TRANSCRIPT OF RADIO INTERVIEW WITH SHELDON BROWN, "TAKE IT FROM US", 27.08.2013.

Theme Song: Sarita Murdoch's "Many Lines".

Sheldon Brown: Well, I'm Sheldon Brown, and this is Mental Health Radio "Take it from us", and that's our theme tune that identifies Take It From Us, as our Mental Heath show every Tuesday. That's the theme music – Sarita Murdoch's *Many Lines* – from a CD. I really recommend that you take a look on the website for this CD. It's called the *Soul Project* and it was a special project put together by the Mental Health Foundation under one of their media grants. But you know it was also created as a way to decrease stigma and discrimination around mental illness, and that's certainly one of the goals of Take It From Us to reduce stigma and discrimination, and to build mental health awareness. So, today we have the privilege of talking to an academic who's been honoured for his services to schizophrenia – and our guest is a prolific writer and researcher, and founded the New Zealand Schizophrenia Research Group – I'm going to be saying that word quite a lot today, so I need to get it right. He's a strong supporter in the early days of Schizophrenia Fellowship, which of course now is called Supporting Families; and our guest has also been involved with Like Minds in the Wairarapa over the years. Dr Robert Miller is an honorary fellow at the Department of Psychological Medicine of Otago University Medical School in Wellington, an advocate of a "big picture approach" to mental health in this country, and we'll hear exactly what he means by this, and his belief that the mental health sector needs more coherence. Now Dr Miller is the phone from his home in Masterton, but before just connecting with him, he's asked us to play a short part of Beethoven's violin concerto.

Beethoven Violin Concerto (First Movement) Jascha Heifetz and Boston Symphony Orchestra, under the baton of Charles Munch.

Sheldon: Robert, are you there on the 'phone?

Robert: Hello, Sheldon, nice to hear you.

Sheldon: Good to hear from you, and great of you to be available for us. We've played that piece which you recommended, especially as you have an explanation, I think, for that piece of music.

Robert: Well – It's the opening of the first movement of Beethoven's violin concerto. It's one of the loveliest movements that Beethoven wrote – and the very way it begins – there's something special about it, which sort of symbolizes something for me. I don't think the listeners may have heard the very first notes – five very quiet drum taps – bom,bom,bom,bom bom – and then two lovely phrases on the woodwind, and then the strings come in with the same rhythm as those drum taps, but completely out of key. . . Now that set's up tension in the movement, and Beethoven spends the next ten minutes trying to resolve the tension he has deliberately set up. . .and I think there's something there . . .he's deliberately creating a bit of tension in order to seek a deeper level of harmony. Understand?

Sheldon: I do. I thought that by playing this piece of music there might be a relevance to schizophrenia.

Robert: It's relevant to many things where we try to resolve conflict.

Sheldon: And are you suggesting that there is an element of conflict in schizophrenia?

Robert: Well – in mental health issues altogether – it has never been free from controversy, has it?

Sheldon: Well, that's very true. Now in 2007 you were honoured for services to schizophrenia. Could you tell our listeners about some of your work which led to that New Year's honour?

Robert: Well, look – as a researcher, what I've been doing over the years has been pretty unusual. It's theoretical work – It's all based in the library, not in a laboratory or a clinic. I call it library-based theoretical research. Universities generally don't like it, because it brings no money into their coffers.

Sheldon: It doesn't bring money?

Robert: It doesn't bring money into the university.

Sheldon: I see. Right

Robert: It's rarely funded – but the objective is to bring together the huge amount of information which we now have in the academic libraries, never properly digested, never properly integrated, and I try to put together vast jigsaw puzzles, which actually make sense – and I'm not particularly bothered about producing papers which boost my prestige, that of individuals or organizations, but actually – dare I say it – I'm try to help understanding of these very difficult issues – partly about normal brain function, partly about brain function in major mental disorders.

Sheldon: Schizophrenia *is* a little bit of a jig-saw, isn't it? It'd be fair to describe it that way?

Robert: It's a colossal jig-saw puzzle.

Sheldon: Colossal jig-saw puzzle! You also describe the label as somewhat controversial. What makes it controversial?

