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**The critical professional and social policy:
Negotiating dilemmas in the UK Mental Health Act campaign**

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Biographical note

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Abstract

The critical professional psychologist wishing to influence social policy is faced with a number of competing imperatives. Through the means of a case study of UK government proposals to reform mental health legislation, I describe some of the dilemmas encountered and my attempts to address them. I review the rationales and evaluate the effects of interventions in professional and non-professional networks. Rather than being primarily theoretical, my aim is to provoke discussion and debate about the position of the critical psychologist who also occupies a position as a professional.

Introduction

Thirty years ago Ingleby argued that the goals of professionals employed by the State were bound up in the 'efficient regulation and protection of a particular political structure' (1974: 322). He saw the unwritten contract of psychologists as the maintenance of the status quo of society: 'adaptation of people to the social structure is our yardstick, not the adaptation of social structure to people' (1974: 322). Barely a decade ago, Reicher was both echoing and updating Ingleby's critique of psychology. He saw the contract of psychologists as a Faustian one: academic psychologists could say whatever they wanted provided this remained divorced from practice or activism.

Of course, the contradictions which psychologists subjectively face in their everyday work are intimately related to the historical forces which created the conditions for the psychological complex itself (Rose 1985). However, whilst both Ingleby's and Reicher's chapters end on a relatively optimistic note arguing that it is possible for psychologists to work for social change, they write only in very general terms about how psychologists might actually go about things differently. In general, much academic critical psychology has been better at describing these contradictions and tracing their historical roots than in identifying how to grapple with them though there are notable exceptions (e.g. Ahmed 2003; Dell & Anderson in press; Paré & Lerner 2004; Prilleltensky & Nelson 2002).

As a clinical psychologist influenced by critical psychology, I have tried to work in ways which seek to avoid pathologising people with mental health problems, for example through using Narrative Therapy approaches and by conducting research which attempts to deconstruct clinical categories. However, I am constantly aware of the wider injustices which people with mental health problems experience, for example the inequalities inherent in how the mental health system operates and the pernicious influence of multinational drug companies (Johnstone 2000). In addition, mental health services users¹ are routinely portrayed in the media in a negative light (Philo 1996) and face discrimination in a wide range of spheres of life including employment, parental rights, housing, immigration, insurance, health care and access to justice (Sayce 1998). One particular form of discrimination is that, in contrast to the area of physical health where people are generally free to refuse treatment if they wish to, mental health service users can, in most countries, be compulsorily detained in a psychiatric hospital and forced to have psychiatric medication.

Action to influence these broader issues requires change at the level of social policy. The opportunity to change legislation governing compulsory psychiatric treatment does not come round very often: it last changed in the UK in 1983 and, before that, in 1959. Thus when the Labour government announced plans to reform mental health law in 1998 it was important to respond. However, the professional wishing to influence social policy is immediately faced with two key challenges: can one work within professional structures whilst trying to avoid the attendant dangers of the expert discourse; and can one work collaboratively with other groups and manage the negotiation of the compromises which are inevitable when bringing different groups together?

The expert discourse: its possibilities and dangers

Those wishing to bring political and social change argue that it may be tactically useful, at certain times, to appeal to an expert discourse as part of those struggles. As Kitzinger puts it, 'for psychologists wanting to change the world, the rhetoric of traditional mainstream psychology is a very important piece of legitimation' (1997: 214). Whilst this may lead to short-term political success, she notes that traditional assumptions about psychological knowledge and the role of psychology are thus reinforced. In other words, there is an ever-present danger of psychologists colluding with the status quo.

However, psychologists exist in contexts 'in which things are always already going on or being done' (Willig 1998: 96) and clinical psychologists are already involved, for better or worse, in particular kinds of actions like psychotherapy. Indeed, as Burton and Kagan (in press) have argued, there is a case for psychologists to be less concerned with the internal problems of psychology and, instead, to focus on serving the needs of oppressed groups. Willig (2003) has argued that it 'seems impossible to engage with the world as we find it without perpetuating some of its less desirable features. However, in order to change the world, we must engage with it'. The question then becomes not whether but, rather, *how* to act. But how are we to judge which actions are better than others?

