Stop Making Sense: Alienation and Mental Health

By Peadar O'Grady

"*In a higher phase of communist society, after the enslaving subordination of individuals under division of labour, and therewith also the antithesis between mental and physical labour, has vanished; after labour, from a mere means of life, has become the prime necessity of life…society [can] inscribe on its banner:*
From each according to his abilities, to each according to his needs."[1] Karl Marx

In the past ten years or so there is evidence of a very welcome, growing body of criticism of current approaches to mental health from journalists, academics, health-workers and service users, individually and as organised groups. Journalist, Robert Whitaker's 2010 book, *Anatomy of an Epidemic*, brilliantly details the dilemma of rising levels of people in the US officially considered 'disabled' by mental illness:

"In 2007 the disability rate (for mental illness) was 1 in every 76 Americans. That's more than double the rate in 1987, and six times the rate in 1955."[2]

These two periods are important because they roughly coincide with the increasing use of medication for mental illness (so-called 'anti-psychotics' and antidepressants in the 50s and 60s and so-called 'second-generation antipsychotics' and SSRI 'antidepressants' in the 90s and 00s) seriously undermining the claims of effectiveness for these 'wonderdrugs'. Whitaker and others (eg. Moncrieff 2009, Bentall 2010, Thomas 2014) highlight the longstanding concerns of a failing response by mental health services to rising levels of disabling distress, including the possibility that prescription drugs are fueling the problem, rather than relieving it, through offering minor symptom relief in the short term, but running the risk of tolerance, dependency and withdrawal (often mistaken for relapse) in long-term patients/service-users for whom it can be quite difficult and even dangerous to stop using these drugs, especially if they are stopped abruptly rather than tapered off more gradually.

The other related focus of criticism is the lack of validity and reliability of psychiatric labelling or diagnosis for many conditions. Validity of a medical diagnosis means the extent to which it reflects a cluster of symptoms connected by a common causation or outcome and reliability means the tendency of doctors to agree on using the same (or any) label or diagnosis when assessing the same person. A key concern is that personal and social problems are being 'medicalised', involving the use of a diagnosis, often without any substantive evidence to back it up, but with a presumed underlying, usually biological, weakness in the individual and a consequent failure to examine psychological and social factors in causation or care. Despite a broad consensus of the need for a 'bio-psycho-social' approach to mental health (such as in Ireland's government policy

[1] Marx, Karl (1875) *Critique of the Gotha Programme*
[2] Whitaker, R (2010), *Anatomy of an Epidemic*, p7

statement: *Vision for Change*[3]), critics suggest that we have ended up instead with a 'Bio-biobio' approach **(**Read et al 2009). While, for mental health problems, much research has emphasised the vital importance of psychological factors such as the experience of childhood trauma, abuse and neglect (eg Bebbington et al 2004) as well as social factors such as social inequality (eg Wilkinson and Pickett's *The Spirit Level*, 2009) Thomas (2014) appropriately complains that:

"…Having gone to the trouble of adducing evidence that social, economic and political factors are central to our understanding of a wide range of mental health problems, those factors are then left unattended."[4]

The third main focus of criticism is the question of access to mental health services and the quantity and quality of services available, particularly access to a range of not just medical, but also psychological and social interventions[5] and the particular importance of consent and trust in the use of hospitalisation and the use of chemical, physical and legal restraint and seclusion.

In this article I will argue that the crisis in mental health is a real one and that the social movements highlighting the failure of the current shallow, individual, physical and biological approach to mental health opens up the potential for both a deeper understanding of the social roots of mental health problems but also for broader social and political approaches to prevention and care.

What is Wrong with Biology?

From Darwin's theory of evolution to the discovery of antibiotics and DNA structure, there have been some positively revolutionary discoveries in biology. It is worth emphasising from the start that what is wrong with the 'biological' approach in mental health comes from a crude and narrow mis-application of biology. A broad view of biology, as found in any secondary school textbook, not only includes the structure and function of individuals but also the wider ecology of species in their interactions with their own and other species and with the wider environment. A narrow view has meant the propagation of a vague and unsupported theory that underlying a variety of mental health problems is an underlying 'chemical imbalance' in the individual's brain.