Robert: Er – well – let's go back to history. Like psychiatry as a whole, the term schizophrenia has always been controversial. . . . But the key figure in this was a man called Emil Kraepelin, who was a German psychiatrist at the height of his powers about a hundred years ago. Now he developed a concept called *dementia praecox* – that's the forerunner of the term schizophrenia. Dementia praecox means "early dementia" – dementia developing in young people. Now to equate the disorder we now call schizophrenia with any sort of dementia, I think is definitely wrong. Emil Kraepelin, in his prime, also thought he had discovered ways to separate this entity from manic depressive illness – what we now call bipolar disorder – but even he, by the time he died, knew that those criteria he had come up with were not very reliable. For myself – well, this is a hundred years later – schizophrenia as a scientific concept is still not very good . . .It's not completely useless as a concept, so I seek to refine the concept, so that it might become more useful in practice.

Sheldon: I've never heard the link between schizophrenia and suggestions of early dementia.

Robert: That's the history of it.

Sheldon: Is that still a sort of topical belief round schizophrenia?

Robert: Not explicitly. . .Of course, dementia means, more or less by definition almost, that you're not going to get better. . .and that hangs around the word schizophrenia, but I think it's wrong. I think it's completely wrong.

Sheldon: So, the possibility of recovery from schizophrenia – there's a definite good prospect of recovery?

Robert: Well . . . Let's go back to Emil Kraepelin and dementia praecox. By definition - I think one can say – it had an inevitable very bad outlook; and these were the patients in his asylum who did not recover well enough to be discharged. Now that's no way to define any diagnosis, because no-one then is concerned with effective treatment. Nowadays we know that assumption is completely wrong. Many people given this diagnosis - and I should say that includes myself – come to lead rich, independent and fulfilled lives. Nevertheless, there are many who do not. I have to say – about recovery – I don't know what is possible. In particular, I don't know how much of the impairment in people given this diagnosis is a product of some, as yet poorly-understood illness, and how much is the result of the crushing weight of stigma and discrimination – which I have known, of course, but not now, I'm glad to say. We need some good research to try to resolve that question.

Sheldon: In your own experience though, you've declared that you have personal experience of schizophrenia. . . I mean, you've obviously had a fulfilling life, and you've won this honour for your research. Surely, you're a living example of recovery?

Robert: . . .and there are plenty more. Sure, there are plenty more.

Sheldon: . . .and you're sure there are plenty more people. I mean, as part of the work you've done with schizophrenia, and you've mentioned that a lot of it has been in libraries and research and that sort of thing. I mean, have you had the opportunity to get out and talk to consumers, patients?

Robert: I came to New Zealand in 1977. Even before that I had joined the newly formed organization in Britain, called National Schizophrenia Fellowship; and just after I arrived – a few months after I arrived – the equivalent organization started in this country. Three very brave women from Christchurch started it. . . . and so I was involved with the Dunedin branch right from the very beginning. I wasn't prepared to listen to what I was told. I was not prepared to accept what was in the textbooks. I wanted to get as close to the "coal-face" as possible – as close to the "grass roots". So – in those early days of SF – well - Schizophrenia Fellowship in Dunedin, as it was then, – I wanted to listen, and see what conclusions I could come up with, as close to the "coal-face" as possible. . .and I'm still trying to do that.

Sheldon: All right! . . . I assume that you came from the UK?

Robert: Right

Sheldon: Was there a difference, do you think, in understanding between the UK and New Zealand, in the seventies, when you arrived here?

Robert: That's a difficult one to answer. I mean, we've come an enormous long way in New Zealand since 1977; but the same can be said in Britain. Frankly, the reason why I decided to emigrate was because it was becoming very clear – crystal clear to me – that I was never going to get a secure job in universities in Britain, because I was not prepared to hide my own mental health history.

Sheldon: I see. So, you've been on the receiving end of discrimination from your academic colleagues?

Robert: Oh yes. . . .and in New Zealand, I think I struck it lucky, when I came to new Zealand – I was offered a job – and I think that is not a reflection of New Zealand as a

whole, but is a reflection of the wisdom of one person, who offered me the job, in Otago.

Sheldon: Right. . . but did you have a sense though that there was a more relaxed attitude here in New Zealand, or was it as discriminatory as your experiences back in the UK?

Robert: Difficult to say. . . I mean, my overall impression on arriving in New Zealand was a sense of relief. There are fewer people, and therefore people are more valuable.

Sheldon: Right [laughing] Of course.

Robert: That's not a comment on mental health attitudes, which were pretty barbaric then. Some of them still are now.

