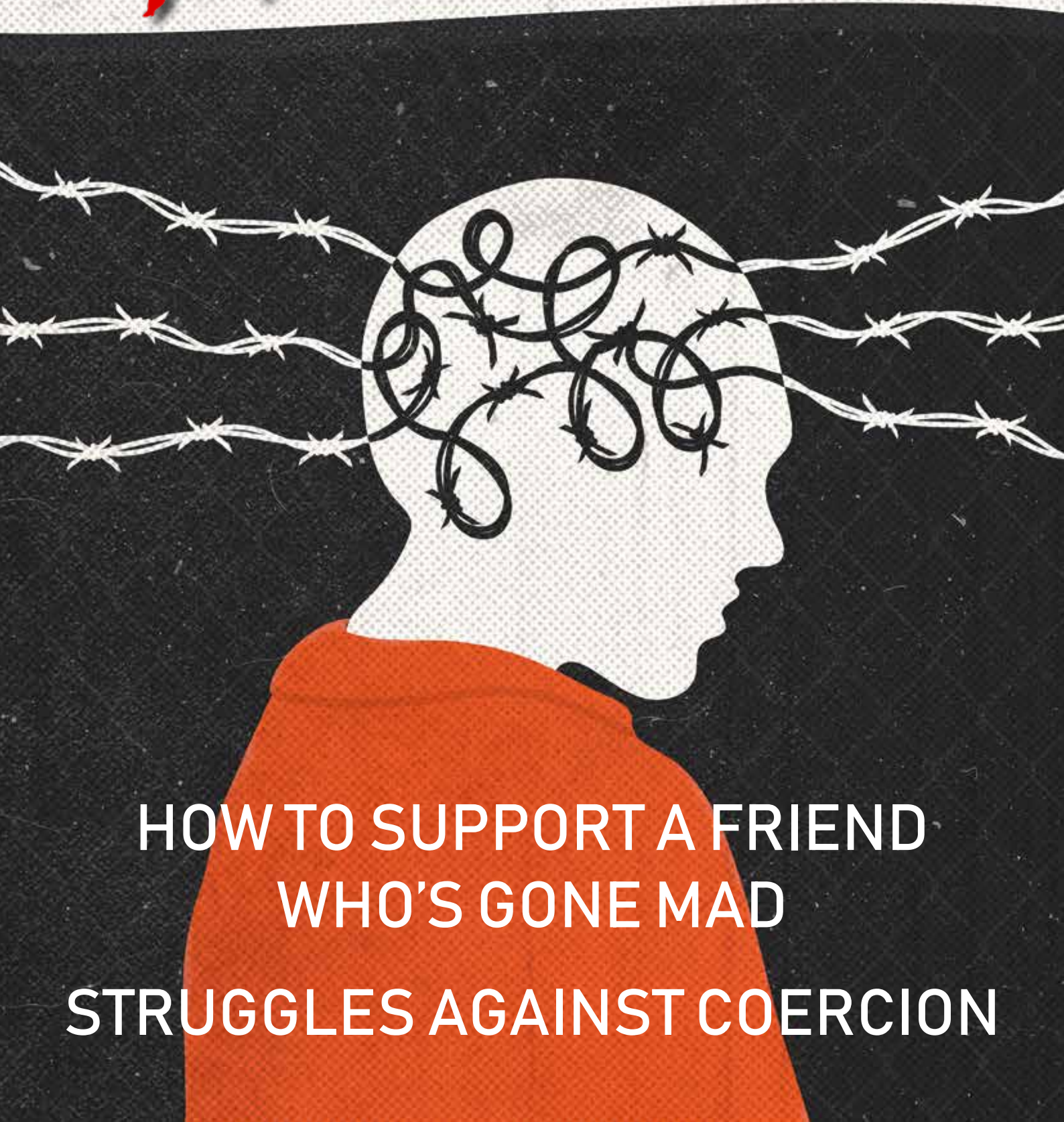


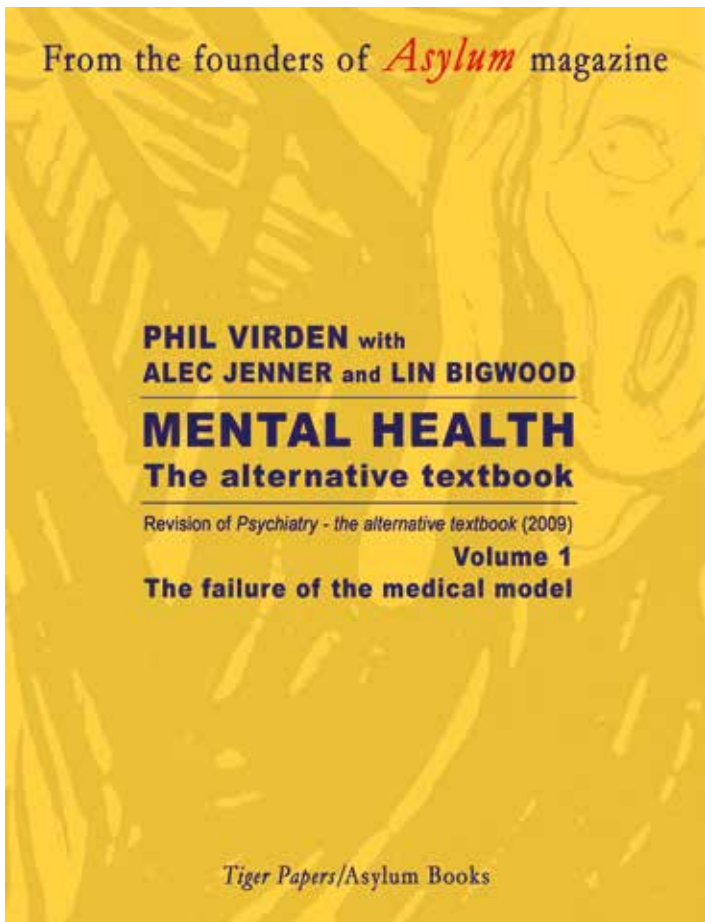
Asylum

the radical mental health magazine

Spring 2019
Volume 26
Number 1
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STRUGGLES AGAINST COERCION**



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Asylum readers' group in Lancaster

Asylum readers in Lancaster meet quarterly to discuss each new issue of the magazine. Our meetings – open to all – are hosted by Critical and Creative Approaches to Mental Health Practice (CCrAMHP), a local discussion group that meets six weekly.

Our next Asylum readers' group meeting is on Thursday 9 May 2019 from 7-9pm in room 4 at the Friends Meeting House, Meeting House Lane, Lancaster, LA1 1TX. We will be discussing the Spring issue of Asylum (*Asylum 26-1*). If you are not yet a subscriber, you can pick up a copy at Atticus bookshop in Lancaster.

**Interested to join us?
We'll save a chair for you!**

For further information about CCrAMHP, and forthcoming meetings, visit www.ccramp.org.uk or email – ccramp@gmail.com

Live elsewhere in the country and keen to meet with other Asylum readers?
Why not set up an Asylum readers' group of your own?





