# Challenging ideas in mental health

## 18 hours study

## Level 2: Intermediate

# Challenging ideas in mental health

# Contents

# Introduction

This course takes you on a journey of discovery where you are invited to challenge ideas, both new and old, in relation to mental health. It is made up of a series of three extracts. The first extract, ‘Boundaries of explanation’, sets out the theme of boundaries: boundaries within and between groups; within and between explanatory frameworks; and within and between experiences of mental health and distress. The second extract, ‘Whose risk is it anyway?’, considers a critical account of the increasing focus on risk (particularly risk to others) in policies and professional practice since the 1980s. The third extract, ‘The business of madness’, looks at two controversial areas of mental health: the growth of mental health as a business, driven in part by market forces, and the profit motive.

This OpenLearn course provides a sample of Level 2 study in Health and Social Care.

# Learning outcomes

After studying this course, you should be able to:

- understand the complexity and dilemmas of diverse perspectives in the field of mental health and distress
- undestand the importance of service users/'survivors' experiences and perspectives
- understand how mental health issues affect everyone
- understand the range of risks faced by service users/'survivors' in their everyday lives.

# 1 Extract 1: Boundaries of explanation

## 1.1 Introduction

This extract looks at what we are calling ‘boundaries of explanation’. It tackles key issues such as:

- What are mental health and distress – and who decides?
- What are the views of people who have acquired a label of ‘mental illness’?
- What are the views of those who determine – and patrol – the boundary between mental distress and ‘normality’?

The extract looks at language and terminology and the differences between people. It looks at medical and social models, and their competing claims, and introduces a holistic model which embraces key aspects of both approaches.

## 1.2 Boundaries of exclusion

The first idea to come under critical consideration is that of boundaries. Boundaries can be helpful and, indeed, we use them here as a means of exploring different, and competing, explanations of mental health and distress. However, they can also be limiting and excluding, emphasising the differences between people, some of which run very deep. At their simplest, boundaries put limits on tasks so that they appear manageable. They help to mark out personal space in a shared office, or indicate the extent of someone's home and garden. Boundaries are often physical, represented by partitions or walls or fences, to show who is allowed in and who is not (and under what terms).

The sorts of boundaries we consider here are more *social* than physical. They also define ‘who's in and who's out’, as Shakespeare's King Lear explains:

> So we'll live,
>
> And pray, and sing, and tell old tales, and laugh
>
> At gilded butterflies, and hear poor rogues
>
> Talk of court news; and we'll talk with them too –
>
> Who loses and who wins; who's in, who's out –
>
> And take upon's the mystery of things …

(King Lear, Act V, Scene iii, lines 11–16)

The king at this point was excluded from the royal court and was more at one with the ‘poor rogues’ on the outside. This was because he had crossed a social divide – into madness. He was on the other side of a crucial social boundary that determines ‘who's out’ on account of their mental distress. In many ways, social boundaries are the most pervasive. They serve to exclude people who look or behave differently, and they are much harder to shift than a garden fence.

## 1.2.1 Boundaries and terminology

In another context Shakespeare asked, ‘What's in a name?’, and suggested by way of an answer that a rose may smell as sweet whatever it is called. In the context of social boundaries, however, the language used is actually very important in determining ‘who's in’ and ‘who's out’.

### Activity 1: Looking at language

1 hour 0 minutes

What is the language of mental distress? Who are the people who experience it?

Make a list of all the words you can think of (in past as well as present usage, and including colloquial and slang words) that describe the condition or experience. Then list the words used to refer to the people who have the condition or experience, again including slang terms.

Then read the articles by Rachel Perkins and Diana Rose (Readings 1 and 2 below) and write a short summary of the authors' views on language and terminology.

Click to view Reading 1.

Click to view Reading 2.

View discussion - Activity 1: Looking at language

What are we to make of this? One conclusion to be drawn is that there are no easy answers to the question of what terminology to use, nor any ready-to-use terms that are acceptable to everyone. However, this course aims to draw on these accounts – and the accounts of others – to use language that is acceptable and meaningful. This probably means using ‘mental distress’, but not in a way that demeans or trivialises. Instead, it means taking a positive stand – celebrating difference and diversity, valuing people's experiences of mental distress and supporting their rights, especially their right to be included in the mainstream of society.

## 1.2.2 Boundaries of difference

One of the things that language does is define and give a name to differences between people – to delineate the boundaries that separate them. In the mental health field, the

'mad' are at one end of the social divide that separates the 'normal' from the 'abnormal'. They are 'the other', a point made in the article by Perkins (above): 'To be mad is to be defined as "other"'.

This is a recurring theme in the mental health field. In the following passage Abina Parshad-Griffin, Chair of the Mental Health Action Group for the Disability Rights Commission (DRC), reflects on 'otherness' and what it means to be 'the other':

> I could use different aspects of who I am that make the whole of me, as a kind of through-the-looking-glass. And I can give an example: being mixed race, if I had to fill in different forms in various countries, I'd have to tick different boxes. So in South Africa, I would have been 'coloured'. In America, I would be 'black' because one drop of Black blood makes you 'black', and excluded. In South America, I could possibly be 'mixed race', or I could even pass for 'white' when you have the hierarchy of colour coding. But guess what I'm called in England or the UK? 'Other'. And it's that otherness that is part of my identity, and I believe that mental health discrimination is that otherness which is sometimes indefinable. But you pick it up – this overt and covert discrimination. I call it 'psychophobia': fear of mental illness. And there are certain conditions. Like somebody asks me, 'What do you do?' And I say, 'Schizophrenia.' You know that's going to be a conversation-stopper and you will also know that it's going to be associated with violence, with antisocial behaviour, which is not at all the case. That's rare.
>
> (Disability Rights Commission, taped conversation, n.d.)

To be 'other', in many instances, is to be on the wrong side of the boundary. The fact that Parshad-Griffin is mixed race gives her an officially designated category of 'other' in the UK. In addition, of course, her experience of mental distress reinforces her 'otherness'. To be regarded as 'other' is to be treated differently, which often means prejudice and discrimination. 'Otherness' comes into play at all levels, but especially, it seems, when mental distress triggers 'psychophobia' in the people around. Although Parshad-Griffin's situation also features 'double discrimination' (Baxter et al., 1990) because of her mixed race designation, in many ways it is typical of the experiences of people who have periods of mental distress. Psychophobia leads to prejudice and discrimination. This may be something you have experienced yourself or have witnessed in others.

The point of creating 'others' or a 'them', according to Harper (2002a, p. 8), is that it projects problems on to other people so that we 'get to see ourselves as normal'. May (2000) suggests that the 'us' and 'them' ideas that are prevalent in the mental health services should be challenged: 'Such ideas assume that there are "ill" people and there are "well" people, and an uncrossable void exists between them' (p. 25).

Being seen as someone with mental health problems may result in discrimination, often of a severe kind, as many people have found to their cost. The experience of

being on the ‘other’ side of the mental health/distress boundary may be accompanied by unemployment, breakdown of relationships, low income and poor housing.

## Activity 2: A quiet night on Roundhay Wing

1 hour 0 minutes

You should now watch the three video sequences below, ‘A quiet night on Roundhay Wing’. This is a story of people who have been designated as ‘other’ and confined to the psychiatric wing of St James's Hospital in Leeds.

The film was scripted and acted by mental health service users/survivors. It is hard-hitting, especially in its references to the people and practices that have dominated – and defined – their lives, often over many years. It is a true story in the sense that it is grounded in and reflects people's real experiences, but the events portrayed did not actually take place.

Watch the video clips now. When you write your notes afterwards, you may find it helpful to divide them into:

- your *reactions* to what you saw and heard; in other words, what you felt as you watched it;
- your *reflections* on the key messages: what you thought after the film had ended.

Click below to view video clip 1. ( Part 1: 10 minutes)

Video content is not available in this format.

Clip 1

View transcript - Clip 1

Click below to view video clip 2. (Part 2: 4 minutes)

Video content is not available in this format.

Clip 2

View transcript - Clip 2

Click below to view video clip 3. (Part 3: 10 minutes)

Video content is not available in this format.

Clip 3

View transcript - Clip 3

View discussion - Activity 2: A quiet night on Roundhay Wing

# 1.2.3 Boundaries of 'normality'

The origin of the 'other' in society is the widespread human tendency to create categories where people who don't fit in can be placed away from the mainstream. Social categories may lead to prejudice and discrimination, but may also lead to the physical separation of people to the margins of that society. Sibley (1995) traces the physical marginalisation of people in what he calls the 'geographies of exclusion'. Part of the process of exclusion is where the 'bad', the 'mad' and the 'imperfect' are deemed to be 'other' and, often in stereotyped form, are disregarded or rejected.

Being the 'other' in mental health terms means being on the 'them' side of the normality/abnormality boundary. What does it mean to be regarded as abnormal? Indeed, what is the nature of mental distress? What does it mean to have mental health problems? It all depends on where the boundaries are drawn, and by whom. A boundary may often be drawn, for example, in a way that differentiates mental distress from ideas of what constitutes mental health and wellbeing. A person experiencing mental distress is, therefore, at least temporarily on the other side of the divide from those who are 'normal' or 'sane'. Boundaries divide and define, but do they help to explain?

A recent definition of mental disorder states that '"Mental disorder" means any disability or disorder of mind or brain which results in an impairment or disturbance of mental functioning; and "mentally disordered" is to be read accordingly' (Department of Health, 2002, p. 3).

So that's clear, then. Or is it? The concept of disorder suggests its counterpart – that there is some sort of mental 'order', an internal state where there is calm and coherence. The boundary between mental health and mental disorder is also concerned with the controversial idea of normality and what society regards as normal (Coppock and Hopton, 2000). It may be more helpful, in human terms, to think of a continuum of mental health and distress. Instead of being on one side of a social divide or the other, we are at varying points on the continuum and can move along it, back and forth, stopping and (re)starting as life changes. This is a more inclusive way of thinking about mental distress, avoiding the fixed boundary between 'them' and 'us', and allowing everyone to move between points as circumstances change and episodes of distress come and go.

This is not a view shared by everyone. In the article by Rachel Perkins (Reading 1) that you read in Activity 1, she argues against the notion of a continuum on the grounds that it disguises and diminishes real differences between people. What needs to change, in her view, is the value we give to those differences. What do you think? The next activity gives you the opportunity to reflect on what 'normality' means.

## Activity 3: What is mental 'normality'?

0 hours 20 minutes

Think about what normality means to you. In what ways do you consider yourself to be normal? Note down some thoughts and, if possible, discuss your views with someone else.

View discussion - Activity 3: What is mental 'normality'?

It is interesting to think about how normality and abnormality come to be defined in society. This point is taken up by Shaw and Woodward (in press), who suggest that people are less tolerant of unhappiness. This has led to more and more medicalisation of what at other times and in other countries might be regarded as normal human distress. Another take on the pathologising of day-to-day life experiences is the (rather tongue-in-cheek) concept of happiness as an abnormal state (Bentall, 1992). It is abnormal in the sense that it is not something experienced as ordinary and everyday. There are, of course, dangers in extending the boundaries of abnormality ever further, and the absurdity of classifying happiness as 'a major affective disorder, pleasant type', for instance, is plain to see. The nature of normality is contested, and so too is the nature of mental illness or distress. In the next section, we look at competing explanations of mental distress.


# 1.3 Ways of viewing mental distress

The first point to note is that there are two key competing ways of viewing mental illness or distress: physical and social. One of the functions of this course is to draw together aspects of these accounts in order to cross the boundaries that they create and maintain. Our aim in this respect is to devise a third way, a more rounded and holistic approach that brings together the best of both worlds. In the meantime, though, the physical and social explanations predominate. Physical explanations are based on, for example, notions of brain dysfunction or genetic predisposition. Mental distress, in those terms, is a disorder of the mind, akin to a physical illness. Social explanations, on the other hand, are based on an understanding of difference and discrimination: on structural factors in society that separate people and may come to oppress them. Another way of understanding mental distress – and this links with our 'third way',

the holistic (whole person) approach – is to view it from the standpoint of those who have experienced it. This is an important vantage point. The next activity invites you to read, and reflect on, the personal experiences of one woman who has experienced mental distress.

## Activity 4: Personal experiences of mental distress

0 hours 30 minutes

Read the short extract below by Veronica Dewan. Make notes on how she explains the origins of her mental distress.

