

## **Speaking Out**

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This paper is about the experience of speaking out, often in print, about systems I don't like or can't understand. Often, not understanding is where it begins. Like a child I can't stop asking 'why' if the question pops into my head. I'm only vaguely interested in how; I'm much more interested in why. For example I'm less interested in the concept of personality disorder or the intricacies of attachment theory than why these things are suddenly fashionable. Psychotherapists have, for almost a century, attempted to understand the meanings of people diagnosed schizophrenic; I want to know why voice hearers are suddenly all the rage. Why do managers adopt militaristic and business jargon, refer to their staff as "resources" and then feel surprised staff feel alienated? Asking questions is a route to learning; questioning established systems can be a route to the margins. It is a way of making friends and enemies and coming up with some uncomfortable reflections on your own place in the scheme of things.

This paper addresses the personal impact of asking questions and speaking out in three systems: clinical psychology, psychiatry and NHS management. For readers unfamiliar with the various ways this speaking out has taken place, some examples are first given.

### **Clinical Psychology**

#### ***The Division of Clinical Psychology***

Clinical psychology makes bold claims to be a scientist practitioner profession. It finds itself in the invidious position of also claiming expertise in human relationships whilst psychologists are not being noticeably better at human relationships than members of other professions. We are not alone in this paradox: builders and plumbers are notorious for rarely working on their own homes, general practitioners are not particularly healthy and many child experts have no children. The particular combination of wanting to appear scientists and experts in people makes

the profession vulnerable to criticism concerning both aspirations. British applied psychology's lead professional body, the Division of Clinical Psychology of the British Psychological Society, has embraced much of the rhetoric typical of professions (the need to "protect the public", for "accountability", etc.). In doing so, the Division has failed to examine scientifically whether this rhetoric translates into reality. The surge towards statutory registration of psychologists in Britain has, for example, been accompanied by no data indicating that the public would be protected through registering clinicians. In agreeing, virtually without debate, to embark on various government-backed projects, for example the establishment of Korner monitoring and the READ codes, the profession has abrogated both its scientific responsibility (failing to ask if Korner works) and its pretensions to understanding people (how do people react when asked to categorize conduct in a coded form?). The response from both the DCP committee and, in print, from DCP members (Tyler, 2000) to my own attempts to question these professional moves has been close to vilification.

### ***ECT, the DCP and ME***

In 1992 I found myself, as editor of *Clinical Psychology Forum* (the house journal of the DCP), under examination by the committee of the Division of Clinical Psychology. For some time before I had published spoof advertisements and notices in the pages of *Forum* poking fun at some of the more po-faced aspects of my profession; our claim to be scientist-practitioners, our inability to fill posts in certain departments and so on. A regular column, Herman Ewtix, had also fired some harmless pot shots at the profession over the years. By 1991, at least one eminent member of the profession had had enough. The *Forum* of July of that year included a spoof ad and a piece by Herman Ewtix, which suggested that some senior members of the profession might be considered to be fat cats. There was an article by a service recipient objecting to the Electro-Convulsive Therapy (ECT) she had been given (Kelmsley, 1991) and another by me calling on the DCP for support in speaking out about ECT and other treatments (Newnes, 1991). To its credit, the committee ratified the right of the editor to publish articles of this type. The process took some two hours, however, and included calls on the author of Herman Ewtix to justify his position and in depth questioning of my sense of humor (my counter suggestion that we have a humor sub-committee was not considered amusing). My wisdom in publishing a service user's account was put under scrutiny. Critically, the DCP failed to respond to the appeal

for its help in speaking out about ECT. Given that it had just spent a great deal of energy debating whether freedom of speech in its own journal was permissible this came as no surprise. The messenger had been aimed at, if not shot, and the message ignored altogether (Newnes, 1995).

### ***Harmful clinical psychology***

Clinical psychology claims to have some powerful techniques at its disposal. The idea that these techniques can be harmful, or that the profession might need to more critically examine its own value base, is not new, but is hardly popular. I have presented seminars on harmful clinical psychology to trainees and qualified clinical psychologists since the early 1990s (cf: Newnes, 1993). These sessions include details of our profession's foundation which are less than comforting and frequently come as a surprise to people; our close links with the eugenics movement, our willingness to borrow theory and practice from many other professions, particularly psychiatry, before claiming these as our own, our compliance with a range of abusive procedures and regimes in both psychiatry and learning disability services and so on (cf: Newnes, 1997). As a profession dominated by self-interest, it is not only in the clinical sphere that we have gone along with and profited from dubious ideologies. The Thatcher years of power saw Britain's National Health Service transformed by the rhetoric of business and industry. Health Authorities were divided into purchasers or providers, the NHS was assumed to be bureaucracy ridden and in desperate need of reform, human resources sections replaced personnel departments as staff were commodified; efficiency was suddenly the key to better services. As scientist practitioners, clinical psychologists might have been expected to, at the very least, set up ways of testing the effectiveness of this new culture. Instead, we were swept along with the new competitiveness, created accounting systems and audit trails, and described research or teaching previously offered in the context of our existing role as "added value". In the five years 1991-1995, *Clinical Psychology Forum* received and published only nine critiques of this commercialization of the NHS and 36 papers on audit, marketing and service costs. Some critics (Mair, 1988; O'Loughlin, 1994) were dismissed as woolly radicals uninterested in accountability and out of touch with the needs of a modern health service. This charge is even more common for those questioning current government policies.