This speculative 'chemical imbalance' theory has meant both the neglect of psychological and social factors but, ironically, also the neglect of real biological factors too. One of the most important tasks in addressing mental health problems is a medical one: to look for any emergency physical condition and advise on the contribution of any other physical factors to the person's mental health condition. Overemphasising a 'chemical imbalance' can mean a delay in accessing medical investigation of more orthodox medical causes such as infection, hormone problems (such as Diabetes or

[3] *A Vision for Change* (2006), page 8
[4] Thomas, P (2014) p72
[5] A vision for Change (2006), p13

Thyroid disease), brain disorders (such as dementia) or adverse drug reactions. Access to good mental health services depends vitally on appropriate access to good medical services also. There is no contradiction in this. It is not that the biomedical model 'works' for physical health and doesn't for mental health but that both areas of medicine are not well served by an overly 'biomedical' approach which ignores social factors in prevention and care. If modern 'Mental Health' services now exclude, rather than integrate, those more physical aspects (such as dementia, epilepsy, diabetes etc) then the subjective suffering, (such as anxiety, social withdrawal, or hearing voices), that is left is more prone to value judgements which then tend to be either treated as entirely different to physical concerns (by many critical psychiatrists) or treated as if they are diseases just like any other (by many mainstream psychiatrists). This is arguably true also of the experience of patients who experience subjective physical pain (for which there is still no objective measure either) without evidence of an objective underlying physical cause, and hence the tendency to crudely label them as suffering from a psychiatric disorder instead. The tendency to describe causation as primarily biological or indeed primarily social or cultural are described as 'determinist' or 'reductionist' ie everything is determined by or can be reduced to one primary factor. Biologists such as Rose, Lewontin and Kamin have rejected both 'Biological Determinism' and 'Social Determinism' as inadequate approaches to complex phenomena like mental health:

"A full understanding of the human condition demands an integration of the biological and the social, in which neither is given primacy…but in which they are seen as related in a dialectical manner, a manner that distinguishes epistemologically between levels of explanation relating to the individual and levels relating to the social without collapsing one into the other or denying the existence of either."[6]

Separation of objective 'facts' from subjective 'values' and hiding the subjective nature of the process of identifying what is or isn't a fact in science has been described as 'scientific positivism'[7]. In his superb critical analysis of psychiatry: *Psychopolitics*, Peter Sedgwick praises the critical theorists (of the 'anti-psychiatry' movement) of the last period of popular cultural criticism of mental health approaches in the 50s, 60s and 70s (such as Michel Foucault, Thomas Szasz, R.D. Laing and Irving Goffman):
"They have shown convincingly that both diagnoses and treatment measures in psychiatry are founded on ethical judgements and social demands whose content is sometimes reactionary, often controversial and nearly always left unstated. Mental illness is a social construction; psychiatry is a social institution, incorporating the values and demands of its surrounding society."[8]

However he just as quickly warns of the crucial weakness of rightly criticising positivism in psychiatry (mental health medicine) but accepting it for (physical health) medicine generally:

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[6] Rose et al (1990): *Not in Our Genes*, page 75
[7] Sedgwick, P (1982): *Psychopolitics*, page 23
[8] Sedgwick, P (1982): *Psychopolitics*, page 25.

"In seizing on the value-laden, subjective, political elements of psychiatric diagnosis and treatment, they have implicitly – and sometimes indeed explicitly – conceded the value-free, apolitical and 'objective' character of medicine in general…The immanentists [critics of psychiatric validity] of anti-psychiatry have accomplished the feat of criticising the concept of mental illness without ever examining the (surely more inclusive and logically prior) concept of illness…If we examine the logical structure of our judgements of illness (whether 'physical' or 'mental') it may prove possible to reduce the distance between psychiatry and other streams of medicine by working in the reverse direction… not by annexing psychopathology to the technical instrumentation of the natural sciences but by revealing the character of all illness and disease, health and treatment, as social constructions. For social constructions they most certainly are."[9]