Mental health rarely reaches the top of the public policy agenda and, with a parliamentary majority of 171, the government were in a strong position to push its proposals forward regardless of protest. Attempts to influence it therefore needed to be both co-ordinated and collaborative in order that maximum political pressure was exerted.

The challenge of collaborative work

Until recently, there has been relatively little written by critical psychologists about the process of doing collaborative work. Paré & Lerner (2004) explicitly focus on this topic and the contributors to their book describe ways of collaborating in the separate domains of therapy, supervision, teaching and research. However, the work I will describe here cuts across such traditional categories. For example, within professional networks, whilst I drew on research in trying to influence policy I did not see my role primarily as a researcher and so models of collaborative research (e.g. Willig & Drury 2004) or of influencing social policy through research (e.g. Prilleltensky & Nelson 2002b) were of limited help. Moreover, within non-professional networks my role was primarily as an activist.

If 'praxis is what lies between what is desirable and what is achievable' (Prilleltensky & Nelson 2002a: 158) then it is important to try to develop ways of judging which alliances and compromises are necessary and which are beyond the pale. As Willig (2003) notes, 'the need to form alliances, to create a "United Front" with those whose views diverge from ours, in the interests of a specific strategic goal, exerts pressures which are not always easy to negotiate. Equally, the decision of where to draw the line and who not to work with, perhaps on principle, is a difficult one to take'. An even more complicated issue is where there are different views within groups as well

as between them. It is more straightforward to join with the oppressed when there is agreement about key objectives. However, within groups of psychiatric survivors, as we will see below, there is often disagreement about key issues like the role of compulsory treatment. Should one work towards consensus or not? How can this best be managed?

In this paper, I will present a case study of work to influence mental health policy. I have generally found it more helpful to read examples of practice than the broad theoretical generalisations privileged within the academy but such accounts are generally more messy and complex. It is one thing to state one's allegiance to a set of abstract principles, but how to realise them? In what ways do the dilemmatic subject positions set up for us by the contradictions inherent in psychology come into play and how might we best address them?

I will give examples of some of the activities I conducted in work both within professional structures and in collaboration with other social movements for change. My focus will be both on the broader processes which come into play when one attempts to work critically as a professional and on my subjective experience of them. My aim is not to present what I think are the 'right' answers but to describe some of my actions, their rationale and my documentation and evaluation of them. Through this I hope that other critical applied psychologists might develop working models which enable them to balance priorities, engage in flexible and tactically-aware interventions and evaluate them.

Reforming the mental health act

In the UK the number of all psychiatric in-patients who were compulsorily treated doubled between 1992 and 2000, with the percentage rising from 9.2 to 13.5 (Salize & Dressing 2004). There were a total of 46,900 compulsory detentions in England in 2002-2003 (Department of Health 2003). This treatment is governed by the 1983 Mental Health Act (MHA) and, in 1998, the Labour government announced that they planned to reform mental health legislation.

The government stated that changes to the Act were required because it was outdated as a result of the increasing shift from hospital-based to community care (Department of Health 2000). It was also in need of reform to bring it in line with the 1998 Human Rights Act in which the European Convention on Human Rights was incorporated into British law. Indeed, a number of human rights-based legal challenges have recently been lost by the government (Bindman et al 2003). The government also claimed that the general public had lost confidence in mental health services as a result of a 'tragic toll of homicides and suicides involving such patients' (Department of Health 2000: 1). In the absence of any evidence of such a lack of confidence it seems clear that the government was motivated by other factors including concern about tabloid news headlines exaggerating the risk posed by people with mental health problems (Harper 2004; Laurance 2003).

The path to legislative change, especially contentious areas of social policy like mental health, is a long one. Since 1998 the government have published: a review by an expert committee (Department of Health 1999a); two government green papers

(Department of Health 1999b, 1999c); a white paper (Department of Health 2000); and a draft bill (Department of Health 2002). A further draft bill was at the time of writing in September 2004 for pre-legislative scrutiny (Department of Health 2004)².