### Veronica Dewan

I became engaged in an official system of care at birth, a system that denigrated my Indian heritage, a system that made meaningless my true identity. It was my first encounter with social services in 1957 at six weeks of age – an illegitimate, 'mixed race', hard-to-place baby. […]

Several inpatient admissions to an acute psychiatric ward compounded childhood and adult experiences of racism, misunderstanding and intimidation. I persisted with suicidal plans and attempts, and was severely depressed, with psychotic episodes of manifestations of my adoptive mother's attempts to kill me as a child. The underlying requirement of the psychiatric system appeared to involve fully internalising the racism, to make me completely ill forever. […]

As I challenge more and more my own perceptions, question their origins and try to understand my place in the world, I believe that the official care system tried to silence me into living a life that was not my own. While institutional racism continues, by its insidious nature, to cause so much unarticulated pain, I have to be vigilant in holding onto my right to exist, as a Black woman of dual heritage. The people who have no interest or motive in controlling me, but only a willingness to engage through mutual love, acceptance and respect, are those who remain in my life.

(Source: Dewan, 2001, pp. 44–9)

View discussion - Activity 4: Personal experiences of mental distress

Is mental distress a cry for help? Is it a form of resistance? Or is it a response to 'unarticulated pain'?

# 2 Extract 2: Whose risk is it anyway?

## 2.1 Introduction

Western society is increasingly preoccupied with concerns about risk, so much so that some sociologists now define it as 'risk society' (Beck, 1992). It is argued that people in general are experiencing heightened levels of anxiety in response to rapid technological and social change. News stories in the media are filled with warnings and dire predictions for the future. This is particularly true when the potential consequences appear to be both catastrophic and difficult to predict, such as nuclear accidents, BSE ('mad cow disease'), and so on. Intense pressure is exerted on politicians and others, particularly through the media, to prevent disasters and take the blame when they occur. As one commentator puts it, 'Safety has become the fundamental value of the 1990s' (Furedi, 1998, p. 1).

Risk has certainly become a central concept in mental health policies and practice, particularly since the implementation of community care in the early 1990s. Community care policies have been highlighted both by the media and by government as a failure, partly because they have failed to provide service users/survivors with the support they need in the community. However, they are also regarded as a failure because of the *perception* that they have led to an increased risk of violence by people experiencing mental health problems. The focus has been on homicide in particular. It is important to emphasise that this is a perception rather than a fact, because research evidence strongly suggests that there has not been an increase in homicides by people experiencing mental health problems. In this extract you will critically examine the way risk has become a central concept in mental health policy. You will explore why this may have happened and the impact it has on the experiences of service users/survivors and on professional practice.

The next section addresses the way risk is defined, and highlights the fact that risk is a problematic concept. The extract then moves on to explore the concept of risk in mental health policies. It also looks at the impact of the new 'culture of risk' on both service users/survivors and mental health professionals.

## 2.2 What is risk?

'Risk' is a word which is used frequently and in many different contexts. On the face of it, it can seem as though the word has a clear meaning, but when you start to examine the different ways it is used it seems less straightforward. This is because 'risk' is not a real thing in the world, it is a *concept*, which simply means it is an idea expressed in words. In fact, the more you explore it, the more you realise risk is a problematic concept: it has been defined in a number of ways and so means different things in different contexts and to different people. There has been a lot of debate about the meaning of risk in recent times because it is seen as increasingly central to modern life. This section explores the meaning of risk and looks at the different explanations offered for its increased prominence. Examining how people use the

word in everyday life may help to unpack its meaning, and so this is the focus of the next activity.

## Activity 5: Exploring the meaning of risk

0 hours 15 minutes

Take a few minutes to think about how you would define the word risk and make a note of your ideas. If you get the opportunity, ask other people what they think the word means, and make a note of what they say too. Look out for two important ideas: that risk involves the chance, likelihood, or probability (or similar words) of something happening, and it often involves the chance of something 'bad' happening or something 'good' happening, or perhaps both.

View discussion - Activity 5: Exploring the meaning of risk

The likelihood of something happening can be assessed in two ways: in mathematical or in more qualitative terms. The mathematical approach involves measuring the probability of an event occurring and giving a figure that summarises the risk. For example, before consenting to an operation a patient might be given a figure that describes the likelihood of the procedure being successful, such as 'a 1 in 100' chance of success. This would mean for every 100 patients who had undergone the same operation, it had been a success for one of them. Of course, this means it had been a failure for the other 99. This would clearly not be as good as being told there is 'a 1 in 2' chance of success, which would mean the operation had been a success for one out of every two patients. Qualitative approaches use words instead of figures, by saying the likelihood of an outcome is, for instance, 'quite likely', 'very likely' or 'very unlikely'. In both mathematical and qualitative approaches, some assessment of the likelihood is being made.

In the context of mental health, a similar distinction is drawn between two kinds of risk assessment: 'actuarial' and 'clinical' (Parsloe, 1999). Actuarial risk assessments use statistical information about populations to help make decisions about who may be 'at risk', depending on whether or not they belong to a high-risk group. For example, in suicide risk assessment it is known that higher-risk groups are people who are older, male, separated, divorced or widowed, live alone, are unemployed or retired, are in poor health, have a mental illness, or abuse substances (Alberg et al., 1996). Clinical risk assessment is when professionals use their informed judgement to assess the level of risk. This judgement may be based on experience as much as statistical knowledge about risk factors. Most risk assessment involves some combination of these two approaches.

Closely linked to the likelihood of an outcome occurring is the second important aspect of defining risk, which is the nature of the outcome. To continue the example of a medical procedure, a patient might be making a decision about a relatively minor operation which involves only local anaesthesia. The possible outcomes associated with such minor surgery are normally far less serious than those involved in an

operation under general anaesthetic, because the general anaesthetic itself carries some degree of risk. So, decisions about risk often involve consideration not only of how likely an event is to happen, but also what the consequences might be if things go wrong: whether it is ‘high consequence’ or ‘low consequence’.

Some definitions of risk incorporate the possibility of good outcomes as well as bad. For example, if you buy a lottery ticket, you might say that you are taking a ‘risk’ because there is a chance of a bad outcome (you might lose your money) or a good outcome (you might win some money back). In fact, this association between risk and gambling goes back a very long way, at least to the seventeenth century. An argument has been proposed in the mental health literature that we need to return to this way of thinking about risk. This would mean seeing risk assessment as a way of *balancing* the possibility of good outcomes against the possibility of bad ones (Davis, 1996).

However, a number of commentators have argued that risk is not really thought of in terms of balancing good and bad outcomes any more. They argue that in Western societies risk now generally refers only to the possibility of a bad outcome and there are important reasons why it has taken on this meaning. Mary Douglas (1992) is one of the most influential thinkers in this area and she argues that risk in modern Western societies now equals danger: ‘the word *risk* now means danger; *high risk* means a lot of danger’ (Douglas, 1992, p. 24).

Danger is clearly a word associated with negative outcomes. For Douglas, one of the reasons the word risk is more prominent is that it implies a rational, scientific capacity to measure danger accurately. It is therefore well-suited to modern industrialised societies where there is rapid technological change. This is because, as you have already seen, risk is associated with words like ‘probability’, where an estimate can be given for the chances of something occurring in mathematical terms. The appeal of risk is that it gives us the sense of dangers being measurable scientifically and therefore manageable.

Douglas has also argued that risk has become a central concept in modern life because it has a ‘forensic’ function. Blame is primarily centred on the failure of someone to assess risk accurately and then to take the steps necessary to prevent a tragic incident. So the concept of risk enables people to look back at tragic events and attribute blame for them to someone else. The media play a key role in shaping how we all think about risk and the process of attributing blame. The next activity focuses on risk-related stories in the newspapers to explore how risk issues are presented in the media. This may help clarify further some of the complex issues to do with risk you have considered so far.

## Activity 6: Exploring risk in the media

0 hours 30 minutes

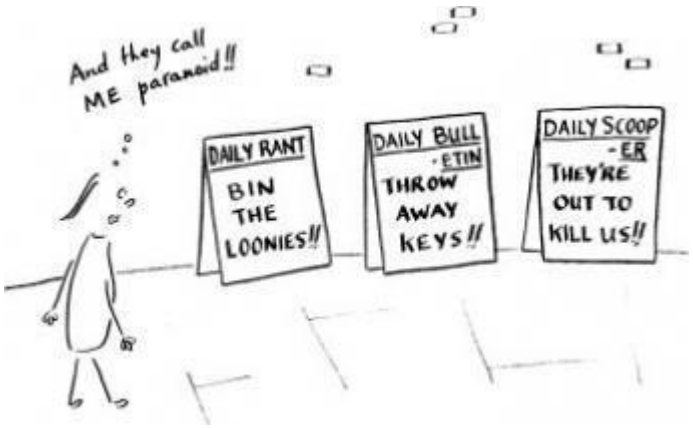
Look at two newspapers that are clearly aimed at different sectors of the population (such as the *Independent* and the *Sun*, or the *Guardian* and the *Daily Mail*) from the past few days. Scan the headlines for stories that are concerned with risk in some way.

Some may actually have the word ‘risk’ in the headline, but most will not. You may find risk-related words such as danger, hazard or warning instead. Read through the articles you find and start to analyse the way risk is being presented. Look out for the dimensions of risk you have already considered in this section as follows:

- the likelihood of something happening (which might be expressed mathematically, i.e. using statistics, or qualitatively);
- a focus on bad outcomes as opposed to good ones;
- the seriousness of the outcome;
- whether anyone is being blamed.

Make a note of what you find under a separate heading for each newspaper.

View discussion - Activity 6: Exploring risk in the media




This activity suggests another important dimension of risk, which is that risk is *political*. The way risks are presented in different parts of the media and elsewhere vary according to the perspective of the groups or individuals concerned. These different perspectives often come into conflict with one another. Some groups may seek to ‘play down’ a risk, while others may seek to magnify it. Some kinds of risks are given greater weight than others because of what they mean, culturally or politically, and so the amount of attention different risks receive is not always proportionate to the actual likelihood of an event occurring. One of the best examples of this is in relation to child mortality. The biggest single risk facing school-age children is road accidents. However, this kind of risk receives far less attention in the media than child abduction and murder by a stranger, which is presented as an increasing problem, despite the evidence to the contrary:

> Many parents simply do not believe that, over the years, the number of children murdered by strangers has remained fairly static. On average it has been five per year. A few highly publicised child murders have helped shape the impression that such tragedies ‘could happen to every child’.
>
> (Furedi, 1998, p. 24)

Another good example of disproportionate attention given to low probability events in the media is the focus on homicide by someone experiencing mental health problems. It is argued that this has been one of the most significant contributions to the 'fear factor' about mental health since community care policies were introduced. It has been noted that modern images of people experiencing mental illness as a danger or threat have been linked to 'violent masculinity' (Pearson, 1999, p. 166). In mental health terms, the reporting of negative images of mental disorder, particularly stories that relate to violence and especially those that include elements of racist stereotypes of black men, are very powerful (Keating et al., 2002; Sayce, 1995). The next section further explores the central position of risk as a concept in connection with mental health and distress.

# 2.3 Community care, fear and the 'high-risk' service user

So far in this course you have seen how the concept of risk has come to suggest danger. This section explores in greater depth how the changes that have led to this situation have impacted on mental health policies and practice. The next activity involves reading an article to help you consider risk in the context of mental health services.

## Activity 7: Risk and mental health policies

1 hour 0 minutes

Click on Reading 3 by Hazel Kemshall below. As you read, make a note of your answers to the following questions:

- How are risk reduction and risk taking defined?
- According to Kemshall, which of the two is the more dominant in mental health policy?
- What are the main reasons for this emphasis?

Click to view Reading 3.

View discussion - Activity 7: Risk and mental health policies

The major change in mental health policy in recent years has been the shift from asylum care to care in the community. There has been a great deal of debate about whether this policy has been a success or not. The government has stated that community care has failed, and community care policies have also been presented in a negative light in the media. However, one thing is clear: the media portrayal of people experiencing mental health problems in general is overwhelmingly negative. In particular, community care has been linked with an increase in violent attacks by people experiencing mental distress. Community care has been 'socially structured'

so that it is now equated with violence committed by people experiencing a mental health problem.

The debate about the supposed link between mental distress and the risk of violence to other people is fraught with difficulty, and you have already examined some of the issues. Consider for a moment the question of how 'violence' itself should be defined. In some studies, violence has included relatively minor acts which have been excluded from other studies. In other words, different studies have been measuring different things. However, studies do consistently show that the vast majority of people who act violently in our society are *not* experiencing mental distress. The main risk factors for violence are being male, young, less well-off and under the influence of alcohol. Equally, the vast majority of people who do experience mental distress, or have a history of it, never behave violently. To this extent, the link between mental distress and violence is very weak. However, some studies have shown that a small number of people may be at increased risk of becoming violent towards other people, but only when they are actively unwell (Hodgins, 1993; Monahan and Steadman, 1994). It is important to emphasise that this is not the same as saying that *rates* of violence have increased.