The radical mental health magazine

Volume 26, Number 1, Spring 2019
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Asylum, formerly the magazine for democratic psychiatry, was established in 1986 as a forum for free debate, open to anyone with an interest in psychiatry and mental health politics, practice and policy. We were inspired by the democratic psychiatry movement in Italy and continue to be influenced by radical mental health movements around the world, including the psychiatric survivor and Mad liberation movements. We welcome contributions from service users, ex-users or survivors; activists, family members and frontline psychiatric or mental health workers (anonymously, if you wish). The magazine is not-for-profit and run by a collective of unpaid volunteers. We are open to anyone who wants to help produce, develop and distribute the magazine, working in a spirit of equality and democracy. Please contact us if you would like to help.

The views expressed in the magazine are those of the individual contributors and not necessarily those of the collective. Articles are accepted in good faith and every effort is made to ensure fairness and veracity. editors@asylummagazine.org

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Editorial

ASYLUM calls itself the radical mental health magazine. Being radical, or critical, may seem like a relatively straightforward project, but it isn't always easy to define, or straightforward to put into practice. There are underlying tensions and disagreements about this: for example, how Mad Liberation can best be achieved; or how to develop more democratic mental health services. Tensions can sometimes be positive, helpful and creative. However, our current political context seems to be exacerbating them in unhelpful and damaging ways. We are living in a society deeply divided post-Trump/Brexit; with a fractured political Left opposition; with continued threats to welfare and support services. All of this contributes to a climate of fear and mistrust. There are plenty of positive examples of unity, support and solidarity, but underlying divisions are often amplified on social media and sometimes accompanied by personal attack and criticism. This cannot be good for our individual or collective mental health.

ASYLUM has always tried to be open to all sections of the radical or critical survivor and mental health community, even though they may sometimes disagree. The main purpose of the magazine is to provide a space where diverse critical perspectives can be heard. Sometimes this feels difficult to achieve with quick-fire responses encouraged by social media. This is one of the reasons why we persist with our printed magazine format, where publication timescales encourage more thoughtful debate and discussion.

If you think we are not covering something important, please write in and let us know. Consider writing something yourself. We understand that sometimes people feel the need to write anonymously, especially in the current context, and we welcome all constructive contributions. We always try and avoid inaccuracies and personal attacks – in *any* articles we publish.

We recognise that we have sometimes failed sufficiently to acknowledge important contributions. For example, Donnard White, whose article we re-publish in this issue, helped us out over many years in the early days. More recently, we also didn't give sufficient credit for the hard work of survivor artists, like Nick Lloyd, who helped us considerably with our redesign last year. We take these failings seriously and try to address them, however inadequately. We apologise and try to do better next time.

ASYLUM is a not-for-profit magazine run by a group of unpaid volunteers. Despite our best efforts we still have a very limited circulation. We rely upon the support of our valued readers and supporters. We receive no external sponsorship or funding. PCCS Books kindly print and distribute the magazine for us, but no-one makes any money out of this. We barely break even. We simply, but not easily, try to provide a forum for dignified, honest debate and discussion about mental health issues. ■

Helen Spandler

Managing Editor, on behalf of the Editorial Collective



THE STRUGGLE AGAINST COMPULSION

In the last issue of Asylum PETER CAMPBELL, veteran survivor activist, reflected on survivor activism in the 1980s. In this article he revisits one of the survivor movement's key demands – reducing compulsion – and asks: how far have we come?

Compulsion lies at the heart of the psychiatric enterprise. It is hard to imagine mental health services as currently constituted being able to function without the use of compulsory powers. They are a key implement in the tool-bag of mental health workers who are dependent on them in their day to day practice. In recent years the proportion of in-patients who are detained for treatment has risen inexorably. For very many people with a mental illness diagnosis mental health care can only mean compulsory care.

In this situation there are several dilemmas. The Mental Health Act is a discriminatory piece of legislation. Although it gives some elements of protection, it takes far more away. Compulsory powers creates a group of people (those with a mental illness diagnosis) who are essentially second class citizens. They have significantly less rights than the rest of society. They can be detained at a place for substantial periods of time against their will. They can be forced to accept treatments they have specifically refused. All this can happen even when their distress has not robbed them of the capacity to make decisions. Many people who have only a passing acquaintance with the mental health system are surprised when made aware of the latter fact. They presume that compulsory detention and treatment only happens when “the mentally-ill” have no insight and have lost control of themselves. They do not realize the amount of power that has been handed over to psychiatrists and other mental health workers.

The Mental Health Act has always been problematic for the UK survivors movement. Many activists have personal experience of being on the receiving end of compulsion. They often have first-hand knowledge of coercive interventions like restraint and solitary confinement and understand only too well what it is like to lose their freedom within an admission ward. Furthermore, the existence of the Mental Health Act does not only have an impact on formal patients. Informal patients also know that compulsion is always a real possibility and that in certain circumstances they can be prevented from leaving the ward and then compulsorily detained. The Mental Health Act sets the atmosphere of care and reminds recipients of care that they are fundamentally powerless.

The UK survivors movement is not homogenous. Different individuals and groups have different priorities. Nevertheless, they have always come together to campaign around the Mental Health Act. Many of them would like to see compulsory powers reduced or even abandoned

altogether and this desire is growing. But over the last thirty years survivor activists have been almost unanimous in calling for no extension of compulsory powers under the Act. This has been a major focus of their campaigning and has, until recently, met with very little success.

Since the first introduction of the 1983 Mental Health Act there were calls to extend its scope. These focussed on the addition of community supervision/treatment orders. Their target was the so-called revolving door patient – people who were admitted and discharged and then re-admitted after a short period of time. The concern was to find ways to make this group comply with treatment. This really meant ensuring they continued to take their medication. Failing to do so was seen as the principle reason why people relapsed and had to go back into hospital. The survivor movement challenged this analysis and asserted that what was needed was not treatment compliance but better therapeutic relationships and that increased compulsory powers were an obstacle to these developing. Living in the community under a licence was not acceptable and did not address the complex difficulties of recipients' lives.

In 1987 the Mental Health Act Commission distributed a discussion document on Community Treatment Orders with a view to making recommendations to the government. This provoked widespread debate and revealed a division of opinion. While the Royal College of Psychiatrists supported the introduction of Community Treatment Orders, several professional organisations like the Community Psychiatric Nurses Association opposed it. The survivor movement, then in its infancy, also opposed it, and made its voice heard. Almost for the first time, the movement was asserting its views on the Mental Health Act and this had an impact. In the end, and partly as a result of work by survivor activists, the Mental Health Act Commission was unable to make a clear recommendation. The introduction of Community Treatment Orders fell by the wayside.

But this was not the end of the road. Proposals for extending compulsory treatment into the community remained on the menu. They were revisited in the early 1990s. At that time there was serious public concern that certain people with a mental illness diagnosis were slipping through the safety net of services. The widely publicized cases of Ben Silcock, who climbed into the lion's den at London Zoo, and Christopher Clunis, who killed Jonathan Zito, a complete stranger, in a tube station, highlighted the problem. As a result, the government went ahead with plans to give mental health workers increased powers of community supervision and eventually supervised discharge was introduced in the Mental Health (Patients in the Community Act) 1995. It

was a piece of legislation that was not popular. Some felt it went too far, others that it did not go far enough.