Sheldon: Right. Well that's a bold thing to say, that some of the attitudes are still pretty barbaric. . . That's your feeling?

Robert: It's very variable. Of course it's very variable. Every society has a mixture of very wise, kind, intelligent people, always trying to help people, and others who don't see it that way.

Sheldon: Sorry, but I'm having a little difficulty actually hearing you.

Robert [speaking louder]: Is that better?

Sheldon: It's a little better. It's a bit of a coincidence that somebody outside the studio who does quite a lot of telephone interviews, mentioned that calls within New Zealand aren't all that clear. . .and yet calls overseas seem to be crystal clear. . .So, I just have been struggling. Let's go to another music break, and we're going to play some more of the Beethoven Violin Concerto. . . about another two-and-a half minutes of it, so we'll come back.

Robert: Great, Sheldon.

More of Jascha Heifetz and the Boston Symphony Orchestra.

Sheldon: . . .and we're talking to Robert Miller, who is on the 'phone from Masterton . . .and we're thinking that maybe there's a few hills between here and Masterton, Robert, so, maybe that's one of the reasons why we're not picking up some of the words as clearly as we would have liked. You're still there?

Robert: Yes, I am. Look, I'll speak louder. Is that going to be better?

Sheldon: Yes, that sounds much much clearer. Our own Like Minds team here in Auckland are encouraging the rethink of schizophrenia, something I know you're interested in; and you've already suggested that there needs to be a rethink about it. Is there a way to reframe schizophrenia, so that stigma and discrimination lessens?

Robert: Well, I think I may have already said that I think it's not a very solid concept from a scientific point of view – but not completely useless. . . so what I try to do, is to refine it. Partly, what I think is the problem is that we have this word schizophrenia, and because we've got one word, we think it's one thing – but probably we're mixing things up together which are really quite different, some of which will respond to medication, and some of them which don't; some of which may be more a result of trauma, abuse and so on, and obviously with evidence relating what is called schizophrenia to trauma in immigrant groups, and so on. The concept of schizophrenia as we have it at present isn't precise enough; and what I try to do – and I'm reading quite a lot in the last year or two about issues of trauma in relation to what is called schizophrenia – I have a sort of metaphor about this: It's a tree, or perhaps it's a tree

with two trunks, one of which is called schizophrenia, the other perhaps called bipolar disorder – and that is a controversial issue, as I've already said. But around this tree, with it's one or two trunks, we have a whole lot of creepers and vines, some of which are quite substantial; and some people think those creepers and vines are all part of the same tree, and I don't think we know that yet. So – what I'm trying to do – I was an anatomist, and anatomy is all about dissection – so I'm trying, conceptually, to dissect what is the core disorder, that is what might be called schizophrenia - and we might change the name – and what is something else with a completely different cause – so, this is quite a difficult job. . .and you need to know a hell of a lot of information before you can start to do this dissection work.

Sheldon: Those creepers, and other sort of underbrush that you talk about in your analogy there – Are they likely to be things like trauma and psychosis?

Robert: Did you say trauma - and what?

Sheldon: Psychosis.

Robert: Look – let's come back to psychosis in a bit.

Sheldon: Ah ha

Robert: . . .because I think - the issue of the relationship between schizophrenia and psychosis is a big one, which we should talk about – but trauma - yes: What I've been reading about – I've been going back to the early days of psychiatry, sort of hundred years ago or more – at the time when so-called dynamic psychiatry [was beginning], the time of Sigmund Freud in Vienna, that sort of thing. Two disorders were then very much on the radar screen. One of them was called "conversion disorder" – well – according to Freud, it was anxiety which was not expressed as anxiety but was "converted" into complaints about bodily symptoms. . . and the other one was dissociation, or what, at that time was called Multiple Personality Disorder[1]. That disorder came back a hundred years later, as Multiple Personality Disorder. Now it is called Dissociative Identity Disorder[2]. Both of these are somehow related to trauma, perhaps in different ways, and at different ages. Both of them have the potential to confuse, and get confused with schizophrenia and "muddies the waters" So, I'm reading all about those, to see if I can understand those – as a brain theoretician, as well; and if I could – then we could start to see what were the vines, which were the creepers, and which were the trunk. Make sense?

Sheldon: It does make sense. I mean, my immediate thought there is – So, how do you get the medication right, if it's such a complicated picture?