Contentious issues in the proposals

A detailed analysis of the proposals is beyond the scope of this paper and the reader is referred elsewhere for a more comprehensive discussion (e.g. Cooke et al 2001, 2002b; Parliamentary Office of Science and Technology 2003). In order to provide a context for issues touched on later, I will briefly outline five main areas of concern: definitions and criteria; compulsory treatment in the community; the clinical supervisor role; the notion of personality disorder; and preventive detention.

a) Definitions and criteria

Currently, doctors and a social worker can order compulsory psychiatric treatment under a number of sections of the Act (being given such treatment is known informally as 'sectioning') if a person is considered a risk to themselves or others as a result of 'mental disorder' which is defined in relation to psychiatric categories seen by many as problematic (e.g. Hare-Mustin & Maracek 1997).

Both the white paper and draft bill included a very broad definition of 'mental disorder'. To the extent that this reduced reliance on a flawed psychiatric diagnostic system, this was a positive move. However, this was not accompanied by stringent criteria which would provide clear limits on the circumstances in which treatment could be given compulsorily. The absence of such limits could lead to an increase in the number of people treated compulsorily especially at a time of increasingly defensive professional practice (Laurance 2003). The expert committee had argued that compulsory treatment should only take place when a person lacked -- perhaps only temporarily -- the capacity to properly give or withhold consent because of their mental health problems. However, the government did not include capacity to consent as a criterion in their proposals.

b) Compulsory treatment in the community

Currently, compulsory psychiatric treatment can only take place in a hospital. For the vast majority the main intervention they receive is psychiatric medication which can have many negative side effects (Johnstone 2000). Both the draft bill and the white paper had noted that compulsory treatment was to be extended into the community -- in other words a person would no longer need to be a hospital in-patient to be 'sectioned'. This led many psychiatric survivor groups to fear that they would be forcibly injected at home and that there would be no escape from unwanted treatment. An increasing number of in-patient beds have been occupied by those treated compulsorily and some have argued that the total number of beds available acts as an informal upper limit on the numbers of people who can be 'sectioned' at any one time. Given that compulsory treatment was to no longer rely on a person being an in-patient

(and therefore the number of beds available), it is possible that this move could fuel a continued increase in the number of people being treated compulsorily.

c) The clinical supervisor role

Currently the person with legal responsibility for compulsory treatment is the service user's consultant psychiatrist. Both the white paper and draft bill proposed replacing this role with that of a 'clinical supervisor' who would probably be the professional most involved in planning their care. The white paper also proposed that this role could be fulfilled not only by psychiatrists but also 'consultant psychologists'. Thus under these proposals, some clinical psychologists could soon have the powers to detain people for compulsory treatment.

d) Personality disorder

The white paper placed a lot of emphasis on public protection with a whole section of proposals aimed at 'high risk patients' which included what it called 'dangerous people with severe personality disorder' -- variously referred to in policy documents and discussions as 'DSPD' or 'D&SPD'.

There were two concerns in relation to DSPD. Firstly, the use of the concept of personality disorder was disquieting because of its circular definition: this person behaves violently because they have a personality disorder; we know they have personality disorder because they behave violently. Secondly, policy documents were often ambiguous about the relationship between dangerousness and personality disorder. In the white paper the focus was on people who were felt to be dangerous as a result of their personality disorder. However psychiatric survivors with a diagnosis of personality disorder feared that they would be more likely to receive compulsory treatment under the proposals. Moreover, the difficulties with the reliability and validity of personality disorder are notorious and the judgement of whether a person's 'dangerousness' arose from 'it' or not is no less problematic. This led to concern that the government was attempting to address issues of public protection through mental health legislation rather than other more appropriate means.

e) Preventive detention

Under the 1983 Act, detention and compulsory treatment of people with a diagnosis of personality disorder was only allowed if it was judged that the condition was 'treatable'. This was to prevent long-term indefinite detention but the government viewed this as a loophole which should be closed. Detention was now to be allowed in cases where the person's problems could be 'managed' -- a much less stringent criterion than 'treated'

In addition, the government wanted to find a mechanism for detaining people thought to be dangerous regardless of whether they had received a criminal conviction or, if they had received one, to continue detaining them after they had completed their sentence. Whilst this might be regarded as a breach of the Human Rights Act recent

case law suggests that this actually provides relatively little protection for those regarded as being of 'unsound mind' (Bindman et al 2003)³.