Dissatisfaction with supervised discharge was reflected in the amended Mental Health Act that came into operation in 2008. This introduced full-blown Community Treatment Orders and extended the power of mental health workers. Once again, the underlying imperative was to ensure that recipients stayed in contact with services and did not stop taking their medication. It was hoped this would cut down the re-admission rate of people with on-going mental distress. For many campaigners, not just survivor activists, this was a further step in the wrong direction and a victory for a risk-averse culture that undermined the rights and autonomy of people with a mental illness diagnosis. Compulsion and the threat of compulsion had been successfully asserted.

At the time of writing this article, the latest Mental Health Act Review has just published its recommendations (December 2018). It is not yet clear how the Government will respond and how far-reaching any legislation will be. Nevertheless, the Review contains some good proposals and shows a degree of sensitivity to the negative effects of compulsory powers. After ten years in operation it is rather clear that Community Treatment Orders are neither desirable nor effective. The rates of re-admissions have not decreased. Even the most enthusiastic cheerleaders for CTOs are having second thoughts. However, faced with this situation the Review does not call for them to be scrapped but suggests tighter regulation. If there is no evidence of effectiveness after five more years then the use of compulsion in the community should be re-visited. The recognition of the problems of CTOs is welcome but the response seems a little timid.

One long-standing problem area that the Review addresses is the use of police station cells as a place of safety for individuals in mental distress awaiting assessment having been picked up by police in a public place. The use of police station cells means seclusion and

seclusion is a euphemism for solitary confinement. It is quite wrong that people in mental distress should be put into solitary confinement at the peak of their crisis. This would not be tolerated for any other group of disabled people and reveals a fundamental failure of the caring imagination. The fact that we have continued with this practice for more than thirty years is little short of a scandal. Thankfully the Review comes out clearly against the use of police station cells as a place of safety and proposes that it should be phased out in the next few years. It is a proposal that is long overdue and should be widely welcomed.

Overall, although it contains some good things, the Review does not bite the bullet when it comes to compulsion. It falls far short of the provisions of the United Nation's Convention on the Rights of Persons with Disabilities. People with a mental illness diagnosis will not have equal rights. They will remain second class citizens. It will still be possible under certain circumstances for them to be compulsorily detained and treated even though they retain decision-making capacity. In this respect the Review is a disappointment to many survivor activists and other campaigners.

If compulsion is to remain a feature of the mental health system as seems inevitable, it is essential that something is done to moderate its effects. In the first place, the rising use of compulsion needs to be properly investigated and measures put in place to reverse the trend. It is not acceptable that around 50% of in-patients are formal patients. It is also vital that mental health workers are fully aware of the negative effects of compulsion. The use of threat (of compulsion) needs to be eliminated. Compulsion should be seen for what it is: a perilous intervention that has a damaging impact on therapeutic relationships. The 2018 Mental Health Act Review does not recommend extending compulsory powers. That is a relief, given the history of the last 35 years. Nevertheless, compulsion is going to remain a central feature of services. The war against it is likely to continue. ■



‘拘束された人’ / ‘Constrained people’. By fotoriatonko

IN DEFENSE OF VILLAINY: WHAT VILLAINS CAN TEACH US ABOUT MAD PRIDE

ANDY COLLINGS and EMILY SHEERA CUTLER discuss the role of villains in our unjust society and suggest they have similarities with Mad activists

Emily:

As a kid, superhero movies seemed so simple. The heroes were good and deserved to win; the villains were the “bad guys” that deserved to be defeated. But I’ve begun to realize that the villains are usually right. Often, they make important – and accurate – points about society, the context of the story, and the other characters. I would even go so far as to say that they are the voice of reason.

Andy:

Superheroes are relentless defenders of the status quo, struggling day and night to ensure that nothing ever changes. Their fundamental assumption is that the world is good and fair as it currently exists. Superheroes see themselves as enforcers of the *Just World Hypothesis*, which holds that a person’s actions bring morally fair and fitting consequences to them. If heroes did not believe in the justness of the world, it would hardly make sense for them to risk their lives on the world’s behalf.

Let’s look at an example from my all-time favorite superhero movie: *Spiderman 2*. Peter Parker, AKA Spiderman, is constantly falling behind on rent, missing class, and losing the girl, but believes that if he put in the effort he could succeed at anything he put his mind to. Meanwhile, Otto Octavius, AKA Doctor Octopus, is a deformed and discredited scientist with no remaining family and no hope of ever being able to live a normal life. The only way he sees to redeem himself is to finish his final experiment (by any means necessary), hoping that if he proves he wasn’t wrong, he can re-enter society. And what choice has he been given? Unlike Peter Parker, he doesn’t have any illusion that he could succeed at anything he puts his mind to. For Doctor Otto Octavius the world is not just.

Ultimately, I think it is not Peter Parker but Otto Octavius who is correct in his assessment of the world. Every day, we place each other in very specific boxes. “He looks like such a dude bro,” I think when I see a



Photograph by Patrick Wood

guy in a faded American-flag muscle shirt at Walmart. But I know a guy who wears those kinds of shirts and is *also* an amazing filmmaker and *also* a high-level competitive videogamer. No box can really contain the infinite complexity of him. And that is to say nothing of racial stereotypes, gender norms, or our assessments of others’ sanity. To force someone in a box is to deny them all the other options outside that box. Otto was right to rebel against that insufferable cruelty.

Emily:

Another film that I adore is *Phantom of the Opera*. The villain, the Phantom, has a facial disfigurement and was sold to a freak show at a young age. He is treated cruelly due to his appearance and grows up to be a violent person. When asked to show some compassion, he says, “The world showed no compassion to me.” Unlike the protagonist, who has had the privilege of being treated with compassion throughout her life, the Phantom has been treated with disgust, mockery, cruelty, violence, and shaming for every moment of his existence. He understands just how awful the world can be and works hard to match its awfulness.

Like Doctor Octopus, the Phantom has been forced into a box. His appearance and his lifetime of trauma have left him without many options. He can either be the passive target of relentless cruelty, or he can embody the

cruelty and violence he has been victimized by and throw it back into the world. Rather than playing the role of the “perfect victim” – a victim who does not fight back, and who remains kind and moral despite the cruelty around them – the Phantom takes matters into his own hands and rebels against the social order.

The Phantom is vilified for his whole life, and so he embodies villainy.

Andy:

Being the Phantom is the dream, the fantasy. We wish we were bold enough to push back against the injustices of the world, but we’re not. We want to be the one to BS the system, the guy who quits his awful job with the music of a rented mariachi band and the applause of our jealous co-workers guiding us on, but we’re not. Walter White, the protagonist of *Breaking Bad*, is. Walter has been cut out of the billion-dollar business he co-founded, has to work at a carwash to make ends meet, and then gets cancer. The world is not just to him, but everyone seems to keep acting like it must be. So he fights back, and we love him for it – even though he’s an asshole.