In order to make sense of this issue, it can be helpful to focus on understanding the nature of some of the symptoms of some forms of mental distress, particularly paranoia. When someone is behaving in ways that others view as 'irrational', the behaviour still makes perfect sense to that person. For example, if I believed that my postman was in the CIA and was plotting to assassinate me and my family, but there was no evidence that this was true, it could be safely assumed that my belief was 'irrational'. However, within this irrationality, any efforts I made to defend myself, such as barricading my front door or threatening the postman when he delivered the post, would make sense because they would be a 'rational' response to a perceived threat that I was convinced was real. If, at the same time, I was hearing voices that were directing me to attack the postman before being attacked myself, it is not difficult to understand how threats or even violence might be one possible outcome. This scenario illustrates that there is 'rationality-within-irrationality' (Link and Stueve, 1994), particularly with intense feelings of paranoia. When some people are very paranoid and terrified that they might be attacked themselves, a violent or threatening response 'in self-defence' can result. Such behaviour is often completely out of character for those people.

The media present a picture which increasingly links mental distress with violent behaviour. The focus on the rare event of homicides in the community by people experiencing mental distress has resulted in the *perception* that the number of such events has increased under community care. A number of studies have demonstrated this is not the case (for example, Taylor and Gunn, 1999). Most tellingly, the five-year report of the *National Confidential Inquiry into Homicide and Suicide by People with Mental Illness* (DH, 2001) included the following statement under the heading of 'Stigma':

> One of the most distressing problems facing people with mental illness is the prejudice and discrimination they face from society at large. In

> particular, the assumption that they are likely to be violent is painful and destructive. The Department of Health, the Royal College of Psychiatrists and others have attempted to tackle these public perceptions and pejorative press reporting through campaigns that aim to give the facts about the risks presented by the mentally ill. Key findings in this report should be used in this way. For example, the killing of strangers by people with mental illness is rare; most stranger homicides are committed by young men without mental illness who are under the influence of alcohol or drugs. The public may fear the mentally ill but they are more at risk from heavy drinkers.
>
> (DH, 2001, p. 152)

The idea that mental distress can be very frightening, for both those who experience it and those close to them, is hardly new. Many people who have written about how mental health services have developed have emphasised the importance of social fears and anxieties as determining factors in the way mental health care is organised. The asylums of earlier centuries, for example, are often portrayed as institutions designed to 'protect' society as much as, if not more than, the people who were detained in them.

It is argued that community care policies have resulted in many of these fears being revisited with a special force because they may reflect deep-rooted *cultural* fears of mental distress (Pearson, 1999). Presenting the media with 'the facts' is likely to have little impact on such deep-rooted fears and this may explain why this strategy has so far failed to prevent negative media reporting. These fears are about what it means to be 'mentally distressed' in a society which is undergoing rapid change, one consequence of which, it is argued, is that 'rationality' and social order are valued particularly highly.

You have seen that there has been a focus in policy and the media on what individuals may experience or do to other people. However, there is good evidence in the relevant literature of important risks posed by *organisations and services* to service users/survivors. In other words, sometimes services are organised in a way that means service users/survivors are exposed to risks they otherwise might not encounter. A good example is the way discharge planning tends to emphasise the importance of someone's preparedness for discharge. Decisions about this are often based on relatively narrow measures of someone's fitness, relating to the treatment for whatever is identified as their primary mental health issue. People may be discharged with insufficient support networks in place because of this emphasis on risk rather than on their needs (Parton, 2001). Organisations tend to focus on preventing bad outcomes for which they are likely to be penalised financially. In particular, the culture of risk assessment has its origins in the increasingly litigious culture of the NHS in general. Organisations are afraid of being sued, and individual professionals are afraid of being publicly vilified.

Different groups of service users/survivors are affected in different ways by the culture of risk and defensive practices in mental health services. One particular group that is adversely affected, and about whom a culture of fear has developed, is young

men diagnosed as experiencing schizophrenia. Within this group, black men are particularly 'at risk' of being regarded with fear and mistrust. Research has shown that people from particular ethnic groups are over-represented in some psychiatric diagnostic categories compared with other ethnic groups. One of the most hotly debated issues relates to the over-representation of African-Caribbean men with a diagnosis of schizophrenia.

There is also an over-representation of African-Caribbean men in terms of the kinds of services they are likely to receive. They are more likely to experience coercive forms of intervention, such as compulsory admission to hospital or detention via the police. In terms of explaining this over-representation, one very powerful argument presented in some studies is that black people are less likely to voluntarily seek support from services than their white counterparts. This is because of the poor experiences many black people have had of mainstream services. Therefore they are less likely to benefit from support, from their GP for example, during the early stages of their experience of mental distress. When they do eventually come into contact with services, they are thus more likely to do so because they have become very distressed.

The relationship between ethnicity and violence is another good example of how the media have contributed to distorted images of particular issues. In a general sense, media reporting of crime contributes to an association between black people – especially young black men – and certain types of crime (particularly muggings and other forms of violence). This means that young black men are at risk of becoming the victims of a particularly powerful cocktail of distorted images. This is an issue which has been actively addressed by some services in order to adequately meet the needs of particular groups of service users/survivors.

Fanon Care is an organisation based in south-west London which provides specialist mental health services for African and Caribbean people living in the area (Southside Partnership, n.d.). In particular, it stresses the importance of early intervention in order to avoid crises. It is a good example of an approach to services which emphasises people's needs rather than risks. The organisation's vision statement says:

> Fanon Care's vision is of:
>
> - A society that puts people first and provides them with a choice of the highest quality services aimed at promoting mental well-being, delivered by people who want to make a difference.
> - A society where black people in mental distress are valued and included as equal citizens in the communities in which they live.
> - A society where there is much greater public understanding of the issues they face, and where diversity is valued.
> - A society that recognises the oppressive nature of racism and its effects on mental well-being.

It is clear that a disproportionate amount of attention is given to the risk of violence by people experiencing mental distress compared with other risks affecting them. This adversely affects some groups more than others. There is a *perceived* link between mental distress and violence, and this perception itself gives rise to a number of risks for service users. At least six have been identified by Alberg et al. (1996), although you may be able to think of more:

1. The priority given to risk of violence may mean that other types of risk – such as the risk of self-harm – are not addressed.
2. Professionals appear to relate differently to someone who is identified as a risk for violence: for instance, they may be afraid or critical.
3. The label 'violent' is highly stigmatising and tends to stick, even when a person is no longer at risk of becoming violent.
4. People can be blamed for their violent actions even though it may be a symptom of their illness rather than behavioural.
5. People who have become violent in the past are often placed in secure conditions where there is a high risk of violence to them from other patients.
6. Someone who has become violent in the past is more likely to be detained compulsorarily and therefore have less say in their treatment and care options.

So, the narrow focus on the risk of violence has serious implications for service users/survivors and their everyday experiences of services and professionals. As well as perpetuating a negative image of mental health service users/survivors, it also means that other risks that are just as real and pressing tend to be neglected. In part, this problem can be addressed by professionals in their practice by paying closer attention to service users'/survivors' perspectives on risk.

# 3 Extract 3: The business of madness

## 3.1 Introduction

In this extract you consider mental health as a business. This is not the way mental health services are usually regarded, as it is more common, at least in the UK, to regard them as public services. However, ideas about being more businesslike in health and social care have gained prominence in recent years. What does being a business, or more businesslike, mean? For one thing, it implies a profit motive: goods or services delivered to make money for private companies and their shareholders. This is quite controversial when applied to mental health services. There is a tension between mental health services as a business – a growth industry – and as a regulated public service. Caught between the two are the service users/survivors and their families. How are their needs met by the competing forces in the mental health marketplace?

Being a business, or businesslike, also suggests the importance of delivering what customers want so that the provider stays in business and flourishes. Further, it means being efficient, systematic and practical. That, at least on the face of it, looks like a very positive attribute for mental health services.

This extract takes these three issues – the profit motive, delivering what the customer wants, and efficient, systematic and practical services – as its organising framework. In Section 3.2 you begin to consider the concept of mental health as a business, and in Section 3.3 you focus on the profit motive and the controversial role of pharmaceutical companies. Section 3.4 considers 'what the customer wants', and Section 3.5 tackles the question of efficient, systematic and practical services through an examination of two mechanisms set in place to promote them – the National Institute for Clinical Excellence (NICE) guidelines and the National Service Framework for Mental Health.

## 3.2 Mental health as business: introducing the debate

Is mental health a business? There are a number of signs that it could be, and Activity 8 presents a discussion between two people with strong views on mental health services and how they should be delivered. Dr Harvey Gordon is a forensic psychiatrist who has been a long-term consultant at Broadmoor High Security Hospital, and also a consultant at the Maudesley Hospital in London. Jim Read has worked for many years in organisations and networks of mental health service users/survivors as a consultant, trainer and writer.

### Activity 8: Mental health as business

1 hour 0 minutes

Listen to the two sequences of audio below. You might find it helpful to listen right through both, with the questions in front of you, and then make detailed notes after a second hearing.

- What does 'business' mean to Jim and Harvey?
- What are their main points of difference?
- Are there any areas where they agree?

Click play to listen to audio clip 1 (10 minutes).

Audio content is not available in this format.

Audio clip 1

View transcript - Audio clip 1

Click play to listen to audio clip 2 (10 minutes).

Audio content is not available in this format.

Audio clip 2

View transcript - Audio clip 2

View discussion - Activity 8: Mental health as business

In the next section you focus on one strand of this debate, touched on by Jim and Harvey – the role of drug companies, and the lure of the profit motive.

# 3.3 Mental health as business: the profit motive

There is little question that the use of drugs to treat mental distress has become the dominant strategy. The historian Edward Shorter puts it graphically:

> If there is one central intellectual reality at the end of the twentieth century, it is that the biological approach to psychiatry – treating mental illness as a genetically influenced disorder of brain chemistry – has been a smashing success.
>
> (Shorter, 1997, p. vii)

Perhaps the most controversial aspect of mental health services and their relationship to business is the role of major companies which manufacture and market drugs.

## 3.3.1 A conflict of interest

One of the difficulties of the involvement of drug companies in the mental health field is that it produces a conflict of interest. To put it crudely, drug companies rely on a continuing supply of patients to keep them in business. This is not always congruent with people's best interests, as you will see below. Although mental health services are intended to help people experiencing mental distress, they also have other driving forces. The market economy model of provision has encouraged the expansion of various aspects of mental health care, but has fuelled, in particular, the development and promotion of drugs to such an extent that it is now a huge business. Between 1992 and 1997 government spending on mental health services rose from £2.6bn to £2.8bn (Bird, 1999), and current plans indicate further rises. The impact of the pharmaceutical industry is perhaps most pronounced in the USA, where there is a view that 'psychiatry has been almost bought out by the drug companies' (Mosher, 1999, p. 16).

Concern about this conflict of interest has a long history. In 1965, a journalist from the *Washington Post* wrote about the 'therapeutic nightmare' of psychiatric drugs being used to control 'millions' (Mintz, 1965). In 1974, the *American Journal of Psychiatry* raised concerns that ties between the American Psychiatric Association (APA) and pharmaceutical companies were going beyond the bounds of professionalism, compromising the organisation's principles, and in some instances involving members in conflicts of interest (Breggin, 1993). By the 1980s a small but visible lobby within psychiatry was opposing the influence of the pharmaceutical companies. The main concerns were that:

- Drug companies influenced individual psychiatrists' prescribing decisions through heavy promotion at the conferences and in the academic journals they sponsored.
- The dependence of university research departments on drug company funding might lead to bias in their results, particularly the results of studies evaluating the efficacy and safety of particular drugs.

(Source: Metzl, 2003, p. 140)

More recently, for example, there is a growing medicalisation of everyday life, with new conditions such as ADHD being 'discovered' and then treated with drugs. The use of Ritalin to treat children with this newly discovered 'problem' is widespread, with millions of children being given it daily. At the same time, autism diagnoses have increased 1,000 per cent over a decade, paving the way, some argue, for the introduction of a new drug to treat it (Boyle, 2003).


Drug companies advertise in apparently independent academic journals. This advert appeared in the *American Journal of Psychiatry* in 1960–61

View description - Drug companies advertise in apparently independent academic journals. This advert ...

