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‘From Mental Patient to Service User: Deinstitutionalisation and the
Emergence of the Mental Health Service User Movement in Scotland
1971-2006’

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Abstract

Until recently research on the history of psychiatry was largely focused on the institutions where this controversial branch of medicine emerged, on its practitioners, treatments, theories and clinical practices, and the shifting social, institutional and legal contexts in which it has developed. Two pioneering figures in the histories of psychiatry and medicine, Michel Foucault and Roy Porter, opened the historiographical field up to much broader perspectives, expanding the range of sources and interpretations to encompass a wide-lens focus on matters such as the relationships between histories of madness and rationality, ‘the patient’s view’ and ‘anti-authority struggles’ by psychiatric patients. The study undertaken here seeks to develop aspects of the historiographical approaches advanced by Foucault and Porter by investigating how psychiatric patients engaged in collective action and campaigned for reform to mental health services in late twentieth-century Scotland. Through an excavation, description and analysis of untapped archival and oral history sources, I chart the spaces of emergence and trace the intersecting lines of descent of the ‘Scottish user movement’ in the era of deinstitutionalisation. By examining the records of patients’ groups and oral history interviews with activists, I reveal how this small but significant social movement was formed through the interplay between top-down social and governmental practices and bottom-up resistance and action by patients. The study makes visible the characters, voices, settings, events and actions, which made up the changing discursive and social practices of patients’ groups in Scotland over the last half-century.

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Author's declaration

I declare that, except where explicit reference is made to the contribution of others, that this dissertation is the result of my own work and has not been submitted for any other degree at the University of Glasgow or any other institution.

Signature.....

Printed name.....

Abbreviations

BBC – British Broadcasting Corporation

CAPS – Consultation and Advocacy Promotion Service

EAMH – Edinburgh Association for Mental Health

EUf – Edinburgh Users’ Forum

GAMH – Glasgow Association for Mental Health

GAP – Glasgow Advisory People

HUG – Highland Users’ Group

IRA – Irish Republican Army

IT – International Times

LUF – Lothian Users’ Forum

MPU – Mental Patients’ Union

MWCS – Mental Welfare Commission for Scotland

NAMH – National Association for Mental Health

NHS – National Health Service

OMH – Oor Mad History Project

PNP – People Not Psychiatry

REHPC – Royal Edinburgh Hospital Patients’ Council

SAMH – Scottish Association for Mental Health

SCCL – Scottish Council for Civil Liberties

SUMP – Scottish Union of Mental Patients

SUN – Scottish Users’ Network

SHG – Survivors History Group

SSO – Survivors Speak Out

UCS – Upper Clyde Shipbuilders

UKAN – United Kingdom Advocacy Network

VOX – Voices of Experience

WFMH – World Federation for Mental Health

WHO – World Health Organisation

CHAPTER 1**INTRODUCTION: TOWARDS A HISTORY OF COLLECTIVE ACTION BY PATIENTS**

1.1 Introduction

The system of treatment and care of the mentally ill in the UK was transformed during the course of the twentieth century. The following are all significant markers of transformation in the field: the move away from the custodial framework of the Victorian Poor Law; the coming of the NHS and the inclusion of mental health services within it; the closure of most of the old Victorian asylums and their replacement by 'community care'; and the growth of biomedicine and the development of new therapeutic technologies, especially psychoactive drugs. But was this, in the words of one commentator, a time of 'innovation without change'?¹ If these unmistakable shifts in the field of mental health in post-war Britain have not sustained the promise of cure once held out by psychiatric medicine, the suspicion expressed in these words might not be altogether misplaced. The problem of chronic mental illness is still with us today. While scientists continue to search for the next 'targeted' drug treatment or psychosurgical procedure to control the symptoms of schizophrenia more successfully, many of those responsible for the treatment and care of the mentally ill appear to have disabused themselves of the belief in the imminent prospect of a cure for such 'severe and enduring' conditions emerging. Therapeutic optimism in relation to the treatment of mental illness has waxed and waned throughout the twentieth century, but a decidedly hard-headed assessment of how to manage such conditions now characterises the contemporary discourse of recovery which, in its simplest and clearest expression, is a critique of the notion of cure. Recovery is about a person with a severe and enduring condition such as schizophrenia living a meaningful life, as defined by the person, in spite of the continuing presence of the symptoms of this debilitating illness. Beyond this minimalist definition, it turns out that the much vaunted recovery model of care is an amorphous creature which simultaneously discards the hope for cure, while reviving the hope for something less clearly defined in advance by the medical expertise of psychiatry.

Research on the history of psychiatry and mental health care reveals that questions of values are implicated, as much as matters of fact and the development of scientific knowledge, in this politically contentious field of work. To take a perspective on the field is to address conflicts of values, however well concealed beneath the rhetoric of value-free, scientific objectivity. Disengagement from questions of values and politics is a failure to confront important features of the histories of medicine and health. There can be no doubt about the growth of knowledge and technological innovation in medicine during the last century. Inevitably questions of whether scientific and technological progress equates to humanitarian progress in the matter of care and social attitudes towards mental illness will not be answered simply by appeals to the ever expanding evidence-base of scientific endeavours far removed from the everyday practices of

¹ David Brandon, *Innovation Without Change? Consumer Power in Psychiatric Services* (London: Macmillan, 1991), pp. 1-2.

governing the mentally ill. Competing knowledge claims go hand in hand with value judgements in debates over what mental illness or madness is, who should count a condition as pathological, and how society should respond to such conditions so defined.

For those most intimately involved in addressing the problems of mental illness in our society, questions of what values and ethics are guiding practices, how power is exercised, how politics and policy are implicated, are an inescapable feature of their knowledge and practice: first, because it is directed towards intervention in human thought and conduct; second, because psychiatric patients can be detained and treated against their will without having committed a crime or broken a law; and third, because the state and governmental authorities have not disengaged entirely from such complex human and social problems, notwithstanding some appearances to the contrary. The practices of the management of the mentally ill in society are as much a matter of social government, as they are medical treatment and care. Social government, does not merely concern state intervention, decisions made by politicians in Cabinet or Parliament, civil servants in Whitehall (Westminster) and St Andrews House (Edinburgh), or councillors at city hall. Whilst it involves all those forms of government, it also involves social work departments within local authorities, managers in the NHS, the interventions and administrations of the law, the courts, police, welfare bureaucracies and charitable organisations. The professionals and workers on the ground in the field of mental health do not occupy positions of political or value neutrality. In their relationships and interactions they form a complex web of competing interests and relations of power and knowledge within society. In addition to community psychiatric nurses, psychiatrists have been joined by predominantly non-medical practitioners, including psychologists, social workers, occupational therapists, social care workers, counsellors and others. Mental health care in the late twentieth century became an increasingly multi-disciplinary enterprise shaped by knowledge and practice not so obviously associated with medicine. The aforementioned shifts and the redistributions of power in the field of mental health care have not always been welcomed by psychiatrists.

In a 2008 article by a group of mainly university-based academic psychiatrists, the authors lament a 'creeping devaluation of medicine' and the 'false assumption that severe psychiatric illness equates only to chronicity and poor treatment response'.² They go on to argue that 'patients referred by their general practitioner should be assessed by a named psychiatrist rather than an anonymous team'.³ They describe the psychiatrist as 'the most appropriately skilled and experienced professional on the team' and regard 'the model of distributed responsibility and leadership as a pragmatic, short-term response to recent crises in staffing and morale in general psychiatry'.⁴ Whilst they claim to regard multidisciplinary working as a 'welcome advance', they believe that

² Nick Craddock, Danny Antebi, Mary-Jane Attenburrow et al., 'Wake-up call for British psychiatry', *The British Journal of Psychiatry* 193 (2008), p. 6.

³ *Ibid.*, p. 7.

⁴ *Ibid.*, pp. 7-8.

'changes in psychiatric practice and thinking within the UK NHS are in danger of throwing the baby out with the bathwater'.⁵

This article provoked some lively responses and vigorous debate. The debates which ensued served to highlight some of the fault lines running through contemporary mental health care and within psychiatry, not least some continuing tensions between proponents of biomedical and psycho-social interventions in mental health care. Conspicuous by its absence in this article by Craddock et al, however, was any attempt to engage with questions of why groups of psychiatric patients, or mental health service users, have challenged the perceived paternalism of their profession. There is no consideration given to the question of why a movement of service users, or psychiatric 'survivors', has emerged in the last half century, often challenging a reductionist biomedical approach in psychiatry. In response to commentary on their article Craddock et al, claim not to be 'terribly interested in what is past'.⁶ The failure of some psychiatrists to reflect critically on the history of their profession, and the sometimes hostile reactions to psychiatry by groups of patients, is indicative of a defensive attitude within this controversial branch of medicine. However it is not surprising that the profession has gone on the defensive at times when its authority has long been under attack from different quarters. Historians have entered these debates with their own particular interpretive perspectives such that it would be naïve to think that they could offer something like a pure description or 'view from nowhere' of the unfolding of these conflicts of perspective. However, if historians are prepared to address the criticism that 'history related to mental health is dominated by the history of asylums, psychiatry and medicine', and move beyond an approach to the history of mental health which privileges the knowledge of psychiatry, then a clearer view of some of these tensions will emerge.⁷ The collective activities and concerns of groups formed by psychiatric patients and their allies in recent decades offer a glimpse into the tensions, the politics, the conflicts of values and the shifting relations of power and knowledge which are a feature of mental health care in the late twentieth and early twenty-first centuries. This study describes and analyses the emergence and transformation of collective action by psychiatric patients in Scotland between 1971 and 2006. In this chapter, first it is necessary to reflect briefly on how historians and sociologists of medicine have conceived of the history of patients, and second, to introduce an approach derived from Michel Foucault which does not leave the patient dominated or voiceless, but which seeks to situate collective action in geographical and discursive contexts, paying attention to the ways in which patients have resisted psychiatry, and the changing discourses, tactics and strategies they have employed in their struggles.

⁵ Ibid., p. 8.

⁶ Nick Craddock, Danny Antebi, Mary-Jane Attenburrow et al., 'Wake-up call: Response from authors' *British Journal of Psychiatry* 19 October 2008 <http://bjp.rcpsych.org/content/193/1/6#wake-up-call-response-from-authors> [accessed 12 October 2012].

⁷ Kirsten Maclean, 'Introduction', in *Oor Mad History: A Community History of the Lothian Mental Health Service User Movement* (Edinburgh: Living Memory Association, 2010), p. 8.

1.2 'The Patient's View': Towards a History of Collective Action by Psychiatric Patients

Two conflicting views of the patient's place in the medical encounter have been concerned, on the one hand, with how the figure of the patient was constructed by discourses of medicine, and on the other, with how the patient exerted some degree of control, autonomy or choice over their medical treatment. David Armstrong has argued that in modern times the patient is an artefact of the 'medical gaze'.⁸ According to Armstrong, during the twentieth century 'the patient's view was not, in this sense, a discovery or the product of some humanistic enlightenment. It was a technique demanded by medicine to illuminate the dark spaces of the mind and social relationships'.⁹ Conversely Roy Porter has suggested that 'even under medical control patients have by no means been so passive as the various "medicalization" theories [...] might lead us to believe'.¹⁰ In response to such views, Alex Mold has urged caution, warning that 'it should not be assumed that individual agency disappeared with the development of biomedicine, but nor is it the case that patients were either autonomous individuals or powerless subjects'.¹¹ The concern expressed by Mold is suggestive of a possible middle-way between the two approaches exemplified in the perspectives of Armstrong and Porter on 'the patient's view'. In a demand for a more balanced account of the history of medicine by 'doing medical history from below', Porter emphasised that it 'takes two to make a medical encounter – the sick person as well as the doctor'.¹² He goes on

Indeed, it often takes many more than two, because medical events have frequently been complex social rituals involving family and community as well as sufferers and physicians. Moreover, a great deal of healing in the past (as, of course, in the present) has involved professional practitioners only marginally, or not at all, and has been primarily a tale of medical self-help, or community care. In medicine's history, the initiatives have often come from, and power has frequently rested with, the sufferer, or with lay people in general, rather than with the individual physician or the medical profession at large.¹³

Other influential works on the relationship between the patient and medicine have emphasised the extent to which the balance of power in the medical encounter had shifted in favour of the doctor with the rise of 'hospital medicine'.¹⁴ In a seminal work Nicholas Jewson argued that the move from 'bedside medicine' to predominantly hospital-based medicine in the late 18th and early 19th centuries marked 'the disappearance of the sick man from medical cosmology' and established a

⁸ David Armstrong, 'The Rise of Surveillance Medicine', *Sociology of Health and Illness* 17 (1995), p. 396.

⁹ David Armstrong, 'The Patient's View', *Social Science and Medicine* 18 (1984), p. 739.

¹⁰ Roy Porter, 'The Patient's View Doing Medical History from Below', *Theory and Society* 14 (1985), p. 194.

¹¹ Alex Mold, 'Making the Patient-Consumer in Margaret Thatcher's Britain', *Historical Journal* 54 (2011), p. 512.

¹² Porter, 'The Patient's View', p. 175.

¹³ *Ibid.*, p. 175.

¹⁴ Erwin Ackerknecht, *Short History of Medicine* (Baltimore, MD: The Johns Hopkins University Press, 1982), p. 146.

doctor-patient relationship dominated by professionals.¹⁵ Mary Fissell developed the line of argument that with the invention of hospital medicine during the 18th century, ‘doctors begin to sound like doctors, and patients’ voices disappear’.¹⁶ A similar kind of claim is made about the relation between psychiatrists and their patients, the sane and the mad, in Michel Foucault’s controversial and influential study of the history of psychiatry. Foucault avers that the mad were excluded from discourse with the rise of modern psychiatry:

The constitution of madness as mental illness [...] bears witness to a rupture in dialogue [...] and expels from memory all those imperfect words, of no fixed syntax in which the exchange between madness and reason was carried out. The language of psychiatry which is a monologue of reason about madness has been established only on the basis of that silence.¹⁷

Sociologists influenced by Foucault, such as Armstrong and Nikolas Rose, have studied the way in which medical discourses and practices have, not simply silenced or excluded patients, but rather, formed and shaped subjects and objects, from scientific knowledge, expertise and regulation.¹⁸ This follows an approach in which Foucault suggested ‘depriving the subject (or its substitute) of its role as originator and analysing the subject as a variable and complex function of discourse’.¹⁹ This has led to the charge that such a form of analysis banishes the possibility of human agency in processes of social construction and transformation, making the human subject the product of dominant discourses, with little or no room for individual freedom. Foucault has responded that where power is exercised there is always resistance and that power relations involve an interplay in which those implicated are always seeking to modify and alter the balance of power and how it is exercised. Foucault’s engagement with the history of psychiatry has focused more on how power has been exercised over psychiatric patients, their exclusion and marginalisation, and less on the forms of resistance to psychiatric power and knowledge by patients. In his *History of Madness* Foucault offered a romanticised view of resistance embodied in the artistic and literary works of figures like Friedrich Nietzsche and Vincent van Gogh, rather than taking account of forms of collective resistance of psychiatric patients. He did however recognise emerging forms of resistance to psychiatric authority by patients in the 1970s, and began to articulate new ways of conceiving these ‘anti-authority struggles’ in his later work.²⁰

In response to the Foucaultian sociological approaches of Armstrong and Rose, sociologist Nick Crossley has claimed that ‘power and dominant discourses have been the key focus of analysis, to

¹⁵ Nicholas D. Jewson, ‘The disappearance of the sick-man from medical cosmology, 1770–1870’, *Sociology* 10 (1976), pp. 225–244.

¹⁶ Mary E. Fissell, ‘The Disappearance of the Patient’s Narrative and the Invention of Hospital Medicine’, in *British Medicine in an Age of Reform*, ed. Andrew Wear and Roger French (London: Routledge, 1991), p. 99.

¹⁷ Michel Foucault, *History of Madness* (London: Routledge, 2006), p. xxviii.

¹⁸ See Nikolas Rose, ‘The Discipline of Mental Health: The Power of Psychiatry’, in *The Power of Psychiatry*, ed. Peter Miller and Nikolas Rose (London: Polity, 1986), pp. 43–84.

¹⁹ Michel Foucault, ‘What is an Author?’, in *The Foucault Reader*, ed. Paul Rabinow (London: Penguin, 1984), p. 118.

²⁰ Michel Foucault, ‘The Subject and Power’, in *Power: Essential Works of Foucault 1954–1984 Volume Three*, ed. James D. Faubion (London: Penguin, 2002), p. 329.

the detriment of the proper consideration of resistance and counter-discourses'.²¹ In his research Crossley sought to give proper consideration to groups of patients who contested psychiatric medicine in the second half of the twentieth century in Britain.²² But for Foucault any study of the various forms of resistance by psychiatric patients cannot be conducted without taking into account 'how the mentally ill were governed':

Governmentality in the widest sense of the term, as the group of relations of power and techniques which allow these relations of power to be exercised [...] How the mentally ill were governed [...] I put the word to govern in quotation marks, giving it both a rich and wide meaning; how the patients were governed, what one did with them, what status they were given, where they were placed, in what type of treatment, what kind of surveillance, also acts of kindness, philanthropy, economic field, care to be given to the ill: it is all that, I think one must try to see.²³

Government is conceived as 'the way in which the conduct of individuals or of groups might be directed [...] To govern, in this sense, is to structure the field of possible action of others'.²⁴ Foucault stressed that 'power is born out of a plurality of relationships which are grafted onto something else, born from something else, and permit the development of something else' and 'if there was no resistance, there would be no power relations because it would simply be a matter of obedience'.²⁵ Historians have tended to focus on the 'Foucaultian perspective which emphasises the patient as a construct of the medical sciences'.²⁶ The Foucaultian patient is seen as 'subjugated, submissive, docile, powerless [...] a symbol of medicalization gone wrong' and 'portrayed as characteristically voiceless'.²⁷ Whilst this is a well-rehearsed perspective of Foucault's, it is not the only view he articulated and tends to ignore works of his in which he presented a more nuanced approach to the interplay of power and resistance. The exercise of power over the mad, their social and spatial exclusion, their confinement to large asylums in the past, not only played a negative role of exclusion, but also played a positive role of organization, mostly for the psychiatric profession, but eventually for psychiatric patients resisting medical discourses and psychiatric power also.²⁸ The asylums provided a base from which the modern psychiatric profession emerged and expert knowledge was claimed. In the twentieth century the asylums became a focus for critique and resistance by patients and others. Foucault's analyses, which extended beyond psychiatric medicine, also recognised the importance in the 'politics of health', of religious groups,

²¹ Nick Crossley, 'R.D. Laing and the British Anti-Psychiatry Movement: A Socio-Historical Analysis', *Social Science and Medicine* 47 (1998), p. 877.

²² See Nick Crossley, *Contesting Psychiatry: Social Movements in Mental Health* (Abingdon: Routledge, 2006).

²³ Michel Foucault, 'What Our Present Is', in *The Politics of Truth*, ed. Sylvère Lotringer (Los Angeles: Semiotext(e), 1997), p. 135.

²⁴ Foucault, 'The Subject and Power', p. 341.

²⁵ Michel Foucault, 'Clarifications on the Question of Power', p. 260, and 'Sex, Power and the Politics of Identity', p. 386, in *Foucault Live*, ed. Sylvère Lotringer, (New York: Semiotext(e), 1996).

²⁶ Flurin Condrau, 'The Patient's View Meets the Clinical Gaze', *Social History of Medicine* 20 (2007), p. 536.

²⁷ Alexandra Bacopoulos-Viau and Aude Fauvel, 'The Patient's Turn: Roy Porter and Psychiatry's Tales, Thirty Years On', *Medical History* 60 (2016), pp. 5; 7.

²⁸ See Michel Foucault, *History of Madness* (London: Routledge, 2006), p. 101.

dissenting movements, charitable and benevolent associations and philanthropic societies, in addition to medical professionals, and the state. Part of the interest of madness and the social response to it for the historian is how the political significance of psychiatry goes well beyond the doctor-patient power relation, being susceptible to shifts of a much wider social, cultural, political and economic nature. There is an intricate network of social relations to be analysed, encompassing the ways in which the mad are governed in the broadest sense. But Foucault claims that

Our relationship to madness is a historically established relationship, and [...] it is through many actions, reactions, etc. ...through many battles, many conflicts to respond to a certain number of problems, that specific solutions are chosen.²⁹

Relationships are in perpetual slippage from one another [...] we have perpetual mobility, essential fragility or rather the complex interplay between what replicates the same process and what transforms it.³⁰

The production of knowledge of mental illness was historically contingent on the removal of people from society and their internment in asylums.³¹ However, by the same token such an act of exclusion and segregation served, in due course, to collectivise some groups of patients. Crossley points out that, ‘through its labels and categories psychiatry imposed a unified identity upon this population, which they, in turn, were able to appropriate for themselves [...] able to experience themselves as a unified class of subjects and to form a collective identity’.³² Foucault, who was skeptical about framing resistance and counter-discourses in terms of collective identity, saw ‘a relationship of struggle between two adversaries’ as ‘the result of power relations with the conflicts and cleavages they engender’.³³

Flurin Condrau has suggested that ‘the real minefield for the history of patients is to begin to make sense of Foucault’.³⁴ He writes that, ‘a Porter-esque history of the patient’s view and a Foucaultian analysis of discourse and power leaves us with the paradoxical relation of a mainly empirical view “from below” and a theoretically informed account of how the patient gets constructed through discourse, knowledge and power’.³⁵ For Condrau ‘history from below implies power struggles, resistance and perhaps even a popular movement’, but ‘if history from below has to do with power structures, then patients appear to be the least likely group to challenge medical power and influence’.³⁶ Condrau claims that a ‘political background for patients is not easy to

²⁹ Foucault, ‘What Our Present Is’, p. 139.

³⁰ Michel Foucault, ‘What is Critique?’ in *The Politics of Truth*, ed. Sylvere Lotringer, (Los Angeles: Semiotext(e), 1997), p. 65.

³¹ Roy Porter wrote that ‘the rise of psychological medicine was more the consequence than the cause of the rise of the insane asylum. Psychiatry could flourish once, but not before, large numbers of inmates were crowded into asylums’, *A Social History of Madness* (London: Phoenix Giants, 1996), p. 17.

³² Nick Crossley, ‘Fish, Field, Habitus and Madness: the first wave mental health users movement in Great Britain’, *British Journal of Sociology* 50 (1999), p. 659.

³³ Foucault, ‘The Subject and Power’, p. 348.

³⁴ Condrau, ‘The Patient’s View Meets the Clinical Gaze’, p. 527.

³⁵ *Ibid.*, pp. 527-528.

³⁶ *Ibid.*, pp. 533-534.

unearth'.³⁷ Similarly, writing in the 1950s on the prospects for patients organizing themselves into collectives of one kind or other, sociologist Talcott Parsons articulated a conception of the 'sick role' of the patient in which

the two most dangerous potentialities, namely group formation and successful establishment of the claim to legitimacy, are avoided. The sick are tied up, not with other deviants to form a sub-culture of the sick, but each with a group of the non-sick, his personal circle and, above all, physicians [...] deprived of the possibility of forming a solidary collectivity.³⁸

Contrary to Parsons' analysis of the 'sick role', from the mid-twentieth century onwards a 'non-deferential collective identity amongst the disabled and chronic sick' formed and patient-led campaign groups emerged across a number of western nations, taking collective action to challenge medical authority, sometimes forming sub-cultures of the sick.³⁹ These bottom-up movements included groups of psychiatric patients. These patient groups emerged during a time when across the western world psychiatric medicine and mental health services were beginning to undergo a process of 'deinstitutionalisation'. This process involved a shift from a single institution of mental health care and treatment, the mental hospital, to a variety of other sites in the community. Condrau has argued that 'there is a debate to be had between largely empirically driven accounts of the history of patients and a more Foucaultian perspective'.⁴⁰ But, 'the history of patients' he claims, 'has always suffered from a lack of methodological inspiration'.⁴¹ If Condrau had found that 'a political background for patients is not easy to unearth', others have found that whilst it may not be easy, it can be done.⁴² If, as Foucault remarks, patients' voices have been 'buried or masked in functionalist coherences or formal systematizations' then unearthing the documents which reveal the discourses and practices of resistance may involve looking beyond hospital records and case notes compiled by doctors.⁴³ As Kerry Davies relates, 'there has been a definite shift in the physical spaces and communication patterns available, and thus in the nature of patients' voices and silences, since 1948'.⁴⁴ The records of patient unions, advocacy projects, self-help and support groups which emerged in the twentieth century are becoming available, allowing a glimpse into the ways in which patients have resisted not only psychiatric power, but also how they have challenged health services, welfare bureaucracies and other governmental authorities. As the sources emerge,

³⁷ Ibid., p. 534.

³⁸ Talcott Parsons, *The Social System* (New York: Free Press, 1951), p. 477.

³⁹ Malcolm Nicolson and George Lowis 'The Early History of the Multiple Sclerosis Society of Great Britain and Northern Ireland: A Socio-Historical Study of Lay/Practitioner Interaction in the context of a Medical Charity', *Medical History* 4 (2002), p. 173.

⁴⁰ Condrau, 'The Patient's View Meets the Clinical Gaze', pp. 535-536.

⁴¹ Ibid., p. 536.

⁴² See Nicholas Hervey, 'Advocacy or Folly: The Alleged Lunatics' Friends Society, 1845-63', *Medical History* 30 (1986), pp. 245-275; Nick Crossley, *Contesting Psychiatry: Social Movements in Mental Health* (Abingdon: Routledge, 2006).

⁴³ Michel Foucault, *Society Must Be Defended: Lectures at the College de France, 1975-1976*, ed. Mauro Bertani and Alessandro Fontana, General ed. François Ewald and Alessandro Fontana, trans. by David Macey (London: Penguin, 2003), p. 7.

⁴⁴ Kerry Davies, "'Silenced and Censored Travellers'? Patients' Narratives and Patients' Voices: Perspectives on the History of Mental Illness since 1948', *Society for the Social History of Medicine* 14 (2001), p. 272.

so do the questions of method and how to approach them. Foucault was not well received by some historians, but even his critics admit that the influence of his work on the histories of madness and psychiatry has been huge and contains no small measure of methodological inspiration either.⁴⁵ As Colin Jones and Roy Porter have remarked, ‘one may still acknowledge that Foucault has had an often highly beneficial impact on the study of the past without necessarily authorizing his exact interpretations’.⁴⁶ Foucault’s archaeological and genealogical approaches to history can provide some insights into how to do a ‘medical history from below’ which is empirically driven and theoretically informed.⁴⁷ It is possible to analyse the discourses and practices of marginal groups of resistant patients and describe their transformations over time in a way that gives due and balanced consideration to the specific contexts from which they emerged, the tensions which marked their development, and how they were shaped by social and material factors, relations of power and government.

1.3 Archaeology and Genealogy

Foucault adopted what he called an archaeological method. Archaeology is a form of discourse analysis concerned with discursive practices, with ‘who is speaking, when, where, with what authority, in what kind of voice, through what kinds of material mediums’.⁴⁸ Social and material factors facilitate and limit, enable and constrain what can be said, by whom, where and when. Such an approach describes how discursive practices change and how they are situated in a broader nexus of spaces and social practices: it investigates ‘how discursive practices come to be articulated in conjunction with a wide range of institutions and social practices’.⁴⁹ One aspect of this analysis which is often overlooked is the importance of space and extra-discursive material factors. Archaeology is ‘an enquiry whose aim is to rediscover [...] within what space of order knowledge is constituted’ and is a ‘description of the archive’.⁵⁰

⁴⁵ See Arthur Still and Irving Velody eds., *Rewriting the History of Madness: Studies in Foucault’s ‘Histoire de la folie’* (London: Routledge, 1992); Allan Megill, ‘The Reception of Foucault by Historians’, *Journal of the History of Ideas* 48 (1987), pp. 117-141; R.A. Houston, *Madness and Society in Eighteenth-Century Scotland* (Oxford: Clarendon, 2000), pp. 10-14; Andrew Scull, ‘Michel Foucault’s History of Madness’, *History of the Human Sciences* 3 (1990), pp. 57-67; Andrew Scull, ‘The Fictions of Foucault’s Scholarship’, *Times Literary Supplement* 21 May 2007 <<http://www.the-tls.co.uk/articles/private/the-fictions-of-foucaults-scholarship-2/>> [accessed 17 October 2012].

⁴⁶ Colin Jones and Roy Porter, ‘Introduction’ in *Reassessing Foucault: Power, Medicine and the Body* (London, Routledge: 1994), p. 5.

⁴⁷ Porter, ‘The Patient’s View Doing Medical History from Below’, pp. 175-198.

⁴⁸ Chris Philo, ‘Review Essay: Michel Foucault, *Psychiatric Power: Lectures at the Collège de France 1973-1974*. Ed Jacques Lagrange. Translated by Graham Burchell (New York: Palgrave Macmillan, 2006)’, *Foucault Studies*, 4 (2007), p. 158.

⁴⁹ Nigel Dodd, *Social Theory and Modernity* (Cambridge: Polity Press, 1999), p. 102.

⁵⁰ Michel Foucault, *The Order of Things: An Archaeology of the Human Sciences* (New York: Vintage Books, 1970), pp. xxi-xxii; Michel Foucault, ‘The Archaeology of Knowledge’ in *Foucault Live*, ed. Sylvère Lotringer (New York: Semiotext(e), 1996), p. 57.

The archaeological method pays close attention to the connection between knowledge and location, to where discursive practices are articulated, and to how they are tied to particular places, shaped by material conditions and relations of power and government. Geographers have drawn attention to how Foucault's archaeology and genealogy is attuned to the significance of specific sitings, settings, spaces and places, in the formation of forms of resistance and counter-discourses.⁵¹

Chris Philo remarks that Foucault

sees the spaces of dispersion through which the things under study are scattered across a landscape and are related to one another simply through their geography [...] by being near to one another, or far away, by being positioned in certain locations or associated with certain types of environment.⁵²

Studying the emergence of collective action by psychiatric patients in relation to a policy – 'deinstitutionalisation', or the closure of the asylums – which concerns a spatial or locational transformation in a national context, one must pay attention to geographical and geopolitical factors: 'the formation of discourses [...] need to be analysed [...] in terms of tactics and strategies of power. Tactics and strategies deployed through implantations, distributions, demarcations, control of territories and organisations of domains which could well make up a sort of geopolitics'.⁵³ An archaeological approach determines 'differences defined by geographical regions'.⁵⁴ Since the purpose of the study here is to recount the formation and transformation of the collective action, resistance and counter-discourses of psychiatric patients in a national context, it must focus on how the movement was localised, how it was mobilised and formed networks.. Foucault refers to 'the astonishing efficacy of discontinuous, particular and local critiques' and 'the strange efficacy, when it came to jamming the workings of the psychiatric institution, of the discourse, the discourses – and they really were very localised – of antipsychiatry'.⁵⁵ To probe such a claim in a national context, archaeology, as a 'method specific to the analysis of local discursivities', can be employed to understand how critique and resistance was articulated by individuals and groups in response to the settings in which they found themselves.⁵⁶

Foucault's genealogical approach to history is anti-essentialist, questioning the naturalness and inevitability of social practices, opposing teleological conceptions of history as mono-causal, linear, moving in a single direction and traceable to a single origin. It is 'gray, meticulous and patiently documentary [...] requires patience and knowledge of details, and it depends on a vast

⁵¹ For example, see Chris Philo, "'Bellicose History" and "Local Discursivities": An Archaeological Reading of Michel Foucault's *Society Must Be Defended*', in *Space, Knowledge and Power: Foucault and Geography* (Aldershot: Ashgate, 2007), pp. 358-363.

⁵² Chris Philo, 'Foucault's Geography', in *Thinking Space* ed. Mike Crang and Nigel Thrift (London: Routledge, 2000), pp. 220-221.

⁵³ Michel Foucault, 'Questions on Geography: Interviewers: The Editors of the Journal *Hérodote*' in *Michel Foucault: Power/Knowledge: Selected Interviews and Writings, 1972-1977* (Brighton: Harvester Press, 1980), p. 77.

⁵⁴ Foucault, *Society Must Be Defended*, p. 179.

⁵⁵ *Ibid.*, pp. 5-6.

⁵⁶ *Ibid.*, p. 10.

accumulation of source material [and] demands relentless erudition'.⁵⁷ Genealogy is sensitive to the particular, the local and contingent in its analysis of socio-historical change, and attentive to a profusion of events which follow no smooth trajectory: 'it must record the singularity of events outside any monotonous finality'.⁵⁸ It complements the archaeological focus on discourse and knowledge formation at specific points in time and space with an attention to the discontinuity and descent of discourses, their relationship to action, their tactical and strategic application in resistance to particular authorities, and their place in social struggles. Genealogy is primarily a descriptive history of the present, concerned with how a social phenomenon has come to be what it is today. It charts how discursive practices are accidentally and strategically assembled and reconfigured over time and employed tactically in struggles to alter power relations. It traces complex, contingent and fragile networks and is concerned with the 'meticulous rediscovery of struggles and the raw memory of fights', attending to the 'perspectival [...] polemical and strategic character of knowledge'.⁵⁹ Different discursive practices and forms of resistance over time and space are incommensurable and one cannot trace a smooth logical progression from one to another, but by 'isolat[ing] the scenes where they engaged in different roles', their multiple lines of descent can be charted, making up a complex metaphorical kinship network or family tree.⁶⁰ Genealogy is concerned with studying the past not merely for its own sake, but in order to understand the history of the present, tracing the discontinuous, complex and intersecting lines of descent of contemporary discursive and social practices.

Genealogy involves a reversal of perspective to construct a 'history from below' which attends to marginal discourses and 'subjugated knowledges': 'let us give the term *genealogy* to the union of erudite knowledge and local memories which allows us to establish a historical knowledge of struggles'.⁶¹ Foucault refers to 'local' and 'subjugated' knowledges which, as Philo states, 'implicate the production of critiques – counterknowledges – emerging from particular people, settings, sites, points and maybe networks'.⁶² Foucault states that:

By subjugated knowledges I mean two things: on the one hand, I am referring to the historical contents that have been buried and disguised in a functionalist coherence or formal systematization [...] On the other hand, I believe that by subjugated knowledges one should understand something else, something which in a sense is altogether different, namely, a whole set of knowledges that have been disqualified as inadequate to their task or insufficiently elaborated: naive knowledges, located low down on the hierarchy, beneath the required level of cognition or scientificity [...]: the knowledge of the psychiatrized, the patient, the nurse, the doctor, that is parallel to, marginal to, medical knowledge.⁶³

⁵⁷ Foucault, 'Nietzsche, Genealogy, History', pp. 76-77.

⁵⁸ *Ibid.*, p. 76.

⁵⁹ Foucault, *Society Must Be Defended*, p. 8; also Michel Foucault, 'Truth and Juridical Forms', in *Power: Essential Works of Foucault 1954-1984 Volume Three*, ed. James D. Faubion (London: Penguin, 2002), p. 14.

⁶⁰ *Ibid.*

⁶¹ Foucault, *Society Must Be Defended*, p. 8.

⁶² Philo, "'Bellicose History" and "Local Discursivities"', p. 346.

⁶³ Foucault, *Society Must Be Defended*, p. 7.

Excavating the submerged knowledges of psychiatric patients who engaged in collective action enables us to recover local memories, critiques and counterknowledges. Since groups of patients resisting psychiatric and state power have been dispersed across time and space, it is important to focus on the specific contexts from which they emerged. The study undertaken here will excavate subjugated knowledges by bringing to light untapped archival materials and entertaining the claims to attention of local memories recorded in oral history interviews. This approach considers how participants in collective action exercised a ‘particular knowledge, a knowledge that is local, regional or differential, incapable of unanimity [...] different from all the knowledges that surround it’—that which ‘people know at a local level [...] that made the[ir] critique possible’.⁶⁴ Geographer Paul Routledge has treated social movements as ‘multiplicities explored through the concept of terrain of resistance [...] providing an understanding of how place is central to particular terrains of resistance and the creation and articulation of alternative knowledges’ through a ‘critical geopolitics’.⁶⁵ In turn Helen Spandler has developed Routledge’s notion of ‘convergent spaces’, ‘to explore the emergence of particular spaces of psychiatric contention [...] to understand the opportunities and limitations of more grounded “place specific” settings’.⁶⁶ Convergent spaces imply ‘a heterogenous affinity of common ground between various social movements, grass roots initiatives, non-governmental organisations and other formations, wherein certain interests, goals, tactics and strategies converge’.⁶⁷ A convergent space ‘is a space of facilitation, solidarity, communication, co-ordination and information sharing’ where such groupings converge or intersect.⁶⁸ Such approaches are fundamentally concerned with questions of historical geography – to do with space, place, location and environment.⁶⁹ The Foucaultian concern with ‘spaces of dispersion’ draws attention to what Philo has described as the ‘relational play of differences, juxtapositions and contingencies’.⁷⁰ By looking at history through a geographical lens, an archaeological and genealogical approach to studying collective action by psychiatric patients describes and analyses how the discursive tactics and strategies employed by activists were shaped by and adapted to contingent local and national, place-specific, geopolitical contexts.

⁶⁴ Ibid., pp. 7-8.

⁶⁵ Paul Routledge, ‘Critical geopolitics and terrains of resistance’, *Political Geography* 15 (1996), p. 510.

⁶⁶ Helen Spandler, ‘Spaces of psychiatric contention: A case study of a therapeutic community’, *Health & Place* 15 (2009), p. 672-673.

⁶⁷ Paul Routledge, ‘Convergent Space and the Fluidity of Networks’ in ‘Alternative Futures and Popular Protest’: Seventh International Conference, 17-19 April 2001, Vol.11 eds. Colin Barker and Mike Tyllesley. (Manchester: Manchester Metropolitan University, 2001), p. 1.

⁶⁸ Paul Routledge, ‘Convergence space: process geographies of grassroots globalization networks’, *Transactions of the Institute of British Geographers* 28 (2003), p. 345.

⁶⁹ Philo, ‘Bellicose History’, p. 358.

⁷⁰ Ibid., p. 360.

1.4 The Emergence of the Mental Health Service User Movement in the UK

In recent decades there has been a growing body of literature on the history of what has come to be known as mental health service user, or psychiatric survivor, movement. Much of the work on the history of the UK incarnation of this movement has focused specifically on developments in England.⁷¹ These movements have involved psychiatric patients or mental health service users forming campaign groups and taking collective action to resist psychiatric power, to influence government policy and develop alternatives to traditional psychiatric treatments. By doing so they have attempted to alter power relations in the medical encounter and in wider society, challenging the state and other government and health authorities to listen to their concerns. While some of the studies have paid attention to continuities from the professional-led anti-psychiatry movement of the 1960s to the action of mental patients' unions in England in the 1970s, the role of pioneers from Scotland has either been exaggerated or downplayed.⁷² The direction of influence from Scotland to England of the professional-led anti-psychiatry movement has been explored, but the role of Scottish psychiatric patients in the wider UK movement has received little attention.⁷³ For example, the Glasgow-born psychiatrist R.D. Laing is frequently described as the founder of the anti-psychiatry movement, even after he disowned the anti-psychiatry label.⁷⁴ Subsequent critics of psychiatry and patient activists in England have downplayed their links to the 1960s anti-psychiatry

⁷¹ See Jan Wallcraft and Michael Bryant, *The Mental Health Service User Movement in England* (London: Sainsbury Centre for Mental Health, 2003); Jan Wallcraft, Jim Read and Angela Sweeney *On Our Own Terms: Users and Survivors of Mental Health Services Working Together for Change* (London: Sainsbury Centre for Mental Health, 2003); Claire Baron, *Asylum to Anarchy*, (London, Free Association Press, 1987); Helen Spandler, *Asylum to Action: Paddington Day Hospital, Therapeutic Communities and Beyond* (London: Jessica Kingsley, 2006); Anne Rogers and David Pilgrim, 'Pulling Down Churches: Accounting for the British Mental Health Users' Movement', *Sociology of Health & Illness* 13 (1991), pp.129-148; Nick Crossley and Michele Crossley 'Patient' voices, social movements and the habitus; how psychiatric survivors 'speak out', *Social Science & Medicine* 52 (2001), pp. 1477-1489; Nick Crossley, 'Working Utopias and Social Movements: An Investigation Using Case Study Materials from Radical Mental Health Movements in Britain', *Sociology* 33 (1999), pp. 809-830; Nick Crossley, 'Fish, Field, Habitus and Madness: The First Wave Mental Health Users Movement in Britain', *British Journal of Sociology* 50 (1999), pp. 647-670; Nick Crossley, 'Mental health, resistance and social movements: The collective-confrontational dimension', *Health Education Journal* 61 (2002), pp. 138-152; Nick Crossley, 'The field of psychiatric contention in the UK, 1960-2000', *Social Science and Medicine* 62 (2006), pp. 552-563.

⁷² The role of Scottish psychiatrist R.D. Laing and 'anti-psychiatry' in influencing the emergence of collective action by psychiatric patients in Nick Crossley's account is seen as exaggerated by Survivors History Group. See Survivors History Group, 'Survivors History Group take a critical look at historians', in *Critical Perspectives on User Involvement* eds. Marian Barnes and Phil Cotterell (Bristol: Policy Press, 2011), pp. 7-18. The Scottish dimension of the mental patients' union movement of the 1970s has been passed over and dismissed by Nick Crossley in *Contesting Psychiatry*.

⁷³ See Andrew Roberts, 'Scotland the Brave' in *Mental Health Today* 9 (2009), pp.16-18; Andrew Scull, 'The peculiarities of the Scots? Scottish influences on the development of English psychiatry, 1700-1980', *History of Psychiatry* 22 (2011), pp. 403-415.

⁷⁴ See Crossley, 'R.D. Laing and the British Anti-Psychiatry Movement'

movement and have emphasised their autonomy and independence from these professional-led critiques of psychiatry.⁷⁵

It is also often claimed that it was the policies of the Conservative governments of the 1980s and 1990s that facilitated the emergence of a mental health service user movement in the UK. The NHS and Community Care Act 1990 introduced a kind of internal market into the supply of health and social care and helped to initiate a discourse of health consumerism. According to leading mental health service user activists and researchers, Diana Rose and Peter Campbell, ‘it can well be argued that service user activists first rode into the corridors of power in the UK on the back of health service consumerism’.⁷⁶ In her study of Paddington Day Hospital, London, where a Mental Patients’ Union (MPU) was formed in 1973, Spandler argues that the development of psychiatry through therapeutic community models of care provided a context in which a collective identity amongst psychiatric patients could emerge.⁷⁷ However, it was an old Victorian asylum where the first recorded patients’ union was founded in the UK, out-with a therapeutic community context and before deinstitutionalisation was seriously underway in Scotland. The Scottish Union of Mental Patients (SUMP) formed in 1971 at Hartwood Hospital, Lanarkshire, based neither on the philosophical critique of psychiatry by R.D. Laing of the 1960s, nor the principles of free market economics and health service consumerism of the 1980s and 90s. It was based instead on a sense of solidarity which developed between a small group of patients detained in locked wards.⁷⁸

It has long been argued that the policy and practice of deinstitutionalization, the closure of the asylums, was at least partially motivated by a desire on the part of government to cut public expenditure.⁷⁹ From the 1950s in England and from the 1970s in Scotland, the population of long-stay mental patients in hospital declined and there were repeated criticisms from mental health charities, professionals, carers and patients that central government was not committed to putting in adequate resources to develop the community-based care which was supposed to replace the old psychiatric institutions. The absence of adequate alternative service provision was a motivation for the creation of self-help groups, while at the same time groups of psychiatric patients organised themselves through voluntary sector mental health associations. Whilst it has been argued that a culture of self-determination created by the neo-liberal policies of privatization and cutting public expenditure may have provided the ground for a grass roots consumer based movement in mental health, Rose and Campbell claim that service user activists intentions were not the same as the

⁷⁵ See Duncan Double (ed), *Critical Psychiatry: The Limits of Madness* (Basingstoke: Palgrave Macmillan 2006); David Ingleby (ed), *Critical Psychiatry: The Politics of Mental Health* (Harmondsworth : Penguin, 1981); Survivors History Group, ‘Survivors History Group take a critical look at historians’, pp. 7-18.

⁷⁶ Peter Campbell and Diana Rose, ‘Action for Change in the UK: Thirty Years of the User/Survivor Movement’ in *The SAGE Handbook of Mental Health and Illness* ed. David Pilgrim, Anne Rogers and Bernice Pescosolido (London: SAGE, 2011), p. 455.

⁷⁷ Spandler, *Asylum to Action*, p. 21.

⁷⁸ Roberts, ‘Scotland the Brave’, p. 17.

⁷⁹ Joan Busfield, *Managing Madness* (London: Unwin Hyman, 1986); Simon Goodwin, *Community Care and the Future of Mental Health Services* (Ashgate: Avebury, 1993); Andrew Scull, *Decarceration: Community Treatment and the Deviant: A Radical View* (Oxford: Polity Press, 1984).

government's.⁸⁰ The 1990 NHS and Care in the Community Act opened up all health services to market economics placing great emphasis on patients making choices about their care and treatment and doing things for themselves. For the Conservative government this was a means of securing services that were as efficient and as cost-effective as possible. For service user activists it was an opportunity to have their voices heard which they could ill-afford to refuse, regardless of their ideological commitments. Whatever the intention behind the policy shift, the growth of service user groups accelerated in the UK following the 1990 Act.

A preliminary study of the early origins of the UK movement suggests that the initial impetus for a grass-roots patient-led movement in mental health came before the neo-liberal policies of the Conservative governments of the 1980s and 90s, developing out of a collectivist strategy characteristic of the 1970s, which leaned more to the left of the political spectrum than the right.⁸¹ The beginnings of the first of the mental patients' unions of the 1970s in a Scottish asylum are all too readily passed over in existing accounts of the wider UK service user movement. Nick Crossley claims that a patient-led mental health movement 'began, in Britain, with the formation of the Mental Patients Union [MPU]' in 1973:

[A]lthough [the MPU] is not the first example of protest activity by psychiatric patients in the history of the mental health services, it is the first link in the unbroken chain of 'patient' activism which leads through to the present day. The MPU were pre-dated slightly by a *Scottish Union of Mental Patients* (SUMP), who formed in 1971, but this group folded relatively quickly.⁸²

Survivors History Group, which is collecting archives and researching the history of the movement, dismiss this claim:

In fact, continuity between SUMP and MPU was strong. Tommie Ritchie, the founder of SUMP, left Scotland for London in June 1972. He, and fellow member Robin Farquharson, took part in the founding meetings of the union in March and April 1973, when Tommie signed himself "RITCHIE - LONDON - SEX - SUPERSTAR". Robin died, tragically, between the two meetings, but Tommie was a very active member of an MPU house for two years and he lodged the records of SUMP with the MPU. Extracts were published in *MPU News* in February 1974. The Scottish experience fed directly into MPU practice.⁸³

The secretary of Survivors History Group, Andrew Roberts claims that

Scotland pioneered the user movement in the United Kingdom [...] At least twice in as many decades it was Scottish patients who put their full force on the lever of history. Academic historians have given the credit, for both occasions, to London. But new evidence suggests Scotland led the way.⁸⁴

This study aims to explore Roberts' claim that Scotland pioneered the movement in the UK and investigate the wider significance of the apparent precedence of Scottish patient activism in the early 70s and 80s. I will also seek to build on Crossley's studies, which addressed the social

⁸⁰ Campbell and Rose, 'Action for Change in the UK', p. 455.

⁸¹ Andrew Roberts, 'Scotland the Brave' in *Mental Health Today* 9 (2009), pp. 16-18.

⁸² Crossley, *Contesting Psychiatry*, p. 144.

⁸³ Survivors History Group, 'Survivors History Group take a critical look at historians', p. 12.

⁸⁴ Roberts, 'Scotland the Brave', pp. 16-18.

conditions which gave rise to the movement and allowed it to flourish in the UK, by focusing specifically on the emergence of collective action by psychiatric patients in Scotland.

1.5 Sources, Methods, Aims and Questions

Archives collected to preserve the records of the mental patients' unions, voluntary mental health organisations, self-help and campaign groups, open up the histories of the mental health service user/survivor movement. Oor Mad History is a community history project in Edinburgh funded by NHS Lothian which has collected and archived the documents of service user groups in Scotland. According to the Oor Mad History Project, 'as a whole, history related to mental health is dominated by the history of asylums, psychiatry or medicine. Little has been recorded of the histories of those who have experienced the system first hand or who have come together to change it'.⁸⁵ Anne O'Donnell a service user activist from Oor Mad History claims that, 'we have long been the objects of social policy, of professional discourses and of the history of psychiatry. We have been constructed as people who are passive, rather than people who can act, however limiting the structural issues may be'.⁸⁶ Survivors History Group is a project based in London which is collecting archives to preserve records of many of the campaign groups led by mental health service users in the UK. It is fair to say that that only recently has the approach to 'history from below' reached the figure of the psychiatric patient. Thus far academic historians have left it to others to make sense of the history of collective action by psychiatric patients and their resistance to medical and social attitudes towards them. I will examine the untapped primary sources collected by these groups, which include: pamphlets, posters, minutes of patient group meetings, conference reports, newsletters, conference speeches, correspondence, training videos, a TV programme, magazines, archives of oral history interviews with patient activists and their allies, alongside government policy documents, NHS literature, reports by regulatory bodies, parliamentary committee reports, documents produced by organisations from the voluntary sector and many other publications of interest dating from the period under study. Through a description of the archive of the service user movement and an analysis of the discursive formation and transformation of the movement, the conditions and circumstances out of which it has grown and under which it has developed and shifted, are revealed. An archaeology of local discursivities and subjugated knowledges, and a genealogy of social practices and power struggles, will make coherent a number of separate developments and provide a framework for understanding the transformation of complex discursive, institutional and social practices.⁸⁷ This will involve tracing

⁸⁵ CAPS (The Consultation and Advocacy Promotion Service) *Oor Mad History: A Community History of the Lothian Mental Health Service User Movement* (Edinburgh: Living Memory Association, 2010), p. 17.

⁸⁶ Anne O'Donnell, 'Oor Mad History: Community history as a way of revitalising mental health collective advocacy', *CONCEPT* 18 (2008), pp. 162-170.

⁸⁷ For Foucault's genealogical and archaeological approaches, see the following: Michel Foucault, *Archaeology of Knowledge*, trans. by Alan Sheridan (Abingdon: Routledge, 2003); *History of Madness*.

the multifaceted branches of the genealogical tree of the contemporary mental health service user movement, showing how elements from established and emerging discursive strategies and practices have been assembled and transformed in the process of its construction.

Social practices and material conditions shape and modify discourses, and in turn discourses shape social practices and have material effects. Neither is more fundamental than the other. A symmetrical account of their interaction invokes both social practices and material conditions, discursive and non-discursive factors, privileging none. An analysis of discursive transformations and shifting relations of power and production in mental health care reveal how social movements depend on environmental shifts of a social, political and economic nature, which produce openings where resistant patients have been able to collectively exploit the vulnerability of established dominant discourses and practices. Description of discourses and practices allows us to answer the question of what patient activists and service user groups did and said and how they moved and changed over time between 1971 and 2005.

Alex Mold has argued that ‘the patient-consumer that was made in Thatcher’s Britain was a malleable figure, bearing the marks of more than one sculptor’.⁸⁸ Similarly, the mental health service user movement which emerged in Scotland in the last half-century bears the marks of many sculptors, involving various social groupings and important individual figures, constituted by shifting relations of power and traversed by a congeries of discourses. That is not to say that collective action by patients was formed in a space and through a practice shaped entirely by external factors. The resistant identities forged by patient activists were increasingly fluid, provisional and negotiable, as they sought to effect change through active agency and public discourse. Charting collective action by psychiatric patients reveals vicissitudes and tensions over questions of identity and purpose and ‘seeks the subtle, singular and subindividual marks that might possibly intersect in them to form a network that is difficult to unravel’.⁸⁹ In the words of Foucault, ‘the search for descent is not the erecting of foundations: on the contrary, it disturbs what was previously considered immobile; it fragments what was thought unified; it shows the heterogeneity of what was imagined consistent with itself’.⁹⁰

Questions addressed in this study are: Where, when and how did collective action emerge? Which social and material conditions made the emergence of collective action possible? What tactics and strategies did patient groups employ in their resistance to psychiatric and state authorities? How did particular groups express grievances? How did groups employ discourses and broader cultural symbols? What is the relationship between local discursivities and sub-cultures,

Translated by Jonathan Murphy and Jean Khalfa. (Abingdon: Routledge, 2006); *Psychiatric Power: Lectures at the Collège De France 1973-74*. English series Ed. Arnold I. Davidson. Translated by Graham Burchell. (Hampshire: Palgrave Macmillan, 2006); Mitchell Dean, *Critical and Effective Histories: Foucault’s Methods and Historical Sociology* (London: Routledge, 1994), esp. Chs. 1 and 2.

⁸⁸ Alex Mold, ‘Making the Patient-Consumer in Margaret Thatcher’s Britain’ in *Historical Journal* 54 (2011), pp. 509-528.

⁸⁹ Foucault, ‘Nietzsche, Genealogy, History’, p. 81.

⁹⁰ *Ibid.*, p. 82.

and the discursive field of the broader culture? What is the relationship between the policy of deinstitutionalisation and the emergence and descent of contemporary collective action by psychiatric patients? How did groups define their identities, both for their own members and for others? How were discourses and identities linked to forms of action, resistance, protest and experimental social practices?

The aim is to provide a symmetrical and balanced analysis of the movement which does not prioritize the social or the material, the discursive or the non-discursive, but invokes each of these multiple determining elements in its account of the emergence of collective action by psychiatric patients in Scotland. The spatial and geo-political dimensions of the mental health service user movement must not be underestimated. The separate legislation between Scotland and the rest of the UK, differences in professional and administrative attitudes, the slower pace of deinstitutionalisation in Scotland and the shifting political landscape before and after Scottish devolution, not to mention the tensions and conflicts within the movement between groups from different regions, indicate the importance of material, geographical factors in the emergence and transformation of the movement in Scotland. The primary purpose here is to recount the emergence of a mental health service user movement in Scotland by tracing the multiple lineages of this contemporary phenomenon. Much of the account presented here, given that so little has been published on the history of collective action by psychiatric patients in Scotland, is primarily descriptive, establishing what was said and done, and recounting how individuals, groups, events and settings were significant in the mobilisation of collective action. As Allan Megill helpfully reminds us, ‘historiography is a collective enterprise, and it is quite possible for an individual historian to forgo, in greater or lesser degree, the telling of a narrative that is already largely known’.⁹¹ But when investigating a history that is largely unknown, or not well known, ‘the question, “What was the case? is primal: it precedes the explanation-seeking question’, a question which is concerned with discovering a cause that connects *explanans* and *explanandum*’.⁹² A cultural heritage is never as might be imagined, ‘an acquisition, a possession that grows and solidifies; rather it is an unstable assemblage of faults, fissures and heterogeneous layers’.⁹³ By employing an archaeological and anatomising method and genealogical design this study of the mental health service user movement in Scotland is not a linear story of progress organised around the single unifying principle or cause of deinstitutionalization, but instead it relies on differences, separations and dispersion. The resulting approach is a narrative history of the movement in Scotland, an ‘anatomising narrative of character’⁹⁴ which breaks down the mobilisation of

⁹¹ Allan Megill, ‘Recounting the Past: “Description,” Explanation, and Narrative in’ Historiography’, *The American Historical Review* 94 (1989), p. 651.

⁹² *Ibid.*, p. 648.

⁹³ Foucault, ‘Nietzsche, Genealogy, History’, p. 82.

⁹⁴ Megill contrasts an anatomising narrative of character with a sequential narrative of action. However, they are not mutually exclusive. Narrative history is primarily concerned with ‘recounting’, with description of what was the case: see ‘Recounting the Past’, p. 646.

collective actions over time and space into their constituent parts, including individuals and groups, events, characters and settings, so that it becomes a ‘massively differentiated entity’, which speaks with many voices and is a sum of individual histories⁹⁵ – ‘the purpose of history, guided by genealogy, is not to discover the roots of our identity, but to commit itself to its dissipation’.⁹⁶

Condrau has called for ‘carefully contextualised analyses of patients’, suggesting that ‘the way forward’ is ‘to engage with debates that have raged elsewhere and to claim intellectual, empirical and theoretical importance in a field that has been for long enough dominated by empirical, perhaps even descriptive, case studies’.⁹⁷ He concedes that there ‘there can never really be enough’ case studies, but he warns of ‘the charm of the sources’, like Ludmilla Jordanova, who implies that ‘descriptive’ and ‘anecdotal’ accounts are lesser forms of historiography compared with those ‘with a strong conceptual focus’ and those with ‘a clear sense of the theoretical issues at stake and a systematic set of models to pursue’.⁹⁸ Whilst these suggestions are apposite, the present study should like to rehabilitate a descriptive and narrative approach, one which values the juxtaposition of the range of voices of those who sought to become more than just psychiatric patients. Such an approach seeks to give space to the voices of patients and ‘goes beyond mere fact and surface appearances’:

It presents detail, context, emotion, and the webs of social relationships that join persons to one another. Thick description evokes emotionality and self-feelings. It inserts history into experience. It establishes the significance of an experience, or the sequence of events, for the person or persons in question. In thick description, the voices, feelings, actions, and meanings of interacting individuals are heard.⁹⁹

The approach taken here follows the lead of Roy Porter, wishing ‘simply and quite literally to see what [patients] had to say. It is curious how little this has been done; we have been preoccupied with explaining away what they said’.¹⁰⁰

It was necessary to make selective choices about which patient groups to focus on in this study. Having investigated which groups existed in Scotland by a process of archival research and through contact with Oor Mad History, Survivors History Group and current patient or user-led organisations, some selection criteria have been followed. The study concentrates on groups of local and national scope, meaning groups which formed in response to local problems and comprised people from a particular locality, but which also addressed issues of wider national concern and which made contact with other groups beyond their locality. Since the interest is in how groups and networks of patients formed, how they were motivated by grievances and made demands, how they voiced their messages and selected symbols, and how their discourses and

⁹⁵ Fernand Braudel, *The Mediterranean and the Mediterranean World in the Age of Philip II, Volume I* translated by Sian Reynolds, 2 Vols (New York: Harper and Row, 1966), p. 13.

⁹⁶ Michel Foucault, ‘Nietzsche, Genealogy, History’, in *The Foucault Reader* ed. Paul Rabinow (Harmondsworth: Penguin, 1991, c.1984), p. 95.

⁹⁷ Condrau, ‘The Patient’s View Meets the Clinical Gaze’, p. 536.

⁹⁸ Ludmilla Jordanova, ‘The Social Construction of Medical Knowledge’, *Social History of Medicine* 8 (1995), pp. 361; 374.

⁹⁹ Norman K. Denzin, *Interpretive Interactionism* (Newbury Park, CA: Sage, 1989), p. 83.

¹⁰⁰ Roy Porter, *A Social History of Madness* (London: Phoenix Giants, 1996), pp. 1-2.

practices moved and travelled within Scotland and the UK, the focus is oriented towards the question of how patients in Scotland sought to build a movement or network of national scope. The first such group in Scotland which left a paper trail sufficient for detailed investigation is the short-lived but significant Scottish Union of Mental Patients (SUMP), which came and went between 1971 and 1972. This study will primarily focus on SUMP, on a collection of Glasgow-based self-help groups called LINK clubs active in the 1980s, an Edinburgh-based group called Awareness and a national network, Scottish Users' Network (SUN), both formed in the late 1980s and active through the 1990s. The study will also pay considerable attention to a national user magazine, *Beyond Diagnosis*, published in the 1990s, and a series of national events, such as MIND conferences in the 1980s and Scottish Users Conferences held in the 1990s. Other groups are mentioned and extensive reflections from individuals involved in various groups are drawn upon and quoted *in extenso*. A more comprehensive, though by no means exhaustive, list of groups is provided in a timeline which is included as an Appendix.

The period under investigation could be described as contemporary. Issues under discussion encompass the broader post-war period up till the present day, but the history of collective action of patients is foregrounded. The focus is on the period stretching from the formation of SUMP in 1971 to the formation of the current national user-led organisation in Scotland, Voices of Experience, in 2006. The account presented here is at once a collection of local and national histories, and histories of sub-cultures of the sick. What is presented depends on multiple perspective and voices, providing a close-up and careful delineation of particularities and details. It provides a preliminary anatomy of the micro-politics of patient and user groups, situated in a national context. It aims to understand how patient groups responded to social change, particularly the policies and processes of deinstitutionalisation, and how they attempted to initiate changes in subjectivity and society. The study itself hopes to initiate broader discussion and deeper inquiry into the histories of collective action by psychiatric patients. Anatomy takes on a 'loose-jointed narrative form', containing 'violent dislocations of the customary logic of narrative'.¹⁰¹ It seeks at once to perform synthesis and analysis, to survey broad temporal and spatial spheres, while also providing microscopic details of individual and collective, local and national experiences, pursuing digressions via the many intersecting branches of the movement's genealogy. Such an approach expands the range of sources and interpretations used to explore the relationships between discursive practices, the exercise of and resistance to power in healthcare systems, the production of knowledge, practices of citizenship and the construction of space and subjectivity. It also hopes to reveal something of the relationship between the histories of reason and histories of madness.¹⁰² The anatomising narrative which ensues here is a 'dissection', a miscellany, an 'encyclopaedic

¹⁰¹ Northrop Frye, *Anatomy of Criticism: Four Essays* (Princeton, Princeton University Press, 1957), pp. 309-310.

¹⁰² I share Roy Porter's view that 'Foucault was quite right to insist that the history of unreason must be coterminous with the history of reason' and that 'what the mad say [...] focuses and puts to the test the nature and limits of rationality'. See Porter, *Social History of Madness*, p. 3.

farrago', a dialogue, an open-ended enquiry within the bounds of the selection criteria, but which does not aim to terminate in an all-embracing monolithic and mono-causal explanatory conclusion.¹⁰³ It tries to convey the dialogic and polyphonic, seeking to mingle many voices and to let them play-off against and alongside one another, revealing some of the myriad means by which psychiatric patients in Scotland have tried to redefine themselves and their place in society by taking collective action.

¹⁰³ Frye, *Anatomy*, pp. 308-314.

CHAPTER 2
FROM ASYLUM TO ACTION

2.1 Introduction

This chapter explores how a group of patients participated in collective action at an old Victorian asylum in North Lanarkshire, Scotland, in 1971. The emergence of the first 'mental patients' union' in the UK is revealed in the documents of the Scottish Union of Mental Patients (SUMP), authored between 1967 and 1972 by a patient of Hartwood Hospital, Thomas Ritchie. These documents give an insight into the life of Ritchie and his fellow SUMP members detained in the locked wards at Hartwood. The SUMP documents reveal the grievances which motivated patients to form a 'union'. Close examination of the SUMP documents authored by Ritchie alongside statements by fellow Hartwood patients and the published writings of another SUMP member, Robin Farquharson, reveals the significant roles that pioneering figures played in initiating collective action in the early 1970s. Comparison of the activist biographies of Ritchie and Farquharson reveals some of the distinguishing features of SUMP compared with its immediate predecessor and successor patient groups in the 1960s and 70s, which both men participated in. Life histories are interesting and informative in their own right, but biographies can also contribute to an understanding of broader social and cultural histories and genealogies of patient activism. An analysis of the discursive tactics and strategies employed by Ritchie and Farquharson situated within the context of social and material circumstances, reveals how nascent collective action by psychiatric patients in Scotland was shaped by the asylum space and challenges to it from within and without.

2.2 From the Victorian Asylum to a Mental Health Service for the Twentieth Century

The Alleged Lunatics' Friend Society and the Lunacy Law Reform Association had protested and campaigned in England in the 19th century, but it was not until the emergence of mental patient unionism in the 1970s that a more widespread and enduring 'mental health service user movement' began to develop in the UK.¹⁰⁴ Unlike its English successor the Mental Patients' Union (MPU), which formed in 1973 at a day-hospital in London, SUMP emerged from 'the bowels of an old Victorian asylum'.¹⁰⁵ Originally Lanark District Asylum, it was opened in 1895, situated in a rural area of the central lowlands of Scotland. The asylum was built for 500 patients and had its own staff-houses, gardens, farm, power-plant, reservoir, railway-line and cemetery. Imposing twin clock-towers, which were a distinctive feature of the large asylums built in Victorian Britain, dominated the group of buildings. Shortly before World War II buildings were erected about one and a half miles from Hartwood to be used as a 'mental deficiency' hospital. With the coming of the

¹⁰⁴ Nicholas Hervey, 'Advocacy or Folly: The Alleged Lunatics' Friends Society, 1845-63', *Medical History* 30 (1986), pp. 245-275.

¹⁰⁵ Andrew Roberts, 'Scotland the Brave', *Mental Health Today* 9 (2009), pp. 16-18.

war, the buildings, known as the Hill hospital, were used for evacuated psychiatric patients from Bangour Village Hospital. When the war ended the Hill hospital, Hartwoodhill Hospital, was used for psychiatric patients. By the 1950s there were approximately 2,500 patients at the Hartwood and Hartwoodhill sites.¹⁰⁶

Hartwood Asylum, a poem composed around 1922 attributed to a 'Calder Nethan' portrays the Victorian asylum in the early 20th century:

*Far o'er the fields, the moor, the wood,
and burns that sometimes rise in flood,
from out the haze of distant gloom,
the twin towers of Hartwood loom.*

*Retreat or prison, gaol or home,
for those who ceaselessly do come,
to live a second childhood – where
there is a refuge for them – there.*

*Ah! Folks who stay in 'hapless town',
whose days are dim and clouded down,
at least you're warm and dry, and fed,
with firmness, care and patience led*

*May times bring other, brighter days,
some rays of hope, shine through the haze,
and coming years relieve the strain,
of troubles that affect the brain.*

*Succeeding generations' day,
wear out the weaklings from the fray,
bring forth a stronger, abler race,
with wisdom for restraint and grace.*

*With less turmoil, and of strife,
'ring in the nobler modes of life
with sweeter manners, purer laws',
and strength to help the afflicted's cause¹⁰⁷*

This poem is remarkable for the images of Victorian asylumdom it evokes. The atmosphere of Hartwood's relatively remote, isolated, and rural location is conveyed. The poem expresses ambivalence about whether the asylum is a place of care or control. It is a place for unfortunates, the 'hapless', where people are treated like children. It is a 'refuge' from the pressures of ordinary life. Notions of morality sit alongside medical notions. Eugenics thinking is also evident in the reference to 'weaklings' and 'a stronger, abler race'.

By the time SUMP was formed at Hartwood in 1971, ideas about the nature, causes, and treatment of mental illness had developed. Legislative reform and therapeutic innovations had stimulated hope for a return of the 'afflicted' to the world beyond the isolated and self-contained social and moral universe of the Victorian asylum. Moral treatment in Victorian times had stressed

¹⁰⁶ *Programme for Official Closure of Hartwood and Hartwoodhill Hospitals*, Thursday 24 February 2011, p. 6.

¹⁰⁷ *Ibid.*, p. 8.

the value of taking persons away from the pressures of ordinary life and moving them into a place of asylum or refuge which would be therapeutic for them. In post-war Britain the technical solutions of medicine, in the form of physical treatments, were perceived to possess the curative power which would allow patients to return to their communities from exile in these large isolated institutions.¹⁰⁸ Despite the fact that physical treatments such as prefrontal leucotomy and insulin coma treatment, which were used mainly in the 1940s, were controversial, they, along with drug treatments and electro-convulsive therapy, stimulated renewed confidence in a biomedical approach to mental illness. In 1943 prefrontal leucotomy was hailed by one of Scotland's most eminent psychiatrists, Professor D.K. Henderson, as 'one of the marvels of modern medical practice' and the Portuguese neurologist who developed the surgical technique was awarded the Nobel Prize for this curious 'innovation' in 1949.¹⁰⁹

Around the same time, however, psycho-social approaches to the care of the mentally ill were also being developed. The activities of psychiatrists and psychologists during World War II gained them increasingly sympathetic recognition. Although an 'open-door' policy operated as early as 1869 at Fife and Kinross Asylum, it is believed that Dingleton Hospital in Melrose, in 1949, was the first asylum in Britain to operate an open-door policy throughout the institution, allowing patients the opportunity to move freely around the institution and beyond, signalling a movement away from the custodial function of the old asylums, which by that time were renamed mental hospitals.¹¹⁰ In the 1950s 'therapeutic community' approaches to treatment and care emerged and group therapy was adopted in a few pioneering hospitals where patients were increasingly expected to become active participants in their own, and each other's, treatment. This approach was seen by its proponents as encouraging patients to take more responsibility and as democratising the hierarchical structure of authority within mental hospitals.¹¹¹ These practices were guided by ideas about how social and environmental factors shape health and illness. Dingleton in particular became widely renowned for its employment of a therapeutic community approach, especially after the arrival in 1962 of social psychiatrist Maxwell Jones, who moved group therapy from the hospital into community settings.¹¹²

The therapeutic community approach adopted by Jones was by no means the norm in mental hospitals of the time, but the ideas and practices highlighted questions about the role of the hospital environment and social milieu in effecting the rehabilitation of psychiatric patients. Jones was well

¹⁰⁸ Douglas Bennett and Isobel Morris, 'Deinstitutionalization in the United Kingdom', *International Journal of Mental Health* 11 (1983), p. 8.

¹⁰⁹ *One Hundred and Thirty-First Annual Report, For the Year 1943, of the Royal Edinburgh Hospital for Mental and Nervous Disorders* (Edinburgh: 1943), p. 12. held at Lothian Health Services Archive, LHB LHB7/7/16/4.

¹¹⁰ George Macdonald Bell, 'A mental hospital with open doors', *International Journal of Social Psychiatry* 1 (1955), pp. 42-48.

¹¹¹ Catherine Fussinger, "'Therapeutic community'", psychiatry's reformers and antipsychiatrists: reconsidering changes in the field of psychiatry after World War II', *History of Psychiatry* 22 (2011), pp. 148-151.

¹¹² Maxwell Jones, *The Process of Change* (London: Routledge and Kegan Paul, 1982).

travelled and often visited hospitals ‘promoting change and controversy’ and ‘arousing devotion and opposition around himself’.¹¹³ A friend and colleague of Jones, David Clark, was medical superintendent at Fulbourn Hospital, Cambridgeshire, from 1953 to 1983, where he introduced a therapeutic community approach. According to Clark, Jones ‘was perhaps at his best in a one-day visit to an institution or hospital’ – ‘after a visit from Max a hospital would be reverberating for weeks with new ideas and challenges’.¹¹⁴ Jones ‘put himself in the position of the radical, the outsider, the challenger of ancient asylum assumptions’.¹¹⁵ Clark remembers how, at a refresher course for medical superintendents in 1957, Jones was ‘teasing some of the more pompous members’ and was ‘always challenging’ Clark for his ‘Establishment ways’, acting as ‘a delightful gadfly in the side of the Establishment’.¹¹⁶ Both brought up in Edinburgh, they ‘had long talks on the Spiritual Dimensions’ of their lives, since ‘both had transcendent experiences and were trying to make sense of them, both starting from a Scots pragmatic view-point’.¹¹⁷ A pioneering figure with a ‘puckish charm’, ‘mercurial temperament and [...] boldness in confronting people and situations’, Jones’ ‘joy in elevating the humble was matched by a savage delight in humiliating the pompous, the rigid, the traditional’.¹¹⁸

Other such psychiatric provocateurs, some with interests in social analyses of psychiatric power, in spirituality and provoking change, would emerge as the 1960s rolled on, and they would come from within and out with psychiatry, from asylum and ‘post-asylum’ spaces, from therapeutic communities, from social science disciplines in the academy, even from politicians, patients and from emerging counter-cultures and sub-cultures in wider society.¹¹⁹ Therapeutic communities were never widely introduced in mental hospitals, but some notable charitable organisations in England, such as the Richmond Fellowship and the Philadelphia Association, offered alternative places of care for the mentally ill which operated on their principles of democratic and egalitarian social organisation.¹²⁰ The Philadelphia Association in particular was established by yet more controversial mercurial figures, the so-called ‘anti-psychiatrists’, to whom I will return to later in the chapter. These projects which emerged in the 1960s, however, were marginal to the public mental health services, still dominated by mental hospitals which did not adopt the kind of reform that Jones had introduced at Dingleton.