Many of us who consider ourselves to be more ‘discerning’ viewers (including myself) sneer at people who actually like Walter, who root for him. “Don’t you get it? He’s an asshole! He’s the bad guy!” we say to them. But I suspect they don’t disagree that he’s an asshole or even a villain. They disagree that it disqualifies him from being a role model. After surviving 9/11 and the economic collapse of the late 2000s in the same decade, is it any wonder that people have lost faith in the “justness” of the world around them? Walter had every right to rebel against that with every fiber of his being; we have the right to savor every glorious moment of his rebellion.

Emily:

So what does this have to do with Mad Pride?

The Mad Pride movement is full of people who comprehend just how horrible the world can be, and who have been punished for their comprehension of that fact. While the rest of the world is “well-adjusted” to oppression – either because they do not know about it or are not affected by it – people who go “mad” cannot handle it. They cannot smile, be happy, and function productively in a system rooted in violence. And instead of being valued for their insight into how oppressive the world is, they are told they are mentally ill.

Villains, too, comprehend just how horrible the world can be. They have been made powerless and understand the impact of this powerlessness. But instead of being made even *more* powerless by psychiatrization, they find ways to correct the power imbalance. In response to a violent system of oppression, they launch a violent rebellion.

There is little more satisfying than watching someone who has been rendered powerless reclaiming their power, fighting back, and reversing the power imbalance. Yes, it is violent, it is evil, it is immoral, it is wicked – but that is what the world deserves. Sometimes, the world deserves villainy. A world in which your life’s work can be stolen and healthcare denied, a world in which a child can be sold into a freak show and in which people face lifelong shaming due to their appearance – these worlds deserve villainy.

Similarly, the real world deserves madness. A crazy-making world – i.e. ours – merits a crazy reaction.

Andy:

If we as a society can begin to see the world as unjust, then maybe we can humanize reactions to that unjust world – including madness. The desire for flawed characters struggling against an unfair world has rippled out to more than villains. A new wave of protagonists have been traumatised and, funnily enough, react to that trauma in ways that could be considered ‘mad.’ But they’re not handled as psych patients or as dangerous wackos. They’re just... people.

Jessica Jones is an alcoholic superhero who was orphaned, kidnapped, raped, and coerced into murder and yet is portrayed with compassion and empathy. *Bojack Horseman* is a washed up actor struggling with intergenerational trauma in the shallow, status-focused culture of Hollywood. And in *13 Reasons Why*, we witness a variety of characters go “mad” in response to oppressive dynamics like bullying and sexual violence in the school system. The catalyst for all of the events in these shows is a human response to layers upon layers of ostracization, objectification, and abuse.

Through all of these shows, we are fundamentally redefining the traditional role of “hero.” A hero doesn’t have to be a goody-two-shoes anymore. A hero can also just be a person reacting to a messed up world in a way that we find relatable.

Emily:

At the end of the day, we are all just trying to survive. While more traditional superheroes represent the idealistic notion of saving the world from any threat or injustice – villains (and the newest wave of TV show heroes) represent the finding of small ways to regain power in a fundamentally disempowering society.

And so do we. In many ways, “madness” represents the act of finding some small way to regain power in a world that has made us powerless. Instead of being pathologized or psychiatrized, this act should be celebrated. In a capitalist, racist, sexist, queer-antagonistic, ableist, sizeist, lookist, sanist society, we have found our way to a tiny victory. Let’s celebrate. ■

Lunacy, Liberty and Law: A tale of two shackles?



Pinel freeing the insane from their chains (at la Salpêtrière). Oil painting by T. Robert-Fleury, ca. 1876. Credit: Wellcome Collection. CC BY

SABINA DOSANI questions whether the mad have been liberated from mass confinement

Tony Robert-Fleury's 1876 painting, 'Pinel Freeing the Insane,' is one of my favourite works of art. I first came across it during my training to become a psychiatrist, in the early 2000s. A few years earlier in the 1990s, while still a medical student, I had been a psychiatric in-patient. I was never detained under the Mental Health Act; my liberty was never limited. It was that sort of ward, for 'informal' patients. Some of the friends I made on that ward had been 'sectioned' on other admissions. My mind goes back to their stories, their accounts of fear and sometimes relief, whenever I look at Fleury's painting.

Community Treatment Orders

CTOs are a legal tool, compelling patients to accept treatment. Tim Lambert, a psychiatrist investigating treatments administered to a group of patients on CTOs, published his findings that 'proportionally more patients with a CTO are prescribed long acting antipsychotics rather than oral second generation antipsychotics.' The CTO emerged in the context of a neoliberal state, initiated by Thatcher in the late 1970s and continued by Labour during the Blair years. It is my opinion that CTOs are a legacy of UK neoliberalism.

To what extent are patients in the community – who are subject to the legal conditions of CTOs – at greater liberty than those depicted in Fleury's painting? I use

Michel Foucault's analysis to question whether allowing residence and movement away from hospital through Community Treatment Orders (CTOs) actually delivers greater liberty.

Madness and Civilisation

Michel Foucault's 1961 book *Madness and Civilisation* presents a 'prehistory' of psychiatry, criticising what he termed 'The Great Confinement', claiming that in the 18th and 19th Centuries, prisons, workhouses and madhouses were established to deal with the 'social inconvenience' of the mad. This occurred, he suggested, due to breakdown of dialogue between 'reason and unreason'. In his view, reason dictated that 'madness' be negated as 'unreason.' This climate, he claimed, helped the psychiatric profession to claim great power in the late 18th and early 19th Centuries. He argued the 'great confinement' arose as a way of managing the fluctuating condition of the poor and marginalised during the emergence of capitalism; and that Philippe Pinel did not change that dynamic. So he did not accept Fleury's view of Pinel as a saviour-liberator. He argued that unchaining doesn't deliver liberty. On the contrary, he noted a steep rise in those incarcerated in the Bicêtre under Pinel's medical directorship and asserts many were detained while awaiting Revolutionary Tribunal hearings.

Enlightened Progress?

In England in 1790, Hannah Mills, a young Quaker suffering from melancholy, was sent to York Asylum. Members of the Religious Society of Friends were denied access. Mills died in suspicious circumstances. Samuel Tuke founded the York Retreat after Mills' death. In the name of 'enlightened progress', he proposed, 'moral treatment: kindness, reason and humanity.' Patients enjoyed daily walks, gardening and sewing. Historian Roy Porter described Tuke's methods as re-humanising: 'moral treatment aimed to revive the dormant humanity of the mad, by treating them as endowed with normal emotions'. Influenced by Tuke's work at the York Retreat, John Connolly also advocated moral treatment. When he became head of Hanwell Asylum in 1893, he was renowned for prohibiting restraint.

Foucault believed there was untold political motivation: 'Tuke's work was carried along by the readjustment of English social welfare legislation.' Foucault stressed sinister dimensions of moral therapy, in its potential for political abuses of psychiatry. He considered it uncivilised to remove physical chains, for them to be replaced by forced work, when a person might not feel well enough. Historian Andrew Scull takes issue with Foucault's romanticisation: 'Notions of the mad roaming free in the countryside must be considered alongside facts that they were beaten, chained-up or left to die.'