Whatever the cause, the trend of prescribing drugs opened the divide between the psychiatric professions and charities such as Mind that campaigned on behalf of people experiencing mental distress. The run-up to the Mental Health Act 1983 saw Mind and others arguing for stricter controls on the use of drugs for patients detained against their will. A decade later the pharmaceutical industry was rethinking its strategy for marketing to the NHS, following the creation of the internal market:

> Glaxo Laboratories has an NHS Relations Unit which was set up in response to the major changes in the NHS structure […] Links are being established at managerial level in regional health authorities, district health authorities and family health services authorities.
>
> (Glaxo, 1991)

Persuading professionals to prescribe a particular drug is vitally important to drug companies. For example, a single prescription for paroxetine (Seroxat) is £22, while diazepam (Valium) is 90p. Just how big is the market for antidepressants? Table 1 gives an indication of the market for three antidepressants: fluoxetine (Prozac), paroxetine (Seroxat) and venlafaxine (Efexor XL).

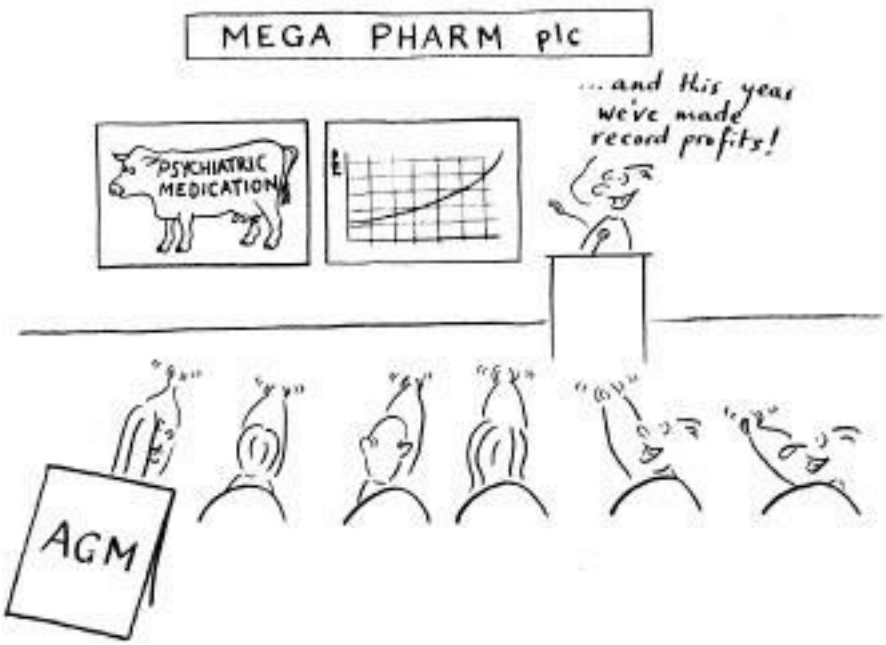
Table 1 The antidepressant market (England)

| | Total number of items dispensed (000s) | | Cost per item (£) |
|---|---|---|---|
| | **1991** | **2003** | **2003** |
| Fluoxetine | 365.30 | 4,288.00 | 8.57 |
| Paroxetine | 53.60 | 2,869.30 | 22.40 |
| Venlafaxine | – | 2,633.70 | 35.01 |

(Source: DH, 2004)

As Table 1 illustrates, the growth in the market for this new generation of antidepressants has been dramatic, and marketing strategies are an ongoing focus for pharmaceutical companies. This growth is raising some concerns, as the following extract illustrates.

> While health regulators are becoming increasingly anxious to control the use of Seroxat and other antidepressants, drug companies – equally anxious to gain as much income as possible from their medicinal cash cows – are trying to expand their uptake.
>
> GlaxoSmithKline has made billions out of Seroxat and sees no reason why this should halt, it would appear. One of its internal marketing documents shows the company planned to double sales by targeting people who suffer from a widely recognised condition known as social phobias.
>
> (Doward and McKie, 2004, p. 7)



So, it can be extremely lucrative for a company to produce and successfully market a drug which is widely prescribed. Just how did this situation come about? In the next section you look at the history of the use of drugs for people experiencing mental distress by tracking the introduction of successive waves of medication, from early antipsychotics to selective seratonin re-uptake inhibitors (SSRIs).

# 3.4 Pharmaceuticals for mental health: a brief history

The 'revolution' in drug therapy is widely credited with causing the mass closure of psychiatric hospitals in the 1950s and 1960s, meaning that patients who had previously been considered too much of a danger to themselves or others could be safely housed 'in the community' as long as they took the medication. However, the trend for a reduction in numbers was already evident at the time the drugs in question began to be available, and academics such as Joan Busfield and Andrew Scull argue strongly that the correlation between the two is much less clear than previously suggested (Busfield, 1986; Scull, 1984).

Whether or not it enabled closure of the large institutions, there is no question that medication has revolutionised the way people experiencing mental health problems are treated. Drug treatments had obvious advantages over their immediate precursors, physical restraint and lobotomy. Although the effects of the early antipsychotics can be compared to the effects of lobotomy (Breggin, 1993), it was thought that they would have a short-term impact which would cease when the drug was no longer being administered. Combined with the impact of a series of scandals about conditions in long stay hospitals (Scull, 1984), drugs which enabled people to leave institutions appeared highly attractive.

## Activity 9: Pros and cons

0 hours 20 minutes

Consider the advantages of antipsychotic medication in terms of the interests of service users/survivors, professionals and the state, and make brief notes.

View discussion - Activity 9: Pros and cons

However, there were disadvantages. From a service user's/survivor's perspective, the less damaging effects of the drugs had to be weighed against a long list of debilitating side effects. Since the first appearance of antipsychotic drugs in 1952, their side effects have become better understood. Originally termed 'neuroleptic' (because they attached themselves to neurons in the brain), the early antipsychotics were considered to have mainly sedative effects. (Another name for drugs in this class is 'major tranquillisers'; examples are chlorpromazine, thioridazine and haloperidol.) Many of the symptoms later termed 'side effects', such as drowsiness and apathy, were originally described as the intended functions of the drugs (Breggin, 1993). Breggin, a

fierce critic of the influence of the pharmaceutical industry, argues that only later did the pharmaceutical companies begin to claim that the drugs had a therapeutic effect on psychosis.

Throughout the 1950s and 1960s, the doses of antipsychotics prescribed began to increase, perhaps as a result of aggressive marketing by drug company representatives, who argued that the ability of the drugs to combat symptoms increased with the amount taken (Rogers and Pilgrim, 2003). While there is no evidence that the therapeutic value of the drugs *does* increase with dose, the same cannot be said of their side effects.

Following the thalidomide crisis in the UK in the late 1950s and early 1960s, when over 6,000 children were born with severe disabilities because of a drug administered to their mothers during pregnancy, a system of routine reporting of any adverse effects of prescribed drugs was introduced, voluntary for health professionals but obligatory for pharmaceutical companies (MHRA, 2003).

This involved doctors completing a yellow slip describing the prescription and reported side effects and submitting it to the Committee on Safety of Medicines. Since the introduction of antipsychotic drugs, critics of the medication had suspected that their adverse effects were being under-reported. It was suggested that virtually everyone for whom these drugs were prescribed experienced some unpleasant effects. In response, Mind launched its own Yellow Card scheme in 1995, encouraging service users themselves to report unwanted side effects directly to the charity. Although run as a campaign and not a scientific study, the results went a long way towards supporting the claims of under-reporting (Cobb, 2001).

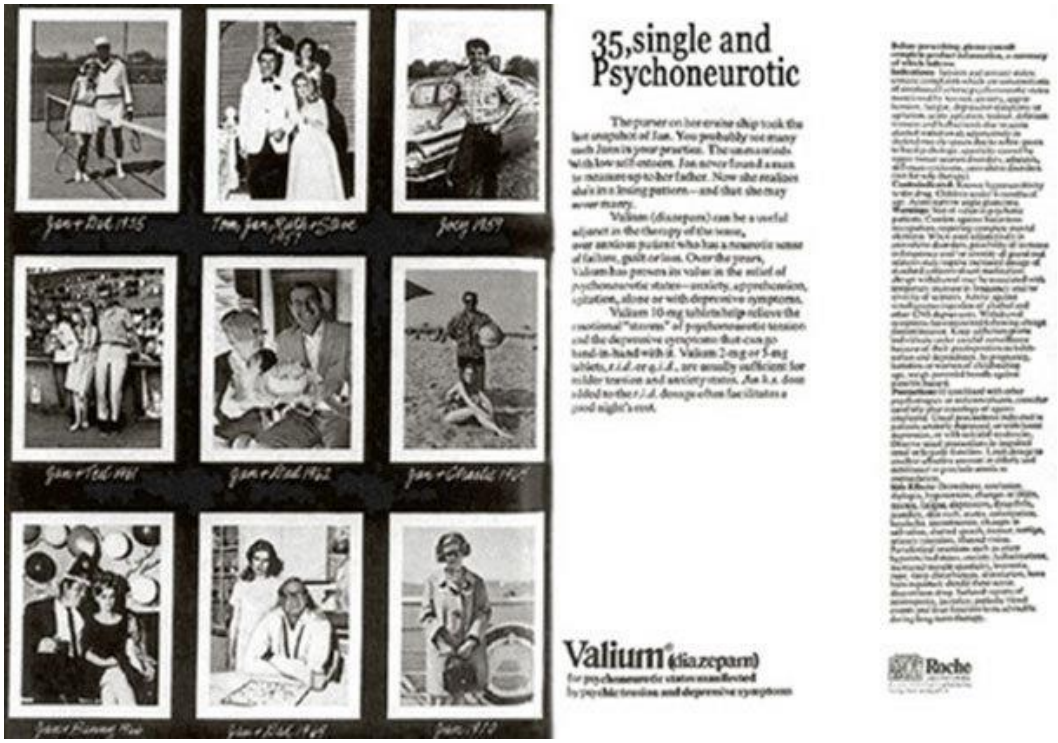
In the 1990s the drug companies themselves produced scientific evidence of the unpleasant effects of antipsychotic drugs, but only when a set of new, more expensive alternatives, the ‘atypical’ antipsychotics such as clozapine and risperidone, was available. The effects of the older antipsychotics include a range of movement disorders such as tardive dyskinesia (TD) (Brown and Funk, 1986).

# 3.5 Benzodiazepine tranquillisers, Prozac and the SSRIs

One of the most significant ranges of drugs ever produced is the benzodiazepine tranquillisers (usually classed as ‘minor tranquillisers’ or ‘hypnotics’), often prescribed as a remedy for ‘minor’ disorders such as depression, sleeplessness and anxiety. In effect, they extended the range of conditions that could be treated by medication. The best-known example is probably Valium.


(Source: Metzl, 2003, p. 151)

Valium was advertised as addressing a range of problems. Here 'psychic tension' is the condition to be treated. The advert appeared in the *American Journal of Psychiatry* in 1965



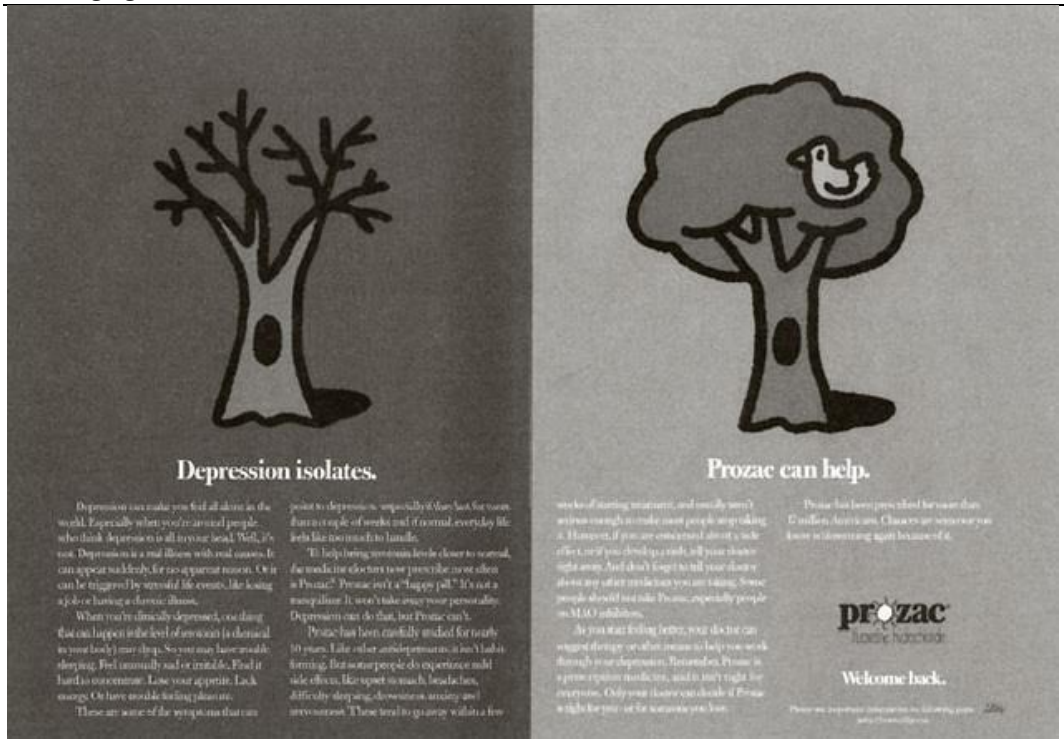
(Source: Metzl, 2003, p. 149)

Here being '35, single and psychoneurotic' is the problem Valium can treat. From the *Archives of General Psychiatry* in 1970

Like their predecessors, these drugs began to attract criticism from a number of different quarters. Some pointed to the dangers of addiction (Agrawal, 1978), while others said that the drugs were being used to help women endure gender oppression rather than escape it (Johnstone, 1989; Waldron, 1977). The adverts reproduced here certainly suggest a heavy focus on women's problems.