¹¹³ David Clark, ‘Therapeutic Community Memories: Maxwell Jones’ on website of the Planned Environment Therapy Trust Archive and Study Centre On-line Publication, May 2005, http://www.pettrust.org.uk/index.php?option=com_content&view=article&id=781:therapeutic-community-memories-maxwell-jones&catid=241&Itemid=407 [accessed 15 May 2016].

¹¹⁴ Ibid.

¹¹⁵ Ibid.

¹¹⁶ Ibid.

¹¹⁷ Ibid.

¹¹⁸ Ibid.

¹¹⁹ Chris Philo, ‘Post-asylum geographies: an introduction’, *Health and Place* 6 (2002), pp. 135–136.

¹²⁰ See Elly Jansen (Ed.), *The Therapeutic Community: Outside the Hospital* (London: Croon Helm, 1980).

2.3 The Death Knell of the Asylums?

Following World War II, the National Health Services (Scotland) Act 1947 transferred responsibility for hospital treatment and care for the mentally ill from the local authorities to the Secretary of State for Scotland. This nationalised and centralised system meant that the state was more likely to become the target of democratic demands in relation to healthcare and welfare. Ministers of state were expected to meet their duties in relation to public provision for the health and welfare needs of British citizens. The NHS (Scotland) Act 1947 and the National Assistance Act 1948 heralded the final parting with the Poor Law system and an end to the stigmatising discourse of pauper lunacy. These Acts of Parliament gave local authorities power to provide community based services for the mentally ill. Whilst local authorities were given discretionary powers to provide community mental health services, no statutory obligation was placed on them to do so. At the international level psychiatric institutions were coming under scrutiny from the World Health Organisation (WHO). In 1953 the WHO produced a report *The Community Mental Hospital Third Report of the Expert Committee on Mental Health*. One of the co-authors of the report was T.P. Rees, the medical superintendent at Warlingham Hospital in Croydon, who had brought a therapeutic community approach into the hospital. The report stated that

the need to provide more psychiatric hospital beds is being over-emphasised at present in some countries of western Europe and North America to the detriment of the provision of other services which would reduce the need for the admission of patients into psychiatric hospitals or alternatively reduce the length of stay of those patients who must be admitted [...] There is no doubt that in the past too much attention has been given to the mere provision of further psychiatric beds and too little to the development of a real community mental health service.¹²¹

This call for a shift in the pattern of provision from one dominated by large institutions to a ‘community mental health service’ was to be a recurring theme in the second half of the 20th century throughout the western world. In the 1950s, the introduction of new drugs, most notably, chlorpromazine, lithium, sedatives, stimulants and the tricyclic antidepressants, contributed greatly to the therapeutic optimism already present within psychiatric medicine.¹²² The new generation of drugs were purported to treat underlying diseases and relieve specific symptoms. It was hoped that they would allow patients to be discharged from hospital earlier and potentially abolish the long-stay function of the mental hospital. The Mental Health (Scotland) Act 1960 had followed the Act of 1959 for the rest of the UK in stressing the need for more voluntary and informal means of admission of patients to mental hospitals. The general purpose of the 1960 Act was to ensure that

¹²¹ WHO, *The Community Mental Hospital Third Report of the Expert Committee on Mental Health* (Geneva, Palais de nations: 1953) p. 4.

¹²² Edward Shorter sees the introduction of Largactil (chlorpromazine) as having initiated a ‘revolution in psychiatry’, transforming it ‘from a branch of social work to a field that called for the most precise knowledge of pharmacology’. See his *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: John Wiley, 1997), p. 255.

legal formalities did not obstruct the exercise of psychiatric treatment, removing burdensome administrative and judicial processes.¹²³ It aimed to reduce both the numbers admitted to hospital and periods of detention, and like the NHS Act, acknowledged the need for supportive community services to be provided by local authorities. The legislative reform and therapeutic innovation was thought to contribute to tackling the stigma of mental illness and mental hospitals, depicting mental illness as just like a physical illness requiring medical treatment, and representing psychiatry as a legitimate branch of general medicine. The emphasis of the 1960 Act on voluntary and informal admission resulted in a shift from a position in 1960 when 65% of patients at Scottish mental illness and mental deficiency hospitals other than the State hospital were compulsorily detained, to only 8% of such patients being compulsorily detained in 1970.¹²⁴

A year after the Scottish Act, the UK Secretary of State for Health, Enoch Powell, delivered a searing speech at the annual conference of the mental health charity, the National Association for Mental Health (NAMH), outlining his ambition to close the old asylums. In the speech he envisaged ‘the elimination of by far the greater part of this country's mental hospitals as they exist today’.¹²⁵ He warned the audience, mainly made up of mental health professionals, that

this is a colossal undertaking, not so much in the new physical provision which it involves, as in the sheer inertia of mind and matter which it requires to overcome. There they stand, isolated, majestic, imperious, brooded over by the gigantic water-tower and chimney combined, rising unmistakable and daunting out of the countryside — the asylums which our forefathers built with such immense solidity to express the notions of their day. Do not for a moment underestimate their powers of resistance to our assault. Let me describe some of the defences which we have to storm.¹²⁶

This speech appeared to sound the death knell for the old asylum system, as Powell affirmed that ‘for the great majority of these establishments there is no future appropriate use’.¹²⁷ He exhorted his audience ‘to strive to alter our whole mentality about hospitals, and about mental hospitals especially’.¹²⁸

In 1962, separate *Hospital Plans* were produced for Scotland and the rest of the UK. The plan for England and Wales included a proposal for the reduction of mental hospital provision based on statistical projections from mental hospital population figures for England and Wales. However, in Scotland there was reticence about making such a proposal. The Scottish plan stated that the advent of new mental health legislation and the increasing emphasis on community care imparted ‘an element of uncertainty into this part of the hospital service’, but that there was ‘little evidence yet

¹²³ Dorothy Wilson, ‘Mental Health Services’, in *Social Services in Scotland*, ed. John English (Edinburgh: Scottish Academic Press, 1988), p. 80.

¹²⁴ MWCS, *A Duty to Care: An account of the work of the Mental Welfare Commission for Scotland between 1962 and 1972* (Edinburgh: HMSO, 1972), p. 7.

¹²⁵ The full text of Enoch Powell’s ‘water-tower’ speech to the NAMH conference in 1961 is available on www.studymore.org.uk/xpowell.htm.

¹²⁶ *Ibid.*

¹²⁷ *Ibid.*

¹²⁸ *Ibid.*

in the Scottish figures of any very large run-down of the total hospital population'.¹²⁹ No targets for reduced figures were set and no standard ratio of psychiatric beds to population was adopted.¹³⁰ At the end of 1961 there was a resident population of 19,672 in mental hospitals, 380 per hundred thousand population.¹³¹ The total resident population of Scottish mental hospitals barely changed in the next decade, fluctuating between 19,000 and 20,000 between 1961 and 1972.¹³² At the end of 1973 the resident population was 18,632.¹³³ This was a rate of 370 per hundred thousand population compared with an English occupancy rate of 190.¹³⁴ Evidently a decade after his 'water tower' speech, Powell's ambitions had yet to be realised, especially in Scotland.

By the 1960s mental hospitals were seen by many, including the UK Minister for Health, as obsolete institutions. There was a changing climate of opinion in which a diminished role for mental hospitals was envisaged. The Mental Health Act's emphasis on voluntary treatment with the consent of the patient illuminated a tension between how psychiatry regarded its patients and how the law encouraged patients to regard themselves.¹³⁵ The small and short-lived 'mental patients' union' at Hartwood petitioned against the specific conditions at the hospital, yet their efforts can be seen as part of broader cultural and political shift from 'beyond the walls of the asylum'. Whilst legislative changes and developments in psychopharmacology were meant to bring about a revolution in mental health care which promised to return the mental patient to social conformity, ironically they also created opportunities to those for whom 'liberation from the asylum meant a liberation from psychiatric conformity'.¹³⁶

2.4 Scottish Union of Mental Patients

SUMP arose out of the petition that was signed by 27 patients towards the end of July 1971 demanding 'redress of grievances and better conditions' at Hartwood Hospital.¹³⁷ The 'Foundation Members' were the petitioners in Ward Seven who had 'the courage to make their complaints and sign the petition' along with three patients from the closed wards eight and ten to whom the petition was 'smuggled out'. The petition was 'put forward' on the 26 July 1971. In a SUMP document written around this time it is claimed that

¹²⁹ Department of Health for Scotland, *Hospital Plan for Scotland* (Edinburgh: HMSO, 1962), quoted in F.M.Martin, *Between the Acts: Community Mental Health Services 1959-1983* (London: Nuffield Provincial Hospitals Trust, 1984), pp. 66-67.

¹³⁰ F.M.Martin, *Between the Acts: Community Mental Health Services 1959-1983* (London: Nuffield Provincial Hospitals Trust, 1984), pp. 67-69.

¹³¹ *Ibid.*, p. 67.

¹³² *Ibid.*, pp. 67-68.

¹³³ *Ibid.*, p. 68.

¹³⁴ *Ibid.*

¹³⁵ Ann Claytor, 'A Changing Faith?: A History of Developments in radical Critiques of Psychiatry since the 1960s' (unpublished PhD thesis, University of Sheffield, 1993), p. 259.

¹³⁶ Peter Barham, *Closing the Asylum: The Mental Patient in Modern Society* (London: Penguin, 1997), p. 12.

¹³⁷ Thomas Ritchie, 'The Nature of the Association SUMP, It's Policy and Aims', (circa.1971-72), p. 1.

had we had accessibility to all the patients and the time we could probably get more [...] But even to a small united band of 27 the authorities were prepared to give heedful ear, whereas the solitary plaintiff gets nowhere. [Mental Welfare] Commissioners came from Melville Street, Edinburgh and several personal grievances have been redressed. They are waiting for a formal document of grievance in writing.¹³⁸

The idea for a union was first mooted by an elderly patient in the geriatric ward fifteen, Archie Meek who was aged 91. He first suggested the idea when Thomas Ritchie was shaving him as part of duties he had undertaken at Hartwood: ‘Christ, Tam,’ he demanded, ‘Whit are us auld men tae dae if ye ever leave us? We’re a’ dividid frae yin anither. Kin ye no start up a union afore ye go? Fur dividid we fa!’¹³⁹ According to Ritchie the old man ‘was probably one of the original pre-Great War trade unionists’.¹⁴⁰ Later Ritchie ‘put the suggestion jokingly’ to a ‘social worker’, Felicity Harris, ‘but she took it seriously. Why don’t you start a union of mental patients, Tommy? There’s no reason why you shouldn’t’. Ritchie was a state patient at Hartwood, having been sent there after he was arrested and charged with breach of the peace in 1963 at Lanark Sheriff Court, ‘with a restriction on my discharge whereby only Secretary of State for Scotland had the power to discharge me’.¹⁴¹ He authored a document, referred to elsewhere as ‘the Manifesto’, and a ‘Journal of SUMP’s days’, most of which was written and compiled in the months of July and August in 1971, but some of which was recorded as early as 1966 and as late as July 1972. The Manifesto document was initially created to be presented to the Mental Welfare Commission for Scotland (MWCS) which investigated complaints by patients. Within the document is a short autobiographical account, including what Ritchie describes as a ‘case history’ of his life leading up to and during his time in Hartwood (9 pages). A large section of the document details his personal grievances from 1966-1971 (around 20 pages), the personal grievances of other patient members and ‘general’ grievances of all patient members (around 19 pages). It is important to try to reconstruct the specific problems which SUMP was formed to address. By examining the SUMP documents, the context of their production and intended audience can be explored. The SUMP documents must be comprehended in the light of social, material and political circumstances both proximate and remote and understood with reference to the principal member and author of the SUMP documents, Thomas Ritchie and the situation of the group of patients, particularly in ward seven at Hartwood, with whom he took action.

2.5 From Personal to Collective Grievances

According to Ritchie initially he was meant to be detained at Hartwood for only 15 months when he was admitted in 1963. He remained a patient of Hartwood until 1972. He had been in mental

¹³⁸ Ibid., p. 3.

¹³⁹ Ibid., p. 2.

¹⁴⁰ Ibid.

¹⁴¹ Thomas Ritchie, ‘My Own Grievances (Current)’ in SUMP Documents, (1971), p.1.

hospitals, including Hartwood, Crichton Royal in Dumfries and Leigh House in Coventry, prior to this eight year-long spell at Hartwood.¹⁴² He had not anticipated such a long stay:

I certainly didn't know what I was in for that morning in the Sheriff Court at Lanark eight years ago. I could never have imagined in those days exactly what would be entailed in being a ward of the Secretary of State, for the effective reality of the matter is that State patients simply do not have any rights.¹⁴³

He had travelled around the UK and Ireland as a young man, spending time in Glasgow, London, Belfast, Dublin, Brighton, Coventry and Lanark.¹⁴⁴ Within the SUMP documents he details aspects of his upbringing, employment, travels, drug habits and his experience of psychiatric hospitals.¹⁴⁵ In the 1950s he had 'drifted into photography' and had experienced 'brushes with the law' on a handful of occasions, mainly for driving under the influence of alcohol, but also for forging prescriptions to obtain drugs. He received drug treatment, including anti-depressants and chlorpromazine, and was given electro-convulsive therapy (ECT) during his spells in hospital.¹⁴⁶ It appears that he did not have any links with trade unions prior to the formation of SUMP and in fact he had worked casually for the Conservative and Unionist Party as 'a kind of pollster', before being detained at Hartwood.¹⁴⁷ The autobiographical section, or as Ritchie refers to it, his 'case history', leads up to a list of personal 'grievances for redress'. He explained, 'I have not once broken the law since I've been here, but I do see some of the hospital's rules as being more honoured in the breach than in the observance'.¹⁴⁸ After starting a course at Bellshill Industrial Rehabilitation Unit (IRU), he recounted how he had received good tutorial comment and marks for his papers but that it had been 'slow going because of a lack of co-operation from this hospital':

Let me illustrate: On July 2 [1967] I was shifted into the top-security section of Ward 7, ostensibly because I was 'not well' but actually because I made a strongly worded protest to the doctor about lack of exercise and fresh air (some of us, myself included, have not been outside the ward in 5 weeks; we are told that this is due to the shortage of staff). I also complained about the poor quality of the food and the bad conditions generally. I made these complaints somewhat heatedly – an indication that I was not well, apparently. *I was not violent*. I have never been violent. And the sickroom is supposed to be for violent cases.¹⁴⁹

Ritchie concluded the 'case history' section with the following list of personal 'grievances for redress':

No parole – I should like 'full parole' restored as soon as possible, i.e. freedom to go out and come in within reason.
No facilities for study whatsoever – These I should like as soon as possible.

¹⁴² Thomas Ritchie, 'Introduction' in SUMP Documents, (1971), pp. ii-ix.

¹⁴³ Ritchie, 'My Own Grievances', p.1.

¹⁴⁴ Ritchie, 'Introduction', pp. ii-ix.

¹⁴⁵ *Ibid.*, pp. ii-ix.

¹⁴⁶ *Ibid.*, pp. ii-ix.

¹⁴⁷ *Ibid.*, p. v.

¹⁴⁸ *Ibid.*, p. viii.

¹⁴⁹ *Ibid.*, pp. viii-ix.

No treatment for my addiction – I should like to be transferred to another hospital where the drug problem is better understood and more sympathetically dealt with.
 Brutality to helpless patients – I want this stopped forthwith.
 I should like it placed on record that I do not consider that I should have been detained under Part V of the Act in the first place.

- The Sickroom, Ward Seven, Hartwood
 September 1967.¹⁵⁰

He had expressed personal grievances throughout his time at Hartwood but had found that ‘the solitary plaintiff gets nowhere’:

Through my first seven years I tried all the constitutional means available in vain effort to have my grievances redressed. The ‘normal channels’ they talk about look good on paper. In effect they are functionless in the service of an aggrieved State patient. The latter very soon finds that it is useless complaining about anything.¹⁵¹

With the help of a sympathetic occupational therapist at Hartwood Ritchie started studying for A-levels via a London university and was beginning to find a critical voice. Prior to sitting exams in the summer of 1969 Ritchie had been attending the IRU at Belshill from November 1968 until February 1969, completing a three month course ‘with an excellent report’. He was aggrieved that no employment was found for him by the Home and Health Department.¹⁵² The IRUs were meant to provide opportunities for the mentally and physically disabled to be rehabilitated back into some form of employment. He passed two A-level exams six months later in 1969 – ‘Still no job was found for me!’¹⁵³ Ritchie’s attempts to find a way out of Hartwood and into work around this time gained urgency. By 1971 he reflected that

the conviction grows in many that they will die in hospital (this one), their ability to rehabilitate themselves outside diminishing with the passing years. I myself have the feeling that I must make a now-or-never effort to get out this year, for with every passing day my prospects of success are marginally less.¹⁵⁴

The state social worker had written to Ritchie in December 1970 informing him that he himself had been ill and had been unable to attend to the matter of Ritchie’s rehabilitation into work.¹⁵⁵ In the SUMP documents Ritchie drew attention to the fact that the Department of the Secretary of State for Scotland, the Home and Health Department, had only one social worker to deal with all the State Patients in Scotland. Ritchie lamented, ‘When he stops work, the social progress of all the patients in his care also comes to a halt’.¹⁵⁶ Ritchie believed that the state social worker had colluded in the ‘deliberate sabotage’ of his career, which seemed to be ‘a complete negation of the

¹⁵⁰ Ibid., p. ix.

¹⁵¹ Ritchie, ‘My Own Grievances’, p. 1.

¹⁵² Ibid., p. 2.

¹⁵³ Ibid.

¹⁵⁴ Ibid.

¹⁵⁵ Ibid., p. 3.

¹⁵⁶ Ibid.

functions of the State Social worker and the Ministry of Labour'.¹⁵⁷ He claimed that 'whilst letting me go out every day in search of a job during most of the winter, [the state social worker], abetted by the Ministries of Labour in Shotts and Wishaw, had no intention from the start of permitting me to take work should I find it'.¹⁵⁸ Ritchie's experience was not uncommon. Research conducted by Vicky Long into post-war industrial therapy in Britain has found that often the 'Ministry of Labour sabotaged the efforts of mental health care providers to help their patients gain work'.¹⁵⁹ Ritchie described the difficulties which awaited him outside of the hospital in wider society:

The high rate of unemployment makes job-seeking in Scotland a soul-testing experience, even when all other factors are ideal. The experience is apt to be a trifle more intense when you happen to be a long-term patient from a mental hospital who has not been employed in eight years. Such a person is well down the list of types which prospective employers are on the look-out for.¹⁶⁰

In May 1971 his hopes were renewed when he found assistance from an organisation called Glasgow Advisory People (GAP). He claimed that

had it not been for GAP I should still have been wallowing helplessly in the bureaucratic quagmire but luckily I took the chance and went AWOL to visit that Organization in Glasgow. Another patient [...] had written recently and told me how a group of voluntary social workers calling themselves Glasgow Advisory People had given him invaluable assistance in his fight against Hartwood [...] GAP [...] brought pressure to bear on Hartwood so that I finally got started on my [second] IRU course not much more than a week or so later.¹⁶¹

It was 'a detached social worker connected to GAP', that had taken Ritchie's suggestion to start a union seriously when he first mentioned the idea.¹⁶² GAP was founded as an information service by Glasgow graduate Felicity Harris. According to London-based underground newspaper *International Times (IT)*, GAP was an 'umbrella structure' which housed a legal clinic, Claimants Union, Black Box news agency, White Panthers (far left group), Seed Centre and Drug Care unit, 'all of which worked with Glasgow's large freak population and the poor of the surrounding district'.¹⁶³ But even after GAP's involvement, Ritchie went on to experience further difficulties with the Hartwood hierarchy. He complained that the medical superintendent at the hospital, 'Dr. Graham's going on his summer vacation saw the final sabotage of my IRU course by two senior nurses of Hartwood'.¹⁶⁴ During the summer of 1971 he ran away from the hospital three times in as many months.¹⁶⁵ Reflecting on one of these occasions he lamented, 'I loathed the place and I hated

¹⁵⁷ Ibid., p. 6.

¹⁵⁸ Ibid., p. 8.

¹⁵⁹ Vicky Long, 'Rethinking Post-war Mental Health Care: Industrial Therapy and the Chronic Mental Patient in Britain', *Social History of Medicine* 26 (2013), p. 757.

¹⁶⁰ Ibid., p. 4.

¹⁶¹ Ibid., pp. 8-9.

¹⁶² Ibid., pp. 10-11

¹⁶³ *International Times* 121, 13-27 January 1971, from on-line archive

http://www.internationaltimes.it/archive/page.php?i=IT_1972-01-13_B-IT-Volume-1_Iss-121_006&view=text [accessed 15 May 2016].

¹⁶⁴ Ibid., p. 12.

¹⁶⁵ Ibid., p. 1.

the thought of going back to it all. This hatred stemmed from fear of the unpredictable things that could happen to me when incompetent and just plain-stupid staff were in charge'.¹⁶⁶

Ritchie's own personal predicament stands out because he is the author of the SUMP documents. Inevitably his particular perspective colours the entire textual body of evidence for the existence of this 'mental patients' union' which came and went within a year between 1971 and 1972. Grievances of seven other patients were listed in the documents and short contributions by a few other patients were included. One patient apparently demanded 'immediate access to his own cash', 'full parole immediately' and wanted 'to be released as soon as possible' to the care of his niece.¹⁶⁷ The same patient wrote on July 3 1971 that 'ever since being admitted...I have been acting as Secretary of Hartwood Patients' Social Club committee – a group of patients of both sexes'.¹⁶⁸ He listed the duties he undertook in this role, concluding that 'the foregoing to my mind completely disposes of any suggestion that my mental faculties are in the least sub-normal'.¹⁶⁹ Another patient wanted 'to have the promises made to him by the state officials concerned with his case to be fulfilled forthwith' and 'that suitable accommodation be found for him and that he be released immediately'.¹⁷⁰ One wanted 'an immediate stop to the brutality, and better, more positive medical treatment'.¹⁷¹ Another wanted 'his release at once, having entered Hartwood voluntarily'.¹⁷² Although most patients were 'voluntary' following the Mental Health Act, in practice it seems that some of those who entered hospital 'voluntarily' found their consensual stay turn into *de facto* confinement. In August 1971 in the UK, internment practices were most likely to be associated with the new policy introduced by the British government in Northern Ireland, where 342 men from Catholic Nationalist communities, and suspected of IRA involvement, were rounded up and imprisoned without trial by the British Army in Operation Demetrius.¹⁷³ However, some individuals in the UK, like Ritchie and some of the SUMP cohort felt that they and other mental patients had been nothing other than victims of internment practices themselves.

One avowed reason Ritchie joined with others to take collective action was that his individual complaints had fallen on deaf ears and had not resulted in his discharge from hospital. The assistance received from GAP in dealing with the hospital authorities immediately preceded the 'petition for the redress of grievances' by SUMP. This experience with GAP revealed to Ritchie the value and effectiveness of collective action. Whilst the evidence for activity on the part of other SUMP members is scant beyond the specific grievances of other patients and a few brief biographical details, the documents capture how they longed for a life beyond the locked wards at

¹⁶⁶ Ibid., p. 14.

¹⁶⁷ Thomas Ritchie, 'The Personal Grievances of Other Patients', (1971), p. 1.

¹⁶⁸ Thomas, Ritchie, 'Particular Grievances of Other Patients' in SUMP documents, (1971), p. 21.

¹⁶⁹ Ibid., p. 20.

¹⁷⁰ Ritchie, 'The Personal Grievances of Other Patients', p. 1.

¹⁷¹ Ibid., p. 1.

¹⁷² Ibid., p. 2.

¹⁷³ See Martin J. McCleery, 'Debunking the Myths of Operation Demetrius: The Introduction of Internment in Northern Ireland in 1971', *Irish Political Studies* 27 (2012), pp. 411-430.

Hartwood. Some members, like Ritchie, were state patients and the view is expressed that it would have been better for them had they been sent to prison, for at least in prison they would have known when they would be released from custody.¹⁷⁴ One patient who signed the petition had been at Hartwood for over eleven years, having originally been sent by the Court ‘for his own safety’ because he was an epileptic. According to the SUMP documents this was supposed to be a short-term measure until such time as there was a vacancy in an epileptic home for him.¹⁷⁵ Another had been in Hartwood for fourteen years for breach of probation, also an epileptic and a victim of polio.¹⁷⁶ In a letter written and sent to Ritchie by a patient who was ‘on the run’ from Hartwood, particular emphasis was laid on the location of locked-ward seven, where most of the petitioners were detained. He wrote:

There is a ward 7. It is actually a punishment ward. I think there should never be a ward of that type. Even the canteen is closed every night. I tell you they run the hospital to please themselves. As for the nurses they are in it for just one purpose and that is money, and money alone. During the period I spent in the hospital I received no medication of any type. As I write this letter I am on the run. I have spent my time hiding in a lodging house. At least you can communicate with people, whereas in the hospital you can’t. I firmly believe the medication the patients receive there just can’t help them. I know it is entirely up to oneself. I am prepared to finish my time in prison, as I have taken into consideration, realising that I have broken probation. When one becomes a patient one loses all self-respect. At the moment I am sleeping in terrible conditions. But I am free.¹⁷⁷

Ritchie added a rejoinder that this patient ‘puts it rather mildly when he says that you cannot communicate in Hartwood’. Ritchie underlined the frustration patients felt:

Nobody (I refer to staff) seems to listen to what anyone else says. I have heard this actual process of message-decay in the Public Sector on numerous occasions in Hartwood; what comes out of the pipeline at the other end has changed beyond recognition from what went in at this end.

The communication breakdown in Hartwood is permanent. It exists at all levels and along all lines: between doctors and nurses, doctors and doctors, nurses and nurses, doctors and patients, nurses and patient. One shudders to think what tangle the external lines linking Hartwood with the world outside have wound themselves into! If a patient complains about anything, the subject matter of the complaint gets scrambled in the passing so that nothing is ever done about it.¹⁷⁸

‘Message-decay’, according to the *Oxford Dictionary of Media and Communication*, is ‘the corruption of a message over time through the diminishing recall of information by audiences’.¹⁷⁹ Ritchie attempted to overcome this problem by circumventing the Hartwood authorities. He publicised the SUMP message beyond the hospital, in the hope of finding more sympathetic audiences. The Mental Welfare Commission for Scotland (MWCS) was SUMP’s first intended

¹⁷⁴ Ritchie, ‘Particular Grievances of Other Patients’, p. 21.

¹⁷⁵ Ibid.

¹⁷⁶ Ibid.

¹⁷⁷ Ibid.

¹⁷⁸ Thomas Ritchie, ‘The General Grievances – Part Two’ in the SUMP documents, (1971), p. 25.

¹⁷⁹ Daniel Chandler and Ron Munday (ed), *Oxford Dictionary of Media and Communication* (Oxford University Press, 2011).

<<http://www.oxfordreference.com/view/10.1093/acref/9780199568758.001.0001/acref-9780199568758-e-1713?rskey=c4KdoN&result=1>> [accessed 6 October 2015].

audience beyond the walls of the asylum, but Ritchie was also addressing a wider constituency in the SUMP documents. He asked, rhetorically:

Who exploits [mental patients] for heaven's sake? Mental patients are exploited by the whole of society in various ways. For example, they are positively exploited as a cheap labour force at harvest time. They are negatively exploited by the niggardly budgeting which puts them right at the bottom of the health services.¹⁸⁰

Ask yourselves this one, taxpayers. What do such public-servants as Graham, Greenshields, and the rest do for their money? If you know anything of these gentlemen, you'll find yourself hard put to answer the question [...] This public sector sickness in regard to Mental Health Services is more than a local phenomenon. There seems to be a chronic malaise eating at the NHS mental hospitals on a national scale – and I do not allude to that No-account Species, the British Mental Patient.¹⁸¹

The grievances which motivated SUMP members to agitate were place-specific, but Ritchie addressed the situation of mental patients in British asylums more broadly. Indeed, such grievances were by no means uncommon among asylum patients and were long-established. In his studies of patient letters from the late-nineteenth and early-twentieth centuries at the Royal Edinburgh Asylum, Allan Beveridge finds that patients wrote 'to complain, to get out, to communicate with the outside world, to plead their sanity, to condemn the Asylum, to criticise other inmates or express affection for them'.¹⁸² Likewise Jonathan Andrews discovers that patients' letters and case notes from Gartnavel Royal Asylum were 'full of sardonic commentary on the tortures of their "home" at Gartnavel [...] and the majority of patients whose opinion is accessible from case notes and correspondence [...] appealed repeatedly for their discharge'.¹⁸³ Continuities abound in the records of patients' grievances at Scottish asylums from the nineteenth into the twentieth century. The studies of Beveridge and Andrews 'reflect the daily concerns and frustrations of institutional life - the irritation of living with fellow patients, the poor food, the noise, the skirmishes with attendants' and the 'regimental monotony and conformity of asylum life'.¹⁸⁴ Andrews argues that overcrowding at Gartnavel Royal 'during the second third of the twentieth century created just as many, if not more, tensions between dehumanised patients and over-worked nurses, than had pervaded the nineteenth-century asylum'.¹⁸⁵ The SUMP documents reveal just such tensions between patients and staff at Hartwood in the 1960s and 1970s, but – unlike the messages from the individual patient letters examined by Beveridge – the collective grievances articulated by Ritchie in the Manifesto reached an audience beyond the walls of the asylum.

2.6 Audiences Beyond the Walls of the Asylum

¹⁸⁰ Ritchie, 'The Nature of the Association SUMP', p. 2.

¹⁸¹ Thomas Ritchie, 'Tabulate Grievances and Some Suggested Remedies – These are for the attention of the Mental Welfare Commission', (1971).

¹⁸² Allan Beveridge, 'Life in the Asylum: Patients' letters from Morningside, 1873-1908', *History of Psychiatry* ix (1998), p. 435.

¹⁸³ Jonathan Andrews, 'The patient population'. Ed. J. Andrews and I. Smith *'Let There Be Light Again'. A History of Gartnavel Royal Hospital From Its Beginnings to the Present Day* (Glasgow: Gartnavel Royal Hospital, 1993), pp. 111-112.

¹⁸⁴ Beveridge, 'Life in the Asylum', p. 461; Andrews, 'The patient population', p. 115.

¹⁸⁵ Andrews, p. 113.

The MWCS was the most obvious official channel through which SUMP members could voice their grievances. The Mental Health (Scotland) Act of 1960 had dissolved the General Board of Control for Scotland and in 1962 the MWCS was established to continue carrying out some of the functions of the Board. Its general remit was to

exercise protective functions in respect of persons who may by reasons of mental disorder be incapable of adequately protecting their persons and interests [...] to make inquiry into any case where it appears to them that there may be ill-treatment, deficiency in care or treatment, or improper detention of any person who may be suffering from mental disorder.¹⁸⁶

According to the MWCS there was ‘no question of complaints being submitted through recognised channels, or being sifted before reaching the commission’.¹⁸⁷ Commissioners visited Hartwood in 1971 giving patients the opportunity to complain. Patients made grievances known to visiting commissioners. Following the verbal complaints made during the MWCS visit a ‘formal document of grievance in writing’ was planned and Ritchie undertook the task. The grievances expressed in the SUMP document sent sometime around August 1971, included allegations of deficiency of treatment and even references to the use of unreasonable force to restrain patients. Ritchie remarked that ‘staff-to-patient violence and brutality [in] 1967 [...] was an everyday occurrence not to be remarked upon’ and that ‘although I maintain that brutality is on the way out, [another patient] holds the view that things are pretty much as they always were’.¹⁸⁸ He claimed that ‘there is rather more rough-handling and scruff-of-the-necking than one would expect to see in a hospital, even be it a NHS mental hospital, if indeed one would expect to find any such treatment dispensed at all in a hospital’.¹⁸⁹ However, most of the grievances of SUMP foundation members did not refer to specific allegations of brutality, but rather to general conditions at the hospital. Indeed, according to the 1972 MWCS report *A Duty to Care* it was claimed that ‘it is rare, but not unknown to find instances of deliberate ill-treatment or wilful neglect. More commonly it has been found that restrictive practices, once accepted as the norm, have been continued into an age when they are no longer acceptable’.¹⁹⁰ The general grievances of patients listed in the SUMP document for the MWCS reflected this to some extent. The following list of general grievances was produced in the documents authored by Ritchie:

Poor communication
 Poor service generally, esp. in the inaccessibility of the doctors to the patients as manifest by the formers’ irregular and infrequent appearances
 Patients without parole
 The deliberate ignoring of, rejection or glossing-over of patients’ complaints at all levels by the hospital hierarchy

¹⁸⁶ MWCS, *A Duty to Care*, p. 20

¹⁸⁷ *Ibid.*, p. 5.

¹⁸⁸ Thomas Ritchie, ‘The General Grievances Part 1’ in the SUMP documents, (1971), p. 24.

¹⁸⁹ Ritchie, ‘Particular Grievances of Other Patients’, p. 20a.

¹⁹⁰ MWCS, *A Duty to Care*, p.5.

Segregation of the sexes
 Stratification, and concomitant evils
 Poor food (the cheapest available) badly cooked and badly served – anything good enough for patient attitude
 Waste and extravagance
 Ward Seven - The evil of the past saturates the very brickwork of the Lower Wards. The stench of it lingers still. ‘Evacuate and Gut’... is a pretty general consensus of W7 patients’ opinion
 Erratic opening hours of hospital canteens; their poor and sloppy service; attitude of present staff to patients
 Overcrowding.¹⁹¹

The MWCS report *Duty to Care* compared the role of MWCS with that of the Mental Health Review Tribunals under the English Mental Health Act of 1959. Commissioners from Scotland, having attended hearings of the Tribunals in England, ‘noted the differences in approach and procedure’.¹⁹² They concluded that ‘there is no body in England which corresponds in function to the Mental Welfare Commission for Scotland’.¹⁹³ The report stated that

The English Tribunals must consider whether continued detention of a mentally disordered person is necessary in the interests of his health or safety, or for the protection of other people. They do not require to have regard to the care or supervision available for him if discharged. In Scotland it is a statutory requirement to have regard to these factors. It is the experience of the Commission that this is a humane and sensible provision, even where detention is no longer necessary in the interests of the patient’s health or safety, or for the protection for other persons.¹⁹⁴

The comparison made by MWCS sought to cast the Scottish approach and procedure as more enlightened, or more ‘humane and sensible’ than the English system.¹⁹⁵ This must be seen in the context of the Hospital Plan for Scotland as compared with the plan in England and Wales. There was no plan at the Scottish Home and Health Department within the Scottish Office to drastically reduce the resident population of mental hospitals in Scotland, which remained fairly constant. The Scottish approach in which large mental hospitals still dominated the pattern of care was underpinned by the idea that it is not ‘humane’ or ‘sensible’ to close hospital beds because there was no alternative community based service to take the place of the hospital-based provision. However humane, sensible or reasonable this line of argument may have been, it illuminated the fact that in Scotland community-based alternatives were not available. Despite having put the official seal of approval on the concept of community care with its emphasis on voluntary admission, legislation did not bring about any significant development of community mental health services. At the end of 1971 there were only 12 hostels in the whole of Scotland, which at that time catered for 65 mentally defective and 42 mentally ill persons.¹⁹⁶

¹⁹¹ Ritchie, ‘Tabulate Grievances and Some Suggested Remedies – These are for the attention of the Mental Welfare Commission’.

¹⁹² MWCS, *A Duty to Care*, p. 7.

¹⁹³ Ibid.

¹⁹⁴ Ibid., p. 6.

¹⁹⁵ Ibid.

¹⁹⁶ John Murphy, *The British Social Services: The Scottish Dimension* (Edinburgh: Scottish Academic Press, 1992), p. 66.

In a Q & A section in the SUMP documents, the question is posed, ‘Why ‘Scottish’ rather than ‘National’ [Union of Mental Patients]?’ Ritchie answers,

Certainly not for reasons of rabid porridge-and-bagpipes patriotism! Rather the opposite, in fact, with regard to the secondary reason – which is to draw attention to the fact that there are variations between Scotland and England & Wales in respect of the mental health service. We have a different Act of Parliament to start with. We are run by a different government department... As far as mental patients are concerned this set up is N.F.G. and most inefficiently run... The main reason for ‘Scottish’, however, is to contrive the abbreviation SUMP – a level below which you cannot sink.¹⁹⁷

The implication was that Scotland did not compare favourably with the rest of the UK in regard to mental health services. He offered no explicit argument as to why the mental health services in Scotland were more ‘inefficiently run’ than England. Indeed Ritchie alluded to hospital ‘scandals’ which had been reported and investigated in England in order to decry the plight of mental patients in the UK as a whole:

Have you noticed the showing up that mental patients are getting these days?

There has been one damned scandal after another necessitating one governmental enquiry after another.¹⁹⁸

The newly-admitted patient to a NHS mental hospital is about to discover that his sorrows have only just begun. The abject and straitened circumstances of the mental patient do not bear thinking about by any normally sensitive fellow human being. They certainly do not stand up to any prolonged examination, as the numerous official investigations have shown.

Yet the solutions offered by these official bodies against brutality and other abuses in mental hospitals have never been more than makeshift. We do not see the Ombudsman proposal as going any further than 1/3 of the way towards the ultimate solution to these recurring scandals.

We do see the recent proposal that England and Wales adopt the Scottish system of Mental Welfare Commissioners as being nothing more than derisory. Put forward as a solution to the problem of E[ngland] and W[ales] in this connection, the implication is obvious, namely that we in Scotland do not have mental hospital problems!

-To which we patients can but answer, ‘OH YEAH!’¹⁹⁹

The proposal for an ombudsman applied to the rest of the UK and not Scotland, but clearly Ritchie was aware of events south of the border.²⁰⁰ Whilst SUMP was formed for the purpose of taking action against the specific conditions at Hartwood, Ritchie expressed an ambition to form an organisation beyond the walls of the asylum, which would transcend specific concerns with the conditions at Hartwood. Ritchie demonstrated an awareness of both strains and opportunities of the context in which he found himself. After he was discharged from Hartwood in October 1971, he

¹⁹⁷ Ritchie, ‘The Nature of the Association SUMP’, p. 1.

¹⁹⁸ *Ibid.*, p. 1.

¹⁹⁹ Thomas Ritchie, ‘Advantages of patients in mental hospitals having their own fully democratic and autonomous national association or union’ in SUMP documents, (circa 1971-72).

²⁰⁰ A number of official hospital and government enquiries in England and Wales found abuses in mental institutions. The first investigations stemmed from the publication of *Sans Everything: A Case to Answer* (London: Aegis, 1967) by Barbara Robb, a campaigner for the elderly, which revealed abuse of dementia patients. Official Inquiry Reports into the following NHS hospitals were published: Ely Hospital, Cardiff (1969); Farleigh Hospital, Somerset (1971); Whittingham Hospital, Lancashire (1972).

sought to develop the union by recruiting more members, including women. He made visits to Gartnavel and Gartloch hospitals. The SUMP membership list contained 100 entries, but there is no evidence of any significant coordinated activity following the petition by the original group of 'foundation members' at Hartwood. Ritchie enlisted the support and advice of established social institutions including the Scottish Council for Civil Liberties (SCCL), homeless charities the Simon Community and Shelter, trade union officials, local churches and his local MP. While these organisations were listed as 'active sympathisers' in the SUMP journal, there is no evidence to suggest that significant material resources of any kind were made available to SUMP. It is clear, however, that by associating SUMP with such established social and civic institutions Ritchie hoped to lend credibility to the idea of mental patients taking collective action and gain more widespread support. Yet he also aimed to reach a more 'anti-establishment' audience beyond the walls of the asylum and indeed, beyond Scotland. GAP was part of this alternative society scene he hoped to appeal to.

In October 1971 he sent a copy of the SUMP documents to the editor of *Ink* magazine. *Ink* was part of the London underground press which offered a space for visions of an alternative society to be articulated.²⁰¹ The colourful pages of these newspapers gave various counter-cultural groups the opportunity to express themselves on issues ranging from art, music, sex, drugs, alternative lifestyles and philosophies, to more mainstream political issues. The underground press was an expression of the emerging counter-cultures of the 1960s and a medium through which social boundaries were challenged and tested. The offices of underground press newspapers were regularly raided and two newspapers, *Oz* and *IT* (*International Times*), were prosecuted on charges of obscenity and conspiracy to corrupt public morals. *Ink* was launched in May 1971 and had grown out of *Oz*. *Ink* described itself as 'The Other Newspaper' and took a more serious and overtly political approach to *Oz*. John Lloyd, later editor of the *New Statesman*, was *Ink* editor when Ritchie sent the SUMP manuscript to the underground paper in 1971. Lloyd remarked in a 2009 interview that 'you had issues taken up, often quite intemperately, which have passed now into normal, liberal practice'.²⁰² He reflected that the underground press newspapers 'were good-hearted and opened up a whole series of things. *Frendz* and *IT* were very druggy and the staff were famously stoned, while *Ink* was more lefty in a non-denominational way'.²⁰³ One commentator, Tony Palmer remarked in 1971 that *Ink*'s 'sole concern was information denied the possibility of broadcast elsewhere' and that 'it spoke for a minority, ill-defined and incoherent though the minority might have been'.²⁰⁴ Palmer claimed that 'without a public voice, they might well turn to

²⁰¹ See Elizabeth Nelson, *The British Counter-Culture, 1966-73: A Study of the Underground Press* (London: Macmillan, 1989).

²⁰² Duncan Campbell, 'London Underground', *New Statesman*, 14 August 2008, <http://www.newstatesman.com/life-and-society/2008/08/underground-press-gay-ink-sex> [accessed 15 May 2016].

²⁰³ *Ibid.*

²⁰⁴ Tony Palmer, 'The Underground', *The Spectator*, 6 August 1971, p. 10.

more silent protest. *Ink* was their opportunity to use the democratic process of debate'.²⁰⁵ *Ink* published an extract of the SUMP documents authored by Ritchie, claiming that there was 'accumulating evidence that mental institutions in this country and elsewhere are being run as an extension of the prison system – i.e., remove the problems by making the constituents of it invisible and depriving them of their basic rights'.²⁰⁶ The newspaper told its readers that 'anyone wishing to read this extraordinary document should send to *Ink* for a copy'.²⁰⁷

SUMP and *Ink* had started and folded around the same time, both lasting no longer than a year. The Glasgow information service GAP which 'assisted' Ritchie in his 'fight against Hartwood' also came and went around the same time. In the November 1971 issue of *Ink* which published an extract of the SUMP documents, the newspaper reported that

Another attempt at alternative service collapses, for the moment. GAP the Glasgow Advisory People's centre, folded last week after months of internal bickering, increasing mistrust and mounting debts.

GAP though latterly less and less in touch with reality and with the people, did have good aims and at times good practice. The Legal Clinic and the information service helped out many who might otherwise have gone to the wall.²⁰⁸

IT reported that 'internecine squabbles, pig hassles and the continual character assassination seem to have obscured GAP's precarious financial situation [...] The groups that worked under the GAP umbrella re-formed in various parts of the city'.²⁰⁹

Like many of the alternative social and political experiments of the 1960s and 70s, SUMP, *Ink* and GAP were short-lived. By the time *Ink* had sent its final letter to Ritchie, the underground newspaper was on the verge of folding and within a few months SUMP had also folded and Ritchie was in London. SUMP could not have found two more different kinds of audience for its message, than MWCS and *Ink*. The MWCS was an official body to which the patients at Hartwood could make formal complaints. *Ink* newspaper was an underground publication known for its rhetorical flourishes and informal tone. There is a clear tension running through the discourse employed by Ritchie between appealing to established social authority and challenging it. The communication with MWCS reflected the immediate practical objectives of the original signatories of the petition at Hartwood to improve conditions and seek release. Ritchie sought the approval and support of established organisations, appealing to traditions of trade unionism and protest, but he also looked to the emerging counter-culture as a means to express and circulate the discourse of mental patient unionism. There is an almost legal tone and style in places as Ritchie sought to present his own personal case and the collective case of SUMP, supported by sound reasoning and evidence. However the style shifts back and forth between a carefully reasoned and measured formal tone, to a satirical skittishness, employing humour and hyperbole. The bursts of rambunctious satirical style

²⁰⁵ Ibid.

²⁰⁶ 'Mental Prisons - Suicide and Despair', *Ink*, 16 November 1971, p. 4.

²⁰⁷ Ibid.

²⁰⁸ 'GAP Widens', *Ink*, 16 November 1971, p. 5.

²⁰⁹ *IT*, No. 121, 13-27 January 1971, p. 6.

in the SUMP message would have sat comfortably in the pages of *Ink*, which sold itself as 'Superlative, stupendous, sizzling, sensational, superfluous, silly, superb'.²¹⁰

Colin Jones has identified an 'act of negation and inversion' as being central to the discourse and action of the professional-led 'anti-psychiatry' of R.D. Laing.²¹¹ This feature of 'anti-psychiatry', according to Jones, aimed both at highlighting its 'now-ness and its place within the contestatory counter culture'.²¹² Ritchie had sought to transcend the specific limits on space and communication at Hartwood in a similar fashion, by looking beyond the immediate audience at the MWCS and enacting his own 'symbolic inversion of medical authority and established legitimacy'.²¹³ This symbolic inversion had a cultural resonance beyond the walls of the asylum and the 'official channels' through which SUMP had sought redress. Ritchie's writing demonstrated a tendency which Colin Jones has identified in Laingian 'anti-psychiatry', to 'oscillate perennially between a serious content-based critique of conventional psychiatry and a gestural politics of carnivalesque inversion and symbolic performance'.²¹⁴

The 'carnavalesque' was a literary form identified by Mikhail Bakhtin as subverting the authority of dominant discourses through humour. The carnivalesque shares an affinity with Menippean satire, being 'opposed to that one-sided and gloomy official seriousness which is dogmatic and hostile to evolution and change'.²¹⁵ The reliance on a mixture of the refined and the coarse, the 'unrestrained carnival word - familiar, cynically frank, eccentric, eulogistic-abusive' was employed in a rhetorical strategy of symbolic inversion.²¹⁶ For a voiceless minority group like the mentally ill, however, gestural politics could be effective in forging a shared identity with others, attracting new recruits to the cause, and more simply in having their voice heard and being noticed. Any 'carnavalesque inversion and symbolic performance' by Ritchie would have resonated more with the readership of *Ink* than with the commissioners at MWCS. However the rhetorical effect of Ritchie's satiric scorn can be appreciated by any sensitive reader. The satirical and subversive style was employed to poke fun at the 'incompetent' and unfeeling staff at Hartwood, even when recounting examples of cruelty. No doubt gallows humour had its own survival value in everyday life for patients, but in this document composed by Ritchie, humour and images of the grotesque were employed to make a serious point while simultaneously satirising the staff. Ritchie recalled how an assistant nurse had prevented a patient 'from getting out of bed and going to the toilet by sitting himself squarely on top of the patient':

²¹⁰ *Ink*, 16 November 1971, p. 12.

²¹¹ Colin Jones, 'Raising the Anti: Jan Foudraïne, Ronald Laing and Anti-Psychiatry', in *Cultures of Psychiatry and Mental Health Care in Postwar Britain and the Netherlands*, ed. Marijke Gijswijt-Hofstra and Roy Porter (Amsterdam: Rodopi, 1998), p. 285.

²¹² *Ibid.*, p. 289.

²¹³ *Ibid.*, p. 292.

²¹⁴ *Ibid.*, p. 289.

²¹⁵ Mikhail Bakhtin, *Problems of Dostoevsky's Poetics*. Edited and translated by Caryl Emerson. (Minneapolis: University of Minnesota Press, 1984), p. 160.

²¹⁶ *Ibid.*, p. 130.

Now X is no lightweight, being dense of body as well of mind, and I don't see it doing the victim's internals any good to have this great mass squat his thick arse hard on top of his belly for a goodish 40 or 50 minutes. Mind you, I don't think the cruelty was intentional. X would see it as being 'fur the man's ain guid'.²¹⁷

Ritchie mocked the haughty condescension of psychiatrists towards patients at Hartwood. The Manifesto is littered with sardonic commentaries on the perceived grandiloquence of the psychiatric profession:

The infrequency and irregularity of appearance by Hartwood psychiatrists is a pretty general complaint throughout the hospital. When this VIP does show up for a round of the wards, he or she is often in a hurry; more important business than mental patients may await the Hartwood consultant's attention, and you will find that when you try to consult this grand personage he or she will be walking away from you all the time. As to the consultation, you and/or your visiting relative(s) must expect to be summoned and kept waiting for the great man's pleasure. His time is precious, yours is valueless.²¹⁸

Ritchie concluded his invective against the psychiatrists at Hartwood by pleading, 'To the Psychiatrists of that hellish place I say: "You cruel bastards!" And, Christ, how I mean it!²¹⁹ In the Manifesto Ritchie often portrays the degrading rituals at the hospital by employing stigmatising language to refer to patients for rhetorical effect. Some would describe this as an instance of 'taking back language that has been used to oppress'.²²⁰ He invites his readers on a Bedlamesque tour of the asylum to observe the spectacle at 'feeding time':

Now all you people who come to visit Hartwood and are taken round on conducted tours, why not insist upon being shown the brutes from 7, 8, 9 and 10 at feeding time in the main hall? The midday show is the best, 12.45-13.15.²²¹

Ritchie reflected the rigidly time-tabled, grindingly monotonous and predictable regime by comparing the regularity of meals at Hartwood with the 'movements of heavenly bodies' for comic effect:

There is a stellar precision about what is served at Hartwood on any given day of the week that would match the unalterability in the movements of the heavenly bodies. You say that the next eclipse of the sun won't be seen in these islands till the 1990s: I tell you that on the third Monday in April of 1979 there will be served to the patients of Hartwood potatoes and mince; if it be fried fish on the first Friday of December, 1976, it will be boiled fish on the second, the converse also being true, naturally.²²²

Black humour, serio-comic discourse, images of the grotesque, sarcasm, irony, parody, in short, wit, helped patients at Hartwood cope with the oppressive practices and bizarre rituals at the hospital. Ritchie sought to rise above it by satirising it. Ritchie recounts how even 'a patient in ward 9 who cannot be brought round to criticise anybody or anything, puts it this way,

²¹⁷ Ritchie, 'The Particular Grievances of Other Patients', p. 20a.

²¹⁸ Ibid.

²¹⁹ Ritchie, 'Particular grievances', p. 20B.

²²⁰ Jennifer M. Poole and Jennifer Ward, 'Breaking open the bone: Storying, Sanism and Mad Grief', in *Mad Matters: A Critical Reader in Canadian Mad Studies*, Ed. Brenda A. LeFrançois, Robert Menzies and Geoffrey Reaume (Toronto: Canadian Scholars' Press, 2013), p. 96.

²²¹ Ritchie, 'The General Grievances – Part Two', p. 30.

²²² Ibid., p. 31.

remonstratingly - 'take the charitable view Mr. Ritchie. Nobody can say that Hartwood doesn't make it easy for him to go on a diet'.²²³

SUMP member Robin Farquharson, another playful provocateur, was unmistakably part of the 'London Underground' during the 1960s and early 1970s, and his was the first name on the list of SUMP members who was not a Hartwood patient. It seems he had a short stay at Gartloch Hospital before being transferred to Epsom. A South African, ex-Cambridge don and prize-winning researcher on voting theory, he was in and out of mental hospitals during the 1960s and had been excluded from the Kingsley Hall therapeutic community by the so-called 'anti-psychiatrist' R.D. Laing.²²⁴ Laing said of Farquharson that 'he was a very strange guy [...] very intelligent and totally out of his fucking mind'.²²⁵ Farquharson's involvement with SUMP was most likely tangential, perhaps signing up as a member when Ritchie visited Gartloch. Farquharson's account of temporary homelessness in London, *Drop Out!*, inspired by LSD guru Timothy Leary, reads in places like a whistle-stop psychogeographical tour of the streets, interspersed with encounters with hippie London, in which he extols the virtues of LSD.²²⁶ He helped find premises in London for a group called People Not Psychiatry (discussed below pp. 64-5). He was involved in anti-apartheid campaigning and numerous 'alternative society' projects, including the White Panther movement, squat communities, free festivals, the Anti-University, the information service BIT, its newspaper *Bitman*, and other underground press publications *Freek Press* and *Friends*. Ritchie was far removed from these activist and counter-cultural scenes whilst at Hartwood, but, when he also found himself in London in 1973, he too gave expression to fashionable tastes for sex, drugs, rock 'n' roll and the sexual revolution. Having already acknowledged his long-term drug addiction problems in the SUMP Manifesto, at the founding meeting of MPU Ritchie signed himself 'RITCHIE - LONDON - SEX - SUPERSTAR'.²²⁷ (SHG, 2011: 12). While SUMP was formed in resistance to the regime at Hartwood, it was also an expression of wider anti-institutional sentiment, of emerging attitudes of social liberalism and counter-cultural forces beyond the asylum and, indeed, beyond Scotland. Yet, when Ritchie was writing the Manifesto in Scotland in 1971, it was the more sober tradition of trade unionism to which he appealed when making his case.

²²³ *Ibid.*, pp. 30-31.

²²⁴ Laing's account of Farquharson's exclusion is detailed in conversation with Bob Mullan in the late 1980s, appearing in Bob Mullan *Mad to be Normal: Conversations with R.D. Laing*. (London: Free Association Books, 1995), pp. 181, 189; Farquharson's account of his exclusion is contained in Robin Farquharson, *Drop Out!* (Harmondsworth: Penguin, 1971), p. 54. First published in 1968 by Anthony Blond.

²²⁵ Laing interviewed in Mullan, *Mad*, p. 189.

²²⁶ Farquharson, *Drop Out!*

²²⁷ Survivors History Group (SHG), 'Survivors History Group takes a critical look at historians', in *Critical Perspectives on User Involvement*. Ed. Marian Barnes and Phil Cotterell (Bristol: Policy Press, 2011), p. 12.

2.7 Discourse of Unionism

A discourse of unionism was central to the case outlined by Ritchie for ‘patients in mental hospitals having their own fully democratic and autonomous national association or union’.²²⁸ He claimed that

The same advantage, more or less, would accrue to such a body in the field of collective bargaining as those enjoyed by trades unions proper. As combinations of workers formed for the purpose of taking united action against employers for the improvement of wages and other working conditions find that success is overwhelmingly more probable, so too would combinations of patients find that a united front against Hospital Authority would be much more rewarding than the frustrating neglect they meet with should they act individually.²²⁹

Despite the flippant comment in which Ritchie claimed that the reason for naming the group SUMP was to contrive the abbreviation which would allow for the creation of the slogan, ‘SUMP - a level below which you cannot sink’, the seriousness and contextual significance of the ‘unionist’ discourse of SUMP cannot be discounted. As Ritchie said, the old man whose idea it was to start a union in the first place had ‘probably been one of the pre-Great War trade unionists’. Not far from Hartwood the coal and steel industries of Lanarkshire had been in decline since after the Great War. Industries may have been contracting in Scotland, but traditions of trade unionism lived on. Workers continued to organise collectively to advance their own interests, to improve wages and conditions and to halt the decline of their industries and the jobs they provided. Most notably, one charismatic and eloquent trade union shop steward and Communist local councillor of the Upper-Clyde Shipbuilders (UCS), Jimmy Reid, came to prominence in 1971. Instead of striking, UCS staged a ‘work-in’ to complete orders after Ted Heath’s Conservative government decided to remove state subsidy from the shipyards. The ‘work-in’ received great support and ultimately it was successful in persuading the government to back down and continue to support the shipyard. At the beginning of the 1970s, some 11 million out of a workforce of 23 million belonged to a trade union in the UK and by the end of the decade membership peaked at a historic high of over 13 million in 1979.²³⁰ Marxist historian Raphael Samuel has remarked that trade unionism was ‘not only a cause’, it was ‘something approaching a workers faith’ in which there was ‘a quasi-religious impulse at work [...] a search for self-transcendence; the claim to collective dignity by reference to the past; the joy of wider belonging’.²³¹

SUMP made claim to the collective dignity of mental patients by referring to and imaginatively associating with the past and present traditions of trade unions of the locality. Indeed in the *SUMP Journal*, Clydebank Div. Shipyard Shop Stewards were listed as ‘sympathisers who had given

²²⁸ Ritchie, ‘Advantages’, (1971).

²²⁹ Ibid.

²³⁰ Department for Business Innovation & Skills, *Trade Union Membership 2012: Statistical Bulletin* (2013), p. 7. <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/299291/bis-13-p77-trade-union-membership-2012-corrrection.pdf> [accessed 7 March 2013].

²³¹ Raphael Samuel, *The Lost World of British Communism* (London: Verso, 2006), pp. 210-211.

SUMP active support'.²³² No further details about the 'active support' were provided but the explicit association with the activity of the UCS demonstrates how industrial conflict beyond the walls of the asylum could shape Ritchie's discourse, strategy and tactics. The list of 'advantages of patients in mental hospitals having their own fully democratic and autonomous national association or union' in the SUMP Manifesto continued:

Most unions, be they craft-guild or industrial, also develop 'friendly society' activities offering their members additional insurance against sickness or accident. This is an excellent service in so far as it goes. But it cannot go right into the mental hospital with a sick union member to ensure that he gets proper care and attention. No, the sick member is strictly on his own as things are now – never more so than when he is admitted to a mental hospital run by the NHS. And this at a time when he is already distressed mentally and depressed, and never more in need of communal help.

Most of all, perhaps, will he find the need of a brotherhood when the diminishing payments from Social Security reach their minimum of £1.20 weekly – not much of a cushion this, and scant protection against outrageous fortune and general exploitation of the weak by the strong.²³³

The employment of the discourse of trade unionism, the talk of 'collective bargaining', 'combinations', 'united front', 'friendly society activities', 'communal help' and 'the need of a brotherhood', shows how the tactics and rhetoric of the trade union movement was appropriated by Ritchie for mental patients. The point Ritchie goes on to make is that, if nurses and doctors could organise in this way, then patients should be able to do so too. In 1971 the Royal Medico-Psychological Association changed its status to that of a medical royal college, the Royal College of Psychiatrists. It had travelled a long way from its origins as the Association of Medical Officers of Asylums and Hospitals for the Insane, founded in 1841, with a membership of only 44.²³⁴ The specific momentary value and significance of the discourse of unionism was clear to Ritchie. The time seemed ripe for patients to organise themselves collectively in response to developments in the field of mental health and in the broader culture. In the SUMP documents Ritchie posed the question 'Why should mental patients need a union?':

For the same reasons as other bodies or groups of people with something in common, [mental patients] need a Union or association to protect their special interests – only more so. Nurses and ancillaries have two Unions. Doctors have their professional body to guard their interest and preserve the esoteric mistiness of their calling. And with what rare diligence does that August Body we all know protect its own! Watch the ranks close when lesser creatures presume to question [...]

Self-governing associations, guilds or Unions protect all those whose livelihood depends on the Mental Health Services. Indeed the only section which does not speak with a united voice is the one comprising the nuts themselves! – the poor creatures for whom the mental hospitals were built, and for whom, presumably, they are intended to function.²³⁵

The idea that mental patients might negotiate over their treatment and the conditions of mental health services through a democratic representative body was a radical departure. Ritchie

²³² Thomas Ritchie, *Journal of SUMP's Days, 1971-1972*, p. 1.

²³³ Ritchie, 'Advantages'.

²³⁴ Martin, *Between the Acts*, p. 125.

²³⁵ Ritchie, 'The Nature of the Association SUMP, Its Policy and Aims', p. 2.

demonstrated a courage and capacity for critical reflection on the situation of mental patients and an ambition to develop forms of practical self-organisation enabling them to act upon their shared situation. He questioned the privileged 'esoteric' knowledge of psychiatry. He employed his local knowledge of Hartwood and related it to what he knew about the situation more generally in the UK, where psychiatry and its institutions were coming under attack from various quarters. SUMP politicised the situation of the mental patient by employing the notion of 'collective bargaining' associating with the activities of the well established and powerful trade union movement. Ritchie sought the support and advice of friends, acquaintances, mental health professionals, his MP, the press, churches, charities and pressure groups. The list of sympathisers in the SUMP Journal included a consultant psychiatrist, a worker from the Simon Community which supported homeless people, a *Sunday Mail* journalist, a Unitarian Reverend, a solicitor, a GP, a housewife and fieldworker of the Scottish Council for Civil Liberties (SCCL).²³⁶

Of the 100 listed SUMP members fifteen were from SCCL including the Secretary, Chairman, Vice-Presidents and executive committee members. In the SUMP journal executive committee members of SCCL were listed as members of SUMP 'by association'. On 27 March 1972 *The Herald* reported on SUMP after it spoken to Ritchie and the vice-chairman of SCCL, Edgar Prais. Glasgow-based lawyer Prais was quoted in the newspaper report, as saying: 'We have a large dossier from this man on his own case [...] A union to look after patients' rights seem to be an entirely suitable and desirable thing to have'.²³⁷ The report also quoted Ritchie, who said

I expected to be there for about fifteen months but I finished up there for eight years. My original restriction required the Secretary of State's approval before I could be released, but a year before I was released the restriction was removed on the grounds that my treatment hadn't worked, which didn't strike me as very logical. It was then left to my consultant to decide, but eventually this restriction was also removed and I was given voluntary patient status. I took the option of leaving.²³⁸

The article went on to explain that 'during his final year Mr. Ritchie absconded from the hospital three times to draw attention to his case, returning when he ran out of money'.²³⁹ Ritchie told *The Herald*, 'I don't think this harmed my chances of release. They were getting a bit fed up with me. I had already gone through every appeal procedure open to me without success. I even wrote to the Prime Minister'.²⁴⁰ Interestingly *The Herald* article noted that Ritchie 'hopes his organisation will get support from trade unions', but the SUMP *Journal* records that only a few months later Ritchie left Scotland and SUMP behind to travel to London. It is not clear whether Ritchie returned to Scotland after this particular trip to London, but what is certain is that by March 1973 he was present at the founding meetings of the MPU at Paddington Day Hospital, London. He remained involved with the London MPU for at least two years and was resident at an MPU house. The

²³⁶ Ritchie, *Journal*, p. 1.

²³⁷ 'Special Union to be formed for mental patients', *The Herald*, 27 March 1972, p. 2.

²³⁸ *Ibid.*

²³⁹ *Ibid.*

²⁴⁰ *Ibid.*

discourse of unionism employed by Ritchie and the call for collective action was taken up by groups of patients across the country during the 1970s as MPUs were formed in Portsmouth, Manchester, Dundee, at Roundway Hospital, Horton Hospital, Hackney Hospital, Shenley Hospital and Broadmoor.²⁴¹

Jimmy Reid, the trade union leader of the UCS work-in, was elected Rector at University of Glasgow in 1971 and delivered a famous Rectorial address, entitled 'Alienation' at the university in 1972. The speech was reprinted verbatim in the *New York Times*, described there as 'the greatest speech since President Lincoln's Gettysburg Address'. It came to be known as the 'rat-race speech' and its message reached far beyond the assembled audience at University of Glasgow on that day. Reid declared that :

Alienation is the precise and correctly applied word for describing the major social problem in Britain today [...] It is expressed by those young people who want to opt out of society, by drop outs, the so-called maladjusted, those-who seek to escape permanently from the reality of society through intoxicants and narcotics [...]

It is my sincere contention that anyone who can be totally adjusted to our society is in greater need of psychiatric analysis and treatment than anyone else [...]

The big challenge to our civilisation is not *Oz*, a magazine I haven't even seen let alone read [...]The challenge we face is that of rooting out anything and everything that distorts and devalues human relations [...]

To the students I address this appeal. Reject these attitudes. Reject the values and false morality that underlie these attitudes. A rat race is for rats. We're not rats. We're human beings [...]²⁴²

The entrance of the vocabulary of trade unionism into the discourse of mental patients protesting against their confinement and treatment in the early 1970s was mirrored by the permeation of the concerns of the 'underground' into this famous speech by Reid. The speech expressed an almost Laingian perspective, sympathising with the 'maladjusted', referring to psychiatry, drugs, the underground press and 'drop-outs'. It is not difficult to see how this charismatic Scottish trade union figure, who had gained international recognition, could have become a source of inspiration for Ritchie. Whether or not Ritchie heard this speech, a discursive exchange between left-wing politics and emerging counter-cultures was finding echoes, resonances and reverberations in the most unlikely places. Ritchie was able to exploit the increasing permeability of the asylum space, transgressing its boundaries and actively resisting his detention at Hartwood, by forging tactical interactions and communications across the boundaries of the asylum space. Whether support was given to SUMP by UCS shop stewards or not, and there is no evidence beyond Ritchie's testimony, the proximity of Ritchie and his fellow SUMP members to the events of 1971-72 in Glasgow, and their closeness to the industrial heartlands of Scotland, undoubtedly shaped the principles of SUMP and the discourse which Ritchie employed. The 1960s and 70s brewed a subversive cocktail into

²⁴¹ See Survivors History Group (SHG) (2015) Mental Health and Survivors Movement <<http://studymore.org.uk/mpu.htm#1974>>

²⁴² James Reid, *Alienation* (Glasgow: University of Glasgow Publications, 1972), pp. 5-7.

which diverse characters, settings and discourses mixed together. Bold figures were challenging orthodoxy and subverting hierarchy. An unlikely mix of psychiatric patients, an alternative information service in Glasgow, the underground press in London, radical psychiatrists working within and out with the NHS, a Glasgow Communist trade union leader, a maverick classical scholar-turned-classical economic liberal politician and Minister of Health, a Harvard academic-cum-LSD guru and many others, were all helping to create a counter-cultural climate in which old traditions, institutions, norms and values were being overturned symbolically, if not yet in actuality.

2.8 From a Revolt Against the Asylum Space to the Creation of Post-Asylum Spaces: Shifting 'Terrains of Resistance'

The SUMP documents authored by Ritchie drew attention to the constraints on communication and movement imposed by the social and material boundaries of the asylum space at Hartwood. Echoing Powell's pronouncements on the asylum as obsolete, Ritchie drew attention to the parole system operating at Hartwood and the restrictions on the freedom of movement of ward seven patients. The regime of social and material order of the asylum space shaped the patients' concerns. Ritchie questioned the therapeutic value of being locked up in wards. '[Parole] should be abolished as an outmoded device', he implored, 'I see this as nothing more than official childishness and sometimes spite',

The very word sounds obsolete [...] As a system of treatment it's action is negative. It brings misery in its wake. Consider the patient without parole: Can you doctors not perceive the grinding monotony of pacing up and down the corridors of locked wards; cannot the doctors themselves have the humanity to stop the practice? It is they who impose these periods of incarceration presumably for curative purposes? But is it curative? How many people hold the belief that getting locked up has some therapeutic value? How would doctors like it? Can't they imagine themselves in the same circumstances as their patients? Have they no empathy at all? The normal Hartwood practice is that if a patient shows signs of frustration in Outer Ward Seven by breaking windows, he is put in the smaller still more frustrating Inner part. The logic of the psychiatrist – when the patient is non-paying that is.²⁴³

It was not only the uncaring attitude of the doctors towards non-fee paying patients which concerned the SUMP members, but also the construction of the hierarchical spatial parameters which contained and subjugated patients at Hartwood. 'Segregation' and 'stratification' were listed as general grievances and Ritchie detailed how the clothes on patients' backs and the food on their plates at meal times did not escape the system of stratification and regulation within the hospital. He wrote that

You are effectively classified and graded according to the ward you are in. This applies both to the living-conditions and to the treatment you receive. Hence the reason for most complaints originating in Ward 7, where the 'worst cases' go, the female equivalent being Ward 3. I cannot talk for the women's side in this matter, but I can state without qualification that in the male side preference is given according to ward in

²⁴³ Ritchie, 'The General Grievances – Part Two', pp. 26-27.

the hospital issue of clothing. Very few of the new articles of clothing, for instance percolate down to Ward 7. The issue of fine socks is restricted to the Hill Wards 16, 18, 21 and 22. The strata go down in the following order from Ward 16:- 18, 22, 15, 21, 9, 10, 8 and 7. Even what you eat depends on what ward you are in. Patients in 10, 9, 8 and 7 do not get any jam on the table. 'Battery feeding' is the order of the day in the main dining hall, or more accurately, 'feeding place'. There is always an unholy rush to get the patients' meals over and done with; bells ringing to summon you for food, bells ring between courses, bells let you know when to go.²⁴⁴

The hierarchical ranking of the asylum wards, it was claimed, left SUMP members in the lower strata. According to Ritchie even the staff did not deny that conditions there were unacceptable. But apparently they tended to blame others. He wrote that

There is an average population of about 110 in Ward 7, including the Sickroom, which is a locked ward within a ward. A goodish proportion of this population are 'permanent' patients who will probably die in Hartwood, probably in their own Ward 7 Sickroom. These long-termers are not all psychotic by any means. With 55 patients, i.e. half the present number, Seven would still be overcrowded [...]

Yes, [Ward] Seven is overcrowded, the doctors and other Hartwood dignitaries will resignedly agree, shrugging a despairing shoulder. But what can they do about it? The fault, they say, lies with the woolly-headed amateurs who planned the framework of the NHS. We professionals don't have much say, they maintain.²⁴⁵

When patients in ward seven realised that work was commencing to rebuild on an airing court at the hospital, 'they thought that they were going to get a new dayroom or recreation-hall or something'.²⁴⁶ 'Not on their collective nellies!' Ritchie blasted, 'the new building is to be Hartwood's Dispensary for the 1970s'.²⁴⁷ According to Ritchie, the space for the new dispensary was 'until recently an enclosed yard; this resembled what you'd imagine an abandoned playground in Ghost Town Elementary to be like – weeds up through the macadam, dust of all ages in every corner, litter, seagull droppings – all the normal and usual indications of an affluent neighbourhood'.²⁴⁸ He asked:

Is a new dispensary more pressingly needed than additional living and sleeping space for Ward 7 patients? – And all the other basic requirements that Seven lacks, like: a visitor's room; recreation room; separate TV room; decent, more secure and ample locker-space for patients; comfortable chairs and a couch or two for patients to stretch out in, instead of on the floor as at present; some board games like Monopoly, Scrabble, etc.; better and larger toilets and WCs; better and more hygienic shaving arrangements and facilities than at present (so few sinks, so many patients). Those are only some of the needs of this damnable ward.²⁴⁹

In practice SUMP was an ad hoc protest group guided by the enthusiasm and determination of one man who had set his sights on a number of objectives specifically concerned with conditions at Hartwood and others which were more aspirational. SUMP may not have immediately spawned a movement, but it was the first of a number of mental patients' unions which were established in the UK in the 1970s. After he was released from Hartwood in October 1971 Ritchie was unable to

²⁴⁴ Ibid., pp. 28-30.

²⁴⁵ Ibid., pp. 32-33.

²⁴⁶ Ibid., p. 33.

²⁴⁷ Ibid.

²⁴⁸ Ibid., pp. 32-33.

²⁴⁹ Ibid., pp. 33-34.

garner the level of moral support or material resource necessary to develop SUMP from an ad hoc protest to a national union. He had no job and little money to survive on and the *Journal* which contains dated diary entries from 1972 reveals signs of frustration at his lack of progress. In 1972 he abandoned his attempts to develop the union in Scotland altogether and left Glasgow for London. Whilst the protest of SUMP was limited and short-lived it seems premature to dismiss SUMP as insignificant in the history of collective action by psychiatric patients because it did not, according to Nick Crossley, have the 'degree of spatio-temporal extension and continuity' required to be considered as part of a wider movement.²⁵⁰

Nick Crossley claims that there was 'no direct line of influence from SUMP to the MPU'.²⁵¹ Survivors History Group (SHG) disputes this claim, arguing that 'continuity between SUMP and MPU was strong [and] the Scottish experience fed directly into MPU practice'.²⁵² Thomas Ritchie and Robin Farquharson were among the founding members of MPU at Paddington Day Hospital. Farquharson was instrumental in finding premises for MPU and a union residence was named after him following his tragic death in the early weeks of the organisation's existence. Ritchie was an active member at an MPU house for at least two years in London from 1973 to 1975. Ritchie was more representative, though by no means a typical example, of a figure which seemed to be on the way out - the long-stay patient. Farquharson on the other hand, had been a less constrained and more mobile patient than the 'foundation members' of SUMP who had been locked up in Hartwood for years. During the 1960s and early 1970s Farquharson was re-admitted to hospitals on numerous occasions, but was detained for relatively short periods - a typical example of the emerging figure of the short-stay, 'revolving-door patient'.