Sedgwick argues convincingly that 'illness' or 'disease' are not 'natural states' they depend on human judgement. Nature has no view, in an occurrence of 'potato blight', on whether the potato has a 'disease' or the blight fungus is being 'foddered'; nature does not take sides, humans do. If someone puts down poison for rats they don't ring the vet at the same time. However, one might think that in the case of human 'illness' we are safe to presume that we are all on the human's side so that anything causing suffering, impairment or disability could be considered a disease, but this is still an attitude, which while admirable, is still often contested. Firstly 'we' don't always take the side of the human. US President Ronald Reagan refused to fund research into AIDS and infamously refused to even say the word in public because he wasn't on the side of those who suffered, as he was politically opposed to gay rights and promoted a repulsive 'gay plague' or 'god's retribution' political attitude. Clearly also in wars (never voted for by any public majority it should be noted) a decision is taken by the ruling class that the deaths of humans are to be encouraged and planned for rather than avoided or prevented. Second we don't always identify the cause as a problem, for example cigarette companies took decades to admit their products caused any harm. Today reliance on cars, poor quality food, alcohol, arms and inequality are played down and denied as major health concerns.

Any satisfactory approach to mental health must acknowledge that people have physical bodies, psychological or 'mental experiences (thoughts, feelings and actions) in a dynamic interaction with their immediate and wider social environment. It is crucial to see that this applies to any satisfactory theory of health, whether physical or mental. When we divide 'Health' into physical and mental then, we must remember that this division is artificial and that one always involves the other. If we take Diabetes Mellitus as an example of an increasingly important public health concern we can, and usually initially do, consider it as a physical health problem. It involves a failure of sugar regulation with high levels of blood sugar and consequences for the health of other organs such as kidneys, heart, eyes and skin. The current rise in incidence is due to a relative imbalance between food energy intake and exercise output and approaches to treatment involve changing this imbalance as well as directly reducing blood sugar levels with drugs and treating the physical complications. Looked at from a mental or psychological perspective our eating and exercise behaviours are clearly important and

[9] Sedgwick, P (1982): *Psychopolitics*, page 26-7.

can be related to feelings of desiring food as reward or comfort, lacking motivation to exercise and experiencing mood changes related to excessively high or low blood sugars. From a social perspective we can see the practical difficulties of accessing nutritious food or opportunities to take part in enjoyable forms of exercise due to cost or pressures of work or care duties.as well as the pernicious influence of multinational food corporations in promoting overconsumption of food high in sugar,fat and salt (the ultimate cause of the current epidemic). Risk of Diabetes is also very significantly increased in people on 'anti-psychotic' medication but this is often not mentioned when first prescribed. The effects of diabetes, and its common companion obesity, are levels of impairment that can involve disability in 'social and occupational function' such as work and caring relationships. We can therefore look at Diabetes from a physical, psychological or social viewpoint and it is as much a social as a physical illness. What is common to all three views is the loss of control experienced by the individual concerned in terms of their bio-medical, psychological and social situations including work and relationships with others ('occupational and social function').

It is not the case either that a physical cause of a mental health problem implies a physical treatment and similarly for social causes and cures. 'Organic' psychiatric/medical disorders such as Dementia, despite a clear physical cause, have no particularly effective drug treatment and depend profoundly on psychological and social approaches to care (and increasingly encouraging lifestyle approaches to prevention). On the other hand, 'functional' disorders such as 'depression', 'psychosis' or 'PTSD' not alone have social causes in loss and trauma but also have physical consequences in poor physical health, substance abuse especially alcohol (and its physical and mental consequences) and suicide. Death is the ultimate physical outcome and mental health factors are increasingly being acknowledged for their fatal consequences. Childhood is commonly acknowledged now as a very significant source of the majority of adult mental health problems, but equally mental health problems in parents are the leading cause of mental health problems in children. Lack of control over occupational and social stress is common to both. The effects of social class and inequality mean a greater incidence of mental and physical health problems based on class and inequality and lack of control at work[10].