## Psychiatry

### *The Anti-psychiatry placement*

Psychiatry is not in good health at the beginning of the third millennium. Its role as agent of social control is to the fore, its complicity with drug companies open to public scrutiny and the weakness of its pretensions to diagnostic surety regularly exposed. Despite these cracks in the psy-complex (Peter Breggin's, 1991, term for the collective vested interests of psychiatry and the pharmaceutical industry), psychiatry wields enormous power and has remarkable resources at its disposal to promote a deterministic, genetically driven, bio-chemically based view of humanity. Those who dispute its claim to authority over the human condition receive short shrift (Johnstone, 1993). Since 1994 I have offered an opportunity for clinical psychology trainees to critically examine the psychiatric system and clinical psychology's place within it (Newnes and MacLachlan, 1996; Newnes, Hagan and Cox, 2000). This anti-psychiatry placement has gradually shifted focus to a more thorough examination of the role that clinical psychology plays in the psy-complex (Cox and Kelly, in press). The placement is only one aspect of local attempts to speak out about the mental health system.

### *User involvement in services*

The Shropshire Advocacy Forum was founded in 1992. I was on its steering group and later joined the Patients' Council Support Group. Mental health professionals have a great deal to offer advocacy and similar endeavors. (Holmes, 1996; MacLachlan, 1996; Newnes and Shalan, 1997; Newnes, 2001). Shropshire's department of psychological therapies employs service users on interview panels and contracts with ex-service users as management and training consultants (Long, Newnes and MacLachlan, 1999; Newnes, 2001). Promoting the user perspective is not always popular with either clinicians or management. Both groups find that there is frequently an embarrassing mis-match between what services are intended to provide and the experience of service recipients (cf: Goodwin, Holmes, Newnes and Waltho, 1999). Helping services users speak out about the state of twenty-first century psychiatry in word (e.g., as speakers at mental health conferences or seminars) or print (Hudson, 1999) is only grudgingly accepted by managers already overwhelmed by a huge range of diverse government and staff demands.

## **Management**

### ***Trying to make sense of management***

The National Health Service is a monument to the dedication of the majority of its staff. Its sheer size and unusual commitment of its workforce, many of whom remain loyal for political reasons, militates against borrowing tools from industry, yet this is what its management consistently attempts. Chief executives and chairmen are drafted in from business and the armed forces. Accountants with limited knowledge of state run agencies are asked to audit financial and other systems. Clinicians, who find themselves managing staff are expected to act as if these people are significantly different from the population which, at any other time, they might meet as patients (Newnes, 2000). Management systems in an organization as vast as the NHS are bound to be flawed, inconsistently applied and, at times, appear crazy. Senior NHS managers, however, are full of rhetoric about efficiency, effectiveness and accountability. An extraordinary amount of time is spent worrying about petty rule infringement, for example, in submitting incomplete clinical activity data, while wholesale incompetence, corruption, and in the case of some clinical procedures, negligence simply goes undetected. Speaking out about management process, for example, the complexities of clinical note taking and case note retention (Newnes, 1995) or the lack of coherent health strategy is difficult. As a general rule, a management group would rather pay large fees to an external consultant to highlight problems than listen to one of its own managers.

In psychiatry particularly, the absence of a clear and coherent service philosophy, be it a commitment to socialized medicine or social role valorization (Wolfensberger, 1998) is problematic: psychiatric service users are especially vulnerable to clinicians claiming that private medical treatment would be preferable or to cost-driven attempts to only provide mixed sex wards or so-called rehabilitation facilities in the grounds of psychiatric hospitals. Speaking out about either concern (Newnes, 1998) will result in contemptuous dismissal as an idealist.

## **Effects of speaking out**

### ***Does it change anything?***

Speaking out can be a dispiriting business. Services users and professionals can be left pretty despondent at their apparent failure to change very much. Health service systems are large, have

a diversity of functions and many agendas alongside that of serving the public. For some, speaking out in such a context seems hopeless and frightening. A psychiatric inpatient commented to our local patients' council, "If I complain, they will probably give me an injection". Another said, "It's no use saying anything – they don't listen to us patients". Similar comments were received in a survey of staff attitudes to consumer surveys: "It's a good idea, but it won't change anything" (Spencer, 1995). There is good reason for this cynicism. Two public enquiries at Ashworth Special Hospital (Blom-Cooper, 1995; Fallon et al. 1999), prompted by individuals speaking out, suggested the closure of the hospital. The recommendation was ignored. Professor Steve Baldwin and other leading psychologists and psychiatrists (Breggin, 2001) have campaigned for many years to prevent the use of Ritalin and similar stimulants with children, a battle Professor Baldwin describes as "winnable". Yet, Ritalin was recently sanctioned for regular (and more regulated) use by the British government's National Institute for Clinical Excellence, in effect a clean bill of health for amphetamine-like drugs. Despite many years of recording literally thousands of complaints and concerns about ECT, neither the American Food and Drug Administration (FDA) nor the numerous ECT pressure groups in the United States have managed to get ECT machines reclassified as Class III (high-risk) medical devices, i.e., devices that must be proven safe before their use (CTIP, 2000).