The law, then and now

The 1774 Act for the Regulation of Private Madhouses was the first Act of Parliament preventing wrongful incarceration of people deemed sane. It stipulated that 'madhouse keepers could only accept a paying patient on the signed certificate of a medical man.' Our current Mental Health Act requires two such signatures. A CTO is an option for patients detained under Section 3 of the Act and unrestricted criminal patients. Section 3 is a detention order for assessment and treatment, lasting up to six months, at the end of which it can be renewed.

In 1774, the onus was on proving sanity: 'For the individual named insane, it was sanity that became impossible to prove. The law might want to protect the individual's liberty...lost when he or she was declared insane.' Under the current Act, patients liable to detention can appeal to a tribunal, in an attempt to regain their liberty. However, Gosney and colleagues found tribunals discharged just 4.1% of those who appealed.

Although CTOs are used internationally, they were not introduced into the Mental Health Act in England and Wales until 2007. Perhaps the reason why CTOs were introduced in the 2007 Mental Health Act reforms relates to Connolly and his legacy. To ease pressure on Hanwell, a new asylum was built under Connolly's steer, at Colney Hatch, on Friern Barnet Road. In 1959, Colney Hatch became Friern Barnet Hospital. Then, in 1981, as part of a policy of introducing free-market competition into public sector spending, 'The Care in the Community' green paper recommended closure of long-stay mental hospitals. In 1989, Friern Barnet Hospital was sold to Comer Homes, a luxury property developer.

Roy Porter commented on the effects of asylum closures, 'controversy rages, within and beyond the profession, about the success (or failure) of deinstitutionalisation and community care, leading to calls (from both the profession and the public) to bring back the traditional asylum as a safe haven for the insane.' Andrew Scull describes community care that took place after closure of the asylums in Britain as a 'dismal and depressing experience.' His economic detail is bleak: '£300 million was spent on the mentally ill receiving institutional treatment, a mere £6.5 million was spent on 'care in the community.'"

The 1795 repeal of the Settlement Act meant responsibility of the mad moved from parish to private enterprise. Politically driven closure of mental hospitals, and 'care in the community' policy paralleled this. The failure of 'care in the community', especially for those with schizophrenia, who lack insight, and therefore have poor compliance with medication, led to so-called 'revolving door patients.'

CTOs were introduced to address non-compliance by patients with severe mental illness who are now largely treated in the community. If neoliberal administrations

had not closed asylums and sold so many to property developers, we would arguably not need CTOs.

Foucault argued it is better to have someone chained, than pretend they are free, yet under surveillance. He said of the power imbalance, 'the chains that hindered the exercise of his free will were removed, but only so he could be stripped of that will itself, which was transferred to and alienated in the doctors' will.'

Chapman was made subject to a CTO in 2009 after twenty-five admissions to hospital with psychosis. He described being stripped of his will under the conditions of the CTO, 'Instead of them being concerned out of care and compassion for the problem I was having, there was reason for them to be responsible and have authority over me. It was the mental health equivalent of having a tag. If I became unwell again or stopped taking my medication – like re-offending – I would have gone straight back into hospital.'

Solo-navigation Sailors

Foucault's *Madness and Civilisation* referred to 'Stultifera Navis', the Ship of Fools. Using this analogy

I suggest that compelling patients to treatment in the community smashes up their ship, replacing it with a flotilla of lone sailors. The collective identity of the asylum is lost and the mentally ill are left isolated. Patient support groups and the solidarity often found on inpatient units is jettisoned.

Patients liable to a CTO have some liberties in common with those of unchained asylum patients, including liberty of thought and liberty of discussion. Patients on CTOs are able to discuss their liberty at an appeal to the Mental Health Tribunal, although they are statistically unlikely to regain it. Given that CTO conditions include an identified address for patients, their liberty is arguably less than those unchained by Pinel and Tuke. Given the numbers of patients on CTOs who are compelled to have injectable antipsychotic treatment, neither are they free from the adverse effects of medication. Therefore, I conclude they have only the surface appearance of liberty. ■

Sabina Dosani is a consultant child and adolescent psychiatrist with lived experience of mental illness.



Image: 'Abstract brick wall obstructing freedom'. By dtvphoto.

Mad Pride or Prejudice?

Laetitia Levi responds to some recent articles in ASYLUM and challenges the merits of 'Mad Pride' politic.

Mad Pride was originally inspired by the 'Pride' of those whose acts have been granted deletion from the DSM bible of bad behaviour (i.e. homosexuality). But 'Mad Pride' just sounds oppositional, seeking the attention of those with the power to judge social ills and announce insanity. In effect, playing the fool, begging for credentials instead of owning them. Meanwhile, those expressions of human distress that are deemed outside the realms of social acceptance, remain penned in (this now includes many normal expressions of childhood).

Making political what can be approached physically, spiritually and socially, seems like handing the chains back to the jailers. Ironically claiming the name 'mad' could be considered as self-harm. I think this is similar to the way that the use of the word 'nigger' achieves no freedom when used to provoke reaction. Surely, we are at a stage now where we can transcend the definitions in the DSM, a sordid dictionary of suffering in which only the behaviours of the ones voting on it and compiling it, and their comrades, escape inclusion. If one of us ('us', being humanity) can lose our human rights when deemed unfit enough, all of us should care. All of us are capable of being traumatised, and all of us need be able to come to terms with that fact. Equally, all of us are capable of healing. So, to parade a self-imposed title of 'mad', though entertaining, isn't liberating when there really is no 'us' and 'them'.

A healer should be one who is themselves healed – implying they know, internally, of healing and the chasm that has been healed – and so they don't view themselves as superior, immune or 'other'. The 'healer' should be able to hold the wounded, without subjecting them to violent pain, without disorienting them further, without terrorising or silencing them with cold judgment and intimidation. They should be able to stand still with the un-healed, so that fear loses its potency. They should have no fear of the savage wreck for knowing that in themselves.

'Mad Pride' is an invitation for ridicule, not the destroying of false categories and the mending of safe boundaries. One who knows the nature of their wretchedness doesn't celebrate it, deny it or rebel against it. As for 'Mad resistance to pain' (ASYLUM 25.4, 2018: p5-6), how can we resist pain in ourselves and from whom do we seek permission to resist it? Seeking the 'right' to drown out pain in drugs or life-wrecking, frightening behaviour isn't progress or 'pride' at all, it's immature and dangerous. We live in a culture that uses substances over processes (e.g. seeking spiritual guidance, gaining

physical health, leaving harmful behaviours alone, developing psychological resilience, rites of passage, honouring survivors of trauma); relying on a passive fix rather than a lifetime of commitment.

I suggest that no-one marching proudly on the streets is being truly oppressed. We must remember those who are. Bob Sapey suggests in his article 'Challenging Psychiatric Coercion' (ASYLUM, 19:1 1991) that classifications of dangerousness could and should be extended to include those acts that are not listed in the DSM as of unsound mind. If so, perhaps we should bear in mind those whose trauma led them not to 'rock n roll', university degrees and Valium but to life sentences – institutional confinement, prison or hospital. I think that people who are knowledgeable about these matters need to be serving all with their knowledge, not squandering it on claiming the right to dope themselves as they see fit.