While 'medicalisation', treating social problems as if they were primarily biological in origin, is an important concern, the narrow focus on individual cure rather than mass prevention also tends to be neglected. In medicine the experience of the treatment of Tuberculosis (TB) or Malaria show both the advantages and limitations of a narrow 'biological' approach to 'physical illness'. In the nineteenth and twentieth centuries TB killed millions of immune-suppressed, usually poor, malnourished people, living in damp, cold and overcrowded housing that aided the spread of the disease through coughing. Well before the advent of antibiotics, there was a massive decline in TB through improvements in immunity by improved nutrition and warm, dry housing as well as decreased contagion through less overcrowded housing. Today we know that prevention of TB is key by keeping up nutrition and housing standards while screening vulnerable groups and treating with antibiotics. Malaria, similarly, can be treated when

[10] Wilkinson, R et al (2010): *The Spirit Level*, P256

the person is sick, with anti-malarial drugs, but is also prevented by combating the malaria-carrying mosquitoes by using nets, door and window screens and mending holes in housing, as well as killing mosquitoes and clearing rubbish tips and swamps where they lay their eggs. Failure of adequate prevention of TB and malaria leads to outbreaks and rising levels of drug resistant cases.

It is obvious that social housing and nutrition policies are also preventive health measures for these deadly diseases and that an approach to these diseases which focused solely on individual susceptibility would be inadequate. Even vaccination relies on high degrees of participation and social organisation to be effective, and as we have seen with Ebola vaccination, drug companies are loath to invest in drugs for diseases in poor populations. In healthcare generally the question of not just how much care but what kind of care is crucial. In mental health care the issue of control over what care we consent to crucially involves issues of access and availability to good quality social as well as medical care but also our right to refuse care, especially, but not only, inadequate or harmful care. However arguments for abandoning public provision by critics like Szasz in favour of individual private fee-paying practice need to be opposed as an inadequate response to mental suffering on a mass scale. Sedgwick concludes:

"Even with physical illness, the concept of a 'social disease' is indispensable in the understanding and treatment of, for example, tuberculosis. Preventive medicine and public medicine are bound to invoke social explanations and social measures, to occupy a space which occurs, in short, in the intersection between medicine and politics. My case points, not to the technologising of illness, to the medicalisation of moral values, but on the contrary to the politicisation of medical goals. I am arguing, that without the concept of illness – including the concept of mental illness…– we shall be unable to make demands on the health service facilities of the society we live in."[11]

The excessive focus today on biomedical/biological causes and solutions begs the question of why this might be so. Why not an overemphasis on social factors? As I have discussed above, there was a popular engagement with the social causation of mental health problems in the 50s, 60s and 70s, a period of general social upheaval and the questioning of and resistance to the accepted wisdom of war, imperialism and a range of oppressions especially racism, sexism, sectarianism and homophobia and disability discrimination. It was tempting to ascribe all suffering to social causes and even to interpret psychotic experiences like delusions and hallucinations as transformative experiences towards personal growth as Laing did. However, by the end of the 1970s and the turn economically and politically towards neoliberalism, emphasising free markets and individualism rather than planning and collective social organisation, there was a swing from social to biological determinism. Three reasons seem obvious for the advantage of a biological focus for the conservative capitalist reorganisation project of neoliberalism.

First, at an ideological level, any movement away from social explanations, particularly wider economic and political ones, moved the debate away from looking for causes and

[11] Sedgwick, P (1982): *Psychopolitics*, p40

solutions, particularly revolutionary political ones, in that area. Economic and political solutions, it could be argued, were not relevant where the problem is biological and to do with individual weakness. As we have seen in the case of TB this is not self evident but open to controversy and argument, but still the focus on individual vulnerability, brain structure, brain chemistry and genetic inheritance drained the funding and support for scientific research and undermined political arguments at a time when trade unions and left-wing organisations were under attack and in retreat in the 80s and 90s.