Farquharson was born in Pretoria, South Africa in 1930. He came to Oxford University in 1950 and was in and out of mental hospitals in the south of England throughout the 1960s. In 1961 his DPhil thesis *Theory of Voting* from Nuffield College, Oxford was awarded the Monograph prize of the American Academy of Arts and Sciences in the field of the social sciences, and later published as a monograph by Blackwell publishers and Yale University Press.²⁵³ In 1965 he had his South African passport withdrawn for his part in lobbying on behalf of the South African Non-Racial Olympic Committee (SAN-ROC) for South Africa's exclusion from the 1964 Olympic Games in Tokyo.²⁵⁴ He became a British citizen in 1968 and in the same year his account of 'dropping out' in London was published. In the preface to the book, *Drop Out!*, he wrote 'I am a manic-depressive. When I'm up, I have no judgement, but fantastic drive; when I'm down, I have judgement, but no

²⁵⁰ Nick Crossley, 'Fish, field, habitus and madness: the first wave mental health users movement in Great Britain', *British Journal of Sociology* 50 (1999), p. 652.

²⁵¹ Nick Crossley, *Contesting Psychiatry: Social Movements in Mental Health* (Abingdon: Routledge, 2006), p. 144.

²⁵² Survivors History Group, 'Survivors History Group takes a critical look at historians', in *Critical Perspectives on User Involvement*, ed. Marion Barnes and Phil Cotterell (Bristol: Policy Press, 2011), pp. 11-12.

²⁵³ Robin Farquharson, *Theory of Voting* (Oxford: Blackwell, 1969).

²⁵⁴ Farquharson, *Drop Out!*, from short biography on the first unnumbered page of the book.

drive at all. In between I pass for normal well enough'.²⁵⁵ He revealed that he had 'a history over twelve years of intermittent psychosis, mania, cyclothymia'.²⁵⁶ According to the philosopher Michael Dummett, who co-authored scholarly journal articles with Farquharson, he was an 'exceptionally brilliant young man', but his

psychosis prevented him from accomplishing any more research. When he lost his Cambridge post, he abandoned academic life and lived the life of a hippy in London [...] had it not been for the illness that afflicted him, he would doubtless have become a very famous man, and probably have led a happy life. As it was, after the age of 25 he lived a miserable life and died a miserable death; and his early pioneering work was forgotten by almost everyone.²⁵⁷

In *Drop Out!* Farquharson referred to 'the manic high whose recurrence had dogged my life since 1955 when as a candidate for a Fellowship of All Souls, I had destroyed my chances by a telephone call to the Warden, calling him from his high table to tell him that I had a message from God for him'.²⁵⁸ In the opening chapter Farquharson explained how he had abandoned academic life to 'drop out':

I had often heard the slogan 'Turn on, tune in, drop out'. Though I understood the words, they meant to me nothing significant. I considered the flower people and the hippies in a way attractive, people I admired in a way because I long considered myself basically hostile to convention, though unlike them I had always, or almost always, submitted to it. But two months or so ago, on television, I had seen and heard Dr Timothy Leary, who had been, as I had been, a university don and the author of learned works and whose academic career, like mine, though for different reasons, had collapsed in ruins. Yet he, unlike me, had carved an existence and a name for himself almost from scratch, in the non-academic world. When I had heard him he had put a simple message: 'Drop out'. I don't recall his exact words, but in essence he was saying, 'Rid yourself of responsibility, quit the rat-race. Don't obey society's paralysing conventions, you have a simple road to escape them. Leave your job, leave the acquisitive society, you can still inhabit its cities physically while nevertheless becoming totally insulated from the ulcer-generating pressures of its oppressive system of employee and of boss, of high salaries never overtaking rising costs and rising standards of living. Step out of the trap; the door is open. 'Drop out!'²⁵⁹

In 1967 Farquharson had stayed at a therapeutic community based at Kingsley Hall in the east-end of London established as an alternative to hospital-based psychiatric treatment. This therapeutic community was created in 1965 by the Philadelphia Association, an organisation co-founded by the so called 'anti-psychiatrists' R.D. Laing, David Cooper and others. As Farquharson remembers it, 'I had been evicted by Ronnie Laing from his 'household' for psychotics at Kingsley Hall, for use and abuse of the telephone – 40 minutes to Canada at five in the morning he didn't find funny; he never grasped, I think, that I had made the call only because no one in all the Hall was willing to wake up and talk with me'.²⁶⁰ Laing remarked that Farquharson 'was about 16 stone, he didn't like

²⁵⁵ Ibid., p. 7.

²⁵⁶ Ibid., pp. 51-52.

²⁵⁷ Michael Dummett, 'The work and life of Robin Farquharson', *Social Choice and Welfare* 25 (2005), pp. 475; 482-483.

²⁵⁸ Farquharson, *Drop Out!*, p. 53

²⁵⁹ Ibid., pp. 13-14.

²⁶⁰ Ibid., p. 54.

walls, so he went on a rampage, smashing and ripping everything, trying to knock doors and walls down – what are you going to do with someone like that?’²⁶¹

Farquharson moved between numerous counter-cultural experiments in London, including the Anti-University. David Cooper and Joseph Berke of the Philadelphia Association were leaders of the Anti-University project, which started out in Shoreditch in London’s east-end. David Cooper, who coined the term ‘anti-psychiatry’, saw the ‘anti-university’ like ‘anti-psychiatry’, as part of a broader social and cultural revolt against the ‘institutionalisation of experience and action in this society’.²⁶² According to Cooper ‘by a transactional network of expertise we can transform each institution – family, school, university, mental hospital, factory – each art form, into a revolutionary centre for a transforming consciousness’.²⁶³ The anti-university operated from a series of short-term addresses and taught courses on subjects including ‘Black Power’, ‘Counter-Culture’ and ‘Revolution’. Speaking in a BBC interview in 1968 Cooper revealed that

the ‘anti’ signifies a basic change in the rules of the game, whatever game one is playing, whether this is in the context of a hospital, a certain art form, academic situation, but a basic, radical, qualitative change in the rules of the game, whereby the basic aim is to break down all false compartmentalisations, in other words, boxes that people get into [...] In fact what we are aiming at is the breaking open or explosion of all boxes!²⁶⁴

Farquharson also frequented another counter-cultural hub, the Arts Lab, a place he wrote about in *Drop Out!* According to the founder of this alternative arts centre, Jim Haynes, it was

an ‘ENERGY CENTRE’ where anything can happen depending on the needs of the people running each individual Lab and the characteristics of the building. A Lab is a NON-INSTITUTION. We all know what a hospital, theatre, police station and other institutions have in the way of boundaries, but a Lab's boundaries should be limitless [...] I am interested in creating a fluid COMMUNE situation where a group of people live and work together.²⁶⁵

In *Drop Out!* Farquharson wrote about being barred from the Arts Lab by Haynes after he was deemed to have transgressed the bounds of acceptable behaviour at yet another counter-cultural space. Farquharson drifted between counter-cultural groups in London in the manner of the Situationist ‘derive’ or drift. According to French Situationist Guy Debord,

during a certain period [the drifter] drop[s] their usual motives for movement and action, their relations, their work and leisure activities, and let themselves be drawn by the attractions of the terrain and the encounters they find there [...] But the *dérive* includes both this letting go and its necessary contradiction:

²⁶¹ Mullan, *Mad*, p. 181.

²⁶² David Cooper, ‘Beyond Words’, in *The Dialectics of Liberation*, Ed. David Cooper (Harmondsworth: Penguin, 1968), p. 197.

²⁶³ *Ibid.*

²⁶⁴ BBC TV interview with David Cooper available at <<http://antihistory.org/tagged/Antiuniversity-of-London>> [accessed on 11 July 2013].

²⁶⁵ Jim Haynes, Arts Lab Newsletter Issue 1, produced by BIT Information Service (then resident at 141 Westbourne Park Road) in October 1969 which contains information and listings from each Lab. Available at http://www.internationaltimes.it/archive/page.php?i=IT_1969-10-10_B-IT-Volume-1_Iss-66_016&view=text [accessed on 12 June 2013].

the domination of psychogeographical variations by the knowledge and calculation of their possibilities.²⁶⁶

That was in essence the journey which Farquharson had embarked upon to 'drop out' and 'drift'. He was involved in BIT, a 24-Hour Free Information and Help Service in London founded in 1968 by John Hopkins, also founder of the underground press newspaper *International Times* (IT). BIT was not dissimilar in its aims to the GAP organisation which had given support to Thomas Ritchie in Glasgow. The name BIT came from IT, but also referred to Binary Information Transfer 'the smallest unit of information that can be processed by a computer in memory of the original aim of computerising the service'.²⁶⁷ BIT considered itself as part of the emerging 'alternative society'. Farquharson contributed to BIT's magazine, *Bitman*. In the first issue of *Bitman* stated that the purpose of BIT was to 'help make contacts & build circuits & blow minds & get projects off the ground' and 'carry information on the growth of alternative structures in this country'.²⁶⁸ BIT was involved in creating 'free spaces', such as the Windsor Free Festival, supporting communes and the Arts Lab with funds. Farquharson had participated in a number of communes which were part of the growing squat communities in London. He was also involved with far left group the White Panthers. The underground press paper *Friends* reported that Farquharson claimed to be the group's 'minister of propaganda'.²⁶⁹ He was arrested at the Isle of Wight Festival in 1970 where he, along with others, 'wished to declare the festival free'.²⁷⁰ He appears on Murray Lerner's documentary film of the festival, 'busily rousing the rabble and decrying the organisers. "It's become a feudal system... the rockstars are a new aristocracy... the promoters, the groupies, are their courtiers"'.²⁷¹ In *Drop Out!* he remarked how commune members belonged to a community, the principal purpose of which was to provide a communal space which opened channels of communication making it possible for separate individuals to form themselves into a single 'entity' or 'organism':

On the wall of [Commune One Hempstead]'s single-room was the one identifying feature of all the communes I have since seen in London – a wall newspaper. Drawings, poems, notices, advertisements. The open communication channel that made the group a commune and not just a collection of three people, but an entity. An entity whose mode of functioning was not clearly defined, but whose members clearly had formed themselves into one organism.²⁷²

²⁶⁶ Guy Debord, 'Theory of the Dérive' (December 1958), in *Situationist International Anthology* ed. and trans. Ken Knabb (Berkeley: Bureau of Public Secrets, 2006), p. 62.

²⁶⁷ *Emergency Bitman* Issue 5, 1 March 1973, pp. 2-10. quoted in <http://studymore.org.uk/arcaandv.htm#BIT>.

²⁶⁸ *Bitman* Issue 1, May 1970, available at http://hqinfo.blogspot.co.uk/2012/06/70s-culture-bitman1_13.html [accessed on 17 June 2013].

²⁶⁹ *Friends* 2 October 1970, article available at <http://www.ukrockfestivals.com/iow-frendz2.html> [accessed 17 June 2013].

²⁷⁰ *Freek Press* newsletter, available at <http://www.ukrockfestivals.com/iow-70-freek-press-2.html> [accessed 17 June 2013].

²⁷¹ Gavin Haynes, 'An Essay about *Message to Love*', 31 August 2010, *Vice*. Available at http://www.vice.com/en_uk/read/an-essay-about-message-to-love [accessed 17 June 2013].

²⁷² *Ibid.*, pp. 89-90

He was keen to break down boundaries which constrained and confined as he sought to find alternative post-asylum spaces for those suffering from mental illness. His chance came when he was involved with a group called People Not Psychiatry (PNP). PNP sought to provide ‘a real people’s alternative to objective and objectifying psychiatry’.²⁷³ It was a loose-knit network of individual correspondents and groups scattered across the UK.²⁷⁴ Farquharson had first written to PNP founder Michael Barnett in 1969. Barnett writes that Farquharson’s aim was ‘to get a house like Kingsley Hall except that it will also have people in it who are not currently agonizing and who can act as helpers, though there should be no rigid frontier. [Farquharson] would obviously be on both sides of whatever frontier there was’.²⁷⁵ After exchanging letters, Farquharson and Barnett met. In his 1973 book on PNP Barnett spends nearly a whole chapter describing Farquharson’s involvement with PNP and emphasises the significance of Farquharson’s role in searching for and finding a house for PNP:

We talked of sanctuaries [...] Robin deeply wanted such a place and had committed himself wholly to finding it. He saw such an environment as providing him with the support he would need when he was freaking out, so that he could go through it, which hospitals did not allow, but blocked [...] He thought he would combine his renewed efforts to set up such a house with PNP’s search for the same thing [...]

[He] resuscitated the Situationists Housing Association along with Rhaune Laslett who was running the Community Settlement (now a Trust) in Notting Hill. Rhaune was on good terms with many councils and was likely to be able to find somewhere for Robin and others [...] I heard he had persuaded Leon Redler of the Philadelphia Association and Anni Soldi to join the Association’s committee.²⁷⁶

Farquharson had formed the Situationists Housing Association and had persuaded community activist Rhaune Laslett and Leon Redler of the Philadelphia Association to join its committee. Rhaune Laslett had co-founded the London Free School and was the principal organiser of the Notting Hill Festival or Fayre, forerunner of the Notting Hill Carnival. She ran the Notting Hill Neighbourhood Service – one of the first voluntary services to offer free legal and drugs advice. Farquharson first came in contact with Laslett after he was referred to her organisation by the drugs charity Release. Barnett recalled that there was some debate over the form that Farquharson’s post-asylum space of ‘sanctuary’ would take:

Should we have infrastructure members there or, like Kingsley Hall, only those who were in chaos, and wanting to use the house for their own breakdowns and experimentations? If no one living there was made or felt responsible for the whole or for others in it, then it could find its own natural level. But then there were great risks involved, together with the overwhelming question as to whether people in great need, or needing care, could really help and support one another, and move towards health and certainty. At Kingsley Hall there had been no interference from so-called helpers, little or no therapy from the so-called qualified and sane, but had Kingsley Hall really been a success? Robin promised to renew his efforts to persuade someone or somebody to offer PNP a house, of which he would then become a part.²⁷⁷

²⁷³ Michael Barnett, *People Not Psychiatry: A Human Alternative to Psychotherapy* (London: Allen & Unwin, 1973), p. 100.

²⁷⁴ *Ibid.*, p. 90.

²⁷⁵ *Ibid.*, pp. 191-192.

²⁷⁶ *Ibid.*, p. 192.

²⁷⁷ *Ibid.*, p. 193.

Barnett wrote, that once PNP had its house

from the moment they moved in the world shuddered. Robin, I heard, was going berserk. Nothing could stop him from celebrating continuously [...] Now that he had his house he thought everything could be. But PNP people, like any others, have limits, and these Robin transgressed at the house again and again.²⁷⁸

Eventually the few other people living with Farquharson agreed that he would be excluded and they 'quietly re-let his room' to someone else after he had been taken into hospital having allegedly assaulted a police officer.²⁷⁹ Once again Farquharson had been excluded from another alternative community of the counter-culture. The repeated exclusion of Farquharson from these post-asylum spaces created by activists reveals how exclusionary practices of the asylum could be reproduced in the radical post-asylum spaces created outside the hospital in activist communities of the counter-culture. Ultimately Farquharson suffered a miserable end in 1973, dying from injuries caused by a fire at a squat where he had been staying with two Irish labourers. These two men were convicted with 'unlawful killing' and the case highlighted the precariousness of Farquharson's life of drifting through the shifting experimental spaces of the counter-culture. In a special issue of *Bitman* in memory of Farquharson George Firsoff wrote that

Robin Farquharson in full cry was able to wreak havoc in a commune of freaks as well as in a straight organisation and when this happened to us and we could not get through to him or calm him down we also ended calling for men in white coats. It must have been a terrible blow for Robin to be rejected by his own tribe and although he did not bear a permanent grudge, I understand now he would rather anything than fall into the hands of the men in white coats.²⁸⁰

Farquharson had achieved a kind of legendary status in pockets of the alternative society of the counter-cultures. He was remembered for his charisma, his intelligence, wit and ability to 'dr[a]w happenings' to him.²⁸¹ Farquharson died shortly after the first meetings of the MPU in London. He had offered premises to the MPU which had been procured by squatting shortly before his death. Posthumously the MPU headquarters at Mayola Road were named *Robin Farquharson House* in his memory. Through his capacity to drift between the 'circuits' and 'contacts' of the London 'underground' and his irrepressible energy he had helped to appropriate some of the first patient-constructed, post-asylum spaces.

²⁷⁸ Ibid., p. 194

²⁷⁹ Claytor, 'A Changing Faith?', p. 310.

²⁸⁰ George Firsoff, *Bitman*, Issue 6, 'Ex Bitman Robin' issue, extract available at <http://studymore.org.uk/mpu.htm#BIT> [accessed 4 August 2012].

²⁸¹ Barnett, p. 192.

2.9 From Psychopharmacology to Class Consciousness and Transcendental Liberation: The Use of Psychoactive Drugs Contested

An issue which was personally significant for Ritchie and Farquharson, and reflected in the psychiatric and counter cultures of the 1960s and 1970s, was drug use. 'Therapeutic' and 'recreational' use of new psychoactive drugs was becoming an increasingly widespread social and cultural phenomena. The medical, social and legal problems associated with drug use were a growing matter of concern during the 1960s. Both Ritchie and Farquharson had experienced these problems first-hand. Both had been recipients of psychiatric drug treatment and both had experimented with other drugs. Ritchie described himself as a 'drug addict'. In the section of the SUMP manifesto documents headed 'The Amphetamine-Addiction Story', he wrote:

Amphetamine, being far the most vital issue in my life (that air, food, etc., are of equal importance is understood), I am treating it here as a separate issue. Much more than half of my waking hours are spent with thoughts of the drug and how to get it foremost in my mind [...]

Parallel to other personal grievances runs the burning and growing resentment I felt and feel against Doctor Graham and Hartwood for refusing to acknowledge that I am a chronic drug-addict [...]

I know how I feel better than anybody else knows how I feel, be he the greatest ever psychiatrist. I know what makes me feel well and what does not. For 17 years I have been addicted to amphetamine. It has become central to my existence. When I have it life is bearable; when I am deprived of it I'd rather be dead. That is the simple truth. It is now a physical necessity that I have regular supply of the drug. The Hartwood people deny that this is so and have always done so.²⁸²

The significance of the issue of drugs in Ritchie's resistance to psychiatric authority is revealed in an episode he recounts of his admission to Crichton Royal hospital when, he writes, 'the seed of my cynical view of the medical profession and drugs was first implanted':

Admitted at the same time as me, but on a fee-paying basis, was a wealthy lady from Lancaster. We compared notes and discovered that our case histories in the matter of drugs were almost identical. We were forgers of prescriptions for the purpose of acquiring the drugs in the amphetamine range, it being Preludin specifically that we both went for oftenest. But our respective treatments were different. Whereas they suggested I try a 'different kind of happiness' and put me on one of the antidepressants [...] they prescribed the lady from Lancaster Preludin, from the very first day! No different from pipers these physicians are they!²⁸³

The fact that the 'wealthy lady' was prescribed her drug of choice demonstrated to Ritchie the degree of control she was able to exercise in the medical encounter as a fee-paying patient. He had become aware of how class could shape the balance of power between the doctor and the patient in the medical encounter. Having been given chlorpromazine at Crichton Royal and at Hartwood, a drug which had revolutionized psychiatric treatment in the 1950s, but according to Ritchie, a drug he had 'very little use for', he reached his own conclusion about the psychopharmacological

²⁸² Thomas Ritchie, 'The Amphetamine-Addiction Story' in SUMP Documents, 1971, p. 17.

²⁸³ Ritchie, 'Introduction', p. vi.

solutions required for his problems.²⁸⁴ Of chlorpromazine (better known by the name Largactil), Ritchie said ‘this is the one they call “artificial hibernation”, whether in jest I wouldn’t like to say’.²⁸⁵ The increasing availability of a range of psychoactive drugs outside the official channels of state-sanctioned medicine during the mid-20th century allowed people to bypass an encounter with the prescribing psychiatrist and experiment with a variety of mind-altering drugs for themselves. Ritchie's appetite for stimulant drugs was whetted by a doctor, but not in the usual clinical settings. Ritchie had spent 1953-1954 in Ireland, eventually 'setting up shop' in Belfast, 'taking the occasional Drinamyl in those days, more often than not prescribed by my doctor (I was obese)'.²⁸⁶ First introduced in 1950, Drinamyl (or Dexamyl), was marketed as an antidepressant medication that did not cause agitation, and also as an anti-anxiety and diet drug. Amphetamine had previously been marketed as an antidepressant (under the Benzedrine Sulfate brand) beginning around 1938. The amphetamine in Drinamyl was intended to elevate mood, while its barbiturate content countered the 'side-effects' of the amphetamine. In 1955 Ritchie met a doctor in a Dublin pub and they 'struck up an alcoholic friendship'.²⁸⁷ According to Ritchie:

He asked me if there was anything he could do for me. I said yes - sit down and write me out a dozen or so post-dated prescriptions for Drinamyl. He said that he would do better than that and thereon asked me to forget about Drinamyl and company. There was now on the open market a perfectly harmless substitute every bit as effective. I could get it without a prescription. It was called 'Preludin'. He wrote it down for me. Thus I started on Preludin (esoteric name 'phenmetrazine hydrochloride'). It soon became a daily requirement and that is how regularly I took it until the year 1960.²⁸⁸

Thus a doctor had encouraged Ritchie's use of stimulant drugs. His addiction to the 'near-amphetamine' Preludin seems to have been given a new lease of life after this medical encounter outside normal clinical settings. In 1960 Ritchie was convicted for a second time for drink-driving and sentenced to three months in prison, the same punishment he received for his first offence. When he came out of Brixton prison he returned to Brighton to find that his flat had been burgled and his car had been stolen 'with about £1000 worth of photographic equipment inside':

My business was topsy-turvy after 2 months of neglect (my appointments book entries were a write off, for example). But these setbacks were the least I had to face and I might have survived them with the help of my central stimulant. Preludin, however, was no longer available on the free market, its sale having come under restriction whilst I was inside. Without it anything approximating a normal life was impossible. The prospect was so bleak that I had a nervous breakdown and felt I had to return to my home in Lanark, probably one of the worst decisions I've ever taken in my life, for Lanark is located within the Bible-Belt-cum-Missal-Meridian of Central Scotland. Drug addict indeed!²⁸⁹

It was at this point that Ritchie went to Hartwoodhill Hospital as a voluntary patient: 'It took me less than a month to get the strength of the place and realised that it was no damned good for my

²⁸⁴ Ibid.

²⁸⁵ Ibid.

²⁸⁶ Ibid., p. iii.

²⁸⁷ Ibid.

²⁸⁸ Ibid.

²⁸⁹ Ibid., p. iv.

condition, or anybody else's for that part. I discharged myself'.²⁹⁰ After going to stay with friends in Coventry and searching for work there, he was admitted voluntarily to Leigh House, at the Central Hospital, Warwick. He received treatment, including ECT, over a period of six weeks. After a temporary job driving an ice cream van in Coventry, he was again unemployed and returned to Lanark. He spent six months looking for work, but without success. After a row with his aunt he left Lanark, this time for Dublin, where he got a temporary job selling cigarette vending machines. But the job only lasted for a couple of months:

Preludin was still freely purchaseable in the Republic of Ireland and I stayed on in Dublin, earning a precarious living in various similar types of jobs. Then Preludin became difficult to obtain and I could not work without it. So back I had to go to Lanark [...] But I ran foul with the law again, this time for forging prescriptions.²⁹¹

Ritchie was sent to Crichton Royal Hospital at Dumfries in April 1963 on a year's probation. He spent five months there until it was discovered that he had been taking drugs brought in from Dublin by a friend. He was then sent to Barlinnie prison for a month for breach of probation: 'On the very night of my release from Barlinnie I was arrested and charged with breach of the peace, once again at Lanark court. The Sheriff sent me to this hospital, Hartwood'. And he remained a patient there until 1971.

Farquharson, on the other hand became an advocate of LSD in his book *Drop Out!* He credited LSD with having brought about a profound change in his attitude towards himself, his mania and the society in which he was living:

It is very clear that the three experiences a) the religious experience b) the psychotic experience and c) the LSD experience are, as far as I am concerned at any rate, simply sights on the same landscape through different windows [...] The combination of the three experiences (one experience?) has profoundly changed my life attitudes and situation. The LSD insight has enabled me to make sense of what before had seemed like a purposeless affliction. Not only is it much clearer to me what is happening when my mania rages; I am also now in a position to accept the fact of the psychosis as something validly and perhaps valuably deflecting my life from its previous direction, and able to apply my energies to finding exactly what that direction should be and following it [...]

The definition of an addictive drug is that once the organism has become accustomed to it, continued doses are necessary merely to enable the user to function normally, while larger and larger quantities are required to produce the original effect. LSD is not an addictive drug. Money is.²⁹²

LSD, according to Farquharson had supported his 'liberation from the fetters of convention'.²⁹³ His description of the drug's broader effect on his attitudes and outlook reflected the counter-cultural images of LSD of the time. The 'first event' of the anti-university was the Congress on the Dialectics of Liberation, held at London's Roundhouse and organised by four psychiatrists, or 'anti-psychiatrists', R.D. Laing, David Cooper, Joseph Berke and Leon Redler.²⁹⁴ This was a two-week

²⁹⁰ Ibid.

²⁹¹ Ibid., p. v.

²⁹² Farquharson, *Drop Out!*, pp. 110-112

²⁹³ Ibid., p.111.

²⁹⁴ David Cooper, 'Introduction', in *The Dialectics of Liberation*, ed. David Cooper (Harmondsworth: Penguin, 1968), p. 11.

event at which intellectuals and activist figures spoke, including Black Panther Stokely Carmichael, critical theorist Herbert Marcuse, poet Allan Ginsberg and others.

Joseph Berke described psychosis as 'a waking dream [...] akin to some extent to the LSD experience'.²⁹⁵ R.D. Laing, who excluded Farquharson from Kingsley Hall in 1967, had experimented with LSD at Kingsley Hall and in his own psychotherapeutic practice and had extolled its therapeutic virtues at the annual conference of NAMH in 1966. Even the Royal Medico-Psychological Association (now the Royal College of Psychiatrists) had considered the therapeutic benefits of LSD and other psychedelic drugs, holding a three day conference in London on 'Hallucinogenic Drugs and their Psychotherapeutic Use' in 1961. The British MP Christopher Mayhew, who contributed to the conference, had participated in a controversial experiment for BBC television in 1955 in which he was administered the drug mescaline by psychiatrist Humphry Osmond and filmed while under the influence of the drug. Drugs such as LSD and mescaline were regarded by some psychiatrists as 'psychotomimetics'—drugs which were thought to induce experiences which mimic psychosis. The programme was never broadcast on television, but the fact that a respected psychiatrist and politician had been willing to experiment so publicly with such drugs demonstrated the professional and medical interest in their therapeutic potential before they became associated with subversive anti-establishment youth and counter-cultures in the late 1960s. Osmond had coined the term 'psychedelic' and had previously administered mescaline to Aldous Huxley, who wrote about the experience in *The Doors of Perception*.²⁹⁶ Huxley was the first to associate the psychedelic drug experience, religious experience and the psychotic experience. Mayhew, writing in his autobiography over thirty years after the mescaline experiment, claimed that 'after hundreds of thousands have taken drugs of this kind, often with bizarre or ridiculous results, I still look on this mescaline experiment, professionally supervised and filmed, as the most interesting experience of my life'.²⁹⁷ He went so far as to say that

Psychiatrists would - and indeed did - explain the experience in terms of depersonalisation, time distortion, light hallucinations and the disintegration of the ego. But I thought then, and still think now, that a truer explanation is that I had had an experience that had taken place outside time, that I had visited, by a short cut, the timeless world known to mystics and to some schizophrenics.²⁹⁸

Mayhew felt compelled to ask: 'is there no dividing line between sacred and psychotic mystical experiences? Given that its causes and results are so vastly different, how could the end-product of sanctity and insanity be substantially the same?'²⁹⁹ By the time Farquharson was writing about LSD in 1968 the drug had become associated with hippie culture and was outlawed. Farquharson saw

²⁹⁵ Joseph Berke 'Therapeutic Community Models: II Kingsley Hall', in *The Therapeutic Community: Outside the Hospital*. Ed. Elly Jansen (London: Croom Helm, 1980), p. 95.

²⁹⁶ Aldous Huxley, *The Doors of Perception* (Glasgow: Flamingo, 1994). Originally published (London: Chatto & Windus, 1954).

²⁹⁷ Christopher Mayhew, *Time to Explain* (London: Hutchinson, 1987), p. 150.

²⁹⁸ *Ibid.*, p. 151.

²⁹⁹ *Ibid.*

the LSD experience, the religious experience and the psychotic experience as ‘variants of a single phenomenon’ and declared that ‘one model models all’.³⁰⁰ Keen to reassure readers, he wrote that

it is sight, not illusion. There *is* another world, there *is* a transcendent reality, there *is* a spiritual plane. Once accessible only to the privileged or the deranged, legendary or imaginary to everyone, this realm is open now to anyone who cares to look. Observations of terrain are reproducible under laboratory conditions. ‘The incompatibility of science and religion used to make sense. It long made sense to me. It doesn’t make sense any more.’³⁰¹

Farquharson’s pronouncements echoed the discourse of the ‘anti-psychiatrists’ Cooper, Berke and Laing with his suggestion that his psychotic illness may have been ‘validly and perhaps valuably deflecting’ his life from ‘its previous direction’. It was akin to a view articulated by Laing that ‘madness need not be all breakdown’, but that ‘it is also breakthrough. It is potentially liberation and renewal, as well as enslavement and existential death’.³⁰² David Cooper described schizophrenia as a project ‘to rediscover a pristine wholeness that really lies outside one’s history, but which is pointed to by one’s history. This wholeness undercuts the differentiation of experience. It undercuts the false divisions within and between the arts and sciences’.³⁰³ The gurus of anti-psychiatry and psychedelia had set Farquharson on a path through spaces of convergence where short-lived cultural experiments abounded.

Something of a mythology has grown around Farquharson, in relation to his use of drugs and alcohol and his alleged occult abilities and numerous other alleged activities. Over forty years after his death the internet is well-stocked with rumours of Farquharson’s outlandish behaviour. One worth remarking upon in the Scottish context is from someone who claims to have been involved in the Glasgow branch of the White Panthers, a group Farquharson had been involved in, and another point of connection between Ritchie, Farquharson and SUMP. On the video-sharing site YouTube, an individual with the moniker ‘Hashbury Stumble’ posted the following comments in May 2016:

I accompanied Robin when he attempted to buy John Brown Shipbuilders during the UCS workers sit-in in 1971 when I was a member of the White Panther Party (Glasgow Chapter). The events which followed contributed to the most memorable day in my life. There is only one other person, still alive, who knows the full story of that day & it highlights the fine line between genius & mental illness.³⁰⁴

While the identity of the author of these comments is a mystery, it suggests that Farquharson was in the Glasgow conurbation at this time and given that such behaviour was wholly characteristic of Farquharson and given that he signed up as a SUMP member around this time, it is entirely plausible that the statement is accurate.

³⁰⁰ Farquharson, *Drop Out!*, p. 110.

³⁰¹ *Ibid.*, p. 110

³⁰² R.D. Laing, *The Politics of Experience* (London: Penguin, 1967), p. 110.

³⁰³ Cooper, ‘Beyond Words’, p. 201.

³⁰⁴ ‘Hashbury Stumble’ comment at <https://www.youtube.com/watch?v=k66ybHgpZzU> [accessed 20 July 2016].

The accumulation of intricate discursive, institutional and social relationships between new strains of left-wing and anarchist politics, youth cultures, ‘underground’ scenes, counter-cultures and drug cultures, and the articulation of connections between drug experiences, religious experiences and psychosis, by psychiatrists, artists, politicians, patients and others, emerged at a time when clinicians, scientists and lay persons alike, were gaining confidence in their experimentations with psychoactive drug technologies. These technical experimentations were allied to explorations and transformations of subjectivity. Laing, at the peak of his psychedelic powers at Kingsley Hall, called for an ‘exploration of inner space’. While on the one hand material spaces were being constructed and deconstructed in attempts to fashion alternatives to traditional social institutions, some were physically transforming their brain chemistry with drugs, in pursuit of transcendence of one kind or another. It would be easy to dismiss Ritchie as a hedonist, responsible for his own choice to take drugs, and hence, responsible for abusing them and becoming dependent on them. But one must remember how enthusiastic psychiatrists, eager to enhance the status of psychiatry as a branch of medicine, and GPs, looking to address psychiatric and lifestyle problems quickly and efficiently, so willingly embraced the technological revolution of the 1950s and 60s. Medical doctors recommended these technical fixes to all manner of malcontents, from so called ‘drop-outs’, to people with weight problems and anxious and depressed housewives. The medical and legal issues surrounding drugs were starkly apparent to both Ritchie and Farquharson, who had their own mixed experiences of drugs, psychiatric, licit and illicit, and their own diverse encounters with medical doctors, in a variety of settings. Some drugs went from being available over-the-counter, to being available only on prescription from a qualified medic. Some new drugs which became available on the open market were used by some as substitutes for drugs which had come under restrictions. An illicit drug economy was also taking off. The Dangerous Drugs Act 1964 was regularly updated with new offences to include new substances, leading to the comprehensive Misuse of Drugs Act 1970.³⁰⁵ Likewise the Obscene Publications Act 1959 and 1964 were used to exercise control on free expression and used to target underground press publications.³⁰⁶ Whilst in some cases Ritchie and Farquharson made their own choices in relations to drugs, and in others the choice was made for them, they and their personal biographies draw attention to the ways in which the uses of drugs were constructed, symbolically and materially, by contingent cultural and political contests across diverse contexts in postwar Britain. No doubt there were hypocrisies on all sides of these contestations. As Colin Jones has remarked, for counter-cultural gurus like Laing and Leary, and by extension for others like Cooper, Berke, Huxley, Osmond and Farquharson, to mention just a few, ‘sedating was repressive and bad, seemingly, tripping on LSD was life-enhancing, good and society-challenging’: ‘the attacks on

³⁰⁵ Alastair J. Reid, ‘The dialectics of liberation: the old left, the new left and the counter-culture’, in *Structures and Transformations in Modern British History*, ed. David Feldman and Jon Lawrence (Cambridge: Cambridge University Press, 2011), p. 273.

³⁰⁶ *Ibid.*

drugs as a means of psychiatric and social control within the mental hospital was juxtaposed against a hedonistic indulgence out of which the new entrepreneurs of the drug culture were making fat profits'.³⁰⁷

2.10 Provocateurs, Tricksters, Convergent Spaces and Counter-Conducts

Thomas Ritchie and Robin Farquharson proved to be articulate and motivated leaders within emerging sub-cultures of collective action by mental patients in the late 1960s and early 70s. But it would be wrong to subscribe to a 'Great Man' interpretation of the roots of collective action, however effective these men were in getting things started. Whilst individual actors made collective action possible, numerous social and material factors, a congeries of economic, political, cultural, technological and geographical conditions, made it possible for them to speak and act in the ways that they did. Men have featured heavily in the story told here and for a few different reasons. Men still dominated public life in this period. Male and female patients at Hartwood were segregated and allowed very minimal contact on rare occasions, as Ritchie complains about repeatedly in the Manifesto. Jones has commented that 'anti-psychiatry – like much of the 1960s counter-culture – was very largely boy's stuff, a guy thing'. Indeed, perhaps the most pivotal figures, besides Meek and Ritchie, in getting SUMP started in the first place were the occupational therapist, Miss Darling, who encouraged and assisted Ritchie to advance his education at Hartwood and Felicity Harris, the founder of GAP. Much of the 1960s countercultural Left was marked by masculinism and misogyny, and Ritchie's signing himself as a 'sex superstar' may indicate that he embraced the so-called sexual revolution at just the time when critical feminists became increasingly vociferous in challenging this tendency, particularly in the wake of the Manson cult killings in the U.S.³⁰⁸ What is unmistakable about the male figures that have appear in this chapter is that on the face of it they comprise a unlikely mix - Maxwell Jones, Enoch Powell, Archie Meek, Jimmy Reid, Timothy Leary, R.D. Laing, David Cooper, Christopher Mayhew, Aldous Huxley, Humphry Osmond, Thomas Ritchie, Robin Farquharson, even J.M Keynes and Bertrand Russell who Ritchie named as 'posthumous patron saints of SUMP' – but in one way or another they were all quite independent maverick figures intent on making their own individual mark on the world in a very public way.

The activity of SUMP was initially very specifically concerned with the particular setting at Hartwood, but when Ritchie was discharged from hospital he extended his concerns to embrace

³⁰⁷ Jones, 'Raising the Anti', p. 291.

³⁰⁸ Robin Morgan wrote that 'Manson is only the logical extreme of the normal American male's fantasy, whether he is Dick Nixon or Mark Rudd: master of a harem, women to do all the shitwork, from raising babies and cooking and hustling to killing people on command', in her excoriating 1970 essay 'Goodbye to All That', published in *Rat*, a counterculture and New Left newspaper in New York City. The paper was taken over by women from women's liberation groups in January 1970, reacting to the sexist content and male dominance at the paper. Morgan wrote: 'Goodbye, goodbye forever, counterfeit Left, counterleft, male-dominated cracked-glass mirror reflection of the Amerikan Nightmare'. Available at <http://blog.fair-use.org/2007/09/29/goodbye-to-all-that-by-robin-morgan-1970/> [accessed on 16 July 2016].

conditions at other mental institutions surrounding Glasgow, where he recruited more members and where he hoped to provide a befriending service for 'visitorless patients'. The activity of groups as SUMP, PNP and MPU, and the various groups they or their members had forged connections with, exemplify Alberto Melucci's account of 'new social movements' as groups working to create experimental social spaces, exploring new forms of identity and experimenting with unconventional social practices and ways of living.³⁰⁹ Clear 'differences defined by geographical regions' marked the contrast between the revolt against the asylum space at Hartwood and the formation of alternative 'post-asylum spaces' by the groups in London which Ritchie and Farquharson participated in before and after SUMP.

The environment at Hartwood, where members of SUMP lived in cramped and unhygienic conditions, where they were severely restricted in their freedom of movement and their ability to communicate beyond the locked doors of their ward, may have reinforced solidarity among patients in ward 7. Such a location would be an unlikely candidate for what geographer Paul Routledge calls 'convergent spaces'. Such spaces, he says, are settings which facilitate the enactment of processes of communication, co-ordination, information-sharing and resource mobilisation. As Andrew Roberts observed 'an asylum is no place to call collective meetings'.³¹⁰ The SUMP petition to the MWCS had to be smuggled out from ward 7 to ward 8 and 10 to be signed by SUMP members. When Ritchie left Hartwood it is possible that he had difficulty in recreating the solidarity of the core membership which had petitioned the MWCS from Hartwood. Whatever difficulties Ritchie had developing a distinctly Scottish Union after he was discharged from Hartwood, the torch paper had been lit for mental patient unionism. By 1974 a UK-wide Federation of Mental Patients Union was established, including a Dundee branch of the MPU, established in October 1973.

Helen Spandler has identified charismatic figures she calls 'tricksters' who emerge at or between various boundaries of time and place, articulate new conflicts and demands, but who require particular conducive social settings in which their energies can be put to work to facilitate innovation. She argues that Paddington Day Hospital, where the MPU was formed, was a convergent space which 'enabled innovation to occur through a collectivised social setting where commonalities were expressed, new resistant identities forged and 'tricksters' emerged to challenge and subvert psychiatric authority'.³¹¹ Whilst Ritchie and his SUMP colleagues had articulated new conflicts and demands at Hartwood, the alternative structures and spaces which Farquharson had sought, did not appear to be available to Ritchie at Hartwood on first glance. However, Ritchie was evidently a resourceful person. The SUMP discourse was shaped by the constraints at Hartwood, as well as by openings created by the increasing permeability of the asylum space. Ritchie benefited

³⁰⁹ Alberto Melucci, *Nomads of the Present* (London: Radius, 1989) and *Challenging Codes* (Cambridge: Cambridge University Press, 1996).

³¹⁰ Roberts, 'Scotland the Brave', p. 17.

³¹¹ Helen Spandler, 'Spaces of psychiatric contention: A case study of a therapeutic community', *Health & Place* 15 (2009), p. 672-673.

from the encouragement and support of an occupational therapist at Hartwood to study and complete A-levels through a correspondence course.³¹² This, along with the support he received from GAP when he absconded in June 1971 and the inspiration of the radical action of the UCS workers, demonstrated how the enclosed and enclosing environment of Hartwood was increasingly susceptible to challenges from both inside and outside of the hospital. Ritchie was aware of wider challenges to the asylum regime and official enquiries into mental institutions in England and Wales, and was eager to exploit the interstices being created. By conducting a dialogue with the contingencies that shaped the social and material conditions of existence for patients at Hartwood in 1971, Ritchie forged a rhetorical strategy, appropriating and improvising the means of persuasion available to him in the broader culture of the time.

The SUMP discourse entailed a strategic mobility and polyphony, involving tactical interactions and communication relays, across the boundaries of the asylum space. The discourse was shaped by social and material circumstances, but was also employed to produce effects in specific contexts and audiences. The rhetorical strategy that Ritchie deployed was serio-comic: sometimes refined and earnestly reasoned, at other times ironic and derisive, coarse and impetuous. His writing displayed considerable sensitivity, ingenuity and wit, as well as intemperance and frivolity. He articulated a demand for specific changes at Hartwood and expressed solidarity with fellow mental patients. SUMP enacted an innovative form of collective bargaining through its petitioning of the MWCS and invented novel rhetoric and tactics with which to engage and to provoke wider audiences. Transgressive acts of civil disobedience and free speech made it possible to resist the regime of confinement at Hartwood, spreading the message of solidarity and subversion beyond the asylum walls. The more formalised aspect of his rhetorical strategy, which drew on practices of collective bargaining, mutual aid and civil rights, spoke to proximate official audiences, established civic and social institutions, such as MWCS, SCCL, trade unions, charities and churches, as well as to a broader constituency of concerned citizens. The cynical and comical aspect of the strategy was no less concerned with persuading, but performed its ‘carnavalesque symbolic inversion’ of psychiatric and asylum authority by means of provocative acts of free speech, mockery and satiric scorn, no doubt finding audiences more receptive to such rhetoric via GAP and the underground press.³¹³

To recall Routledge’s concept of convergence introduced in the opening chapter, a convergent space implies a ‘heterogeneous affinity of common ground between various social movements, grass roots initiatives, non-governmental organisations and other formations, wherein certain interests, goals, tactics and strategies converge’.³¹⁴ Ritchie had found such a place in GAP when he absconded from Hartwood. He had tried and failed to develop SUMP beyond Hartwood, despite

³¹² Ritchie, ‘Introduction’, p. viii.

³¹³ Jones, *Raising the Anti*, pp. 285; 292.

³¹⁴ Routledge, ‘Convergent Space and the Fluidity of Networks’ in ‘Alternative Futures and Popular Protest’: Seventh International Conference, 17-19 April 2001, Vol.11 ed. Colin Barker and Mike Tyllesley. (Manchester: Manchester Metropolitan University, 2001), p. 1.

attempts to find common ground with some of the established local institutions and voluntary action groups. He had failed to forge the networks of ‘communication, solidarity, information-sharing and mutual support’ necessary to develop and sustain a broader psychiatric resistance movement.³¹⁵ But it wasn't through lack of sustained effort that Ritchie failed in his ambition to gain widespread support for SUMP in the Glasgow area.

SUMP initiated a ‘counter-conduct’ at Hartwood, a form of ‘struggle against the procedures implemented for conducting others’ in which there was a ‘counter-society aspect, a carnival aspect, overturning social relations and hierarchy’.³¹⁶ In counter-conduct there is resistance to ‘a quite specific form of power that takes as its object the conduct of individuals’.³¹⁷ As Michel Foucault asks:

Just as there have been forms of resistance to power as the exercise of political sovereignty and just as there have been other equally intentional forms of resistance or refusal that were directed at power in the form of economic exploitation, have there not been forms of resistance to power as conducting?³¹⁸

2.11 Conclusion

Ritchie and Farquharson turned the symbolic and material tools of psychiatry and the principles and structures of the asylum space against their captors in acts of subversion. Medical experts and institutions sought to take responsibility for their conduct and the patient collectives sought to destabilize and subvert the mechanisms employed to govern the conduct of those diagnosed mentally ill. SUMP's struggle was motivated by the perceived breakdown in communication at Hartwood, by the interplay of relations of power, the social and material order of the asylum space and contingent external events permeating the asylum space from within and without. Ritchie and Farquharson had a feel for what was contingent in the present moment. Their carnivalesque critique was a playful and provocative performance, seeking to break down boundaries and conventions. They were at once makers and products of emerging cultures, combining the sacred and the profane, shattering the solemnities and pieties of psychiatric orthodoxy and hierarchy and exposing the vice and folly of asylum life to public scrutiny. By seizing on these contingencies, Ritchie improvised tactics to destabilise relations of power at Hartwood. The exercise of power and spatial organisation at Hartwood structured the field of possible actions of patients; and, through reflection on the social and material boundaries of Hartwood and via provocative acts of free speech, Ritchie transgressed the asylum order. He used his local knowledge of Hartwood to mount a critique of the asylum system in the UK, sounding a clarion call for mental patients to engage in collective action. Although few heeded his call, in the summer of 1971 SUMP demonstrated a capacity for resistance

³¹⁵ Routledge, ‘Convergence space’, p. 345.

³¹⁶ Michel Foucault, *Security, Territory, Population: Lectures at the Collège de France 1977-78* (Basingstoke: Palgrave Macmillan, 2007), pp. 201; 211-212.

³¹⁷ Arnold I. Davidson, ‘In praise of counter-conduct’, *History of the Human Sciences* 24 (2011), p. 27.

³¹⁸ Foucault, *Security*, p. 195.

and practical self-organisation not previously seen amongst asylum patients in Scotland or elsewhere (at least in Britain). Informed by the campaigning and propaganda activities of GAP, UCS and SCCL, SUMP employed practices of free speech, collective bargaining, and mutual aid to initiate a novel counter-conduct. Ritchie and Farquharson and their SUMP cohort may not have enacted their counter-conduct, in the words of the ‘Hartwood Hospital’ poem, ‘with sweeter manners’ or ‘purer laws’, ‘with wisdom for restraint and grace’, but they did exercise considerable ‘strength [of character] to help the afflicted’s cause’.

Case-studies of groups such as SUMP and MPU can be compared, not only for what they reveal about the local circumstances which shaped their emergence, but also for what they reveal about broader differences defined by geographical regions and chronological boundaries. The biographies of pivotal figures in mental patient unionism, like Ritchie and Farquharson, reveal much about broader cultural phenomena, those discursive, institutional and social practices and processes, which intersected and shaped collective action by psychiatric patients. That said, there is no indication in the SUMP documents that Ritchie was aware of professional-led ‘anti-psychiatry’ before founding SUMP, although Farquharson had been a resident of Kingsley Hall, the cockpit of British ‘anti-psychiatry’ led by R.D. Laing and David Cooper.

The cases of SUMP and MPU manifest in microcosm a significant difference in deinstitutionalisation between Scotland and the rest of the UK. When the MPU emerged at Paddington in 1973, the rate of the resident population of mental hospitals in Scotland was 370 per hundred thousand, compared with an English occupancy rate of 190.³¹⁹ SUMP emerged from an old asylum, whereas MPU was formed at a day hospital. As Martin observed, ‘day hospital facilities were unknown in Scotland before the mid-seventies’.³²⁰ Despite having played a pioneering role over the previous century, with the introduction of boarding-out and open-door policies, Scottish mental hospitals in the 1970s were overcrowded and retained large numbers of long-term residents. A decade after the UK Health Minister Enoch Powell announced in 1961 that ‘for the great majority of these establishments there is no future appropriate use,’ Scotland remained stubbornly yoked to traditional forms of institutional provision. It is perhaps not surprising that the first mental patients’ union in the UK emerged from an old asylum in Scotland, at a time when a diminished role was envisaged for such institutions in the UK and throughout the West.

When they were not in hospital, Ritchie and Farquharson ‘drifted’ from place to place in such a way that they were not tied to one location, they were mobile and they were able to sustain their resistant identities and careers of activism beyond the confines and limitations of particular places. The paths they had taken from PNP, to SUMP, to the MPU, had meandered through the old Hartwood and Gartloch asylums, the counter-cultural points of contact of the underground press, the anti-chambers of anti-psychiatry and the anti-university, the alternative information services, an

³¹⁹ Martin, *Between the Acts*, p. 68.

³²⁰ *Ibid.*, p. 70.

inner-city day hospital and a network of squats, communes and crash-pads in London. Psychiatric patients began to forge activist identities and organise collectively, but for drifters like Ritchie and Farquharson, these emerging activist identities were precariously constituted in the shifting 'terrains of resistance' of the emerging 'post-asylum spaces'. As the Dundee MPU demonstrated in its decision to change its name in 1975 'because of the stigma attached the label mental patient', the struggle over identity by psychiatric patients had only just begun.³²¹ While the people who started the unions at the beginning of 1970s may have been willing to identify as mental patients, by the end of the decade the mental patient union movement had collapsed with all but one or two of the unions disbanded. From the ashes of the abortive attempt to sustain a UK-wide movement on the basis of a shared identity of mental patient-hood and an identification with the collectivist principles and forms of organisation of the trade union movement, arose a new wave of collective action in the late 1970s which would begin to challenge the 'sick role' implied in accepting the 'mental patient' label.

³²¹ See 1973 entry in Appendix: Timeline for further details on the Dundee MPU.

CHAPTER 3
FROM ASSOCIATIONS TO ACTION

3.1 Introduction

This chapter explores the increasingly active role of the voluntary sector in advocating for psychiatric patients from the late 1970s onwards. Sharing concerns over the lack of reform of mental health services in Scotland, local and national mental health associations and groups of psychiatric patients and ex-patients in Glasgow and Edinburgh found common ground on which to campaign. By facilitating local self-help groups and international mental health conferences, local and national mental health associations in the voluntary sector opened up 'post-asylum' spaces where patients came together to articulate collective concerns to health professionals and governmental authorities. The 'terrains of resistance' in the politics of mental health shifted during this period at local, regional, national and international levels, as psychiatric hospitals reduced bed numbers. Nationalising and localising tendencies of collective action became more salient as networks of patient activists emerged, enabling international exchanges between activists from across the world. This chapter traces some of the intertwined global, national and local lines of descent of emerging discourses and practices of patient activists during the 1980s.

3.2 Stands Scotland Where It Did?

Long after the 1960 Mental Health (Scotland) Act and Enoch Powell's call for psychiatric hospital closures in 1961, there was little change to the overall shape of the hospital-dominated mental health service in Scotland. Despite a substantial top-down reorganisation of the NHS in Scotland in 1972, and the passing of the Mental Health (Scotland) Act in 1984, a community mental health service for Scotland was still more aspiration than reality. In a broad survey of the field of mental health in the UK between the Mental Health Acts of 1959 and 1983 in England and Wales, and the Acts of 1960 and 1984 in Scotland, F.M. Martin asked, 'Stands Scotland where it did?'.³²² His study is an exception in the historiography of post-war mental health services for the attention it gives to Scotland and its recognition of significant 'Anglo-Scottish differentiation' within the union state. It is evident from the findings of Martin, then Professor of Social Administration at the University of Glasgow, that little had changed during this period in mental health services in Scotland compared with the rest of the UK. By 1985 there remained proportionately twice as many people in Scotland under in-patient care as there was in England.³²³ Martin noted that compared with England the development of mental health services in Scotland had not kept pace in the provision of day hospital facilities, specialised local authority social work services, and general hospital provision for psychiatric patients.³²⁴ No formal commitment was given, as there had been in England, to

³²² F.M. Martin, *Between the Acts: Community Mental Health Services 1959-1983* (London: The Nuffield Provincial Hospitals Trust, 1984), p. 66.

³²³ Barham, *Closing the Asylum*, p. 36.

³²⁴ Martin, pp. 68-71.

replace mental hospitals with psychiatric units in general hospitals in Scotland. In the mid-1970s 1/4 of all psychiatric hospital admissions in England were to general hospital psychiatric units, whereas in Scotland only 1/8 of admissions were to general hospitals.³²⁵ In the 1970s and 1980s Scotland had higher bed numbers, higher overall admission rates and longer average length of stays in hospital compared with the rest of the UK. The fact that there had been no equivalent in Scotland of the 1975 White Paper for England and Wales, *Better Services for the Mentally Ill*, was indicative of the lack of public debate on mental health and what Martin described as 'an excess of complacency and a lack of self-examination in the central department and in the relevant professions' in Scotland.³²⁶ A report published by the Mental Welfare Commission for Scotland (MWCS) in 1975, *No Place to Go* concluded that

It is not proper to detain a mentally disordered person in hospital if, having regard to the care and supervision available to him outside, his continued detention is not required in the interests of his health or safety, or for the protection of other persons. Patients in this category suffer from a degree of mental disorder. The crucial aspect of this problem is the care and supervision available outside hospital. In this matter responsibility lies with local authorities through their social work departments. The provision of suitable accommodation outwith hospital for such patients proceeds at a distressingly slow rate [...] Too many patients remain in hospital because they have no place to go.³²⁷

In *No Place to Go* the MWCS concluded that a 'more specific legal obligation must be imposed on an identified authority, to provide suitable accommodation in the community for mentally disordered patients capable of living there with a degree of support. Adequate financial provision must be made to enable this to be done'.³²⁸ Local authorities were never compelled to provide mental health services and social work had traditionally accorded priority to child care. Six years later, a 1981 MWCS report, *Does the Patient Come First?*, noted that with problems of 'inter-professional rivalry' and 'unreasonable tension between employing authorities and staff [...] there is a real danger that [...] the welfare of the patient [...] may be overlooked'.³²⁹ Industrial strife during the 1970s and 1980s left some institutions grossly understaffed and contributed to a strained atmosphere, which reached crescendo in 1982 when 13 health unions were seeking a pay increase and there was a NHS day of action in which 120,000 people marched in rallies at different locations across the UK.³³⁰

³²⁵ Ibid., p. 68.

³²⁶ Ibid., p. 72.

³²⁷ Mental Welfare Commission for Scotland, *No Place to Go: An account of the work of the Commission since the publication of 'A Duty to Care' in 1972* (Edinburgh: Her Majesty's Stationery Office, 1975), p. 5.

³²⁸ Ibid., p.27.

³²⁹ Mental Welfare Commission for Scotland, *Does the Patient Come First? An account of the work of the Mental Welfare Commission for Scotland between 1975 and 1980* (Edinburgh: Her Majesty's Stationery Office, 1975).

³³⁰ See Geoffrey Rivett, *From Cradle to Grave: Fifty Years of the NHS* (London: King's Fund, 1998), pp. 352-353; see also, Dale Evans, 'Nurses Are Worth More: The 1982 Health Workers' Dispute', in *The NHS is 60 Undervalued, Under-funded, Undermined* (London: Radical History Network of North East London, 2008), pp. 24-29 available at <https://libcom.org/files/The%20NHS%20is%2060.pdf> [accessed 12 August 2014].

The 1984 Mental Health (Scotland) Act effected little change to services on the ground other than to establish social workers with appropriate training as mental health officers to assess cases for compulsory admission to hospital. This created a path for social workers to specialise in mental health and was an attempt to counter-balance the power of psychiatry in the process of compulsory admission. This was not an insignificant development in the long-term. It was an indication of how mental health professionals other than doctors were only just beginning to play an increasingly significant role in psychiatric admissions process and the provision of mental health services. Professionalisation and specialisation of mental health workers in areas such as social work, nursing, clinical psychology and occupational therapy presented a challenge to the authority of psychiatric medicine, but in the short-term the old structures of the mental health system remained intact after the 1984 Act. There were still inadequate relations between local authorities, housing associations and health boards to foster the development of joint planning between different agencies for the provision of community care. A committee had been set up in 1977 by the Scottish Home and Health Department to review mental health services for adults in Scotland, but did not publish its report until 1985. It is remarkable that in *Mental Health in Focus*, which had itself been eight years in the making, it is nonchalantly and ironically stated that 'the staffing requirements of social work departments have been under discussion since they were set up in 1970 and we look forward to an early decision'.³³¹ The long gestation period was noted by critics from within academia and the voluntary sector. The committee was made up of a range of professionals from psychiatry, nursing, social work and occupational therapy, as well as a health service administrator, the Director of voluntary sector organization, the Scottish Association for Mental Health (SAMH) and a councillor from Strathclyde Regional Council. *Mental Health in Focus* stated that that 'the mental health services in Scotland are a deprived area of care' and claimed that future development of mental health services should involve 'improving the balance between community care and in-patient care'.³³²

After the report was criticised for failing to address the future of psychiatric hospitals, another working group of medical professionals was commissioned by the Scottish Home and Health Department to review psychiatric hospitals. When *Mental Hospitals in Focus* was published in 1989 it concluded that 'there remain groups of patients whose mental illness renders them either recurrently or permanently so disturbed as to make inpatient care the preferred method of treatment on humanitarian and social as much as on medical grounds'.³³³ 'Public comment', the report noted, 'now increasingly focuses on concern about the wisdom of wholesale mental hospital closure if the

³³¹ Scottish Home and Health Department, *Mental Health in Focus: Report on the Mental Health Services for Adults in Scotland, prepared by a Working Group set up by the Mental Disorder Programme Planning Group of the Advisory Council on Social Work and the Scottish Health Service Planning Council* (Edinburgh: Her Majesty's Stationery Office, 1985), p. 91.

³³² *Ibid.*, p. 16.

³³³ Scottish Home and Health Department, *Mental Hospitals in Focus: Report by a Working Group of the National Medical Consultative Committee on the Future Role of Mental Illness Hospitals in Scotland* (Edinburgh: Her Majesty's Stationery Office, 1989), p. 16.

consequence is to be the accumulation on the streets of clearly disordered people who, though they must be *in* the community are not an integral part *of* the community'.³³⁴ Against a tide of deinstitutionalisation of mental health services sweeping through countries across the western world, the 'medical consultative committee' appointed by the Scottish Office to conduct this review declared that while 'in some countries community care has assumed the dimension of a crusade, often with frank political overtones', there was a 'need for major reconstruction of present mental illness hospital provision and the construction of new types of inpatient facility'.³³⁵

In a two-volume report published in 1987 by SAMH, *Creating Community Mental Health Services in Scotland*, Nancy Drucker, a University of Edinburgh social policy lecturer and member of SAMH's management committee, claimed that Scotland was 'disfigured by its lack of community mental health services'.³³⁶ Drucker had been instrumental in prompting a follow-up report from the Home and Health Department, drawing 'attention to the scant attention paid in [the *Mental Health in Focus* report] to the key question of the role and future of Scottish mental hospitals [...] and on the implications of any future plans for Scotland's ageing stock of buildings and facilities'.³³⁷ She noted *Mental Health in Focus*'s claim that it was 'the first comprehensive report on these services ever to have been produced', yet she found it to be grossly inadequate because so much of it was 'exhortatory rather than informative or analytic'.³³⁸ In particular, she remarked that 'perhaps the most serious defect is the failure ever to attempt to see the world from the users' point of view'.³³⁹ Voluntary sector organisations in Scotland had become vociferous in their criticism of central government, local authorities and health boards for failing to develop community-based alternatives to the psychiatric hospital. The SAMH report claimed that 'successful planning is a combination of bottom up and top down approaches. Planning has to start at the point of individual need and service contact'.³⁴⁰ David Hunter, an academic researcher on social and health policy at the University of Aberdeen, and Drucker, argued that 'the organisational arrangements for integrated planning in Scotland are much weaker than elsewhere in the UK [...] Mechanisms to put pressure on the Scottish Office do not exist'.³⁴¹

In England and Wales health and social services were the joint responsibility of a single department, the Department of Health and Social Security. Whereas at the Scottish Home and Health Department the responsibility was for health, not social services, and there was a lack of

³³⁴ Ibid., p. 12.

³³⁵ Ibid., p. 40.

³³⁶ Nancy Drucker, 'Editor's Introduction', in *Creating Community Mental Health Services: Volume 1 The Issues*, ed. Nancy Drucker (Edinburgh: SAMH, 1987), p. v.

³³⁷ Scottish Home and Health Department, *Mental Hospitals*, p. 10.

³³⁸ Nancy Drucker, 'Lost in the haar: A critique of *Mental Health in Focus*' in *Scottish Government Yearbook 1986* (Edinburgh: University of Edinburgh, 1986), pp. 70, 88.

³³⁹ Ibid., p. 73.

³⁴⁰ David Hunter and Nancy Drucker, 'Planning for Mental Health: More Rhetoric than Commitment', *Creating Community Mental Health Services: Volume 1 The Issues*, ed. Nancy Drucker (Edinburgh: SAMH, 1987), p. 116.

³⁴¹ Ibid., p. 107.

action on mental health service planning and reform, despite the recognition in Scottish Office-commissioned reports in 1980 and 1985 of the deficiency of provision for those diagnosed mentally ill. In 1980 the report *Scottish Health Authorities Priorities for the Eighties* (SHAPE), mental health was identified in the priority category for health spending and this was endorsed by the Secretary of State. This report, produced by the Scottish Health Services Planning Council within the Department for Home and Health at the Scottish Office, called for joint planning and sharing of resources between health boards, local authority social work departments and voluntary agencies. Yet there was no participation in the production of the report by the equivalent planning body for social work in the Scottish Office, the Social Work Services Group (SWSG). On the other hand, for the rest of the UK, in 1985 the House of Commons Social Services Committee reported in two volumes (900 pages, including evidence submitted and witness statements) on *Care in the Community for Mentally Handicapped and Mentally Ill People*, which noted that the committee 'had difficulty in hearing the authentic voice of the ultimate consumers of community care'.³⁴² Hunter and Drucker pointed out that the equivalent committee for Scotland which covered all areas of policy for the country, the Scottish Affairs Committee, had 'a territorial rather than a departmental remit and the range of areas it must keep under observation is therefore far wider'.³⁴³ 'Furthermore', they added, 'the Scottish Affairs Committee has become notoriously inactive in recent years'.³⁴⁴ In the 1980s there was a growing awareness in Scotland of Anglo-Scottish disparity in patterns of mental health service provision, planning and monitoring, and differences in democratic accountability. Because there 'has always been great caution in Scotland among doctors about letting go of beds and embracing community alternatives', Hunter and Wistow suggested that:

one could be cynical and argue that the maintenance of long-stay beds has made it easy for local authority social work departments to fail to acknowledge any responsibilities on their part, a luxury denied England and Wales where the pressure to close hospital beds and whole hospitals has been greater. Such an imbalance has probably also made it harder to make the shift towards community care *within* the NHS.³⁴⁵

In the foreword to the SAMH report, which contained contributions from voluntary sector officials and workers, from mental health professionals and 'consumer views', the organisation's Chairman, Lord McCluskey, decried 'the gap between rhetoric and reality in the support of those whose needs are neglected by the professional and statutory services', the 'haphazardness and sketchiness of response, both at a professional and agency level' and 'the Faustian bargain that has been struck by the prescribing of tranquilising drugs, which too often have brought a temporary palliation at the

³⁴² House of Commons, *Second Report from the Social Services Committee Session 1984-5, Community Care with Special Reference to Adult Mentally Ill and Handicapped People* (London: HMSO, 1985), paragraph 31.

³⁴³ *Ibid.*, p. 110.

³⁴⁴ *Ibid.*

³⁴⁵ David J. Hunter and Gerald Wistow, 'The Scottish Difference: Policy and Practice', in *Scottish Government Yearbook 1986* (Edinburgh: University of Edinburgh, 1988), p. 95.

price of hellish dependency'.³⁴⁶ He suggested that 'perhaps we need a new language, a new vocabulary to bring home to the general public and to politicians the anguish and despair of so many who need but lack help'.³⁴⁷ McCluskey was Solicitor General for Scotland from 1974 to 1979. In 1976 he was created a life peer and in 1984 he was appointed a Senator of the College of Justice, a judge of the Court of Session and High Court of Justiciary, Scotland's supreme courts. He was also the first serving judge to deliver the BBC's Reith Lectures, which he gave in 1986. The BBC had accepted his suggestion that they should mark his lectureship by contributing to various charities. A donation was made to SAMH and it is claimed that 'without the donation, it is extremely unlikely that [the two-volume publication by SAMH in 1987] could have been published at all'.³⁴⁸ By the end of the 1980s the voluntary sector had become an increasingly significant, though small, part of the economy of mental health care in Scotland and a critical voice in debates over the future direction of mental health services.³⁴⁹ Mental health associations emphasised that 'voluntary organisations offer services which tend not to be undertaken by statutory bodies', such as:

campaigning for the rights of mentally ill people; educating the public about mental illness; providing mental health information services; providing informal support services; providing a forum for the public, users of services and professionals to express their opinions on mental health services; offering people and their families a chance to support each other and campaign for better services; and allowing groups an opportunity to look at how prescribed roles and lifestyles may affect mental health.³⁵⁰

Broadly, the number of charities in the UK had steadily increased since the 1960s, as had the number of people volunteering.³⁵¹ SAMH, local mental health associations and charities were beginning to campaign on policy and develop small-scale, short-term, community mental health services. But McCluskey complained that 'in one voluntary agency after another, we see the commitment of voluntary sacrifice frustrated by the chronic absence of adequate finance'.³⁵² Whilst Scotland in 1990 stood more or less where it did in 1960 in terms of the continued dominance of the psychiatric hospital, even when 'the great bulk of emotional disturbance is located in the community', it had moved on considerably in terms of the advocacy and pressure-group roles which organisations like SAMH were adopting.³⁵³ Although the voluntary sector worked mainly at a local level, on a small-scale and barely sustained by low levels of resource, critical and high profile voices, including eminent legal figures and social policy researchers within national mental

³⁴⁶ Lord McCluskey, 'Foreword', in *Creating Community Mental Health Services: Volume I The Issues*, ed. Nancy Drucker (Edinburgh: SAMH, 1987), p. iii.

³⁴⁷ *Ibid.*, p. iv.

³⁴⁸ Nancy Drucker, 'Editor's Introduction', p. x.

³⁴⁹ See examples of nascent community services in *Creating Community Mental Health Services: Volume II Community Services in Practice*, ed. Nancy Drucker (Edinburgh: SAMH, 1987).

³⁵⁰ Carolyn Maxwell, 'The Role of the Voluntary Sector', in *Creating Community Mental Health Services: Volume I The Issues*, ed. Nancy Drucker (Edinburgh: SAMH, 1987), pp. 45-46.

³⁵¹ Matthew Hilton, James McKay, Nicholas Crowson and Jean-Francois Mouhot, '“The Big Society”: civic participation and the state in modern Britain', *History and Policy*, paper 103, <http://www.historyandpolicy.org/policy-papers/papers/the-big-society-civic-participation-and-the-state-in-modern-britain> [accessed 11 June 2016].

³⁵² *Ibid.*, p. iii.

³⁵³ Scottish Home and Health Department, *Mental Health in Focus*, p. 49.

health associations, developed their role campaigning for patient rights and for reform to mental health services in the UK through the 1970s and 1980s.

3.3 A Change of MIND

During the 1970s existing charities and voluntary organisations in the field of mental health underwent change and new organisations emerged.³⁵⁴ In the UK context the National Association for Mental Health (NAMH) became one of the most prominent of such organisations after World War II and the creation of the NHS and the welfare state.³⁵⁵ Its activities, however, did not extend to Scotland, which had its own separate association in SAMH. Both organisations, however, moved in a similar direction in this decade as they re-examined their *raison d'être* in response to perceived problems at both local and national levels. In 1969 members of the Church of Scientology had attempted to take over NAMH after around 300 of them had infiltrated the organisation.³⁵⁶ Ultimately the attempted takeover was thwarted, but it played a part in prompting NAMH to rethink its role. An article in *Hospital World* in 1969 claimed that NAMH had 'developed from a polite, reassuring body, uttering words of comfort to all those involved with mental health, to an organisation which is now firmly on the side of the patient and not at all scared of speaking its mind when the need arises'.³⁵⁷ The infiltration by Scientology, a shortage of funds and the sense that the organisation's Establishment credentials had fallen out of fashion, gave NAMH the impetus to embark upon a new campaign which would attract resources and clarify its role at the start of the 1970s.³⁵⁸

Changes in personnel in the leadership of NAMH around this time were particularly significant for the organisation, both symbolically and practically. The 'MIND campaign' which ran from 1971 to 1973 was launched and NAMH was rebranded as MIND. Former Labour MP and future Secretary of State for Social Services, David Ennals, became the MIND campaign director. A new Director for the whole organisation, Tony Smythe, was appointed in 1974, succeeding Mary

³⁵⁴ The following are some of the voluntary sector mental health organisations which were established in Scotland in the 1970s and 1980s: Mental Health Foundation Scotland (1974); National Schizophrenia Fellowship Scotland (1974); (Reconstituted) Scottish Association for Mental Health (1976); WASP Phobic Support Groups (1976); Glasgow Association for Mental Health (1978); Alzheimer's Disease Society (1979); The Richmond Fellowship (1979); Falkirk District Association for Mental Health (1981); Edinburgh Association for Mental Health (1982); Manic Depression Fellowship (1983); Penumbra (1985).

³⁵⁵ Nick Crossley, 'Transforming the mental health field: The early history of the National Association for Mental Health', *Sociology of Health and Illness* 20 4 (1998), pp. 458-488.

³⁵⁶ For two different perspectives on this episode and background to the dispute between Scientologists and the NAMH, see C.H. Rolph, *Believe What You Like: An Account of the Dispute Between the Scientologists and the National Association for Mental Health* (London: Andre Deutsch Limited, 1973), and D.R. Dalton, *Two Disparate Philosophies: The Controversy Between the Scientologists and the National Association for Mental Health* (London: Regency Press, 1973).

³⁵⁷ Quoted in C.H. Rolph, *Believe What You Like: An Account of the Dispute Between the Scientologists and the National Association for Mental Health* (London: Andre Deutsch Limited, 1973), p. 89.

³⁵⁸ Nick Crossley, *Contesting Psychiatry: Social Movements in mental Health* (Abingdon: Routledge, 2006), p. 135; See also Vicky Long, *Destigmatising Mental Illness?: Professional politics and public education in Britain, 1870-1970* (Manchester: Manchester University Press, 2014), pp. 175-178.

Appleby, who had been at the helm for over 20 years. Smythe left his post as general secretary for the National Council for Civil Liberties (NCCL) to join MIND. He had been involved in the counter-cultural Anti-University project initiated by David Cooper. There Smythe had taught a course on the 'problems of ordinary individuals who find themselves the victims of bureaucracy, discrimination, or the abuse of power by the authorities' and 'the respective merits and demerits of authoritarian and libertarian approaches to social organisation'.³⁵⁹ American civil rights lawyer Larry Gostin was brought in to head MIND's new legal and welfare rights service. In the 1970s the organisation positioned itself as a campaigning pressure group, informed by a civil libertarian political philosophy and espousing a legalistic discourse promoting the individual rights of patients. Organisations such as NCCL and MIND were vehicles through which mental health was increasingly politicised and notions of mental health advocacy were introduced. The reports of scandals at mental institutions in England and Wales in the late 1960s and early 1970s helped to shape the response of organisations like MIND around this time.³⁶⁰ The uncovering of abuse at these old institutions which housed long-term patients encouraged increasing preoccupation at MIND with limiting medical power, after the Mental Health Act (1959 in England and Wales, which NAMH had campaigned for) had relieved hospital admissions processes of burdensome legal red-tape.