This is a matter of interest to all that possess humanity. We live in a society that currently chooses to ignore the recommendations of the report of the United Nations High Commissioner for Human Rights regarding mental health and human rights. We can't control that, but we can choose to live with dignity anyway. We live in a hierarchy that depends on its weakest, but we can make ourselves central to our lives, choose the way we live and how we treat others, and stop giving our power away. No to suicide and substance abuse, yes to setting an example to the children who are now increasingly subject to psychiatric coercion. Humans require rights and deserve healing. Don't wait for a professional to one day find the atom that started all trauma, and the corresponding chemical to paralyse it, or to re-distribute the imbalance of power in society. Instead use the power that is in our own hands and never give that up. ■



Mad Resistance to Pain?

Emily Cutler responds

Emily Cutler wrote the article 'Prescription Abolition and the Politics of Mad Pride' in the last issue of ASYLUM. So, we invited her to respond to Pride or Prejudice?

In my opinion, Mad Pride does not mean reifying diagnostic categories or reinforcing the binary between madness and sanity. Rather, Mad Pride is about acknowledging the universality and commonness of extreme states, suicidality, substance use, voices and visions, and other experiences pathologized by the DSM. Everyone experiences these phenomena to some extent, although some variations of these experiences are much more stigmatized than others. I think this needs to be acknowledged.

Mad Pride is about acknowledging the validity of these experiences and celebrating the “madness” – or reactions to madness – within all of us, and making the world a safer place for people to experience madness. I would also argue that Mad Pride has very little to do with appealing to psychiatric professionals; it is about building solidarity, community, and safety among all who want the freedom to experience these phenomena and cope with the painfulness of the world in whatever way they would like. Without fear of pathologisation, judgment or coercion.

I'd also like to question the categorization of substance use, suicidality, and other ways people choose

to cope with the painfulness of the world as “immature” or “dangerous.” Who decides which behaviours are dangerous and which are not? I personally feel that judging and shaming others for behaviours that don't hurt anyone else can be quite dangerous to their self-esteem and emotional well-being. We all want to feel valued; however, we live in a society that encourages us to relentlessly judge people based on their appearance, intelligence, wealth, and status.

I also feel that the capitalist system, which requires high degrees of labour and productivity for each person to receive basic healthcare, housing, and food, is quite dangerous, and increasingly so for those who are unable to meet these productivity requirements for whatever reason. Yet, the capitalist system and our relentless biases and judgments are usually not considered “dangerous”, while the ways people choose to react to and cope with these issues are seen this way. That seems victim-blaming and backwards to me.

I'm also very interested in the categorization of these coping mechanisms as “immature”. What is wrong with immaturity? If maturity means meeting capitalism's increasing demands for productivity and reacting to cruel judgments and biases in a way that maintains our productivity and does not make anyone feel too uncomfortable, maturity is not a goal I'd like to strive for. ■

STOP THE IMPLEMENTATION OF THE COMPULSIVE COMMUNITY TREATMENT IN THE GREEK MENTAL HEALTH SYSTEM

It is well known that, after about 30 years of a supposed psychiatric reform in Greece, there was not even the slightest step towards a Community based Mental Health System. The situation that prevails in Mental Health in Greece is a totally Hospital-based System, with repressive characteristics, with almost no community services and with involuntary admissions in mental health units to have reached about 65% of all admissions – always executed by police with handcuffs.

In face of this situation, the only answer, elaborated by the Ministry of Health, in preparation for its implementation, is the introduction, also in Greece, of 'Compulsive Community Treatment'. That is, after a

medical certificate by a psychiatrist and the order by the public prosecutor, the patient has to conform to this order ('Community Treatment Order' – CTO) for taking his/her medicines (basically in the monthly, or quarterly injection form), otherwise he/she be involuntarily hospitalized in a mental health unit (in a mental hospital or a general hospital).

It is a practice that establishes a further diffusion and, at the same time, hardening of the social control in the community. Towards a psychiatric practice that, instead of putting in priority and pursuing a real therapeutic relation with the patient, a real communication, interaction and negotiation on equal base with the

psychiatrist, it will follow, even more than now, a repressive approach by transferring the institutional practices in the community, in the place where the patient lives. With the person to experience therapy, the therapeutic relation, as a continuous coercion, as an eternal compulsion, with impending the threat of the consequences if he/she refuses this coercive drug therapy.

This is the official approach to the high percentage of involuntary hospitalizations, an approach aiming to decrease this percentage, but just as an image, since it does not put into question the system that produces them. At the same time it is well known that the declared aim, internationally, of 'Compulsive Community Treatment', (being the decrease of the involuntary hospitalizations and of the prevailing phenomenon of 'revolving door') was not achieved – the result was a complete failure. Although data suggest (where available) that compulsory treatment in the community, such as Community Treatment Orders, are largely ineffective in preventing re-admission to hospital and restrict patient autonomy they remain a rapidly expanding form of involuntary treatment in many countries (see 'Mapping and Understanding Exclusion: Institutional, coercive and community-based services and practices across Europe'. Project report. Mental Health Europe, Brussels, Belgium, 2018).

The only real answer to this huge number of involuntary hospitalizations is the promotion and development of a Comprehensive Community-based Mental Health System, with all the needed financing, properly stuffed (in numbers and training) and an alternative psychiatric 'practice and culture', radical alternative to institutionalization, inside and outside the mental health units.

Therefore, the meeting '40#180 DEMOCRACY AND COMMUNITY MENTAL HEALTHCARE. Participation, citizenship and reform processes in Italy and worldwide 40 years after law 180. Conference of collective subjects and organizations for change', with more than 500 delegates from 32 countries, organized with the



Image: 'Say no! to coercion'
By Tristano Ajmone

WHO and International Mental Health Collaborating Network (IMHCN); World Association Psychosocial Rehabilitation (WAPR); UNASAM; Fondazione Franca e Franco Basaglia; LegaCoopSociali FVG; Conferenza Permanente per la Salute Mentale nel Mondo 'Franco Basaglia' (CoPerSaMM); StopOpg; Forum Salute Mentale; Società Italiana Epidemiologia Psichiatrica (SIEP); Psichiatria Democratica (PD); European Community Mental Health Service providers network (EuCoMS); World Association for Psychosocial Rehabilitation (WAPR) Italia; World Federation for Mental Health (WFMH) supports the following statement and position:

'Compulsive Community Treatment' must not be implemented in Greece and nowhere. ■

Hidden Gems from Asylum's Back Catalogue

I recently had the welcome task of reading through every single back issue of *Asylum*¹. The first issue of the magazine was published in Spring 1986, so that's over 30 years of magazines. I came across many articles I thought deserved another reading, so I've decided to re-publish a few stand-out pieces from our back catalogue. I'd like to prioritise: articles written by lesser known authors, especially service users and survivors; articles that still seem relevant; and those that develop experiential knowledge (knowledge generated from experience). In this regard, I suggest that these articles prefigure what has become known as Mad Studies.

Readers may agree or not with my choices. If you can remember any *Asylum* articles you think we should re-publish then please let us know. We'll hopefully publish more in future issues.

The first article I've decided to include has a nice story around it.