Robert: Ah! Medication! Very controversial.

Sheldon: I might have caught you out there a little bit?

Robert: I've got plenty to say about medication. . . . .I think antipsychotic medication *does* work. There are *many* side effects – we could go into the side effects – but my real worry, even after these things have been prescribed for sixty years - psychiatrists often don't know the best way to use those medications. In particular, I'm worried that they don't get the dose right. There's not much explicit evidence on this – but using indirect ways of reaching a conclusion, I think people who are prescribed these medications vary in their sensitivity to them very much. Between the least sensitive

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[1] In DSM-III.

[2] In DSM-IV

and the most sensitive to these medications, the dose may be a ten-fold, or even a twenty-fold difference. Now, if you're going on the doses recommended by the manufacturer, which are based on studies of aggregate doses – you know – averaged over a lot of people, without looking at individual sensitivity – of course, some people are going to be massively overdosed. I think that's a lot of the problem. We talk about all the various side effects. If we could find a way of determining the minimum, or optimal dose, individualised to each person, I think a lot of those side effects would be far less or even none at all – non-existent.

Sheldon: Are you aware of what the sort of strategy – the prescribing strategy – is, if there's such a difference in sensitivity, among people experiencing schizophrenia? I mean – do prescribers start off with the average dose, and then either reduce it or increase it, depending on what the outcomes are?

Robert: I don't know the answer to that, Sheldon. I do ask this question quite often. I've never got very good answers. I think good psychiatrists are probably doing just what you say, and many others aren't. As for me - when I was first prescribed these medications, which was back in the late sixties – for several years, I was completely wiped out – because I was overdosed. I was completely sedated. It was only when I got to Glasgow university, and was free from anyone who was controlling my dose – I started to mess around with the dose. Now that's dangerous, actually. I wouldn't recommend it to anyone. You should'nt do it without consulting someone – Tell someone what you're doing, either a friend, your GP, your psychiatrist – You shouldn't do it single handed. . .but in the end, I worked out that the right dose for me was about a sixth or an eighth of what I had actually been prescribed.

Sheldon: So, if we have any listeners today who have heard your own personal experience, that, in the sixties you were wiped out by the dosage – You were sleepy, probably unable to function particularly well, what would you recommend to those people, who may want to take some action as a result of hearing your comments?

Robert: If they identify with those comments - it might be motor symptoms, it might be excessive sedation . . .I cannot comment about all the details. With the modern drugs, often it's weight gain, and I don't know whether what I'm saying about dose applies to that. . .I really don't. . . .But . . .if they think side effects are intolerable, they should talk to their psychiatrist. and say 'I'm not sure that we've got the right dose. Can we try reducing it a bit? That's not necessarily stopping it – that might be asking for trouble. But if that patient – shall we say, that person on medication – doesn't feel confident enough to do this by himself, or herself – take a friend along with you, especially someone who knows a bit about it – to help them to reinforce you, to boost your confidence, in this process of negotiation. Make sense?

Sheldon: Yeah. That makes very good sense. . .and I am involved with the "wellness recovery action plan strategy" and we've got a workshop going at the moment, and one of the planks of wellness recovery is advocating and speaking up; and I think one of the areas where we do need to speak up is when it comes to medication. . . but obviously Take It From Us" and you yourself are not advocating any changes to medication without talking to prescribers.

Robert: . . .Look can I go back to the very first time when I got interested in brain research. This is at the age of seventeen, in my last year at school, when I saw in the school library the transcript of the 1954 Reith lectures . .and that was what first fired my interest in brain research. So . . . even before going to university, I was interested

in brain research. I had been thinking of the issues about the relationship between mind and brain. Then I got to be a medical student, and I never completed the medical degree of course – but before I became ill – I'd already thought a lot about the brain and the mind. Now . . .that's an enormous advantage for me, in accepting the fact of mental illness, the fact that medications might work. For people who haven't been on that journey, it's much more difficult. . . and therefore I do insist . . .if you're thinking of stopping your medication, don't do it single handed. Ask someone to help you.

Sheldon: Well we certainly don't advocate on the air stopping medication, and particularly for schizophrenia or psychosis; but we do hear, Robert, a lot about "chemical imbalance" in mental health. Is this a factor with schizophrenia?