Second, the biological approach elevated the status of doctors and chemists as authorities and experts and undermined the standing of sociologists, psychologists, journalists and others with a more social and less individual approach. At the same time, doctors and chemists were just what the rising industrial power of Big Pharma, the major drug companies, needed to develop, test, trial and prescribe their drugs. The mass consumption of psychoactive drugs is relatively recent, with only a small number of sedative and stimulant drugs, which were infrequently used, before the Second World War. Consumption accelerated in the 70s with drugs like Diazepam ('Valium'), but experienced a setback with the growing awareness of tolerance, withdrawal and talk of 'addiction' to these drugs. There has been an explosion in use again in the 1990s with the advent of SSRIs like Fluoxetine ('Prozac') and newer tranquilisers like Risperidone ('Risperdal') and increasing use of all of these drugs as well as amphetamine-like stimulants in children; all with a weak research base for effectiveness particularly in the long term and a playing-down of adverse effects. Instead of tolerance and withdrawal leading to caution, any talk of withdrawal and dependency or addiction has been effectively suppressed and withdrawal symptoms treated as relapse. In the absence of systematic support for patients who might benefit from tapered withdrawal regimes and psychosocial support, many patients who start medication for a potentially short-term illness may find themselves still on medication many years later. While little difference can sometimes be seen in short term outcomes for either antidepressants or psychotherapy, there is a better long-term outcome for psychotherapy with fewer relapses[12]. Few studies or services look at the outcome of social interventions (such as housing, occupation, financial support or early access to psychosocial supports) for mental illnesses. In areas in Ireland or the UK where psychotherapy is available in the public service, the waiting list is often 6 months or more, while private therapists are immediately available for those who can pay, and drugs are the only available short-term option for those who can't afford private psychotherapy.

This leads us to also ask the question that if the 50s to the 70s was a period of questioning social causes and solutions and the 80s to the 00s was a reversion to individual and biological questions, then why might there be a crisis now? Much criticism is directed at doctors and drugs. The ideological impact of the recent global economic crisis has meant an undermining of the credibility of the system and authority in general. For the drug companies there is also the economic impact of old drugs coming off patent and a lack of development of new drugs to replace them. Their own greed has meant that they have largely imitated the stimulant or sedative and other chemical properties of existing drugs

[12] Kirsch, Irving (2009) *The Emperor's new Drugs*, p160

and made exaggerated claims about their effectiveness and superiority over older drugs and psychosocial supports. As one editor of a prominent psychiatric journal put it:

"The data are in, and it is clear that a massive experiment has failed: despite decades of research and billions of dollars invested not a single mechanistically novel drug has reached the psychiatric market in more than 30 years."[13]

A method of evaluating a large batch of studies together called 'Meta-analysis' has also been very helpful in showing that claims for the effectiveness of psychiatric drugs is weak at best. Lies, threats to researchers and downright fraud litter the history of drug research in recent decades but meta-analysis and popular accounts of drug ineffectiveness and side-effects may make it more difficult in the near future for drug companies to repeat the same trick again.

Alienation and Mental Health

Central to most common mental health problems is fear. The term 'anxiety' is used particularly when the threat is not immediate or is unclear, but it is fear by another name. Fear prompts two solutions: fight or flight, but for many in the modern world there is instead a feeling of paralysis, because they are fighting or fleeing from an unknown threat which seems permanently present but always hidden. Whether the particular mental illness does not involve major disorganisation of thought or perception (traditionally called neurosis) or is severe with disorganisation of thought or perception (psychosis) or brain functioning (Delirium and Dementia), fear is often a central component of suffering and distress because it is distinctly unpleasant when it persists without resolution. Other moods such as anger, depression or behaviours such as phobic avoidance, compulsions or substance abuse such as alcoholism are often secondary to fear. In some cases the fear can be related to an immediately identifiable cause, for example loss of memory in dementia, distorted perception in delirium, pain in physical conditions as well as threats of violence or loss (eg loved ones, job or house). In the more clearly political sphere there is the direct fear and misery caused by exploitation (long hours, low pay, intense work) and oppression (racism, sexism, homophobia etc).

However, sometimes our fear feels unclear; an unpleasant feeling of emptiness, lack of fulfillment and missed opportunity. These common feelings of fearful unease and lack of fulfillment, that are hard to isolate a cause for, have long been pondered by social commentators such as Durkheim, who believed it stemmed from social isolation or 'anomie' and could lead to suicide, but also by Karl Marx who suggested that this 'feeling' of alienation stemmed from an actual, real alienation. Marx called it the Alienation of Labour because it centres on a real loss of control over ones capacity for creative and productive work and the consequences of that loss of control for ones relationship to their work, their own self and to other human beings.