A Chance Encounter

I was helping run an *Asylum* stall at a *Friends of East End Loonies (FEEL)* event at Kingsley Hall in East London last year. I started chatting to the people around the *Speak*

1. This project was facilitated by a small research bursary from the Wellcome Trust. The Wellcome Library in London has a full back catalogue of *Asylum* in its collection

Out Against Psychiatry stall which was next to ours. I vaguely recognised one chap on the stall who turned out to be Donnard White. I hadn't seen Donnard in well over 20 years. Describing himself as a 'service evader' (rather than a service user) Donnard had been involved in *Asylum* in the early days. I remembered he had fallen out with Alec Jenner (one of our founders) and *Asylum*, but we chatted and reminisced amicably. I told him I was reading all the early issues of the magazine and was considering publishing a 'Best of Asylum' collection. He asked what articles I'd include. I said I'd just read a great article that I'd love to include, but because it was written anonymously it'd be difficult to get the author's permission to re-publish it. "What was it about?" he asked. When I said it was called "*What to do if a friend goes mad*" Donnard looked rather shocked, and I worried I'd put my foot in it. However, rather fortuitously, it turned out Donnard himself was the author. He explained why he'd written it anonymously and agreed we could re-publish it, this time with his name.

I think the article is still very relevant today. In particular, it's a nice antidote to the often patronising 'anti-stigma' campaigns & 'let's just talk' advice that tends to be circulated today. These rarely deal with the practicalities of supporting people in extreme states without recourse to dominant psychiatric frameworks. ■

Helen Spandler

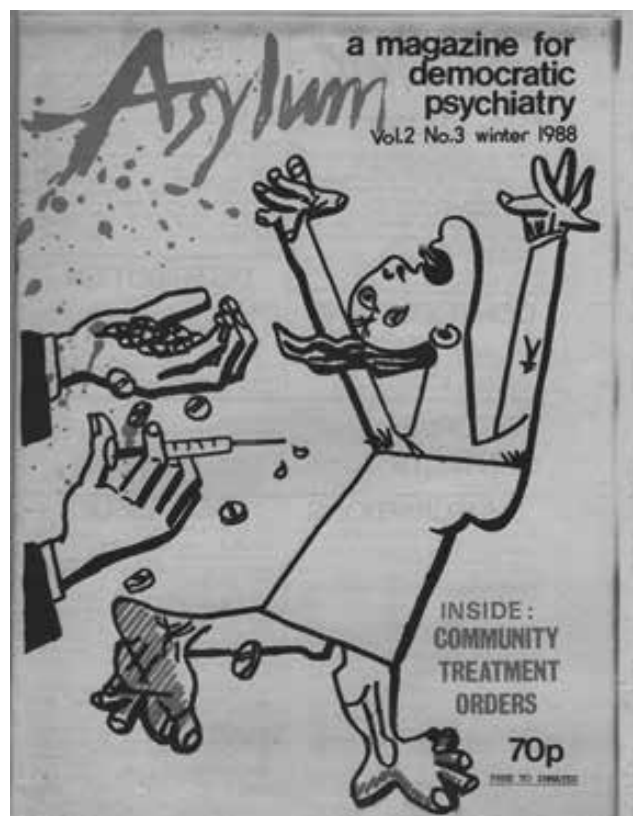
What to do if a friend goes mad

DONNARD WHITE

Note: This article was published anonymously in Asylum 2.3 (1987). It has been lightly edited and cut down to fit our current submission policy.

This is an attempt to give some practical advice on a problem most people don't have much experience of but is becoming increasingly common amongst those on the margins of society. Most people realise that carting someone off to the thought police in the loony bin is, if anything, worse than handing them over to the real police – but it's very difficult to think of an alternative when faced with an extremely exhausting and terrifying situation.

What is madness? Well, we're all, and that certainly includes me, pretty fucked up, and we live in a society where there is a great deal of oppression – that is we don't have real control over our lives a lot of the time. We have to conform to what those at the top of the hierarchy think we should do, whether at work or in other relationships. That is what is known as alienation. However, people aren't really free to talk about this as it affects them directly in their actual relationships at work



and elsewhere. Imagine trying to talk openly about who makes decisions at work – you would be got rid of first.

No, a lot of people's feelings about their lives are kept suppressed, and only come out in madness, in strikes, or riots. What represses this, the language of those on top, is ideology; in other words, lies which serve to disguise reality. People who try to express themselves too openly about what they feel are likely to experience hostility and rejection and, if they push it too far, actual violence. Anyway, the more people try to open up about their feelings, the more fear they cause in other people, and in themselves. That increasing fear, paranoia, sense of being a lonely spirit in a hostile world, leads to the extreme perceptions of reality and desperation known as madness.

The kind of threatening ideas that mad people have about the world are very rational, in fact often a much more rational assessment of their increasingly extreme position in the community than those which most of us consider normal. That does not mean that these ideas are necessarily correct, but the fact that they are a much deeper and frightening insight into life than we are used to is very threatening. As the 'mad' person, and those around him or her who are frightened of catching this madness grow more terrified, violence breaks out, with the mad person afraid of what the others will do to him or her, and seeing them in extreme terms. There is a lot of punching and kicking and smashing objects, and sometimes the thoughts of the mad person are so speeded up that their whole command of language and ability to form coherent sentences, or string sentences together, breaks down completely, which is terrifying for them.

Fear multiplies as people get less sleep, and it is at this stage that people, despite their moral scruples, feel they can't cope and hand the person over to the authorities. So what can be done about this situation? The first thing that needs to be pointed out is that nothing should be done without consulting the mad person concerned, and they have total authority in every decision. That doesn't prevent you pointing out the situation and making suggestions to which they can say no. This can be frustrating, but is very important to them in restoring to them the power of their personal autonomy, which has probably been threatened or invalidated in some way, making them go mad in the first place.

Firstly, the situation needs to be faced as a problem that needs organised action. The more people involved, the better. A small number of people are much more likely to suffer from fear or exhaustion, a large number of people, acting supportively as a community, has the resources to cope. If the person's madness has arisen out of the relationships with the people he or she is living with, he or she may feel safer if he or she goes to stay in a safe house somewhere else, where they have the space to see who they want or be alone. Madness is often due to a lack of safe space.

In the past I have organised a rota of people to be with the person at all times, but it occurs to me that I have never asked them if they wanted to see those people or be alone. In situations of emergency it is often very difficult to communicate with someone who is mad and you end up taking decision for them, which is bad but sometimes unavoidable. You should ask their permission first, though. Anyway, in this situation the people concerned need a lot of support themselves, both emotionally and physically, with good food and money. It's important to make sure that everyone eats well.

In dealing with the person it is very important to constantly reassure them that they are safe and that no-one is going to harm them, or do anything against their will. Madness is basically about fear, and when people realise they're safe and cared about, they will quite quickly calm down again but this may take a month or more. Never use violence against someone who is obviously being violent because they're terrified. You can restrain someone by holding them down until they calm down.

It's very important to be honest with someone who is mad about what you think and feel, especially if you feel scared or threatened by them. Probably a lot of the reason they went mad was because people were emotionally dishonest to them. Ultimately, if people are given enough love and care, and someone to talk to, however frightening it all is, it will eventually come right. It is also a good idea to go off to the country as it's much more peaceful and everybody can let go without fear of the police.