These areas of concern meant that I saw the proposals as a missed opportunity to rethink the rights of mental health service users. I felt that it would be less discriminatory to not have separate mental health legislation at all and, instead, to look at the issue of impaired judgement across the board, incorporating mental health problems into a broader Incapacity Act (Parliamentary Office of Science and Technology, 2003). I had worked in public sector mental health services for over ten years and, having moved to an academic post I hoped to have more time and energy to influence policy. But where to put one's energies?

Weighing up how to influence the proposals

I considered working through the British Psychological Society (BPS), my professional organisation. Reasons for this approach included: the government were open to meetings with professional groups; the expert discourse was thus accorded social status and access; if critical people were not involved there was the danger that only those concerned with 'guild interests' (Hare-Mustin & Maracek 1997) would be; there was also the possibility of encouraging the BPS to become more involved with the Mental Health Alliance -- a broad grouping of sixty independent sector charities, survivor groups and professional bodies. Reasons against professional-level involvement included the dangers of achieving short-term gains without challenging the notion that professional knowledge is value-laden and provisional and that the government might seek to buy psychologists off with the seductions of apparent power and influence.

It also seemed possible to intervene through alliances and collaboration with mental health service user/psychiatric survivor groups and groups of critical professionals like the Critical Psychiatry Network. I was already involved with the Critical Mental Health Forum in London. Here there were good reasons for becoming involved. There has been a tradition of critical professionals working as 'allies' of survivor groups like the Hearing Voices Network. It seemed possible that a coalition could be built, but one which would also put the experiences and concerns of those likely to be subject to compulsory treatment at the forefront. There were no real reasons against other than a limited resource of time and energy.

I would like to say that I endeavoured to weigh up the relative merits of these different domains of intervention but the reality is more prosaic. Events were fast-moving and I ended up becoming involved with both. A large part of the reason for this was a result of the organic development of personal contacts with individuals and groups over time.

Working within professional structures

The initial part of my involvement with the BPS consisted largely of lots of discussions with colleagues in the BPS Division of Clinical Psychology (DCP) in order to formulate a response. The BPS has a total membership of approximately

30,000 and there are about 6,000 clinical psychologists in the UK of whom just over 4,000 are members of the division. We were keen that the society should present a consensus statement since we felt a united front would have more influence than a position where the government could divide and rule. However, as a result of our consultations with other BPS members, it became clear that a consensus statement rejecting compulsory treatment and its extension into the community and which rejected notions of personality disorder *per se* was not possible. One reason for this was that the notion of personality disorder was in common use by many forensic clinical psychologists. Moreover, many currently worked with people under 'section' but felt they had little influence over the sectioning process even when they were the main profession involved. As a result, some were attracted to the possibility of acquiring clinical supervisor powers. I was disappointed but not that surprised by this but judged that we could make progress on other areas so instead we focused on areas of agreement, especially the need for stringent criteria (e.g. relating to capacity to consent) limiting the use of compulsory treatment.

For me, the experience of negotiating compromises in order to maintain a united front was problematic. Critical psychology does not and cannot provide a blueprint for action in situations like this. I worried that, at the first hurdle we were prepared to concede on important points of principle and wondered whether others would be critical of these decisions. On the other hand, it seemed to me that there was more prospect of getting the government to concede on the issue of criteria. Maybe it would not be possible at this point in history to achieve the wholesale review of mental health legislation I thought was necessary. The main thing I learnt from this experience was that it was important to treat such decisions as provisional and to continually keep them under review. There were three main areas of action which I will briefly summarise.