SAMH, which was founded in 1920 to provide support to local associations, reconstituted in 1976 and, like NAMH, developed its role as a political pressure group. Whilst there was a major emphasis on upholding the negative rights of patients within MIND, in Scotland, where community services were developing at an even slower pace than in England, a demand for the creation of community care services out-with the old asylums became an overriding concern for advocates in the voluntary sector. These concerns, over perceived deficits in mental health service provision, were shared across the UK and beyond. At the World Federation for Mental Health, established in 1948 to encourage the development of mental health services throughout the world by fostering 'world citizenship', there was a renewed impetus to build international links between national mental health associations.³⁶¹ Edith Morgan, a long-term worker and former Deputy Director of MIND became Vice President at WFMH in 1979 (later becoming President 1985-1987) and organised a conference in Belgium on 'Alternatives to Mental Hospitals' in 1980.³⁶² She started publishing a newsletter twice a year 'to inform the European mental health associations' and 'to

³⁵⁹ Jakob Jakobsen, 'Antiuniversity of London - Antihistory Tabloid', *Antihistory* <<http://files.antihistory.org/AntiTabloid.pdf>> [accessed 5 January 2014], p. 29.

³⁶⁰ Official Inquiry Reports into the following NHS hospitals were published: Ely Hospital, Cardiff (1969); Farleigh Hospital, Somerset (1971); Whittingham Hospital, Lancashire (1972); Coldharbour Hospital, Dorset (1973).

³⁶¹ Mathew Thomson, 'Before Anti-Psychiatry: "Mental Health" in Wartime Britain', in *Cultures of Psychiatry and Mental Health Care in Postwar Britain and the Netherlands*, ed. Marijke Gijswijt-Hofstra and Roy Porter (Amsterdam: Rodopi, 1998), p. 50; See also Eugene Brody, *The Search for Mental Health: A History and Memoir of WFMH 1948-1997* (Baltimore: William & Wilkins, 1998).

³⁶² Josée Van Remoortel, *History of Mental Health Europe 1985-2010* (Brussels: Mental Health Europe-Santé Mentale Europe, 2010), p. 13.

stimulate the exchange of information' between workers and 'collaboration beyond the country borders'.³⁶³ Morgan set up the international Good Practices in Mental Health project which published reports on the state of mental health services from various cities and regions across the world.

However, to many observers it seemed that MIND was preoccupied with emphasising patients' rights by limiting medical power, instead of supporting increased levels of resource to sustain mental health services and public education. Christopher Mayhew, who had been Chair of MIND for seven years, resigned his position in 1978 after he became disillusioned with the thrust of the organisation's campaigning activities.³⁶⁴ Mayhew had presented a television series on psychiatric hospitals shown on the BBC in 1957, which aimed to raise public awareness of mental illness and its treatment.³⁶⁵ For the purpose of the programme he had spent 'some days' in a hospital ward at a psychiatric hospital and patients were interviewed, but their faces were not shown.³⁶⁶ Through his positions as MP and current affairs broadcaster, he had sought to bring attention to the plight of the mentally ill and had participated in parliamentary debates on reform of mental health legislation in the 1950s leading up to the Mental Health Act of 1959. Reflecting on the period of change at MIND during the 1970s, he later remarked that

My MIND colleagues and I began campaigning vigorously - too vigorously, I now think - for lessening the pressure on hospitals by discharging patients into community care. This was the right policy but was carried too far too fast. The provision of care in the community was inadequate, and I fear that many patients were discharged who would have been happier in hospital and would have improved more quickly there.³⁶⁷

Anthony Clare, a psychiatrist who did much to raise public awareness of mental health through his radio and television programmes on the BBC, resigned from MIND's team of sympathetic practitioners. Writing in the MIND magazine *Mind Out* in 1981 he said that 'MIND has developed a lusty appetite for legal reform and the issue of patients' civil rights that strikes psychiatrists as excessive and potentially damaging to many other activities for which MIND is in existence'.³⁶⁸ Some years earlier in the preface to Larry Gostin's 1975 book published by MIND, *A Human Condition: Volume 1*, Director Tony Smythe, who was aware of such concerns, was at pains to point out that 'we do not feel that a strictly legalistic approach would in itself be relevant to a human condition which is often complex and insufficiently understood and to a public service that is hard pressed for resources and adequately trained staff'.³⁶⁹ Certainly the local mental health associations, which operated largely independently of the national association in England and

³⁶³ *Ibid.*, p. 12.

³⁶⁴ Ann Claytor, 'A Changing Faith?: A History of Developments in Radical Critiques of Psychiatry since the 1960s' (unpublished PhD thesis, University of Sheffield, 1993), p.

³⁶⁵ Christopher Mayhew, *Time to Explain: An Autobiography* (London: Hutchinson, 1987), pp. 154-155.

³⁶⁶ *Ibid.*

³⁶⁷ *Ibid.*, pp. 193-194.

³⁶⁸ Anthony Clare, 'Can the law reform psychiatric care?', *Mind Out* April issue (1981), p. 17.

³⁶⁹ Tony Smythe, 'Preface' to *A Human Condition: Volume 1*, Larry O. Gostin (Slough: MIND), p. 10.

Wales, were able to champion local concerns, tried to provide stop-gap services and put pressure on local authorities. It was left to local mental health associations in Scotland and SAMH to respond to the country's distinct problems in mental health provision. The perceived radicalism of MIND had provoked such opprobrium amongst some observers in England that towards the end of the 1980s a new mental health charity SANE (Schizophrenia: A National Emergency), was set up. SANE's founder, a campaigning journalist, Marjorie Wallace, claimed that MIND was 'politically motivated by anti-psychiatry views and its civil liberties background and did not take into account the liberties of the families'.³⁷⁰ Wallace asserted that 'it was MIND's policy which had been the inspiration behind community care in Britain, urging the government to destroy every psychiatric hospital before community care could work'.³⁷¹ This statement reflected a growing mood of resentment towards MIND amongst some relatives of the mentally ill and voluntary organisations such as SANE and the National Schizophrenia Fellowship, which sought to represent the interests of relatives and families of patients. Yet, psychiatric patients like Peter Campbell, a Scot living in England, were critical of MIND for different reasons. In a letter to the MIND publication *Open Mind* in 1985, he expressed the view that

There are many people who do not wish MIND to speak on their behalf. They are capable and willing to speak for themselves without the intervention of a professional body as an interpreter [...] some of their continuing dissatisfaction is because many agencies, including MIND, are so lukewarm in allowing them direct access or a voice. To such a group the trumpeted position of advocate is more an obstacle than an avenue. It seems MIND wants to run things on their terms. It is MIND for the mentally ill, not MIND with the mentally ill. My second major concern is that advocacy will only act as a cement for the system in which it operates. Whatever the commitment to the players, the game is still the same and the reserve team is highly unlikely to be allowed on the pitch. MIND bestrides the field of mental health and says it is our advocate. I think it is time MIND sharpened up its ideas of what it can and cannot, will and will not do. Then perhaps the rest of us would have a better chance of a go.³⁷²

In the early 1970s the mental patient union movement had emerged from NHS institutions such as Hartwood Hospital and Paddington Day Hospital. Despite the creation of a Federation of Mental Patients' Unions at a Manchester conference in 1974, by the end of the decade most mental patient unions had disbanded, though the Dundee branch of the MPU, which had changed its name to the Westfield Association, was still in existence. Later in the decade Huw Richards, a social worker attached to Leverndale Hospital, set about creating a local mental health association in Glasgow, offering psychiatric patients the opportunity to form their own self-help groups across the city. Unlike SUMP, the new wave of collective action by patients in the late 1970s emerged from spaces which lay outside of NHS institutions, facilitated by voluntary and charitable organisations. While some, like Peter Campbell, complained that such organisations wanted 'to run things on their own terms', local organisations across the UK were beginning to provide activists with more opportunities to speak out and campaign on issues on *their* own terms.

³⁷⁰ Marjorie Wallace, 'Interview with Marjorie Wallace, MBE', *Psychiatric Bulletin* 20 (1996), p. 546.

³⁷¹ Ibid.

³⁷² Peter Campbell, 'Advocacy', *Open Mind* 18 December 85/ January 86 (1985/1986), p. 17.

3.4 LINK/GAMH

The self-help groups Richards had encouraged were called LINK Clubs, the first of which was established in 1976 at Iona House on the Gartnavel Royal site, Glasgow.³⁷³ It was initially conceived as a self-help group and social club for psychiatric patients and ex-patients to make social contact and support each other. In 1978 Richards brought together a group of people at the Glasgow Council for Voluntary Organisations (GCVO), establishing the Glasgow Association for Mental Health (GAMH) to provide social support services to psychiatric patients and ex-patients.³⁷⁴ GAMH and LINK merged in 1979 and received substantial Urban Aid funding for 'areas of multiple deprivation', mediated through the Regional Council.³⁷⁵ LINK/GAMH claimed that 'the voluntary sector acts as a catalyst for producing change; as guardian of the interests of patients and their families; as a lobby to secure resources; as a provider of innovative services'.³⁷⁶ The new organisation set its sights on these objectives at the beginning of the 1980s in an economic climate which was not favourable to claims to resources for the care of the mentally ill. It was the absence of day care and other community based mental health services which prompted LINK/GAMH to develop a rehabilitation programme which aimed to promote 'optimum recovery from the effects of mental illness and social distress and at encouraging independent living using available community resources'.³⁷⁷ Writing of the state of mental health services in Glasgow in 1983 for Edith Morgan's Good Practices in Mental Health project, Richards remarked that

there is a notable absence of Day Care, Sheltered Housing and Industrial Training provision, for example, and a relatively small voluntary sector compared to Hospital based projects and statutory services. There are also few projects which have grown out of local community activity and a notable absence of campaigning activity and advocacy in the Mental Health field.³⁷⁸

A community development approach was adopted at LINK/GAMH, intended to encourage project participants to think of themselves as responsible and critical participants in, not passive recipients of services. It sought to develop the skills of patients and ex-patients and to 'empower' them. This approach challenged the passive 'sick role' that state-sanctioned medicine had allotted to psychiatric patients by encouraging them to become active citizens. LINK club member Betty Hannah described how 'in our self-help groups we find a listening ear and the support we need':

Since coming to LINK/GAMH I have taken part in many different things of interest. A course on advocacy and empowerment has given me much to strive for – to be able to help myself and to represent the views of others who feel unable to do so. Our group training serves to show the need for

³⁷³ Tom Campbell, 'Ring out the old...', *Inside Out*, 6, (1985), p. 5.

³⁷⁴ *Ibid.*

³⁷⁵ Jackie Gulstad, *The Right to be Ordinary: A study of obstacles and achievements in community care in Scotland* (Glasgow: Glasgow Special Housing group, 1987), p. 15.

³⁷⁶ Martin, p. 164.

³⁷⁷ Huw Richards, 'The Resource Centre Programme: LINK/Association for Mental Health Project 14', in *Mental Health Projects in Glasgow* (Glasgow: LINK: GAMH, 1983).

³⁷⁸ Huw Richards, 'Introduction', in *Mental Health Projects in Glasgow* (Glasgow: LINK: GAMH, 1983).

support both for ourselves and for each other. We can find our voice and reach a point where we know we can help others [...] The kindness shown to me has helped me to survive and has given me something to live for [...] Our recent training in public speaking has, like all our other projects, been full of good humour and fun – the best antidote for all ills! We all have a voice and we have been learning to use it. Similarly in our action group we can plan for the future – hoping to see some of our ideas become reality.³⁷⁹

The organisation's Advice and Resource Centre offered individuals 'time, a place and skilled help to develop self-confidence, through setting goals around life issues'.³⁸⁰ The recovery programme involved group work and discussion. Workshops were held on social and interpersonal skills, housing and welfare rights, occupation, work and leisure.³⁸¹ The centre was independent of existing psychiatric facilities and located close to the centre of Glasgow. By 1983 there were nine LINK clubs across Glasgow and a LINK Forum was established, to which the individual clubs elected representatives.³⁸² The Forum was created to coordinate club activities and 'strengthen the voice of the consumer within the Association'.³⁸³ It aimed 'to promote the principle of self-help among people with mental health problems', 'to educate professionals and the public about mental illness and mental health', and 'to organise working parties on various mental health issues, e.g. the proposed Amendment to the Mental Health Act (Scotland) 1960'.³⁸⁴ Richards' vision of the emerging voluntary sector in the field of mental health in Scotland was that 'voluntary and self-help projects' such as LINK/GAMH

represent the capacity that sufferers of a range of problems, and their relatives, have to come together for support, mutual aid, problem-sharing and solving [...] These projects often provide access to information and rights and to enhance the status of sufferers and those disabled by illness.

Voluntary and self-help projects often cater for needs, and encourage aspirations, which are not and perhaps should not be met, or promoted by Statutory Welfare Agencies. Such projects are likely to be innovative, challenging to existing professional practice [...] Such projects also have the ability in some cases to become effective campaigning and pressure groups for better services [...] Volunteers, relatives and sufferers often lack confidence in expressing their feelings, ideas and needs because they are encouraged to regard Doctors, Nurses, Social Workers and other professionals as expert and all-knowing. Knowledgeable, sincere and well-trained, most undoubtedly are, but sufferers, consumers, relatives and voluntary carers have the vitally important key to a fuller understanding and response to the experience of illness and disablement.³⁸⁵

Richards was appointed as the first Director of the newly merged LINK/GAMH, after two years as Secretary of GAMH. On leaving the organisation in 1985 members presented Richards with a framed scroll, inscribed *To Our Leader*. On his departure, the association's Chairman Tom Campbell remarked that Richards'

³⁷⁹ Betty Hannah, 'Finding my voice', republished in *Beyond Diagnosis 1* (1990), p. 10. OMH/15/15.

³⁸⁰ Richards, 'The Resource Centre Programme'.

³⁸¹ Ibid.

³⁸² Vince Edkins, 'The LINK Forum: LINK/Glasgow Association for Mental Health', in *Mental Health Projects in Glasgow* (Glasgow: LINK: GAMH, 1983).

³⁸³ Ibid.

³⁸⁴ Ibid.

³⁸⁵ Huw Richards, 'Voluntary and Self-Help Services', in *Mental Health Projects in Glasgow* (Glasgow: LINK: GAMH, 1983).

formidable organising capacities, his concern for the welfare of those with mental health problems, his imagination and vision and his extensive knowledge of the mental health world and the administrative and political environment in which mental health services must struggle to survive, all contributed to the Association's rapid and varied growth.³⁸⁶

Whilst such organisations lived under constant uncertainty about future funding, voluntary sector outfits such as LINK/GAMH were able to develop initiatives relatively unconstrained by the limitations imposed by cultures of hierarchy, deference and medical paternalism which characterised the NHS. The atmosphere of informality in the places they created for people to congregate and socialise, encouraged them to discuss concerns about their psychiatric treatment and their life problems in general. In such spaces it was possible for established professional, medical and scientific discourses on mental health to be contested and counter-narratives to be exchanged and circulated without the worry that criticisms would be interpreted as yet more signs of mental illness. Traditionally office bearers at the national mental health association, SAMH, included some of Scotland's most eminent psychiatrists. But from the late 1970s onwards, in both SAMH and GAMH, and other voluntary sector organisations, professionals and volunteers from non-medical backgrounds were beginning to take a leading role in the work they did. Post-asylum spaces, such as those opened up by LINK/GAMH, had allowed psychiatric patients 'to actively replace themselves to create spaces in which marginality and marginalised collective identities can be embraced and valued'.³⁸⁷ LINK club members, unlike SUMP members, were not long-term residents of psychiatric hospitals, and for many, the LINK clubs were the only social contact they had and, indeed, the only access to some form of care and support that was available to them.

Developing the view of sociologist Erving Goffman that places such as asylums were 'fateful for the inmates' civilian self', Hester Parr has argued that in the context of community-based care, possibilities emerged 'for reclaiming a lost or institutionalised "civil self"' and that such possibilities were 'partly constituted by inventive uses of mainstream social spaces'.³⁸⁸ In a study of psychiatric patients living 'in the community' in a town in the North of England in the late 1980s, Peter Barham found that all the people he interviewed had 'experienced difficulty in surmounting an identity as a 'mental patient' and 'their personhood was constantly on probation'.³⁸⁹ A number of common themes and concerns of the people Barham had interviewed emerged, including 'the barriers to equality with other people, the experience of being made to feel less of a person or an inferior person [...] and the demoralisation produced by a health and welfare system that treats them as secondary sort of people or as a children'.³⁹⁰ The creation of spaces where marginality was

³⁸⁶ Campbell, 'Ring out the old...', p. 5.

³⁸⁷ Vera Chouinard, 'Life at the margins: disabled women's exploration of ableist spaces', in *Embodied Geographies: Spaces, Bodies and Routes of Passage*, ed. E.K. Teather (London: Routledge, 1999), p. 142.

³⁸⁸ Hester Parr, *Mental Health and Social Space: Towards Inclusionary Geographies* (Oxford: Blackwell, 2008), p. 17.

³⁸⁹ Peter Barham, 'From the asylum to the community: The mental patient in postwar Britain', in *Cultures of Psychiatry and Mental Health Care in Postwar Britain and the Netherlands*, ed. Marijke Gijswijt-Hofstra and Roy Porter (Amsterdam: Rodopi, 1998), p. 222.

³⁹⁰ *Ibid.*, p. 224.

common to former hospital patients living in the community, such as the LINK club members, made it possible for them to discuss and debate openly and critically about their experiences of psychiatric medicine and the common challenges they faced in their lives. Resources, however small, were put into developing innovative schemes which sought to address problems of housing and unemployment. Patients began to address issues which extended beyond psychiatric treatment and mental health care to encompass broader social problems of poverty, housing, employment, discrimination and political issues. By working independently of the public sector and the hospital management structure of the NHS, Richards had encouraged patients not to regard professionals as 'expert and all-knowing', but to think of themselves as having valuable experience and knowledge to contribute to personal and social change.³⁹¹ He saw the voluntary sector both as a means to defend collective welfare provision and as a way 'to open up spaces of innovation and contestation outside the bureaucratic compass of the state'.³⁹² The political demands made by 'consumers' from this Glasgow-based organisation did not conform to a neat binary division between politics of left or right. The Conservative government from 1979 promoted voluntary action and self-help by operating funding schemes available to voluntary organisations and housing associations independently of the Labour-controlled local authorities.³⁹³ In a political and economic environment less favourable to collectivist political ideology, class war rhetoric and trade union militancy, the promotion of voluntary and self-help activity was seized upon by mental health advocates in the 1980s as an opportunity to be exploited rather than seen as a barrier to advancing collective goals. Yet, the model of voluntary and self-help activity which Richards promoted was characterised more by principles and practices of mutual aid than by the concept of the autonomous individual which drove the Thatcher government agendas of the 1980s.

3.5 From Self-Help to Collective Action

The Glasgow LINK clubs were advertised in the MIND Information Bulletin for winter 1981/82 as 'social clubs' which addressed problems such as:

shyness, isolation, loneliness, difficulty in making friends, lack of personal and social confidence, coming to terms with having been mentally ill, and the feelings of guilt, shame, fear and sense of stigma which still surround being or having been a psychiatric patient [...] by offering support, care, understanding and a helping hand when members are feeling down, a place to go to and friends to be with as part of an active social life.³⁹⁴

By 1984 Richards' ambition for the LINK clubs to take collective action to demand better services was realised in practice by the LINK Educational and Action in Mental Health group.

³⁹¹ Richards, p. 31.

³⁹² Mark Cresswell and Helen Spandler, 'Peter Sedgwick's legacy for the politics of mental health', *Social Theory and Health* 7 2 (2009), p. 140.

³⁹³ Maxwell, 'The Role of the Voluntary Sector', p. 44.

³⁹⁴ MIND Information Bulletin December 1981/January 1982 available at <http://studymore.org.uk/mpu.htm#Link1981> > [accessed 10 March 2015].

Individuals from this group were finding a critical voice, and collectively, they began to articulate a critique of the Scottish mental health system. Through Richards' involvement with WFMH he had developed his contacts with MIND, and LINK members were given the opportunity to attend the annual MIND conference in 1983. Those who attended were dismayed at the absence of patient involvement in the conference presentations, seminars and workshops. The following year the Education and Action group made its own presentation to the 1984 MIND conference. The conference was named *Life After Mental Illness? Opportunities in an Age of Unemployment*. On the conference notices three 'special features' were mentioned. These included: 'greater opportunity for conference members to make their own contribution'; 'particular attention to the potential of voluntary groups like MIND associations'; and 'listening to what former sufferers from mental illness say about what really matters where life after mental illness is concerned'.³⁹⁵

Six LINK Club members, Christine Cowan, Charlie Reid, Elvira McLay, John McManus, Vince Edkins and Tam Graham, presented a tape-slide programme to the MIND audience. This 'tape-slide show' involved playing a tape recording whilst a slide show was presented. Members of the group told stories of their own personal journeys through the mental health system, interspersed with critical commentary on policy and the state of mental health services in Scotland, addressing issues of hospitals, community care, self-help, housing, employment and discrimination. The slides showed cartoons which illustrated the facts, figures and themes under discussion and the group took questions from the audience afterwards. Twenty-nine year old Christine Cowan led the presentation. She told the audience:

My life seems to be dominated by the fact that I've been in a psychiatric hospital three times. I saw a lot of psychiatrists all of whom said that they couldn't help me and referred me along to see somebody else. The first time I was in hospital I was in for about three weeks. Then I went along to the day hospital but I ended up walking out. I fought with the staff because they tried to get me to talk about my problems in group therapy and this was unacceptable to me. I ended up going into hospital in Dumfries where I had ECT, [...] a form of treatment that I did not want to have. I felt that the staff used a lot of subtle pressure to get me to sign the form to have this treatment. As it turned out, ECT never helped me because when I went back home from the hospital I just sank again into a very deep depression. I was fortunate the third time I went into hospital because there a doctor helped me, spent a lot of time with me on a regular basis and he was kind and made me feel that he saw me as a human being and not just as a patient.³⁹⁶

She underlined the importance of the quality of the doctor-patient relationship in achieving a therapeutic outcome. Charlie Reid, the oldest member of the group, told the MIND audience that when he first went into hospital as a psychiatric patient in 1946

There was a pre-Victorian attitude to mental patients: locked wards, patients put under sedation for days and at that time there was a lot of experimentation on patients for different cures, some of them for the better, some for the worse. I was asked if I would take ECT and I was amongst the first to receive it. I remember the army psychiatrist on finding out I had got this shock treatment more interested in how it

³⁹⁵ MIND conference notices quoted at Survivors History Group digital archive, Mental Health and Survivors Movements <<http://studymore.org.uk/mpu.htm#22.10.1984>> [accessed 10 March 2015].

³⁹⁶ Christine Cowan, 'In the MIND's Eye', *Inside Out* 6 (1985), p. 11.

worked and what I thought of it instead of my mental health at that time, because he had never seen it, and this is called Mental Health Cure. I still have nightmares regarding shock treatment.

This is why we need organisations like LINK/GAMH, MIND and other groups from all over the world to prevent experimentation on mental health patients [...] I am glad at my late age seeing something being done for the young who unfortunately may someday come under mental care. Good luck and strength to you all who have taken up the fight for mental and ex-mental patients, and I wish there were people like you all doing what you can, which if I had had the help I might have had a happier life and health.³⁹⁷

Having expressed her views on the treatment she received in hospital, Cowan went on to tell the audience about how she came to be involved in LINK/GAMH:

When I came along to LINK I had no friends, I didn't go out anywhere, even to go down to the local shops was a terrible ordeal for me and it wasn't easy for me to go along, but people made me feel welcome. They accepted me for the way I was at the time. When I started going back to the club people seemed really glad when I walked into the room and that made me feel really good, because [...] the image I had of myself was [...] horrible, [...] my self-confidence had been shattered and it was nice just to be with people who didn't have high expectations of me.³⁹⁸

The LINK/GAMH resource centre and the LINK clubs, which met in local halls and flats, functioned as convergent spaces by facilitating the enactment of processes of solidarity, communication and information-sharing. For their members the LINK clubs provided valuable social contact. The fact that LINK clubs members were often isolated and disconnected individuals, some of whom struggled with social interaction and being in public places, made it all the more admirable that they found the courage to share their personal stories on such a public platform as the MIND AGM. Having initially attended their local LINK clubs for the opportunity for companionship, eventually some had become politicised by the experience of associating with other people with a shared experience of psychiatric treatment and social isolation. Elvira McLay told the MIND audience that 'in a world of unemployment, voluntary work keeps you in contact'.³⁹⁹ John McManus recalled how at weekends he 'took to wandering' by himself, 'drinking too much' and 'building up resentments towards society'. He 'felt alienated - like an alien'.⁴⁰⁰ Through the LINK/GAMH rehabilitation programme McManus visited a commune founded by feminists at Laurieston Hall in the south west of Scotland. There he met people who had come from across Europe and he appreciated this rare exposure to different ways of life and cultures, having grown up in a deprived area of Glasgow, with limited experience of the world beyond. His visit to this alternative cultural space gave him an opportunity to meet new people from foreign countries and look beyond his narrow social and cultural horizon. This made a marked impression on him:

It was quite an experience, it was something completely new to me [and] opened up a whole new world to me and I can see more things in the future now, more chance of things happening for me than before in the hospital, when I couldn't see any future on the horizon at all.⁴⁰¹

³⁹⁷ Charlie Reid, 'In the MIND's Eye', *Inside Out* 6 (1985), p. 10.

³⁹⁸ Cowan, 'In the MIND's Eye', p. 11.

³⁹⁹ Elvira McLay, 'In the MIND's Eye', *Inside Out* 6 (1985), p. 8.

⁴⁰⁰ John McManus, 'In the MIND's Eye', *Inside Out* 6 (1985), p. 9.

⁴⁰¹ *Ibid.*

Tam Graham was in the army when he found himself admitted to a series of military hospitals, where he was examined by psychiatrists and received drug treatment. When he returned home he was instructed by his GP to see a psychiatrist, who then sent him to Hartwood Hospital:

When I walked in I got the shock of my life. There were about fifty beds in the one room. I took one look and decided that I was not staying. I then got the train home [...] When I saw the doctor I told him that the hospital was a disgrace and that I was not going back.⁴⁰²

He spoke of leaving hospital again on another occasion when he was heavily medicated: 'I left because I felt like a zombie walking about the ward zonked out of my head with this stuff'.⁴⁰³ He concluded that, 'I am glad that I had my breakdown in the army and not in Civvie Street, for I think that the hospitals that I attended leave a lot to be desired because of lack of resources put into mental health treatment'.⁴⁰⁴

Both John McManus and Christine Cowan expressed forthright views on their experiences of industrial therapy, complaining of the indignity and economic exploitation involved in the work they had undertaken at IRUs. For Cowan industrial therapy was 'totally unacceptable' because 'it was so simple, it was degrading, it was insulting to me and at that time I really believed that I was very stupid'.⁴⁰⁵ McManus claimed that

it was just pure exploitation, putting cardboard and things together, sticking cake boxes together, putting elastic bands in cellophane packets. The people there are maybe getting, say, £1.50 a week, for doing all this repetitive work all the time, and they done an awful lot thinking they were going to get more money, and they didn't.⁴⁰⁶

The appearance of the Glasgow group at the MIND conference inaugurated a period in which MIND, and its annual conference in particular, would begin to provide a platform for patient activists to speak, and a space where new relationships between local groups from across the country could form and develop. The Education and Action group was the first group of patients and ex-patients that had taken to the stage of the MIND conference in the 1980s. What was remarkable about this first opportunity for patients to speak at the MIND annual conference was that it was given to a group from Scotland. MIND had no presence in Scotland and the group spoke to a largely non-Scottish audience in London on policy matters specific to Scotland. But LINK/GAMH was unique because unlike other voluntary action groups 'which try to meet particular needs within populations of at most 200,000, [it] was the only organisation of its kind in an area of about a million people'.⁴⁰⁷ By addressing policy questions and by attempting to raise the level of debate about the proper scope and organisation of community

⁴⁰² Thomas Graham, 'In the MIND's Eye', *Inside Out* 6 (1985), p. 12.

⁴⁰³ Ibid.

⁴⁰⁴ Ibid.

⁴⁰⁵ Cowan, 'In the MIND's Eye', p. 11.

⁴⁰⁶ McManus, 'In the MIND's Eye', p. 9.

⁴⁰⁷ Martin, p. 164.

mental health services in Scotland, the organisation had carved out a niche role for itself. This was not the only setting in which the Education and Action group had delivered its presentation. The group presented at local community centres in Glasgow, to trainee nurses at Gartnavel Royal Hospital and to social work students at the University of Glasgow. Huw Richards was instrumental in arranging these opportunities for LINK members to reach wider audiences through his professional experience and contacts.

In the presentation the group stated that the 'personal experiences of the six must be seen in the context of the state of mental health services in Scotland'.⁴⁰⁸ Christine Cowan led the critical commentary on the Scottish mental health system:

When we speak of mental health services in Scotland we are really referring to mental illness services of a psychiatric and almost totally hospital-based kind. The psychiatric hospital services are and have been seen as dealing with the mental health problem. In Scotland we have a situation where we have 80% more psychiatric beds than England and Wales. When this is linked to the fact that Scotland has less than 12% of the day care places that exist in England and Wales, we can see the archaic attitudes that prevail in Scotland.⁴⁰⁹

Although Scotland had not advanced a hospital closure programme, or an alternative community-based health or social service, it was believed that the hospital regime ensured the best protection against exploitation and neglect for vulnerable people. But opponents of this approach, like LINK, thought that many hospital facilities could be replaced by small scale services to address the problems of the majority of sufferers, who lived in the community, and for whom a long stay in hospital was no longer desirable or feasible.

Cowan continued by situating the work of LINK/GAMH in the context of a period of government inactivity in relation to mental health care:

One of the main difficulties in the present situation at a policy level has been the total lack of any sort of statement by the Scottish Office on the question of mental health services [...] It is high time that the occupants of St. Andrew's House get their act together on this question. At LINK/GAMH we have pushed for some sort of policy statement using our influence as the most active pressure group on mental health issues in Scotland. We have also used the pages of our magazine *Inside Out*, pressurising the government to come clean as regards the future of mental health services in Scotland, as well as promoting our views as to what the provision in this field should be.⁴¹⁰

Cowan set out facts and figures, suggesting that discharge targets should be set for Scotland, as had been done for the rest of the UK over 20 years before:

It is clear that many psychiatric hospitals function as two hospitals in one. Firstly, as a psycho-geriatric and long-term provision and secondly, as a short-time respite for acute problems.

The problem with the first type is that too many have been allowed to become dumping grounds for people who society would prefer to forget [...] These include the long-term chronically mentally ill and the elderly amongst the mentally ill. The figures are quite startling: 5000 people have lived in these

⁴⁰⁸ 'In the MIND's Eye', p. 7.

⁴⁰⁹ Education and Action in Mental Health Group, 'Life After Mental Illness' personal video recording by Thurstine Bassett 22 October 1984.

⁴¹⁰ Ibid.

institutions for more than ten years, and over 8000 of those permanently resident in mental hospitals are over 65, with women outnumbering men.

In the second type we mentioned, the main problem is the increasing subsequent rates of readmission for those with greater problems. A figure which is up 30% from 1967. Figures show also that 80% of people are discharged within one year, which would suggest, that in terms of people's life span, most of the mental illness problem is in the community most of the time, which illustrates the inadequacies of the almost completely hospital-based services in Scotland.

We would propose that there are discharge targets set to ensure that the build-up of permanent residents is avoided and that money follows patients out into the community to ensure that rates of readmission are kept down [...] There is also a need for more preventative services and 'crisis' services to keep the initial admission rates down, and to aid the over-stretched hospital resources.⁴¹¹

Over 20 years after the UK Minister for Health had taken to the stage at the NAMH annual conference in 1961 to announce plans to close the old asylums, LINK members found themselves at the same event in 1984 demanding 'a closure programme of the more antiquated hospitals and the selling of surplus health board land to release adequate funding for the building of smaller units in the community'.⁴¹² The large reductions in the resident hospital population envisaged by Enoch Powell had not been realised, not least in Scotland, but it was clear that this group of activists in the 1980s endorsed the policy of 'deinstitutionalisation' pursued in England, where some health authorities were well into the planning process for a new pattern of services and hospital closures.⁴¹³

3.6 Goodbye to 'Being the Good Obedient Patient': Life Beyond the Asylum and the 'Sick Role'

Underlining some of the challenges faced by psychiatric patients and ex-patients living in the community, the group spoke of how access to employment and housing was a pressing need for their members. Unlike the SUMP members who had spent years at Hartwood Hospital, many of the people involved at LINK had experienced shorter hospital stays and faced problems specific to life outside of the hospital in wider society. These problems did not exclusively concern issues of confinement, health or illness, access to treatment, freedom from coercion or hospital conditions. They also concerned what Peter Barham has described as 'questions of valuation' and 'their place in a moral community' which 'involves in equal measure questions of identity and material questions'.⁴¹⁴ In the presentation the LINK members claimed that patients and ex-patients were 'caught in the invalidity benefits trap' and that 'putting ex-patients on long-term fixed benefits is

⁴¹¹ Ibid.

⁴¹² Ibid.

⁴¹³ Department for Health and Social Security (DHSS), *Care in Action. A Handbook of Policies and Priorities for the Health and Personal Social Services in England* (London: HMSO, 1981); House of Commons, *Second Report from the Social Services Committee Session 1984-5, Community Care with Special Reference to Adult Mentally Ill and Handicapped People* (London: HMSO, 1985)

⁴¹⁴ Peter Barham and Robert Hayward, *From the Mental Patient to the Person* (London: Routledge, 1991), pp. 138; 142.

similar to putting them on the dole, it is expensive, unproductive, healthy and degrading'.⁴¹⁵ They recounted a scheme in which LINK/GAMH had created over 100 jobs funded by the Manpower Services Commission, but concluded that these were 'jobs that lead nowhere'.⁴¹⁶ They discussed how 'ex-patients face difficulty in finding adequate accommodation', claiming that 'many patients in psychiatric hospitals could be discharged if places in appropriately staffed hostels were available'.⁴¹⁷ LINK had managed to secure 27 tenancies to enable some members to live independently, but the group spoke of an 'urgent need for more coordination between housing associations, hospitals, social work departments and local housing departments'.⁴¹⁸ They stressed the need for a range of accommodation including 'hostels, group homes, supported accommodation and access to normal housing'.⁴¹⁹

Summing up their demands, they called for 'a major policy and financial commitment from the Scottish Office to enable the development of community care', emphasising that 'local authorities must recognise their responsibilities for community care'.⁴²⁰ The presentation concluded with a definition of the concept of self-help as the Educational and Action group had understood it, demanding a 'move away from the abrogation of patients' rights, the confidence and dignity stripping activities so prevalent in psychiatric hospitals today':

Psychiatric patients are people first and foremost and should be respected as such. To this end we would propose an increased role of advocacy and the setting up of patients' councils similar to some of those of European countries.

The aim should be the achievement of maximum independence, integration into the community and normal living conditions with sufficient support where necessary [...] Provision of access to housing and employment are essential to helping people to rebuild their lives which have been shattered by mental illness. What we mean by self-help in these and other areas is organising ourselves to get what we need, and doing so on our own terms, and not allowing ourselves to be patronised or led by the nose under any circumstances [...] In our view self-help enables people to regain their self-confidence, their self-respect and gives them the chance to lead their lives with the dignity so often denied by psychiatric services.⁴²¹

The LINK presentation to the MIND AGM in 1984 was filmed by Brighton-based social worker Thurstine Bassett. The following year in 1985 Bassett was awarded a grant to produce a training video for health and social care professionals and he travelled to Glasgow to film the Education and Action group on their home turf. Alongside the interviews with the Glasgow group, the film, *Speaking From Experience*, featured self-help groups in England and patients councils in the Netherlands. In the film Christine Cowan explained her motivations for becoming involved in campaigning:

⁴¹⁵ Education and Action in Mental Health Group, 'Life After Mental Illness' video.

⁴¹⁶ Ibid.

⁴¹⁷ Ibid.

⁴¹⁸ Ibid.

⁴¹⁹ Ibid.

⁴²⁰ Ibid.

⁴²¹ Ibid.

I'd just like to see the people who look after the mentally ill being made more aware of the rights and needs of psychiatric patients and perhaps being educated to look at patients as human beings [...] We are not encouraged to think about our own treatment. We are not encouraged to challenge how we are looked after. We are usually encouraged to accept our role of being the good obedient patient.⁴²²

Having taken the presentation to social work students at University of Glasgow, Cowan remarked, 'I understand that social work students don't get very much in their training on the issues of mental illness, so I'd like to think that we maybe managed to prick the consciousness of some of them'.⁴²³ Tam Graham commented that 'in Gartnavel the trainee nurses [...] were kind of taken aback at what actually happened to people. They were saying to themselves, "does this actually happen in psychiatric hospitals?"'.⁴²⁴ Having gained great encouragement from the reception of their presentation at the MIND conference, Graham revealed, 'when we came back we sort of grasped what had happened [...] We said, "we've got to do something. This is the beginning of something big"'.⁴²⁵ However, Cowan stressed that it was a 'gradual process of becoming more active and having a stronger voice'.⁴²⁶ Somewhat in tension with what Graham had said, she remarked, 'I think what's important is to realise that taking these shows to other people takes a lot of time and energy and it's just a matter of trying to pace ourselves'.⁴²⁷ She explained that:

Some of us, myself included, have been around in LINK for quite a while and I was pouring a lot of my energy into the association and it gave me a new opportunity to channel my energy - a lot of the anger and the pain and the rage that I feel about my own experiences - out there to the appropriate people, to the people outside this organisation who are the ones that should be providing better mental health services.⁴²⁸

Graham concurred, adding that 'one of the main reasons why people stay in this organisation is just to go out and help to improve things'.⁴²⁹ The group was keen to reach a wider audience and develop links with other groups. They were ambitious to bring their message to a range of people, including mental health professionals, general practitioners, relatives, other patients and ex-patients and the wider public. Cowan wanted to see more patient-led education and training for social workers and GPs, claiming that 'many of them are not able to cope with people who are maybe presenting with physical problems when it's really psychologically based'.⁴³⁰ She also wanted to see more work with relatives of patients because 'some families seem to reject the mentally ill member of the unit because of ignorance and fear'.⁴³¹ Graham believed that wider social attitudes could be changed by providing better education in schools: 'They should start educating people at an early age about

⁴²² Christine Cowan, 'Speaking from experience' training video produced by Thurstine Bassett for ESCATA (1985).

⁴²³ Ibid.

⁴²⁴ Thomas Graham, 'Speaking from experience' training video produced by Thurstine Bassett for ESCATA (1985).

⁴²⁵ Ibid.

⁴²⁶ Graham, 'Speaking from experience'.

⁴²⁷ Cowan, 'Speaking from experience'.

⁴²⁸ Ibid.

⁴²⁹ Graham, 'Speaking from experience'.

⁴³⁰ Cowan, 'Speaking from experience'.

⁴³¹ Graham, 'Speaking from experience'.

mental illness, because they don't know...it could happen to anybody'.⁴³² Charlie Reid commented that he wanted to see the group get 'more shows into the community centres'.⁴³³

In the interview with Bassett they explained how they were struggling to find finances to fund a trip to the WFMH Congress at Brighton that year, where the *Speaking From Experience* film would be shown publicly for the first time to an international audience. The group had been on their travels yet again in 1985, including the AGM of the Grimsby Cleethorpes and District Local Association for Mental Health, where they had made contacts with local self-help groups.⁴³⁴ In the same year Tam Graham participated in a television programme broadcast in the UK on the new and somewhat provocative Channel 4 station which had commissioned films to raise awareness of mental health. The film, *We're Not Mad, We're Angry*, was produced by a collective of psychiatric patients from across the UK with support from Bassett. Participants described their experiences and were forthright in their criticism of mental health services and psychiatry. Graham recounted an occasion when he was admitted to hospital and was given pyjamas and a dressing gown that was about 'five times too big'.⁴³⁵ He asked the doctor why his clothes had been taken away. The doctor told him it was 'normal procedure' and that 'it all depends on how you get on in this group therapy'. Graham explained on TV that patients had to go 'into group therapy and [...] you had to ask a group of adults if you could get your clothes back'.⁴³⁶

Patients from across the UK were becoming involved in local action groups and developing links with others further afield. Christine Cowan was enthusiastic about the prospect of linking up with groups from beyond Scotland and the UK at the WFMH congress, where LINK members would get to meet, for the first time, US and European patient groups involved in self-help and campaigning activities. On the *Speaking from Experience* film she explained why she was looking forward to the occasion:

I think it would be such an exciting opportunity for the consumers to go down and air our views and be treated seriously by other professional people and maybe we will meet other consumers from other countries and other associations and just to be able to share our experiences and maybe learn from each other's mistakes and maybe learn about all the good things that we have all been able to carry out.⁴³⁷

The Education and Action group had demonstrated a willingness to engage in community action locally and nationally, to educate professionals and the public. The use of the language of 'consumerism' demonstrated a shift in how patients saw themselves. No longer simply identifying as 'mental patients', as SUMP and the other MPUs had done in the 1970s, the LINK group were

⁴³² Ibid.

⁴³³ Charlie Reid, 'Speaking from experience' training video produced by Thurstine Bassett for ESCATA (1985).

⁴³⁴ Survivors History Group, Mental Health and Survivor Movements, <<http://studymore.org.uk/mpu.htm#1985>> [accessed 22 March 2015].

⁴³⁵ *We're Not Mad, We're Angry*, Multiple Image Productions for Channel 4 aired on 17 November 1986 available at <<https://m.youtube.com/watch?v=qD36mImveoY>> [accessed 26 March 2015].

⁴³⁶ Ibid.

⁴³⁷ Cowan, 'Speaking from experience'.

referring to themselves as 'consumers' of mental health services. By doing so they were looking to challenge the traditional 'role of being the good obedient patient', looking to move beyond a passive 'sick role'. But they were also appealing to a discourse that would play to the political ideology of the incumbent government, emphasising independent living and self-help. They expanded their activities and inspired groups from different parts of the UK by broadening their horizons and taking their message further afield. By reaching out beyond Scotland they encountered opportunities to develop their pressure group activities and contribute to the emergence of national and international networks of cooperation between activist groups.

3.7 International Associations

By 1983 Tony Smythe and Larry Gostin had both left MIND. It was under the the new Director of MIND, Chris Heginbotham, that the organisation became involved in hosting the WFMH congress in 1985. Heginbotham had been an active member of WFMH before his appointment to MIND. In his first year at the helm, MIND co-sponsored a conference with WFMH in London in 1982. The President of WFMH at the time, Eugene Brody had previously expressed his interest in emerging patient activism in mental health. According to Brody, 'I suggested the organisation of an 'Atlantic Basin' meeting to be held [...] in England as a way of bringing consumers and self-help organisations into our framework'.⁴³⁸ So in July 1985 when the WFMH congress came to the UK, patient activists from Scotland, the US, Denmark, Italy and the Netherlands attended in Brighton. Some English patients who got wind of this event were aggrieved that they had not been invited to attend. According to Frank Bangay who was involved with London-based activist group Campaign Against Psychiatric Oppression (CAPO), formerly Protection of the Rights of Mental Patients in Therapy (PROMPT)

We changed our name to CAPO - Campaign Against Psychiatric Oppression - so we could free ourselves from the 'mental patient' tag, and with the help of a few others we started to win CAPO some credibility. During the summer three of us [...] attended, uninvited, the *Mental Health 2000* conference in Brighton. We put up our stall in the entrance and it was there that the Dutch patients' group (invited over by MIND) met us, and negotiated our stall into the conference. They helped us a lot, and we brought to MIND's notice that no English recipients had been invited to MIND's conferences, yet there were many professionals talking about the 'mentally ill'.⁴³⁹

Dutch patients attending the congress negotiated with the organisers of the event to let this group of English 'recipients', of which Bangay was part, into the conference. A Charter was produced during the conference from three workshops, each looking at different themes. A group of patients from various countries took over one of the themes and produced a section of the charter, which they

⁴³⁸ Eugene Brody, *The Search for Mental Health: A History and Memoir of WFMH 1948-1997* (Baltimore: William & Wilkins, 1998), p. 368.

⁴³⁹ Frank Bangay, 'Piece of ourselves: a tribute to Eric Irwin', *Asylum - a magazine for democratic psychiatry* 3 1 (1988) at <<http://studymore.org.uk/mpur3.htm>> [accessed 11 April 2015].

gave the title, 'Self Determination as a Human Right and It's Implication for Mental Health Services'. In the declaration the group stated that

We reject the belief that those suffering from all forms of emotional distress have a medical condition called 'mental illness' and that others are necessarily mentally 'healthier' [...]

People who already feel helpless, insecure and victimised suffer further loss of dignity, respect, self-worth and personal power in the 'mental health' system.

Advocacy is a process through which individuals and groups articulate and pursue their needs and interests. This process necessarily involves conflict with a 'mental health' system which creates passivity and dependency.⁴⁴⁰

Naming itself the Declaration Group for Self and Citizen Advocacy, their declaration called for

-all patients to have an independent person of their choice to help represent them and assist them to voice their own wishes [...]

-the setting up and development of autonomous patient groups and councils which will give patients collectively the power to determine how their needs and interests will be realised [...]

-the giving of full and complete information about psychiatric drugs, legal rights, and the availability of non-medical alternatives to every patient as a matter of right.⁴⁴¹

The Dutch patient groups represented at the conference were particularly influential in the creation of patients councils in the UK, the first of which was founded in Nottingham in 1986. Soon many others followed. By 1991 there were patients' councils in seven psychiatric hospitals in Scotland. The training video in which the Glasgow LINK club activists participated alongside other groups, including Dutch patients' councils, had informed the process of setting up the Nottingham Patients' Council which, in turn, influenced the formation of other patient councils in the UK. There was much cross-pollination between groups in different parts of the UK, in Europe and the US. The WFMH Congress in July of 1985 paved the way to the MIND annual conference in November, which for the first time was targeted at patients and not professionals. The November conference in London was called, *From Patients to People*. LINK club members attended and contributed once again, but this time the entire programme of the 1985 conference was focused on issues of concern to patients which the Glasgow group had raised for the first time in the previous year. Following the 1985 MIND conference LINK club members appeared on the cover of *Social Work Today*.⁴⁴² This publication of the British Association of Social Workers was 'the top circulation journal for everyone in social services'. The cover headline read, 'We Can Succeed' - Former Mental Patients'. The cover photograph portrayed the LINK group on the steps of Kensington town hall as they struck a confident pose of ebullience and defiance, with clenched fists raised. These national and international conferences provided the opportunity for patient activist

⁴⁴⁰ WFMH, *Charter Mental Health 2000* (1985) <<http://studymore.org.uk/mpu.htm#WorldCongress1985>> [accessed 11 April 2015].

⁴⁴¹ Ibid.

⁴⁴² *Social Work Today*, 17 15 (1985).

groups and individuals to meet and plan future cooperation. The *Social Work Today* piece spread the message of the LINK Education and Action group to a wider professional audience. Following the conferences in July and November, a group of people who had first met at these events managed to secure funds to bring together patients and ex-patients from across the country for a national meeting in January 1986. The message of the Glasgow group had found a wide audience across the country via participation in these national and international conference events, and through various print and broadcasting media, including video, television and a professional social work journal.

The message of 'patients becoming people' from the November conference had also reached the House of Lords. In the weeks following the conference, Lord Mottistone called attention to it in the second chamber. He claimed that a

matter for concern is that so-called 'patient power' may develop as strongly in this country as it seems to be doing in the United States and certain European countries such as Holland. In this connection, the support apparently being given to this totally erroneous movement by MIND much concerns me.⁴⁴³

He went on:

The problem is that mentally ill people can sometimes be incapable of deciding on the best treatment for themselves. There have to be arrangements for their care in the hands of people professionally qualified so to do. If such arrangements are not made, the persons concerned may well be driven to suicide or destitution, and their families will suffer much hardship in the process. Bodies like the Campaign Against Psychiatric Oppression are not only misguided: they are evil.⁴⁴⁴

Lord Ennals, now Chair of MIND, responded to Lord Mottistone's comments in the House of Lords. He parried

I know nothing about 'patient power' but most patients have no power at all and those whose only residence is a mental hospital do not even have a vote, let alone political power or any other sort of power. This is quite different from 'patient power', or whatever the noble Lord, Lord Mottistone, has heard. I believe that people who are patients must be consulted about their own future. They are people as well as patients.⁴⁴⁵

In response Lord Mottistone remarked, 'I have here the programme of the conference that he chaired last week. I must confess that the titles of the subjects spoken about frighten me. It seemed to be a conference more on the politics of civil liberties than on care for the mentally disabled'.⁴⁴⁶

Mottistone was the founding Chair of Schizophrenia A National Emergency (SANE), the voluntary organisation established by Marjorie Wallace in 1986 as a counter-weight to MIND, to lobby against hospital closures and to represent the interests of the relatives of psychiatric patients. SANE launched a poster campaign in 1989 with messages such as:

⁴⁴³ Lord Mottistone, HL Deb 4 December 1985 vol 468 cc1310
<http://hansard.millbanksystems.com/lords/1985/dec/04/care-of-the-mentally-ill#column_1317>

⁴⁴⁴ Ibid.

⁴⁴⁵ Lord Ennals, HL Deb 4 December 1985 vol 468 cc1315
<http://hansard.millbanksystems.com/lords/1985/dec/04/care-of-the-mentally-ill#column_1317>

⁴⁴⁶ Lord Mottistone, HL Deb 4 December 1985 vol 468 cc1376
<http://hansard.millbanksystems.com/lords/1985/dec/04/care-of-the-mentally-ill#column_1317>

SHE THINKS YOU WANT TO KILL HER
 YOU THINK SHE WANTS TO KILL YOU
 THEY THINK SHE'LL GO AWAY

and

HE THINKS HE'S JESUS
 YOU THINK HE'S A KILLER
 THEY THINK HE'S FINE

At a meeting in January 1986 members of LINK, along with people from other groups from across the UK founded a new national organisation called Survivors Speak Out (SSO). This group, instead of using the terms, 'patient', 'consumer', 'service user' or 'recipient', decided to identify as 'survivors', because they saw themselves as 'survivors of a mental health system' and 'survivors of difficult life experiences'. Members of SSO were involved in demonstrating against the SANE poster campaign. They saw the discourse circulated by SANE as fuelling the stigmatisation and demoralisation which they had to struggle against to 'survive'. SSO aimed to facilitate communication between individuals and groups across the UK, promoting 'self-advocacy'. The main objectives of the organisation, at the beginning, were to produce a newsletter and to organise a national conference where activists could come together to discuss the way forward for collective action. The conference eventually took place over a weekend at Edale Youth Hostel in the Peak District in the autumn of 1987. The event was important, because like the MIND events which went before, it brought more people from different parts of the UK together, except this time the entire agenda was shaped by patients, not professionals or established mental health associations. About 100 people attended, including a small number of allies and a Charter of Needs and Demands was unanimously agreed. SSO would play an important part in spreading the discourse of 'self-advocacy' in the late 1980s and early 1990s. They did this by sending speakers to local events where patients were interested in taking collective action and by producing and selling a Self-Advocacy Action Pack, which contained practical advice about how to set up and run a local action group. The Pack emphasises that 'self-advocacy means people speaking and acting for themselves [...] is about power – about people regaining power over their own lives':

The psychiatric system in this country seems peculiarly designed to deny power to those who enter it. Such powerlessness is then reinforced by the practices and attitudes of the wider society into which the recipients of services eventually emerge [...] Self-advocacy groups are first and foremost pressure groups not therapeutic support groups.⁴⁴⁷

By 1987 founding member of SSO Peter Campbell believed that the most important achievement of SSO was 'the growth of real personal links between many people in different groups and in different parts of the country' and he believed that 'this network of mutual feeling is the foundation

⁴⁴⁷ Survivors Speak Out (SSO), *Self-Advocacy Pack – Empowering Mental Health Service Users* (London: Survivors Speak Out, 1988), pp. 1, 4.

of broader cooperation between groups and individuals in the future'.⁴⁴⁸ Although there was great confidence amongst SSO activists about working together, it was recognised that the 'membership is dispersed across the UK and Eire which seriously limits our capacity to communicate regularly as a group'.⁴⁴⁹ In 1987 Lorraine Bell a coordinator at SSO remarked that because most members were 'already committed to local activities' it would be 'crucial to our personal survival and capacity to continue our work that we don't overburden ourselves; conferences in particular are very stressful. In terms of maintaining tolerable levels of stress we are sailing very close to the wind'.⁴⁵⁰ The pack warned that

just because you are asked to address a group of social workers doesn't mean the world is at your feet [...] As recipients we feel more powerful when people listen to us because we have not been listened to before, not because we actually are more powerful through the process'.⁴⁵¹

SSO articulated a discourse which moved beyond the promotion of the concept of advocacy. By identifying themselves as 'survivors' of psychiatry they were sending out a strong oppositional message to governmental and psychiatric authorities. Although the LINK club members had started by identifying themselves as 'consumers' of mental health services, Tam Graham and Charlie Reid, who were involved in the early meetings of SSO came to think of themselves as 'survivors' of psychiatry and saw the creation of this national network as their proudest achievement in mental health activism.⁴⁵² One CAPO member remarked that 'survivors of the mental health system are no more consumers of mental health services than cockroaches are consumers of Rentokil'.⁴⁵³ The shifts in discourse employed by activists during the 1980s was highly significant, because it indicated that patients were no longer willing to accept a passive sick role and were beginning to define themselves and their problems in ways that did not defer to medical authorities or depend on a psychiatric discourse of 'mental illness' and mental patienthood.

A report produced by the Royal College of Psychiatrists (RCP) on patient advocacy in 1989 commented that SSO, 'by name alone leaves little doubt that its members do not support present mental health practices'.⁴⁵⁴ Writing in the *Psychiatric Bulletin*, the RCP journal in which this report was published, one psychiatrist, Peter Tyrer remarked that

whatever reservations psychiatrists may have about the movement, it is not going to go away and the form it takes will depend a great deal on the reaction of the psychiatric establishment [...] far too many of our dissatisfied customers find their way into the ranks of fringe organisations such as Scientologists and

⁴⁴⁸ Lorraine Bell, 'Survivors Speak Out: A national self-advocacy network', in *Power in Strange Places*, ed. Ingrid Barker and Edward Peck (London: Good Practices in Mental Health, 1987), p. 17.

⁴⁴⁹ Ibid.

⁴⁵⁰ Bell, 'Survivors Speak Out', p. 17.

⁴⁵¹ SSO, *Self-Advocacy Pack*, p. 4.

⁴⁵² In the early 1990s a Glasgow day centre was named *The Charlie Reid Centre* after Reid's death. In the lobby of the premises a plaque recorded his pride in founding SSO and identifying as a survivor. The day centre was closed in 2014.

⁴⁵³ Ingrid Barker and Edward Peck, 'Think it through: Theoretical perspectives', in *Power in Strange Places*, ed. Ingrid Barker and Edward Peck (London: Good Practices in Mental Health, 1987), p. 1.

⁴⁵⁴ Royal College of Psychiatrists, 'Patient advocacy - Report for Public Policy Committee', *Psychiatric Bulletin* 13, (1989), p. 716.

the Moonies where prejudices against psychiatry are rampant. The user movement in psychiatry is now a healthy and aggressive toddler but if we ignore its development it could well show signs of delinquency.⁴⁵⁵

Subsequently two psychiatrists responded to Tyrer's comments in a letter to the *Bulletin*: 'we hope we understand him correctly. Blind indifference and calculated ignorance will be as damaging as active opposition to the users' movements; patients engaging in battle with psychiatrists is perhaps a mass sickness that psychiatrists really could cure'.⁴⁵⁶ The psychiatrists in question, T.J.G Kendall and Alec Jenner, had established *Asylum* magazine in 1986. In the letter they remarked that

it is a magazine that is dedicated to an open debate and to enhance a dialogue between workers and users [...] sadly professionals seem unenthusiastic about this debate and rarely send articles. Many of the user groups such as Survivors Speak Out, Campaign Against Psychiatric Oppression [...] and many others, on the other hand, have used our *Asylum* magazine.⁴⁵⁷

Jenner had been inspired by the *Psichiatria Democratica* movement in Italy led by psychiatrist Franco Basaglia, and R.D. Laing, with whom he had struck up a friendship. This Italian movement had successfully campaigned for the closure of psychiatric hospitals when in 1978 legislation was passed which made new admissions to psychiatric hospitals illegal and initiated the gradual dismantling of psychiatric hospitals in Italy. What Kendall and Jenner identified as a need 'to enhance dialogue between workers and users' was a problem which even the most cooperative groups of patients and their allies in the voluntary sector would face. It seemed that while tentative steps had been made towards increasing opportunities for dialogue between patients and professionals outside of clinical settings, neither patient activists nor psychiatrists were in a rush to find common ground together. National fora like the MIND conferences and *Asylum* magazine, however, at the very least started to open channels of communication between 'users', and potentially between 'users and workers', enhancing opportunities for dialogue and cooperation.

The emergence of movements outside the UK and their successes in establishing effective pressure groups inspired UK-based activists.⁴⁵⁸ Christine Cowan was prescient in recognising the potential which the national and international conferences held for creating new national and international links, building networks, sharing information and learning from other examples of practice. Andrew Roberts claimed that Scotland pioneered the movement in the UK with SUMP in 1971 and LINK in the early 1980s. It is fair to say the appearance of the LINK club members at the MIND conference in 1984 inaugurated a new era of national and international cooperation between mental health activists from across the UK and beyond. But the direction of influence between Scotland and the rest of the UK was not one-way and groups in England were developing independently of what was happening in Scotland. Groups from Scotland learned from English

⁴⁵⁵ Peter Tyrer, 'Arming the weak: the growth of patient power in psychiatry', *Psychiatric Bulletin* 13 (1989), p. 308.

⁴⁵⁶ T.J.G. Kendall and F.A. Jenner, 'Asylum: a new magazine', *Psychiatric Bulletin* 13 (1989), p. 572.

⁴⁵⁷ *Ibid.*, p. 571.

⁴⁵⁸ SSO, *Self-Advocacy Pack*, p. 3.

activists and all UK groups were inspired by activities abroad. It was with support and advice from south of the border that patient activism was initiated in Edinburgh in the late 1980s.

3.8 Raising Awareness in Edinburgh

Similar to the LINK clubs in Glasgow, Awareness was a group of psychiatric patients and allies in Edinburgh which developed out of meetings organised by voluntary sector workers in 1988.

Edinburgh Association for Mental Health (EAMH) worker and founding member of Awareness, Be Morris reflected on how a heckler at her first MIND conference made a marked impression on her:

One of the strongest memories is of a very elderly chap at that first MIND conference. He'd had RD Laing as his psychiatrist and I remember his name was Joseph and he stood up and he bellowed right down the auditorium to the platform 'When are you going to stop locking us up?' and I think he put an expletive in there as well. You could feel the shock. I don't think most people had ever heard a service user actually stand up and be vocal like that. And slowly there was a small ripple of applause that eventually rose to a crescendo and the panel just looked completely nonplussed, just by the energy of the thing I think, as much as the question.⁴⁵⁹

The MIND conferences had become spaces of facilitation, communication, co-ordination, information sharing and politicisation, creating opportunities for cooperation between individuals and groups from across the country. Morris emphasised the importance of these meetings:

We'd met people at the MIND conferences [...] where users were very vocal and very angry about how they had been treated in psychiatric hospitals, how they had been treated in the community by professionals and the kind of yawning gap of power between service users and professionals at the time [...] We'd met Mike Lawson who then became the Vice Chair of MIND and he was keen on helping us set something up here. So we met at a number of different meetings. We had one [...] that was about how people with mental health problems were portrayed. We were a bit stunned at how many folk were there.⁴⁶⁰

Inspired by activist groups they had met at the conferences organised by MIND, a small group of Edinburgh-based voluntary sector workers wanted to bring 'service users' in Edinburgh together. Despite the fact that MIND had no presence in Scotland, it was the convergent spaces created by the MIND conferences, and the action taken by SSO to help set up self-advocacy groups across the UK, which encouraged the creation of Awareness. Yet before any contact was made with activists from England, a public meeting advertised under the name of *Democracy in Psychiatry* was held in Edinburgh in January 1988. It was organised by Colin Murray, a social work student on placement at a local drop-in centre run by Barony Housing Association for vulnerable adults, called Contact Point. Around 70 people attended the meeting. According to Murray, 'Although it had been advertised in Edinburgh, people from Glasgow and from Aberdeen came [...] People just snarled

⁴⁵⁹ Be Morris interviewed by Alistair McIntyre, August 2009, OMH/1/5.

⁴⁶⁰ Ibid.

off at their experiences and how wrong it all was and the injustice of it.⁴⁶¹ EAMH worker Morris recalls:

My strongest memories of the early days are how lively and energetic it felt. It really felt as if it was something major happening. It was a movement along with lots of other movements that were very vocal at the time like the women's movement, the black movement. It felt like at last, folk were standing up, forming a strong alliance and making strong statements that were going to make societal changes [...]

The main thing was the power thing, feeling disrespected, not listened to, feeling that people were only interested in a set of symptoms and medicating them. People were extremely angry and they just felt they were seen more as their illness than as a person [...] At that time people's anger was mostly directed towards psychiatry.⁴⁶²

Murray had worked in a psychiatric hospital and his experience led him to study some of the critical literature of the so called 'anti-psychiatrists':

the anti-psychiatry movement had been and gone but the ideas hadn't disappeared by any stretch [...] Some of my thinking was really strongly rooted in the anti-psychiatry movement [...] and what I'd seen of consultant psychiatrists. So it was about the power thing [...] from the start it was about power and the damage that it does to people in therapeutic environments [...] it started putting [...] some sort of context around what I was experiencing, what I was seeing [...] and I thought, oh, there's a whole body of thought that actually supports some of the views that I'm coming to.⁴⁶³

The meeting organised by Murray in Edinburgh was named after the *Psichiatria Democratica* movement in Italy. Murray remarked that 'the Glasgow people were well noisy, and I do remember having to kinda tell them to shut up a lot, that this was a meeting for Edinburgh, because they already had some stuff going on'.⁴⁶⁴ Following this initial gathering, further meetings were organised later that year in Edinburgh to which SSO activists were invited to speak. Murray recalled that 'by the time the second meeting came around I'd found out about Survivors Speak Out [...] they were really quite clear that it was a user only group and that was the way forward, so it wasn't so straight forward for me to be able to relate to people like that. Other folk who were coming in were able to forge links better than any worker could'.⁴⁶⁵

Colin Murray, Be Morris, Shulah Allan, who was Director of EAMH and Anne Bardsley, a service user, attended an *International Conference on User Involvement in Mental Health Services* held at The University of Sussex under the auspices of MIND and Brighton Health Authority in September 1988. Speakers included Mike Lawson, a founding member of both the MPU and SSO, and Judi Chamberlin, an American psychiatric survivor who had been involved with activist groups in the US since the 1970s. A couple of months after this conference, Mike Lawson was elected vice-chair of MIND, replacing psychiatrist, *British Journal of Psychiatry* editor and historian of psychiatry, Dr Hugh Freeman. In an interview given some years later Lawson referred to his 'being elected Vice Chair of National MIND as a collective action [...] amongst survivors and our groups

⁴⁶¹ Colin Murray interviewed by Phil Barnard, August 2009, OMH/1/4.

⁴⁶² Morris, OMH/1/5.

⁴⁶³ Murray, OMH/1/4.

⁴⁶⁴ Ibid.

⁴⁶⁵ Ibid.

and lobbies'.⁴⁶⁶ Judi Chamberlin was author of a book first published in the US in 1978. *On Our Own: Patient-Controlled Alternatives to the Mental Health System* was published in the UK by MIND a few months after the conference in 1988. Shulah Allan remembered:

people who used services talking about the need for things to be really different and how unjust things were, it was all about medication and that sort of stuff and feeling that what I'd been doing was just mucking around on the sidelines and had to come back and do something about it in Edinburgh.⁴⁶⁷

Lawson and another SSO activist Ivy Buckland came to speak in Edinburgh after meeting the group at the conference in Brighton. Colin Murray remembered that:

It was other people from outside who had turned up and said things that we were feeling and getting. And they were a little bit further on than us at the time. So it was like the torch was getting held up. And people like Ivy, a lot of it was down to individuals. Ivy was a very charismatic speaker [...] you could not listen to Ivy and not be affected. And similarly with Mike, a charismatic speaker, and inspiring to listen to and talk with. And it was out of those meetings that Awareness got started.⁴⁶⁸

The Awareness group started in 1989 and met fortnightly. Most of the time between six and ten members attended these meetings. Awareness member Graham Morgan put it starkly:

Most of us were exceptionally angry at the way we had been treated and very keen to make a change. We didn't trust psychiatrists, we didn't trust most workers and we thought that life, once you had been labelled with a diagnosis of mental illness, was pretty awful. We wanted to change the stigma, we wanted to change the services, to have a say in everything that happened, to be equal people, to be respected for who we were. We didn't want to be put on medication or sectioned or put in hospitals, we'd have liked the hospitals to be torn down, sectioning abandoned forever and the psychiatrists put in re-education camps.⁴⁶⁹

There were differences of opinion in the early days about what the role of the group should be. Some members believed it was not possible to do both self-help type support and campaigning. Others believed that support, discussion, campaigning and education should all fall within the remit of the group. There were discussions over whether to develop a constitution for the group to be given charitable status, whether it needed funds to achieve its goals and whether charitable organisations could 'take a political stance'.⁴⁷⁰ Jeff, an Awareness member working in the voluntary sector remarked on how the politics of the time were formative for this group in Edinburgh:

It was a Thatcher, right wing, monetarist, Tory government, public expenditure cuts were deep and incisive, the miners' strike in the 1980s, you know, the attack on working class values and principles and communities was high on the agenda of the Conservative government at the time. So the climate, political climate, was difficult and not very encouraging, although I do think within that it always creates a better campaigning user movement because people are more angry that nobody is listening to them.⁴⁷¹

⁴⁶⁶ Mike Lawson interviewed by Giles Martin, May 1999. Mental Health Media, <<http://www.webarchive.org.uk/wayback/archive/20121013223258/http://www.insidestories.org/node/6>> [accessed 29 April 2015].

⁴⁶⁷ Shulah Allan interviewed by Kirsten Maclean, May 2010, OMH/1/6.

⁴⁶⁸ Murray, OMH/1/4.

⁴⁶⁹ Graham Morgan interviewed by Phil Barnard and Kirsten Maclean, August 2009, OMH/1/2.

⁴⁷⁰ Awareness meeting minutes, 22 October 1990, OMH/3/2.

⁴⁷¹ Jeff interviewed by Alistair McIntyre, October 2009, OMH/1/8.

Colin Murray commented that

the people who were involved, all of us at that time had sort of history, we were involved or we were active in radical left wing politics [...] and it was transposed into this work environment. Yeah there's all this class struggle but look at what's going on in our everyday work. Worse! It was very amenable to that sort of analysis, power notions and so on.⁴⁷²

The wider economic and political situation was changing in Scotland. Whilst Irish Republicanism had taken on an extreme and violent form in the 1970s, constitutional questions and nationalist sentiment in other parts of the UK also came to the fore in the wake of the discovery of North Sea oil and the electoral success of the non-violent nationalist political parties in Scotland and Wales. In 1979 a referendum was held on devolution and the creation of a Scottish assembly. With low voter turnout and a requirement that 40% of the Scottish electorate vote in favour of devolution, it did not come to pass, despite 51.6% of those who voted being in favour.⁴⁷³ Scotland would wait another 20 years for devolution, but even in the 1970s it was becoming apparent that in the smaller nations of the UK the legitimacy of the Union state was coming under increased scrutiny and in the extreme cases, paramilitary attack.

The collapse of old manufacturing industries in Scotland and the high levels of unemployment which resulted in the 1980s had a marked effect on Scottish attitudes towards Scotland's place within the UK. The Conservative government's move to 'roll back the state' in the 1980s meant an end to the post-war consensus, a break with corporatist policies and the closure and privatisation of state-owned industries and public utilities. Instead of yielding economic growth and social harmony, corporatism in the 1970s had resulted in stagflation and social conflict.⁴⁷⁴ Private enterprise, not public ownership, was to be the driver of social and economic life under the rule of Margaret Thatcher. As a result of the deindustrialisation of Scotland and the denationalisation of British industry which followed in the 1980s, a class-based, collectivist culture and identity, the inheritance of Scotland's distinct industrial past, came under the strain from policies of the Thatcher government. The economic insecurity which market forces imposed on the population resulted in dislocations of family and community life.⁴⁷⁵ The destruction of nationalised industry in the UK was not only a social and economic catastrophe for some communities, but signaled an end to cherished British institutions, serving to chip away further at a shared sense of Britishness and to delegitimise the constitutional arrangements of the UK. During a time when the far-right National Front and Ulster Unionists and Loyalists commandeered the Union Jack as the badge of their British identity, for many people in the UK, a unitary British identity was giving way to

⁴⁷² Murray, OMH/1/4.

⁴⁷³ John Bochel and David Denver, 'The Outcome', in *The Referendum Experience Scotland 1979* ed. John Bochel, David Denver and Allan McCartney (Aberdeen: Aberdeen University Press, 1981), pp. 140-146.

⁴⁷⁴ Gray, *Enlightenment's Wake: Politics and Culture at the Close of the Modern Age* (London: Routledge, 1995), p. 110.

⁴⁷⁵ See Richard J. Finlay, 'Thatcherism and the Union' and W.L. Miller, 'The Death of Unionism?', in *Scotland and the Union 1707-2007* ed. T.M. Devine (Edinburgh: Edinburgh University Press, 2008), pp. 157-174; 175-192.

multiculturalism and more complex cultural identities and ethnicities, often based on nationality or geography, but also on ideology, class, race, religion, gender, disability, or membership of some other group or groups. Social and political movements based on group interests defined by a shared experience of injustice, cultural imperialism and marginalisation, such as second-wave feminism, gay pride, nationalist and post-colonial movements increasingly came to the fore during the 1970s and 80s. Winds of change in the global and national economy, trade union militancy, civil rights campaigns, nationalist movements and postcolonial identity politics in the 1970s, followed by a move to the right with the election of the Conservative Party in 1979, were highly formative for the development of collective action by psychiatric patients in late 20th century Scotland. By the end of the 1980s the Conservative government of Margaret Thatcher was extremely unpopular in Scotland. An irony of the Thatcherite revolution was that large-scale economic change resulted in larger numbers of people in Scotland being dependent on social security benefit payments.⁴⁷⁶ By the 1987 general election the Conservative share of the vote in the average Scottish constituency was nearly 20% below what it would have been if Scotland had voted in line with Britain as a whole.⁴⁷⁷ The proportion of the professional, administrative and managerial class voting for the Conservative Party fell below 30% in Scotland.⁴⁷⁸ When the new Community Charge was introduced in Scotland in 1989, better known as the poll tax, mass resistance to the policy in Scotland issued in civil disobedience as a campaign of non-payment was launched embracing working and middle-classes.⁴⁷⁹ In the same year the Scottish Constitutional Convention was established, an association of Scottish political parties, churches and other civic groups, that drew up a blueprint for Scottish devolution. The rising support for Scottish self-government and the political struggles of the 1980s had an unmistakable impact of the activity of groups like Awareness.

Awareness member Adrienne Sinclair-Chalmers recounted that 'having come from a political and trade union background [...] myself, I thought this is the game for me! I can relate to that and so I started going to Awareness regularly'.⁴⁸⁰ Another Edinburgh activist John McDonald recalled that

In the late 70s and early 80s I was involved with politics, campaigning politics, left wing politics, anything - you name it, I'd support it. Then I began to get fed up with sort of 'what's happened with the people like me?' so I went to see [and] there was nothing. It was like there was this hidden thing. We were all supporting gay rights, we were all supporting Northern Irish prisoners [...] but nothing really for our lot and I wrote a little article for an independent Labour pub in the late '80s and that was about mental health and why isn't it included and I wrote an article for Socialist Organiser which was a paper I

⁴⁷⁶ T.M. Devine, *The Scottish Nation 1700-2007* (London: Penguin, 2006), p. 599.

⁴⁷⁷ David Butler and Dennis Kavanagh, *The British General Election 1987* (London: Palgrave Macmillan, 1988), p. 162.

⁴⁷⁸ Ronald J. Johnston, Charles J. Pattie and John G. Allsopp, *A Nation Dividing? The Electoral Map of Great Britain, 1979-1987* (London: Longmans, 1988), p. 142.

⁴⁷⁹ See Michael Lavalette and Gerry Mooney, "'No poll tax here!': The Tories, Social Policy and the Great Poll Tax Rebellion, 1987-1991", in *Class Struggle and Social Welfare*, ed. Michael Lavalette and Gerry Mooney (London: Routledge, 2000), pp. 199-227.