Addiction to benzodiazepines continues to be a major topic of controversy. In 2001 a study conducted for the BBC TV programme *Panorama* (*The Tranquilliser Trap*, broadcast 13 May 2001) showed that 28 per cent of people being prescribed benzodiazepines had been taking them not for the recommended four weeks, but for more than ten years.

In 1987 came Prozac (fluoxetine), one of the range of drugs known as the selective seratonin re-uptake inhibitors (SSRIs). According to trials commissioned by the drug companies, these new drugs were non-addictive and had fewer side effects. They were marketed alongside benzodiazepines for a wide range of conditions from 'generalised anxiety disorder' to severe depression and schizophrenia. These drugs aim to actually 'cure' the 'illness', arguably taking mental distress further out of its social and holistic context. In the USA, SSRIs have been marketed directly to the public in an effort to get people to persuade their doctors to prescribe them. SmithKline Beecham spent $30m marketing the SSRI Seroxat (Paxil) directly to customers in the USA in 1999 alone (Rogers and Pilgrim, 2003). Marketing campaigns began to hint that as well as curing depression and anxiety, SSRIs could enhance functioning in healthy people.

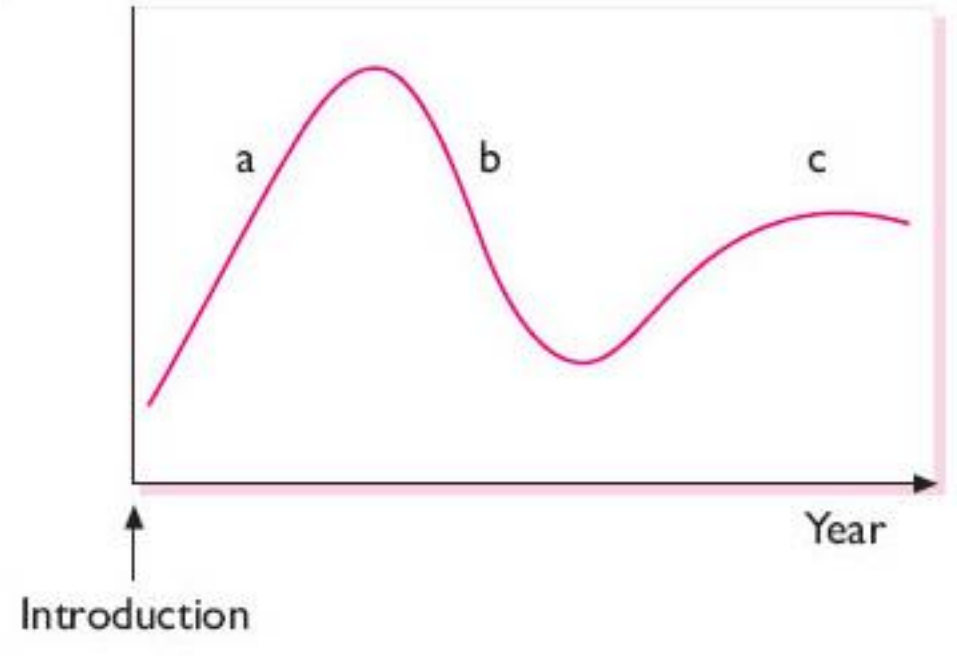



(Source: Metzl, 2003, p. 161)

Prozac advertisement in the magazine *Self* (1998)

Such direct marketing is banned in the UK, but the media were nevertheless susceptible to stories planted about the new 'wonder drugs'. To an NHS that was already having to defend itself against both charities and doctors clamouring for the most expensive remedies with fewer side effects, this presented a new challenge. The government responded to the problem of keeping health-related costs under control by creating in 1999 the National Institute for Clinical Excellence (NICE), a semi-autonomous body charged with deciding which drugs represent good value to the taxpayer.

Throughout the 1990s evidence emerged that SSRIs might not be as safe as originally thought (Breggin, 1993). The cycle of acceptance for new drugs such as the SSRIs, as with their predecessors, has followed the pattern shown below in Figure 1. The graph shows a peak reflecting initial wild enthusiasm that everything can be cured, followed by devaluation as side effects become public, followed by stability as rational use is established.




(Source: Metzl, 2003, p. 168)

Figure 1 Prescription patterns for new drugs

In summary, then, although medication has had a beneficial effect on many millions of people experiencing mental distress, there remain serious concerns over:

- a series of drug types claimed to be problem-free, all of which have had unexpected effects on at least some people;
- the influence of pharmaceutical companies on medical personnel, the research agenda, university departments and even governments;
- the difficulties of obtaining unbiased evidence;
- the costs to the public purse of certain heavily promoted drugs.

# Conclusion

This free course provided an introduction to studying Health and Social Care. It took you through a series of exercises designed to develop your approach to study and learning at a distance and helped to improve your confidence as an independent learner.

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# Activity 1: Looking at language

## Discussion


Your list probably contained some or all of the following terms: lunacy, mania, madness, insanity, mental ill health, mental illness, mental distress, mental health problems. More specifically, you may have mentioned schizophrenia, depression, anxiety, neurosis, psychopathology and paranoia. One of the course testers suggested possession and witchcraft.

Your list of names for the people concerned probably contained some or all of the following: lunatic, madman/woman, mentally ill person and mental patient, as well as slang terms such as loony, nutter, psycho, schizo and weirdo. Course testers added: mental, maniac, barking, loopy, touched, unhinged and highly strung. In addition, there are the names adopted by people on the receiving end of the terminology and services, such as users, clients and survivors. Some of these terms are combined to become mental health service users/survivors.

The two authors are themselves users of mental health services as well as being involved in mental health research and practice. Perkins dismisses the word ‘distress’ as being too inclusive. Her argument is that everyone experiences distress but not everyone experiences ‘madness’, and to claim they do is to diminish and trivialise the latter experience. She suggests that service users should ‘embrace mad pride’ and celebrate their differences. Rose accepts that some service users regard their experience as an illness that can be treated. She argues, however, in favour of the term ‘mental distress’. At the same time, she suggests that this should be linked with a more positive outlook that includes valuing and learning from that experience, and connecting it with ‘the discourse of rights’.

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# Activity 2: A quiet night on Roundhay Wing

## Discussion

This a thought-provoking play. It aroused a mixture of reactions in the course team when we watched it together. It is easy to identify with the people who are the ‘others’ in society's terms, but it may be harder to accept their views of those they regard as their oppressors and gaolers. Doctors, nurses, hospitals, day centres and drug companies all come in for criticism. Whatever your views, record them fully now.

This is your ‘benchmark’, a record of where you stand.

Back

# Activity 3: What is mental ‘normality’?

## Discussion

It is not easy to define normality as it differs over time and between cultures. However, there is a sense of it meaning the ordinary or everyday aspects of life. This was certainly what course testers thought when asked what normality meant to them. One said:

> Normality for me is ‘everyday’. This might cover a range of emotions and feelings, from boredom and dissatisfaction to happy and engaged. Normality includes the usual, whether that be activities such as shopping, working or driving, or the uncommon but planned-for, such as going on holiday.

Another said:

> Normality means day-to-day coping and rational thoughts; an ability to look at things objectively.

By way of contrast, creative artists and inspirational leaders live at least some of their lives in ways that are not ordinary and everyday. They may not be normal in that sense. But with talents that are way beyond those of the average person, they may come to be greatly revered. Other people, on the wrong side of the divide, may fare less well. The challenges of defining normality are highlighted well by Johnstone:

> How quiet do you have to be before you can be called withdrawn? How angry is aggressive? How sudden is impulsive? How unusual is delusional? How excited is manic? How miserable is depressed? The answers are to be found not in some special measuring skill imparted during psychiatric training, but in the psychiatrist's and relatives' shared beliefs about how ‘normal’ people should behave.
>
> (Johnstone, 1989, p. 243)

Back

# Activity 4: Personal experiences of mental distress

## Discussion

Veronica's explanation of her mental distress includes:

- admission into care as an illegitimate, mixed race, hard-to-place baby;
- childhood experiences of racism (combined with the denigration of her heritage);
- admissions to hospital;
- suicide bids;
- breakdown of the relationship with her adoptive mother.

The author acknowledges the importance of her personal experiences and histories. Abuse, rejection and separation played a part in creating her experiences of mental distress. She also highlights how her experiences of mental health systems had a negative impact on their lives, compounding her original difficulties. She has a voice now, as a survivor and writer, but the systems of the time sought to silence her. Her accounts also point to structural factors within society – racism, discrimination and oppression.

Back

# Activity 5: Exploring the meaning of risk

## Discussion

The following are some examples that course testers came up with when they did this activity:

- Risk only exists when there is something to lose.
- Risk involves an assessment of the likelihood of any particular outcome occurring.
- Risk can lead to failure.
- Risk is sometimes defined by you, sometimes by others about you.
- Risk is the probability of a predicted outcome occurring.

Although your definitions of risk may be different, they are likely to involve the two ingredients of the chance of something happening and the nature of the outcome, which might be good, bad or both.

Back

# Activity 6: Exploring risk in the media

## Discussion

In analysing the articles you may well have noticed references to likelihood in some form. These may have been in the shape of quantitative risk estimates, including references to probability such as ‘twice as likely’ or ‘three times more likely’. You may also have noted more qualitative statements, such as ‘very likely’ or ‘higher risk’. In terms of the nature of the outcomes, the focus in press reports tends to be on bad outcomes rather than good. You may have noticed that some newspapers tend to go into greater depth in their reports, and often make an attempt to analyse findings in a more sophisticated way. They tend to use more complex language and discuss the implications of reports more thoroughly, although this is not always the case.

Course testers who did this activity commented that headlines about risk in ‘tabloid’ newspapers tended to be more sensationalist. For example, one headline simply said, ‘We Will Die’! In contrast, other newspapers seemed to try to give more factual accounts of potential outcomes.

Back

# Activity 7: Risk and mental health policies

## Discussion

The article describes risk reduction as a basically defensive response to the perceived failure of community care policies. Rather than focusing on the needs of all service users/survivors and providing services accordingly, risk reduction strategies encourage the focus to fall on small groups of 'high-risk' people. Kemshall argues this is currently the dominant approach in policy.

This article emphasises that risk taking has its roots in service user/survivor empowerment and involvement and is seen as a necessary part of life. It is underpinned by a focus on the radical values of empowerment and structural change. It challenges risk reduction strategies by reducing stigma, dependence and over-protection.

Risk taking is about professionals and service users/survivors working together to ensure that decisions about risk take account of their possible benefits as well as the possibility of bad outcomes.

Back

# Activity 8: Mental health as business

## Discussion

What does ‘business’ mean? Course testers noted the following:

- ‘affected by financial factors’; ‘budget constraints’ (HG)
- contrasted with a public service (HG)
- constant reorganisation in the NHS (to make it more businesslike?) (JR)
- choice for service users (both)
- the use of direct payments to put the user in charge (JR)
- pharmaceutical companies are motivated by financial gain, but they need to produce something that doctors will prescribe and people will benefit from (HG)
- new markets for drugs are created by identifying new conditions needing treatment (HG)
- standardising services is difficult because of geographical constraints on where people can get treatment (HG) and because the quality of services depends on the people delivering them (JR)
- community-based services, which may well be less expensive, produce better outcomes than services which rely heavily on drugs (JR).