[13] Fibiger, C (2012) *Schizophrenia bulletin*, p649

To many people the theory of alienation is still unfamiliar (Marx ironically also called it the 'estrangement' of labour). While our lack of control over work is arguably the most important social factor in the cause of human misery it is also the most potentially politically explosive and therefore suppressed. It is remarkable how, when financial worries are ranked the most common; and workplace stress is also very common and distressing; and that stressed parents are such an important factor in mediating fear and mental health problems in children; we hear so little of work as the cause of mental illness and distress but often hear of the concern of the effect of mental health problems on someone's ability to work (it is possible even to view the choice of use of stimulating or sedating drugs as reflecting whether or not there is pressure on a person to go to work or not). Even though effects on 'Social and occupational function' are a defining feature of mental illness in official classifications, most discussion is on immediate social relations but very little if any thing is said about wider social, economic and political factors in causing mental illness. At times it seems like the deal is that if we don't talk of work or wider social issues then we can ease off on blaming family and other immediate relationships even where those are relevant. Unemployment (but also fear of unemployment) is a well established cause of fear and distress and is closely connected with suicide. Suicide rates tend to rise and fall in tandem with unemployment rates and yet in discussions of suicide prevention unemployment solutions are rarely mentioned in political circles except on the left, even though government spending on welfare has been shown to be effective in reducing the impact of unemployment on suicide.[14]

In a capitalist economy work is organised around production of commodities, that is goods and services for sale for profit on an increasingly global market. As animals we are defined by action (as opposed to plants or rocks) and as humans we depend for survival on reproduction (similar to other animals) but also on the production of our needs (food, shelter, clothes, fuel etc) in a way that is unlike any other animal, in that we work in a collective, creative and planned way transforming our environment and not simply dependent on crude instinct. Through history, how work is organised socially has had a profound effect on us individually and in social groups. Marx noted that capitalist production as it evolved and dominated over the past three or four hundred years involved the complete alienation or loss of control over the product of labour and the process of labour. Increasingly workers did not own the 'means of production'; the place of work and the tools to do it were increasingly owned by an employer class and workers had only their labour power, their potential to work, to sell on a labour market. As Marx put it:

"The activity of the worker is not his spontaneous activity. It belongs to another. It is a loss of his self."[15]

The products made by workers are not theirs to use or dispose of, and success or failure of these products is defined by buying and selling in a 'market', rather than by their quality or usefulness(even though most people rate military weapons very low in terms of value they are very successful in sales). Competition between bosses in the market means

[14] Stuckler, David et al (2009), *The Lancet*, 374:315-23
[15] Marx, K (1844): *Economic and Philosophical Manuscripts*,

a constant drive to increase production rates and reduce costs leading to pressure to work longer hours, work harder and for less pay. In this setting it has become an, often unacknowledged, norm for workers to consider their work as something they do out of necessity to make the money to live rather than as an enjoyable activity in its own right. Need for money and fear of unemployment become the motivators rather than any desire to express oneself through work: 'There's only one thing worse than having to get up for work and that is not having to get up for work' expresses this sentiment towards work, of dissatisfaction and fear. Competition for jobs, wages and welfare, pits one worker or group of workers against another, often unseen and unknown group.

Finally, in its drive to realise profits, capitalism systematically encourages more consumption encouraging what Marx called 'false appetites', most crudely through advertising, promoting a feeling of a need to consume more and more. With a loss of control in the sphere of production, workers can find some solace in minor levels of control in their work or leisure activities or in their consumption habits (food, drugs, entertainments, clothes and personal adornment etc) and in their apparent control of this consumption.

The production of housing in Ireland in the Celtic Tiger years is a good example of alienated labour in one industry and its devastating effects on workers in that industry but also on workers generally. A building boom meant a massive increase in house building, but because houses were produced as commodities on a market rather than for need, houses were too expensive for most workers to obtain where they wanted them or of the size they needed. As a result many workers bought small flats in cities or houses with long commutes from work and/or family, adding cost, stress and inconvenience and removing sources of personal support leading to increased levels of mental health problems particularly when the crash came. Even the loans for the houses were bought and sold in bundles as commodities. The bubble in house prices and housing-based financial products eventually burst and crashed the house-building industry throwing over a hundred thousand builders out of work and onto dole queues and forced emigration. The ongoing 'market failure' in housing has meant a general recession, lower living standards and a severe housing shortage. Intensive, poor quality building and planning of housing reaped a whirlwind of dissatisfaction, fear, dislocation and distress due to the lack of control over housing policy in Ireland, and dependency instead on the chaos of the capitalist market.

