psychosocial disabilities in the thinking, planning and design of this event. While a few networks were approached to provide 'experts by experiences' to attend panels on themes already decided on, there has been no meaningful consultation or involvement of user-led and disabled people's organisations not already signed up to the 'Movement for Global Mental Health' agenda or funding to enable a wide range of representatives to attend."

Jhilmil Breckenridge, a poet, writer and activist and founder of the Bhor Foundation in India, believes that it is a matter of concern that the plan being discussed in the UK this week "will just be 'dumped' into low resource settings with programmes planned in India, Ghana, Nigeria, Uganda and Kenya."

"There needs to be more thought as what works for an anti-stigma campaign in a first world country

will definitely not work in the same way in a country like India," she said. "In addition, these kind of campaigns continue to perpetuate an ableist lens, one that may portray a person with psychosocial disability as a 'burden' and an economic cost. The language needs to change, the lens needs to change, and we certainly should not be 'dumping' or 'exporting' medication, treatment, or marketing plans to these countries. Furthermore, there are problems other than stigma that need tackling first in a country like India, and the words 'stigma' and 'recovery' are all ableist concepts that need more critical thought."

In the latest report, the Lancet commission places an increased emphasis on a "rights-based" approach and demonstrates a greater appreciation for cultural differences and respect for the lived-experiences of those affected than previous reports. However, scholars and activists have raised issues with the details of how the global mental health movement will be implemented.

Dr. China Mills, a leading scholar in the field of global mental health, raised concerns that "while the Commission talks about partnership with people with psychosocial disability, the production of the Report did not involve consultation with experts by experience, who should be involved right from the start". She also takes issue with the way the Report frames "mental distress as an economic burden, which while perhaps successful in getting governments on board, also risks constructing distress in stigmatizing and discriminatory ways (e.g. as 'costly' and burdensome), and overlooks the economic and political determinants of mental distress."

Lisa Cosgrove, PhD, a psychologist and Professor at the University of Massachusetts Boston along with her doctoral students, has organized professionals in support of the open-letter. She explained that attention should be given to the voices of mental health service-users and activists who "challenge the current paradigm of mental health care." "Scientific research, as well as the lived experience of those who have been diagnosed with a mental disorder, points to the need for change."

In an interview with UMass Boston doctoral student Justin Karter, psychiatric epidemiologist, Dr. Melissa Raven, from the University of Adelaide in Australia, took issue with the numbers being used to justify the urgency of the global mental health movement. She explains that "these alarming statistics about the prevalence of mental disorders and the treatment gap" contain multiple issues including, "the validity of using diagnostic criteria that have been developed in Western settings and using them in other countries, particularly lower and middle-income countries." ■

# Asylum, the radical mental health magazine

We have changed the name of Asylum, to the radical mental health magazine. We used to be called the magazine for democratic psychiatry because we were inspired by the Italian movement to close down large mental hospitals and develop more democratic mental health services. We are still proud of our roots but we want to extend our reach, beyond psychiatry or even 'democratic' psychiatry. We are also influenced by the psychiatric survivor and Mad liberation movements and people have told us over the years that they think democratic psychiatry is an oxymoron. We don't know if we agree, but we do want to keep it an open question.

## Help us extend our reach

We depend on our readers to get the word out about Asylum magazine. We want to extend the reach of the magazine and get it bookshops; libraries and services. Can you help?

- **Can you buy a subscription for a family member or friend? It'd make a great Christmas present!**
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**Many Thanks!**

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Send creative writing and poetry submissions to:  
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For reasons of editing and printing, please send any graphics as jpegs (or equivalent) with a resolution of at least 300dpi.

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