Points of difference: the major area is over the use of drugs. Jim is basically against the use of drugs to treat mental distress, while Harvey offers a spirited defence of them, for the benefit not only of service users/survivors but also of their families.

Points of agreement: both speakers agree that it is not easy to offer choice in this context. And neither of them wholeheartedly embraces the idea of mental health services run on business principles.

Back

# Activity 9: Pros and cons

## Discussion

Antipsychotic drugs had advantages for all concerned:

- For service users/survivors, they reduced the likelihood of institutionalisation and of permanent brain damage through psychosurgery, and opened the possibility of a better life.
- For professionals, they moved public perception away from ‘gaoler’ towards ‘doctor’, reinforcing psychiatrists' power to understand and treat ‘madness’ because they could prescribe drug treatment.
- For the state, they offered the possibility of cheap management of ‘deviant’ individuals, and a less obviously restrictive set of practices than large institutions, which might (and did) draw criticism from civil liberties campaigners.

Back

# Drug companies advertise in apparently independent academic journals. This advert appeared in the American Journal of Psychiatry in 1960–61

## Description

Figure i005

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# Clip 1

# Transcript

**Angel:**

The city has as many faces as the sea.

**Councillor:**

It's a modern European city

**Housewife:**

It's a bloody dump, that wall runs with damp in winter.

**Poet:**

It's an owl in sheep's clothing, white lions roaring on the town hall steps.

**Pensioner:**

It's a nightmare on South Parkway after dark.

**Motorist:**

The best thing to come out of Leeds is the M62.

**Angel:**

It's said that Rudolf Steiner came here for a few hours once and left never to return.

**Rudolf Steiner:**

We stayed as short time as possible in this curiously featureless modern city. Its aspect is dour, I doubt it will be possible to base a school here. The river is pestilent with dyes from the mills. There are bad spirits in this place! A deep fog pervaded for several hours which marred our visit to the workhouse

**St James:**

Which later became St James's hospital, now they call it Jimmy's. Bloody heathens.

**Angel:**

As the millennium comes and goes, see Gledhow Wing presenting its façade of red brick and glass to the west. A proud monument to maternity and birth, to rebirth and regeneration. But this is Roundhay wing, no direct sunlight reaches this place. It nestles between other grander hospital blocks for real medicine, like oncology, cardiology and having a nose that's slightly too big. It's like an old shed that some eccentric has refused to sell so that the red towers have sprung up around it leaving a little island of the past at their feet. It is the year 2000. The cries of those desperate to leave ...

**(lots of people) :**

Let us out, let us out ...

**Angel:**

... are matched by those who are desperate to enter ...

**(lots of people) :**

Let us in, let us in ...

**Angel:**

... but this is the only service in the world where the customer is always wrong.

**The Doctor:**

Those who want to get into a place like this are obviously suffering from disorders of the personality and are untreatable. So we cannot let them in. Those on the other hand who wish to leave do not yet realise that they are ill which is the first step to recovery, so we cannot let them out.

**'Cured' patient:**

Please let me stay. Please. I like it here, the food's nice, its warm. I want to stay forever, please. I really like it here.

**The Doctor:**

Ah, she's cured. Nurse, discharge the patient.

**Nurse O'Render:**

Come on sunshine.

**'Cured' patient:**

No, I'm not cured. Get off me ... No, no ...

**Angel:**

Some people find a way out unexpectedly.

**'Discharged' patient:**

The doctor said to me 'Are you hearing voices?' And the voices said to me 'Say no'. So I said no and then they let me go.

**Angel:**

Now night has fallen like a sedative. Stillness covers the sleepers like a new duvet. The soft heat rises from pipes that were old when spitfires flew over the city and the sweat steam and you wake up full of strange dreams

**1st Sleeper:**

Penalty shoot out in front of the old Cop. Everton, fourth round replay. Bloody awful night, pissing down. I've got to score to keep us in. The goalkeeper's my old French teacher.

**2nd Sleeper:**

Middleton Wood, but it's a jungle. I've been lost for days. Then I come to a clearing and there's Tesco's. I go in to buy some bread and the checkout girl turns into a leopard

**3rd Sleeper:**

Trying to catch a train. A big old steam engine with the name plate William Wordsworth. It's just started to leave and I'm gaining on it until I feel something holding me back. I look down and there's all these daffodils, thousands of them grabbing at me ankles.

**Angel:**

The walls are nailed and painted shut but outside you can sense a raw west Yorkshire night. It's a quiet night down in the doctor's flat where Dr Uberdose fuddles his eiderdown as he dreams of a ward round at the People's Dispensary for Sick Animals on Leyland Street

**The Doctor:**

This dog is much too dozy. I prescribe an antidepressant.

**Nurse O'Render:**

But sir, he's been hyperactive all day and he kept us up half the night.

**The Doctor:**

What, barking?

**Nurse O'Render:**

Yeah

**The Doctor:**

I prescribe cognitive behavioural therapy and 6,000 mg of chlorpromazine!

**Nurse O'Render:**

Right.

**1st Lost Soul:**

It's a bit parky!

**2nd Lost Soul:**

It smells of wool and coal, bad for the chest.

**3rd Lost Soul:**

Chips with curry. And I'll have some scraps on that if you've got them.

**1st Lost Soul:**

Nazi graffiti.

**2nd Lost Soul:**

Breaking glass.

**3rd Lost Soul:**

Guard dogs barking, hallucinating burglary, at each sad city footstep.

**Angel:**

It's a quiet night down along the main corridor where the ghosts of all the ages mingle and drift in flood strip lighting so bright you half expect Man United or the Chicago Bulls to come trotting out.

**Speaker:**

But not everyone is asleep. On the women's ward transactions are being made in Roundhay Wing's main currency.

**2nd Lost Soul:**

Have you got a spare cigarette love?

**3rd Lost Soul:**

Only a roll up if I can find the stuff, it's in here somewhere.

**2nd Lost Soul:**

Hurry up love, I'm desperate. My husband's coming tomorrow, but till then I'm stuck.

**3rd Lost Soul:**

Well, here's a bit of baccy, filters. Not fussy about filters are you?

**2nd Lost Soul:**

I'll take as it comes me love. Have you got a roach though. I like a bit of roach in me joint.

**3rd Lost Soul:**

Well, haven't got a plant here but under me bed there is one.

**2nd Lost Soul:**

I won't tell those Gestapo bastards in the office about this. Call themselves nurses ...urghh

**3rd Lost Soul:**

Can we get a light on here. I can't roll in the dark.

**2nd Lost Soul:**

If we put the light on the nurses will come and they'll put us to bed.

**3rd Lost Soul:**

Bloody hell, here's a fag of sorts.

**2nd Lost Soul:**

Thank you love

**3rd Lost Soul:**

That's it until tomorrow.

**2nd Lost Soul:**

That's just what I need.

**Angel:**

In the treatment room a blue spark flickers from a loose wire as if the shock machine is dreaming. In the TV lounge the night nurse stares at an empty TV screen although the programme finished three hours ago and the screen is just a swarm of electronic insects.

**Speaker:**

In a dormitory for eight, enclosed by Dorothy Perkins curtains, about to wake from a three-day sleep induced by an enormous dose of Largactyl introduced

intravenously into a delicate part of the anatomy - Jonathan X.

**Jonathan X:**

Bloody leave me alone.

**Angel:**

In his night stallion he is fighting off an army of white-coated nurses, shouldering arms of three foot hypodermics, points glistening like bayonets at the Regent Street Territorial Parade.

**Voice:**

I've got you sunshine.

**Jonathan X:**

What the bloody hell's going on? Where am I?

**2nd Lost Soul:**

He wants to know where he is.

**Jonathan X:**

What is this place?

**3rd Lost Soul:**

It's the end of the line

**1st Lost Soul:**

The last chance saloon. It's limbo baby

**Jonathan X:**

Can't you talk some sense? Where am I?

**1st Lost Soul:**

You're lost boy, like me. Went for a paper 20 years ago and got abducted by aliens on the 93 to Cookridge. Never been seen since. Used to sing in working men's clubs. I did it my way.

**Voice:**

Not now you don't sunshine.

**Jonathan X:**

But how long have I been here?

**2nd Lost Soul:**

Forever.

**Jonathan X:**

But I don't belong here, it's all been a mistake.

**2nd Lost Soul:**

That's what they said about me. You don't belong here love, just a crack up doing your A' levels. You'll be alright in six months. That was 12 years ago. I write a diary in a special code so they can't get at me.

**Jonathan X:**

But I'm not like the rest of you.

**1st Lost Soul:**

Ha, ha, he's not like the rest of us.

**2nd Lost Soul:**

That's the whole point, you ninny.

**3rd Lost Soul:**

None of us is like the rest of us. That's why we're here.

**Jonathan X:**

I've got to get out.

**All Lost Souls:**

He's got to get out.

**Jonathan X:**

No, but I have, I've got to get out. I've go somewhere to be, I've got to meet someone.

**1st Lost Soul:**

Well, technically the boy is free to leave.

**2nd Lost Soul:**

... but of course if he does try to ...

**3rd Lost Soul:**

... they'll slap him on a Section and they'll make him stay.

**1st Lost Soul:**

It's like the Hotel California.

**2nd Lost Soul:**

Yeah. You can check out, but you can never leave.

**3rd Lost Soul:**

Except it's in West Yorkshire.

**1st Lost Soul:**

You can say ta'ra, but you can never flit.

**Jonathan X:**

Look isn't there any way I can get out?

**1st Lost Soul:**

Only with the permission of the Head Honcho.

**Jonathan X:**

Who's the Head Honcho?

**2nd Lost Soul:**

Only the one who writes the pardons. The one who gives the go head for discharge. Remo himself.

**Jonathan X:**

Remo?

**3rd Lost Soul:**

The Responsible Medical Officer.

**Jonathan X:**

How do I get to see Remo?

**1st Lost Soul:**

You can't.

**2nd Lost Soul:**

He'll see you when he's good and ready.

**3rd Lost Soul:**

And you won't even know who he is.

**1st Lost Soul:**

He's a shape changer.

**2nd Lost Soul:**

Sometimes he'll be round and friendly.

**3rd Lost Soul:**

But the next time you see him he'll be seven foot thin and he'll shout the ward down.

**1st Lost Soul:**

And sometimes he'll be like the good strong father you always wished you'd had.

**2nd Lost Soul:**

Then he'll cheat you out of your weekend leave and laugh in your face.

**3rd Lost Soul:**

And the beauty is, you never know when he's going to come.

**1st Lost Soul:**

The day of the ward round, you can stand around all day and he doesn't come.

**2nd Lost Soul:**

The next day, for no good reason at all he'll be there sharing a laugh in the staff room.

**3rd Lost Soul:**

Or at least, you think it might be him. But you never can tell.

**Jonathan X:**

But there must be some way I can get to see him?

**1st Lost Soul:**

Well, there is one way I've heard of, but its very risky.

Back

# Clip 2

## Transcript

**2nd Lost Soul:**
I don't like this.

**3rd Lost Soul:**
Look we can go back. It's not such a good idea. We could be tucked up warm in bed.

**Jonathan X:**
But this way we can escape. We can leave Roundhay Wing behind forever.

**1st Lost Soul:**
What, leave?

**2nd Lost Soul:**
Leave forever?

**Jonathan X:**
Yes, forever.

**3rd Lost Soul:**
They say the birds tell him when someone's approaching.

**1st Lost Soul:**
Yes, yes, they say that he controls everything.

**Jonathan X:**
I don't believe all that.

**2nd Lost Soul:**
You don't know Remo.

**3rd Lost Soul:**
Remo's a fascist.

**Jonathan X:**
But he's our only chance of getting out of here for good.

**1st Lost Soul:**
What's that.

**2nd Lost Soul:**
In that clearing. It's a light. There's somebody there.

**3rd Lost Soul:**
Ah, a shadowy shape by the fire.

**2nd Lost Soul:**
It's Remo.

**Remo:**
Who is out there? Come forward. Let me see.

**1st Lost Soul:**
It's only us.

**2nd Lost Soul:**
We, we didn't mean to disturb you.

**3rd Lost Soul:**

We're only taking a stroll.

**1st Lost Soul:**

Fascist.

**Remo:**

I heard that. How did you get here? Why do you disturb my peace?