Reform or Revolution

Alienation of labour, therefore takes away work as a source of satisfaction or fulfillment, adds fear of job loss and a sense of suspicion that other people such as employers and other workers pose a threat. Dependency on partial solutions such as consumption, hobbies, spirituality or personal control at work can offer short term relief but can also lead to further social isolation and fear. While anxiety, paranoia, depression, drug addiction, hopelessness and suicide make more sense in this context, the picture is not

one-sided. Isolated passive acceptance is also mixed with united collective resistance in demanding control over work processes and what products are produced on a not-for-profit basis, that is, how much social production takes place in society (of housing, education healthcare, water supply etc). The other side of alienation is the potential for taking control of production back and this potential is held by those who carry out the work of production, the working class, as we see in strikes, occupations and workers' councils.

It is a particular feature of those suffering mental health problems that impairments to their health (and the need for assistance) are either denied or, when addressed, are used as excuses to deny employment altogether. As well as having a right to be off work to recover, people with mental or physical impairments have a right to facilities that minimise the disabling effects of any impairment. Mental health service-users should have the right to work as well as the right to be off work.

In this brief outline of a Marxist approach to critiques of current approaches to mental health, I have attempted to outline the inadequacy of a narrow biological approach as well as the dangers of increasing rather than reducing the tendency to separate physical from mental health, while recommending improvement in the degree of control by patients/service users and health workers in both. I have also tried to highlight the potentially wide application of Marx's theory of alienation to mental health.

The need for unity in political campaigns is a critical factor. Unity between mental and physical health, unity between biological and psychosocial approaches, unity between patients/service users and health workers, unity between individual campaigns based on differing health conditions or geographical areas and unity between organisations based on left-wing, trade union, community or patient/service-user activists. Ultimately, to fully address exploitation, oppression and alienation and their devastating effects on mental health demands a political alternative to capitalism. In *Marxism and Disability*, Roddy Slorach, concludes that:

"In an economy planned and controlled by the majority, science, medicine and social care will be socialised and restructured by providers and users alike. Cooperation on a scale unprecedented in history will provide the basis for a real individualism celebrating diversity, difference, and mutual interdependence. Only such a society can significantly reduce both the causes and the effects of impairment – as well as providing an end to disability."[16]

By way of conclusion I finish with an outline of some suggestions for the kind of principled political demands for improving public mental health for which Peter Sedgwick so passionately advocated:

1. Demands for better mental health services (better quality staff and facilities) should always include demands for better general health services and vice versa.

[16] Slorach, Roddy (2011): *International Socialist Journal*, Issue 129

2. Health services, including mental health services, are best when they are universal, comprehensive, collectively funded by progressive taxation, free at the point of use and democratically planned. The privatisation and commodification of health services, by promoting the buying and selling of insurance or services, increases alienation and worsens services and needs to be opposed by mental health campaigns.

3. Demands for less coercive methods in mental health (Drugs, ECT, Hospitalisation etc) require better services with real choices of psychological and social care (particularly housing, jobs and home care) and require alliances between health workers and patients/service users based on trust and respect.

4. Collective, trade union demands for more control of work processes and products by workers in general, would reduce exploitation and alienation, improve the quality of goods and services, and improve mental health.

5. Demands for increased social provision and workers' control of housing, jobs and social services are particularly important to improve both the mental health of those needing provision but also those working in these services.

6. Increased social provision and workers' control of food and chemicals produced for human consumption would improve safety and prevent inappropriate promotion and consumption through advertising or other means.

7. Physical and mental impairments, at some time in life, are inevitable for all workers but disability, unemployment and homelessness are not. Solidarity is required to ensure optimum support for workers with mental or physical impairments so they do not experience unnecessary disability. Mental health service-users should have the right to work as well as the right to be off work.

8. As well as partial solutions to alienation and mental health problems through reforms to the capitalist system, a socialist solution should include revolutionary social change, involving the recovery of control of production in all spheres, getting rid of all exploiting classes and the false divisions between people and restoring the fulfillment of the need for creative expression through work. Only then can we fulfill the principle:

   "From each according to their abilities, to each according to their needs."

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