Robert: Look . . .you mentioned earlier the words psychosis and schizophrenia. Before I answer that question, can we try and clarify that one?

Sheldon: Well, certainly. Why don't we take another music break, and play the rest of the Beethoven violin concerto? . . .We'll play that now and then come back to talk about the link between psychosis and schizophrenia.

More of Jascha Heifetz and the Boston Symphony Orchestra.

Sheldon: Well we're back live now on the air. You're there Robert?

Robert: Yes, and that's Beethoven; and he sure knows about drama, doesn't he?

Sheldon: Well . . .we haven't ever played classical music, to my knowledge, on Take It From Us, certainly not since I've been hosting the show and involved with the show . . . but it's a very pleasant departure.

Robert: Where are we?

Sheldon: I think we were going to talk about the link between psychosis and schizophrenia.

Robert: Both words are pretty confused actually. . .But "psychosis" is usually thought of as a "transient state of mental turmoil", shall we say.

Sheldon: I think that's a very good description. It's the best description I've heard, of psychosis.

Robert: Now, you could say: "What are the characteristics of it?" . . .Delusions, hallucinations, thought disorder - just words - we could spend a long time discussing each one of those. Schizophrenia itself is a much more long-lasting thing – and in my way of thinking of it, it's a whole lot of what we could call "enduring psychological traits". . . you know – traits: enduring personality features – some of which are impairments, some of which, I believe, under many circumstances – people do better than normal – but one of those traits is a vulnerability to psychotic breakdowns. Now that's how I see the relationship between those two. . .and those psychological traits cover almost all aspects of psychology. They are not drastic impairments. Psychosis IS a drastic impairment, while the state lasts[3]. Those psychological traits which define the longer-term thing . . .some of them are impairments, some of them – I say – are doing "better than normal" - and they don't prevent you from leading a fulfilled life.

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[3] An important point I didn't mention during the interview was that while the active phase of psychosis is transient, it can be so powerful an experience, that its impact is felt long afterwards – as a sort of "hang-over" or "memory effect".

Sheldon: But the psychosis could interrupt that life of contributing, and enjoying, and performing reasonably well.

Robert: Yes. . .the trouble is, this all gets mixed up with the whole issue of stigma and discrimination; and a lot of the strengths of people with these unusual traits – some of them impairments, some of them better than normal – all those are often, for many people, mixed up with a very difficult story – a very difficult journey through life – trying to find employment, trying to find relationships, that sort of thing . . .which makes it very difficult for those people to show their true strengths.

Sheldon: So this issue of "chemical imbalance", which does appear to be becoming a little bit of a myth . . .which is being promoted by the pharmaceutical companies – is it a factor in schizophrenia?

Robert: Look, the reason why I wanted to clarify that about the relation between psychosis and schizophrenia first, was because I can't do it without doing that. The drugs – the medications – they are not anti-schizophrenic; they are anti-psychotic. They control the transient episodes of mental turmoil (as I say). Now I do believe the evidence that says: "This is something to do with overactivity of that messenger substance dopamine." I think this makes a very sound scientific theory. . . .but this is not the whole of schizophrenia. In so far as it is a theory about psychosis, it is a sort of chemical imbalance, but for broader issues of schizophrenia, I think we have to look at many other aspects of brain function. For mental disorders as a whole, I think the idea of chemical imbalance has been massively over-sold.

Sheldon: . . .and it's been over-sold in terms of other mental illnesses, especially depression, I believe.

Robert: Sure

Sheldon: I had the benefit of talking to the chief executive of CASPER – Maria Bradshaw – who has been very much in the news over the last twenty-four hours, with the release by the Chief Coroner of the latest suicide statistics, which are, I think, slightly reduced for those critical age-groups - of young people and Maori; and CASPER believes that some of the work that they have done is responsible for that slight reduction in deaths. . . But she mentioned the SSRIs . . . and I had forgotten what SSRI stood for – but it's "selective serotonin. . ." - just help me here?

Robert: "Reuptake Inhibitor"

Sheldon: Yeah – well, to me, that's a baffling term really, because it seems to be so contradictory. You know, you've sort of got the selective serotonin "reuptake" and "inhibitor". The two seem to be two different things to me.