**Jonathan X:**

We've come to demand that you release us from the spell of Roundhay Wing.

**Remo:**

Ha, ha, to demand!

**Jonathan X:**

Yes.

**Remo:**

That I release you!

**Jonathan X:**

Yes.

**Remo:**

From the spell ...

**Jonathan X:**

Oh for goodness sake. Look you can sign the papers that will release us. Then we'll never have to go back to that place.

**Remo:**

But why do you think you deserve to be released?

**1st Lost Soul:**

We've done nothing wrong.

**2nd Lost Soul:**

No, we're not criminals.

**3rd Lost Soul:**

And what gives you the right to release us?

**1st Lost Soul:**

You fascist.

**Remo:**

Enough. One more word of that and I will call upon my minions. I will have you thrown into the outer darkness, from whence you shall never return.

**1st Lost Soul:**

Not the day hospital!

**Remo:**

You will be tormented by demons for all eternity.

**2nd Lost Soul:**

Not the assertive outreach team.

**3rd Lost Soul:**

Oh, no, not that.

**1st Lost Soul:**

Please, please, we'll do anything.

**Jonathan X:**

Oh, I've had enough of this.

**Remo:**

What are you doing?

**Jonathan X:**

I'm going to see what's underneath that mask

**1st Lost Soul:**

Oh, it isn't a mask.

**Remo:**

This isn't a mask.

**1st Lost Soul:**

It isn't a mask. He really is half rhino.

**Remo:**

Aaaargh...

**Jonathan X:**

Look, I told you it was just a mask. He's just an ordinary man.

**Remo:**

Please, don't hurt me. It was only a game.

**1st Lost Soul:**

Some game.

**2nd Lost Soul:**

Yeah. We didn't think it was a game when you made us wait in the ward round for three hours.
Speaker:
Three hours in the ward round.

**3rd Lost Soul:**

When we came to you complaining about side effects and you put the dose up!

**1st Lost Soul:**

When you stopped leave on the weekend of Princess Di's funeral.

**Remo:**

I'm sorry, I'm sorry. I'll make amends. I'll be nice from now on, I promise.

**Jonathan X:**

So, you're going to sign the paper and let us go?

**Remo:**

I can't do that.
All:
Why not? Why can't you?

**Remo:**

Because if I do they will be angry with me.

**Jonathan X:**

Who'll be angry?

**Remo:**

They will be. The ones above me. The magic bullet makers.

All:
The what?

**Remo:**

You all thought I was the one in charge, but there is one greater than me. He is the king of the magic bullet makers. He lives far away over the Mountain Umoverdose, beyond the Valley Umoverdose.

**1st Lost Soul:**

Well that's it, we'll have to go back. We can't go all that way.

**Jonathan X:**

No, we've got to go on. It's our only chance.

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# Clip 3

## Transcript

**1st Lost Soul:**

God, where are we now?

**2nd Lost Soul:**

Who knows. We're lost. Look at those birds, are they vultures?

**3rd Lost Soul:**

No, they're too big. They look like pterodactyls.

**1st Lost Soul:**

But they're too stiff. Look, they can hardly walk, they're shaking all over.

**2nd Lost Soul:**

They must be Largactyls then. We're in some kind of lost world. Look at those mountains of grey ash and these piles of ancient armchairs everywhere.

**1st Lost Soul:**

It's the valley of the eternal day centre. The land where the television is never switched off. Listen. Look at that murky brown liquid bubbling up.

**2nd Lost Soul:**

It's tea. We must be in a huge underground reservoir. We must be close to the level of the water table.

**3rd Lost Soul:**

Or the tea table.

**Jonathan X:**

Look, over there.

**1st Lost Soul:**

Argh ... skeletons.

**2nd Lost Soul:**

All in rows of armchairs.

**3rd Lost Soul:**

And on the armchairs, mugs of tea.

**1st Lost Soul:**

And it's still hot.

**1st Lost Soul:**

And look. Some of them have still got burnt out stubs in their mouths.

**2nd Lost Soul:**

They died with their fags in.

**(lots):**

Anybody got a fag? Anybody got a ....? Can we play ping pong? Go on can we play ping pong? I want my

cigarettes, I want my cigarettes. Give us a fag mate will you?

**3rd Lost Soul:**

We've got to keep moving, this is no place to hang around.

**1st Lost Soul:**

Look out ... argh ...

**Speaker :**

I want my cigarettes ...

**1st Lost Soul:**

We've made it to the foothills.

**2nd Lost Soul:**

Do you hear music?

**3rd Lost Soul:**

What is it?

**Jonathan X:**

I don't know but we'd better go and see.

**Magic Bullet Maker:**

He don't take his medicine ... come back in a rewind style ... hub dub toil and trub, take another tablet and stick it in your gob, you're never gonna be no-one, you'll never get a job, if you don't take your medicine, you don't take your drug. Take a little chemical from Porton Down, mix it, wax it, stir it down. Take a little chemical inside your head, see what that does to your head, cos you need rewiring your seratonin sucks, you ain't been takin your prescribed drugs. Hey you want a little irony, try this for size, I've forgotten the second verse but here it comes again

**1st Lost Soul:**

It's the magic bullet maker.

**2nd Lost Soul:**

What can we do?

**Jonathan X:**

There's only one thing that will work against magic bullet makers. Give me that aromatherapy gun.

**3rd Lost Soul:**

Be careful, it's dangerous.

**Jonathan X:**

Is it loaded?

**3rd Lost Soul:**

Sure.

**Jonathan X:**

What with?

**1st Lost Soul:**

Sandalwood.

**Jonathan X:**

No good, too subtle. What else have you got?

**1st Lost Soul:**

Lemon, ... er ... night scented stock ... er ... ... lavender ... er Hunslet Lavender

**Jonathan X:**

Hunslet lavender, perfect. Load it up, double dose. OK when I say go we rush them.

**Magic Bullet Maker:**

We are the top pharmaceutical crew, whatever you want we can do it for you, we can take you up, we can take you down, we can take you on a trip to the weird side of town, and when you come back you just won't be the same because you'll be dancing our little game and you want some irony try this for size, I could be up for the Nobel prize, for all my work on the human condition and all of the time I've been raking in the millions. Hub, dub, toil and trub, take another tablet and stick it in your gob. Hub, dub, toil and trub, take another tablet and stick it in your gob ...

**Jonathan X:**

Go!

**Magic Bullet Maker:**

Hub, dub, toil and trub, take another tablet and stick it in your gob ...

**Jonathan X:**

OK, the game's up.

**Magic Bullet Maker:**

What the hell's going on?

**Jonathan X:**

We're wise to you. Tip out that cauldron.

**Magic Bullet Maker:**

What the hell're you doing. That was high quality medicine. You're totally irresponsible.

**1st Lost Soul:**

No, it wasn't. It was crap.

**Magic Bullet Maker:**

Oh, ok. What's the deal? What do you want?

**Jonathan X:**

We want to be released from the spell of Roundhay Wing and we've been told only the king of the magic bullet makers can do it.

**Magic Bullet Maker:**

No, no-one's seen the king for 15 years. He fears contamination. He lives in a protected zone. His food is placed in a special chamber and his rooms are cleaned with a special filter. He only ever communicates by email.

**Jonathan X:**

Ok, come on, this way.

**Magic Bullet Maker:**

Oh, no, you can't go in there.

**The King:**

And there were tulips I seem to recall. Yes, we bought them for the room, crimson tulips. You were standing by the window as a train went past, so you didn't hear what I said properly. You turned around with that smile of yours. Rosemary for remembrance, but what is for forgetting?

**Jonathan X:**

We've come to demand that you release us from the spell of Roundhay Wing.

**The King:**

What can I do?

**3rd Lost Soul:**

Well, everyone says you have the power.

**The King:**

Alas, would that it were so.

**1st Lost Soul:**

What?

**Magic Bullet Maker:**

He means chance would be a fine thing.

**2nd Lost Soul:**

Oh, you mean you don't have the power?

**The King:**

Oh sure I have power. Power is easy. I am the owner of a multinational industrial pharmaceutical empire. I have power, but power isn't enough you see.

**Jonathan X:**

What do you mean?

**The King:**

Look, I'm tired, I've made billions and where did it get me? I'm alone. I can spend a million every day on some new toy, holiday wherever I like. I could buy a country if I wanted but what on earth would I do with it. No, it seems to me that I've been searching for something that no longer exists.

**3rd Lost Soul:**

That photograph?

**The King:**

My Rosemary, gone, forever. She loved me but I felt I had to prove myself to her. I had to make money and give her everything she wanted but she only wanted ... she only wanted ...

**2nd Lost Soul:**

Love?

**The King:**

Yes, love. If only I knew then.

**2nd Lost Soul:**

But it's not too late. No, it's never too late. Julian.

**The King:**

Rosemary, it's you. My Rosemary, and you've learned to play the violin.

**2nd Lost Soul:**

Yes, oh Julian sweetheart. How could I ever leave you?

**The King:**

Because I was stupid, foolish, greedy and bad tempered.

**2nd Lost Soul:**

Yes, there was that. But now we're together we'll never be parted.

**The King:**

I declare a national holiday.

**1st Lost Soul:**

But you can't do that. Only the Queen can do that.

**The King:**

Oh, I'll email her. She'll be alright about it.

**1st Lost Soul:**

Oh.

**The King:**

I intend to disband my empire right now.

**Magic Bullet Maker:**

What?

**The King:**

Yes, from now on my factories will only be used for the manufacture of wholesome goods.

**Magic Bullet Maker:**

But you can't do that. What about me?

**The King:**

I've been thinking. It seems to me I built this empire because I wanted to forget. Perhaps I wanted the world to forget. If everything was forgotten then perhaps I could be free. But now I know true freedom only comes when you can remember everything. Look I'll see you're alright. You can do the music.

**Magic Bullet Maker:**

Ah ... cool.

**The King:**

I'll take out a subscription to Green Peace and send a million immediately to the Zapatistas. Oh I've been looking forward to this for a long time.

**Jonathan X:**

Well, what about our freedom?

**The King:**

How do you mean?

**3rd Lost Soul:**

Well, everybody seems to think that you can set us free.

**The King:**

Look, it served my purpose for people to think that I was in charge of everything, but the truth is I have no power at all. You're free already.

**All**

Oh.

**Voice:**

But tomorrow, when we wake up we'll still be on Roundhay Wing.

**The King:**

No, you see, you have woken up already. Now no-one can make you go back.

**Voice:**

We don't have to go back?

**Angel:**

And they never did. They escaped into the spaces. And as dawn came up over East Leeds, Harehills gleamed like the new Jerusalem. And you could almost believe that God sees every sparrow fall after a quiet night on Roundhay Wing.

**1st Lost Soul:**

Yeah. We were down and we were out. We thought there was nothing to shout about.

**2nd Lost Soul:**

We were down in the mouth we had a long face and the treatment we got was such a disgrace.

**3rd Lost Soul:**

But we didn't give up and we didn't lie down because we knew better times were coming around.

**Jonathan X:**

So we got out at last, now it's all in the past and we know these times are going to last.

**The King:**

Because being mad is not all bad, when you realise it's the world that's sad.

**Magic Bullet Maker:**

Nobody owns us, we're free at last. We're nobody's fools. We're our own fools.

**All**

We're nobody's fools. We're our own fools.

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# Audio clip 1

# Transcript

**Liz Barclay**

Dr Harvey Gordon is a Forensic Psychiatrist who has been a Consultant for eighteen years at the Broadmoor High Security Hospital and is currently a Consultant at the Maudesley Hospital in London and Jim Read has worked for many years in organisations and networks of mental health service users and survivors as a Consultant, a Trainer and a Writer. Jim, if I could start with you. Perhaps you could just give us some idea of your personal experience?

**Jim Read**

Yes. It is many years ago, starting when I was five years old when I was put on sedatives by a child doctor, I believe at the request of my parents and then mainly in a period when I was a young adult in the early 1970s when I had a period of time when I was in one of the old psychiatric hospitals on medication and I guess at that point seen as a long term patient, except I managed to get out of that situation, spend some time in a therapeutic community, and for many years now haven't had anything to do with psychiatry as a service user or patient.

**Liz Barclay**

Although you are working with people who do have those experiences?

**Jim Read**

Absolutely, and my entire incentive to be involved in this came from my own experience. I felt that there were a lot of people who were kind of languishing, if you like, in the mental health system as it was then, who, if they had some breaks, could get out and have a decent life and I wanted that to happen. So about twenty years ago I kind of made that decision, 'this is what I want to do with my life'.