a) Engaging directly with the government

BPS representatives arranged to meet with senior civil servants. The rationale here was to use our socially-sanctioned expert position and the institutional structures of the Society to add weight to our comments. However, the effects were hard to determine. For example, from our first meeting in March 2001, it was clear that whilst these officials were open to refining certain details (e.g. which psychologists might become clinical supervisors) there were other areas where policy was more settled. Officials wanted to have the powers to detain people before they went on to commit offences. However, we argued that predictions of dangerousness for people without a history of violence were notoriously unreliable. Moreover, the society had repeatedly suggested that it would be better to address the risk to the public from people considered to be dangerous through criminal justice legislation. We felt that issues of risk applied across the board and not just to those who had acquired psychiatric diagnoses. We were concerned that, once again, people with mental health problems were being discriminated against and that the government was attempting to address public protection through the back-door via mental health legislation. However, this was a major policy decision which would have required decisions by ministers rather than civil servants and ministers were reluctant to move on this point. I began to realise that officials would only make significant changes if Ministers were persuaded to change their views. This would only happen if political

pressure was brought to bear outside of those meetings and, after a few months, I disengaged from this area of activity for a period.

b) Working with the Mental Health Alliance

The Mental Health Alliance was set up to respond to the Mental Health Act reforms and it put considerable work into maintaining a united front on the reform proposals. One danger, however, was of a lowest common denominator approach where more radical critique was constrained. Policy became what the organisations could agree on which often revolved around basic rights (e.g. the right to have an assessment) and so the Alliance's slogan was 'rights not compulsion'.

It was clear that many Alliance members did not know how to respond to the DSPD provisions and there appeared to be a conceptual vacuum about the issue of dangerousness and DSPD. As a result, psychological expertise in developing non-medical conceptualisations of mental health (e.g. British Psychological Society 2000) and risk was important and one of my colleagues took a lead on this. Work with the Alliance involved attending a lot of meetings, reading and commenting on many drafts of documents. Several policy sub-groups were formed and I joined one relating to the compulsory use of physical treatments like Electro-convulsive therapy (ECT). We agreed on some very useful principles to govern such use. Currently, legislation allows the use of treatments like ECT without consent, particularly as an 'urgent' or 'life-saving' treatment and I wanted the group to agree that this should stop since there is little evidence for its efficacy (Johnstone 2003). Some of the Alliance's member organisations said that ECT should never be given to a person without their consent if they had the capacity to consent but that if they lacked the capacity to consent, it could be given in limited circumstances (e.g. as an 'urgent' treatment).

Once again, I was disappointed by this and found compromises like this difficult -- I felt guilty and impotent. It is easy to criticise politicians for selling out but harder to reconcile this when you are the person making the compromises. Again, I consoled myself by acknowledging that we had made a small step forward on this issue: we had a higher threshold for ECT than currently and had developed much more stringent criteria which provided a mechanism for reviewing the efficacy and safety of ECT under stringent conditions in the future. However, these principles kept on disappearing off later drafts of the policy, supposedly for reasons of space.

c) Intervening with the BPS membership

I and my colleagues threw ourselves into writing articles which would reach different sections of the membership, encouraging people to write the Department of Health and their Members of Parliament about the proposals. We travelled to meetings around the country speaking to groups of clinical psychologists and a public debate was held.

It is a feature of many professional organisations that they are relatively undemocratic and the BPS is no different. I was surprised by how easily a small group of people could influence policy. The society as an institution seems happy to allow people to

devise policy provided they can avoid attracting too much active criticism. The difficulty is that the sheer amount of work involved (reading documents, going to meetings, resolving disputes between different parties, taking telephone calls, responding to emails) becomes extremely wearing -- an issue I discuss in more detail below. However, it raised an important question for us: did we need a mandate from the membership in order to give more weight to our comments? Reasons for this included the strength that popular support would give to DCP policy. We also felt that it was important to evaluate what we were doing and how representative we were of members' views -- we did not want to get to a position where consensus was threatened at a later stage which could then present the government with an opportunity for exploiting divisions. The major reason against was the danger of them not sharing our view and some of our colleagues suggested that it was a mistake to ask the membership what they thought for precisely this reason. We decided to take the chance and sent out a survey with *Clinical Psychology*, the monthly DCP newsletter, in the summer of 2001 to all 4,160 members.