It can appear that speaking out changes nothing. On a small scale, however, saying clearly what is seen as wrong with a system or process can change hearts, minds and conduct. In psychiatry, for example, concerted efforts by service users and their professional allies have resulted in the establishment of better information for recipients of psychoactive medication. There has been a similar shift in the attitudes of mental health professionals to issues of race, gender and poverty. All these changes are, of course, part of a wider cultural change. Speaking out in advance of these cultural changes can be deemed premature, to be hailed as visionary or dismissed as unrealistic. When *Survivors Speak Out* first claimed, over ten years ago, a place for service users on mental health planning committees, the idea was seen as preposterous, a classic case of the inmates taking over the asylum. At the beginning of the twenty-first century, the question is not whether to include services users, but how, and how much to pay them. Changes of this type are seeded by those brave enough to speak out, seeds that will grow and bear fruit when the conditions are right. Equally major shifts can be made in clinical regimes. Peter Breggin's

successful campaigning almost single-handedly prevented most lobotomy being carried out in the United States in the 1970s (Isaac and Armat, 1990). Similarly, ECT has been banned in Holland, Italy and Germany through campaigning pressure groups (Arscott, 1999).

Small changes in management practice can come about by speaking out about sexist or racist remarks at management meetings. Human Resources departments can be used to assist where there is a need to speak out on issues of, for example, equal opportunities and a number of investigations of corporate NHS corruption or clinical concern have been instigated by individuals speaking to the press.

### ***Personal impact***

The personal effects of speaking out include social rejection and physical exhaustion. The person's personal safety and livelihood can be put at risk. Some effects result from an identification of the advocate with devalued and marginalised people. Bender and Wood (1994) discuss the likely impact on whistle-blowers' careers and see the willingness to leave a job as essential. Famously, Moira Poitier, a clinical psychologist working in Ashworth High Security Hospital, spoke out about the treatment of patients. Her testimony was an integral part of the Ashworth Inquiry (Blom-Cooper, 1995) and she received an MBE for her courage. There are other effects, both negative and positive.

There is, for example, a recurring sense of self-doubt; perhaps madness really is only the result of faulty brain biochemistry, perhaps clinical psychology is not just another profession, perhaps NHS management really is concerned, first and foremost, about patients. Being shot as the messenger is commonplace. Remarking, for the umpteenth time that a management process is flawed or a clinical procedure dubious will eventually push the speaker into a corner; to be marginalized as the (unheard) voice of reason, or marked as politically motivated and a trouble-maker. The process is exhausting, not least due to the energy taken up in defending against feeling disliked and the bursts of 3.00am paranoid anxiety. Other effects are more personally idiosyncratic; drinking more alcohol, driving faster, becoming arrogant, getting more easily annoyed at home, even getting bored with the same arguments; it is difficult to keep in mind that just as every new cohort of trainees is exposed to the rhetoric of organic psychiatry or the

unsurpassed excellence of clinical psychology, each cohort will need a dissenting, more critically reflexive voice. Keeping that voice from going hoarse is a strain. So why do it?

Speaking out in the world of mental health is part of a much larger resistance movement; to glibness, to oppression, to the sheer smugness of the psy-complex. It protects the person from a position of bad faith; if some things considered bad are inevitable, then at least we can say they are bad, if others can be changed through voicing concern, then to do otherwise would be cowardly. This is not to say that the courage in speaking out should be taken for granted. For some people, such action is not realistically possible, for many others, speaking out is only possible with a considerable amount of support; from friends, colleagues, unions or local and national networks. The response from others, often strangers across the other side of the world, is immensely heartening. To receive a post-card from someone thousands of miles away saying they have been inspired by your position compensates for many of the voices disagreeing. In the psychiatric field, speaking out as a professional can be enormous fun; inevitably a patients' council meeting is more interesting and diverting than most management meetings. Sitting alongside a psychiatric service user at a rally or on the platform of a conference is at least as satisfying as offering that person psychotherapy. Finally, speaking out almost certainly fulfils a personal script; to be seen as different, to rebel, to be like (or unlike) dad or mum. In my own case I expect the seeds were sown as I watched my dad battle with the inanities of management and the in-justice in the world of factory work. My mum loved him despite his grouchiness; my own position must be Oedipal.

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