**Liz Barclay**

And Dr Gordon, of course you are involved in the delivery of mental health services. To what extent do you feel that those mental health services are delivered as a business, using business as a model. Are services actually delivered in that way?

**Harvey Gordon**

Well there has been an increasing trend over the last ten to fifteen years in that direction, but it creates a certain tension because certainly since the establishment of the National Health Service in 1948, the main principle whether it was physical ill health or mental ill health, was that a patient should receive the treatment that he or she requires irrespective of any financial factors. At the same time the Health Service has to work within a budget, and of course in that regard one can say it is affected by financial factors. I'd be reluctant to think of myself as working as a businessman. I don't wish to operate in that way. The National Health Service is still a public service run largely according to patient need. It is not run according to business principles.

**Liz Barclay**

But isn't there an argument that we get a postcode lottery when it does come to delivery of services because of budgets?

**Harvey Gordon**

Yes, and I think that the current government have made efforts to try and begin streamlining of services with various organisations such as the National Institute of Clinical Excellence which now advises on prioritisation of treatments and that advice, although it is not binding on every region, there is an expectation that it will be taken fully into account.

**Liz Barclay**

Jim, what do you think about the service delivery as a business?

**Jim Read**

I don't think budget constraints is the key issue in mental health and it strikes me that people often have better outcomes in countries where less is spent on mental health in poorer countries. What I do notice is that the governments are always reorganising the National Health Service endlessly and that managers seem to spend most of their time reorganising rather than actually thinking about the service that they deliver. But if you are a patient, what really matters is where you have to go for treatment and what you're given. The major change that has happened in the last decade about that is that increasingly people are treated in the community and that's the sort of thing that actually matters to patients, not whether this one's purchasing from that or this one's delivering this service or what inspection systems you have. To

be honest they don't make a whole lot of difference other than they preoccupy people.

**Liz Barclay**

But isn't there something to be said for standardisation across the board?

**Jim Read**

Well, standardisation, I think, is an interesting issue in mental health because the two things that are never standard are the patients and the practitioners. One of the things the government's introducing at the moment is things like home treatment and assertive outreach teams across the country. Now I think there are some very good home treatment and assertive outreach teams, but that doesn't necessarily mean that they are the ones that are being reproduced, because actually so much in mental health depends on the people who are providing the service and their attitudes and their skills and their orientation and you can put someone who doesn't relate well to a service user in any team and give it any name and any function, it won't be any good. You put someone really good in the worst ward or give them any job title, they would do a good job, so you can't standardise people.

**Liz Barclay**

You can't standardise people, but are people getting a choice?

**Harvey Gordon**

No. I think there is some limitation of choice in regard to mental health. The system is largely arranged by catchment area and it's not impossible, but it is almost impossible to be treated by a psychiatrist and his or her team outwith that catchment area unless you go privately. So in a sense there isn't a great deal of choice. The second problem about choice is that we have to face the tension of where a doctor feels that the right treatment for a patient is X and the patient thinks it is not X but Y. What do you do then? Is there an expectation that the psychiatrist must operate according to the patient's preference?

**Liz Barclay**

Jim?

**Jim Read**

I think choice can be overrated, I think one of the problems of modern society is there is often too much choice. The fact is that the first time you have a mental health crisis, you are not an expert on the

range of treatments that are offered and you want someone to guide you and tell you and to be an expert and to offer you what's best. So to that extent, I don't think choice is always the thing that we should go for. I think where choice is applicable particularly is people who use services over a long period of time often do become knowledgeable, first of all about treatments and services in general but also often about what particularly suits them or works for them. So I think that's where I would like to see more choice and one of the ways you can also do that I think, is by people having direct payments, as is much more widespread with disabled people, with physical impairments. You get a budget that's assessed as being appropriate and then you determine how it is used and have the flexibility to do that. That really puts you in the driving seat in a way that you're not with the kind of monolithic NHS type services where basically you go there and see that doctor or forget it.

**Liz Barclay**

Patients put in the driving seat, but where do the pharmaceutical companies come in?

**Harvey Gordon**

The drug companies they are a business, I think they openly say that they market their medicines for financial gain but at the same time they have to produce medications which doctors are willing to prescribe and which patients are willing to take, so it is a market but it's one which is dependent on the professionals and the public who become mentally unwell finding those medications helpful.

**Liz Barclay**

But isn't there a question of them as businesses creating a market?

**Harvey Gordon**

That has been argued that certain mental conditions are not really mental conditions at all, but socially constructed. I'm really not convinced that just changing the words for what at the end of the day is considerable subjective distress and whether one calls it a disability, a condition or an illness, these things tend to change historically. I suppose one could argue that the distress is engendered by particular societies thinking that something is a disorder and then twenty to thirty years later the same thing is under reconsideration, is no longer regarded as a disorder. I suppose the best examples of that might be some of

the sexual disorders, homosexuality which would have forty years ago both been regarded as a mental disorder in the international classifications and as a crime and now is neither. So it is true that societies themselves can alter what they think is or is not a mental disorder over time.

**Liz Barclay**

But can't that work in the opposite direction too, in that something that people would simply have lived with and addressed within the community, then gets a label and becomes treatable?

**Jim Read**

I suspect that people's expectations of happiness and contentment have risen possibly beyond what is realistic so that people are kind of demanding to be helped when perhaps they might have suffered you know and you can argue about which is the best deal there and that partly perhaps depends on the effectiveness of the help. I also suspect that we're creating more discontent and unhappiness by kind of having a more fragmented and individualistic society, which is more unequal, so I think probably actually the levels of distress in society, in kind of what people usually call advanced capitalist societies, are rising anyway.

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# Audio clip 2

# Transcript

**Liz Barclay**

But let's look at the kinds of drugs that are prescribed. For instance antidepressants, isn't there a danger of an over prescription because of what you have said about people's expectations of help as opposed to suffering, but isn't there a danger that drugs are used and not necessarily the underlying cause of that distress examined?

**Harvey Gordon**

Well it is always possible but that's why there are national and international definitions of what depressive disorder actually is and its variants. Now even if you can identify certain stresses within the person's life or in the environment which has contributed to the person feeling depressed, it doesn't necessarily follow that you can't help to relieve what has been engendered by that stress by biological means. In addition to any environmental assistance, helping with any family conflict, if there's financial problems trying to help with housing issues, all these things are part of modern mental health care in addition to, where appropriate, the medication being prescribed.

**Jim Read**

I'm not saying that people are going to doctors with minor things and getting antidepressants, when people talk about the "worried well" or something I think that is insulting to the level of distress which people experience. But the fact is that the use of antidepressants over the last ten or fifteen years has escalated and you have to think why is this? What are we doing wrong? What are we doing wrong in either GP surgeries or in society in general? There has to be a big problem if that's happening, but no one seems to be that interested and of course the drug companies are in a sense delighted. I'm not convinced about any form of medication actually, I think that it can be quite beguiling because for some people they will experience symptom relief as a result of taking medication, but often once you start taking it, it stacks up problems for later. I was interested to just come across quite recently a review of fifty years of

research into neuroleptics which are the drugs that are given for example to people who have a diagnosis of schizophrenia and the conclusion was that overall, the widespread and long term use of neuroleptics with these people has caused more harm than it has helped.

**Liz Barclay**

You have also said that in some countries where less money is spent on treatment, the results are, I can't actually remember how you put it, but what is your argument for less money being spent on treatment?

**Jim Read**

I am not arguing for less money being spent, but what I am saying is that the World Health Organisation found that actually outcomes for people who qualify if you like, for a diagnosis of schizophrenia, which is a very dubious diagnosis anyway as far as I'm concerned, are actually much better in poorer countries than they are for example in countries like England. There may be a whole load of factors there. One of which is that less psychiatric drugs are used there and that may be the key one, you also have to say that without kind of resorting to cliché and stereotyping, that perhaps people experience less stigma and alienation as a result of having those sorts of distresses in those countries than they do here. Which would then point the way to a much more community based mental health service than the one that still, I think, predominantly looks to drugs as the main form of treatment. I think there are many different ways of dealing with distress and there's plenty of evidence that the sorts of ways that you can research, like psychological therapies are more effective and also much less likely to be harmful or dangerous or dammed unpleasant, all of which can be said about psychiatric drugs. But beyond that in a sense there is everything that the world has to offer, if only we could find a way of bringing that into people's lives and then of course a medically based NHS service isn't going to do that.

**Harvey Gordon**

My experience respecting Jim Read's views that he has just expressed on this, are that in many of the cases that reach hospital, and my practice is both in the community and in hospital, the degree of debilitation to the person and not only to the person but to those he's living with, the people that are looking after him are sometimes worn out. In fact

sometimes they complain that we don't admit the patient when they don't know any longer what to do with him. The longer that the person remains untreated or under treated, the more likelihood there is of much more serious developments. The experience I think uniformly of psychiatrists who work in this field, that we are called upon all the time to intervene preferably with the patient and the carers agreement, regrettably from time to time without it and that's unfortunate but it's a repercussion of the fact that mental illness is not always the same as physical illness, the person as they get more and more unwell they lose the objectivity of their judgement and they do things which in their normal state of mind they wouldn't do.

**Liz Barclay**

But once that intervention is made, how important is it to get the balance right between treating the condition with drugs and treating with alternatives?

**Harvey Gordon**

Well, I think Jim's right that throughout the whole drug era, since the early 'fifties, we've used cognitive therapy, we've used behaviour therapy, we've used dynamic psychotherapy, which indeed started before the drug era, and all these things are used now usually in combination with medication, sometimes instead of. But the argument simply does not conform to my experience, which is not to say that Jim is wrong, but it is simply out with my experience that in all cases, non- medication type interventions results in a successful resolution of all this distress and symptomatology.

**Liz Barclay**

What changes would you like to see to the delivery of mental health services in the next five years? What do you think is the key thing that you'd like to see changed and why?

**Jim Read**

I suppose I'd start with things not getting worse and that means the government getting rid of this ridiculous mental health bill, which they keep kind of threatening us with, which would mean more people being forced to take medication that they don't want. I think it would mean let's stop giving amphetamines to children which is a kind of current new trend and do something about the escalation of antidepressants. That would be a good start. I'd like to see far more staff trained to use psychological therapies and I'd

like to see the knowledge and wisdom of people who have had a diagnosis of mental illness and find ways out of the role of being long term service users, to be really made use of and this whole business of what expertise people do have because they've been in the system, being used properly, not as a kind of tokenistic add on user involvement exercise that everyone has to tick a box to say that they've done, but as something that actually drives and forms a new mental health service which is not reliant on psychiatric drugs.

**Liz Barclay**

Dr Gordon?

**Harvey Gordon**

I certainly entirely support the view that the mental health professionals need to listen. At the end of the day I think it's our obligation to use our training and experience which does at the moment include a prominent role for medication, I would be defensive of that. In fact, I would say that if you said tomorrow that the psychiatric profession can carry on treating mentally ill people, but you cannot use medication anymore, you have to use other means, then I think we would be considerably disadvantaged and so would the patient population and I don't think that anyone would thank us for that at the end of the day. If you would to say to me, 'you cannot use medication anymore', I would feel that I would not have enough confidence that many of my patients would recover sufficiently. Because I see everyday, I see these treatments working. Now I think Jim is quite right to say that there are side effects, in fact if you have cancer as a life threatening condition and we shouldn't forget that mental illnesses can be life threatening conditions, there can be suicides, there can be accidents, rarely there can be homicides and there is quite morbidity associated with mental ill health. So I think it is vital that we recognise that these illnesses are very powerful and in order to combat them we have to have powerful means to do so.

**Jim Read**

They've not been very successful have they? We seem to be kind of focusing at the moment on what the government will call long term and serious mental illness. Drugs never cure anything, people often do not like taking them, they're often pretty dangerous,

they can kill people, people kill themselves while on medication and people relapse on medication.

**Harvey Gordon**

Well, I have no doubt that the relapse rate is far lower when a person who is suffering from a mental illness is on the appropriate medication. All of the studies on suicides, completed suicides, have shown that the patient was either not on antidepressants at the time or was on a very inadequate dosage. It is true there are some suicides who are on ordinary doses of antidepressants, but not many.

**Jim Read**

Well, it's true that people use their antidepressants to kill themselves and it's also true that people, who have used the so-called modern antidepressants, have sometimes actually developed suicidal symptoms as a result of taking them.

**Liz Barclay**

There, unfortunately, we have to leave it, gentleman. Jim Read and Dr Harvey Gordon, thank you.

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