Six hundred and eighty-one members responded -- a response rate of just over 16%. Although this was low, it was hard to judge if this was an unusually low response rate since this was the first time this kind of survey had been conducted and we were aware that the percentage of members who voted in BPS elections was often very low. The survey (Cooke et al 2002a) focused on three key areas where the society already had a developed policy and we sought to see how many members would agree with that position. Only twenty-nine per cent felt we should resist the development of proposals for clinical psychologists to become clinical supervisors, compared with seventy-one per cent who thought we should be 'open to this development'. Fifty-two per cent were willing to become clinical supervisors if offered appropriate training with thirty two per cent unwilling to volunteer if given the choice and only sixteen per cent willing to refuse 'even if put under pressure'. However, ninety-nine per cent agreed that 'access to psychological interventions for people who have exhibited violent behaviour should not be dependent on the person being assessed as "personality disordered"' and eighty-four per cent agreed that mental health legislation was an inappropriate vehicle for public protection. Furthermore, ninety-one per cent agreed that compulsory treatment should not be based on unreliable predictions of dangerousness.

Overall, the responses were in line with the position we had adopted and thus gave us a mandate. However, I was disappointed and angry that there was only a small number prepared to reject the clinical supervisor role. It seemed to me that clinical psychologists were either being too fatalistic or too open-minded. A benign interpretation might be that many members had not felt informed enough to definitively reject a concept about which they had only been informed a few months before. However, a glance through some of the comments written on the survey about this role suggested a variety of reasons: that it might help weaken psychiatry's grip on power; and that psychologists would use the powers more humanely than psychiatrists. Other, even more depressing, comments suggested that we should ensure that pay was commensurate with the new powers.

This experience showed me that certain resources are required in order to sustain oneself in working for social change. I realised that I needed to see some sign that battles could be won and that there was a constituency of support. I eventually

became a less active member of the society's working party towards the end of 2001. Whilst there was some disappointment and tiredness on my part it would be all too easy to view this as just another example of activist burnout. However, my withdrawal was also based on a pragmatic evaluation of where I was directing my energies. The BPS work was taking up huge amounts of time and energy and I felt much of my time was spent like a diplomat trying to help develop consensus and my own views were being squeezed out in the process. I also felt that the impact of the Society was quite limited at this point. Clearly, the policy was being driven politically and ministers did not seem to be open to rethinking fundamental aspects of their policy. I felt that my time would be better spent trying to increase political pressure on them.

Working with the Critical Mental Health Forum and other groups.

The Forum was set up at the beginning of 2001. Together with the Critical Psychiatry Network and Mad Pride, we had organised a picket of the headquarters of the Association of British Pharmaceutical Industries and of the first day of the Royal College of Psychiatrists' annual conference in July of that year. These had been modestly successful in getting media coverage which was an important part of our strategy.

Attendees at the forum included current and ex-service users and survivors, critical mental health professionals (some of whom had also used psychiatric services themselves) and academics. Whilst all shared broad critiques of the mental health system, there were differing views about priorities and solutions. For example we had a number of discussions about compulsory treatment and its extension into the community. Strong arguments were made against it, both by professionals and by people who had been subject to it: it was an abuse of the human right to self-determination and was dehumanising; it obscured the fact that people often didn't comply with 'treatment' as this solely consisted of psychiatric drugs with unpleasant side effects. Similarly, strong arguments were made for it by members including people who had been subject to it: that, whilst unpleasant and distressing at the time, it did mean that people in crisis and who had not been fully aware of what they were doing had been contained and not gone on to harm themselves. Similarly, some worried that the use of compulsory treatment would increase especially in a context of loose criteria and increasingly defensive practice. Others felt that, if some element of compulsion was necessary, people should not be forced to go into in-patient wards which were often poorly-resourced and frightening places to be. It was hard to come to a consensus statement against compulsory treatment *per se* and discussions like this led to the decision to call ourselves a 'forum' for debate rather than a group which might imply a unified position. Although consensus was not possible on this issue, there were plenty of other concerns on which we could agree – for example that service users should have a choice of what treatment they would prefer, that it should be a last and not a first resort and so on (see Critical Mental Health Forum 2002 for more detail).

In August 2002 we organised a demonstration, which about fifty people attended, outside the Department of Health headquarters and released a statement on the

reforms (Critical Mental Health Forum 2002) which was included with a petition which we handed into the prime minister's office in Downing Street.