⁴⁸⁰ Adrienne Sinclair-Chalmers interviewed by Jim McGill, June 2009, OMH/1/3.

supported at the time but there was nothing really around. I read an article in the Guardian I think about Survivors Speak Out and I heard it had been launched and I heard what it was doing and there was a guy called Mike Lawson and he'd been involved in [...] the Mental Patients Union in London, which I'd never heard of [...] so I met [...] Mike Lawson and [...] Peter Campbell [at a meeting in Edinburgh]. They were the sort of leading lights.⁴⁸¹

Graham Morgan noted that he did not come from a political, trade union or campaigning background, but in 1983 he had joined a voluntary organisation 'aimed at getting young people out of psychiatric hospitals into their own accommodation in the city of Sheffield'.⁴⁸² After 'increasing democratisation within that organisation volunteers and users began to have an increasing say'.⁴⁸³ A 'user-run drop in or crisis service for young people', McMurphy's, was set up, named after the central character in the Ken Kesey novel *One Flew Over the Cuckoo's Nest*.⁴⁸⁴ He recalls how after he moved to Edinburgh in the late 80s

I'd been directed towards community development and I had no idea what it was. I had no idea what group facilitation was, I had no idea about anything left, right or centre, except we were trying to get groups of people to change the world. And the more we could do it together the better it would be. But in the initial days it was a wonderful buzz of activity and talking and rushing around and feeling that everything was going to change.⁴⁸⁵

Awareness sought funds from local voluntary organisations. Early on the group identified that members had different needs and that there was a lack of clear direction. But it continued to meet for five years and served mainly as a forum for discussion and would become the launch-pad for campaigns on local mental health issues in Edinburgh. Soon after Awareness started up, developments elsewhere in Edinburgh lent encouragement to the people in this small group to branch out. Royal Edinburgh Hospital had approached EAMH to look at running a Patients Council. For Be Morris 'everything seemed to be going off in tandem. There was a lot happening at once. It was a very busy and active period with lots of people going to different meetings and setting stuff up'.⁴⁸⁶ On reflection Shulah Allan commented that EAMH

wasn't that big, but in a way it was quite powerful because I had all the doors open [...] it's always been my view that you can't give people power they have to take it from you [...] my job was to help people take that power back. They had to take it, I couldn't take it for them [...] But just to set up the environment where people could and then let it fly.⁴⁸⁷

According to Murray, 'Awareness met regularly in a dingy little room in EAMH. And we smoked and shouted and argued and generally had a really good rant. Then we went to the pub and did more of it and went home exhausted'.⁴⁸⁸ Anne Bardsley highlighted the significance of having a space in which she felt comfortable and relaxed:

⁴⁸¹ John Macdonald interviewed by Jim McGill, October 2009, OMH/1/10.

⁴⁸² Morgan, OMH/1/2.

⁴⁸³ Ibid.

⁴⁸⁴ Ibid.

⁴⁸⁵ Ibid.

⁴⁸⁶ Morris, OMH/1/5.

⁴⁸⁷ Allan, OMH/1/6.

⁴⁸⁸ Murray, OMH/1/4.

The other place we met was a little place called Contact Point, and it had a wee fire, I remember it had armchairs and a wee fire and a wee kitchen. It was like a real fire. It was a nice wee cosy place and it was a nice wee happy place, and you could just actually relax there.⁴⁸⁹

Likewise Awareness member and voluntary sector worker Jeff remarked on the significance of having a 'meeting place':

Contact Point, you know, the Barony, was a kind of meeting place that gave comfort, gave a bit of support, gave a bit of warmth, gave a bit of human dignity, a bit of real human concern, interaction, no pressure, come if you want, sit down and say nothing if you want, get a heat by the fire, have a cup of tea, have a blether, don't have a blether, read a book, have a game of chess, don't have a game of chess. So it was kind of about choice, you know, 'I want to come here and fester in the corner' and 'I dinnae'. In those days you could smoke in public buildings [laughter], so folk came and just sat and had a fag and enjoyed it and liked the company and then maybe they'd been coming for weeks or months and kind of started to speak about things.⁴⁹⁰

Such spaces were the concrete embodiment of what Erving Goffman called 'geographies of licence [...] places pervaded by a feeling of relaxation and self-determination'.⁴⁹¹ Though, he spoke of such spaces in the context of the asylum. Like the GAMH resource centre in Glasgow, these community spaces which EAMH made available to the Awareness group offered a place where its members were able to speak about issues which affected their lives, particularly around their contact with psychiatric and mental health services. Also like the Glasgow group, Awareness was open to outside support and influence from national and international activist groups. Awareness members attended a lecture at the Edinburgh Filmhouse in 1990 given by American activist and author of *On Our Own*, Judi Chamberlin. Murray was astounded at the reaction of the audience to her presentation. Reflecting on the occasion, he said

the first thing I ever saw about user controlled services [was] Judi Chamberlin [when] she came to the Filmhouse to give a talk. The room was full of consultants [...] just about every consultant [psychiatrist] at the Royal Ed[inburgh] was there. And this woman just talked away. And she was fantastic, absolutely brilliant, she was extremely radical and no fire and brimstone about her, and you're kinda sitting there and she had that American way of just kind of taking you along with her, and it's not until the end do you realise you've gone on this journey and you've ended up thinking, absolutely get rid of the professionals altogether. The only way for this to be done is for people to use the services themselves. That was her message and at the end of it all those consultants got up and gave her a standing ovation. 'What is going on?' It was so bizarre.⁴⁹²

Around a year after Awareness was established it was

being asked to represent users on all sorts of different committees, consultations, 'what do you think of this before we do it?' We really needed to look at getting something more organised and structured. So Awareness and at the time the Lothian Mental Health Forum [for voluntary organisations] got together and put a funding proposal together to form CAPS [Consultation and Advocacy Promotion Service].⁴⁹³

⁴⁸⁹ Anne Bardsley interviewed by Terry Burgoyne and Kirsten Maclean, July 2009, OMH/1/1.

⁴⁹⁰ Jeff, OMH/1/8.

⁴⁹¹ Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (New York: Anchor Books, 1961), pp. 230-231.

⁴⁹² Murray, OMH/1/4.

⁴⁹³ Morris, OMH/1/5.

Another member, Adrienne Sinclair Chalmers, emphasised that

Awareness was a small group of people. It knew it was basically self-appointed [...] and this was the time that Care in the Community was coming in and it was just getting absolutely inundated with consult on this consult on that and can you send someone to this meeting and someone to be a member of this group and it couldn't cope.⁴⁹⁴

Murray recalled that by 1990 'it was the amount of requests that were coming in to Awareness, that's where the thinking started that maybe there was a need for an organisation that can consult on things. That was the very beginning of CAPS'.⁴⁹⁵ Awareness members discovered that local authorities and health boards were increasingly expected to consult patients on the health and social services they received as a result of the Community Care Act in 1990: 'we found that suddenly listening to the service user's voice had become paramount in terms of lots of different people's funding applications, and Health and Social Work [authorities] were all being told they had to listen to the service user's voice'. Reflecting on this period, Shulah Allan commented that

[I was able to] put in EAMH resources, skills [...] working with people to get CAPS going. At the same time I was invited [...] to go and set up a Patients Council at the Royal Ed[inburgh Hospital] [...] it all started to intermingle because we all started to go on each other's committees.⁴⁹⁶

3.9 Conclusion

Local, national and international mental health associations like WFMH, MIND, SAMH, GAMH and EAMH played a significant role in fostering an environment where psychiatric patients could speak out and take action from the late 1970s onwards. Energetic workers, including social workers and voluntary sector workers, worked through mental health associations to support the development of social clubs, self-help groups, pressure-group activities and discussion groups. They did this by promoting a discourse of advocacy and empowerment, and by opening up physical spaces to 'consumers', 'recipients' and 'service users', facilitating the emergence of new 'terrains of resistance' and 'geographies of licence', where patient activists could converge, from local drop-in centres to international conference platforms. These spaces of convergence facilitated and engendered processes of solidarity, communication, information-sharing, networking and resource mobilisation. By the end of the 1980s Scotland was a country in which the asylum spaces created in the 19th century still dominated the landscape of mental health services. Scottish activists, supported by local, national and international mental health associations were becoming increasingly angered by the fact that, beyond the hospital, there was little help available to patients and ex-patients. Individuals working through the voluntary sector, especially Huw Richards, Colin Murray, Be Morris and Shullah Allan, were important figures in the promotion of advocacy in

⁴⁹⁴ Sinclair-Chalmers, OMH/1/3.

⁴⁹⁵ Murray, OMH/1/4.

⁴⁹⁶ Allan, OMH/1/6.

Scotland in the 1980s, but this was only the beginning of the journey for many. These allies would be crucial in the continued development of activism at a local and national level in Scotland into the 1990s.

The creation of pockets of 'post-asylum spaces' available through voluntary sector organisations provided a base for groups to organise their activities in a supportive environment. The informality and absence of rigid hierarchy encouraged a relaxed atmosphere in which people related to each other as equals and not as objects of charity. LINK and Awareness were the two small activist groups in Scotland which participated in a new wave of activism in the UK during the 1980s. The Glasgow group in particular pioneered patient involvement in the MIND conferences, which were principal spaces of convergence for activists and their allies in the 1980s prior to the formation of SSO and the emergence of local action groups and patients' councils across the UK. The discourse employed by the Glasgow group focused on the importance of self-help and consumerism chiming with the Thatcher government ideology, but also highlighted the shortcomings of the under resourced statutory mental health service. The Edinburgh group emphasised the imbalance of power between psychiatrists and their patients. Whilst other local groups in the UK were engaged in promoting innovative practices, Roberts is right to draw attention to the significance of the LINK group's appearance at the MIND conference in 1984. This was a significant event in the development of the national movement which created SSO in 1986. The Glasgow group had demonstrated the value of bringing their message to a national audience and their capacity for public speaking on political issues. Speaking out publically and making a case for change also demonstrated the capacity of those diagnosed mentally ill for public reasoning. Emerging action groups of patients and ex-patients began to think of themselves as people and active citizens before thinking of themselves as patients.

While the message was important, so was the medium. Advancing beyond SUMP in terms of the audiences they were able to reach, LINK and Awareness utilised the MIND conference floor, national TV, local drop-in and resource centres, the top circulation social work journal, and developed international links, at a time when they had little access to formal political structures. If Thomas Ritchie had performed a carnivalesque inversion of psychiatric power using his local knowledge of Hartwood and estimable wit, LINK and Awareness deepened the analysis of the situation of psychiatric patients in Scotland, engaging in a critical public debate about the future of public mental health services. The contact LINK and Awareness made with groups of activists beyond Scotland, from England, Europe and the US made a marked impression on them. LINK members went on to become founding members of SSO and the support and inspiration that SSO gave to people in Edinburgh helped to create the Awareness group. The names of these two groups, LINK and Awareness, to some extent reflects the role they played in the history of patient activism in Scotland. This was a period in which national and international 'links' were initiated and developed through the network of local and national mental health 'associations', which cooperated through the World Federation of Mental Health, to raise 'awareness' to take collective 'action' and

to 'educate'. New strands of discourse on power and self-determination circulated via these voluntary associations and activist groups as patient activists sought to define their identity on their own terms and demonstrate competence and rationality in the face of psychiatric and governmental authorities which intervened in their lives on the basis of their assumed irrationality and incapacity.

The increasing links between local and national associations, and between national associations from across the world, however, led patient groups to compare and contrast their fortunes with that of other groups from other places. Colin Murray reflected on his attendance with other Scottish activists at a MIND conference in the late 1980s:

We started a bit behind them [English-based groups such as SSO] but we had got ahead and things were more advanced here than they were down south. I think it was me and Be [Morris] and Anne [Bardsley] sat pounding the table, 'We are doing just as well as them. In fact we're doing better. Let's have a national conference in Scotland for users. There is something to celebrate and shout about and bring more people together'.⁴⁹⁷

Although Tam Graham and Charlie Reid were founding members of SSO, the opportunities for involvement in this network's activities were limited because most of its members were based in England and its meetings were held south of the border. While LINK and Awareness articulated concerns which were shared by many of their counterparts in England and elsewhere, they had identified issues of concern which were specific to their local areas in Glasgow and Edinburgh and to the broader Scottish policy context. Cleavages between right and left, between nations within the union state, regions within Scotland and between classes and identity groups in the late 20th century were only just beginning to commence on peripheral battlegrounds where a 'national mental health service user movement' was emerging in Scotland at the beginning of the 1990s.

⁴⁹⁷ Murray, OMH/1/4.

CHAPTER 4
THE EMERGENCE OF THE SCOTTISH USER MOVEMENT

4.1 Thatcher, Health Consumerism and the Community Care Act

The Conservative government led by Margaret Thatcher from 1979 transformed the shape of social and economic life in the UK more than any other previous administration since Clement Atlee's post-war Labour government. The situation of psychiatric patients in Scotland did not escape the Thatcherite revolution. Her governments' attacks on a 'culture of dependency' were part of a larger ideological project to 'roll back the state', to reduce public expenditure and encourage self-reliance and greater individual responsibility amongst citizens. It was in the 1980s and 1990s that the NHS as a whole was reconfigured from what Rudolf Klein described as a 'church' model to a 'garage' model, involving a shift 'from paternalism to consumerism, from need to demand, from planning to choice'.⁴⁹⁸ A major step towards reform in this direction came with the appointment in 1983 of Roy Griffiths, Director of the Sainsbury supermarket firm, to conduct an inquiry and produce a report on restructuring the NHS. In the *National Health Service Management Inquiry Report* Griffiths proposed the introduction of non-clinical, general managers into the NHS, who, in turn, would initiate consultation with consumers to 'secure the best possible services for the patient'.⁴⁹⁹ When the government acted on Griffiths' recommendations it sought to introduce a more business-like approach to managing the NHS, which would improve cost-effectiveness and efficiency.

Alex Mold has claimed that 'the tools used in the making of the patient-consumer by patient groups were co-opted by the Thatcher government and used to create a more individualised figure'.⁵⁰⁰ Mold argues that as citizens were increasingly reconfigured as consumers under the Thatcher regime during the 1980s, 'the emphasis moved from the duty of the state to provide universal coverage and towards the rights of individuals to make choices about the services that they used'.⁵⁰¹ Some activists from Glasgow LINK such as Christine Cowan employed the term 'consumer' and emphasised the importance of 'self-help', yet many of the LINK action group's proposals for reform in 1984 demanded a more activist and interventionist state, not a rolling back of the state. The language of self-help and consumerism could easily confuse however, since it seemed to play more to the Conservative government's fetishisation of individual choice than to the principle of universal coverage embodied by the institutions of the welfare state. While LINK members did seek reform to the organisational structures of mental health services, calling for joint-planning, they were more concerned with the substantive issues they encountered directly in their lives: material structures of the hospitals, overcrowding, exploitation in industrial therapy, the lack of alternative material spaces of care 'in the community', staff-patient relationships, physical

⁴⁹⁸ Rudolf Klein, *The New Politics of the NHS: From Creation to Reinvention* (Oxford: Radcliffe, 2006), pp. 253-55.

⁴⁹⁹ Roy Griffiths, 'NHS Management Enquiry 6 October 1983 (Griffiths Report)', in *National Health Service Management in the 1980s: Policymaking on the Hoof?* ed. Stephen Harrison (Aldershot: Avebury, 1994), p. 175.

⁵⁰⁰ Alex Mold, 'Making the patient-consumer in Margaret Thatcher's Britain', *Historical Journal* 54 (2011), p. 511.

⁵⁰¹ *Ibid.*, p. 510.

methods of treatment such as ECT and drugs, housing and employment opportunities, stigma and discrimination. Nevertheless LINK embodied in various forms the type of voluntary and self-help activity the Conservative Party had promoted in its 1979 election Manifesto. The Conservatives had pledged to 'do more to help people to help themselves, and families to look after their own' and to 'encourage the voluntary movement and self-help groups working in partnership with the statutory services'.⁵⁰² The direction in which reform was travelling appeared to present an opportunity for such groups, even if the intentions and objectives of the government and the mental health activists were very different.

When Griffiths was later asked by the government to produce policy proposals for community care, he described it as 'everybody's distant cousin but nobody's baby', referring to the lack of clear demarcation of responsibilities between health boards, social work departments, housing departments and private and voluntary sectors.⁵⁰³ In the 1988 *Community Care: Agenda for Action* green paper, he recommended that social work departments in local authorities should take the lead role in identifying community care needs and he urged that 'it is vital that social service authorities see themselves as the arrangers and purchasers of care services and not monopolistic providers'.⁵⁰⁴ This was the basic idea which lay at the heart of the NHS and Community Care Act of 1990 which introduced a type of internal market into health and social care services. A greater role for private and voluntary sector providers of care was envisaged in a mixed economy of care as the Act placed a statutory obligation on local authorities to plan and commission care and to consult service users in the planning of these services. Whatever opportunities the reforms of the Conservative government made possible for patient activists however, the 'mental health service user movement' or 'user movement' as it was now being called, were more inclined to look leftwards to the Labour Party to heed its demands. Director of Camden MIND and radical psychologist David Hill was successful in securing a meeting between a coalition of mental health user groups and opposition MPs in 1989 through contacts in the Labour Party.⁵⁰⁵ Over 40 people, from patients' councils, consumer networks and advocacy projects, from across the UK, including four representatives from Scotland, met Robin Cook, Shadow Health Minister and MPs Harriet Harman and Keith Vaz at the House of Commons. Patients or 'service users' made their contributions to the discussion under three main headings: 'User Involvement in Planning and Management of Services'; 'Types of Services'; and 'Political issues (minority groups, ideology of services etc.)'.⁵⁰⁶ The fact that such a meeting had taken place at all demonstrated how far collective action by psychiatric patients had come. Thomas Ritchie of SUMP had written to the Prime Minister and met with his local MP in

⁵⁰² Conservative and Unionist Party, *Conservative General Election Manifesto 1979* <<http://www.margaretthatcher.org/document/110858>> [accessed 20 April 2015].

⁵⁰³ Roy Griffiths, *Community Care: Agenda for Action* (London: UK HMSO, 1988), p. iv.

⁵⁰⁴ *Ibid.*, p. 5.

⁵⁰⁵ Jan Wallcraft, 'Report on "Labour Listens" - A meeting set up by David Hill between 40 mental health service users and Robin Cook, Shadow Health Minister at the House of Commons on Tuesday 20th June 1989', OMH/22/4.

⁵⁰⁶ *Ibid.*

1971, but by 1990 sufficient connections had developed between groups from across the UK and sufficient recognition was now being accorded to their activities that a Shadow Health Minister was willing to meet with a large delegation of activists and their allies at the House of Commons.

The language of consumerism and self-help had surfaced in the discourse of Glasgow LINK club members, yet the Glasgow group did not call for the state to cut back on psychiatric services or withdraw from its duties in relation to collective health and welfare provision. The demand was not for less state intervention, but more state planning and investment. They wanted better mental health services which met their needs and treated them with dignity. If some patients were identifying themselves as consumers, it was not simply because they subscribed to a consumerist privileging of the value of choice, or a belief that market mechanisms and competition could deliver better services for patients. By identifying as 'consumers' they sought to shake off the submissive 'sick role' of the patient. In a sense it was opportunistic to don the 'consumer' label in the circumstances. Perhaps by using the language that appealed to the reforming instincts of the government, they sought to exploit an opportunity to be taken more seriously as 'consumers' in a climate where patient choice, health consumerism, the market, self-help and voluntary action were promoted by the government. To identify as a 'patient consumer' was to position oneself as an individual with a right to self-determination, as opposed to being positioned as a passive and obedient patient. The use of the word consumer was based on the presumption that it elevated the status of the patient. Looking back on the time when he first became involved in mental health activism in the late 1980s Colin Murray remembers that, 'Thatcher was just ruling the roost at the time politically in the country and the miners had been thrashed. And yet in mental health there was this very radical opposition movement going on and everywhere else was wanting to become more consumerist, make more money, drink more champagne'.⁵⁰⁷ Murray did not see his calls for 'democracy in psychiatry' as having anything to do with 'consumerism' or the market ideology of the Thatcher government. Adrienne Sinclair-Chalmers, on the other hand believed that the 'stuff that the Tories were doing created a space where we could elbow our way in'.⁵⁰⁸

The questions and debates over the use of certain terms of self-definition indicate the extent to which activists were engaged in struggles over discourse and identity and how the symbolic battleground was concretely tied to material realities, to the socio-political context and the exercise of power by government. Foucault emphasised that discourse is neither exclusively an effect nor an instrument of power: 'discourse is not simply that which translates struggles or systems of domination, but is the thing for which and by which there is struggle'.⁵⁰⁹ Those who resisted psychiatric power and dominant discourses and practices of mental health care from the 1970s onwards, started to challenge the terms which psychiatry and society used to describe them. Peter

⁵⁰⁷ Colin Murray interviewed by Phil Barnard, August 2009, OMH/1/4.

⁵⁰⁸ Adrienne Sinclair-Chalmers interviewed by Jim McGill, June 2009, OMH/1/3.

⁵⁰⁹ Michel Foucault, 'The order of discourse', in *Untying the Text: A Poststructural Anthology*, ed. Robert Young (Boston: Routledge & Kegan Paul, 1981), pp. 52-3.

Campbell claims that 'user/survivor action is often significantly different from mainstream self-help work because of its concentration on social, structural and political change rather than individual change'.⁵¹⁰ As Roy Porter remarked, psychiatric patients are often 'deeply conscious of having been made to feel different' with 'a sense of being rendered a non-person'.⁵¹¹ The 'walled and locked asylum [...] underscored the difference'.⁵¹² In response patients stake 'counter-claims, to shore up that sense of personhood and identity which they feel is eroded by psychiatry and society'.⁵¹³ But even within the emerging 'user movement' in the late 1980s and early 1990s there was a range of views on the appropriate use of language of self-definition. 'Consumer' was a term which gained some traction in the 1980s, but was quickly opposed by terms such as 'recipient', 'survivor' or 'service user'. 'Recipient' was chosen because it was said to underline the 'passive or involuntary nature of many people's relationship with services'.⁵¹⁴ 'Consumer' was criticised as giving a 'false impression of the power, freedom and choice service users actually exercise'.⁵¹⁵ 'Survivor' was felt to convey 'a definite criticism of services, emphasising the obstacles individuals have to overcome in their lives' but was also disliked by some activists for being 'too negative and confrontational'.⁵¹⁶ 'Service user' became the definition of choice for most UK activist groups, particularly in Scotland, perhaps because it was perceived as a neutral term which was less politically or value-laden. The term 'service user' did seem to capture the fact that while many activists may have wanted to tear down the system, or have nothing to do with it at all, their pragmatism won out because many could not or would not escape their contact with it. They were campaigning for change to services to be of better use to them by meeting their needs.

The NHS and Community Care Act was unusual in that it applied to Scotland, as well as other parts of the UK, unlike Mental Health Acts over the previous century when separate legislation was enacted for Scotland, usually a year after the rest of the UK. However it was around this time that a distinctly Scottish movement of user activists began to emerge and largely separated from the activities of the rest of the UK movement, despite the involvement of Scottish activists in the founding of Survivors Speak Out (SSO) during the 1980s. The final decade of the 20th century saw the emergence of a wide range of local and national groups, including a new national users' network in Scotland. The rest of this chapter will explore the emergence and development of the network and the discourse of advocacy which activists used to articulate demands and outline strategies for campaigning in Scotland. By taking the expressed views of user activists as the main

⁵¹⁰ Peter Campbell, 'The history of the user movement in the United Kingdom', in *Mental Health Matters: A Reader*, ed. Tom Heller, Jill Reynolds, Roger Gomm, Rosemary Muston and Stephen Pattison (London: Palgrave, 1996), p. 220.

⁵¹¹ Roy Porter, *A Social History of Madness: Stories of the Insane* (London: Phoenix Giants, 1996), p. 25. (First published by Weidenfeld & Nicolson, 1987).

⁵¹² *Ibid.*

⁵¹³ *Ibid.*

⁵¹⁴ Peter Campbell, *Some Things You Should Know About User/Survivor Action* (London: MIND, 2006), Guide 1.

⁵¹⁵ *Ibid.*

⁵¹⁶ *Ibid.*

reference point of analysis I draw heavily on witness testimonies from oral history interviews and examine the documentary archives of user groups and advocacy organisations, to reveal the dynamic relations and tensions between individuals and organisations and the discourses and spaces which mediated, linked and divided them. What emerges is an account of the process of collective identity formation and the patterns of cooperation and contestation which characterised the myriad family resemblances and differences within the movement in the 1990s.

4.2 The Emergence of the Scottish User Movement

In the wake of the Community Care Act there was an expectation that users would participate in planning, monitoring and evaluation of services. Awareness member Ann Bardsley, who was also on the management board at SAMH, stressed that this was a major turning point for groups 'trying to achieve being noticed, actually saying, "We're here, we belong in the community". Community Care Act had just come in. They're saying they wanted consultation with service users. We're saying 'Right we're here, listen to what we've got to say'.⁵¹⁷ But while a sense of momentum was felt by activists there was also hesitation at the prospect of treading such uncharted territory.

Bardsley recalled that

Even when people were asking us what we wanted we didn't know, because we'd never been asked before. We'd never been asked what services we needed [...] We'd never been asked: do we need administrative back up, do we need the use of telephones, do we need the use of a photocopier? We'd never had time to think out all the things we needed, or what services we'd like to see implemented. And this was a brand new concept of being asked, whereas up until this point in time you were told. Now you were asked—totally different area.⁵¹⁸

Similarly, another member of Awareness recalled that in the beginning the group was 'struggling to work out what to do'.⁵¹⁹ Following the emergence of local groups in Scotland such as the LINK clubs in Glasgow and Awareness in Edinburgh and the establishment of the UK national network Survivors Speak Out (SSO), some Scottish activists were encouraged by their allies in the voluntary sector to work towards developing a national network in Scotland. One of the foremost proponents of a national group was Huw Richards, by this time a social work commissioner at MWCS and head of a committee on 'self-help in mental health' at the European Regional Council of the World Federation for Mental Health (WFMH), having left LINK/GAMH earlier in the decade to work as an advisor at the Scottish Office.⁵²⁰ Shulah Allan remembered that 'staff got the notion of setting up some sort of national organisation [...] to promote the user movement in Scotland. And that was when SUN [Scottish Users' Network] started [...] and that was very much

⁵¹⁷ Anne Bardsley interviewed by Terry Burgoyne and Kirsten Maclean, July 2009, OMH/1/1.

⁵¹⁸ Ibid.

⁵¹⁹ LR interviewed by Kirsten Maclean at various times in 2009, OMH/1/73.

⁵²⁰ Josée Van Remoortel, *History of Mental Health Europe 1985-2010* (Brussels: Mental Health Europe-Santé Mentale Europe, 2010), p. 17.

supported by this guy [Huw Richards] at the Mental Welfare Commission'.⁵²¹ But according to Allan 'nobody thought it was worth a candle. It was far too big to work. It was never going to work to have a sort of national Scottish movement, ridiculous'.⁵²² Scottish Users' Network (SUN) formed at a meeting in Perth in 1989 and early on obtained funding for a year from the Unemployed Voluntary Action Fund to cover the cost of travelling expenses for members to attend conferences and other events across Scotland to promote the new network. A constitution was adopted which limited membership to individuals and excluded organisations in order to prevent a single local user group from dominating the national network. SUN aimed to bring

an independent voice of users and ex-users of mental health services in Scotland, through which people can exchange information, give mutual support and raise public awareness of mental health issues, promote the civil, legal and human rights of people who have been labelled, diagnosed or treated as mentally ill [and] provide the opportunity for people to be in contact with colleagues throughout the country. It is a forum for discussion of issues and the concerns of Users. SUN will cooperate with all in setting needful priorities for Action. The development of SUN as a major User Movement is based on local groups linking into the SUN National Network.⁵²³

Colin Murray commented that 'Huw [Richards] [...] was very slick, cruised around in government circles and all that jazz, but he was very sympathetic to the stuff that was going on. He saw the advocacy bit right away. Got it in ways other people didn't'.⁵²⁴ Richards was aware of some of the dangers, as well as the opportunities, which flowed from the reorganisation of mental health care and increased user involvement. Murray remembered how Richards 'wrote [...] off his own back, these two sides of A4 about how to resist incorporation'.⁵²⁵ In this document, which had the title 'Beyond Tokenism- Some Thoughts for the Scottish Users Network', Richards explained:

'Tokenism' I take to be the process by which any minority interest (ethnic, religious, gender based, and in this context psychiatric patients and users of mental health services) is included within processes of decision-making of culturally powerful institutional structures in such a way that their inclusion becomes purely symbolic. The voice of the minority interest though loud remains structurally no more powerful or effective than it was before its inclusion. 'Tokenism' is a form of exchange of counterfeit currency; it is making an effort but doing no more than is minimally necessary, i.e. it is a hollow gesture. Lord Acton's famous phrase that 'power corrupts but absolute power corrupts absolutely' can be appropriately rephrased particularly in the light of Marcuse's concept of 'repressive tolerance' as 'power co-opts, and absolute power co-opts absolutely'. In short 'tokenism' is seen as both inclusive and neutralizing [...]

The attraction of becoming in even a token way part of the 'system' also concern our needs, the real, specific human needs for welfare through change and betterment, yet as Marcuse again notes, 'how we can satisfy his needs without hurting himself, without reproducing through his aspirations and satisfactions his dependence on an exploitative apparatus which in satisfying his needs perpetuates his servitude'.⁵²⁶

⁵²¹ Allan, OMH/1/6.

⁵²² Ibid.

⁵²³ Scottish Users Network Information Leaflet, OMH/16/1/13.

⁵²⁴ Murray, OMH/1/4.

⁵²⁵ Ibid.

⁵²⁶ Huw Richards, 'Beyond Tokenism- Some Thoughts for the Scottish Users' Network', OMH/16/10/1.

Richards' reference to Herbert Marcuse's concept of 'repressive tolerance' and Murray's reading of the anti-psychiatrists demonstrates the extent to which the thought of the New Left and anti-psychiatry from the 1960s could still permeate the discourse of those who initiated user groups in the 1980s. Marcuse had been a speaker at the 1967 Dialectics of Liberation conference organised by the 'anti-psychiatrists' his thought chimed unmistakably with the counter-cultural spirit of the 1960s. Better known nowadays as a 'cultural Marxist', Marcuse's concept of repressive tolerance has been implicated in controversial contemporary debates around 'safe spaces' and 'no-platforming' of speakers at university events because of his apparent advocacy of the suppression of free speech.⁵²⁷ In his essay 'Repressive Tolerance', Marcuse wrote that '[repressive tolerance] strengthens the tyranny of the majority' and he warned that government 'tolerates opposition within the framework determined by the constituted authorities'.⁵²⁸ He proposed an alternative 'liberating tolerance', which 'would mean intolerance against movements from the Right and toleration of movements from the Left' and, he asserts that 'the exercise of civil rights by those who don't have them presupposes the withdrawal of civil rights from those who prevent their exercise'.⁵²⁹ Marcuse's ideas found favour on the Left in Britain, but not on the Right.

Richards and Murray did not regard themselves as children of Thatcher and were aware of the potential dangers of users being co-opted into government and professional agendas, or being tamed by a 'framework determined by the constituted authorities'.⁵³⁰ Richards and Murray themselves were mental health 'workers', not 'users'. The tensions which could exist between 'users' and 'workers' were becoming increasingly apparent at the beginning of the 1990s. The U.S. 'mental patient liberation movement' leader Judi Chamberlin travelled around the world during the late 1980s and early 1990s, stopping off in Edinburgh in 1990, to bring the message of 'separatism', user-only groups and user-controlled services. Murray remembers that

the tensions were that the workers were not necessarily trusted [...] And to be a worker, at that you just had to accept that why should somebody trust you right off. And that was something you had to earn [...] I think that the user only is probably the best way to go, but without allies it wouldn't have happened, it's that straight forward [...] Of the allies there were a core of four or five of us [...] we'd sit in the pub and have long conversations about what our role would be and how we did not want to get into that business of just mirroring power relationships that people were really suffering from. So there was lots of soul searching on our part. How do we do this, we need to be careful, can we say this, can we say that, should we push it or can we stand back?⁵³¹

⁵²⁷ Much scholarly work has been conducted on 'Cultural Marxism', but the term has become part of more popular parlance due to the use of the term by right-wing critics, particularly the American paleoconservatives, Pat Buchanan and William S. Lind. See Lind's widely delivered speech 'The Origins of Political Correctness' 5 February 2000 at < <http://www.academia.org/the-origins-of-political-correctness/> > [accessed 5 May 2015]. See also Dennis Dworkin, *Cultural Marxism in Postwar Britain: History, the New Left, and the Origins of Cultural Studies* (Durham, NC: Duke University Press, 1997).

⁵²⁸ Herbert Marcuse, 'Repressive Tolerance', in *A Critique of Pure Tolerance* eds. Robert Paul Wolff, Barrington Moore, Jr., and Herbert Marcuse (Boston: Beacon Press, 1965), pp. 82-83.

⁵²⁹ *Ibid.*, p. 110.

⁵³⁰ *Ibid.*, p. 83.

⁵³¹ Murray, OMH/1/4.

Despite not being a 'user' himself, it was the perceived radical separatist, or user-only agenda of SSO which had inspired Murray and which had so impressed him about the message which Judi Chamberlin had brought to an Edinburgh audience in 1990. Of SSO he said:

It was user only, and was very radical, they weren't taking prisoners. 'This is what we need. We need it now. If you are not going to give us it we'll ignore you and get on with people who will help us', is the polite way of putting it. They were far more, very, radical some of them, very anti-worker at times. But what you'd expect with what had happened to people. That [...] was quite a hard thing as a worker. For a lot of workers that put them off.⁵³²

Anne Bardsley observed that

most of the voluntary organisations were our allies [...] it was very much a 'them and us' situation at the time. And it was the professionals within the hospital and you've got your statutory organisations [...] They were run by a medical model. Now outside of that there wasn't a medical model.⁵³³

Pioneers of the groups in Glasgow who were not themselves 'users' regarded themselves not so much leaders of a new movement, but 'allies'. Colin Murray, Be Morris, Jeff Frew, Huw Richards and Shulah Allan, none of them patients or ex-patients, stressed that advocates should be independent of professionals or workers of health and social services. User activists such as Graham Morgan and Anne Bardsley could be regarded as having crossed the user/worker divide, having become paid workers with user-led advocacy projects. Jim McGill, a user who also became a paid advocate in Lothian in the 1990s remembers that at times there were 'accusations of just selling out and just becoming part of the thing that we were questioning, the services [...] the system'.⁵³⁴ He explained that

There's always been an issue [...] that if we're encouraging service users to go into employment or to become paid advocates for example [...] does that change the balance of things? Do they then become seen as something else and then we're creating another level of them and us stuff — 'he used to be a service user but he's a paid advocate now'.⁵³⁵

Murray recalled that

Mental health officers were saying but [...] we're the advocates, nurses were saying we're the advocates for people. Well, no, you are part of the problem actually. Folk didn't like hearing that. There were probably more sophisticated ways we could have gone about saying that. But at that time we didn't care and that possibly alienated some potential allies [...] We weren't taking prisoners.⁵³⁶

When the Consultation and Advocacy Promotion Service (CAPS) was formed in Edinburgh in 1991 to support the development of a forum for local users and to promote advocacy in the Lothian region it soon had its own office space. Shulah Allan saw the physical separation of CAPS from

⁵³² Ibid.

⁵³³ Bardsley, OMH/1/1.

⁵³⁴ Jim McGill interviewed by Phil Barnard, May 2009, OMH/1/36.

⁵³⁵ Ibid.

⁵³⁶ Murray, OMH/1/4.

EAMH with its own concrete material space as a significant development, symbolising the growing independence of users from the association:

I think for the first time people got that opportunity, people physically had a place like this which wasn't EAMH or Penumbra [mental health charity], it was actually theirs. That was so important. A space that's yours. When you walk in the door you are the important person, there for you and what you need.⁵³⁷

Awareness member Graham Morgan became a paid project worker with CAPS and around the same time Anne Bardsley became the first national advocacy worker for SAMH, both tasked with promoting the development of advocacy and user groups at regional and national levels respectively. Awareness continued to meet well into the 1990s with changes of personnel along the way, even after it had contributed to the rapid expansion of a network of groups in the Lothian region through the creation of CAPS. Morgan set out to develop a Lothian-wide 'users forum', bringing together existing groups and helping to facilitate service user participation in consultation with government and health authorities. According to Sinclair-Chalmers, the Lothian User Forum (LUF), established in 1992, was 'an extremely broad church':

I don't think I've ever come across a wider cross section of folk as I have in Edinburgh, well the then Lothian Users Forum. Really different backgrounds, there were people who had been in hospital for decades, there were people who dipped in and out, there were people who had never been in hospital. It [...] just made all that stuff about the way that the services pigeon hole people [...] so damned irrelevant.⁵³⁸

Morgan remarked that voluntary sector allies such as Murray, Morris and Allan

facilitated us doing things but they quickly made sure we took control. So they were just ready for us to do something, just yearning for us to be there. As soon as we were there, they let us do things. We found it a bit confusing sometimes that they just wanted us to do it rather than do it for us.⁵³⁹

The Awareness group continued to meet after the emergence of CAPS and LUF but at a meeting in March 1993 it was suggested that 'Awareness could be the think tank of the forum, in other words it could be for [the forum] what the Fabian Society are for the Labour Party'.⁵⁴⁰ Discussion and debates within the group often dealt with issues affecting service users more generally, as well as specific local concerns. There was a great appetite for critical analyses of the broader social and political situation in which service users found themselves. Those who participated in the formation of SUN, like the founders and members of LINK, Awareness, CAPS, the Royal Edinburgh Hospital Patients' Council (REHPC) and LUF, gained encouragement and inspiration from the contact they had made with U.S., European and English activists at the 1985 World Mental Health Congress, at MIND conferences and from the subsequent formation of SSO. Members from LINK, Awareness and the Westfield Association (formerly the Dundee MPU) were involved in the early

⁵³⁷ Shulah Allan interviewed by Kirsten Maclean, May 2010, OMH/1/6.

⁵³⁸ Sinclair-Chalmers, OMH/1/3.

⁵³⁹ Morgan, OMH/1/2.

⁵⁴⁰ Awareness meeting minutes, 8 March 1993, OMH/3/2.

meetings of SUN. The creation of this national group by a coalition of local activists was intended to build a distinct national movement by developing connections across Scotland and supporting the emergence of new local groups in places where they did not exist. Activists and their allies in the voluntary sector sought to organise conferences in Scotland on specifically Scottish concerns, having been inspired by the level of national coordination achieved in countries as different as the US and the Netherlands. It seemed useless to speak only to a largely English audience at MIND about the specificities of problems in Scotland which did not concern them. It was not practical or affordable for the unemployed or low-paid to travel to England on a regular basis to link up with SSO and other local groups south of the border when mental health services in England and Scotland were separately administered and governed by a different legal framework. To Scottish activists it seemed that if they were to effect change to mental health services in Scotland, they would have to develop a distinctly Scottish national user network.

4.3 Discourse of Self-Advocacy

In her post at SAMH Anne Bardsley produced a report on the state of mental health advocacy in Scotland and described how the SAMH national advocacy project sought to advance the discourse and practice of advocacy through Scotland. She travelled around the country during 1991 to meet with patients' councils and existing local advocacy projects and user groups. An information booklet promoting advocacy and empowerment was produced and circulated around Scotland. She wrote that

Once a diagnosis of mental illness is made by professionals, the user is often swept along in a process over which he or she has little control [...] The assumption is made that the user is incapable of thinking rationally or making decisions [...] After twenty or thirty years in hospital many are being discharged under the banner of 'care in the community' but with no consultation or choice about where to live or who they live with [...]

Advocacy in its various forms offers users of mental health services a way to fight against a system which disempowers them in the name of treatment. For many users, it is other users and ex-users who offer the best support and advice. If users are to develop their own power, individually and collectively, they need support, contacts, information and resources [...] By making contacts, linking people together and promoting good practice the project is moving advocacy up the agenda [...] A promising start has been made – but there is clearly a long way to go before all users are treated as citizens with rights rather than just bodies with symptoms.⁵⁴¹

Advocacy is needed because many people cannot speak up for themselves [...] Many are marginalised within society, not taken seriously, often dehumanised by institutions and have little control over decisions taken which affect their lives—they are disempowered.⁵⁴²

⁵⁴¹ Anne Bardsley, 'Preface', in Scottish Association for Mental Health (SAMH), *Advocacy Report* (Edinburgh: SAMH, 1991).

⁵⁴² Scottish Association for Mental Health (SAMH), *Advocacy and Empowerment: A User's Guide* (Edinburgh: SAMH, 1991), p. 5.

'Empowerment' was emphasised as an important component of advocacy, because it enabled 'people to take the opportunity to regain power over their own lives while recognising the imbalance of power'.⁵⁴³ From the late 1980s onwards user activists conceived of their collective action explicitly in terms of an attempt to alter power relations between psychiatrists and patients, between the state and citizens, by 'fighting the system' and improving their capacity for autonomous action and self-determination. Peter Campbell noted the 'fundamental pragmatism of user/survivor action in the 1980s and 1990s' and 'the tendency [of user groups] to promote and prioritise self-advocacy (people speaking out and acting for themselves) rather than to establish coherent positions on important issues or coordinate unified programmes for action'.⁵⁴⁴ The discourse of advocacy was capacious enough to include a wide range of views, giving people the opportunity to exercise free speech and express their own individual views without feeling the need to toe a party line. However as Campbell observed, activists were also 'united by common and devalued experiences and a desire to reformulate that experience and use it to improve the status and living conditions of people diagnosed as being mentally ill'.⁵⁴⁵ In Scotland the action undertaken by SUN, by Anne Bardsley through the SAMH advocacy project and by Graham Morgan through CAPS, did involve something of an attempt to 'coordinate unified programmes of action' at local, regional and national levels in Scotland. Reflecting on differences between Scotland and England in 1991, Bardsley opined that:

Users in England seem to have greater access to funding, to attend planning meetings, produce literature, and to attend and deliver training courses. Users in England certainly seem to speak at more conferences, lead more workshops, give advice to more projects and to have a louder and more articulate voice. One reason for this may be that Scotland still has more patients in hospitals per head of population than England. The user movement in Scotland has still to be formally recognised and accepted as a legitimate, articulate movement which can help to shape future services for mental health service users.⁵⁴⁶

There was a sense amongst those who attended the meetings in Edinburgh at the end of the 1980s, such as Colin Murray, Be Morris, Shullah Allan and Anne Bardsley, that Scotland has been on the periphery of user action until Awareness, CAPS and SUN came along. This highlights the extent to which groups in one locality could be either unaware, or dismissive, of what had been achieved by groups in other parts of the country. When Murray called the Edinburgh 'Democracy in Psychiatry' meeting in 1988, people from other parts of Scotland, including Glasgow, came along. He remembers that

the Glasgow people [...] already had some stuff going on, I mean, Glasgow Association for Mental Health had some drop-in services or something that had some sort of user involvement about them, so they [...] already got into it just as part of [an] accumulated development approach to mental health, not necessarily politicised.⁵⁴⁷

⁵⁴³ Ibid., p. 7.

⁵⁴⁴ Campbell, 'The history of the user movement in the United Kingdom', p. 222.

⁵⁴⁵ Ibid.

⁵⁴⁶ Ibid., p. 5.

⁵⁴⁷ Murray, OMH/1/4.

Allan claims that in the early days SUN

had such a Glasgow bias [because] there was no localised user movement going on in Glasgow. I mean GAMH said they were, but I don't think they were and that's why a lot of people got involved in SUN because it was the only way they could be involved in the user movement and development.⁵⁴⁸

Insofar as the LINK clubs were started years before the Awareness group by professionals and had been dependent on the local mental health association, Murray was correct. Allan was referring to the fact that around the time SUN came into being many of its members were drawn from Glasgow, former members of LINK who had become disillusioned with the relationship between GAMH and LINK and became more involved with SUN. However, the irony is that Allan and Murray were not themselves users and they, as workers, considered themselves to have been instrumental in the development of collective action in Edinburgh by Awareness and other user groups. Murray himself had said that without allies 'it wouldn't have happened'.⁵⁴⁹ There is however some reluctance by Murray and Allan in these comments to acknowledge that LINK's dependence on GAMH and voluntary workers for support was equivalent to the dependence of Awareness and CAPS on EAMH and their workers for similar support. Anyone who had heard, seen or read about the 1984 MIND conference presentation by LINK members could not have been in any doubt that this Glasgow group had been 'politicised', even if their politicisation was the result of an 'accumulated development approach' initiated by professionals or workers. At the turn of the decade the identity politics of the user movement in Scotland entered a new local-national dynamic, as local contexts of activism and resistance interplayed with broader national processes. There was a growing awareness of opportunities for national and transnational collective action. But the user movement was also shaped by territorially-defined group identities and regional geopolitics and groups often defined themselves and their activities against what groups in other places were doing, whether in Scotland, England, or elsewhere.

The discourse of advocacy was in the ascendancy at the beginning of the 1990s, but the grievances which motivated people to take action remained much as they had for SUMP in 1971 and for LINK in 1984. Adrienne Sinclair Chalmers, who was an active member and worker in user groups in Lothian throughout the 1990s and into the 2000s, reflected that 'what we had in common was that we weren't getting treated very well by psychiatric services, just some basic things like nobody ever listened to a damn thing you said'.⁵⁵⁰ Another activist with LUF and REHPC, Maggie Keppie, 'could see there were things wrong with the way people were getting treated and the way the hospitals were run. Basically if you had a mental health problem you were a second-class citizen'.⁵⁵¹ Another activist summed up the general concerns of individuals who became involved in user groups at that time:

⁵⁴⁸ Allan, OMH/1/6.

⁵⁴⁹ Murray, OMH/1/4.

⁵⁵⁰ Sinclair-Chalmers, OMH/1/3.

⁵⁵¹ Maggie Keppie interviewed by Jennifer Booth, July 2009, OMH/1/9.

I wanted to see change. I didn't think the services were good enough. There was nothing after discharge from hospital. Psychiatrists were not listening, there was no emotional support. It was very isolating coming out of hospital and also isolating being in hospital. Being in hospital makes you ill and then coming out makes you isolated then that made you ill. Round and round in circles. I felt that it wasn't just me, that other people probably felt the same.⁵⁵²

For Sinclair-Chalmers, 'It was such a big achievement getting everyone together in the first place. It was something that we had to work out for ourselves and we had to establish our identity, because we didn't know who we were because it hadn't been done before'.⁵⁵³ By 1989 local and national groups of activists in the UK increasingly came to think of themselves as participating in an international 'movement'. And the emerging national movement in the UK had its leading figures.

As Scottish activist John Macdonald had remarked, Peter Campbell was regarded as a 'leading light' of the UK movement.⁵⁵⁴ Campbell was a main contact for activists across the UK through his role as Secretary of SSO. He quickly established himself as a leading figure in the UK movement in the late 1980s through his involvement in founding SSO, through his appearance on and scripting of the Channel 4 docudrama *We're Not Mad... We're Angry*, and later through his lucid writing on mental health in journal articles, book chapters and his involvement with Survivors Poetry. Campbell grew up in Scotland, but spent most of his adult life in England. He was 17 years old when he was first admitted to Royal Liff Dundee Hospital in 1967, shortly after he arrived at Cambridge to study history.⁵⁵⁵ In the late 1990s he remarked that going into a psychiatric hospital

was an eye opener for someone like me coming from an upper middle class background to suddenly go into this ward, which was basically serving Dundee, with a lot of working class people with different lifestyles altogether from me [...] I was the youngest [...] and the other patients were extremely kind and supportive to me, and two or three of them kind of befriended me and it was ok [...] It's one of my stays in psychiatric hospital that I look back on without any particular anger or horror. I mean basically it was a reasonable experience.⁵⁵⁶

Decades on from this first 'reasonable experience' of hospital Campbell described himself as a 'survivor':

I do feel that I'm a survivor [...] I'm a mental health system survivor [...] I feel that while on the one hand the psychiatric system, the asylum, mental health services in the community, all the rest of it, have helped and supported me, but in the end they don't meet my needs and haven't met my needs over the course of thirty odd years [...] I'm still surviving a system, an obstacle course [...] that actually puts you in an invidious situation [...]

I suppose as a revolving door patient, if that's what I am, I feel that mental health services have actually been quite good at getting me through crises. I mean I've gone from six month admissions to six week admissions and in terms of getting me off my knees and out on the street again, the acute ward does quite well. But what it doesn't do is help prevent these things happening. Until recent years it hasn't appeared to be interested in that at all and it doesn't actually help me to come to terms with my experience, not only

⁵⁵² LR, OMH/1/73.

⁵⁵³ Sinclair-Chalmers, OMH/1/3.

⁵⁵⁴ John Macdonald interviewed by Jim McGill, October 2009, OMH/1/10.

⁵⁵⁵ Peter Campbell interviewed by Pete Fleischmann, May 2000, Mental Health Media

<<http://www.webarchive.org.uk/wayback/archive/20121013223523/http://www.insidestories.org/node/52>> [accessed on 20 April 2015].

⁵⁵⁶ Ibid.

my psychotic experience, which it doesn't appear to be interested in, but also my experience of being a mental health service user, being mentally ill in the eyes of society and what does it mean in terms of who I am and who I might become.⁵⁵⁷

Campbell first became involved in local and national activism in the 1980s and at the end of the decade he had a book chapter on the 'self-advocacy movement in the UK' published, (written around 1986, published 1989).⁵⁵⁸ Using sporting and spatial metaphors to characterise his perception of the shifting 'terrain of resistance' in the field of mental health, he wrote:

The dominance of the psychiatrist within the system is now clearly under challenge. The old Victorian asylums, the playing fields of old style psychiatry, are closing down. On different pitches the game may well be played to different rules. Mental health workers faced with the imminence of care in the community have been looking around with concern for different ways. This groundswell of unease has not gone unnoticed by users.⁵⁵⁹

Campbell compared the self-advocacy groups in mental health with antecedent 'social movements':

There is a long tradition of protest against psychiatry [...] One of the elements integral to current self-advocacy is this fundamental and long established protest out of powerlessness [...]

Self-advocacy groups do reflect a real mood, both within society and within the society of the so-called mentally ill. Since 1945, oppressed minorities within Western industrial society have taken huge and positive steps to confront their devalued status. Black power, women's liberation, gay liberation have all become significant social movements. The so-called mentally ill may be mad but we're certainly not stupid. Though a continually devalued class we have nevertheless changed considerably over the last 30 years [...] At no time have I been beyond the community for more than a year consecutively. I am part of the community. I have always been part of the community. To be treated as second-class human being in these circumstances is a bitter cut. The strength of self-advocacy is that it is founded on a changing self-image among service users.⁵⁶⁰

He also attributed some degree of broader purpose to the national movement, identifying a strategy of struggle on two levels:

On a micro-cosmic level self-advocacy is addressing itself to the psychiatric system. On a macro-cosmic level self-advocates in mental health are challenging the whole position of a class of people within society. The psychiatric system is a target, a major target indeed, but within a wider scheme. At this stage with groups so small and with so many avenues available and opening to pressure, it may well be a sign of vitality that there is no unified voice. It is possible that many voices with a unity of feeling will prove to be the most powerful weapon the service user can present.⁵⁶¹

Campbell was a 'leading light' for activists across the UK because of his connectedness, commitment and energy, but also because of his awareness of the historical location of the emerging movement, his ability to reflect and write, to organise experience and provide direction and analysis. By articulating some of the guiding principles, tactics and strategies which had animated the movement, he was able to provide orientation for a broad constituency of activists. Thomas Ritchie had written of the social 'exploitation' of the 'mental patient' in 1971, the equivalent

⁵⁵⁷ Ibid.

⁵⁵⁸ Peter Campbell, 'The Self-Advocacy Movement in the UK', in *Mental Health Care in Crisis* ed. Anny Brackx and Catherine Grimshaw (London: Pluto, 1989), pp. 206-13.

⁵⁵⁹ Ibid., p. 207.

⁵⁶⁰ Ibid., pp. 207-8.

⁵⁶¹ Ibid., p. 209.

of Campbell's assessment of the 'so-called mentally ill' as a 'devalued class' in 1989. Over twenty years on from SUMP, however, there were more opportunities for activists to reach broader audiences and readerships. Campbell took advantage of these opportunities to great effect and in turn helped to create further opportunities for collective action by spreading the message of self-advocacy. The shift in discourse from Ritchie to Campbell is indicative of the move away from class-based arguments concerning the taking of labour power from patients to identity politics concerning changing self-image, despite a degree of intermingling of class and identity components within the discourses of SUMP and SSO. When Campbell came to what was billed as the First Scottish Conference on Mental Health in Glasgow in 1993 he was a well-known figure to Scottish activists. His speech to the Scottish audience paid tribute to the pioneering activities of Glasgow LINK club members, demonstrating the reciprocal influences between Scotland and England and giving the lie to the view that Scotland had lagged behind England in relation to user activism during the 1980s.

Looking back on the previous decade of activism he reflected that Glasgow LINK Education and Action on Mental Health Group was the first group of service users he had come across which was involved in 'making a collective contribution to the debate'.⁵⁶² After he had heard about their 1984 MIND presentation in London he 'wrote to them in Glasgow to find out what was going on'.⁵⁶³ According to Campbell user action had only become 'credible' within recent years following the Community Care Act.⁵⁶⁴ Despite acknowledging that there had been 'progress' with the emergence of groups like LINK and SSO, he warned that by engaging in pressure group and lobbying activities, activists still encountered resistance within health and social services. Campbell's comments lend support to Alex Mold's view that top-down governmental policies and practices in the UK attempted to shape the 'patient-consumer' into an individualised figure. Yet they also show that user activists in mental health were aware that government and 'service providers have a stronger agenda' and sought to resist this individualisation with a collectivist counter-discourse and collective action.⁵⁶⁵ He told the audience that

Service providers and mental health workers are more happy to think of service users as a collection of individuals, who they might be able to empower by giving better information, giving a care programme approach, giving a key worker or giving a care manager than to think of users as a collective, organised movement who are actually getting together and putting forward and lobbying for specific proposals. This is still quite uncomfortable. There is still a feeling that for service users to get organised and form pressure groups, lobbying groups, is not playing the game right [...]

Service providers are often concerned about the representation of service users who are members of local groups. Are they actually hearing the voice of the people they want to hear? [...] The user movement has spent a lot of time trying to develop advocacy projects, specifically designed to help people who have

⁵⁶² Peter Campbell, 'The Contribution of Service Users in the Design and Implementation of Services', in *A Slow Train Coming: Bringing the Mental Health Revolution to Scotland* ed. Christine Dean (Glasgow: The Greater Glasgow Community and Mental Health Services Trust, 1994), p. 99.

⁵⁶³ Ibid.

⁵⁶⁴ Ibid., p. 100.

⁵⁶⁵ Ibid., pp.100-101.

difficulty in voicing their concerns, to voice these concerns. It is not because we are not concerned to allow everybody to have a voice, that people currently don't all have a voice.⁵⁶⁶

Activists based in Scotland were familiar with the problems which Campbell had brought to the attention of the conference audience, which comprised officials from the Scottish Office, health service managers, clinical and academic psychiatrists, social workers, voluntary sector workers and service users. The advocacy report and information booklet produced by the national advocacy worker of SAMH Anne Bardsley distinguished types of advocacy. Collective advocacy in particular was increasingly emphasised by user groups. Alex Mold has argued that the 'patient consumer' was increasingly shaped by the agenda of governments into a more individualised figure during this period.⁵⁶⁷ But in the 1990s mental health service user activists reiterated their commitment to collective action and resisted attempts to shape their agenda from the top-down. Campbell was well-placed to articulate demands which he knew to be popular among users and their groups from his wide-ranging contacts as SSO Secretary. Adrienne Sinclair-Chalmers remembers that in Edinburgh some mental health professionals would say 'oh you're not the real people, the real people are the ones that sit in their houses and don't talk to anyone'.⁵⁶⁸ Campbell perceived himself to be at the more radical end of the movement and was strongly opposed to the dominance of medicine in psychiatry and the dominance of psychiatry in mental health services. He accepted that not all patients identified as survivors of an oppressive system, and not all patients were anti-medication, but he was worried that the radical and critical edge of the movement was in danger of being blunted by top-down managerial agendas of government and health authorities. It was a mainstream and widespread, but radical, demand among activist groups in the UK to call for crisis services. Campbell questioned whether there had been any genuine negotiation or meaningful progress around contentious demands:

One of the other major difficulties is how do you actually ensure that the more radical, the more innovative demands of service users are listened to? In particular, users have some concerns about the length of time it has actually taken for the spontaneous demand for 24 hour crisis services to actually result in something on the ground. User groups have been asking for this for over ten years. Asking for services that provide an alternative destination to hospitals, for services which allow them to go through crisis without being medicated out of consciousness. When this is a clear major demand of users of mental health services, why is it taking so long for that to be addressed?

There is also a major question about the role of medication in mental health care. It is quite clear from the user movement around the world that substantial numbers of users want to see services which don't depend totally on medication [...] Do we need to have so many people on such high doses of medication? Do we have to resort to medication in times of crisis? [...]

There is quite substantial opposition to actually opening up the possibility of services that aren't based on medication and the services are not supporting people who want to withdraw from their medication. If these overall questions aren't actually being addressed, is there really a will to provide a user led service?⁵⁶⁹

⁵⁶⁶ Ibid.

⁵⁶⁷ Mold, 'Making the patient-consumer', p. 511.

⁵⁶⁸ Sinclair-Chalmers, OMH/1/3.

⁵⁶⁹ Campbell, 'The Contribution of Service Users', pp. 101-102.

According to Anne Bardsley

one of the things we did want was a crisis service. Because it was very much any treatment availability was nine to five and nothing at the weekend and the CPNs [community psychiatric nurses] didn't cover the weekends either and we were saying, 'look [...] are you not allowed to have a crisis between five pm on a Friday and nine o'clock on a Monday'.⁵⁷⁰

In Edinburgh user groups and organisations had been demanding non-hospital-based crisis services since the early 1990s and Glasgow LINK had called for them since the 1980s. But the user movement in Scotland was only beginning to establish itself and activists and allies encountered resistance on a number of fronts. Keith Maloney who worked for CAPS from the late 1990s claimed that 'although there were a lot of allies out there, the service user movement still had a lot of people who still didn't really think there was any value in terms of listening to service users'.⁵⁷¹ Shulah Allan remembers

going up to the Royal Ed[inburgh Hospital] and we were just laughed at, just ridiculous. I can remember when I went to the Scottish Office to talk to somebody about advocacy and being told, 'Don't come in here talking about advocacy, advocacy is about lawyers. Find another word for what you want to do'. So you know we were just pooh-poohed but all that did was make you more determined.⁵⁷²

4.4 Scottish Users' Conferences

After the formation of SUN, and following Bardsley's endeavours to develop advocacy in Scotland, the organisation of national user conferences in Scotland signalled an increasing national focus of the movement, as Scotland-based activists sought to carve out a distinct identity for themselves. The first user-organised Scottish Users Conference was held in January 1992, predating the Glasgow event at which Peter Campbell had spoken by over a year. In the foreword to the conference report John Macdonald, Chairman of the conference, wrote that 'the conference enabled us to share the considerable knowledge, which we are often assumed not to have, and to discuss and start to look at the actions needed to transform the position of people in Scotland who are designated/diagnosed as being mentally ill'.⁵⁷³ According to Macdonald 'the history of this conference was started on a train back to Scotland as some people who had been at a MIND conference were fed up of always hearing what was happening in England'.⁵⁷⁴ The conference steering group invited various MPs to speak at the conference and 'were very disappointed not to be able to get anybody, despite it being a general election year'.⁵⁷⁵ The report noted sarcastically that it was 'comforting to know that the user movement in Scotland can rely on all party support!'⁵⁷⁶ It

⁵⁷⁰ Bardsley, OMH/1/1.

⁵⁷¹ Keith Maloney interviewed by Jennifer Booth, August 2010, OMH/1/53.

⁵⁷² Allan, OMH/1/6.

⁵⁷³ 'Report of the First Scottish Users' Conference 1992', OMH/2/7/2.

⁵⁷⁴ Ibid.

⁵⁷⁵ Ibid.

⁵⁷⁶ Ibid.

was decided that the event would be held outside of Glasgow and Edinburgh because it was considered that these locations were 'not very accessible to people travelling from further north and it was recognised that any event in Scotland nearly always take place in these two cities. Central region then became the obvious area for people to meet from all over as Scotland' and eventually Falkirk was chosen.⁵⁷⁷ There were 140 places, 100 for users and 40 for workers. The conference report revealed that the organisers had difficulties obtaining funds: 'Application after application was being turned down even though many of the funding bodies thought that the idea of a users' conference was a really good one'.⁵⁷⁸ The report also highlighted how 'administration at times proved to be a slight problem given that members of the steering group came from different parts of Scotland and were doing different parts of work from different offices some receiving more administrative support than others'.⁵⁷⁹

John Boyd a service user from Nottingham was the first speaker of the day. He urged users in Scotland to cooperate with service providers to reform the system. The second speaker was Anne Bardsley, continuing on the same theme. She had seen the worker/user divide from both sides, having been a patient and now occupying the role of national advocacy worker for SAMH. She urged the user movement to 'develop its identity, maturity and sense of purpose'.⁵⁸⁰ She cautioned the mainly user audience that

A few bad psychiatrists do not make a bad psychiatric service and nor do a few angry service users make the whole of the user movement angry either. It is a case of being positive and constructive. Ask yourself this—how long would you listen to somebody who criticises you, does not take you seriously or treat you with respect? You don't listen long.⁵⁸¹

In the same year Bardsley appeared on a training video, *From Anger to Action*, which featured user activists from across the UK. While she warned users at the conference about being 'positive and constructive', on the film she played up the challenge which advocacy posed to health service authorities, issuing her message to workers and professionals. Individuals who occupied these dual roles trod the line between user and worker, hoping to inform each side about the other. According to Bardsley:

At the moment there are still people pulling in different directions and I think part of that is the threat of advocacy. And the threat of advocacy is something people won't admit to. If you start empowering patients, users, recipients, clients, then somebody is going to have to lose power or start sharing power and that is a major threat. It starts challenging services, challenging practices of services. It starts people saying 'I want my say in this service, I have a valuable contribution to make too and I need to be listened to'. It should give people the opportunity to say, 'Well how can we make our service better?'⁵⁸²

⁵⁷⁷ Ibid.

⁵⁷⁸ Ibid.

⁵⁷⁹ Ibid.

⁵⁸⁰ 'Address From the Chair', p. 3 in 'Scottish Users Conference Report 1993, Care in the Community: Our Needs', OMH/2/7/3.

⁵⁸¹ 'Report of the First Scottish Users' Conference 1992', OMH/2/7/2.

⁵⁸² *From Anger to Action*, Produced and directed by Jim Green. Mental Health Media Council Production, 1992 <https://m.youtube.com/watch?v=Mxp6S_6vyW4> [accessed 2 May 2015].

Workshops at the conference were held to facilitate discussion, information sharing and the expression of views on how services could be improved and how users could organise themselves. The titles of the workshops were: 'Users working with professionals'; 'Users and management committees'; 'Campaigning and education'; 'Women and mental health'; 'Men and mental health'; 'What is Empowerment?'; 'Rural issues'; 'Employment and mental health'; 'Stigma and discrimination'; and 'Alternatives to hospitals and drugs'.⁵⁸³ In the workshop on 'users working with professionals', users complained about: the 'jargon used, which is disempowering in itself'; the institutionalisation of professionals themselves and the guarded hesitancy of opening their doors to other agencies outside their own discipline'; and the 'lack of communication at interdisciplinary levels both up and down their own hierarchy as well as across the board'.⁵⁸⁴ In the workshop users complained that 'everybody passes the buck'; 'if you have had a bad experience of psychiatric services you are made to feel it is your fault'; 'campaigning may lead to withdrawal of funding i.e. taking a political stand'; and 'being fobbed off with money to run a service which will therefore not leave you time to campaign, therefore keeping you quiet'.⁵⁸⁵ The delegates came together to identify common concerns and to challenge 'attitudes, views and practices of professionals' such as:

Deciding what is in a person's best interest without consultation.

Stigmatising and stereotyping people.

Using a medical model in diagnosis without taking other circumstances into consideration i.e. financial, social, economical, environmental, emotional, family.

Use of person's illness as a factor not to empower them i.e. they are too ill or too disturbed or can't understand anyway.

Lack of communication with the person and other agencies.

Not taking people with a mental health problem seriously or treating them with respect as individuals.⁵⁸⁶

The workshop on 'Alternatives to Psychiatric Services' was described in the report as 'one of the most emotive workshops' and for participants it 'brought back painful as well as angry memories of their experience within a psychiatric hospital'.⁵⁸⁷ Users believed that:

There were too many drug treatments.

Psychiatry works to a medical model giving itself a medical status whilst it works to control people who are different.

Once you are in the system you can't get out of the system or the diagnosis which in turn leads to labelling, stigma and discrimination and is impossible to challenge.

Psychiatric services hold the power and authority to compulsorily detain you.

⁵⁸³ 'Report of the First Scottish Users' Conference 1992', OMH/2/7/2.

⁵⁸⁴ Ibid.

⁵⁸⁵ Ibid.

⁵⁸⁶ Ibid.

⁵⁸⁷ Ibid.

There are no counselling services.

There are no real alternatives.⁵⁸⁸

After the success of the first national conference organised by service users in Scotland, a second was held in November 1993 on 'Care in the Community: Our Needs'. An introduction in the conference report by Colin Murray expressed the concern of users that, in the wake of the Community Care Act, their experience was that meaningful change on the ground had yet to be delivered in practice, notwithstanding the high-minded rhetoric of community care:

Many of the new reforms and new systems being established appear to entrench control at the centre, and place even greater emphasis on fiscal decision making. There is a real danger that the community care remit will appear as window dressing that it will be experienced as new clothes for an old ceremony.⁵⁸⁹

The conference chair John Macdonald restated the widespread approval by users of a post-asylum mental health service, but it was stressed that they needed 'to see Community Care as a practical and real commitment'.⁵⁹⁰ He told the audience of nearly 200 delegates:

At the 1993 MIND conference, the under Secretary of State for Health stated that users should be involved in community care planning at all levels. The fact that this is said at all must be a reflection of progress made by users in starting to make known our views and abilities. However we all know too well that user involvement can mean many things to many people [...]

Power is not going to be given; not can we simply take it. It will be gained through the painstaking, careful use of our minds to develop our ideas for change on a sound, thoughtful and practical basis, and to work out our strategies for achieving our objectives.⁵⁹¹

The report listed the 'Missing Service Provision' in Scotland identified by conference delegates:

We all know that funds are not unlimited and some ends can be met more easily and sooner than others [...] but users all over Scotland agree on some very clear and reasonable needs which are not yet being met [...]

The actual service provision which is almost universally lacking and universally desired is community based crisis support: - twenty four hour crisis centres which should be sited in the community, (not hospital based); and properly administered crisis card schemes.

A properly funded advocacy service for each region.

People everywhere wanted social, educational and recreational services not merely offered in day time hours but on evenings and weekends.

Transport was a very big issue particularly for rural areas.

More supported accommodation was on everyone's agenda.

⁵⁸⁸ Ibid.

⁵⁸⁹ Colin Murray, 'Introduction', in 'Scottish Users Conference Report 1993, Care in the Community: Our Needs', p. 2, OMH/2/7/3.

⁵⁹⁰ Nicola Fisher, 'Workshops Introduction and Overview', in 'Scottish Users Conference Report 1993, Care in the Community: Our Needs', p. 6, OMH/2/7/3

⁵⁹¹ John Macdonald, 'Address from the Chair', in 'Scottish Users Conference Report 1993, Care in the Community: Our Needs', p. 3, OMH/2/7/3.

Better public education on mental health matters figured in every workshop.⁵⁹²

At the second Scottish Users Conference the organisers took a strategic approach determined by the geography of Scotland and the community care needs specific to local areas. Workshops this time were not divided thematically, but instead 'arranged by regions: Lothians, Edinburgh, Tayside, Fife, Highlands, Ayrshire, Central, Grampian, Strathclyde and Glasgow'.⁵⁹³ According to the conference chair John Macdonald 'more emphasis has been put on the practical nature of the workshops so that particular recommendations can be produced for each region covered, and these recommendations can then be raised with local authorities, agencies, associations and health boards'.⁵⁹⁴ The report noted that 'the Borders were represented by a report from a group that could not be present on the day' and that 'although we were able to include representatives from the majority of regions, it was simply more than we could afford at the time to cover expenses for representatives from further afield'.⁵⁹⁵ Whilst the first conference had been successful in developing a broad agenda for action, the second sought to produce clearer targets and objectives for local action and the report was sent to regional authorities. Colin Murray remarked that 'it is a fervent hope that this report will continue and broaden the process of dialogue and partnership between those who offer services and those who use them'.⁵⁹⁶ The conference report outlined the difficulties they had in obtaining funding for their activities, but noted that 'despite our financial restrictions and personal pressures, the group members maintained a high commitment to seeing the task through. On a number of occasions it was our personal and collective belief in the future of a national forum which kept the momentum going'.⁵⁹⁷ Unlike the first conference the organising committee managed to attract a Labour MP, Maria Fyfe, to speak to the conference and listen to the concerns of delegates. EAMH worker Tisha Shaw spoke to the conference about the problems experienced by black and minority ethnic service users. Jimmy Laing, who had just published his autobiographical account of fifty years of incarceration in Scottish psychiatric institutions and won MIND book of the year, was due to be a third speaker, but was unable to attend due to illness.⁵⁹⁸

Conference delegates were invited to comment on what they had taken from the event and a sample of the comments were recorded in the conference report. Bill Bell, one of the conference organisers, remarked that

⁵⁹² Fisher, p. 6.

⁵⁹³ Ibid., p. 5.

⁵⁹⁴ Macdonald, 'Address from the Chair', p. 3.

⁵⁹⁵ Colin Murray, 'Introduction', in 'Scottish Users Conference Report 1993, Care in the Community: Our Needs', p. 1, OMH/2/7/3.

⁵⁹⁶ Ibid., p. 2.

⁵⁹⁷ Ibid.

⁵⁹⁸ Jimmy Laing and Dermot McQuarrie, *Fifty Years in the System* (London: Corgi, 1992) (Originally published by Mainstream in 1989).

It made me very much aware of what is happening in other areas of Scotland, in particular the lack of services that some users have to live with day to day. This is to be remarked because we are now in the era of Community Care (or the lack of it!).⁵⁹⁹

Jim Wilson, who was involved with the 'single-disease' charity National Schizophrenia Fellowship, principally an organisation representing the interests of relatives and carers of schizophrenic patients, believed that the conference

was a good initial step towards promoting a United users front in Scotland. I believe as users we must unite and establish our common needs from the mental health services in Scotland [...] From personal experience it would appear users tend to stick to their 'labels' whether they be manic depression or schizophrenia, and while diagnosis may be helpful in determining the treatment of the individual I think it should all come under the umbrella of mental health [...] I would [...] like to see a United users front that can communicate with other organisations at the highest level.⁶⁰⁰

Another delegate George Denning commented that

We are not begging the government, cap in hand, to do us a special favour because of our mental health difficulties. Not at all! As citizens in a supposedly civilised country, we are of the informed opinion that the disadvantaged are simply exercising their civil rights by pointing out that it is the responsibility of the government to provide the services which are needed, and which have been implicitly promised by election manifestos and various citizens charters.⁶⁰¹

In the context of a shifting economy of mental health care, user activists in Scotland, *contra* Mold, who argues that the 'patient consumer' became a more individualised figure after the 1980s, reiterated their commitment to collectivist principles in the face of the imposition of market disciplines, even if there was no detailed, clearly spelled-out position on a social welfare rights agenda. While they expressed a strong commitment to the social democratic traditions of the left against free market ideology, strands and currents of anti-psychiatry, civil rights discourse and identity politics also ran through the activities of the emerging movement. In his concluding remarks as conference chair in 1993, Macdonald looked ahead, envisaging that 'future conferences can bring forward broader issues, such as oppression and civil rights'.⁶⁰² He concluded by drawing parallels between users and other oppressed minority groups: 'Throughout society all sorts of different groups are treated badly [...] by the authorities in power [...] In the USA until the 1970s homosexuality was seen as a medical diagnosis. This has changed dramatically'.⁶⁰³ Referring to a 1923 Church of Scotland report *The Menace of the Irish Race to our Scottish Nationality* Macdonald told the audience that

in the 1920s a statement was put out by the church regarding the purification of the Scottish race, this was in terms of getting rid of the Irish among the population who at the time were stigmatised by a so called high rate of lunacy[...] At that time what was suggested was forcible repatriation of these Irish people.