Robert: Basically what that term means: Serotonin is a messenger substance. . .any messenger substance somehow needs to be inactivated after its release from nerve endings. There are various ways of doing this. One of them is by having a "pump" which pumps the stuff back into the nerve endings. . .and the "reuptake inhibitors" stop that, which means that the serotonin hangs around [outside the nerve cells, so that it can act on them], and can be active for longer than normal.

Sheldon: Oh. I see!

Robert: So, they exaggerate the actions of serotonin. In the context you're talking about – obviously in depression – what's called depression – again: one word – actually it's many different problems. Some of them respond fairly well to CBT, some of them to medication, some to a combination of both. . . and if you're talking about medications, there's quite a wide variety of medications, some of which have nothing to do with

serotonin. So . . .here we have a situation where the diagnoses do not serve their purpose very well, because they don't help you distinguish one thing from another.

Sheldon: . . .and differentiating, I believe between clinical depression and bipolar, is difficult as well.

Robert: That's an interesting one, for me. I mean - the very first antidepressant drug was a drug called *Tofranil*[4] – and I've forgotten what it's chemical name was. It was developed in the 1950s. At first they suspected it was going to be like another chlorpromazine[5] – another antipsychotic drug – so, the very first people they tried it on were people suffering from schizophrenia, or that other related diagnosis, which you might have heard of – "schizoaffective disorder[6]". Now the very first trial on humans, as far as I know, showed that these medications didn't treat depression – they changed depression in people with schizoaffective disorder into florid[7] mania. . . .a very dangerous situation actually – and it does tend to happen still. I think it happened more with those old antidepressant drugs than with SSRIs, but I think this is one of the real dangers of those antidepressant medicines. I'm not saying that those antidepressant medicines are not useful, but I think there are real dangers there: You know – if we had more precise diagnoses, we might be able to avoid those things happening. They actually happened to me, in the nineteen sixties. . .very very bad.

Sheldon: Maria Bradshaw, who I mentioned just a few minutes ago, made a point that I hadn't heard previously, that antidepressant can have a tendency to make people more angry, slightly more violent, and that was a sort of an assertion that I hadn't heard before.

Robert: I'm not sure I want to go down that line, because I think that things like anger and aggression always have complicated causes, and I don't think you can tie them down to one thing. . . .but certainly, what I'm talking about – we could call it an "activation syndrome"[8] – for someone who is already fairly distressed due to depression, and suddenly their mental activity increases massively – anything could happen.

Sheldon: Well, one of the things we promised our listeners, in the introduction was that you're a strong advocate of a "big-picture" approach to mental health, and that mental health generally needs greater coherence. I mean they are big questions, but do you think you could help us understand that a little bit?

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[4] Its other name is Imipramine.

[5] The very first antipsychotic medicine, introduced in about 1954. Also known as Largactil.

[6] Once it was realized that schizophrenia could not always be easily distinguished from bipolar disorder, this term was introduced for those disorders which seemed to be half-way between the two; but, as for many other diagnostic terms in psychiatry, the term is not very satisfactory.

[7] Meaning "dramatic" or "severe".

[8] This response arose from Sheldon's question about the difficulty in differentiating depression from bipolar disorder. As I understand it, this "activation syndrome" occurs more often in people who have the bipolar diagnosis, rather than uncomplicated depression. However, in bipolar disorder, depression is the dominating symptom for much more of the time than is mania. It may happen that no-one knows that a depressed person really has a bipolar disorder, until, sometimes quite dramatically, this activation syndrome is brought about while a person is receiving antidepressant drugs. Again we need better ways to diagnose the different disorders.

Robert: What can I say about that? I don't know what it's like in other countries. I suspect in Britain – in Britain, I don't say the mental health services are better than here – but I think there is more coherence between all the different players. What I mean by that is that in this country, I see all sorts of organizations, some of them in the community, some of them professional organizations, all singing their own song, all of them doing some good, but often a bit defensive about encroachment on their territory, and I see it as a whole lot of petty sources of power, all striving to maintain their power base, in competition with each other, and it is very bad, especially at a time when funding is shrinking. We need more coherence. We need these people to start listening to each other. Realise that they've all got part of the truth, and try to reconcile other people's view of the truth with their own. Make sense?

Sheldon: Well, certainly the government is calling, very strongly, for greater collaboration in all areas of health services, but particularly in mental health. So, do you see any evidence that that is happening?

Robert: . . .Look. . .there's all sorts of players here. There is a large number of different community groups, some of them for consumers, if I can use that word, some of them for caregivers, various professional groups – psychiatrists, clinical psychologists, occupational therapists, and so on.