As with our previous actions, we felt a media strategy was important and a survivor-run film company, Listen to the Voices, recorded the demonstration and it was covered in professional magazines like the Nursing Times and the Health Service Journal whilst Community Care used the demonstration to lead a feature on the reforms (Leason 2002). The Morning Star invited me to write a feature on the reforms and it was also covered in Disability News. However, although we had sent out fifty media releases (aided by the BPS press office and the independent survivor-run Mental Health Media) we got no coverage in the mainstream media. This is not an unusual experience for activists. To popular tabloid newspapers, whose sales are seemingly fuelled by an endless diet of celebrity stories we were, no doubt, an irrelevance. However, broadsheet journalists were, on the whole, more receptive. Unfortunately, many said that they did not cover demonstrations *per se* and that, anyway they were waiting to cover the Mental Health Alliance's planned rally in London in September. Unfortunately, this rally was cancelled at short notice because of extensive press coverage of the murder of two children. The man then suspected (and now convicted) of killing them had been briefly sectioned (though he was later judged fit to stand trial) and some Alliance members were worried about the public reaction to a rally against the Mental Health Act proposals.

Incensed by the rally's cancellation, a number of survivors set up a new group, *No Force* and took over the organisation of the rally, largely via email. It went ahead with 300-400 people attending with placards and a samba band. Another petition was handed into Downing Street as the rally made its way down Whitehall past the Department of Health and then onto the old Bethlem asylum. It was tremendously inspiring to see the rally organised so well at such short notice and without the involvement of professionals' organisations.

I saw these demonstrations and lobbies as helping to provide a focus for, and increasing political pressure on, the government at particular moments, especially during periods of consultation. By September 2002 the Department of Health received 1,900 largely negative responses to their consultation. The bill was delayed for two years whilst the Department of Health worked to redraft it to allay concerns. As this paper was being completed a new draft bill was published (Department of Health 2004) and early indications are that there have been some changes to the legislation. Campaigners remain hopeful that further changes may follow the scrutiny committee's report in 2005.

Reflecting on the interventions

Engagement at a professional level is fraught with difficulties. On the one hand it appears to offer some short-term gains, notably access to government. On the other, as Parker (2003) has argued, 'the idea that nicer people might influence those in power and ameliorate the worst aspects of the Mental Health Bill is also a warrant for institutional recuperation of the opposition; with pernicious consequences well beyond the "engagement"'.

There is a danger of exaggerating how much influence one can have over the government (see for example a fascinating debate about this in Kinderman & May 2003) but there is an equal danger of not taking official opportunities to influence policy, especially at a time when the government has a massive parliamentary majority. I think we should engage with government but also continually evaluate our actions and remain constantly vigilant about whether we are falling into a position of collusion or making a compromise too far.

Decisions about how and when to engage need to be debated. We also need to keep these decisions under review as what is appropriate and helpful at one moment may not be at another. For example, engagement at a professional level was only useful at those times when the government was forced to listen to the views of professionals, psychiatric survivor organisations and other groups. Early indications are that the new draft bill has made some concessions which suggests that change is possible when governments are faced with united opposition from professionals and service users, both groups also exerting political pressure through their Members of Parliament. Even sections of the media were supportive⁴. Mobilising popular protest has at least made the government think again and pressure will need to be kept up as the legislative process goes forward.

Peter Campbell (1999) has discussed some of the politics involved when survivors collaborate with professionals. Of course, in their training, professionals are socialised in practices of contributing to and organising meetings and this creates the danger that professionals can take over in these situations. Unfortunately, effective collaboration takes time and resources and, particularly when legislative reforms are moving at a fast pace, I felt there was not enough time to do this issue justice – another thing to bear in mind if one is spreading one's activities too thinly. I was never sure whether my time in collaborative groups was best spent providing administrative or theoretical support, to ally with survivors or just to get out of their way. Indeed, many survivor groups are forced into alliances because their funding is uncertain (Campbell 1999). Moreover, whilst professional organisations like the BPS may appear to side with survivors there are likely to be conflicts with their own interests. Indeed, many organisations continue to see psychiatric survivors as 'other' rather than recognise that many of its members are or have been users of mental health services (May et al 2003). In this respect it has been heartening to see well-established survivor-run groups like Mad Pride and new ones like No Force and Outcry set up because of a growing dissatisfaction with the lead taken by the Alliance and the lack of authentic voices representing survivors (Main 2003).