⁵⁹⁹ Scottish Users Conference Report 1993, *Care in the Community: Our Needs*, p. 29, OMH/2/7/3.

⁶⁰⁰ Ibid.

⁶⁰¹ Ibid., p. 30.

⁶⁰² Scottish Users Conference Report 1993, *Care in the Community: Our Needs*, p. 27, OMH/2/7/3.

⁶⁰³ Ibid.

We have moved forward from this at least. Now let's go forward together, make allies and find new allies.⁶⁰⁴

These remarks on historic instances of discrimination against the Irish Catholic immigrant population in Scotland and the comment that the country had 'moved forward from this' were ironic in light of the fact that according to Macdonald there was 'an element' of two or three people in SUN during the early 1990s who 'were full of colour and not dissociated totally in their minds, if not in fact, from paramilitary organisations'.⁶⁰⁵ As Macdonald remembers it, claims were made by a Glasgow-based user that he and at least one other member of SUN had procured guns in Northern Ireland, to be sold on for a profit:

Somebody thought it would be a good business move to get the guns and make some money off them. But they couldn't sell them and they had to be chucked in the Clyde before somebody found out about them. That was the story given for why this money had disappeared off the map. And I never really did work out whether the guns actually existed. But it was a really good way of shutting everybody up. I think probably that was the case [...] Having said that, these people were quite talented and they got some things [...] Actually I think it was a smokescreen for somebody just pocketing the money or finding they'd used it and not knowing what to do about it.⁶⁰⁶

Without speculating on whether the guns were imaginary, real, or a 'smokescreen' as Macdonald suggested, the fact that there were activists in the movement willing to associate, in imagination or reality, with Loyalist paramilitaries, who at the time were engaged in sectarian killings of Catholics across the North Channel, demonstrated how the proximity of Scotland to the violent ethno-national conflict in Ireland could impinge upon the activities of the user movement in Scotland and how the identity politics and civil rights discourse of the Scottish user movement was informed, albeit tangentially in this instance, by the wider history, geopolitics and ethno-religious tensions of the UK and Ireland. Even if the story of the guns was a complete fabrication, it indicated how unpleasant fear tactics could be employed to stifle the atmosphere of free and open discussion which the national users' conferences and SUN hoped to facilitate.

It was clear from discussions and debates initiated at the first national user conferences in Scotland that user activists were as much concerned with broader culture building objectives and identity politics, as with making specific demands on the state for resources and services. The national user conferences were significant events in shaping a distinct Scottish agenda, after activists in previous decades had looked beyond Scotland to spread its message and initiate co-operation between nations. Although groups of patients taking collective action were more organised than ever before and government policy had enshrined 'user involvement' in community care planning, there was continuing concern that the policy of 'care in the community' was driven by a government agenda to privatise public services and reduce public expenditure on mental health, social care and welfare. Service user activists, the voluntary sector and health service

⁶⁰⁴ Ibid.

⁶⁰⁵ Macdonald, OMH/1/10.

⁶⁰⁶ Ibid.

professionals were wary of the Conservative government's agendas to 'roll back the state' and tackle a perceived 'culture of welfare dependency'. At the Scottish Office-organised conference which Peter Campbell had spoken to in Glasgow, just weeks before the second Scottish users conference in 1993, Brian Smith from the executive committee of SUN criticised the government for denying substantial funds to SUN, referring to what he described as 'the crippling insult of the Scottish Office'.⁶⁰⁷ He delivered a caustic message to the government:

In the spring of this year I was elected to the executive of SUN. I am a chronic manic depressive, I think, and I am now stabilised on Lithium, I know. Before that I could make a light bulb glow in the dark by touching the two terminals. And with that track record I lost my job, I lost my income, I lost my family and I lost my friends. Slowly and slowly family and friends came back, but not job and not income. So today I am on Mr Lilley's little list – an invalidity benefit scrounger, a poll tax dodger and now a council tax withholder. I count myself as a 'disregard'.⁶⁰⁸

Smith was referring to Peter Lilley, Secretary of State for Social Security, who had given a speech at Conservative Party conference in 1992, outlining his plan to 'close down the something for nothing society' after the numbers of people claiming 'invalidity benefit' had grown.⁶⁰⁹ Lilley's speech was delivered in the form of a pastiche of the Lord High Executioner's 'little list' song from the comic opera *The Mikado* by Gilbert and Sullivan. He took aim at 'scroungers' and 'left wing campaigns', among other targets. Smith delivered his own direct message to the assembled audience at the mental health conference the following year:

I am glad to know that there are some Scottish Office people at this conference. In the Year of Community Care established on April Fools' Day 1993, SUN the user network was denied even the meagre funding it had previously enjoyed. The really patronising insult was the gift of a grant of £1000 to commission a funding brochure. I have a draft of it in my hand now. In other words, it's privatising a public service which put user participation into the legislation. So the government enshrines user input into mental health care planning and action and castrates the only emergent body which represents all users in Scotland suffering from whatever mental illness. I hope you will go back to the Scottish Office and think on that [...] Yes, I'm angry about the funding cut. It is criminal cynicism to will the end and then refuse the means, and that is what seems to have happened to all the people involved in SUN [...] Scotland has a little advantage over England in respect that we can look at our country as a whole without being overwhelmed by the mountain we're looking at.⁶¹⁰

The view of Scotland expressed here by Smith captured the optimistic thinking behind SUN that Scotland as a small nation, compared with England, was in a better position to address matters collectively at the national level by building a close-knit national network. Allies in the voluntary sector in Scotland shared many of the concerns of users about the market ideology driving aspects of the policy on community care. At the Glasgow conference Martin Sime, former Director of SAMH and then Chief Executive of Scottish Council for Voluntary Organisations (SCVO),

⁶⁰⁷ Brian Smith, 'The Contribution of Service Users in the Design and Implementation of Services', in *A Slow Train Coming: Bringing the Mental Health Revolution to Scotland* ed. Christine Dean (Glasgow: The Greater Glasgow Community and Mental Health Services Trust, 1994), p. 109.

⁶⁰⁸ Ibid.

⁶⁰⁹ Invalidity benefit was a social welfare payment made to people with long-term illness or disability. The 'little list' performance by Lilley is worth watching and listening to on the televised recording at <https://www.youtube.com/watch?v=FOx8q3eGq3g> [accessed 31 August 2016].

⁶¹⁰ Ibid., pp. 109-11.

expressed the concerns of mental health associations and charities that the civic ethos of the voluntary sector was under threat with the introduction of competition into mental health care. He warned that

Our collaborative and co-operative instincts founder on the realities of purchaser/provider relationships and the market place which governments and health boards have created [...] The long-standing partnership of the voluntary organisations with local government and our history of sharing and inter-agency agreements has been sorely tested by the competition for re-provision contracts. The voluntary sector is, by and large, committed to the mixed economy of care but will never accept the imposition of an enterprise led and profit driven culture.⁶¹¹

He highlighted how an increasing involvement of voluntary organisations in providing social care services to people with mental health problems impacted on their ability to act as advocates for users:

One of the many challenges which the voluntary sector faces is the need to put aside rivalries and territorialism, which are being stimulated by the market economy [...] The voluntary sector is increasingly concerned about losing its campaigning edge. This challenge takes two distinct forms: firstly the concern that increasing service provision will swamp the public advocacy origins of many groups and secondly, that agencies will become frightened to rock the boat or bite the hand that feeds them.

At another level, the greater involvement of voluntary organisations in actually providing services, the more it seems to me that the balance tips against their legitimacy as advocates for their own service users [...] I would like to see more collaborative work, involving the big providers and local groups, bringing forward new ideas based on the experience of those closest to the ground, allied to the greater organisational capacity of the major agencies [...]

The biggest challenge facing the sector is to practice what it preaches in relation to user involvement. Some of us undoubtedly do risk becoming funding led and service driven, without devoting the space or energy to making sure that we enable the people we work with take control. User involvement in voluntary sector services is an absolute necessity for future health and vitality of voluntary organisations.⁶¹²

Whilst it was true that in 1993 the local and national user groups in Scotland were still dependent on the mental health associations for financial and other forms of material and symbolic support, tensions between users and voluntary sector organisations and their staff did exist. Adrienne Sinclair-Chalmers believed that for the emerging user movement 'the main obstacles were badly disposed workers [...] and despite the fact it likes to think it's all fluffy and cuddly, many of them were voluntary sector people and not statutory sector'.⁶¹³ In her view the interests of voluntary sector mental health organisations and those of service users did not always converge:

There was and is in the voluntary sector just, oh well I can understand it, but people see things and they see there might be some money in that so they want to own it and I'm afraid that there was an organisation, that, well it may not have perceived it to be like this, it may have just thought it was helping, but in some senses it was holding things back.⁶¹⁴

⁶¹¹ Martin Sime, 'The Challenges for Voluntary Organisations', in *A Slow Train Coming: Bringing the Mental Health Revolution to Scotland* ed. Christine Dean (Glasgow: The Greater Glasgow Community and Mental Health Services Trust, 1994), pp. 95-96.

⁶¹² Ibid., pp. 96-7.

⁶¹³ Sinclair-Chalmers, OMH/1/3.

⁶¹⁴ Ibid.

In 1990 John Macdonald founded the user-led magazine *Beyond Diagnosis*, which aimed to be 'The Voice in Scotland of people who have been diagnosed as mentally ill and those with related experiences'.⁶¹⁵ He remembers that during his time at the magazine

I felt that some of the people trying to help or helping *Beyond Diagnosis* were very patronising and they were trying to limit what we were trying to achieve rather than understanding the vision and [...] using their imagination to find ways of backing it.⁶¹⁶

4.5 Building a Culture Beyond Diagnosis

Despite the concerns of users about the relationship between user groups and voluntary sector organisations and their workers, there was genuine optimism that a culture of 'collective advocacy' was growing in Scotland. Gavin Miller has suggested that 'mental health user groups may in fact be doing "double-duty" as both pragmatic alliances, and as new, transnational identity groups'.⁶¹⁷ He notes that user groups seem to be engaged in culture building activities and identity politics concerned with 'the creation of activist identities that call for recognition of a supposed mental illness as a way of life demanding recognition and respect in its own terms'.⁶¹⁸ According to this conception of users 'doing double-duty', on the one hand user groups campaign, destigmatise, educate etc., and on the other, they provide 'a sense of ethnicity by, as it were, reuniting a "diaspora without origins"'.⁶¹⁹ Miller has queried 'if there is even something like a romantic nationalist phase at work' and has suggested that 'perhaps "postcolonial" or "decolonising" would also be appropriate analogical terms for such movements'.⁶²⁰ Perhaps these terms can be applied to the Scottish users movement emerging in the 1990s. The creation of 'a sense of ethnicity' served emotional and psychological needs, providing a sense of belonging and serving to promote the kind of 'anti-inferiorist' or 'post-colonial' ethic which had animated black, Irish, feminist, gay, and other civil rights movements.⁶²¹ According to Graham Morgan

What I got out of it personally was a shared experience, it was meeting other people, I think especially in those years when you have that experience you can feel very isolated and very alone as though, one of my friends called it 'normals', don't understand you. I'm not going to get where you're coming from. So meeting in a room [...] and the people that are there, their actions, their behaviour, their language all chimes with how you feel. It is a wonderful liberation because you feel a part of something and you feel accepted and you feel wonderful that you've got a community readymade for you to join which has the same vision as you. Where before you felt isolated, alone and excluded [...]

⁶¹⁵ *Beyond Diagnosis*, 1, (1990), OMH/15/15.

⁶¹⁶ Macdonald, OMH/1/10.

⁶¹⁷ Gavin Miller, 'Identity and Critique: two hidden logics in transcultural psychiatry', Position Paper for Debating the First Principles of Transcultural Psychiatry AHRC Project, accessible at <http://transculturalpsychiatry.gla.ac.uk/wp-content/uploads/2012/09/DebatingTCP-Miller.pdf> [accessed 12 May 2014].

⁶¹⁸ Ibid.

⁶¹⁹ Ibid.

⁶²⁰ Ibid.

⁶²¹ Ibid.

It's a sharing together of experience and it's a building of a community and if one person raises an issue and it's very important, it's very good and they get it in the media and they campaign on it [...] But if you have a community of people saying [...] we need a cultural shift [...] then you have something that is much more powerful than the individual saying 'this is wrong'. You've got a whole community bringing together their issues, their common cause and their difference and saying, 'Listen to us, believe in us, show us respect, we are not going away. We are not going to disappear. We've been here all along. We've been missed and ignored for centuries and now we're going to be visible. We're not necessarily going to be angry. We're going to be proud of who we are. We may be disgusted by what we go through, but pleased to find the vigour, the hope and the strength to speak out and support each other and know we've got something to give'.⁶²²

For Maggie Keppie the

biggest thing through all these groups, be it EUF [Edinburgh Users' Forum] or the Patients' Council, is actually the friendships you make and the wee light that goes off in your brain that actually says, 'No, I'm not alone. No, I'm not crazy. Because I feel these sorts of things, more people feel them and sometimes I wonder are we the crazy ones or is everyone else [...]

I didn't follow any politics or anything. I had been a private in the army. I hadn't been in any kind of active group before in my life. So half of it was to change the way we were being treated and the circumstances we were in, plus with the Patients' Council was the accommodation and the food, but the other half of it was for the friendship and just knowing that you belonged to something.⁶²³

One activist who was involved in REHPC and SUN, believed that she 'got something from being around other people who had mental health problems, being part of a collective group was important to me'.⁶²⁴ The Scottish Users Conferences had facilitated the circulation of the discourse of advocacy and the development of connections between individuals and groups from different parts of the country. SUN was seen as the vehicle for sustaining collective action at a national level, but the conferences of 1992 and 1993 as singular events had a significant impact on the morale of participants and their sense of belonging to the broader culture of a national movement. The following year in 1994 at the annual general meeting of SUN a motion was proposed that in principle

SUN believes that common interests exist between mental health service users and other groups who experience economic, political, social, cultural and psychological disempowerment. We determine, in the future, to develop positive links with the organisations representing such groups, recognising that such alliances with other people who experience oppression will be of benefit to the user movement.⁶²⁵

By establishing an 'anti-inferiorist' ethic and a non-deferential collective identity, SUN expressed an intention to cooperate with other marginalised and oppressed minority groups. The demand for respect and recognition went beyond the demand for recognition of the distinct identity or difference of people with mental illness diagnoses. They saw themselves as engaged in a struggle for value and a struggle to alter the asymmetric power relations in the psychiatric system and society. Between 1989 and 1994 a distinct Scottish user movement with an identity and

⁶²² Graham Morgan interviewed by Phil Barnard and Kirsten Maclean, August 2009, OMH/1/2.

⁶²³ Keppie, OMH/1/9.

⁶²⁴ Anonymous interviewed by Alistair MacIntyre, July 2009, OMH/1/71.

⁶²⁵ SUN AGM minutes, 31st of March 1994, OMH/16/2/1.

geographical focus apart from the rest of the UK, had emerged, but one which sought to reach out in principle, if rarely in practice, to other marginalised groups in and beyond Scotland. John Macdonald who proposed the motion at the SUN meeting often reflected on history, politics and spirituality in his public speeches during the 1990s. According to Macdonald:

Users of services need the dignity, rights and fulfilment of every other member of society. And our problems are not separate from, but merely an extension and further amplification of theirs. The way we are treated is a litmus test for the health of the whole society. Empowerment is at the heart of this process for it means total acceptance of the person's individuality and that acceptance is also the true way towards healing. And I would like to [draw] people's attention, if they're not aware, to the roots of the term psychiatrist which means 'healer of souls'.⁶²⁶

Reading the work of R.D. Laing was formative of Macdonald's views on madness. Looking back on his psychiatric history, he remembers:

when I was banged up in the early 1970s [...] there was nobody to take up your rights [...] I was involved with the local sort of spiritual type of movement. There was a doctor who happened to be a psychotherapist attached to the movement. I did get a form of medical advocacy [...] from a woman called Winifred Rushforth, a Jungian psychotherapist. Through my involvement with meditation she knew that I didn't really like the medication very much. My understanding of what happened there was that she persuaded the doctors to consider taking me through a course that would enable me to get off the medication rather than me having it for life, and that was quite positive.⁶²⁷

Winifred Rushforth, who died at the age of 98 in 1983, founded the Edinburgh-based Davidson Clinic for Medical Psychotherapy in 1941, facilitating overlapping activities of psychotherapy, Christianity and New Age Spirituality.⁶²⁸ When the Davidson Clinic closed in 1973 it 'left behind three spiritually-inflected legacy organisations: the Salisbury Centre, Sempervivum, and Wellspring'.⁶²⁹ It was around this time that Macdonald was in contact with Rushforth and the meditation and spirituality groups in Edinburgh. These experiences of Macdonald's were contrasted with his time in hospital:

There was so much [that was] negative about the various experiences I had in psychiatric hospitals in the early 1970s. I found it a very brutal process. Even the day hospital the year before, when I'd been depressed, was very, I wouldn't say it was brutal, it was just almost deathly, there was nothing real that could inspire anything [...] 'String designs' was the most creative thing you were offered to do, you know.⁶³⁰

Like Colin Murray, Macdonald had been inspired by the writings of R.D. Laing and this encouraged him to view schizophrenia as a kind of journey:

[At] Havenday Hospital in Hampshire I did have a very compassionate psychiatrist and his view at that time when I finally saw him before coming north, he said, 'John you have to understand that I have to

⁶²⁶ *From Anger to Action*, Produced and directed by Jim Green. Mental Health Media Council Production, 1992 <https://m.youtube.com/watch?v=Mxp6S_6vyW4> [accessed 2 May 2015].

⁶²⁷ Macdonald, OMH/1/10.

⁶²⁸ Gavin Miller, 'Winifred Rushforth and the Davidson Clinic for Medical Psychotherapy: a case study in the overlap of psychotherapy, Christianity and New Age Spirituality', *History of Psychiatry* 26 (2015), pp. 303-317.

⁶²⁹ *Ibid.*, p. 313.

⁶³⁰ Macdonald, OMH/1/10.

restrain the younger psychiatrists, they're just all pro-medication'. He said 'I've read R.D. Laing, I know what you are trying to talk about'. Well I had read R.D. Laing before I even had breakdowns [...] I was lucky or blessed because I had different things going for me, I'd read about because of my mother's mental illness, and the radical late sixties stuff. I'd read about other ways of looking at it. And once it was established that they were calling me 'ill' I could establish that I was on a journey. And once they'd called me schizophrenic, I was on a schizophrenic journey. And that way I had something going for me, an independent way of looking at things. But I was well aware, when I came out of the system and experienced some spiritual healing and a bit of, as I say, advocacy from different places – it wasn't called that then [...] what I'd experienced might not be possible for other people.⁶³¹

Macdonald, like others who were based in Edinburgh in the 1990s, was involved in a number of groups. His journey led him to writing and the creative arts. In 1990 Macdonald was involved in launching the user-led *Beyond Diagnosis* magazine in Edinburgh. The editorial line of the publication, very much in the spirit of R.D. Laing, 'was not to say diagnosis was or wasn't valid, it was to say there was a world beyond it, which was people's lives'.⁶³² *Beyond Diagnosis* raised issues around rights, employment, stigma and discrimination and 'general issues such as politics, the arts and the environment from the point of view of the user'.⁶³³ Since there was overlap of membership between the *Beyond Diagnosis* steering group and SUN, it was hoped that the connections between Glasgow and Edinburgh-based activists would be strengthened and the magazine could complement SUN in the development of a 'national user voice'. In the Editorial of the first issue Macdonald remarked that 'out of sheer geographical necessity we started in one area – Lothian Region [...] the interest and support of SUN has meant we can develop beyond our Lothian base'.⁶³⁴ However by the time the second issue came out in the autumn, new editor Marion Denovan admitted in her editorial that the magazine was 'very much the labour of love' and that 'the future of the magazine hangs very much in the balance'.⁶³⁵ The magazine drew upon the experience of Vincent Donnelly who was on the steering group and was also involved with SUN. Donnelly had worked as a journalist with the Glasgow *Evening Times*. He had also launched the Glasgow archdiocesan magazine *Flourish* and been the press officer for the Catholic Church in Scotland. In the 1980s Donnelly suffered a long depressive illness and became involved with a number of user groups and was part of the large delegation of UK activists that went to the House of Commons in 1989. Despite the difficulties at *Beyond Diagnosis*, Denovan remained ambitious and upbeat, going so far as to say that they were 'aiming to establish the magazine throughout Scotland'.⁶³⁶ Between 1990 and 1994 seven issues of *Beyond Diagnosis* were published. In Issue Six Denovan again devoted much of her editorial to explaining some of the difficulties the magazine faced, apologising for an 'extremely lengthy delay in the publication of issue 6' revealing that 'the

⁶³¹ Ibid.

⁶³² Ibid.

⁶³³ 'Successful Launch Celebrated' in *Beyond Diagnosis* 2 (1990), p. 4. OMH/15/15.

⁶³⁴ John Macdonald, 'Editorial: Care to Know' in *Beyond Diagnosis* 1, (1990), p. 2. OMH/15/15.

⁶³⁵ Marion Denovan, 'Editorial: Labour of Love' in *Beyond Diagnosis* 2, (1990), p. 2. OMH/15/15.

⁶³⁶ Ibid.

magazine nearly went under due to lack of funds, a depleted workforce and also no certain means of production'.⁶³⁷ According to Macdonald

We just knocked our pan in trying to get it off the ground [...] It couldn't continue [with] the lack of understanding on a business front. Things like social enterprises weren't known of then and funding [...] organisations like SAMH and EAMH [...] gave some help, but they didn't really have a good understanding of what we'd have to do to make that thing succeed. I don't think anyone in the voluntary sector really understood the more progressive business models, and there wasn't a lot of understanding of marketing and things like that [...] It should never have had to die but [...] people become ill.⁶³⁸

Macdonald believed that the magazine had given

recognition for the experience and worthwhileness of the people. Also it had a self-help element [...] people could exchange information and understand it wasn't confined to people who'd used services [...] It didn't have to be tied to mental health [...] it wasn't confining people in a certain box. It was actually to express the talent, express their experience, enable people to be greater than they were maybe being pigeon holed. So there was a healing element in it, which I'd felt the need for myself, having been incarcerated [...] Finally, I suppose I verified with myself that I had recovered from the bitterness of the way I'd been treated.⁶³⁹

For Anne O'Donnell, who came in towards the end of *Beyond Diagnosis*, the magazine 'gave a space to be open about having mental health problems' and 'offered creative opportunities [...] photography, poetry, fiction and autobiographical pieces'.⁶⁴⁰ She remarked that 'I don't think I would have got involved with the user movement directly if I hadn't gone through being involved with *Beyond Diagnosis*. It meant that I got to see people and got comfortable in the CAPS office, so it wasn't such a big step'.⁶⁴¹

4.6 The User Voice in Parliament

It was not until 1994 that SUN had its first real opportunity to articulate the views of its members formally to parliament during the course of an investigation into the closure of psychiatric hospitals in Scotland by the House of Commons Scottish Affairs Committee. A memorandum was submitted in writing to the committee by SUN. Jim Kiddie, a user who worked for REHPC and was on the management committee of SAMH, gave evidence to the Scottish Affairs Committee in person.

Kiddie suggested to the committee that

the fact of the matter is that community provision has not grown apace with the developments that have been taking place in terms of reduction of hospital beds [...] we need to bring the process together so that social services, social work and health service are working together to ensure that there are sufficient places in the community.⁶⁴²

⁶³⁷ Marion Denovan, 'Editorial: Love's Labour Almost Lost' in *Beyond Diagnosis*, 6 (undated), p. 2. OMH/15/15.

⁶³⁸ McDonald, OMH/1/10.

⁶³⁹ Ibid.

⁶⁴⁰ Anne O'Donnell interviewed by Jennifer Booth, June 2009, OMH/1/32.

⁶⁴¹ Ibid.

⁶⁴² House of Commons, *Third Report from the Scottish Affairs Committee Session 1994-95, Closure of Psychiatric Hospitals in Scotland Volume II* (London: HMSO, 1995), p. 3.

Reporting the views of users from the Scottish Users' Conferences, Kiddie told the committee that

it was quite clear that what users want for the future are not remote institutions, remote psychiatric institutions [...] Sometimes people who are very distressed in hospital can actually find themselves in a worse condition because of the lack of staffing, the poor conditions, the lack of adequate support services, the failure to provide the developing complementary therapies that exist outside the health service [...] Users want access to advocacy services because in a time of crisis you cannot speak up for yourself [...] We spent far too little on psychiatric services in Scotland over the years compared with other branches of medicine. As users it is about time we stood up, spoke for ourselves and said we make no apologies for wanting more, we deserve more.⁶⁴³

Before he became a psychiatric patient Kiddie had been head of the Grampian region mental health services and an active trade unionist. Reflecting on his own history, Kiddie compared his work in user groups with his work as a mental health service manager:

I was a general manager of mental health services. I actually feel I've had much more influence through my patient experience and the work I did with the Patients' Council and learning from so many people in [...] other organisations.

I saw the abuse of power in Aberdeen by consultant psychiatrists. The disgraceful conditions in 1987 when I went to Cornhill Hospital upset me. I was appalled at how some psychiatrists did not seem to care. So it's R.D. Laing, I always quote him, hated by psychiatrists still in Scotland but revered internationally, who once said, 'I am more frightened by the fearless pursuit of power in the eyes of my fellow psychiatrists than I am by the powerless fear in the eyes of my patients'. I love quoting a psychiatrist to psychiatrists. I think we need more humility on the part of not just the psychiatric profession, but other professions and particularly in the mental health arena, to realise that the real experts are those who are experiencing problems, their own personal problems, unique to the individual, and that they have so much to contribute.⁶⁴⁴

Graham Morgan credited Kiddie with developing good relations between professionals, the hospital management and users during the time he worked for the Patients' Council at the Royal Edinburgh Hospital in the early 1990s. According to Morgan, Kiddie

was very successful in making the senior management at the Royal Ed[inburgh] realise and recognise the need for the Patients' Council and for user involvement, he came from that background of being a manager in mental health and knowing the language that they spoke and I suppose being of that status and class and having it all changed because of his own experiences, so he could also link in with the users. It had got so run down in the Royal Edinburgh. [The Patients' Council] suited the management because they were in a situation where highlighting the inadequacy of the physical structure of the building was quite good for them too because they obviously want [...] to say, 'we need more money for our building'.⁶⁴⁵

Morgan believed that Kiddie

created a balancing act of [...] dialogue where people were listening in a way that they hadn't before and that involved speaking with them, where some of us had come from a background where it was just quite strange to speak to an official or speak to a person in power. It was very different in those days.⁶⁴⁶

When Kiddie was a witness for the Scottish Affairs Committee in Parliament, he was accompanied by three other officials from SAMH. After reporting perspectives from the Scottish Users

⁶⁴³ Ibid., p. 8.

⁶⁴⁴ Jim Kiddie interviewed by Jim McGill, OMH/1/33.

⁶⁴⁵ Morgan, OMH/1/2.

⁶⁴⁶ Ibid.

Conferences he received short shrift from Conservative MP Raymond Robertson. He claimed that Kiddie had asserted that 'most users find hospitals threatening and frightening'.⁶⁴⁷ Until Robertson had used these words there is no evidence in the minutes of evidence that Kiddie had used these words in his witness statements to the committee. Kiddie had remarked that 'institutions can be dangerous places'.⁶⁴⁸ In response to Robertson's demand for him to provide evidence to back up the 'assertion', Kiddie commented:

If you are in an acute ward with 120% occupancy, if you have nurses that are too busy on so-called 'specialing', sitting at the top of stairs watching who is going in and out, no time to speak to you, if you are full of drugs to keep you down and you are frightened, your world has fallen apart, you have lost your job, you have lost your family and so on - I am not being melodramatic; that happens to people - if you do not have access to people who can just sit and talk and listen, because the way to recovery is not just by feeding drugs.⁶⁴⁹

Robertson cut in on Kiddie mid-sentence:

Robertson: Can I stop you there. Can you then table specific instances where these things are happening today?

Kiddie: I think there is concern...

Robertson: No. Can you table us with examples, specific examples of what you are talking about?

Kiddie: Yes; yes.

Robertson: Can you do it then; can you just do that now please.

Kiddie: I can comment that...

Robertson: No, with respect. We have heard what you have had to say, we have listened carefully. I am now asking you to give us concrete examples where we can go to look at it and check it. Can you do that?⁶⁵⁰

Robin Laing, Director of SAMH, then interjected:

Laing: There is a body which is responsible for gathering that information. The Mental Welfare Commission receives reports, about incidents, it receives complaints from patients. In its recently published annual report it actually gives one or two examples of cases of complaints.

Robertson: So we are talking about one or two examples.

Laing: It is an annual report.

Robertson: What I really wanted was evidence to back up what Mr Kiddie said that most users in hospitals - and I quote 'threatening and frightening'. You have been unable to do that so can we move on. In your memorandum you contest the Scottish Office's assertion that a strategy is already in place. Why do you contest that? What do you want to be in the strategy and what do you think the role of the Scottish Office should be?

Laing: Jim, are you happy to move on from that question?

⁶⁴⁷ *Closure of Psychiatric Hospitals*, p. 9.

⁶⁴⁸ *Ibid.*, p. 8.

⁶⁴⁹ *Ibid.*, p.9

⁶⁵⁰ *Ibid.*

Kiddie: No.

Robertson: You did say most hospitals.

Kiddie: I did not. What I did say was that there are places in Scotland where users find remote institutions - of course they find the whole situation - frightening and threatening. Users go into hospital because they are frightened, go in because they are very distressed, they are confused, they need help. I would wish to be supportive of staff working in the health service, many wards are understaffed.⁶⁵¹

Kiddie was browbeaten by Robertson. The Chairman of the Committee, Labour MP, William McKelvey then interjected

McKelvey: I have to interrupt you here because I know what you are saying and it is not that we are not understanding what you are saying. The role of this committee is not to listen to what your views are unless you can name the hospitals in which you are suggesting these difficulties take place. If you said 'all' of them, which I am not suggesting you said, we would understand what you mean. However you have painted a very graphic picture and therefore if a statement were to be made that that is the situation in Scotland we could not accept that is the situation without the evidence. I know about the report that you have considered and that there will be specific cases of specific hospitals, not perhaps of a patient who felt that there might be in the reports but hospitals. We will have to dig that out. It would help us if you were to tell us and point us in the direction, say for example.

Laing: My experience is that if you ask users almost all of them will give you examples. Jim is somebody who has used psychiatric services; I am sure he can give you examples from his own experience of two, maybe three hospitals that he has been in. He is currently working in the Royal Edinburgh and I am sure that he could, if he wished, give examples that are much more current.

Kiddie: I will. Can I say in the Royal Edinburgh Hospital you have an occupancy of 110-120%; that is not good enough.⁶⁵²

Allyson McCollam, Policy Officer at SAMH, now interjected

McCollam: The point is perhaps to get away from individual instances where it almost feels like telling tales and look at aspects of the mental health care system and the way hospitals...

Robertson: I am sorry, I am talking about individual hospitals

McCollam: I am trying to get away from the individual cases

Robertson: Mr Kiddie said that patients would find the Royal Edinburgh threatening and frightening

Kiddie: No, What I am saying is that...

Robertson: If you are not saying that why did you use these words at the beginning?

McCollam: What I am trying to say is that there are aspects of the psychiatric care system which are to do with provision of care through large institutions and one of the effects of that can be very debilitating for people who are already vulnerable and feeling distressed. It may not be the intentional effect but that is one of the very clear reasons for trying to move away from hospital sometimes

Robertson: Your colleague used the words 'threatening and frightening'. He has either got to withdraw them or back them up with evidence. Are you saying the Royal Edinburgh is threatening and frightening to its users?

⁶⁵¹ Ibid.

⁶⁵² Ibid.

Kiddie: What I am saying is that any individual who has experienced mental breakdown in going into a psychiatric hospital and a remote institution, a ward with over 20 people in it, can find that situation very frightening and threatening and I make no apology for that.⁶⁵³

The fact of the matter was that this exchange ensued as a result of Robertson's misquotation and misrepresentation of Kiddie. Robertson continued to make the claim that Kiddie had 'used these words at the beginning', when he had not. He proceeded to suggest that Kiddie had talked about 'most hospitals' being 'threatening and frightening' and claimed that Kiddie would have to 'withdraw' a statement that he did not make. In the end Kiddie did not challenge the misquotation and instead stressed the overcrowding in the Royal Edinburgh Hospital as a clear-cut example of a situation which was unacceptable to users such as himself. What the exchange between the committee and the SAMH representatives demonstrated was that the national mental health association SAMH was still committed to challenging the statutory system by targeting the hospital-based medical approach to mental illness. SAMH now demanded a clear strategy from the Scottish Office to move away from this approach. It was not always comfortable for the committee members to hear. Laing told the committee that 'we would actually like to see a shift which takes us away from the concept of hospitals at all. The hospital idea unfortunately leads us into a medical model of mental health/illness'.⁶⁵⁴ When asked by Labour MP Eric Clarke, 'Do you think that the government is more motivated by financial savings than taking up your philosophy of putting people back into the community?', Laing responded diplomatically

It is a possible interpretation. The way to stop people making this interpretation would be for the government to produce a strategy that says this is what we want, this is why we want it, here is how we are going to get there, here is how we are going to make sure that it happens and this is what we are going to do when it goes wrong.⁶⁵⁵

It was not only psychiatry, hospitals and the central government that came in for criticism during the course of the examination of witnesses. Robert Hughes MP asked Laing, 'Would you agree that within the hospital service the mental health side has always been a Cinderella? With respect, is it not the case that in local government, local government does not actually care very much in the main for mental health services?'⁶⁵⁶ Laing concurred, 'Yes; absolutely. I agree'.⁶⁵⁷ 'How do you change this attitude?' asked Hughes.⁶⁵⁸ Laing suggested, 'maybe Sleeping Beauty is a better analogy: falling asleep for 100 years and having to fight your way through a large thorny hedge to get something'.⁶⁵⁹

Much of the ground covered in the course of SAMH's evidence to the committee had been trodden by previous campaigners. The demands were similar to those expressed by LINK members

⁶⁵³ *Ibid.*, pp. 9-10.

⁶⁵⁴ *Ibid.*, p. 1.

⁶⁵⁵ *Ibid.*, p. 3.

⁶⁵⁶ *Ibid.*, p. 11.

⁶⁵⁷ *Ibid.*

⁶⁵⁸ *Ibid.*

⁶⁵⁹ *Ibid.*, p. 12.

at the MIND conference ten years earlier in 1984, and by Enoch Powell over thirty years earlier in 1961. The difference on this occasion was that a Scottish user voice was being heard by Scottish politicians at the heart of the British state in the Houses Of Parliament. It is notable, however, that despite submitting a memorandum to the Scottish Affairs Committee, SUN was not invited to give evidence. Jim Kiddie was only present to give evidence in person because of his capacity as member of the SAMH management committee. In 1994 the parliamentary space was opened to SAMH, but not to SUN. The so-called 'graphic picture' which Kiddie had 'painted' according to the Chairman, had in fact hinged on Robertson's own misrepresentation of what Kiddie had actually said. The exchanges highlighted the difficulties which user activists encountered in confronting officials, raising questions around whether their views could be accurately represented by politicians, about whether any one user activist or user group could be regarded by authorities as representative of service users as a whole, and the status of the knowledge and reported experience of service users in the eyes of officials. Comments were expressed by select committee members that witness evidence must not be 'anecdotal'. However it was not made clear whether McKelvey and Robertson were arguing that Kiddie's evidence did not count because it was anecdotal, or because no specific examples were given, or because too few examples were given, or because they simply did not think the concrete example of overcrowding at the Royal Edinburgh was actually of any consequence.

4.7 New Dawn or False Dawn for SUN?

While Kiddie was able to participate in giving evidence as part of the SAMH team, SUN was denied the opportunity. It was a matter of regret for the SUN Executive member AB who was responsible for preparing the SUN memorandum for submission to the committee. In a letter to a fellow Executive member in December 1994 AB wrote that he

will work with SAMH, but I say to myself that SAMH is a member of SUN (fact) and not SUN is a member of SAMH (which it isn't) [...] I was a bit hurt to learn that SUN wasn't organised enough to lobby yet, having just done a massive job on the Scottish Affairs Committee which took SUN out to Health Boards, Health Councils and Social Work Directors. You can't win them all.⁶⁶⁰

The minutes of the SUN AGM in March 1994 record that 55 people attended. SUN Chair Jimmy Laing had retired his position due to ill health and a letter from him was read to the AGM in his absence. In it he thanked members for their cooperation during the previous year, but he cautioned that 'whilst being sure that SUN will move forward', he believed that this could 'only be achieved by working together as a team, settling internal unrest, and with all members playing a part in supporting its aims'.⁶⁶¹ These remarks reflected the fact that SUN had struggled to develop its membership base and that there were disagreements amongst the existing membership on how

⁶⁶⁰ SUN correspondence, 12 December 1994, OMH/16/5/1.

⁶⁶¹ SUN AGM minutes, 31 March 1994, OMH/16/2/1.

SUN should develop. It was agreed at the AGM that a constitutional amendment be made to allow 'groups and organisations in the mental health field to join SUN as group members'.⁶⁶² An individual only membership policy had been pursued for the first five years of SUN's existence because there were concerns that a local group could dominate SUN to pursue its own agenda, yet the reality was that the membership had largely been drawn from the small pockets of existing local activist groups.

At a SUN executive committee meeting in November 1994 Jim Kiddie attended as an observer and 'commented on SUN's need to develop links all over the country', noting 'the positive feeling there is for SUN by civil servants in the Scottish Office'.⁶⁶³ It was announced that the voluntary sector organisation the Mental Health Foundation intended to award around £30,000 to SUN, the largest grant it had ever received. At the same meeting there was indecision about whether to base SUN in the 'east or west coast' (Edinburgh or Glasgow).⁶⁶⁴ Regional geopolitics often had a great bearing on the patterns of cooperation and conflict which animated the emerging user movement in Scotland. Relations between some groups and individuals within the movement in Scotland were becoming increasingly fraught with tension despite the newly available finances and the optimistic rhetoric about developing positive links and forming alliances across the country.

The Chair of SUN informed the November meeting that he 'heard of rumblings about SUN, particularly from Lothian and Borders', but that he regarded this as 'positive, showing that any ideas of apathy are unfounded'.⁶⁶⁵ He remarked that he had considered resigning from the Chair, but decided against such a course of action and asked people to make contact with him so that the Executive could address issues of concern. He went on to give assurances that he 'would like to see representation on the Executive from each of the regions in the future'.⁶⁶⁶ John Macdonald sought support from the SUN executive to join the executive of the United Kingdom Advocacy Network (UKAN), a mainly English-based service-user led advocacy organisation which had developed over the previous few years. Edna Conlon from UKAN had spoken at the SUN AGM in March and there had been contact between the two organisations previously through former LINK and SSO member, Tam Graham. The relationships between the regions, between local and national groups, between user groups and larger voluntary sector organisations, were becoming key matters of discussion, strategy, and ultimately, bones of contention, for SUN, just at the time when the organisation was set to receive its largest pot of funding to date.

In a letter sent by AB to another Executive member he admitted that he was 'very wary of SUN going under the generosity of a big provider'.⁶⁶⁷ AB argued for locating premises at an 'Edinburgh address which is not dominated by a provider'. He added that 'I have made no secret of

⁶⁶² SUN correspondence, undated, OMH/16/5/1.

⁶⁶³ SUN meeting minutes, 17 November 1994, OMH/16/3/1.

⁶⁶⁴ Ibid.

⁶⁶⁵ Ibid.

⁶⁶⁶ Ibid.

⁶⁶⁷ SUN correspondence, 12 December 1994, OMH/16/5/1.

my preference for an underground room at CAPS'.⁶⁶⁸ In relation to affiliating with organisations in England he asserted that 'SUN is very wary of UKAN, but it is personalities, not principles'.⁶⁶⁹ Within a few months, at the beginning of 1995 SUN received a grant offer from the Scottish Office. The money was awarded to enhance SUN's role as 'a national network and representative body'.⁶⁷⁰ A strategy was proposed by SUN 'to develop a democratic user body to represent Scotland that will create a dialogue to and from local users' and 'local and regional user groups will be contacted with a view to participation, as will users of large mental health organisations'.⁶⁷¹

It appeared that SUN was looking forward to a new dawn with the financial support of the government, but the 'rumblings' from local groups which the Chair had encountered had now reached the heart of the SUN Executive. Tensions between members of the Executive Committee were such that it was proposed that the SUN Secretary AB's 'membership of SUN be terminated'.⁶⁷² It was pointed out that he had not been elected at the 1994 AGM. Despite agreeing to step down from his post AB continued to act in this role despite a vote to replace him. Within months conflict broke out again. On 22 June 1995 McDonald reported to the SUN Executive Committee meeting on the matter of organisations which 'merited SUN affiliation'.⁶⁷³ Macdonald's view was that SUN should affiliate with MIND and UKAN. He informed the assembled Executive membership that he and Tam Graham were already Scottish representatives of UKAN. After discussion in which affiliation with SANE was also considered, the minutes recorded by AB stated that 'it was decided unanimously to approach MIND and SSO (Survivors Speak Out) with a view to establishing a working relationship'.⁶⁷⁴ At the next meeting in July, however, 'AB was accused of being less than accurate in the minute of 22 June with respect to the recommended SUN affiliations by John Macdonald'.⁶⁷⁵ The minutes of the July meeting recorded that 'there was a certain amount of uncertainty about this'. AB argued that he was 'opposed to affiliating with UKAN as presently claiming UK status whilst an indigenous advocacy service might have a chance to grow'.⁶⁷⁶ In a letter sent by AB to three other members of the Executive on 24 July, he explained that

John's affiliation proposal was not minuted as carried by me because it was not properly proposed, seconded and carried. Affiliation to UKAN was controversial and I would have made a strong case against affiliation, but it was never put to the vote. Graham's motion on MIND and Survivors Speak Out was [...] My general view of John's amendments are that they tend to further John's agenda. If he argues that mine further my agenda, at least until he raised such extensive criticism mine had the support and approval of the executive. What matters to SUN is not the agenda of the author of the minutes as their

⁶⁶⁸ Ibid.

⁶⁶⁹ Ibid.

⁶⁷⁰ SUN meeting minutes, 15 February and 6 March 1995, OMH/16/3/1.

⁶⁷¹ SUN meeting minutes, 23 March 1995, OMH/16/3/1.

⁶⁷² SUN meeting minutes, 11 April 1995, OMH/16/3/1.

⁶⁷³ SUN meeting minutes, 22 June 1995, OMH/16/3/1.

⁶⁷⁴ Ibid.

⁶⁷⁵ SUN meeting minutes, 19 July 1995, OMH/16/3/1.

⁶⁷⁶ Ibid.

fairness as a record. I stand by my minute of 22 June as approved by the Executive at their meeting on 19 July.⁶⁷⁷

In a letter AB sent to Stephen Maxwell, grant holder for SUN and Deputy Director at SCVO, he repeated his claims and elaborated his case:

I have no objection to UKAN's writ running in England (though it makes nonsense of their neat title). But when there is a whole fresh interest in advocacy running in a differently mental health structured Scotland, it seems daft to become a minor group in UKAN when we claim a major role in Scotland.

John's position in all this is that he was to be sent by LUF (Lothian Users' Forum) to a UKAN meeting in Sheffield. He asked SUN for approval and we told him he could go as an observer and report back. He came back as the Scottish member of UKAN executive management committee 1995, along with Tam Graham [...] There is a map in the late spring issue of *The Advocate* [UKAN's magazine] which shows John and Tam ruling Scotland for UKAN. Who gave him this brief for SUN? [...]

Though I could work with UKAN, I wouldn't have John and Tam representing Scotland on my executive [...] At the July meeting we got the [...] motion deferring all affiliations [...] John doesn't like this – and I can see why – because [he says] 'one effect of this has been to compromise and jeopardise the work I have been doing towards creating UKAN in concert with SUN and thereby effecting change towards a strong representative Scottish and UK-wide user movement'. Who gave him that brief? There is a good case to do nothing until we have staff in place and can brief them on SUN here before we get into foreign relations with English organisations.⁶⁷⁸

Months later AB was suspended following a motion of no confidence. After this motion was carried it was proposed that AB should be expelled from membership of SUN 'on the grounds of his persistent failure to acknowledge his democratic accountability to the SUN committee, his refusal when Secretary to implement SUN decisions, and his misrepresentation of SUN's position'.⁶⁷⁹ This motion was opposed by Graham Morgan who believed that AB 'had made major contributions to SUN's development and that his suspension from Secretary's post meant that the problem of Mr AB's failings as Secretary had been resolved'.⁶⁸⁰ An amendment was then introduced after John Macdonald said he was not willing to support the motion at that time but that AB should be informed of the probability of a new resolution for expulsion unless he agreed 'to pass over the materials of Secretaryship as requested, to give a guarantee that as a committee member he accepted the Committee's authority to act on SUN's behalf and that he cease harassment of SUN committee members'.⁶⁸¹ The amendment was agreed, but soon after AB was finally ousted from SUN.

The acrimony of these exchanges was not quickly forgotten. Speaking in 1997 one member reflected that

the history of SUN is chequered to say the least. There was the AB affair. A former secretary, he was totally autocratic, off the wall. AB was SUN. He was finally expelled last year. The next secretary stole

⁶⁷⁷ SUN correspondence, 24 July 1995, OMH/16/4/1.

⁶⁷⁸ SUN correspondence, 12 August 1995, OMH/16/4/1.

⁶⁷⁹ SUN meeting minutes, 26 October 1995, OMH/16/3/1.

⁶⁸⁰ Ibid.

⁶⁸¹ Ibid.

money. So he went. Then [...] the development worker, left under a cloud [...] It was very difficult until AB finally went at the AGM at the end of June – until then, he kept turning up.⁶⁸²

A worker of SUN, who was not a user, commented, 'I've never come across such a volatile group - tears, swearing, stomping out. There's an incredible amount of behind-the-scenes backstabbing and politicking'.⁶⁸³ It was put starkly that:

the very nature of the organisation has been troubled historically with infighting and politicking on the Executive, which is very detrimental to health. It's sometimes more of a battleground than a helping organisation. It's about a lack of a decent standard of ethics, it's about ego and personal agenda issues. It's always been a conglomerate of individuals and not a representative body. It's changing, but it's proving hard work to change the internal culture.⁶⁸⁴

One member summed up a widely-held perception at the time that the roots of the tensions within SUN were due to its being 'dominated in the past by one or two key people whose personalities put people off'.⁶⁸⁵

Whilst it is clear that strong passions entered into the disagreements and there were personality clashes and accusations of individuals pursuing their own agendas, these conflicts were also marked by difficulties in negotiating relationships between different organisations from separate geographical regions. The question of affiliations and overlapping membership of different groups was also at the heart of the problems. Disputes were coloured by regional and national geopolitics. Most of the executive committee members of SUN were involved in groups other than SUN, whether local user groups, larger voluntary organisations or other national networks such as UKAN or SSO. The fora created by user groups could function as spaces of convergence, places of information sharing, cooperation, of free and open discussion and debate. But they could also become agonistic spaces of internal struggle and contention. Evidently some of the tensions were tied to territorial divisions and rivalries. There were debates over which voluntary sector organisation should become a supporting body of SUN, and conflict over which groups to form alliances with. Since some individual members were wearing different hats for separate organisations, conflicts of interest inevitably arose. Consensus was difficult to reach, yet decisions nevertheless had to be made. When deliberation failed, SUN had recourse to procedural democracy and votes were taken. But votes were seldom resolved to everybody's satisfaction, and there were further disputes over whether procedures were properly followed. As committee members were often absent from meetings, durable relationships between individuals were difficult to sustain. The challenges of bringing together a disparate group of people from different parts of the country, to build mutual understanding, trust and agreement, proved difficult to surmount. A small group at the centre of SUN was trying to develop a nationwide movement, yet was finding itself bogged down

⁶⁸² Iain Ferguson 'The potential and limits of mental health service user involvement', (Unpublished PhD thesis, University of Glasgow, 1999), p. 247.

⁶⁸³ *Ibid.*, p. 246.

⁶⁸⁴ *Ibid.*, p. 232.

⁶⁸⁵ *Ibid.*

in the micropolitics of management and the deliberations of democracy in an executive committee of less than 10 people.

In 1998, George Ronald became Director of SUN in a reboot of the organisation. He considered the 'commitment' made by individuals and groups of user activists 'to be almost a calling, a cause even'.⁶⁸⁶ In a SUN newsletter he declared

I have a vision for a national mental health movement that is untarnished by lack of action, in-fighting and petty jealousy. There is a lot of that about and it does nothing for the credibility of the user movement. No individual is bigger than an organisation and no-one is indispensable either.

We owe it to our members to haul SUN into the credibility bracket [...] SUN has not lived up to the expectations of many, and I count myself as having failed in a voluntary capacity for not achieving more in the collective sense over the last few years. Our funders have taken a risk but have backed our commitment to change and the process we are about to undertake is crucial to the mental health user movement in Scotland having a national users' organisation.

I refuse to stand idly by and watch our national users movement being picked off by English-based organisations, when I know full well that in Scotland we have the people, intelligence, commitment and above all, ability, to deliver a first class service to SUN members and deliver we will!⁶⁸⁷

He explained that he

had a relatively brief spell as treasurer of UKAN (United Kingdom Advocacy Network based in Sheffield) where my partner was also Chair of that organisation, but their standards *at that time* did not match ours and we left them to concentrate on using our expertise and energies where they would be better appreciated, hence my return north of the border principally for work reasons.⁶⁸⁸

John Macdonald reflected that at this time 'the relationship between Scotland and the rest of the UK was never quite sorted out. There was representation and I was one of those representatives [...] It was always interesting hearing what other people, what was going on around Britain because I think Scotland can become a bit parochial'.⁶⁸⁹ A working agreement was made between SUN and UKAN to clarify when it was appropriate for the two organisations to apply for funding in Scotland and England and how the national networks could work together. But while national organisations developed, the dominant trend of the 1990s was the growth of opportunities for involvement in consultation with local authorities, health boards and other planning agencies, which had the effect of entrenching the localisation and regionalisation of user activism.

4.8 Geopolitics of Identity and Fragmentation

Under the Conservative government of John Major the two-tier system of regional and district authorities in Scotland was disaggregated and local government was reorganised into smaller local councils. In the Lothians, for example, LUF was reorganised to reflect the geographical boundaries of the planning structures of the new councils created by the Local Government etc (Scotland) Act

⁶⁸⁶ Scottish Users' Network Newsletter, Spring 1998, p. 3, OMH/16/13/1.

⁶⁸⁷ Ibid.

⁶⁸⁸ Ibid., p. 4.

⁶⁸⁹ Macdonald, OMH/1/10.

1994. LUF was reincarnated as Edinburgh Users Forum (EUF), separate from local forums and groups in Midlothian, East Lothian and West Lothian. According to Macdonald after the move from regions/districts to council areas, 'when [LUF] decided to do the same... I think we lost something. I never felt the Edinburgh/Lothians structure ever really hung together and we always had the same health board... I think we maybe made the wrong decision'.⁶⁹⁰ He believed that 'the localised thing [...] prevailed [...] and it demonstrated how bureaucratic and meaningless these local structures [were] [...] Much of the movement is mediated and [...] held in by this sort of bureaucratic nature of the thing'.⁶⁹¹ Despite concerns that geopolitical machinations were shaping the agendas of user groups, activists such as Macdonald attempted to work within the structures which government had created for user consultation. Macdonald remembered clearly that

there was a lot of consultation going on late 1990s and 2000s around the end of the Tory government, the beginning of the Labour government, the beginning of the devolved government. In fact it was 'Consultitus land', but it kept going on and on. Also all the care standards were being established, clinical standards, you name it. So SUN was putting people in there with experience, not just people on their committee but other people who were put in locally.⁶⁹²

Stephen Maxwell, the grant holder for SUN at SCVO, former parliamentary candidate and major figure in the Scottish National Party, recalled that SUN was able to 'respond to policy documents [...] with a high level of competence [...] [but] it was the same group of people under a different name who the Scottish Office were already familiar with from their own individual groups, giving them opinions rather than engaging with a wider constituency'.⁶⁹³ SUN, as well as some active local user groups, made contact with politicians to raise the agenda of mental health and offered members with an appetite for politics an outlet to campaign and participate in protest against cuts in public sector expenditure. In the run-up to the 1997 UK general election, SHINE, The Newsletter of SUN, reported that the organisation had 'asked the four major parties for a statement on their priorities for the development and funding of the mental health services'. Statements from the Labour Party, the Scottish National Party (SNP) and the Conservative Party were elicited and published and it was noted that the 'Liberal Democrats unfortunately did not respond to our request'.⁶⁹⁴ In the same edition of the newsletter, under the headline 'Fight Back!', one user described a protest he attended, a 'day of action over the enforced government cutbacks' and a seminar entitled 'We're Revolting' organised by EUF, described as 'the most invigorating informative experience'.⁶⁹⁵ The user wrote that

The only let down was that even though users from Glasgow and elsewhere had been invited to speak, they did not turn up. Come on Scotland, get it together, as together we stand strong and can stop the cuts. In fact together we can improve the services we use [...] The best way to do so would be to have a users'

⁶⁹⁰ Ibid.

⁶⁹¹ Ibid.

⁶⁹² Ibid.

⁶⁹³ Stephen Maxwell interviewed by Kirsten Maclean, April 2010, OMH/1/68.

⁶⁹⁴ SHINE, The Newsletter of the Scottish Users' Network, May 1997, pp. 2-3, OMH/16/13/1.

⁶⁹⁵ Ibid., p. 4.

overlooking association [...] No political party must ever get away with making cuts to community services which we all need at some time in our lives.⁶⁹⁶

A third Scottish Users Conference also took place in 1997, four years after the previous (second) national conference. At the event Adrienne Sinclair-Chalmers continued to speak 'of the need for the provision of Crisis Centres and twenty-four hour telephone lines to be an integral part of any Community Care Plan'.⁶⁹⁷ George Ronald warned that 'hospitals are being closed and sold whilst remaining hospitals are reducing the amount of beds available to people experiencing mental health problems, without providing adequate community care, resulting in an increase in homelessness of a very vulnerable and needy client group'.⁶⁹⁸ He 'highlighted the need for education of the general public, hopefully reducing the stigma of mental health sufferers and improving their quality of life'.⁶⁹⁹ Malcolm Chisholm, Labour MP and Shadow Spokesman on Community and Housing, attended the conference and participated in 'an open session allowing all those at the conference to put forward their questions'.⁷⁰⁰ There was disagreement about the term 'users' at the conference.⁷⁰¹ One leading activist at the conference remarked that

There's been a sea-change in attitudes in the past few years. People have been going overboard to involve us in consultation - the Scottish Office, the Health board and so on. My cynicism may be proved wrong but while we're talking about making improvements, the powers that be have been making cuts [...] Without money to back up services, it's just a talking shop. We will not sit passively by and watch our lives being destroyed by intolerable funding cuts. Don't give us something and then take it away again. To take funds away from a project that is working is obscene.⁷⁰²

New opportunities had opened up with the 1990 Community Care Act, but while most activists welcomed the proposed closure of old asylums and new opportunities for consultation with health and governmental authorities, suspicions remained that successive Conservative governments did not have mental health service users' best interests at heart. The worries about tokenism foreseen by Huw Richards in the early days of SUN had never been allayed. The election of Tony Blair's New Labour government in 1997 and its promise of a referendum on devolution for Scotland seemed to offer the prospect of a new dispensation for mental health and social care services, especially in the wake of the newly proposed *Framework for Mental Health Services in Scotland*.⁷⁰³ This *Framework* was produced after the Scottish Grand Committee was critical of 'the lack of formal policy objectives for mental health' in Scotland.⁷⁰⁴ The purpose of the *Framework* was to clarify and consolidate existing policy and produce a set of principles and 'priorities for

⁶⁹⁶ Ibid.

⁶⁹⁷ The Scottish Users' Conference 8th of February 1997 Summary, OMH/2/7/4.

⁶⁹⁸ Ibid.

⁶⁹⁹ Ibid.

⁷⁰⁰ Ibid.

⁷⁰¹ Ibid.

⁷⁰² Quoted in Iain Ferguson 'Identity politics or class struggle? The case of the mental health users' movement' in *Class Struggle and Social Welfare*, ed. Michael Lavalette and Gerry Mooney (London: Routledge, 2000), p. 249.

⁷⁰³ Scottish Office, *Framework for Mental Health Services in Scotland* (Edinburgh: Scottish Office, 2007).

⁷⁰⁴ Ibid.

action' in the operation of policy.⁷⁰⁵ After a wide consultation process which involved service users the report identified the following priorities for action: cost-effectiveness, clinical effectiveness and the development of a 'yardstick' against which outcomes could be measured.⁷⁰⁶ One advocacy worker from a West Lothian project believed that

We had a big risk with care in the community just being care on the cheap [...] There was a lot to fight over. Things like the ring-fencing of resources [...] making sure that those were maintained at a level that was required, joined up thinking was required where housing, social work, voluntary sector, everyone, was involved around the table [...] One staff member used to talk about professional tribalism and about the need to break that down [...] stop people fighting over their wee empires and storing up their own resources.⁷⁰⁷

This advocacy project coordinator, Chris Galbraith, remarked that while 'staff had to move away from this very warehouse, maintenance type approach, towards actual working with people [...] there was a lot of politicising, if that's the word. People had their own agendas. I still think patients' welfare was used to dress up other people's agendas'.⁷⁰⁸ He spoke of how, in the wake of changes to local government, the local user groups 'had bigger meetings every now and then, Lothian Users and West Lothian and East or Mid and all came together'.⁷⁰⁹ 'Those sharings were good', said Galbraith, 'but I don't think they created very strong links between [...] some of the group members'.⁷¹⁰ He explained that the West Lothian group 'would try to link in with Scottish Users Network as well, and feed up, but I don't think the links were as strong'.⁷¹¹

Whilst there were challenges in bringing together different agencies and professions alongside user activists to change practices in mental health services, user activists faced their own challenges in working together as campaigners. According to Macdonald 'the problem in SUN was finding enough people to be on a committee who weren't at each other's throats or weren't running some little show themselves'.⁷¹² Although some of SUN's problems were shaped by clashes of personality and the dominance of a few individuals in the organisation, its problems went beyond this. The ambitious scope of the project presented challenges thrown up by the geography of Scotland and the logistics of bringing people together from across the entire country. According to one SUN activist 'a lot of energy was taken up trying to set up the infrastructure for that organisation, trying to ensure that the funding continue, trying to get user groups to join, trying to sort out some of the tensions between people in the executive, some of the members'.⁷¹³ Stephen Maxwell observed that

[SUN's] job was to create a proper users movement throughout Scotland. And that really proved the most difficult bit of the job, because although there was a small network of users or organised users groups with funding of some sort or another, SUN set itself the target of actually establishing new users groups

⁷⁰⁵ Ibid.

⁷⁰⁶ Ibid.

⁷⁰⁷ Chris Galbraith interviewed by Kirsten McLean, October 2009, OMH/1/43.

⁷⁰⁸ Ibid.

⁷⁰⁹ Ibid.

⁷¹⁰ Ibid.

⁷¹¹ Ibid.

⁷¹² Macdonald, OMH/1/10.

⁷¹³ Allison, OMH/1/

in areas where there weren't any. So that was the main criteria I think or the main objective of the organisation for which money was given. And that was where the Scottish Office hoped to see results and they proved pretty difficult.⁷¹⁴

Jim Kiddie remembers that at SUN 'there was some pretty nasty stuff went on there and I mean service users can maybe be nasty to each other at times, reflects what goes on in general society'.⁷¹⁵ He 'had to resign' from SUN because, he thought, 'I'm going to have another mental breakdown if I don't get out'.⁷¹⁶ Another Lothian-based activist, Jonathan, emphasised that one must 'remember, you're dealing with human beings and that can be positive, and that can be negative. People can have horrendous things happen to them and they can still be obnoxious'.⁷¹⁷ He also claimed that, 'SUN has been hijacked many times and it's very difficult in Scotland because there's so many different health groups and areas that it has been used as divide and rule'.⁷¹⁸ Maxwell echoed the comments of Macdonald on the tensions within the SUN committees:

[committee meetings] were very, very hard work [...] simply to get six, seven or eight people who were on the committee to agree. We would go round and round subjects finding it very difficult to agree [...] It was just difficult to reach consensus. And of course there was the usual irregularities of attendance [...] There was also some clashes of personality, clashes are not unusual in voluntary organisations and we had one or two.⁷¹⁹

Based on his experience of activism, Jonathan believed that

if you set up a group of people to be activists it's got a finite life before it gets taken over, diverted, or any funding disappears, or access to office space will change. So you're fighting on various fronts because you're fighting bureaucracy, you're fighting people who are supposed to be the same as you, trying to be activists, but who actually have a different agenda.⁷²⁰

Offering a pessimistic view of the attempts by user groups to take collective democratic decisions, he added that

committees just suck the soul out of you. Sometimes you think, "to hell with this, let's have a benign dictatorship", because at least you know things will get done [...] Within a group some of the things you believe will have to be compromised and it can be difficult respecting somebody's viewpoint when it's stupid and destructive and it's just going to carry on helping support the status quo or something restrictive that's coming up in the future.⁷²¹

According to Adrienne Sinclair-Chalmers from the Edinburgh/Lothian groups

the biggest miss in the user movement is, so far as I'm concerned, we've never had a successful national group. SUN [...] my God, that was enough to strike terror [...] There was people from Perth and Glasgow and [...] it was just awful. There were some people there who really hadn't got a clue [...] It really was a day out and if you want to know about pointless activity and lack of strategy and no plans [...] It was not a pleasant thing to go to, the Scottish Users Network, and I think I managed to get a few people round to the way of thinking that we did need a national users thing but that it should be something different from SUN [...]

⁷¹⁴ Maxwell, OMH/1/68.

⁷¹⁵ Kiddie, OMH/1/33.

⁷¹⁶ Ibid.

⁷¹⁷ Jonathan interviewed by Kirsten Maclean, October 2009, OMH/1/18.

⁷¹⁸ Ibid.

⁷¹⁹ Maxwell, OMH/1/68.

⁷²⁰ Jonathan, OMH/1/18.

⁷²¹ Ibid.

Stupidly, in my opinion, the Mental Health Foundation decided to give them money, and having seen the budget application that went in I can't imagine why anyone would give them any money, and thus was created... a monster. They had a couple of really good staff over the years [...] but the main problem was this damned committee [...] Nearly all of the people who used to go to the SUN meetings before, when it was just the meeting, were still involved in the management committee. And it never works when you are an organisation and you've basically consisted of a group of people [and] when you get staff [...] you've still got all these people who still think they're supposed to be doing all this stuff. It's just a basic thing that goes wrong in organisations. It's not particularly about us, it's not particularly because it was the user movement [...] There were always shenanigans going on and there was a couple of individuals involved in it who [...] if they'd been sensible, they would have been dangerous, but they weren't sensible and they were still quite dangerous.⁷²²

John McDonald remembers that 'even when [SUN] was trying to do the right thing [...] there were the local fiefdoms including Lothian who weren't really wanting to get fully involved [...] We found there was very much an attitude from Lothian and Highland'.⁷²³ Another user claimed that SUN was 'constantly being undermined by other groups'.⁷²⁴ Graham Morgan had moved from Edinburgh to the Highlands in 1996 and created Highland Users Group (HUG). In a short time HUG expanded its activities to reach individuals and groups of users dispersed across a geographically large and diverse area of the north of Scotland. Although Morgan was involved in SUN for a number of years before he founded HUG, according to John Macdonald, there was 'never really dialogue between SUN and HUG, for whatever reason. I'd say there were difficulties on both sides because HUG really wanted to go on its own. They could get the voice of the Scottish Executive without having to go through SUN'.⁷²⁵ Reflecting on the failed attempts to develop SUN, Jim Kiddie underlined that there should have been 'local user forums throughout Scotland that linked into that'.⁷²⁶ Kiddie pointed to how 'CAPS [...] helped to spawn advocacy throughout Lothian'.⁷²⁷ He believed that Lothian 'had a key part to play in setting an example to the rest of Scotland [...] Obviously circumstances can vary locally from place to place. Highland is another example of how they've developed things to suit themselves'.⁷²⁸ For Stephen Maxwell, users who were identified as SUN's 'leading personalities [...] all came and went a bit', between SUN and their local activities:

we had tantrums and vows never to cross the portal of SCVO or SUN again. But it didn't end with a great bang, it ended with a bit of a splutter, around the fact that we knew our funding was coming to an end and [one] particular worker was found to have been claiming [false] expenses [...] So that sort of put a dampener on the final six months or so of the initiative. So we ended up [...] without a national body, having spent [...] probably over three years, £120,000, quite a lot then really. It wasn't peanuts and we couldn't complain that it hadn't been adequately funded.⁷²⁹

⁷²² Sinclair-Chalmers, OMH/1/3.

⁷²³ Macdonald, OMH/1/10.

⁷²⁴ Ferguson, 'The potential and limits of mental health service user involvement', p. 285.

⁷²⁵ Macdonald, OMH/1/10.

⁷²⁶ Kiddie, OMH/1/33.

⁷²⁷ Ibid.

⁷²⁸ Ibid.

⁷²⁹ Maxwell, OMH/1/68.

Fiona Macdonald, who worked with CAPS (as a non-user) from the late 1990s, could not 'remember a time without conflict, some of which was very difficult for people'.⁷³⁰ She recognised the difficulties of managing conflict, claiming that it was

not about avoiding conflict, it's trying to find ways through that, that we can use that energy in a positive way and not let our own fora become a battleground for what are our own issues [...] Collective advocacy is mostly to do with campaigning [...] they are not personal support groups [...] It's a difficult one because, it's also a sign of health that there is conflict and there is free and open discussion. But perhaps that is something for us all to learn is how to manage the impact of that at an individual level because that can be difficult and painful for people.⁷³¹

In 2001 SUN imploded after repeated attempts by users to reform the national network throughout the 1990s. Maxwell remembers that in 1998

the attitude of the SCVO [...] was, 'it'll be a hell of a job getting [...] in three years anyway [...] a stable organisation led by users and capable of operating on the scale which you're claiming to be able to do'. So I suppose in that sense the sceptics were right [...]

Perhaps the problem was that it wasn't organic enough, it wasn't from the grassroots enough [...] a pretty centralised party [...] It has offices in Glasgow, Inverness and so on, but it's a central national organisation, so perhaps it wasn't fair really to ask a development officer to go out and start building these sort of substantial user groups out in the field so to speak, from a central base. The process really needed more support locally than SCVO or SUN was capable of providing.⁷³²

There were tensions and cleavages running through local, regional and national dimensions of the movement in Scotland. It was perhaps inevitable that groups involved in political and campaigning activities would succumb to splits, which are a common feature of party politics, identity politics and social movements more broadly. The territorialism and rivalries which former SAMH and then SCVO Director, Martin Sime had warned of in 1993 became increasingly evident as the decade rolled on. There was undoubtedly conflict between the 'local fiefdoms' as McDonald put it, and between organisations. A humorous symbolic expression of the tensions between SUN and CAPS was the choice of logo for these organisations. After SUN had naturally adopted a sun logo early in its existence, years later CAPS deliberately chose a moon and stars for its logo, with the implication that these organisations were as far apart as night and day.

In the course of his research on the user movement in Scotland, Iain Ferguson interviewed SUN members in the late nineties and observed that SUN in-fighting 'appeared to be linked to a lack of representativeness and accountability, with some individuals acting in what seemed to be a thoroughly individualistic, or even maverick, fashion'.⁷³³ Whilst Ferguson acknowledged the problems of personality differences and what one interviewee described as 'crass individualism', he identified the following factors as contributing to the difficulties: 1) 'the poor mental health of particular individuals, particularly if unacknowledged'; 2) 'the experience of suddenly being given a degree of power and responsibility, perhaps after a lifetime of feeling disempowered and being the

⁷³⁰ Fiona Macdonald interviewed by Jim McGill, August 2009, OMH/1/28.

⁷³¹ Ibid.

⁷³² Maxwell, OMH/1/68.

⁷³³ Ferguson, 'The potential and limits of mental health service user involvement', p. 246.

object of other people's decision-making'; and most importantly 3) 'the lack of clear democratic structures'.⁷³⁴ The ousted SUN Secretary AB had become an unpopular figure by 1995, was described pejoratively by other SUN members as a 'maverick' and held responsible for some of the internal tensions in SUN. But he did articulate a substantive difference between those in SUN who wanted closer ties with the wider UK movement and others who tended towards a kind of nationalist separatism. It is not plausible that one person was responsible for all of SUN's woes. But it is clear that even in the less formal context of a user organisation, a post-asylum 'space of licence', where there was supposedly less hierarchy and greater opportunity of freedom of expression than in a regimented asylum space, power relations, tensions and struggles over discourse were reconstituted between users and users.

Whilst SUN was unable to put into practice the structures of democratic regional representation which were agreed to in principle, conflicts within the user movement in Scotland were not confined to the national organisation SUN. Worries about centralisation were reflected on a smaller scale at a local level. Jim McGill remembers campaigning in East Lothian and Midlothian and trying to get people involved. He would say, 'By the way we're thinking about putting together a service user group'.⁷³⁵ He would get the reply: 'Aye, that'll be Haddington then?' And later on in Midlothian he would get the reply, 'Aye, that'll be at the Orchard Centre then?'⁷³⁶ Even at regional and local level, centralisation was evidently off-putting for people who lived away from town centres and community hubs. McGill reflected that

it's about identity and about people seeing this as being kind of centralised, so what about service users on the periphery of this stuff [...] Because [East Lothian] is a large rural area by definition there will be people with mental health difficulties who don't stay in Haddington [...] there's going to be people out at Dunbar and Cockburnspath and Oldhamstocks and half way up the Lammermuir Hills [...] How do we get them involved?⁷³⁷

Maggie Keppie, who was a major figure in REHPC for many years, reflected that

Between nine and ten years in there was a lot of internal fighting with the Patients' Council plus there was fighting between the Council and the supporting body [...] At the time I did wonder whether the Patients' Council was actually going to survive or whether it was going to be destroyed from within, which was very sad at the time. You had users fighting users, you had users saying workers had done this and workers had done that. It was a really hard time and at one point I really thought the Trust were going to say 'we've had enough'.⁷³⁸

For John McDonald 'you can get sucked into the emotions and the meaning of the movement and the meaning of the movement becomes too much and if you don't know how to get out of it, you are trapped in a situation that can be so damaging'.⁷³⁹ He recalls how

⁷³⁴ Ibid., p. 247.

⁷³⁵ McGill, OMH/1/36.

⁷³⁶ Ibid.

⁷³⁷ Ibid.

⁷³⁸ Keppie, OMH/1/9.

⁷³⁹ Macdonald, OMH/1/10.

