I understand the Committee is discussing: ‘Are mental health services adequately addressing the challenge of Scotland’s mental health problems?’

An academic and past service user I suggest escalating incidence shows they are not, and expansion of the ICD 9 Diagnostic Manual (attached) is one of several indications such escalation will continue - drawing in younger and younger children too. I'm in protracted correspondence with Tony Zigmond, V.P. of the Royal College of Psychiatry who agrees much of what I say, and has difficulty in responding to other issues.

There is no shred of scientific or otherwise reliable evidence for the existence of any so-called mental illness. Diagnoses reflect no more than opinion, just as at one time society burned women as witches because unsupported opinion labelled women evil. We don't do that now, however.

The fundamental Biomedical Model Approach to emotional distress currently labelled mental illness can never resolve the problems since medications, all psychiatry offers, do no more than more or less heavily sedate (with undesirable side effects) while in most cases nature takes its course - only for relapse to occur. The revolving door, with lifetime costs to the state.

The alternative Social Model Approach is well proven, economical, humane, and avoids denying 16 of the 30 U.N. Universal Human Rights as current treatments and detention under M.H. Law does. 87% of diagnosed schizophrenics treated with that Approach experience no second episode, and of the remaining 13% less than 70% experience a third. Note that current service approach to 'Recovery' and 'Back to work' are no substitute for application of the full Social Model, and likely to achieve little more than weed out some malingerers.

For the Committee's possible interest I also attach a brief over-view of the Social Model and would be glad to submit further evidence on request.

The government is well aware of this alternative approach. Pondering why it refuses to trial the system I find only all-pervading influence of the international pharmaceutical industry, on which the current system stands. Powerful vested interests indeed, which I'm prepared to strongly and widely evidence on request.

Please advise if this information will be placed before the Committee for consideration, and when that may be.

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Example: Schizophrenics

A
Neuroleptic/psychotropic medications, compulsion and detention in secure facilities may always be required for some but repeated research shows 87% of diagnosed schizophrenics do not experience repeated illness when treated under the Social Model of Mental Illness, as opposed to the Biomedical Model.

B
Adopting it would generate socio-economic savings in the UK of up to £77Bill./a. (National Audit) and £8Bill./a in Scotland (S.A.M.H.) - with release of significant resources and talent common in people currently inhibited by 'mental illness' diagnoses such as A.D.H.D. or B.A.D.

B1
Service delivery value-for-money is relatively simple to audit

B2
Cost analysis shows the Model requires higher initial investment per patient but increasing savings over the short to long term. It is resource-economical, humane, caring rather than controlling, and employs less ongoing medications which in themselves increase overall treatment costs including those of side effects.

B3
The approach creates considerable semi-skilled care staff employment

Social Model

The Social Model holds the principle causes of emotional distress labelled mental illness are socio-economic including:

- Poverty
- Isolation and loneliness
- Deprivation, and inadequate housing
- Dietary factors
- Lack of place in the person's immediate society
- Poor sense of self worth
- Stigma both local and national
- Lack of a social support network

C1
Such people may be damaged, often more sensitive and vulnerable than average, so can't be helped by simplistically lifting them above poverty level or enabling work.
C2
Strong interventions may include providing housing with a modest degree of comfort; income allowing some flexibility in life; moving to a new community; supporting to re-engage with past satisfying hobbies or interests; encouraging and enabling to take part in the immediate society; dietary guidance (possibly including nutrition and cooking issues) - even provision of a dedicated national dating agency; etc, etc

C3
The patient exercises personal choice over flexible options enabled by flexible funding with guidance. It’s common sense, not rocket science

A
Conversion of the current system requires thorough examination of the failed, unscientific Biomedical Model followed by national debate on what to do, how, and development of a National Programme of Change to the full Social Model

D1
This should be directed towards ultimate implementation of the full Social Model - not just parts of it such as ‘provision of more talking treatments’ or ‘care in the community’, still based on the Biomedical Model

A
Concept viability may be simply tested in a Pilot Project

E1
Cost and other savings would be demonstrated within the first year; most evident in hospital A&E departments, prisons, policing, and homelessness figures

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MH02

Mental Health Services Inquiry
Walter Dean

ICD-9 Mental Disorders List

292 Drug induced psychoses
   . . . other & unspecified

295 Schizophrenic disorders
   . . . other & unspecified

296 Affective psychoses
   . . . other & unspecified

298 Other nonorganic psychoses
   other & unspecified

299 Psychoses with origin specific to childhood
   other specified, Unspecified

300 Neurotic disorders
   Other neurotic disorders; Unspecified

302 Sexual deviations & disorders
   Other specified; Unspecified

305 Nondependent abuse of drugs
   Other, mixed; Other unspecified

306 Physiological malfunction arising from mental factors
   Other specified; Unspecified

307 Special symptoms or syndromes, not elsewhere classified
   Stammering & stuttering; Tics; Repetitive movements; Specific disorders of
   sleep; Unspecified disorders of eating; Enuresis; Encopresis; Psychalgia;
   Other unspecified/unclassified symptoms

308 Acute reaction to stress
   Unspecified mixed disorders

311 Depressive disorder unclassified

312 Disturbance of conduct unclassified
   Under socialized; Aggressive; unaggressive; impulse control not elsewhere
   classified; Mixed disturbance of conduct & emotions; Other unspecified
   unclassified

313 Disturbance of childhood/adolescence emotions
   Other/mixed emotional; Unspecified emotional

315 Specific delays in development
Developmental reading; arithmetical; Developmental speech; language; Other specific; Coordination; Mixed development; Other Unspecified

317 Mild mental retardation

318 Other specified mental retardation
Moderate; Severe; Profound; Unspecified

WHAT IT ALL BOILS DOWN TO

Behaviour a psychiatrist thinks odd can be labelled and force medicated FROM AGE 5