The late Pete Shaughnessy, one of the founders of Mad Pride, argued strongly that debates needed to occur outside of what he saw as the ghetto of mental health conferences and magazines and he was involved in a range of actions which did just that (Shaughnessy 2003). My experience of the media has been that it is possible to do this in a modest way providing both that the journalist is open to this and one is flexible (e.g. BBC News online 2004; Leason 2002; Radcliffe 2003). I think critical psychologists need to become more skilled at intervening in the mainstream arena of the media, learning from other successful campaigns. Organisations like Mental Health Media and the BPS run useful media training days. For those who do not feel appropriately skilled it is perhaps important to reflect on what particular contributions you can make and, at the least, put journalists in touch with survivors.

The final theme I want to discuss is how to cope personally in campaigns like these. In the first eighteen months I took on far too much in relation to this campaign and was trying to work at a level which was personally unsustainable. Things were made more difficult by the fact that I was juggling different kinds of activities in both the BPS/Alliance and the forum in a manner reminiscent of Ussher's (2000) attempt to balance both mainstream and more critical research. Time was swallowed up in a sea of activity. Eventually, I decided that I needed to focus on a smaller range of activities and to do only those things which I felt accorded most with my values. I also decided to work harder at breaking tasks down so they could be easily shared and the forum set up a demonstration-planning sub-group in 2002 to do this. Similarly, now that a new draft bill has been published, I will be resuming some activity within the BPS where we will be attempting to adopt a 'workstream' approach where different groups of people take a lead on activities about which they feel more competent and committed. I will be focusing my energy in the workstream which will be lobbying for changes in the new bill.

However, such innovations do not get away from the fact that these activities are personally wearing. What has been most difficult has been the unpredictability of the amount of time involved. One can sustain a burst of energy on a number of fronts only for a short time but changing social policy takes years. My first involvement in this campaign began in 2000 and now, four years later, the process is still ongoing and is likely to continue for another two years. I have found that it is important to set clear limits on what one personally can do.

I hope that this account is useful in helping others develop and elaborate working models to weigh up the kind of interventions in which they wish to become involved. This kind of action, especially where it cuts across different roles, means that it is not possible to give clear map-like directions to others. However, although complex, inspiring, fun and occasionally tiring and disappointing, direct interventions into social policy are important and necessary if we are to move towards a better world.

Notes

1. Descriptions of people receiving psychiatric interventions are highly contested (Campbell 1999). In this article I will use the term 'psychiatric survivor' to refer to groups who would self-identify in this way, 'in-patient' if I am referring only to those in hospitals and 'service user' elsewhere -- the latter term is the one currently most used in UK policy documents.

2. In the UK legislation goes through a number of stages. First, a green paper is published for consultation summarising a variety of policy options. Second, a white paper is published in which the government outlines its preferred policy option. Increasingly, at this point, the government now publishes draft bills for 'pre-legislative scrutiny' especially where they are more contentious. This is then followed by a bill which is first presented in one of the houses of parliament where it goes through different stages of scrutiny and where amendments are proposed and voted on.

Following this it is passed onto the other house to go through the same stages. Finally it receives Royal Assent and a time is set for its implementation.

3. The 1998 Human Rights Act incorporated the European Convention on Human Rights (1950) into British law. Article 5 states that 'everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law ... the lawful detention of persons for the prevention of the spreading of infectious diseases, *of persons of unsound mind*, alcoholics or drug addicts, or vagrants' (European Convention on Human Rights 1950, emphasis added). This text, written in 1950 was clearly a product of its time and its inclusion in British law without revision thus enshrines discrimination against a number of marginalised groups including people with mental health problems.

4. The Independent on Sunday, for example, ran an excellent campaign against the proposals whilst the health editor of the Independent, who had attended several Critical Mental Health Forum meetings as an observer, published a book critical of many of the reforms (Laurance 2003).

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