I was just involved in hugely dirty politics. It taught me a huge amount. There was a time when personally speaking I realised the life choices I had made had driven me into what I called 'The Mental Health Square Inch' I literally lived, worked, did my voluntary work all within about half a mile and there were links between everything, so strong, that when you were part of the set-up, you know, you had a sort of cushion but it was quite Ugh.. Even going to SUN was actually a liberation from being in the Edinburgh Users' Group.⁷⁴⁰

Iain Ferguson interviewed an Edinburgh-based activist in the late nineties who told him that 'Scotland has got a major problem in user involvement because it is so lacking in cohesion. We have very little association with for example Glasgow which has got to be one of the other major areas and there is quite a lot of divide and rule applied to us'.⁷⁴¹ According to another user activist, Les, he 'wasn't welcomed':

I wasn't part of it. There seemed to be this group of people who all knew each other and they had their 'in' conversations and I felt ostracised. You are there for a meeting to be inclusive, not to have your matey conversations. They might welcome me and say hello and everything; but it was until you're part of the in-crowd you're not part of this.⁷⁴²

He added that although he had done much in terms of participation or involvement in local activities, he did not feel part of a wider movement: 'I don't feel part of some user movement. When people talk about a user movement I don't feel part of that'.⁷⁴³ John Macdonald believed that user groups and advocacy organisations themselves 'became almost like a power structure I have to admit':

I was right in the middle of it, although I felt I was trying to humanise it. Sometimes [...] if the person at the centre of it became threatened, you know it was very easy for anybody who threatened that person to get excluded from the social network and if that didn't work, from other networks. I think there was a lack of recognition of people's talents if they didn't fit into the sort of squirearchy. It was a favouritism system.⁷⁴⁴

Apart from limitations imposed by local, regional and national identities and geographies, and the difficulties of cooperating and coordinating activities in a way that was open, welcoming and inclusive for members, the type of activities user groups engaged in made great demands on individuals. McGill stressed that 'it is a lot of responsibility, it can feel like a lot of responsibility and if we're overloading service users to the point where they become disillusioned or ill, which would be even worse, then we're not doing it properly and I think that's maybe a hard lesson'.⁷⁴⁵ Jeff, who was involved in the Awareness group, believed that the roots of tensions within the movement were that

people were doing all of this voluntarily, a lot of hard work, a lot of time, a lot of personal resources and at the same time as having issues of mental health problems [...] I think with the passion and strength of

⁷⁴⁰ Ibid.

⁷⁴¹ Ferguson, 'The potential and limits of mental health service user involvement', p. 285.

⁷⁴² Les, OMH/1/72.

⁷⁴³ Ibid.

⁷⁴⁴ Macdonald, OMH/1/10.

⁷⁴⁵ McGill, OMH/1/36.

feeling involved in the movement, people maybe put too much of themselves into the movement to make things better and as a result probably adversely affected their mental health and that created tensions between people.⁷⁴⁶

The first national advocacy worker for SAMH, Anne Bardsley remembers the heavy workload in this role:

I started off 30 hours and I was finding [...] I was working about 60 [...] I think it's something that a lot of people with mental health problems feel, you've got to work twice as hard just to feel half as good as everybody else, and I don't think that's right. I ended up in hospital again and at one point I ended off for about a year.⁷⁴⁷

Such sentiments were echoed in the reflections of other user activists of the late nineties period.

Maggie Keppie had a similar experience in her work at REHPC:

Sometimes I could end up doing 80 hours a week at different meetings, different conferences [...] So, burn out. A couple of times I ended up in the Royal Ed[inburgh] because I pushed myself so far and used every brain cell in my head and every ounce of energy in my body.⁷⁴⁸

Graham Morgan emphasised that:

It's more than just work. The stuff that I do is all about changing the world and I believe in it desperately and I'm allowed to do it. I feel more fortunate than almost anyone to be able to do something I love doing and still get paid for it.

I was working in a job [at CAPS] that was promoting the rights of people with mental health problems and promoting their voice. This was a new sort of job. There were very few jobs like this in Scotland. It was maybe the first of its kind in Scotland and I was desperate to do a good job, but I didn't know much about how you work. I didn't know that if you work into the evening that you're allowed to take time off the next day or the week after. I didn't have any confidence in my ability and so for a number of reasons I worked harder and harder, got tired and tired [...] I got to the point where I couldn't stop thinking and I ended up becoming quite ill, well, very seriously ill for quite a long time, because I didn't take time for myself. I didn't look after myself. I didn't accept or look for any critical evaluation of what I'd done and I think that really damaged me.⁷⁴⁹

Perhaps more cynically, Jonathan suggested that

you've got to be careful with this, some people can take on a persona or they find that they have a dramatic role in life, it's not real, but it's a drama and the adrenalin is rushing. They should be something else, take up sports, I mean whatever. People can be destroyed by it.⁷⁵⁰

For Colin Murray user activism 'can be hugely liberating for people and it can be enormously damaging for people and everything in between'.⁷⁵¹ Anne O'Donnell believed that the one thing the user movement gave her was 'that connection between what happens to me as an individual and what happens in broader society', but looking back on the period, she reflects:

⁷⁴⁶ Jeff, OMH/1/8.

⁷⁴⁷ Bardsley, OMH/1/1.

⁷⁴⁸ Keppie, OMH/1/9.

⁷⁴⁹ Graham Morgan in 'Nice Work...if you can get it' film, available at <http://voxsotland.org.uk/vox-collective/> [accessed 3 May 2016].

⁷⁵⁰ Jonathan, OMH/1/18.

⁷⁵¹ Murray, OMH/1/4.

we could have looked after each other and ourselves a lot better. Because people were very impassioned by it, I think they could be intolerant about people who didn't quite see things the way we did and there was some personality conflicts and I wish we'd handled them a lot better. That was in the late nineties. I remember at the start being impressed by the sense of community and solidarity, but I don't know if that was me being idealistic and finding a space where I felt safe or whether it was there and it got diluted by increased demands and the differences that can arise when people work together.⁷⁵²

Activists in the 1990s were engaged in outward-looking and inward-looking politics, speaking to other groups and agencies, trying to transmit a collective message to a broader public, while also talking among themselves. Inevitably they were no less susceptible than any other political actor to the fact that 'political activity seems to encourage many of the less agreeable traits of human nature'.⁷⁵³

4.9 Making Public Their Use of Reason: Instrumental, Communicative and Expressive Rationality

During the period leading up to and following the Community Care Act of 1990, activists and their allies from Scotland compared the fortunes of collective action by patients in Scotland with those of activists in England, and they were determined to develop a distinct national movement. They did this by promoting self-advocacy, by creating a national magazine, a national networking organisation, through assembling their own conference spaces, and by lobbying at the heart of the state legislature in the Houses of Parliament. The Scottish Users' Conferences and *Beyond Diagnosis* constituted public fora for users to critique mental health services, to voice concerns and to express their views, to discuss and debate and to develop relationships across the country and demonstrate their capacities as citizens. The increasing importance of social workers in the field of mental health, first through the 1984 Mental Health Act, then through the Community Care Act, and the increasing participation of the voluntary sector in the mixed economy of mental health care and its changing social relations of production, aided the process of users making their voices heard. Allies like Huw Richards, Shulah Allan, Colin Murray and Be Morris were sympathetic to the social struggles of psychiatric patients and were instrumental in facilitating the access to spaces for users to meet, to debate and organise. Whilst there had been local groups like SUMP, LINK and Awareness in the past, there pre-existed no already constituted national group prior to 1989 when SUN was formed. By this time many of those who had organised local meetings and groups came to see that the activities they were engaged in, they did together as active citizens. Through their public meetings they mounted a critique which questioned particular forms of power from which they tried to free themselves. They refused to be governed in particular ways by particular authorities, with emphasis on the power exercised by psychiatrists in framing their problems as

⁷⁵² O'Donnell, OMH/1/32.

⁷⁵³ Michael Oakshott, *The Politics of Faith and the Politics of Scepticism* ed. Timothy Fuller (London: Yale University Press, 1996), p. 20.

biologically-based, through diagnosis and compulsory drug treatment and by coercively governing their conduct. The state was also a target of their activities and they made demands for central and local government to develop public policy that was more responsive to the needs of service users, to involve service users in policy-making processes, to increase the allocation of resources for mental health services and the development of organisational structures by which a system of community-based mental health care could be realised. The discursive practices employed in public by activists evolved in a social and political context in which the constitutional status of Scotland within the United Kingdom became an increasingly significant factor in the formation of the organisational structures, discourse and practices of user groups. Yet they were engaged in a broader struggle against objectifying and dehumanising tendencies of psychiatric science, medicine, technology and technocracy, which contributed to the diminution of their humanity, dignity, personhood, subjectivity and agency. The sense that a national movement of collective action by psychiatric service users was coming into being in Scotland during the 1990s, was tied not only to territoriality, but also to a sense of shared collective interest amongst those diagnosed mentally ill.

No doubt they were exercised strategic forms of instrumental rationality, calculating the means to achieve certain pre-determined ends. Instrumental reason is often characterised in terms of self-interested actors making a cost/benefit analysis to calculate the consequences of possible actions. Instrumental reason is present if there is an intelligible connection between the ends achieved and the means adopted to achieve them. The forms of political participation which activists engaged in constituted 'new loci for citizenship practices' and evolved new forms of collective political identity and agency, created from the piecemeal assemblage of practices and notions of anti-psychiatric abolitionism, democratic ideals, civil rights, trades unionism and nationalist sentiment.⁷⁵⁴ In the 1990s there was talk of 'fighting against the system', 'imbalance of power', and 'working out strategies to achieve set objectives'. The collective action of users could also be characterised as embodying communicative rationality, when reason is exercised in an 'ideal speech situation', where communication is free from coercion, realising 'deliberative ideals of critical and unrestrained discussions among free and equal participants'.⁷⁵⁵ Certainly there was much emphasis during the 1990s on 'shared experiences', 'building of a community', on establishing 'common needs', 'dialogue and partnership'. In addition to developing 'their own power, individually and collectively', user activists wanted to create 'a democratic body', 'raise public awareness', provide a 'forum for discussion', 'network', 'make contacts', 'link people together', 'exchange information' and 'cooperate'.

⁷⁵⁴ Jakob Svensson, 'Expressive Rationality: A Different Approach for Understanding Participation in Municipal Deliberative Practices', *Communication, Culture and Critique* 1 (2008), p. 203.

⁷⁵⁵ Jakob Svensson, 'The Expressive Turn of Citizenship in Digital Late Modernity', *JeDEM – eJournal of eDemocracy and Open Government* 3 1 (2011), p. 43.

Engaged in a struggle for value, they went beyond the calculation of outcomes and means, and engaged in activities which had their own intrinsic benefits regardless of their practical and strategic use as means to socio-political ends. In this sense some of their activities can be characterised as disinterested, in the manner of aesthetic experience or play. Much of the activity of groups had a conversational rather than a debating thrust, with no clear end in sight and no calculation of defined outcomes. For philosopher Michael Oakeshott the ability to participate in politics as a conversation is far more important than ‘the ability to reason cogently, to make discoveries about the world, or to contrive a better world’.⁷⁵⁶ He was opposed to the view that only results matter in politics. If politics is to be more than administration or economic engineering it must draw on customs and traditions, instead of abstract principles or general doctrines: ‘in its participation in the conversation each voice learns to be playful, learns to understand itself conversationally and to recognise itself as a voice among voices’.⁷⁵⁷ In addition to exercising instrumental and communicative rationality, user activists exhibited expressive rationality.⁷⁵⁸ By expressing their sense of themselves as active citizens, participating with the purpose of expressing their values in a decision-making forum, they were able to claim respect and recognise themselves and others as free and equal. The sense of meaning, purpose, belonging, friendship and the expression of identity that participation bestowed on activists was a powerful motivating factor for many to take part in user groups. In the words of the poem *United We March*, written by James P. Spence and published in *Beyond Diagnosis*, ‘We marched together, staunchly united [...] The unemployed went for the politics. I, new to the ranks, went for the company’.⁷⁵⁹

Participation in these groups and activities were valued for their own sake and yielded intrinsic benefits. For those who formed lasting friendships and some who found their spouses through participation in user groups, they entered into long-term relations of intrinsic value. While some individual activists fell out, others became friends, and some fell in love. These activities are non-instrumental, carried out for their own sake. By attempting to build a culture beyond diagnosis, and by creating a community tied to interest and territory, the movement in Scotland formed a collective identity in which they articulated and expressed an ‘ethno-symbolic nationalism’ and a ‘vision of the quasi-national community of the mad’ which ‘[went] beyond individual life narratives, and bind[ed] them into a larger whole’.⁷⁶⁰ Tangible examples of how there was ‘assertion by the mad of a distinct culture and identity’ from the 1990s and into the 2000s, include: the decision to create a national network separate from the rest of the UK, publication of a national

⁷⁵⁶ Michael Oakeshott, ‘The Voice of Poetry in the Conversation of Mankind’, in *Rationalism in Politics* ed. Timothy Fuller (Indianapolis: Liberty Press, 1991), p. 490.

⁷⁵⁷ *Ibid.*, p. 493.

⁷⁵⁸ This idea was developed by Geoffrey Brennan and Loren Lomasky in *Democracy and Decision: The Pure Theory of Electoral Preference* (Cambridge: Cambridge University Press, 1993) to explain why voting in circumstances where a vote can make no practical difference can still be in accordance with reason.

⁷⁵⁹ James P. Spence, *United We March* in *Beyond Diagnosis* 6, (Undated), p. 13. OMH/15/15.

⁷⁶⁰ Gavin Miller, ‘Madness decolonized?: Madness as transnational identity in Gail Hornstein’s *Agnes’s Jacket*’, *Journal of Medical Humanities*, (in press).

magazine in *Beyond Diagnosis*, the organisation of specifically Scottish users' conferences, activities such as art exhibitions, dramatic performances at the Edinburgh Fringe, the creation of Survivors Poetry Scotland, the inauguration of the Scottish Mental Health Arts and Film Festival in 2007 (still running in 2016) and the wearing of t-shirts emblazoned with 'Glad to be Mad' and 'Pscottish and Proud', and in the case of one prominent Scottish activist, tattooing his arm with the words 'Psychotic and Proud'.⁷⁶¹ Scottish psychiatrist and historian Allan Beveridge, who has written about the links between creativity and madness, has remarked that:

It is both therapeutic and cathartic for a person to make sense of what has happened to them through writing poetry. It allows patients to give their own perspective as opposed to merely hearing the doctor's view. It gives the person back his voice which can be a most empowering experience.⁷⁶²

Just as poetry and writing was empowering and expressive for some, so too was public speaking and the initiation of new networks, organisations, print media, public spaces, communities and the building of sub-cultures. In a letter to *Beyond Diagnosis* one reader wrote that he liked the idea that 'the psychiatric establishment can be changed for the better, gradually, by attrition. Psychiatric Glasnost is better than the wholesale destruction of a system which, despite its faults, could be replaced by a much less humane one if we're not careful. We need to build as much as knock down'.⁷⁶³ Glasnost means 'publicity' or 'openness' in Russian and the concept was employed by Soviet Union leader Mikhail Gorbachev in 1985 to initiate a policy of more open consultative government and wider dissemination of information. *Beyond Diagnosis*, like SUN, struggled for survival throughout its existence in the first half of the 1990s, but while it was unable to sustain itself beyond that period, it, along with numerous projects which emerged in the 1990s, did for a time achieve its 'aim to become a focus and important voice for the diverse views and talents of those throughout our nation who share in an experience that is less understood than shunned'.⁷⁶⁴

Despite their efforts, the project of nationalist separatism was itself subject to the conflicting demands, loyalties and interests of activists, with their allegiances to regional and local communities and groups. The utopian ideal of free and open discussion and national representation set a high bar in aiming for consensus and a common good. The discursive practices of user activists could not be disentangled from intractable internal contestations, struggles and regional identity politics. There were many competing focuses within the movement and it was far more difficult than some had hoped to unite the disparate attitudes and activities of participants. However, even when internal hierarchies and power relations developed within user organisations,

⁷⁶¹ 'Glad to be Mad' t-shirts were made for Edinburgh Users' Forum. See picture in *Oor Mad History: A Community History of the Lothian Mental Health Service User Movement* (Edinburgh: Living Memory Association, 2010), p. 56.; Ron Coleman is the activist with the 'Psychotic and Proud' tattoo and the t-shirt 'Pscottish and Proud' was based on this. The t-shirt can be seen at <http://www.madeconomy.com/product/pscottish-and-proud-t-shirt/>

⁷⁶² 'Home for new voices', *The Herald*, 19 September 1997.

⁷⁶³ Derek Ball, 'Letter' in *Beyond Diagnosis* 4, (1991), p. 4. OMH/15/15.

⁷⁶⁴ John Macdonald, 'Editorial: Care to Know', in *Beyond Diagnosis* 1, (1990), p. 2. OMH/15/15.

and some people were excluded from participation, psychiatric patients exercised their capacities for rational deliberation and democratic participation on a national scale for the first time as a collective group.

4.10 Conclusion

Whilst SUN was criticised by Sinclair-Chalmers for lacking a strategy, it is clear that there was an understanding amongst SUN members from the mid-nineties onwards that the organisation required more democratic structures with local and regional representation. The problem for SUN seemed to be putting these structures into practice and acting on matters which were agreed upon. Colin Murray remarked that it may all have been ‘too big and too early’.⁷⁶⁵ It is clear that expectations were raised by the successes of the early 1990s, such as the emergence of CAPS, its facilitation of a Lothian users’ network and the organisation of Scottish users’ conferences in 1992 and 93. It is also not surprising that some of the key people who were involved in the SUN Executive were also focused on local activism and often more comfortably embedded in the environment of their local groups. Despite the problems experienced at SUN it was a vehicle through which user activists from across Scotland attempted to communicate, share information, mobilise resources, form alliances and campaign. The tensions which existed in SUN were not dissimilar to those which existed at a local level, but perhaps relationships did not have as much time and space to grow as local groups because members were dispersed across the country and were unable to maintain continuous contact and participation. Individuals with a high degree of commitment to their work for user groups and advocacy organisations, whether in paid roles or as office bearers, took on a huge amount of responsibility and a heavy workload, often in more than one role. The challenges activists faced in coordinating activities on a national scale by means of decisions agreed by a small committee were ultimately insurmountable.

The NHS and Community Care Act created an environment in which there was an expectation of user involvement in consultation. Whilst there were always worries that this was merely a tokenistic exercise, it seemed to offer an opportunity for engagement between users of mental health services and the commissioners and providers of services. The Act made available the Mental Illness Specific Grant which was used to fund early user group and advocacy initiatives such as CAPS, but it also promoted a culture which prioritised the values of voluntarism, self-help and choice above all else. Whilst this had the effect of encouraging groups like LINK in the 1980s to use the language of self-help and consumerism, by the end of the 1990s user groups came to an understanding that what they were doing was collective advocacy and there was a strong reaction against the increasing individualisation and marketization of health problems. Whereas in the 1970s activists referred to themselves as ‘mental patients’ and in the 1980s the word ‘consumer’

⁷⁶⁵ Murray, OMH/1/4.

was employed by some Scottish activists from LINK and other UK groups, through the 1990s groups of activists tended to identify as ‘service users’ or ‘users’. However Iain Ferguson found in a survey of forty two service users in Scotland at the turn of the century that: four preferred the term ‘patient’; seven preferred ‘user’; two preferred ‘customer’; two preferred ‘client’; eight preferred ‘survivor’; three preferred ‘member’; four used ‘more than one term’; and twelve used ‘other’ terms altogether.⁷⁶⁶ What is evident from the study of the emergence of the user movement in Scotland in this chapter is that activists in the 1990s, like those in the 1980s, were largely in favour of deinstitutionalisation if that meant a move away from hospital-dominance, but were suspicious that the policy of care in community was being used as cover for a cost-cutting exercise. As Ferguson has remarked there was a ‘danger of service users and their organisations being sucked into endless consultations or given responsibility for managing community-based services under the rhetoric of “empowerment” at a time when both government and local authorities are withdrawing from the provision of welfare services’.⁷⁶⁷

Despite these suspicions, campaigners were engaged in unprecedented activities during the 1990s. User activists in Scotland demonstrated that ‘developing a sense of shared experience and shared identity [was] important as a basis for self-help and the creation of environments within which people can be confident that the impact of their distress is understood’.⁷⁶⁸ The creation of new spaces and discourses provided a base and a basis from which competence was demonstrated and language reclaimed.⁷⁶⁹ However the emerging movement created new sites of struggle. A cursory glance across the extensive quotations of witness testimony and documentary archives in this chapter reveals that user activists increasingly conceived themselves as engaged in a struggle, as the use of the following spatial and military metaphors demonstrates: ‘battleground’, ‘power’, ‘resistance’, ‘strategy’, ‘campaign’, ‘tribalism’, ‘territorialism’ ‘movement’, ‘fiefdom’, ‘squirearchy’, ‘battle’, ‘fighting’, ‘politicking’, ‘weapon’, ‘war’, to name but a few. Although the language employed was often militant, more often than not user groups demonstrated a willingness to work together with allies and to work through the formal structures of consultation created by central government and local authorities. The final chapter will begin by examining the part that user activists played in influencing the new Mental Health Act in the new Scottish Parliament and in regenerating a new national organisation for service users. I will then proceed to work backwards to the emergence of SUMP in 1971, providing an overarching analysis of the transformations of the user movement in Scotland over half a century by reflecting on which forms

⁷⁶⁶ Iain Ferguson, ‘Challenging a ‘spoiled identity’: mental health service users, recognition and redistribution’, in *Disability, Culture and Identity*, ed. Sheila Riddell and Nick Watson (Essex: Pearson Prentice Hall, 2003), p. 69.

⁷⁶⁷ Ferguson, ‘The potential and limits of mental health service user involvement’, p. 249.

⁷⁶⁸ Marian Barnes and Ric Bowl, *Taking Over the Asylum: Empowerment and Mental Health* (Hampshire: Palgrave, 2001), p. 140.

⁷⁶⁹ *Ibid.*, pp.140-2.

and under which conditions the movement has developed, ‘relating individual subjective experiences to the formation of a broader sub-culture’.⁷⁷⁰

⁷⁷⁰ Alexandra Bacopoulos-Viau and Aude Fauvel, ‘The Patient’s Turn: Roy Porter and Psychiatry’s Tales, Thirty Years On’, *Medical History* 60 (2016), p. 12.

CHAPTER 5
FROM MENTAL PATIENT TO SERVICE USER

5.1 Fighting for the Right to Advocacy

Despite the difficulties at Scottish Users' Network (SUN) there was an appetite for reform to mental health legislation in Scotland from the mid-nineties onwards, and not just among patients. In 1995 a conference in Edinburgh was jointly organised by the Law Society of Scotland, the Royal College of Psychiatrists Scottish Division and Scottish Association for Mental Health (SAMH), to provide evidence of an 'emerging consensus' that an overhaul of mental health law was required.⁷⁷¹ In the same year Scottish Advocacy, a coalition of user-led advocacy groups, including mental health and disability groups, formed. This was followed in 1999 by Advocacy 2000, a group of non-user-led organisations which lobbied for patient rights to advocacy.⁷⁷² The landslide Labour Party victory in the 1997 UK general election and the re-convening of the Scottish Parliament in 1999 altered the political landscape in Scotland and seemed to present an opportunity for those promoting mental health advocacy and legislative reform. Yet, in 1998 the UK Health Secretary, Frank Dobson, made a startling claim, which, in one fell swoop, seemed to shatter the assumptions of the community care policy of preceding years. 'Care in the community has failed', Dobson stated:

Discharging people from institutions has brought benefits to some. But it has left many vulnerable patients trying to cope on their own. Others have been left to become a danger to themselves and a nuisance to others. Too many confused and sick people have been left wandering the streets and sleeping rough. A small but significant minority have become a danger to the public as well as themselves.⁷⁷³

This seemed to signal the return of an approach to the problem of mental health which emphasised compulsion and containment, the very approach which reforms of previous Conservative administrations were intended to overcome. Yet, in reality, the NHS had become even more of a top-down and micro-managed monolith with the introduction of consumerist nostrums in the 1980s, now overseen by a non-medical, technocratic managerial cadre empowered by the government of Margaret Thatcher. Often the disappearance of hospital beds meant that ex-hospital patients were simply transferred to care homes in the community, or squalid single bedsits or shared rooms. As one observer noted as early as 1979, in England for some ex-asylum patients it was a matter of their 'locus of living and care [being] transferred from a single lousy institution to multiple wretched ones'.⁷⁷⁴ The new devolved government in Scotland, the Scottish Executive, made up of a coalition of Labour and Liberal Democrats, was elected in 1999 with the promise that the Scottish Parliament would pursue social justice and inclusion. The devolved Parliament was to

⁷⁷¹ Jacqueline Atkinson, *Private and Public Protection: Civil Mental Health Legislation* (Edinburgh: Dunedin Academic Press, 2006), p. 5.

⁷⁷² The Scottish Independent Advocacy Alliance (SIAA), *Towards the Future: A Brief History of Advocacy in Scotland* (Edinburgh: SIAA, 2013), pp. 15-18.

⁷⁷³ Frank Dobson, *Frank Dobson Outlines Third Way for Health* (Department of Health Press Release) (London: Department of Health, 1998).

⁷⁷⁴ John A. Talbott, 'Deinstitutionalisation: avoiding the errors of the past', *Hospital and Community Psychiatry*, 30 (1979), p. 622.

be responsible for all health and social care policy in the country. Although the Labour Party was in power at Holyrood and Westminster, the separation of party and governmental structures north and south of the border amplified differences defined by distinct political cultures and geographies. In the wake of devolution a clear divergence in mental health policy between Scotland and the rest of the UK emerged concerning the balance to be struck between professional interests, patient rights and public protection.⁷⁷⁵ The Advocacy 2000 group worked with the Scottish Executive to produce guidelines for commissioners of advocacy services, emphasising that advocacy groups ‘should be firmly rooted in, supported by and accountable to a geographical community or community of interest’ and ‘cannot be providers of a service and advocates for users of that service’.⁷⁷⁶

The NHS and Community Care Act of 1990 was a rare piece of legislation on mental health because it applied across the UK, unlike previous Mental Health Acts of the 20th century, in which separate legislation was enacted for Scotland, usually a year after legislation was passed for the rest of the UK. The Act had made provision for funds to go to voluntary organisations and user groups via the Mental Illness Specific Grant and shifted some power from health authorities to local government, and from doctors to social workers, diffusing responsibility even further than before, despite the avowed intention to define clearer lines of accountability and responsibility.⁷⁷⁷ Since Powell's ‘water tower’ speech in 1961, there was no rush in Scotland to run down hospital populations with the same speed or zeal as elsewhere in the UK. As Paul Cairney remarks, compared with England, by the end of the 1990s ‘there were [proportionately] more hospital beds, fewer high-profile homicides and a greater separation between mental health and crime’ in Scotland.⁷⁷⁸ As he shrewdly observes, after 1999 ‘the honeymoon period of devolution encourag[ed] ministers to defer issues to expert reviews and encourag[ed] pressure participants to make the legislation work through cooperation and consensus’.⁷⁷⁹ The inexperience of many of the new crop of MSPs and the improvisation and experimentation that was required to operate an entirely new parliamentary committee system, opened the parliamentary process up to professional lobbies and single-issue champions. The 1997 *Framework for Mental Health Services in Scotland*, *contra* Dobson, had reiterated the commitment in Scotland to the principles of community care, (albeit not always realised in practice), ‘to provide support for community-based living [...] [and] to provide, as far as possible and practical, professional care and support at home, or in a homely setting’.⁷⁸⁰ There was no equivalent public backlash against policies of ‘community care’ in Scotland in the 1990s as there had been south of the border from politicians, the media, and

⁷⁷⁵ See Paul Cairney, ‘The “British Policy Style” and Mental Health: Beyond the Headlines’, *Journal of Social Policy* 38 (2009), pp. 671-688.

⁷⁷⁶ SIAA, *Towards the Future*, p. 17.

⁷⁷⁷ The Mental Illness Specific Grant was a revenue grant provided by central government to local authorities for the development of social care services for individuals with mental health problems.

⁷⁷⁸ Cairney, ‘The “British Policy Style”’, p. 686.

⁷⁷⁹ *Ibid.*

⁷⁸⁰ Scottish Office, *Framework for Mental Health Services in Scotland* (Edinburgh: Scottish Office, 1997), p. 2.

organisations such as Schizophrenia A National Emergency (SANE). This was not least because deinstitutionalisation had been occurring at a more gradual pace in Scotland. After a number of high-profile tragedies in England in the 1990s, including homicides involving psychiatric patients, the new Labour UK government framed mental health policy principally as a matter of public safety. This reflected the belief that 'the whole system is in crisis, because it is not coping with the small minority of mentally ill people who are a nuisance or a danger both to themselves and to others'.⁷⁸¹ NIMBYISM ('not in my backyard-ism') was encountered by service users in Scotland, as elsewhere, especially when small residential care units sprang up in residential areas in the wake of hospital ward closures. As Adrienne Sinclair Chalmers recalls, a local housing association had 'terrible trouble [...] when they were attempting to open supported accommodation and they told the neighbours': 'It was like pitch forks and torches. There was a meeting where [...] staff were seriously frightened by this howling mob'.⁷⁸² Notwithstanding such instances of local resistance to change, a broadly favourable political environment and public mood in Scotland, made it possible for a small number of user activists to participate in and contribute to the national-level policy-making process within the new devolved structures of the multi-national UK state.

One of the first major pieces of legislation to go through the Scottish Parliament was a new Mental Health Act. The pressure for change from psychiatrists, lawyers, voluntary organisations and user groups yielded results. A Committee to review the Mental Health (Scotland) Act 1984 was established and chaired by Bruce Millan, former European Commissioner and a Secretary of State for Scotland in the 1970s.⁷⁸³ Jim Kiddie (formerly of Royal Edinburgh Hospital Patients' Council and SUN) and Graham Morgan (formerly of Awareness, Consultation and Advocacy Promotion Service, SUN, and founder of Highland Users' Group (HUG)) were appointed to the Millan Committee as service user representatives. There were 17 committee members, including representatives from medicine, nursing, social work, the legal profession, local authorities, carers and the voluntary sector. User groups such as SUN, Edinburgh Users' Forum (EUF) and HUG participated in the consultation process which was set in train, but SUN folded by the time the bill passed through the Parliament. Users were also represented on the Mental Health Legislation Group, which acted as a consultative body to the Scottish Executive as it prepared a policy statement in 2001.⁷⁸⁴ Some user activists also gave evidence at the Health and Community Care Committee during the scrutiny of the Bill in the Scottish Parliament.

The Millan Report recommended a new 'right to advocacy' to be included in the Act, but the Scottish Executive did not initially include any 'right to advocacy' when it made its policy

⁷⁸¹ *Hansard*, 12 August 1998, col. 145.

<<http://www.publications.parliament.uk/pa/cm199899/cmhansrd/vo981208/debtext/81208-05.htm>> [accessed 7 March 2016].

⁷⁸² Sinclair-Chalmers, OMH/1/3.

⁷⁸³ Scottish Executive, *New Directions: Report On the Review of the Mental Health (Scotland) Act 1984* (Edinburgh: Scottish Executive, 2001).

⁷⁸⁴ Scottish Executive, *Renewing Mental Health Law: Policy Statement* (Edinburgh: Scottish Executive, 2001).

statement. As a result of the 'Let's Get It Right' campaign, made up of a coalition of organisations led by SAMH, a right to access advocacy was reinstated in the draft Bill and was included in the Act. Anne Bardsley remembers that

the movement bombarded politicians, it bombarded human rights campaigners, I mean it literally bombarded everybody. It had to. And the day that got enshrined in law, it wasn't a won battle. I don't think the battle is ever won, it is always a continuous battle, but the users won that particular war.⁷⁸⁵

The inclusion of the right to access advocacy in the Act is widely deemed by user activists to have been a great victory. This meant that patients have the right to access an independent advocate who can help them to have their voice heard and ensure that what they say influences the decisions of clinical staff. Bardsley has suggested that in the history of the Scottish user movement 'the overall main achievement has been getting advocacy enshrined in law'.⁷⁸⁶ According to Jim Kiddie, 'without our involvement there we wouldn't have had anything on advocacy in the Act. So that's why [...] it's important that service users are involved at all levels to influence the debate, to influence the outcome'.⁷⁸⁷ Malcolm Chisholm, Labour Minister for Health and Community Care in the Scottish Executive from 2001 to 2004, remarked that

the view that mental health wasn't just a medical issue and shouldn't be based on a medical model [...] has underpinned the [user] movement from the start and was one of the many lessons I learned from it [...] and it was in no small part their campaigning, along with that of others, which led to Scotland's landmark mental health legislation including new rights to advocacy.⁷⁸⁸

The relationship which had developed in the preceding years between Chisholm and the user movement in Scotland, particularly in Edinburgh where his parliamentary constituency was based, helped to draw some user activists further into lobbying activities and to build a rapport with an important local politician. He had accepted an invitation to attend and speak at the third Scottish Users Conference in 1997 when he was a Westminster MP. Soon after he became an MSP (Member of the Scottish Parliament) and then Health Minister for Scotland. He was not allowed to forget or ignore the existence of the user movement. Adrienne Sinclair-Chalmers recalls how Edinburgh-based user activists had campaigned for the abolition of ECT (electro-convulsive therapy), which involved repeatedly sending postcards emblazoned with the slogan 'Resist ECT!' to Chisholm:

we got about 10,000 postcards printed [...] We started sending them out [...] and he [Chisholm] said every bloody day he would open his post bag and another of these cards would fall out and he was sick of seeing them! I can remember the day before the stage three debate in the Parliament [on the mental health bill] and he phoned me up and I was in the bath. So I was having a conversation with the Health Minister when I was in the bath and he was saying 'oh we're going as far as we can, Adrienne, I'd love to do it but my officials won't let me'. He was a good bloke Malcolm, I think he was the first Health Minister who

⁷⁸⁵ Bardsley, OMH/1/1.

⁷⁸⁶ Ibid.

⁷⁸⁷ Kiddie, OMH/1/33.

⁷⁸⁸ Malcolm Chisholm interviewed by Jim McGill, August 2009, OMH/1/34.

had read RD Laing [...] He was EUF's honorary president for some time, which was obviously a little trick that we used to hook him in.⁷⁸⁹

Kiddie remarked that one of the reasons for the success of the Millan committee's work 'was real partnership and real togetherness, psychiatrists, legal experts, sheriffs, carers, and most importantly, service users, in the shape of Graham and myself, who had a lot to contribute'.⁷⁹⁰ However, Kiddie also echoed the sentiments of Bardsley on the 'continuous battle' which users faced. He warned:

we've always got to be looking over our shoulder and constantly reminding ourselves that not everybody is as enlightened as some of us hopefully are and we've got to defend what we've got, not just defend what we've got but we've got to develop it further. An awful lot of groups are presently excluded from effective advocacy and that's still a challenge out there to be addressed.⁷⁹¹

Whilst the influence that some user activists had brought to bear on policy-making in the early 2000s was widely acknowledged, the fact that the national organisation SUN had unravelled by the time it was underway was a matter of regret for others. Kiddie remarked that 'lots of people think politics is a dirty game but [...] politics affects us all and that's why we've got to get involved with local politics and national politics to actually change legislation and change the way things are'.⁷⁹² For Anne O'Donnell the fact that 'there was no national user voice to represent our views when the new [...] Act [...] was going through the Scottish Parliament was a missed opportunity'.⁷⁹³ Adrienne Sinclair-Chalmers likewise thought that 'there should have been a national organisation that was there to support and coordinate, and it was left to individuals'.⁷⁹⁴

Soon after the Act was passed, some activists made efforts to revive a national organisation for service users in Scotland. Some of these activists had not been involved with SUN, but they were well aware of the problems which had beset previous attempts to develop a national organisation. A conference entitled 'User, Consumer, Survivor, Refuser...' was organised and held in Dundee in June 2004. According to mental health nurse and user activist Shaun McNeil, whilst 'a lot of local and regional mental health service user groups had sprung up [...] there wasn't a lot of drawing things together, it was a bit disparate'.⁷⁹⁵ He recalled that 'we just had a feeling that we've got quite a lot going on now in Scotland and we just had a lot of opportunities here, it's like a dawn of new engagement in terms of changes within the government and us having our own parliament'.⁷⁹⁶ Writing in *The Advocate*, the magazine of UKAN, with colleague Chris O'Sullivan, McNeil informed:

⁷⁸⁹ Sinclair-Chalmers, OMH/1/3.

⁷⁹⁰ Kiddie, OMH/1/33.

⁷⁹¹ Bardsley, OMH/1/1.

⁷⁹² Kiddie, OMH/1/33.

⁷⁹³ O'Donnell, OMH/1/32.

⁷⁹⁴ Sinclair-Chalmers, OMH/1/3.

⁷⁹⁵ Shaun McNeil interviewed by Jim McGill and Kirsten Maclean, October 2009, OMH/1/21.

⁷⁹⁶ *Ibid.*

that the user voice in Scotland, whilst focused and strong in some geographical areas, was neither uniform nor coordinated. Whilst the absolute validity, autonomy and expertise of local user led groups was recognised, it soon became clear that providing what was termed humorously by one member as ‘a Royal College of Service Users’, could form a key component of [the Scottish Executive’s ‘programme for Improving the Mental Health and Wellbeing of Scotland’s population’] [...] There was unquestionably a need to ensure that a diverse, complex and geographically spread group of people were able to make their voices heard in a current agenda of social inclusion, service development, implementation of legislation, citizenship and social activism.⁷⁹⁷

It was reported that the 127 service users who attended the conference gave ‘a clear mandate to set up a national organisation along the lines of a federation with local and regional groups being represented on the national group but retaining their autonomy’.⁷⁹⁸ McNeil explained that there was

huge interest in the conference [...] far more people than we could accommodate and we wanted to specifically bias it. So despite the fact we had 100 people from Glasgow and 100 people from Edinburgh who wanted to come, we wanted to make sure there was somebody there from Orkney [...] from Shetland, from the Western Isles etc., so that we got some kind of idea of what the feeling was like around the country genuinely.⁷⁹⁹

It is evident that the conference was organised with the SUN experience in mind. Although a new national organisation, Voices of Experience (VOX), was eventually constituted in 2006, McNeil admits that ‘it took us quite a bit of time because of the experience of SUN. The government were very much once bitten, twice shy. “Can we organise it properly? Can we have systems in place where we can trust them with the money?”’.⁸⁰⁰ Like SUN, VOX was to provide a ‘national structure’ to make ‘voices heard’, ‘to assist people in speaking out’, ‘to maximise the impact of [their] message’ and for them to take a ‘role in society as active citizens’.⁸⁰¹ As Sinclair-Chalmers remembers it, she ‘was really delighted’ to be at the Dundee conference, but she believed ‘there were people there who had their own agendas’:

you could just see [...] SUN [...] happening all over a-bloody-gain and thinking, no, we can’t do that, this is where it all went wrong the last time. And folk would say “oh forget SUN”. If only we could! [laughter] But you can’t. This is not raking over the past, this is trying not to repeat some very, very silly and basic mistakes that actually set the cause back nationally [...] [I] might be doing it a disservice, but I see the same things going wrong with VOX as had always been wrong.⁸⁰²

These comments demonstrate and highlight the extent to which tensions are built into the activity of forming alliances, campaigning and lobbying, even amongst people who agree on many issues. The staying power of collective action by psychiatric patients is testament to the continuing difficulties they face in their encounters with psychiatry, the NHS and welfare state, but more broadly, it is indicative of the precarious position they occupy in society and their determination to overcome their difficulties with health services, with stigma, poverty, housing, welfare and

⁷⁹⁷ Shaun McNeil and Chris O’Sullivan, ‘VOX - Voices of eXperience (Scotland)’, *The Advocate*, September (2006), p. 18.

⁷⁹⁸ Trish Burnet, ‘User, Consumer, Survivor, Refuser...’, *The Point* 16 (2004), p. 8.

⁷⁹⁹ McNeil, OMH/1/21.

⁸⁰⁰ Ibid.

⁸⁰¹ McNeil and Sullivan, ‘VOX’, p. 18.

⁸⁰² Sinclair-Chalmers, OMH/1/3.

unemployment. Just as Thomas Ritchie had trumpeted collective bargaining and trades unionism in 1971, activists of the 2000s emphasised the collective dimension of the discourse and practice of advocacy. Just as Ritchie had envisaged the possibility of a nationwide union of mental patients acting as a democratic collective bargaining body and counterweight to the Royal College of Psychiatrists, some forty years later Kiddie drew the same comparison, remarking that 'the Royal College of Psychiatrists is a collective advocacy body. If it's good enough for psychiatrists', he said, 'it's good enough for service users'.⁸⁰³ Likewise Bardsley stated that 'to me collective advocacy is like some organisations have a union'.⁸⁰⁴

5.2 A Radicalised Enlightenment?

Was the emergence of collective action by psychiatric patients in Scotland in the late twentieth century part of a broader transnational trend during this period, described by Alexander Callinicos as 'the radicalised Enlightenment', meaning, the 'procession of new political subjects – workers [...] women, colonial subjects, people of colour, oppressed nationalities, lesbians and gays, disabled people [...] emerg[ing] to stake their claim to the liberty and equality won by earlier struggles'?⁸⁰⁵ The eighteenth-century philosopher Immanuel Kant defined enlightenment as a process by which one is released from a 'minority' status, from 'immaturity' or 'tutelage' — that inability to make use of one's own understanding 'without guidance from another'.⁸⁰⁶ The democratic impulse for equality and self-determination in the twentieth century was expressed through the actions of emerging social movements in the West, which campaigned on issues such as civil rights, national liberation, gender, sexuality and race. No doubt the New Left 'credo' that the 'personal is political' and the pursuit of culture-building exercises rooted in shared collective identities made their mark on the collective action of psychiatric patients.⁸⁰⁷ For Kant the motto of enlightenment is 'Sapere aude!' ('Have the courage to use your own understanding!').⁸⁰⁸ The distinctive conception of enlightenment Kant offered was 'the freedom to make public one's use of reason in all matters'.⁸⁰⁹ Foucault emphasises that 'Kant defines *Aufklärung* [enlightenment] in an almost entirely negative

⁸⁰³ Kiddie, OMH/1/33.

⁸⁰⁴ Bardsley, OMH/1/1.

⁸⁰⁵ Alexander Callinicos, *Equality*, (London: Polity, 2000), p. 24. Callinicos takes this expression from Jurgen Habermas, who remarked that 'there is no cure for the wounds of Enlightenment other than the radicalized Enlightenment itself', *Autonomy and Solidarity: Interviews* ed. Peter Dews (London: Verso, 1986) p. 158.

⁸⁰⁶ Immanuel Kant, 'Answer to the Question: What Is Enlightenment?' in *What Is Enlightenment? Eighteenth-Century Answers and Twentieth Century Questions*, ed. James Schmidt (London: University of California Press, 1996), p. 58.

⁸⁰⁷ Malcolm Nicolson, 'Book Review: *Medicine in the Twentieth Century*', *Medical History* 46 (2002), p. 105.

⁸⁰⁸ Kant, 'Answer to the Question: What Is Enlightenment?', p. 58.

⁸⁰⁹ *Ibid.*, p. 59.

way, as an *Ausgang*, an “exit”, a “way out””.⁸¹⁰ There is an emphasis of getting away from, or out of, the ‘minority’ condition associated with the idea of being under the age of full legal responsibility. Perhaps the efforts of activists to get away from, or out of, the old asylum regime and the mental patient identity mirrors the conception of enlightenment articulated by Kant. But enlightenment has an ambiguous status. It is a phenomenon, an ongoing process; yet it is also a task and an obligation. On Kant’s account, if people are indeed able to participate in this process as its voluntary actors, then they have an obligation to do so. It involves an ascetic relationship to self and compels people to produce themselves as autonomous subjects.

For Kant, enlightenment involves the modification of the relations linking will, authority and the use of reason. The minority condition is self-incurred, and its cause lies not in ‘the lack of understanding’, but rather the ‘lack of the resolution and courage to use it without the guidance of another’.⁸¹¹ But Kant qualifies this judgement, writing that

the guardians who have so kindly taken upon themselves the work of supervision [...] Having [...] carefully prevented the docile creatures from daring to take a single step without the leading strings to which they are tied, they next show them the danger which threatens them if they try to walk unaided.⁸¹²

The collective action taken by psychiatric patients can be seen as a ‘process in which people participated collectively and acts of courage accomplished personally’, where individuals were ‘at once elements and agents of a single process’.⁸¹³ A worrying potential implication, however, is that those who were not able or willing to participate in the autonomous use of reason on Kant’s account are relegated to the status of ‘docile creatures’. And for those who participated in collective action, does their status as autonomous actors make them personally responsible for their health problems? Elizabeth Bott has claimed that ‘autonomous is just what most mental [...] patients are not. Either they are social isolates, or they are locked in dependent but conflict-ridden relationships with relatives’.⁸¹⁴ But even if this is true of at least some people, at least some of the time, collective action taken by psychiatric patients seems to suggest that this is not always the case.

Through practical self-organisation, the formation of groups, the organisation of public meetings, conferences and by communicating via print and other media, patients and user activists made public use of their reason. They participated in practices of deliberative democracy as citizens, forming plural and autonomous groups and creating fora for self-expression, discussion and debate. For patients to experience themselves as agents, exercising their own capacities of critical reflection and questioning as part of a collective public discourse, was significant. The activities of groups of patients might have been varied, discontinuous, sporadic, short-lived and

⁸¹⁰ Michel Foucault, ‘What Is Enlightenment?’, in *The Foucault Reader*, ed. Paul Rabinow (London: Penguin, 1991), p. 34.

⁸¹¹ Kant, ‘Answer to the Question: What Is Enlightenment?’, p. 58.

⁸¹² Immanuel Kant, ‘Answer to the Question: What Is Enlightenment?’, in *Kant’s Political Writings*, ed. Hans Reiss (Cambridge: University of Cambridge Press, 1991), p. 54.

⁸¹³ Foucault, ‘What Is Enlightenment?’, p. 35.

⁸¹⁴ Elizabeth Bott, ‘Hospital and Society’, *British Journal of Medical Psychology* 49 (1976), p. 126.

intermittent over decades, but they often involved a component of ethical and political self-transformation. Through collective resistance and self-organisation, subjectivity was refashioned for individuals, as they recovered confidence and a sense of civic selfhood.⁸¹⁵ Collective action was seen by those participating as a transformative mode of action, at least for them, if not for patients more broadly. By coming together in mutual-aid, by writing and speaking out, through discussion, sharing information, debating, and campaigning, patients came to see themselves as exercising civic and political agency. Psychiatric patients made claim to equal respect as autonomous agents. In such arenas reciprocity was key, where participants were able to ‘offer reasons that can be accepted by others who are similarly motivated to find reasons that can be accepted by others’.⁸¹⁶ Able to express themselves as active citizens in a decision-making forum, participants had the opportunity to recognise themselves and others as free and equal, as they looked to draw on common values to settle differences and agree on shared objectives. They made the case for government support and participated in consultation with authorities, promoting the self-governing capacities of the autonomous networks and associations they had formed as participants in civil society. Yet, as we saw in the case of SUN and other groups, the process of seeking consensus often ran aground in conflict and disagreement. The latest national organisation of service users, or ‘people with lived experience of mental health problems’, VOX, is still in existence today, over ten years after its formation, but the experience of SUN demonstrates the difficulty in sustaining a high-level of participation and cooperation over time.

The process that user activists in Scotland participated in involved not only acts of public questioning, reasoning, and resistance, but also consisted in patients exercising practical, situated, local knowledge of their own situations—knowledge not always easily amenable to explicit, propositional formulation, scientific explanation, or theorisation. From Scottish Union of Mental Patients (SUMP) to VOX, psychiatric patients in Scotland exercised and imparted knowledge of their local situations, going from authoring pamphlets, writing letters to politicians and the press, petitioning health and welfare authorities, to addressing large audiences at national and international mental health conferences, organising national user-led conferences, lobbying politicians in parliament, participating in consultation exercises initiated by health and governmental authorities and forming local, regional and national user organisations, with varied activities of campaigning, advocacy, education, peer support, research, and more. They presented ‘challenges to political power, professional authority and personal and collective identity’.⁸¹⁷ Today activists see themselves as ‘experts by experience’ and ‘voices of experience’, with a legitimate contribution to make to a broader body of knowledge of mental health. New fields of ‘survivors

⁸¹⁵ See OMH oral history interviews for numerous examples of people who found that participation in user groups improved their confidence.

⁸¹⁶ Amy Gutmann and Dennis Thompson, *Democracy and Disagreement* (Cambridge, Mass.: Harvard University Press, 1996), p. 53.

⁸¹⁷ Phil Brown and Stephen Zavostoski, ‘Social movements in health: an introduction’ *Sociology of Health and Illness* 26 (2004), p. 679.

research' and 'mad studies' are emerging due to the research and knowledge exchange activities of people who are, or have been, psychiatric patients.⁸¹⁸ Patients increasingly offer their own experiences of mental health and psychiatric services as a species of local knowledge and experiential knowledge, what Foucault called 'subjugated knowledge', which had been suppressed or marginalised by established scientific and medical authorities and structures of institutional power and government.⁸¹⁹ The social liberalism of the 1960s and 1970s and the economic liberalism of the following decades in the UK fostered a 'medical counter culture' and 'medical consumerism', driven by, amongst other things, an urge to reform those institutions seen as obsolete and oppressive, promoting an impulse for freedom, individual rights, autonomy and choice.⁸²⁰ But while collective action by psychiatric patients often revolved around concerns about mental health services, psychiatric diagnosis and treatment, their critiques extended to challenging social attitudes towards psychiatric patients, to redefining concepts of patienthood, health and illness, and the norms governing their conduct. Importantly, collective action was also taken to demand more resources for mental health services and reform of social policy. They sought 'to achieve social rights associated with the *status* of citizenship', to provide 'a forum from which excluded individuals can contribute to the *practice* of citizenship' and to enhance 'the *accountability* of public services to their citizen users'.⁸²¹

Yet, if the spirit of enlightenment is to be found in collective action taken by psychiatric patients in the late twentieth century, it is in the courage of individuals and groups to publicise their plight and demonstrate their own individual and collective capacities, to make public use of their own reason. The user groups had an interest in experiencing themselves as self-governing agents, sometimes striving 'less for external goals than for the self-reflective goal of experiencing the self as agent'.⁸²² Thomas Ritchie turned to publicising his plight because his individual complaints to the hospital authorities were ignored, his 'solitary plaintiff' being subjected to 'message decay', as he put it. The forms of discourse employed by activists shifted over time. As they became increasingly attuned to rapidly changing social, political, cultural and symbolic environments, their messages were shaped and adapted to audiences and circulated via emerging channels of mass media, advertisement and publicity. There were principled and pragmatic reasons for adopting one or other course of action or discourse at any given time, and there was much that was *ad hoc* and

⁸¹⁸ See Angel Sweeney, Peter Beresford, Alison Faulkner, Mary Nettle and Diana Rose (ed.) *This is Survivor Research* (Ross-on-Wye: PCCS Books, 2009); and Brenda A. Le Francois, Robert Menzies and Geoffrey Reaume (ed.) *Mad Matters: A Critical Reader in Canadian Mad Studies* (Toronto: Canadian Scholars' Press, 2013).

⁸¹⁹ Foucault, *Society Must Be Defended*, pp. 7-9.

⁸²⁰ See John Pickstone, 'Production, Community and Consumption: The Political Economy of Twentieth-Century Medicine', in *Medicine in the Twentieth Century*, ed. Roger Cooter and John Pickstone (Amsterdam: Harwood Academic Publishers, 2000), pp. 3; 15-19; and see Mike Saks, 'Medicine and Counter-Culture', pp. 113-123, in the same collection edited by Cooter and Pickstone.

⁸²¹ Marian Barnes, 'Users as Citizens: Collective Action and the Local Governance of Welfare' *Social Policy and Administration* 33 1 (1999), p. 82.

⁸²² Mark Warren, *Nietzsche and Political Thought* (Cambridge, Mass.: MIT Press, 1988), p. 138.

experimental in the approaches taken. Patient activists sought to recover a lost sense of agency and voice. Impulses towards self-determination and self-transcendence existed simultaneously as activists engaged in a practical critique that transformed the relations of individuals to themselves and to others. They recovered a sense of identity, personal agency and gained a sense of belonging to a wider community, through the articulation and communication of shared experiences, interests and values. As Kant wrote:

the inclination and vocation for free thinking - this works back upon the character of the people (who thereby become more and more capable of acting freely) and finally even on the principles of government, which finds to its advantage to treat man, who is now more than a machine, in accord with his dignity.⁸²³

For Peter Campbell action groups sought to 'challenge the perceived status of the diagnosed mentally ill in society' and address the 'problems of role and identity that such a designation heralds'.⁸²⁴ Most importantly 'people d[id] not want to be seen exclusively in terms of their diagnosis, regardless of whether they accept[ed] the medical classification of their problems [as] valid or not'.⁸²⁵ But, there was, says Campbell, a 'reluctance to tell other service users and survivors what to believe in and distaste for replacing psychiatric orthodoxy with a new orthodoxy'.⁸²⁶ This, he believes, 'has encouraged a movement which is more diverse and less coherent than it might otherwise be'.⁸²⁷ He lists some core substantive 'beliefs' of the emerging movement, or general statements of principle:

- belief in the essential competence of people with a mental illness diagnosis
- belief in the value of self-help and collective action
- belief in the value and possibility of self-organisation by service users and survivors
- belief that people with a mental illness diagnosis may have special expertise to offer society as the result of their personal experience.⁸²⁸

He concludes this schemata by suggesting that 'the basic proposition, towards which all these beliefs are pointing, [is] that people with a mental illness have a contribution to make, because of, rather than in spite of their life experiences'.⁸²⁹ The struggles of psychiatric patients, users or survivors, were struggles against the exercise of power, the government of conduct, the privileges of knowledge and often revolved around the question: Who are we?⁸³⁰ They questioned the status of the individual diagnosed as mentally ill and refused to have their lives and identities determined

⁸²³ Kant, "Answer to the Question: What Is Enlightenment?", in *What Is Enlightenment? Eighteenth-Century Answers and Twentieth Century Questions*, ed. James Schmidt (London: University of California Press, 1996), p. 63.

⁸²⁴ Peter Campbell, 'The service user/survivor movement', in *This is Madness: A Critical Look at Psychiatry and the Future of Mental Health Services*, ed. Craig Newnes, Guy Holmes and Cailzie Dunn (Ross-on-Wye: PCCS, 1999), p. 195.

⁸²⁵ *Ibid.*, p. 196.

⁸²⁶ *Ibid.*, p. 199.

⁸²⁷ *Ibid.*

⁸²⁸ *Ibid.*, pp. 199-200.

⁸²⁹ *Ibid.*, p. 200.

⁸³⁰ Foucault, 'The Subject and Power', p. 331.

solely by 'a scientific and administrative inquisition instituted by state and medical powers'.⁸³¹ They did this by working together, by relating to each other - through reciprocity. Yet increasingly Campbell and others would come to see the reluctance to adopt a common ideological or philosophical position as limiting user or survivor groups, proposing that 'one of the major challenges' for activists is 'to find a coherent overall philosophy that can integrate a clearer range of discrete focuses'.⁸³² Campbell underlined the importance of 'supporting each other and working in ways that are empowering for group members and sensitive to the particularity of their lives' and he emphasised that 'the idea that the process is not just about results but about new ways of doing things frequently gets lost altogether'.⁸³³ Whilst activists devised strategic political objectives and instrumental means to achieve their ends, their activities also encompassed the expression and negotiation of identity and the sustenance of communities of belonging.⁸³⁴

User activists and academics Peter Beresford and Jan Wallcraft have reiterated Campbell's point, writing that 'the survivors' movement [...] does not have a clear philosophy of its own' and that the reasons for this may include a 'desire to be inclusive and minimise conflict within, as well as a concern to limit attack from outside'.⁸³⁵ For the UK community history projects, Survivors History Group (SHG), of which Campbell and Beresford are active members, and the Oor Mad History Project (OMH) based in Edinburgh, their efforts are not simply directed towards recounting history, but also towards aiding the struggles of the movement in the present. Beresford suggests that 'if mental health service users/survivors are to take charge of our future, then we must also regain control of our past'.⁸³⁶ OMH has emphasised a desire to 'reclaim' and 'democratise' historical research, 'to challenge current ideas about people who use mental health services' and 'to strengthen the service user voice today and in the future'.⁸³⁷ Edinburgh-based activist Anne O'Donnell, a key figure in the OMH project, suggested that there had been a considerable degree of disillusionment amongst activists about the way user groups had been incorporated into consultation exercises and planning groups, leaving activists with 'less and less time and energy' to focus on what they thought was important, rather than responding to what service providers thought was important.⁸³⁸ OMH, inspired by the work of activists and researchers at Ryerson University in Canada, hoped that 'by reconnecting us to the reasons mental health service users had set up our groups, by learning from

⁸³¹ Ibid.

⁸³² Campbell, 'History of the user movement in the United Kingdom', p. 224.

⁸³³ Ibid., p.223.

⁸³⁴ See Jean L. Cohen, 'Strategy or Identity: New Theoretical Paradigms and Contemporary Social Movements', *Social Research* 52, 4 (1985), pp. 663-716.

⁸³⁵ Peter Beresford and Jan Wallcraft, 'Psychiatric System Survivors and Emancipatory research: Issues, overlaps and differences', in *Doing Disability Research*, ed. Colin Barnes and Geoff Mercer (Leeds: The Disability Press, 1997), pp. 66-87.

⁸³⁶ Peter Beresford, 'Past Tense: Peter Beresford on the need for a survivor-controlled museum of madness', *Open Mind*, May/June, (1998), pp. 11-12.

⁸³⁷ Kirsten Maclean, 'Introduction', in *Oor Mad History: A Community History of the Lothian Mental Health Service User Movement* (Edinburgh: Living Memory Association, 2010), p. 8.

⁸³⁸ Anne O'Donnell, 'Why Oor Mad History?', in *Oor Mad History: A Community History of the Lothian Mental Health Service User Movement* (Edinburgh: Living Memory Association, 2010), p. 12.

the past, and by working together, we could use the past to change our future'.⁸³⁹ Similarly, one of the avowed aims of SHG is 'to build a positive and coherent self-identity'.⁸⁴⁰

By exploring the movement's past we find a variety of values being invoked by activists at different times and places. In the eyes of activists, too often psychiatric patients have been dismissed as non-persons, second-class citizens, or irrational. Madness or mental illness has long been associated with notions of irrationality, incompetence, reduced levels of autonomy, 'lack of insight', disordered thought, behaviour and a lack of control. But the existence of extremes of human suffering, including forms of mental distress, confronts us with questions about the limits of human experience, thought and rationality that elude easy resolution. The questions which confront us indicate problems which test the limits of our understanding. The foregoing narrative reveals that those deemed mad or mentally ill cannot be preserved on the other side of a hard border with reason. There is an intertwining of the exercise of power with the practice of freedom, and between the use of rationality and the experience of madness, which means that there can be no purification of either from the other. As distinct features of what it means to be human they depend on each other for their being. But in the practices of everyday life no pure separation can be drawn between them, as a binary categorization of normal and abnormal, healthy and pathological, would have us believe.

The simple-minded doctrines of rational choice theory and individualism, which prize freedom of choice above all else, have atomized and abstracted human beings from the social world of family, institutions, history, community, civil society and the state, emptying human beings of all local meaning and significance and detaching choice-making from any value or good. A more rounded perspective of human beings would recognise that human lives are social beings marked by tragedy, accident and misfortune, in a world where chance and fate play their part. It would understand that what is most important to human beings, what gives their lives meaning and confers an experience of membership and belonging, is not simply chosen or created by individual selves pursuing their own interests alone. Increasingly, user activists in the 1990s would come to see the return of a stigmatising discourse of welfare dependency - the 'undeserving poor', 'scroungers' and 'skivers' – as relegating psychiatric patients, the long-term sick and disabled, to the status of feckless underclass rump. The difficulty for them was that, whether they were deemed mad, bad, or damaged goods, psychiatric patients were more likely to be poor, and less likely to obtain, or keep, a job. Today, in the first quarter of the twenty-first century, they seem to occupy a fuzzy region of the social fabric, suspended between act and affliction, a double-bind in which they are found wanting one way or another. Whether in work, or on welfare, many are likely to survive on a pittance. In the words of one commentator, viewed through the 'ideological lens of individualism', they are 'broken individuals', exhibiting a 'quintessential failure to achieve the qualities of successful individuality in capitalist society, a failure to achieve psychic unity,

⁸³⁹ Ibid.

⁸⁴⁰ Peter Campbell and Andrew Roberts, 'Survivors' History', *A life in the day*, 13, 3, August (2009), p. 33.

autonomy, self-containment, full possession of thought, and willed, rational, purposive action directed to useful production'.⁸⁴¹ One reason deinstitutionalisation, or closing the asylums, was so appealing to economic liberals such as Enoch Powell and Margaret Thatcher was that, "dependency" of the kind fostered by the asylum system was condemned as an unmitigated evil; in its stead would come "effective, self-reliant productive behaviour".⁸⁴² Widespread trends of modernity, in politics, economics, science, technology, culture and medicine, have bequeathed a legacy of conceiving human beings in narrow terms, as individual, isolated, self-interested, self-reliant, atomized, utility maximisers and information processors, to be preserved in their separate spheres, shorn from any meaningful context and blind to the dynamics of reciprocity, dependence, connectedness and flesh and blood relationships.

According to the psychiatrist and prolific essayist Theodore Dalrymple, it was the collapse of moral standards, a relativism of values, the erosion of the family as an institution, and the irresponsibility and fecklessness of individuals given *carte blanche* by the perverse incentives of the welfare state, that led to large numbers of people being dependent on the state, including psychiatric and welfare services.⁸⁴³ He sees the social liberalism and individualistic counter-cultural spirit of the 1960s promoted by left wing intellectuals as having undermined the traditional family and promoted the transgression of social boundaries through sexual promiscuity and experimentation with drugs. Chief liberators-cum-hellraisers for Dalrymple were people like David Cooper and Timothy Leary, who gave voice to the kinds of ideas and practices - 'Turn on, tune in, drop out' – which had a marked effect on left-wing intellectuals like Robin Farquharson. Dalrymple views R.D. Laing as 'talented', but also 'wayward and self-destructive'.⁸⁴⁴ On Dalrymple's view the 'culture of dependency', rooted in mid-twentieth-century political economy and culture, fostered a kind of moral turpitude. With the obliteration of any distinction between virtue and vice, some people pursue short-term pleasure, intoxicated by feelings of the moment, with little regard for the consequences of their actions. Concerns about welfare dependency has focused attention on those suspected of making false claims for sickness benefits or becoming pregnant in order to be housed by the state and receive welfare payments.⁸⁴⁵ Yet Dalrymple believes that 'the scope of

⁸⁴¹ Robert J. Barrett, 'Interpretations of schizophrenia', *Culture, Medicine & Psychiatry*, 12 (1988), p. 376.

⁸⁴² Barbara Taylor, *The Last Asylum* (London: Hamish Hamilton, 2014), p. 248.

⁸⁴³ See Theodore Dalrymple, *Life at the Bottom: The Worldview That Makes the Underclass* (Chicago: Ivan R. Dee, 2001) and 'Countering the Counter-Culture' speech delivered on 26 April 2016 at the Centre for Independent Studies Australia, available at <https://www.youtube.com/watch?v=ksVoOYmWTYE> [accessed 22 May 2016].

⁸⁴⁴ Theodore Dalrymple, 'Medicine and Letters', *The Spectator*, 11 March 2006, available at <http://www.spectator.co.uk/2006/03/medicine-and-letters/> [accessed January 2016].

⁸⁴⁵ The 'Little List' speech delivered in 1992 by Peter Lilley, Secretary of State for Social Security, at Conservative Party conference, goes like this: 'I've got a little list / Of benefit offenders who I'll soon be rooting out / And who never would be missed / They never would be missed. / There's those who make up bogus claims / In half a dozen names / And councillors who draw the dole / To run left-wing campaigns / They never would be missed / They never would be missed. / There's young ladies who get pregnant just to jump the housing queue / And dads who won't support the kids / of ladies they have ... kissed / And I haven't even mentioned all those sponging socialists / I've got them on my list / And there's none of them be missed / There's none of them be missed'.

psychiatry has since expanded illegitimately, especially in the grotesque over-prescription of psychotropic medication'.⁸⁴⁶ He claims that 'the shortage of beds, brought about by the desire to make financial savings in the context of an ideological assault on the notion of psychiatric illness, has corrupted doctors and nurses by slow but inexorable steps'.⁸⁴⁷ He points to the critiques of psychiatry articulated by R.D. Laing and Michel Foucault as having 'paved the way for an ill-conceived and hasty deinstitutionalization of the mentally ill'.⁸⁴⁸

Peter Campbell and Andrew Roberts of the Survivors History Group have laid great emphasis on the autonomy of collective action by patients and its independence from 'anti-psychiatrists' like Laing. They write that the mental patients' unions in the 1970s 'were part of the cultural revolution of their times'.⁸⁴⁹ But, some histories, they write, 'are less factually accurate than others, and some members of Survivors History Group disagree with some of the interpretations that have been imposed'.⁸⁵⁰ They make the point that 'commentators from outside the movement often emphasise the debt survivor activists owe to anti-psychiatry, whereas survivor activists who were actually involved at the time are more conscious of the movement as an autonomous activity'.⁸⁵¹ It is appropriate to stress this point, but it should not diminish efforts to carefully situate the character of collective action in its social and historical context, that intricate web of environmental and cultural circumstances in which groups have undertaken actions. Many unchosen accidents and formative exterior events accompanied the emergence of collective action by psychiatric patients. Asserting connections and exploring power relations provides structure to unfolding events and shows how people adapted to chance circumstances.

It is clear from the testimony of at least some of the leading activists in Scotland that R.D. Laing and anti-psychiatry were in fact formative influences, even if there was no sense of owing debts. Perhaps Laing, as a Scot, is viewed differently in Scotland. Being one of the nation's most prominent public intellectuals of the twentieth-century as well as its most famous psychiatrist, it is not surprising that he exercised considerable power over the imaginations of a number of activists based in Scotland. In the case of SUMP, Laing and anti-psychiatry did not appear to figure in Thomas Ritchie's thinking, but it would be an oversight not to mention Laing in connection with Robin Farquharson, who was one of the few people to be excluded from Laing's Kingsley Hall therapeutic community. Ritchie and Farquharson demonstrated as much affinity with counter-cultures emerging in the 1960s as with the more traditional left-wing politics of the labour movement and trades unions. The psychedelic-tinged outlook, and the carnivalesque, cynic humour of the underground press is evident in their rhetoric. Ritchie and Farquharson were both transient

⁸⁴⁶ Theodore Dalrymple, 'In the Asylum', in *City Journal* Summer 2005, available at <http://www.city-journal.org/html/asylum-12889.html> [accessed 12 May 2016].

⁸⁴⁷ Ibid.

⁸⁴⁸ Ibid.

⁸⁴⁹ Campbell and Roberts, 'Survivors' History', p. 34.

⁸⁵⁰ Ibid., p. 35.

⁸⁵¹ Ibid.

wanderers in search of a suitable social anchor. The figure of the activist 'patient', which they assumed, and those that followed —the 'consumers', 'recipients', 'users', or 'survivors', and the discourses of patient unionism, voluntarism, consumerism, self-help, citizenship and advocacy— were shaped and sculpted as much from the confluence of chance encounters, contingent events, new institutional structures, therapeutic technologies and changing relations between patients and mental health professionals and workers, as the autonomous actions and choices of patients. These events included technical and spatial transformations, shifts in political economy, changing social relations of production in health services, the emergence of new professions, the evolving structures of the British state, the caprice of politicians, professionals and the media, and a wide range of other far-reaching social, economic, scientific, legal, political and cultural changes of transnational scope. During the period from 1971 to 2006, the shift from a health service founded in communitarianism to the formation of consumerist medicine in a post-industrial service economy, fostered a mental health system in the UK which was increasingly premised on an economic model of contract and market exchange, on cost-effectiveness, efficiency, individual choice and competition. But when SUMP took collective action at Hartwood in 1971 Thomas Ritchie advanced class-based and collectivist arguments amidst the biting satire. When psychiatric patients exerted unprecedented influence on policy-making, with the passage of Mental Health (Care and Treatment) (Scotland) Act 2003, user groups insisted on the significance not just of advocacy, but of collective advocacy by patients.

The post-war welfare settlement in the UK was a particularly important driver of changes in attitudes, creating increased expectations about what state-sanctioned medicine and welfare could deliver to those described by William Beveridge as 'distressed minorities'.⁸⁵² The creation of a universal, state-provided healthcare system and welfare state, guided by egalitarian principles, brought the expectation that all citizens should receive equal regard and entitlement in the matter of healthcare. The birth of the NHS heralded the entrance of 'communitarian medicine' in the UK, fostering a 'sense of social solidarity [...] found both in state-services and in medical charities'.⁸⁵³ The gap between rhetoric and reality in relation to the development of community mental health care became increasingly apparent with each passing decade after the 1960s, fomenting steady discontent. In his analysis of the emergence of mass movements Eric Hoffer observed that 'misery does not automatically generate discontent, nor is the intensity of discontent directly proportionate to the degree of misery'.⁸⁵⁴ Instead, 'discontent is likely to be highest when misery is bearable; when conditions have so improved that an ideal state seems almost within reach'.⁸⁵⁵ This striking assessment acknowledges that 'a grievance is most poignant when almost redressed' and asserts

⁸⁵² William Beveridge quoted in Geoffrey B.A.M. Finlayson, *Citizen, State and Social Welfare in Britain, 1830-1990* (Oxford: Oxford University Press, 1994), p. 328.

⁸⁵³ Pickstone, 'Production, Community and Consumption', pp. 2-3.

⁸⁵⁴ Eric Hoffer, *The True Believer: Thoughts on the Nature of Mass Movements* (London: Secker and Warburg, 1952), p. 41.

⁸⁵⁵ *Ibid.*

that 'it is not actual suffering but the taste of better things which excites people to revolt'.⁸⁵⁶ No doubt a number of post-war developments, including the creation of the NHS and the welfare state, created the expectation of better things to come and the optimistic mood of the 1960s fostered the belief in the possibility of social and political progress. It is perhaps not surprising that mental health workers who were allies of activist groups tended to be drawn from the ranks of emerging professions that did not share the elevated status of medical professionals, such as occupational therapists, psychiatric social workers and voluntary sector workers. They too sought transformation of their status within the hierarchies of health care. Despite the diversity of views amongst activists, clearly there were strong strains of 'anti-psychiatry', scepticism about the role of medicine and critical challenges to the power of psychiatrists to detain patients and frame their problems in biomedical terms. Often the burgeoning ranks of non-medic mental health workers shared and encouraged such scepticism. According to Jeff, a voluntary sector community development worker who was an important ally in the 1980s and 1990s:

I suppose the main campaign, it always will be the campaign, is trying to keep the reins on this medical model taking over everything [...] There's all sorts of different campaigns [...] small battles that were lost and won. But the big war was really on the whole thing to do with the medical model and how that dehumanised and desensitised people.⁸⁵⁷

Perhaps the main campaign has shifted since Jeff made this statement in 2009, from a preoccupation with the shortcomings of bio-medicine and psychiatric power, to concerns about welfare reform, cuts to local health and social care services, and difficulties in accessing support in an era of 'austerity' following the financial crash of 2008. Once again the arguments about the neglect of mental health services by central and local government have returned and the social and economic determinants of mental health have come under the spotlight. In the past, activists drew considerably on discourses and practices from other sources and were also shaped by local, regional and national politics of Scotland and the UK. The emergence of patient counter-conducts and discourses involved the combination of multiple elements 'to produce an assemblage whose status cannot be reduced to prior elements and relations'.⁸⁵⁸ SUMP and its successors, including Dundee MPU, drew on trades unionist discourse during the 1970s when trade union power was at its peak in Britain and membership of trade unions was at an all-time high. But Thomas Ritchie also employed a discourse of civil rights and mutual-aid. LINK drew on the discourse of consumerism which was in vogue with the Conservative government of Margaret Thatcher during the 1980s. But like SUMP, LINK was also concerned with claiming rights and mutual-aid. SUN espoused and practiced a kind of tame constitutional nationalism in the 1990s, sometimes spilling over into expressions of hostility towards organisations in England, after a growing sense of

⁸⁵⁶ Ibid., pp. 41-42.

⁸⁵⁷ Jeff, OMH/1/8.

⁸⁵⁸ Paul Rabinow and Gaymon Bennett, 'From Bioethics to Human Practices, or Assembling Contemporary Equipment', in *Tactical Biopolitics: Art, Activism and Technoscience* ed. Beatriz da Costa and Kavita Philip (Cambridge, Mass.: MIT Press, 2008), p. 398.