Sheldon: Right! . . .and when we do require services - you know – prior to being involved in mental health and working in mental health, I wasn't aware of things even like community mental health centres, a lot of the wonderful services that offer creative things like Toi Ora, Live Arts, Framework that does a lot of art and creativity, used to do bone carving – still does woodwork, and has a woodwork shop. You know - these things are perhaps not even known by the community mental health centres, where it might be your initial stop for some help.

Robert: Yes . . .the people you are talking about . . . I think most of them are doing a good job. But I do think there is a tendency to set up barriers between organizations. Take for instance, what you might call "art therapy" – something like what you were talking about just now, isn't it?

Sheldon: Very much so.

Robert: What I see is young people who come through school – struggling – and then eventually they crash, with serious mental illness. They get to their early twenties, and they have to start rebuilding their life. Now normally during the teenage years, people are discovering who they are, what their strengths are, their personal identity. But *those* people have never had a chance. They need special help, from people who can find out, who this person is – who they could be. . . .just one example of how someone in fields quite different really from the mental health services, can play a big part.

Sheldon: You touched on a point there, that has been a revelation for me, since getting involved in mental health, and that is that schizophrenia – if I can use the words – strikes . . . in the mid-twenties.

Robert: . . .or earlier than that.

Sheldon: . . .earlier than that. Do you have any insights into that, into why it's that age?

Robert: It's a good question. . . .and it goes to the heart of what is the cause of this disorder, if you're thinking of it in brain terms. . . . and I'm not quite sure of the answer. I've got some hints, but since they are fairly tentative, I don't think I should talk about them.

Sheldon: Right. OK. Well, you and I are going to meet next month, when you come to Auckland. Maybe that's something we can chat over coffee.

Robert: Yeah. Sure.

Sheldon: You do talk about this big picture approach, in mental health and mental health services. Who do you see driving that? Has it got to be the government?

Robert: . . .I'm not sure. At present, and for as long as I can remember, there has been no real leadership in this sector – as I say – a whole lot of petty sources of power vying for centre stage. That might even reflect a deliberate "divide and rule" policy coming from above. That *might* be too conspiratorial a view[9]. I'm not sure. . . .I'm not sure who can lead at present. . .but anyone who *can* lead in this sector, needs to be able to take on board very many perspectives, not to challenge them <?in the areas of their own strengths>, but perhaps – respectfully - to challenge the various players when they seem to be dismissive of other players in the field. So . . .I don't know what you want to make of that.

Sheldon: [laughing] Well, I think it's refreshing to hear somebody being outspoken, as you have been, about the realities, because, as you say, there's not many people sticking their head up above the parapet, and talking like this.

Robert: I'm approaching my seventieth birthday actually, and, actually – if your mind is good and your health is good at that age – that is when you ought to be saying those things - because you have less to lose.

Sheldon: [laughing again] Well – that's very good advice! Maybe that's why I can be a bit outspoken as well, because I'm heading in that direction fairly quickly. Well . . . Can I thank you for your time, and making yourself available from Masterton, on what has been rather a scratchy telephone line . . .but we're going to go to our community notices and wrap the show up, so we won't keep you on the line, but, thank you very much, and I look forward to meeting you in person, and I think it's the sixteenth of September.

Robert: Look . . .I had planned to say a little four-line poem before I finished.

Sheldon: Of course, yes. Please do.

Robert: Well, this is from the early eighteenth century. A British poet – Alexander Pope. It's not a statement of fact. It's a statement of faith.

> All nature is but art, unknown to thee.
> All chance, direction that thou can'st not see
> All discord, harmony, not yet understood
> All partial evil, universal good.

Thank you.

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[9] In retrospect it *is* too conspiratorial. The fragmented state of the mental health services is not due to a deliberate "divide and rule" strategy; but it is inevitable, if there is no wise leadership, because there is a large number of valid perspectives – *seemingly* incompatible with each other, but not really so, if only we could do the hard work of listening and trying to understand each other. . . and that will inevitably mean questioning some of our own basic assumptions. . . yet there seems to be no one, even at ministerial level, who can do that, or if they can, who is in a position to use their insights to bring coherence to the sector.

Sheldon: Thank you. We'll post that on our Facebook page, from Take it From Us.