Scottish national identity was recorded in the 1980s.⁸⁵⁹ Certainly there was a pragmatic organisational logic to forming a distinct Scottish national network. But in the wake of the increasing diffusion of the internet towards the end of the 1990s it was possible for activists to communicate, coordinate, share information and develop much broader international networks beyond Scotland.

What is evident from the activities of groups like SUMP, LINK, Awareness, the CAPS, LUF, REHPC, SUN, VOX and other Scottish user groups which have been mentioned little if at all here, is that groups were shaped by local contingencies. To begin with, patients and service users took action in response to the immediate circumstances in which they found themselves. They were also shaped by chance encounters with groups from further afield, from England, Europe the U.S. and Canada. The period between the LINK presentation to MIND in 1984 and the formation of SUN in 1989 was a time of cross-fertilisation and a two-way exchange of ideas and direction of travel between Scotland and England. The diversity and mutability of the discourses employed by different groups at different times reflects a wily pragmatism, and some might argue, even a cautious conservatism amongst the user movement in Scotland. Whilst activists sometimes talked radical, often making sizeable and incompatible demands on psychiatrists, on hospitals, on the NHS and the state, they proved quite flexible, adaptable and willing to enter into cordial negotiations with relevant agencies and authorities when it was required. Self-advocacy in the 1990s was reformist, seeking ways of changing and improving the existing systems, rather than taking up dogmatic ideological positions. This could be seen as selling out, or shameless opportunism, or capture by co-option. In fact, the rhetoric of some individuals speaking in the privacy of their own groups could be quite overheated at times, with the occasional heady talk of abolishing psychiatry and hospitals altogether. Some individuals also took the constitutional nationalist strain in SUN to excessive lengths, being unnecessarily preoccupied with national identity and territory and displaying insular nationalist tendencies, dismissive of the value of building relationships with groups from the rest of the UK. At other times the language used was carefully calibrated to appeal to particular audiences, such as government or social work authorities.

Such practices were no different from any other kind of politics in that regard. In fact, unlike some other, larger, mass movements of civil rights activists, mental health user activists were particularly eager to practice a pragmatic, non-ideological, peaceful and civilised form of politics, especially given the common misconceptions linking psychiatric patients with violence. Their cause would never have got off the ground had they had been driven by ideological zeal, or had they advocated violent resistance. Apart from being morally indefensible and politically suicidal, to tolerate fanaticism or violence would have simply served to reinforce all the stereotypes which cast

⁸⁵⁹ Surveys indicate the people in Scotland increasingly identified as Scottish rather than British. See Alison Park, Caroline Bryson, Elizabeth Clery, John Curtice and Miranda Phillips, *British Social Attitudes: the 30th Report* (London: NatCen Social Research, 2013), pp. 143-145.

psychiatric patients as violent, dangerous and a threat to public order. Large scale demonstrations and other activities of post-war civil rights, nationalist and liberation movements sometimes resulted in violence. Granted that violent consequences, social disorder and civil unrest was not always the intention or sole responsibility of people involved in such mass movements, the record of small mental health user groups in campaigning through peaceful, non-violent action, is exemplary. Whilst the in-fighting in some user organisations during the 1990s could be vicious and damaging to the health of individuals, such vituperative anger and nastiness was not often vented outwards towards other groups. Unlike, for example, the Socialist Patients Collective, founded in Heidelberg in 1970, which was quickly tainted by allegations of association with the Baader Meinhof Group, the user movement in Scotland largely avoided being drawn into associations with revolutionary violence.⁸⁶⁰

In the 1990s there was a broad trend of retreat by Scottish activists and their groups into local, regional and national territorial 'fiefdoms' in the 1990s, from initial signs of broader international engagement in the 1980s. Thomas Ritchie of SUMP was evidently no Scottish nationalist, demanding a single administrative and legal framework for mental health services in the UK. However, during the 1990s, at least one or two prominent figures within SUN were reluctant to collaborate with English-based organisations. No doubt there was more than a hint of territorial thinking and provincialism expressed in such sentiments. But there were different attitudes within the movement on how relationships between local groups and national groups should develop and during the 1990s the Scottish Users' conferences demonstrated an increasing sophistication in the organisational capacities of activists to bring local groups together to address national policy questions, even when there was often much internal division. There were different views on how to compare Scotland with the rest of the UK. Shaun McNeil who was involved in the early development of VOX in the 2000s was particularly positive about the movement's prospects in the wake of devolution. He believed that devolution was 'a really good thing for health and mental health in Scotland'.⁸⁶¹ Speaking of activists in England he claimed that:

They are really jealous of the amount of access, potentially we can have to, for example, the cross party group on mental health and other cross party groups [...] These structures aren't really there down south or in comparable countries [...] in terms of having that kind of accessibility[...] to our little parliament [...] and our MSPs.⁸⁶²

Whilst devolution had afforded unprecedented opportunities for a select few psychiatric patients and ex-patients to participate in consultation and lobbying activities, and to contribute to the development of a new Mental Health Act in Scotland, there is perhaps a danger of overstating the case that there were vast differences in opportunities for activists between Scotland and England.

⁸⁶⁰ Helen Spandler, 'To make an army out of illness', *Asylum: A Magazine for Democratic Psychiatry* 6 4 (1992), pp. 4-16; Wolfgang Huber, *Turn Illness Into A Weapon: For Agitation by the Socialist Patients' Collective at the University of Heidelberg* (English translation) (Heidelberg: KRRIM, 1993).

⁸⁶¹ McNeil, OMH/1/21.

⁸⁶² Ibid.

Speaking in 2009 McNeil remarked that 'the difference between now and then is now we've got our own parliament. Scotland is responsible for its own health. Therefore Scotland is responsible for mental health'.⁸⁶³ Other activists expressed less sanguine attitudes than McNeil. One activist stated that

down south [England] have taken a more political stance and radical stance than we have taken in Scotland. In Scotland we've worked on reforming the service from within, so we have sat in groups and been consulted on things. Whereas I think down south they have said 'well we are going to go away and set up our own service' or 'You haven't started this process right so we'll not join in'.⁸⁶⁴

Jeff remarked that he felt that 'once the government gets their hands on things [...] there was a kind of professionalisation of the user movement'.⁸⁶⁵ Another activist emphasised that in her view psychiatric patients must 'take ownership' of the language of self-definition.⁸⁶⁶ Referring to some English-based activists she remarked:

I have found it really beneficial for my own thinking actually to have had contact with these survivors and they do identify themselves as survivors. In Scotland we don't, and I introduced myself at the first meeting [in England] and said 'In Scotland I am a user of mental health services but as soon as I cross the border I become a survivor'. I am actually personally much more comfortable describing myself as a survivor, because I have survived the mental health system and not everyone does. And I think that [...] politically that is really important.⁸⁶⁷

Likewise John Macdonald expressed his concerns around self-definition and compared Survivors Speak Out (SSO) with Scottish groups:

I think Survivors Speak Out was more radical, personally, although I do accept the term 'survivors' limited it to people who saw themselves like that. Personally I think it is a more dignified and interesting definition than 'service user'. If you are a survivor you can either interpret it as survivor of the illness or survivor of the system, either way it doesn't matter [...] The level of radicalism varies but basically it is a very positive thing. Okay you can go further than survival, but it's saying, 'look, I've survived'. Whereas 'service user' I understand as a technical term to use for certain functions. It's fine but I think there's always been an ongoing debate you know about whether it confines people [...] and there's the other thing that a lot of people outside associate it with drug user. So either way it sort of defines people in a passive role. I know the movement tries to make it more active but [...] there are inherent difficulties with it.⁸⁶⁸

5.3 Beyond Tokenism?

Some activists arrived at the view that the concerns about the potential for 'tokenism' and 'co-option' expressed so powerfully by Huw Richards in the early days of SUN, were well-founded. For Anne O'Donnell a 'kind of radical edge seems to have been crowded out'.⁸⁶⁹ Colin Murray believes that the movement had 'gone soft' because 'there isn't that really radical element that's

⁸⁶³ Ibid.

⁸⁶⁴ Anonymous, OMH/1/71.

⁸⁶⁵ Jeff, OMH/1/8.

⁸⁶⁶ Ibid.

⁸⁶⁷ Anonymous, OMH/1/71.

⁸⁶⁸ Macdonald, OMH/1/10.

⁸⁶⁹ O'Donnell, OMH/1/32.

making a lot of noise, making trouble and getting itself into bother'.⁸⁷⁰ Referring to the 'thoughts on tokenism' and 'repressive tolerance' that Huw Richards offered to SUN in its early days, Murray stated that 'whether you can avoid this at all... I think that's what's happened to a degree'.⁸⁷¹ For Murray 'any kind of movement that is about this sort of change needs those different levels of it':

You need the people who are going to sit down with the suits and do the nice chit-chat and try and influence things that way. You need the radical people out there giving them a kick up the bum and any kind of social change has got that - the civil rights movement in the States in the 1960s, the Black Panthers. And I fear that is missing [...]

You're playing the game in a way, you're joining the other side, there's no other way around that [...] I would really love to see [...] a truly independent organisation [...] What I would like is if organisations like CAPS or the REHPC can find ways of operating free of state funding, because you're truly free to do what you want.⁸⁷²

According to another activist, 'lots of people say, oh we have user involvement, it's a thing now. Of course you wouldn't set up a service now without thinking about user involvement. But when it comes to actually addressing service users agendas I don't think we have got there at all'.⁸⁷³ On the other hand Jim McGill has suggested that 'the whole atmosphere has changed'.⁸⁷⁴ He believes that 'the backdrop against which service user groups are operating now has changed... it's far less confrontational'.⁸⁷⁵ An ally of the movement and advocacy project manager stated that she thought there was 'less lip service about' and there seemed 'to be a commitment from the services to do an awful lot more listening to what service users are saying'.⁸⁷⁶ Malcolm Chisholm stressed that 'there is certainly a recognition in policy that service users should be centrally involved. I suppose the challenge is to make sure that happens in practice... but there is obviously a gap between policy and reality. I do think the policy and the culture have changed significantly'.⁸⁷⁷

Activists sometimes reflected upon what it meant for psychiatric patients 'to move (in the strong sense of belong or participate) in the space of social life'.⁸⁷⁸ Drawing on a notion of 'political space', defined as 'opportunities, moments and channels where citizens can act to potentially affect policies, discourses, decisions and relationships that affect their lives and interests', Anne O'Donnell charted the metaphorical spaces which activist groups moved in as citizens during the 1990s and early 2000s.⁸⁷⁹ In her view, when activists started to demand inclusion in the decisions that shaped their lives, they created a 'claimed' space.⁸⁸⁰ Yet, she thinks that this became an 'invited' space, where activists were 'invited to participate on the terms of the providers, policymakers and

⁸⁷⁰ Murray, OMH/1/4.

⁸⁷¹ Ibid.

⁸⁷² Ibid.

⁸⁷³ Anonymous, OMH/1/71.

⁸⁷⁴ McGill, OMH/1/36.

⁸⁷⁵ Ibid.

⁸⁷⁶ Kathy Hamilton interviewed by Kenny McLeod, July 2009, OMH/1/25.

⁸⁷⁷ Chisholm, OMH/1/34.

⁸⁷⁸ Peter Barham and Robert Hayward, *From the Mental Patient to the Person* (London: Routledge, 1991), p. 142.

⁸⁷⁹ O'Donnell, 'Why Oor Mad History?', p. 14.

⁸⁸⁰ Ibid.

politicians'.⁸⁸¹ According to O'Donnell, for many activists "'closed space" still makes the key decisions about mental health services and policies'.⁸⁸² 'Claimed space' on this analysis 'are spaces which are claimed by less powerful groups', they emerge 'out of sets of common concerns or identifications', and 'may consist of spaces in which like-minded people join together in common pursuits'.⁸⁸³ 'Closed spaces' on the other hand are spaces where 'elites (be they bureaucrats, experts or elected representatives) make decisions, without the need for broader consultation or involvement'.⁸⁸⁴ 'Invited spaces' involve efforts to 'widen participation' but the worry is that the terms of engagement and the agenda are set by elite authorities, making the process tokenistic.⁸⁸⁵ Other activists such as Graham Morgan, who was awarded an MBE for his advocacy work, believed that the creation of VOX did open up new opportunities and channels, particularly at the national and international levels. He commented that 'locally in Highland we can influence services at the very local village community level to the Inverness level to the Highland level. We have an influence across Scotland, across the UK and internationally that didn't exist a few years ago'.⁸⁸⁶ Shaun McNeil stressed the international links that VOX developed in the 2000s, aided by advances in information and communication technologies:

VOX is now part of a collaboration called Interrelate. And Interrelate is now part of the national service user organisations in USA, Canada, New Zealand, Australia, England, Ireland, Scotland. We're helping Wales, we're helping Northern Ireland to get organised as well, so really that came about through VOX linking in to the International Initiative for Mental Health Leadership and through that we got put in contact with national organisations in the other countries and then we, again we saw the value in sharing and sharing experiences and all the different challenges that there are. In some ways in Scotland we're fairly lucky, it's quite small. It's fairly easy to get organised.⁸⁸⁷

Morgan stated that he wanted

to make sure that we develop a network across Scotland which is democratic, is based in the grass roots, is not just the angry people who come to the offices to say 'I've got something to say and I want to campaign on it and I'm cross about it'. It's people in drop-in centres, in their own homes, who love the community mental health team, people who think the psychiatrist is the best person they ever met, people who think medication is the saviour of their life.⁸⁸⁸

Sometimes user groups had cause to fight for access to drugs rather than to challenge their use, or over-use, by doctors. REHPC took up the case of a patient at Royal Edinburgh who was unable to read or write and had been told that Smithkline Beecham had stopped the drug, Redeptin, which he had been receiving for some time. Jim Kiddie remembers taking the matter to the local MP, and meeting with Malcolm Rifkind, a senior figure in the Conservative government at the time: 'we

⁸⁸¹ Ibid., p. 15.

⁸⁸² Ibid.

⁸⁸³ Ibid., p. 14.

⁸⁸⁴ Ibid.

⁸⁸⁵ Ibid.

⁸⁸⁶ Morgan, OMH/1/2.

⁸⁸⁷ McNeil, OMH/1/21.

⁸⁸⁸ Morgan, OMH/1/2.

decided to go to the press and I went to *Scotland On Sunday* and the next weekend there was a two-page spread':

Now what multinational companies don't like is bad publicity. On the Monday I had a telephone call from the managing director of Smithkline Beecham in Geneva, assuring me that this drug would be continued on a named patient basis. Now several hundred people in Scotland benefited from that. Now that's one of our major triumphs.⁸⁸⁹

Others, such as Sinclair-Chalmers express a more sceptical view about the development of relations with more powerful organisations and with government officials. She notes that some activists were 'sucked in by the Scottish Executive as their pet users', that 'they are there because they will do what the Scottish Government [...] tell them to do', and that they 'are more interested in the position'.⁸⁹⁰ The worry is, that activism and resistance, having first been transformed into lobbying, could mutate into careerism. The problem on this view is that, while no doubt leading activists never intended to become voluntary sector bureaucrats, managers, or government worthies, this is what they tended to become. By becoming 'professional' or 'pet' users, was a new 'hierarchy of service user power' created?⁸⁹¹

5.4 Deinstitutionalisation and Its Discontents

The worries about a 'hierarchy of service user power' echoes the Foucaultian concern that power regroups and that we 'run the risk of letting ourselves be determined by more general structures of which we may well not be conscious, and over which we may have no control'.⁸⁹² For Foucault:

the mechanisms [of a disciplinary establishment such as a mental hospital] have a certain tendency to become 'de-institutionalized', to emerge from the closed fortresses in which they once functioned and to circulate in 'free' state; the massive, compact disciplines are broken down into flexible methods of control, which may be transferred and adapted [...] one can [therefore] speak of the formation of a disciplinary society in this movement that stretches from the enclosed disciplines, a sort of social 'quarantine', to an indefinitely generalizable mechanism of 'panopticism'.⁸⁹³

This expresses the idea that psychiatry, having moved from being ensconced in the 'closed fortresses' of the asylums, the discipline extends the exercise of its techniques, its knowledge and power, across a wider sphere. It is able to do this in such a manner that a much larger population, beyond the walls of the asylum, is induced to internalise and reproduce psychiatric discourse - the norms and concepts of psychological science - in everyday life, leading many more people than in the past to describe themselves in terms drawn from the psychological sciences and to think of themselves as potentially suitable cases for psychiatric or psychological treatment. On this view, in

⁸⁸⁹ Kiddie, OMH/1/33.

⁸⁹⁰ Sinclair-Chalmers, OMH/1/3.

⁸⁹¹ Richard Lakeman, James Cook, Patrick McGowan and Jim Walsh, 'Service users, authority, power and protest: A call for renewed activism', *Mental Health Practice* 11 4 (2007), pp. 14-16.

⁸⁹² Foucault, 'What Is Enlightenment?', p. 47.

⁸⁹³ Michel Foucault, *Discipline and Punish: The Birth of the Prison*, Translated by Alan Sheridan (New York: Vintage Books, 1995), pp. 211; 216.

the West, people have been brought to see human tragedies, suffering, and problems of living, as instances of psychological problems, becoming increasingly vigilant for signs of underlying psychopathology. This is but an extension of the idea that social problems are remediable by the solutions of scientific and technical rationality. People come to self-police themselves to the extent that they keep watch for signs of underlying psychopathology and are ready to deliver themselves willingly into the arms of therapists and medical technicians of the soul, armed with the cornucopia of modern psychotherapy and psychopharmacology. Psychiatric medicine, on this view, extended its tentacles through society as a peripheral branch of the state apparatus, ensuring good health and an economically productive population.

Responding to concerns expressed by psychiatrist (now President of the Royal College of Psychiatrists) Simon Wessely about a historic psychiatric 'obsession with severe mental illness', Peter Barham has observed that:

from the angle of a scientific and technical culture with a repair-shop mentality, eager to circumscribe and produce neat solutions to human problems, the long-term mentally ill have failed lamentably as patients - they hang around in their brokenness, and to make matters worse, messy social conditions seem to cling to their persons.⁸⁹⁴

According to this view, long-term chronic patients are an embarrassment to psychiatry, tainting the profession with their stigma and intractability. As Geoff Shepherd has remarked, it 'becomes difficult to justify the expenditure of scarce therapeutic resources on people who are not going to get better... thus the chronic patient represents a problem. They are an embarrassment to a scientific and technical culture which is used to being able to sort out its problems'.⁸⁹⁵ The trend of psychiatry taking more interest in milder forms of psychiatric problems overlaps with a process in which society is increasingly governed by a rationality by which an economy of moral and social regulation is affected. The values of individualism, self-reliance and personal responsibility that post-Thatcher governments tried to inculcate in citizens, were instilled in such a way that the 'so-called retreat from the state can be construed as "re-governmentalization" through other means'.⁸⁹⁶

At the turn of the century in Scotland, and the UK more broadly, activists became increasingly concerned about the economic and political motivations behind the deinstitutionalisation of the old asylum system and the emergence of new techniques of coercion, compulsion and containment, which have replaced the walled and locked asylum. Psychiatry may have been deinstitutionalised, but were patients? As the Physician Superintendent of Gartnavel Royal Hospital noted in 1976, 'psychiatric patients are particularly vulnerable in periods of unemployment and economic

⁸⁹⁴ Barham, *Closing the Asylum*, p. 172.

⁸⁹⁵ Geoff Shepherd, 'Community care: a historical overview', in *Community Care: People Leaving Long-stay Hospitals*, ed. Sheila Sharkey and Sara Barna (London: Routledge, 1990), pp. 14-15.

⁸⁹⁶ Michael Peters, *Poststructuralism, Marxism and Neoliberalism: between theory and politics* (Oxford: Rowman and Littlefield, 2001), p. 78.

recession'.⁸⁹⁷ For many patients and ex-patients modern liberal society has had difficulty in finding a place for people such as they, who fail to meet the requirements for participation in the market. As Ralf Dahrendorf says, 'the crucial fact about the underclass and the persistently unemployed is that they have no stake in society. In a very serious sense, society does not need them. Many in the majority class wish that they would simply go away; and if they did their absence would be barely noticed'.⁸⁹⁸ Psychiatric patients can be found living lonely lives, isolated from society, with no stake in it. As Jeff, ally of the movement, put it:

We are collective, communal animals and that's what makes it important for collective voice and collective action to happen. Because sometimes we're deprived of that kind of community, we're deprived of that collectiveness, we're [...] shut in our wee boxes or we're shut in a ward or we're shut in a room or we're shut away in front of a telly and that's not good for us [...] we're collective animals, we're collective beings and we need to share all these things and I think that's what the movement has given people, is the opportunity to do that.⁸⁹⁹

Albert Nicolson, who spent around twenty years in hospital before returning to 'the community', believed that:

The trouble is that society as a whole community has gone out of the window and it is not just patients who are being put out into the community and left in a house on their own and facing four walls and a television set and having no real contact with the real world, they're just isolated and this isolation doesn't exactly help people to come out of the states they've been in.⁹⁰⁰

He also averred that the authorities 'put people in limbo', that 'it was the society that just didn't understand where you were coming from'.⁹⁰¹ Referring to life in hospital he remarked:

They programme people in here, they don't help people, they don't bring people out of things, they put people in there, an artificial state, zomboid [...] or symbiant, you're neither one thing or the other [...] No wonder you can't handle it when you go outside. If you're rejected by society when you come in, then you're even more so when you go out because you're no there at all. 'He's off his trolley, he's away with the fairies, he's off his heid'. Of course he or she is, you've been modified, you're part one thing, you're part chemical and part you. You go out in this bath [...] of liquid, chemicals [...] which are foreign to your being [...] Psyche is mind, soul, spirit [...] Psychiatry has got nothing to do with it. They blank your mind so you cannae think, you cannae progress, you cannae move on, you've got to refer backwards.⁹⁰²

Graham Morgan commented that 'the big hospitals with thousands of people in are not there and people are not so dramatically abused by the system as they used to be, although you could say abuse is a new indifferent'.⁹⁰³ Another activist suggested that

we've got a lot to learn from the asylums and that might seem like a really strange thing to say but asylum in its true sense is something I think people do want at times when they're distressed. Which is about going somewhere that is safe, comfortable and it's away from your home environment. I think I have

⁸⁹⁷ Gerald Timbury quoted by Vicky Long in 'Rethinking Post-war Mental Health Care: Industrial Therapy and the Chronic Mental Patient in Britain', *Social History of Medicine*, 26 (2013), p. 754.

⁸⁹⁸ Ralf Dahrendorf, *The Modern Social Conflict: An Essay on the Politics of Liberty* (London: Weidenfeld & Nicolson, 1988), p. 161.

⁸⁹⁹ Jeff, OMH/1/8.

⁹⁰⁰ Albert Nicolson interviewed by Jim McGill, September 2009, OMH/1/45.

⁹⁰¹ Ibid.

⁹⁰² Ibid.

⁹⁰³ Morgan, OMH/1/2.

concerns sometimes that the move towards treating people at home when they're distressed. Because quite often your home environment can be contributing to your mental health difficulties.⁹⁰⁴

But for Jim McGill:

We don't need to have these big Victorian hospitals with everything that goes with that, you know, the kind of hospital on the hill, away from the community where people can't see what's going on [...] bringing people back down the hill into their rightful place in the community, that's how it ought to be, that's their rightful place.⁹⁰⁵

John Macdonald remarked that 'clearly it was a massive delay from the late 1950s when it was first announced that community care would come'.⁹⁰⁶ The ethos of asylum, as a place of safety or refuge, was not dismissed entirely by activists in Scotland and the UK more broadly. Although Jeff remarked that collective action by patients was 'like a counterculture to the tyranny of psychiatric institutions', the repeated calls by activists for twenty-four hour crisis services as an alternative destination to psychiatric hospitals embodied the ethos of providing a safe place.⁹⁰⁷ This objective was pursued by user groups across the UK from the 1980s and can be traced back to Robin Farquharson's efforts to found a therapeutic community like Kingsley Hall formed exclusively of ex-patients. After 17 years of campaigning by user groups in Edinburgh, a crisis centre was finally opened in 2007, but it would not be run by patients or ex-patients as activists had hoped. The perspectives of many activists on the need for 'genuine' asylum suggests a considerable degree of ambivalence, even within individuals, about what deinstitutionalisation has brought for psychiatric patients and what kind of system they had hoped to see replace the Victorian asylums. When Bangour Village Hospital in West Lothian closed in 2004, from then on patients from the locale were to be sent to a psychiatric unit within St. John's general hospital in Livingston. While advantages of the move were recognised, some expressed a sense of loss and nostalgia for the old world. As Shaun McNeil remarked, some patients

were disgruntled because you didn't have nice grounds to walk in. It was a less relaxing environment it was a less therapeutic environment in terms of natural light and sunshine, places to walk, recreational things. The village really was really a village in its heyday having a shop and a post office and a tearoom and a working farm and people worked in the farm and worked in the laundries and everything else. So in a way it was like going from a little village to living in the city or something.⁹⁰⁸

Closing the asylum was not a top priority in life for all psychiatric patients. It is perhaps not surprising that it has been difficult for 'the movement' to find a coherent philosophy and identity expressed by all. As Peter Barham remarked 'the permanence and division of "mental patienthood" has to a considerable extent yielded to identities that are altogether more provisional and negotiable'.⁹⁰⁹ Iain Ferguson has cautioned that 'the idea that all mental health service users share a

⁹⁰⁴ Anonymous, OMH/1/71.

⁹⁰⁵ McGill, OMH/1/36.

⁹⁰⁶ Macdonald, OMH/1/10.

⁹⁰⁷ Jeff, OMH/1/8.

⁹⁰⁸ McNeil, OMH/1/21.

⁹⁰⁹ Barham, 'From the Asylum to the Community', p. 235.

common interest which overrides any other interest or division' is a highly dubious notion.⁹¹⁰ Speaking of identity politics in general, Wendy Brown has warned of 'wounded attachments' and 'the moralising revenge of the powerless'.⁹¹¹ According to Brown 'politicised identity [...] enunciates itself, only by retrenching, restating, dramatising and inscribing its pain in politics; it can hold out no future – for itself or others – that triumphs over this pain'.⁹¹² Perhaps activists have sometimes fallen into the trap of accentuating the oppression they saw themselves fighting against and underplaying the positive value content of their objectives. Ann Bardsley cautioned that 'one of the problems with users groups and organisations is that they don't always listen to the people who could well be allies. We are very good at shouting our demands but we are not good at listening to how we can get those demands met [...] it is easy to shout for demand, demand, demand. But we need to realise we need to listen to see how that demand can be met'.⁹¹³ Speaking in the 1980s LINK activist Christine Cowan remarked that

When I first came along to LINK I used to see things in terms of them and us and the goodies were the patients and the baddies were the professionals and what I realise now is that sometimes some psychiatric patients in fact behave that way themselves, the things that they say about professionals in terms of abuse of power and manipulation and dictating, in actual fact some patients themselves start to behave that way too.⁹¹⁴

Such comment serves to emphasise that patients are only human, with all the flaws and fragilities of humankind. Amidst all the demands over the years for self-determination, empowerment and equality of regard, the solidarity and reciprocity expressed and demonstrated by people working together in user groups is something which runs through the different examples of collective action in Scotland from SUMP to VOX. Whilst groups employed strategies and tactics in pursuit of specific social and political objectives, for many participants it was the friendship, sense of belonging, purpose, and community, and the confidence they gained from participation that sustained their involvement. For many, involvement in collective action was not simply an ideological cause to which they were committed in pursuit of set objectives or demands. Instead, collective action was the embodiment of their needs for companionship, human interdependence and connectedness, transcending instrumental considerations. For participants it was not simply abstract ideals, discourses, or ideologies that sustained their collective action, but social relationships which were real, concrete, personal and immediate. During the period from SUMP in 1971, to VOX in 2006, the grievances expressed, the discursive tactics and strategies employed and the forms of practical-self organisation of psychiatric patients, were part of a broader trend of emerging health social movements and patient organisations which involved 'elements of both

⁹¹⁰ Iain Ferguson, 'Identity politics or class struggle? The case of the mental health users' movement' in *Class Struggle and Social Welfare*, ed. Michael Lavalette and Gerry Mooney (London: Routledge, 2000), p. 228.

⁹¹¹ Wendy Brown, *States of Injury: Power and Freedom in Late Modernity* (Princeton: Princeton University Press, 1995), p. 74.

⁹¹² Ibid.

⁹¹³ Bardsley, OMH/1/1.

⁹¹⁴ Cowan, 'Speaking from experience'.

construction and self-construction' and involved 'different groups and actors, including the state'.⁹¹⁵ Material and spatial factors were formative for patient self-organisation, in different settings of asylum and post-asylum spaces. The fluctuating course of mental health problems means that 'when accounting for the nature of collective social action on matters of health and illness, one must consider specific circumstances of corporeal materiality'.⁹¹⁶ Often workers and members of user groups and patient organisations suffered 'burn out' and the continuity of group activities was often interrupted by the mental health problems of activists. Like other conditions such as multiple sclerosis, 'patients are often relatively young, active, articulate individuals with sufficient energy, time and motivation to take an interest in medical and scientific attitudes towards their [illness]', but the 'material realities' of people's problems, whether the 'slow and inconstant course' of their mental health, or difficult socio-economic circumstances, continue to constitute significant and stubborn constraints on the possibilities of action by psychiatric patients.⁹¹⁷

5.5 Conclusion

In the words of the title of an early 1990s mental health conference in Glasgow, deinstitutionalisation in Scotland was a 'slow train coming'. Whilst governmental and health authorities in the mid-to-late twentieth century Scotland always proceeded cautiously compared with England on the issue of psychiatric hospital closure, patient groups sought to shake authorities in Scotland out of any complacent attitude that the country was pursuing a more enlightened approach than the rest of the UK. It is clear from statements made by individuals and groups examined in this study that collective action in Scotland by psychiatric patients was often viewed through the prism of Scotland's distinct place in the United Kingdom, with its own separate legal system and political culture. In a period when Scottish nationalist sentiment was on the rise, culminating in devolution in 1999 and more recently in the referendum on Scottish independence in 2014, it is not surprising that a concern with the place of Scotland in the UK was reflected in the discourse and action of psychiatric patients. In 1971 Thomas Ritchie was in favour of a uniform system of administration across the UK, yet by the turn of the century Scotland reconvened a national legislature, which provided an unprecedented opportunity for at least some activists to influence changes in the law in Scotland.

By posing the question of the emergence and development of collective action by psychiatric patients, we have asked how durable national user organisations in Scotland have come about and which interlocking social and material conditions have had the most striking impact upon what was said and done by activists. It is clear that the social, cultural, political, legal, scientific and

⁹¹⁵ Alex Mold, 'Patient Groups and the Construction of the Patient-Consumer in Britain: An Historical Overview' *Journal of Social Policy* 39 4 (2010), p. 518.

⁹¹⁶ Nicolson and Lewis, 'The Early History of the Multiple Sclerosis Society', p. 174.

⁹¹⁷ *Ibid.*, pp. 142; 173.

economic forces which shaped the formation of collective action by psychiatric patients in Scotland were multifarious, operating above and below the level of national politics and policy. There is no question that unprecedented global forces were at work in the period during which collective action emerged. Globalisation brought new crises of cultures, politics, economics, science and technology, into sharp focus. This study has sought to remain close to what was said and done by individuals and groups from Scotland, whilst situating the discourse and action in wider national and international contexts. As knowledge of local contexts deepens, as descriptions are thickened and the interactions between local, national and international contexts are explored more fully, comparative analyses can reveal the significance of transnational politics of mental health and differences between geographical regions. As Helen Spandler found in her study of Paddington Day Hospital, where SUMP's successor the MPU was formed, taking account of the spaces where collective action emerged is necessary because 'identification with particular places can be of strategic importance to the mobilisation strategies of particular resistance movements'.⁹¹⁸ Paul Routledge who developed the concept of 'convergent spaces' recognised that 'places are important loci of collective memory, then social identity and the capacity to mobilise that identity into configurations of political solidarity [which] are highly dependent upon the processes of place construction and sustenance'.⁹¹⁹ This insight, which Routledge elaborated on the basis of his studies of anti-globalisation movements, is true also of collective action by psychiatric patients in the late twentieth-century, for it was 'action that [was] deeply embedded in place, i.e. local experiences, social relations and power conditions and action that facilitate[d] transnational coalitions'.⁹²⁰ As with the anti-globalisation movements, such collective action has functioned 'with a penumbra of differences, conflicts and compromises' and its 'local contexts of resistance [have] interplay[ed] with global processes'.⁹²¹

SUMP was principally concerned with conditions at Hartwood, but was the first of a number of 1970s MPUs in the UK, embodying a form of discourse and action of national scope and currency. In the 1980s, liaisons and partnerships with mental health associations propelled LINK club into exchanges between groups in England and Scotland, with key members going onto help found national networks SSO and SUN. Patients councils in Scotland followed the Dutch example after international exchanges. The *Psichiatria Democratica* movement in Italy inspired Scottish activists in the 1980s. Ideas about separatism and user-only groups filtered through from the U.S. also. Following the initial promise of national development in the 1990s with the national Scottish Users' Conferences, SUN was racked with personal clashes and poor relationships between the regions. Space and geography was a shaping force, in how activists in Scotland related to, resisted, thematised and constructed asylum and post-asylum spaces. Space is important because

⁹¹⁸ Routledge, 'Convergence space', p. 336.

⁹¹⁹ *Ibid.*

⁹²⁰ *Ibid.*, p. 337.

⁹²¹ *Ibid.*, p. 346.

government is intimately bound to the exercise power over territory and population, structuring the field of possible action of citizens. By forming public fora for discussion, debate, critique and action, psychiatric patients showed themselves willing and able to act on their shared situation in pursuit of empowerment.

The period in which a national mental health service user movement emerged in Scotland was a time of transformation from asylum to post-asylum spaces of mental health care. Multiple factors structured the fields of action within which groups of patients operated. Technological innovation in the sphere of psychopharmacology contributed to the optimistic climate in which Enoch Powell looked towards the end of the asylum era. The growing reliance on drug treatment would also come in for increasing criticism from patients as the movement in Scotland developed. Cultures within the field of mental health during the twentieth century, especially therapeutic community experiments and critiques of psychiatry from within and out with the profession, were amongst multiple formative factors which enabled and delimited collective action. Whilst part of a transnational phenomenon, collective action in Scotland was shaped by local contingent social and material circumstances. From the outset collective action was defined by activists in terms of the place of Scotland in relation to its larger neighbour in the UK. The absence of serious public debate in Scotland during the 1970s was highlighted by activists during the 1980s. By the 1990s groups of patients and allies were sufficiently organised to think and act seriously for the first time on the development of a national network of individual activists and groups in Scotland. The requirement for service user involvement by the Community Care Act created new opportunities for activists to engage with authorities and develop their ideas and strategies. Thomas Ritchie had the ambition to form such a nationwide association of mental patients in the 1970s, but his aim was never realised, despite the spread of mental patient unionism across different parts of the UK, including the emergence of a Dundee MPU after Ritchie's departure from Scotland.

Drawing on the discourse of established social and political movements and counter-cultures, from trade unionism, civil rights campaigns and anti-psychiatry, to consumerism, self-help and advocacy, groups adapted to the social and material milieus from which they emerged by appropriating ideas and practices available to them in broader cultures of the time. They transmitted their message via emerging channels of communication such as the underground press in the 1970s, through local association magazines, by means of training videos for health professionals and, in 1986, by means of a television documentary on the UK-wide Channel 4. Through the 1990s and 2000s consultation exercises with governmental and health authorities ensured that their concerns were heard by public servants, if not always acted on. SUMP protested and petitioned against conditions at Hartwood in 1971. By the time LINK was active in the 1980s the social policy of national government became a target for campaigning by patients. Activists were assisted, and in many ways shaped, by their contact with critical, non-medical professionals and workers. Collective action by psychiatric patients became a focus for enthusiasm on the part of those who were not patients themselves. But it is notable that these allies tended to be non-

psychiatric professionals and workers. They often shared scepticism about biomedical reductionism in mental health. Although activists have sometimes sought to distance their activities from the ideas and practices of R.D. Laing and David Cooper, the ambition to move beyond diagnosis, to tackle broader social issues and to question the individualisation of mental health problems by the biomedical approach, displayed cognate scepticism about psychiatric diagnosis and treatment, and resistance to medicalised categories. Many activists in Scotland acknowledged their interest in R.D. Laing's ideas and it is perhaps not surprising that his work exercised considerable influence on activists in Scotland given that Laing himself was one of the most prominent Scottish public intellectuals of the twentieth century and also a critic of conventional psychiatric practice.

Discourse, like space, was also important, because activists began to assert their right to define and name their own experiences and refused to allow psychiatric diagnoses to define their whole lives. After the MPUs employed the term 'mental patient', collective action took a critical linguistic turn as terms of self-definition were problematised and contested. Concerns are expressed by some contemporary activists that demands made by action groups in the past were sometimes narrowly focused on clinical services. Questions have been raised about how successful user groups were at transcending medical discourse, moving beyond diagnosis or beyond an encompassing identity as patients, or as users of mental health services. Graham Morgan remarked that he has 'slowly realised' that there are 'things outside of mental health and there's a life that doesn't have to be lived purely with people with mental health problems', because he was 'very suspicious of anyone who didn't have any mental health problems'.⁹²² The identification as 'service users' was often thought to be limiting and constraining to patients as they were still tied to their identity *as patients*, defined by their sick role. Equally it was recognised that there is a danger that attempts to surpass the sick role have been used by governments and statutory welfare agencies to shift a disproportionate responsibility onto individuals for their mental health problems, devising 'work capability assessments' which overlook the irregular, inconstant, fluctuating course of such conditions. Others believe that a clearer sense of collective purpose must be articulated and acted upon in order for patients to have a greater impact on policy and practices and to avoid being led by the agendas of others. According to Peter Campbell the 'focus of most service user/survivor activists still seems fixed on the service system. They appear to think of themselves as service users first and citizens second'.⁹²³

Campbell argues 'that a clearer ideology has become necessary to challenge biomedical orthodoxies that will always disempower'.⁹²⁴ He believes, 'it would be helpful if there was a clearer statement of shared beliefs and objectives'.⁹²⁵ But perhaps an emphasis on ideology, belief and

⁹²² Morgan, OMH/1/2.

⁹²³ Campbell, 'The service user/survivor movement', p. 197.

⁹²⁴ Peter Campbell, 'From Little Acorns: The mental health service user movement', in *Beyond the Water Towers: The unfinished revolution in mental health services 1985-2005*, ed. Andy Bell and Peter Lindley (London: The Sainsbury Centre for Mental Health, 2005), p. 82.

⁹²⁵ Ibid.

objectives obscures the point he makes that 'the process is not just about results'.⁹²⁶ The Nietzschean conception of enlightenment as *ethos*, against a Kantian conception of enlightenment as a project, is concerned with the characteristic spirit of a culture or community as manifested in its attitudes. On this account the journey is more important than the destination and the culture does not develop with an explicit instrumental purpose. Although Campbell acknowledges and pays tribute to the emergence of collective action by psychiatric patients and their 'willng[ness] to "come out" and speak openly', he thinks 'there is a danger of being over-impressed, because of the low base from which action began'.⁹²⁷ He believes that 'people with a mental illness diagnosis remain what they have always been: a fundamentally powerless group', at 'the bottom of the pile' and that 'in 2005... [they] are on the lowest rungs of the hierarchy of power' in relation to mental health services and their position in society.⁹²⁸ Campbell has expressed ambivalence about how far collective action has come. Writing in 2005 he articulated this sense of ambivalence. On the one hand he says:

-The situation was very different in 1985 [...] The few independent service user action groups that existed were unfunded, unappreciated and on the margins. When they did capture an audience they were accused of being extremists with nothing positive to offer.

-Service user activists have penetrated areas of the mental health system where their presence, let alone their positive contribution, would have been inconceivable twenty years ago.⁹²⁹

-Service user activists have profoundly influenced the way in which people with a mental illness diagnosis have begun to emerge from the shadows and be recognised as an important creative force in their own right

-Mental health services have become more empowering.⁹³⁰

Yet, on the other hand he says that there is

-Suspicion that [...] government will always respond more enthusiastically to the demand to control people with a mental illness diagnosis than to empower them.⁹³¹

-Fear and preoccupation with perceived violence has increased.⁹³²

-Heavy dependence on the medical model and the quick-fix technology of psychiatric medication.⁹³³

Campbell demands that psychiatry 'step down into the street alongside service users and be guided first by what they want from their lives, not by the knowledge it has been perfecting in

⁹²⁶ See p. 186.

⁹²⁷ Ibid., p. 78.

⁹²⁸ Ibid., p. 79.

⁹²⁹ Ibid., p. 74.

⁹³⁰ Ibid., p. 80.

⁹³¹ Ibid., p. 81.

⁹³² Ibid., p. 80.

⁹³³ Peter Campbell quoted in *Putting the soul back into psychiatry. MindThink Report 1* (London: Mind, 2007), p. 3.

spotless laboratories and ivory tower institutions'.⁹³⁴ He expresses the common concern that 'medication makes a lot of people feel soulless. People are given medication on the understanding that it will enable them to respond to other forms of treatment - but too often that promise is empty and there is only medication'.⁹³⁵ Some psychiatric patients identify their problems in religious and spiritual terms and find it difficult to navigate these religious and spiritual dimensions in a post-Christian culture dominated by technical solutions. Others see their problems as socially produced, linked to issues of poverty, inequality, lack of opportunity and unemployment.

An attempt to break with the past on the back of an optimistic faith in progress, the 'liberation' of psychiatric patients from the asylum regime was meant to deliver them to 'the community' as autonomous individuals. The liberal ideologies of the late twentieth century, which made a fetish of individual choice, neglected the human need for 'a home, a network of common practices and inherited traditions that confers [...] the blessing of a settled identity'.⁹³⁶ As John Gray expresses so powerfully, 'freedom is worth-while and meaningful [...] only against a background of common cultural forms'.⁹³⁷ The progressive vision of world improvement, based on providing technical, managerial and market-driven solutions to social problems, often betrayed an impoverishment of human imagination and sympathy, and a diminution of the dignity of human beings. In the brave new post-asylum world where many patients contend with poverty, stigma, unemployment, discrimination, social isolation, homeless or imprisonment, it is no wonder that groups of patients are as vociferous today in their protestations as SUMP was nearly fifty years ago. If activists of today are searching the past to discover the abstract principles, general doctrines and ideologies, which animated the activities of their predecessors, they will find that what was more important than a guiding ideology was the formation of 'a cultural framework that provide[d] a nexus of trust necessary for voluntary action'.⁹³⁸ The birth of SUMP was driven in part by the Cynic free speech of Thomas Ritchie. Movement ally of the 1990s, Jeff, urges activists to continue this practice, 'nipping the ankles like a wee terrier, not letting people get away with unsavoury practices, keeping at it, keeping the bit between the teeth'.⁹³⁹ Yet it was also through a process of culture building, an ongoing conversation amongst themselves and with others that activists came to be recognised as a community of citizens, creating new forms of civil association.

The exercise of autonomous choice requires 'a cultural environment that is rich in choice-worthy options and inherently public goods' if it is to have value and meaning in people's lives.⁹⁴⁰ For psychiatric patients such options are often few and far between. Although activists stressed the

⁹³⁴ Ibid.

⁹³⁵ Ibid., p. 6.

⁹³⁶ John Gray, 'An Agenda for Green Conservatism', in *Beyond the New Right: Markets, Government and the Common Environment* (Abingdon: Routledge, 1993), p. 125.

⁹³⁷ Ibid.

⁹³⁸ Thomas J. Cheeseman, 'Homo Ludens and Civil Association: The Sublime Nature of Michael Oakeshott's Civil Condition', *Cosmos + Taxi: Studies in Emergent Order and Organization* 1 (2014), p. 43.

⁹³⁹ Jeff, OMH/1/8.

⁹⁴⁰ John Gray, *Enlightenment's Wake*, p. 110.

need to move beyond their diagnoses and define themselves on their own terms, it remains the case that it is through the route of psychiatric diagnosis that people gain access to support from health and welfare agencies. From mental patient, through consumer and survivor, to service user, the fluid, situational and negotiable identities of activists are always in process. It is important to remember also that ‘psychiatric classification doesn’t automatically result in psychiatric or psychological support or intervention (other than medication, which is increasingly administered by your GP and managed by the individual concerned)’.⁹⁴¹ Helen Spandler highlights that whereas in the past people often ‘faked normality’, or hid their distress, in order to be discharged from hospital, ‘we are now faced with the perverse situation where people may have to exaggerate their madness (and emphasise their dangerousness) in order to access or retain services’.⁹⁴² It is not surprising that at a time when ‘psychiatric neglect’ is seen as a greater danger than ‘psychiatric abuse’, the anti-psychiatric rhetoric recedes into the distance and a discourse which targets central government to demand greater resources for mental health services returns.⁹⁴³ Anne Bardsley gives voice to the widespread complaint that government are ‘cutting the beds, cutting the beds and cutting the beds, but they are not providing the services within the community. They are cutting the budgets of the services that are in the community. Now how’s that actually improving things? It’s not’.⁹⁴⁴

The emergence of protest, resistance, critique and self-organisation amongst patients and users was a focus for enthusiasm on the part of those who became allies, often social workers, community development workers, voluntary sector organisations, academics with an interest in social policy, lawyers with an interest in promoting human rights and sometimes, though not often, psychiatrists too. These allies exhibited what Kant refers to as ‘a sympathy of aspiration bordering on enthusiasm’, reflecting an enlightened desire for a more humane psychiatric medicine and a social order that would assure human dignity and respect for persons diagnosed as mentally ill. For patients, participation in collective action sometimes offered ‘the promise and guarantee of finding something that would radically change their subjectivity’.⁹⁴⁵ For ‘people do revolt; that is a fact. And that is how subjectivity (not that of great men, but that of anyone) is brought into history, breathing life into it’:

No one is obliged to find that these confused voices sing better than the others and express the truth itself. It is enough that they exist and that they have against them everything that is dead set on shutting them up for there to be a sense in listening to them and in seeing what they mean to say.⁹⁴⁶

⁹⁴¹ Helen Spandler, ‘From Psychiatric Abuse to Psychiatric Neglect’ *Asylum* 23 (2016), pp. 7-8.

⁹⁴² *Ibid.*

⁹⁴³ *Ibid.*

⁹⁴⁴ Bardsley, OMH/1/1.

⁹⁴⁵ Michel Foucault, ‘Iran: The Spirit of a World Without Spirit’, in *Politics, Philosophy, Culture: Interviews and Other Writings 1977-1984* ed. Lawrence D. Kritzman (New York: Routledge, 1988), p. 218.

⁹⁴⁶ Michel Foucault, ‘Useless to Revolt?’, in *Power: Essential Works of Foucault 1954-1984 Volume Three*, ed. James D. Faubion (London: Penguin, 2002), p. 452.

Together, activists and their allies participated in one of the great transformations in mental health care over the last half-century, alongside the pharmacological revolution, the rise of Big Pharma, the growth of the *Diagnostic and Statistical Manuals of Mental Disorders* (DSMs), and the process of deinstitutionalisation.⁹⁴⁷ Although the issues on which they campaigned are still live today and psychiatric patients face great challenges in relation to psychiatry, the state and in wider society, the example set in this period demonstrates how psychiatric patients, ‘as a result of common experiences (inherited or shared), fe[lt] and articulate[d] the identity of their interests as between themselves’, showing those who exercised power over them that they would not be silenced or cowed in the face of personal adversity, social exclusion and political indifference.⁹⁴⁸

⁹⁴⁷ Mark S Micale, ‘The ten most important changes in psychiatry since World War II’, *History of Psychiatry* 25 (2014), p. 486.

⁹⁴⁸ Edward Palmer Thompson, *The Making of the English Working Class* (London: Victor Gollancz, 1963), p. 9.

APPENDIX**TIMELINE****1949**

Dingleton Hospital was the first in Britain to operate an open-door policy allowing the patients freedom from locked wards. Medical Superintendent Dr George MacDonald Bell introduced the open-door policy.

1953

WHO Report 'The Community Mental Hospital' Third Report of the Expert Committee on Mental Health.

1954

Chlorpromazine (Largactil or Thorazine) first introduced.

1958

Dunlop Committee Report published, which reviewed mental health legislation in Scotland.

1959

Dunlop Committee Second Report.

Dutch Theology student Elly Jansen founded the Richmond Fellowship which was ran on the ethos of a therapeutic community

1960

Mental Health (Scotland) Act.

The 1960 Act dissolved the General Board of Control for Scotland but established the Mental Welfare Commission (est. 1962) to continue carrying out some of the functions of the Board.

R.D. Laing's *The Divided Self* is published.

1961

Minister of Health Enoch Powell gives his famous 'water tower' speech at the annual conference of the National Association for Mental Health (NAMH) (now MIND)

Thomas Szasz's *Myth of Mental Illness* published.

Erving Goffman's *Asylums* published.

On Feb 3rd for the quarterly meeting of the Royal Medico-Psychological Association a three day conference was held in London on ‘Hallucinogenic Drugs and their Psychotherapeutic Use’

Robin Farquharson's D. Phil thesis *An approach to a pure theory of voting procedure* from Nuffield College, Oxford was awarded the Monograph prize of the American Academy of Arts and Sciences in the field of the social sciences.

Michael Dummett and Robin Farquharson ‘Stability in Voting’ published in *Econometrica* 29.

1962

Hospital Plan for Scotland published by Department of Health for Scotland.

Ken Kesey's *One Flew Over the Cuckoo's Nest* published.

Maxwell Jones goes to Dingleton Hospital, Melrose.

1963

Thomas Ritchie is detained in Hartwood Hospital, Shotts, Lanarkshire, under the Mental Health (Scotland) Act.

1964

Michel Foucault's *Folie et deraison: Histoire de la folie a l'age classique*, published in 1961, is translated into English in an abridged edition *Madness and Civilization: A History of Insanity in the Age of Reason*.

Robin Farquharson's research fellowship at Churchill College, Cambridge ended - ‘the wrench I felt resigning my Churchill College fellowship after one year and three nervous breakdowns. Marvellous folk, they gave me £3,000 journey money... under the control of two trustees... [who] let me take it out of the trust account to present to the Home Office, a little disturbed already by my two certification orders, with proof of my means’. Farquharson had his South African passport withdrawn in 1965 for his part in lobbying on behalf of the South African Non-Racial Olympic Committee (SAN-ROC) for South Africa's exclusion from the 1964 Olympic Games in Tokyo. He became a British citizen in 1968.

According to the philosopher Michael Dummett Farquharson's research post at Cambridge ‘ended after the most disastrous of his [manic] outbreaks, when he rented a suite of offices near Oxford Circus in London on behalf of a spurious company, and engaged the services of a large number of

typists, computer operators, etc. How all this was eventually paid for, I do not know; I suppose by the College. In any case, Farquharson's college appointment was ended [...] In the early stages of one of his manic phases, he could be extremely plausible and persuasive. They led to some hilarious episodes; he once succeeded in speaking to Onassis on the telephone, to tell him to bring whaling to an end'.

1965

The Philadelphia Association started a therapeutic community at Kingsley Hall in the East-End of London as a voluntary alternative to compulsory psychiatric treatment in hospital.

1966

R.D. Laing gave a speech at the annual conference of NAMH extolling the virtues of therapy with hallucinogenic drugs such as LSD.

1967

Thomas Ritchie wrote an account of his experiences in Hartwood Hospital in 'The Sick Room', Ward Seven, the high security, locked ward within a ward, at the hospital.

Robin Farquharson was a resident at the Kingsley Hall therapeutic community for a brief period, but was expelled by R.D. Laing.

Congress on the Dialectics of Liberation was held at London's Roundhouse, organised by four psychiatrists R.D. Laing, David Cooper, Joseph Berke and Leon Redler, and included headline speakers, Herbert Marcuse, Allan Ginsberg, Lucien Goldmann, Paul Sweezy, Gregory Bateson and Stokely Carmichael. Erving Goffman was also scheduled to appear, but had to cancel. All speakers were men and no psychiatric patients were invited to speak.

R.D. Laing's *The Politics of Experience and The Bird of Paradise* published.

David Cooper's *Psychiatry and Anti-Psychiatry* published.

Barbara Robb's *Sans Everything* published. This book compiled the allegations of mistreatment of the elderly at mental institutions in England. In the wake of this publication, regional hospital boards appointed committees to investigate the allegations. The enquiries uncovered evidence of abuse, but most of the claims in *Sans Everything* were dismissed as either grossly exaggerated or unsubstantiated.

A nursing assistant at Ely Hospital in Cardiff went to the *News of the World* with serious allegations about the treatment of elderly patients and pilfering by members of staff. The claims were corroborated after an official enquiry that was carried out under the chairmanship of Geoffrey Howe, QC.

1968

Robin Farquharson's *Drop Out!* published by Anthony Blond. The dustcover is designed by Allan Aldridge, an artist who went on to design *The Beatles Illustrated Lyrics*, published in 1969.

BIT 24-Hour Free Information and Help Service, London, was started by photographer John Hopkins, who previously had been involved in founding and writing for the *International Times* (IT) the underground press newspaper, which was first published in 1966. Robin Farquharson contributed to BIT's magazine, *Bitman*.

Robin Farquharson attended meetings of the Anti-University of London, which was instigated by David Cooper and Joseph Berke of the Philadelphia Association.

1969

Robin Farquharson's D. Phil thesis is published as a book, *Theory of Voting*, by Blackwell and Yale University Press.

Scientologists join NAMH in large numbers in an attempt to take the organisation over from within.

PNP (People Not Psychiatry) founded (London and Manchester, but there was also correspondence between people across the UK).

1970

Times article 'A Case of Schizophrenia, by a Correspondent', written by journalist John Pringle about his son, would lead to the formation of National Schizophrenia Fellowship in 1972.

Philadelphia Association's therapeutic community at Kingsley Hall closes.

Freek Press (associated with underground press magazines and newspapers *Friends*, *INK*, and *Oz*) at the Isle of Wight Festival reports in Issue 2, under the headline 'Poet assaulted', that: 'not long after author Robin Farquharson left the Friends tent to distribute *Freek Press* he himself freaked out and scared bystanders. He was quickly ejected from the site and just as quickly returned on the hood of a taxi shouting 'right on, right on'. He was beaten and taken to St Johns by security men. He was removed in a land rover as no one got an ambulance. Many of the St Johns team have not

dealt with drug cases before'. Farquharson had been involved in tearing down the perimeter fences at the festival site as part of a campaign by the far left White Panther group to create free festivals and free spaces.

Sometime between 1970 and 1972, acting as secretary of the Situationist Housing Association (SHA), Robin Farquharson found a squat for People Not Psychiatry (PNP), a network of psychiatric patients and allies seeking alternatives to compulsory psychiatric treatment in hospital.

1971

Scottish Union of Mental Patients (SUMP) founded at Hartwood Hospital, Shotts, Lanarkshire (folds within a year).

Thomas Ritchie writes to John Lloyd, the editor of the counter-culture newspaper *Ink*, in an attempt to publicise SUMP.

1972

National Health Service (Scotland) Act.

A Duty to Care published by Mental Welfare Commission Scotland

Thomas Ritchie moved to London in June.

NAMH changed its name to MIND after NAMH campaign of the same name started in 1971 to clarify its objectives and replenish resources.

National Schizophrenia Fellowship (NSF) founded.

1973

Mental Patients' Union (MPU) founded at Paddington Day Hospital in March 1973, Robin Farquharson and Thomas Ritchie, both former SUMP members, were involved with MPU.

Robin Farquharson offered accommodation to the MPU at Charrington St. N.W.1 London in a house that had been procured by squatting. According to Iain Sinclair in his 1997 book *Lights Out for the Territory: 9 Excursions in the Secret History of London* 'the dominant personality in the shifting commune [at Charrington St] was the South African, ex-Oxford don and hallucinogenic voyager, Robin Farquharson'.

Robin Farquharson died from burns suffered in a fire at a derelict house where he was squatting. Two Irishmen who were living at the house with him were convicted of unlawful killing.

A special obituary edition of counter-cultural magazine, *Bitman*, was published as a tribute to Robin Farquharson after his death.

Dundee Mental Patients' Union (Dundee MPU) founded in October 1973 with contacts inside and outside of Dundee's Royal Liff Hospital. The Dundee MPU changed its name to the Westfield Association, as detailed on the group's website in 2002:

'The Westfield Association was started as a Dundee branch of the Mental Patients Union based in London. The founder members were James Stewart, David Henderson and Arthur Foote. Our first meeting place was the old Y.M.C.A building on Constitution Rd. Dundee. Around a year later some controversy arose around the word 'Mental' being used in the Association's name, it was decided by the patrons that the name 'Mental Patients Union' was just adding further stigma. During a meeting in Westfield Place, Perth Road, Dundee, attended by a psychiatrist and strongly supported by students from Dundee University it was proposed, then agreed that the 'Mental Patients Union' by unanimous vote be dissolved, thus the Westfield Association was born. The Association's meeting venue soon changed to St. Paul's Church on Commercial St. Dundee, it was at this time that the Westfield Association Constitution was created by founder Arthur Foote. From that point on the group was classified as a self-help group. The Westfield Association has fought successful cases involving social security for in-patients and for members who were in the locked ward at Liff Hospital, Dundee. During the seventies, eighties and early nineties the Westfield Association was not allowed to meet in Liff Hospital. In the late seventies articles and letters were published in Le Figaro a French, Paris based Newspaper, encouraging people who had experience of being mental patients to take on board the principles of the Westfield Association'. (see <http://studymore.org.uk/mpu.htm#Westfield>>)

MPU named their headquarters at Mayola Rd *Robin Farquharson House*.

Community Organisation for Psychiatric Emergencies (COPE) evolved out of BIT in London.

1974

A UK Federation of Mental Patients' Unions is formed at a conference at the Music College, University of Manchester.

Mental Health Foundation (MHF) established in Scotland, which, at the time, was mainly a grant-making organisation for medical research into mental illness.

Former General Secretary of the National Council for Civil Liberties (NCCL) Tony Smythe becomes director of MIND.

1975

'No Place to Go' published by the Mental Welfare Commission Scotland

MIND's legal and welfare rights service begins with the appointment of its first legal officer, American civil rights lawyer, Larry Gostin.

1976

First **Glasgow LINK club** founded (continued into the 1990s)

Scottish Association of Mental Health (SAMH), which was founded in 1923, is 'reconstituted', develops 'its role as a political pressure group' and begins concentrating its activities on 'representing the interests of people with mental health problems'.

Larry Gostin's *A Human Condition Volume 1* published.

English group PROMPT (Protection of Rights of Patients in Therapy) founded

1977

Larry Gostin's *A Human Condition Volume 2* published.

A committee is set up by the Scottish Office to review mental health services for adults in Scotland. The committee did not publish its report until 1985.

1978

Glasgow Association for Mental Health (GAMH) starts providing social support services to the people of Greater Glasgow.

Judi Chamberlin's (U.S. activist) *On Our Own. Patient-Controlled Alternatives to the Mental Health System* published in U.S.

1979

Alzheimer's Disease Society founded.

First Richmond Fellowship house (Huntly Lodge) established in Glasgow.

LINK merges with GAMH to create LINK/GAMH.

1981

'Does the Patient Come First?' published by Mental Welfare Commission Scotland.

Glasgow branch of Alzheimer's Disease Society established.

1983

Members of GAMH Link clubs attended the annual MIND conference and were surprised that none of the presentations, seminars or workshops, were presented by patients.

1984

Mental Health (Scotland) Act.

MIND Annual Conference at Kensington Town Hall, London October 22 and 23, 'Life after Mental Illness Opportunities in an Age of Unemployment'.

Education and Action in Mental Health Group (Christine Cowan, Charlie Reid, Tam Graham, Vince Edkins, Elvira Ridley and John McManus) from GAMH Link Clubs give a presentation, which at the annual conference of MIND and discuss personal experiences of psychiatric treatment and critique the Scottish mental health system, discussing issues of policy, discrimination, housing, employment, community care and self help.

1985

Community Care with special reference to adult mentally ill and mentally handicapped people
Second Report from the Social Services Committee published.

Mental Health in Focus: Report on the Mental Health Services for Adults in Scotland published by the Scottish Home and Health Department in and the Scottish Education Department.

'Speaking from Experience' training video, in which members of Education and Action in Mental Health Group appear, is first shown at the World Congress for Mental Health *Mental Health 2000*. CAPO gatecrash the Mental Health 2000 Conference of the World Federation for Mental Health in Brighton. English activists meet activists from Holland, Scotland and the USA. Patients take control of a section of the conference and produce their own Charter, which is published as part of the conference charter.

MIND annual conference 'From Patients to People' at Kensington Town Hall over November 28 and 29 at Kensington Town Hall, London. LINK members and Peter Campbell give presentations.

Members of the Education and Action on Mental Health Group appear on the front cover of the *Social Work Today* journal, 'the top circulation journal for everyone in social services', on 9 December, Volume 17, Number 15.

PROMPT becomes CAPO (Campaign Against Psychiatric Oppression).

1986

Nottingham Patients Council Support Group is the first 'patients' council' in the UK, inspired by Dutch Patients' Councils.

'We're Not Mad, We're Angry' on Eleventh Hour programme shown on Channel 4 in the UK is a docu-drama which is critical of biomedical psychiatry. Current and former psychiatric patients had full editorial control and the script for the drama sections was written by Peter Campbell. (Member of Education and Action in Mental Health group Tam Graham appears on the programme).

GAMH Link Club members Tam Graham, Charlie Reid, Vince Edkins, Elvira McLay, Tassy Thompson lead a seminar at the MIND annual conference over November 13 and 14 in London.

Survivors Speak Out (SSO) founded (continues into the late 1990s) Founding members included Education and Action in Mental Health Group members Charlie Reid and Tam Graham.

Asylum Magazine for Democratic Psychiatry founded in Sheffield. It sought to be 'the freest possible non-partisan forum for anyone in any way involved in mental health work'.

1987

Creating Community Mental Health Services in Scotland 10th Anniversary Publication for the Scottish Association for Mental Health 2 Volumes (Ed. Nancy Drucker) published by SAMH. Volume 2 includes a section of 'Consumer Views'.

SSO organise first conference of mental health service users/survivor activists over a weekend at an Edale Youth Hostel September 18-20 (Education and Action in Mental Health Group member Charlie Reid in attendance). A Charter of Needs is drawn up and unanimously agreed upon by members present.

1988

‘Democracy in Psychiatry’ public meeting held on 8th of January in Edinburgh was called by Colin Murray, a social work student on placement at Barony Housing Association’s Contact Point drop-in centre .

Thomas Clouston Clinic patient group involved in planning of ward closure at the Royal Edinburgh Hospital.

Bangour Village Hospital Patient’s Council set up.

Mind annual conference ‘Common Concerns: International Conference on User Involvement in Mental Health Services’ held September 26-29 in Brighton. Colin Murray, Be Morris and Anne Bardsley, were amongst those who attended.

‘Public Forum for Users of Psychiatric Services’ public meeting held on December 9 in Edinburgh. Service user activists from England were invited to speak.

1989

Mental Hospitals in Focus Report published by the Scottish Home and Health Department and the Scottish Health Services Planning Council.

Over forty mental health service users and others representing mental health action groups, patients’ councils, consumer networks and advocacy projects from across the UK met Robin Cook, Shadow Health Minister and MPs Harriet Harman and Keith Vaz at the House of Commons on 20th of June (including Vincent Donnelly and Mary Fegan from Scotland). Service users made their contributions to the discussion under three main headings – ‘User Involvement in Planning and Management of Services’, ‘Types of Services’ and ‘Political issues (minority groups, ideology of services etc.)’.

Scottish Users’ Network (SUN) (folds in 2001) formed at a meeting in Perth.

Awareness campaign, discussion and support group concerned with people ‘who have the misfortune to need psychiatric care’ formed in Edinburgh and supported by Edinburgh Association for Mental Health. Lasted around six years.

Royal Edinburgh Hospital Patient’s Council set up.

1990

NHS and Community Care Act created a kind of internal market in health and social services. The 'purchaser/provider' split sprang from this Act. Health and social services were divided into units that bought services or provided them.

Launch of magazine *Beyond Diagnosis* based in Edinburgh. (Lasted around six years)

Mental Health Consumer Group founded in Aberdeen.

American mental health service user activist Judy Chamberlin, member of the Boston Liberation Front and author of *On Our Own: Patient-Controlled Alternatives to the Mental Health System*, speaks at the Edinburgh Filmhouse on the 5th of November.

David Brandon's *Innovation Without Change? – Consumer Power in Psychiatric Services* published.

1991

Consultation and Advocacy Promotion Service (CAPS) founded in Edinburgh (still in existence 2016)

Lothian Users Forum founded with the help of CAPS. (became Edinburgh Users' Group)

Patient's Charter published by Department of Health.

Anne Bardsley (member of Awareness and SAMH's national advocacy worker) produces an *Advocacy Report* published by SAMH.

1992

Manic Depressive Fellowship founded.

First Scottish Users Conference held in Falkirk on January 25.

Grampian Mental Health Consumer Conference held in Aberdeen in October.

East Lothian Involvement Group formed (folded late 2000s)

Jimmy Laing's and Dermot McQuarrie's *Fifty Years in the System: One Man's Struggle to Prove His Sanity* is published as new edition (after original publication in 1989).

1993

New Horizons established in the Borders area

Jimmy Laing's and Dermot McQuarrie's *Fifty Years in the System: One Man's Struggle to Prove His Sanity* wins MIND book of the year.

'The first Scottish Conference on Mental Health' held in Glasgow. Speakers at the conference included service users, Peter Campbell, Brian Smith, Jim Read and Lawrence Nugent.

Second Scottish Users Conference 'Care in the Community: Our Needs' held in Falkirk at which Maria Fyfe MP gives a speech and answers questions.

1994

Advocard is established in Edinburgh. It is an independent advocacy service for mental health service users in Edinburgh initiated by service users and funded to be independent of other mental health services provided by the statutory and voluntary sectors.

User Consultation on Service Specifications: Report by the Consultation and Advocacy Promotion Service for Lothian Regional Council Social Work Department published by CAPS

1995

Survivors Poetry Scotland launched as part of the Out of Sight - Out of Mind Exhibition at Kelvingrove Art Gallery.

Scottish Affairs Committee's Report on *The Closure of Psychiatric Hospitals in Scotland* published.

Scottish Users Network submit a memorandum to the Scottish Affairs Committee in which it is stated:

'FACT: SAMH gets more of its income (32 per cent) from the European, Social Fund than it does from the Scottish Office and health boards and regions put together (23 per cent). Does that shame you?'

'AND NOW FOR SOME SERIOUS QUESTIONS TO ASK THE MINISTER.

SUN is a 'user' organisation: think of yourself as one of us and ask these questions on our behalf.....

What will you need when you come out of hospital?

Money, a place to go and some support – not necessarily formal. You may need a social worker like a hole in the head. You may want to run a mile from any doctor.

Support has to be unobtrusive, but sympathetic to our needs, not their convenience. These care plans are a good idea but a sick joke because the funding for the resources just isn't there.

Some social workers share the care plan. Others guard its content like the crown jewels.

Inevitably care plans are skewed to available resource, not perceived need.

If there is no home to go to or no support offered, then it is blankets outside Central Station for another seller of *The Big Issue*.

A serious consideration which affects all discharge decisions is how is the patient going to cope with 'outside' and how is 'outside' going to cope with him/her?

Hospitals can cope with almost anything, with a paid staff on eight-hour shifts and immediate access to tranquilising drugs. The average home does not have these facilities.

Some patients may have to stay long after the crisis has abated because the 'outside' circumstances are unacceptable. There must be beds for them. Otherwise there are continual re-admissions' (House of Commons, *Third Report from the Scottish Affairs Committee Session 1994-95, Closure of Psychiatric Hospitals in Scotland Volume II* (London: HMSO, 1995), pp. 102-103.)

Jim Kiddie is the sole service user witness to be called to give evidence to the committee and he is present as a representative of SAMH, being a member of its management committee.

1996

Highland Users' Group established.

'Because it will help you': A report by mental health service users in Lothian on their experiences of medication published by CAPS.

1997

A Framework for Mental Health Services in Scotland published by Scottish Executive

Third Scottish Users Conference.

LUNA an arts-based mental health project is established in Dundee.

1998

Hearing Voices Network Dundee service user group established. Pat Webster, the mother of a voice hearer and a psychiatric nurse, began the evolution of Dundee Hearing Voices Network in 1997 mainly to support her son

UK Health Minister Frank Dobson claims that, 'Care in the community has failed'.

1999

Scottish Parliament reconvened.

Service Users' Views on Mental Health and Community Care: A Report for the Health and Community Care Committee of the Scottish Parliament compiled by CAPs.

Committee to review the Mental Health (Scotland) Act 1984 established and chaired by the Rt Hon Bruce Millan, former European Commissioner and Secretary of State for Scotland in the Callaghan government. The committee had two service users (Jim Kiddie and Graham Morgan).

2000

Glasgow Mental Health Network service user group established

Little Wing, a forum for people with experience of mental health difficulties based in Dundee, is started. Little Wing met in the same building as The Westfield Association, which started in October 1973 as Dundee Mental Patients Union.

2001

SUN folds after its funding comes to an end.

Launch of "Well?" The Scottish Executive's National Programme for Improving the Mental Health and Wellbeing of Scotland's Population.

2002

Lanarkshire Links service user group founded

On 30 October Graham Morgan (HUG) tells the Health and Community Care Committee, ‘If a compulsory treatment order means that someone does not need to be in hospital and can live with friends, carrying out their usual activities but having a degree of control that may be a good option. However [...] is it the first step towards treating people more forcibly, more paternalistically and in a more authoritarian manner in the community, where normally people would see themselves as free? [...] That worries us’

(Scottish Parliament, Health and Community Care Official Report 30 October, 2002

<http://archive.scottish.parliament.uk/business/committees/historic/health/or-02/he02-2702.htm>).

On 30 October Maggie Keppie (EUF) on community-based compulsory treatment orders at the Health and Community Care Committee: ‘For me, as for everybody else in the room, my home is my home. It is a place where I have fun with my nephews and nieces and to which, after a tough day at the office [...] I can go home, put the music on and sit on the couch. The fact that I would be required to let health professionals and social workers into my home if I was put under compulsion disturbs me [...] If compulsion were to extend to my home, it would become not my home but a house. That is one reason why I would hate to be put under such an order’

(Scottish Parliament, Health and Community Care Official Report 30 October, 2002, available at

<http://archive.scottish.parliament.uk/business/committees/historic/health/or-02/he02-2702.htm>).

2003

Mental Health (Care and Treatment) (Scotland) Act.

Acumen service user group founded in Argyll and Clyde

PLUS Perth and Kinross service user group founded

2004

‘User, Consumer, Survivor, Refuser Conference’ held, June 22 and 23, in Dundee.

2005

Survivors History Group formed after Thurstine Bassett rediscovers videos of MIND AGM 1984 and ‘Speaking from Experience’, both featuring Glasgow LINK club members.

2006

Voices of Experience a national service user organisation is established.

2008

Oor Mad History Project commences after contact with activists in Canada who have collected archives of activist groups and established a Mad People's History course at Ryerson University Toronto. A Mad People's History and Identity Course inspired by the course in Canada ran from 2014 to 2016 at Queen Margaret University, Edinburgh.

Oor Mad History (a poem by Jo McFarlane)

We've archived the story
 for those to come
 who'll look back on achievements
 of those early pioneers
 whose efforts grew into a movement
 that continues to this day,
 and on and on into the future,
 shaping services, affirming our identity
 as experts by experience

Our history
 is written in the pages we've collected,
 in the words of those who played a part;
 recorded through their voices; depicted in their art
 It cannot be erased because it burns within our
 hearts

And if a time should come
 when hope runs dry in people power,
 we'll look back on our history
 and be inspired by what we've done

This is a story of courage and drive,
 though its roots are in the past
 its legacy is live

We've reclaimed the glory,
 the struggle to be free,
 we've taken up our places,
 This is OOR MAD HISTORY!

(Jo McFarlane, *Absent Without Leave, Invisible When Here: Poems in Celebration of Advocacy* published by Scottish Independent Advocacy Alliance, 2013).

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