Ultimately, if you can't cope or communicate with them, you can at least take care of them physically, by feeding them for a couple of weeks, and put them in a bare, soft room. Try smiling. It works wonders. So does giving someone a cuddle. Even if you don't understand at all where a person is at, if you just patiently sit with them over a period of time and listen, you will eventually piece together some kind of meaning. But it takes patience and experience to know how to cope with these ideas and talk someone through. But you only learn by trying – it's just life experience, there's no special theory to learn.

The kind of reality that someone is in when they've gone mad is very distant from that of normality but it is rational and what you have to do is try to understand that rationality in its own terms and try to build a bridge between it and your own. It's important to realise that a mad person's way of perceiving and describing the world is just as valid as your own, but the way they have used language to describe reality has become more and more complex and metaphorical as they have felt what they are saying is invalidated by others. It's important not to invalidate their reality in any way – that is liable to make them feel worse because they feel they can't communicate with others – but to restore communication by more or less agreeing with what they are saying.



Photograph by Jill Anderson

However, the problem is not that their version of reality is different from yours, the problem is that they are afraid that they will be harmed or rejected as a result of their unusual perceptions and you have to reassure them that you accept them. You have to expand their reality and your own and explore what people mean by statements like “I am God” and how they came to that conclusion. I mean there’s no problem in someone being God if they’re happy with it and it doesn’t hurt anyone else – however, in fact it’s probably going to be expressive of a lot of unhappiness that they want to share with someone else. You have to go mad with them for a bit to help them make sense of their lives and come back down to earth. It will be a very different earth though for both of you.

If someone has been carted off to the mental hospital, the more people who go to visit them the better, especially because the authorities are much more prepared to let someone go if they know there are people who will take care of the person and who will cause them trouble if they don’t let them go. I know of a woman who was kidnapped (not against her will, against that of the authorities) by about 50 of her friends and who is now, 2 years later, completely OK – but obviously that needs good preparation. Don’t take any bullshit from psychiatrists or nurses although play them along if you think they might let the person go. Get the person to sign forms saying

that they don’t want Electro Convulsive Therapy (ECT) and heavy tranquilisers, and make sure the psychiatrist gets copies and knows you will take them to court if they force them on your friend, let alone any other harm that might come to them.

If someone is on tranquillisers, try to persuade them to come off, because otherwise they’ll just be a vegetable for the rest of their life, but warn them that they will probably go mad again sooner or later because they haven’t sorted out the original problem. They’ll be very scared and disorientated for a few days when they’re coming off.

So that’s it. Madness is basically about terror, the terror of not being accepted or exposed to violence because your ideas are different and other people find them emotionally difficult. It is the terror of doing non-alienated ‘philosophy’, philosophy in direct relation to reality, instead of what passes as philosophy in our universities. Which is why to academic philosophers, with the exception of Foucault, madness is a taboo subject. The best therapy on this ‘North Face of the Truth’ is the love and care of one’s friends – though usually when people go mad it’s because people are being false to them in some way and are trying to deny it by calling them mentally ill. The best way to help someone who has gone mad is to face your own terror and be honest about your feelings.

Worth reading is ‘I didn’t need to go mad here’ by Joseph Berke (very practical), ‘The Four Gated City’ and ‘Briefing for a descent into Hell’, both by Doris Lessing (two novels on madness) and ‘The Politics of Experience’ by R.D. Laing).

Postscript

It is very kind of *Asylum* to reprint this old article of mine. It was a distillation of various episodes in my life when I’ve interacted with people up against it in a lonely struggle for truth. It’s interesting to compare this with something which is big on the scene these days: Open Dialogue – which might sound like much the same thing. But I dislike very much the professionalisation involved with Open Dialogue: they are offering 3-year courses with certificates – aiming at professionalisation and costing a lot of money (it doesn’t say how much on their website). I have to say that having done this stuff for real – and screwed up and made mistakes, which is part of it – I am extremely sceptical about it. The thrust of my article is actually anti-professionalisation – that basically we were a bunch of squatters and mental health users without much of a clue. I’m sure some of what is taught on an Open Dialogue course is valuable, but I’m not sure that the people who devised it know any more about mental health than you or me – but actually the message is that anyone can do this stuff. I wonder how open to the politics of madness these professionals are. ■

Shitfulness

/ʃɪt(fʊ)lnəs/


- ① the quality or state of being conscious or aware of something. ~~how full of shit one is at every single moment~~
"their mindfulness of the wider cinematic tradition"
" "shitfulness was showing"
- ② a mental state achieved by focusing one's awareness on ~~the~~ ^(or not) ~~how~~ ^{acceptance} present moment, while calmly acknowledging and accepting one's ~~shit everything is~~ feelings, thoughts, and bodily sensations, used as a therapeutic ~~shit, shitty status and absolute shit~~ technique.

Why shitfulness?!

"Shitfulness is like mindfulness, only shitty."

When positive thinking just doesn't cut it anymore, maybe it's time to embrace shitfulness.

Shitfulness is about not even trying to fight how shit things are, because you are so immersed in feeling shit that little rays of sunshine cannot even exist for you.

oh fuck off sun, will you?? 

WHAT SHITFULNESS IS NOT

Shitfulness isn't about giving up forever. It's about giving up for today. Maybe tomorrow also. Heck, relish in the sad for a fucking week if you must.

& once you've relished enough,

You fucking come back.
(because you have to. & you always do.)

Shitfulness is about ...

- giving yourself permission to feel like shit.
- knowing it's OKAY to feel shitty.

I've found it more helpful to sit with the shit for a while, rather than constantly trying to fight it. When I try to stop feeling shit arbitrarily, I actually feel worse. But when I accept that I'm feeling shit, I allow my feelings to happen, and I can take steps to soften them and to be kind to myself.

HOW TO PRACTICE SHITFULNESS ?

- ① Sit. Or don't sit. Maybe lie down. In a bed. Or your couch. There there. Maybe you're in the dark. That's okay.
- ② Focus on No actually don't focus on anything specific. Everything is shit. Whichever bit you look at: IT'S SHIT.
- ③ Breathe in and out. Embrace just how FUCKED everything feels.

GR8. YOU ARE NOW CONSCIOUSLY SHITFUL. WOOHOO !!

4

What MAKES shitfulness okay ?

Sometimes we just want to wallow, or need to wallow.

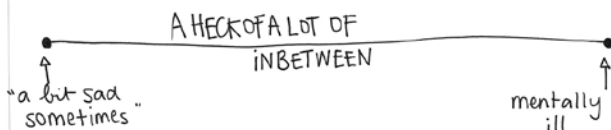
Sometimes we just need to embrace things as hopeless so we can say:
I'LL TRY AGAIN TOMORROW

Shitfulness is temporary.

Embracing shitfulness is embracing a temporary feeling of full frontal shit, & labelling it to make it less scary.

5

DON'T YOU GET STUCK IN THE SHITFUL STATE



Wherever you fall on this line, shitfulness is not somewhere to STAY. It's a REST STOP. It's somewhere you can feel safe for a bit. You don't have to perform in shitfulness.

But shitfulness is different from depression or from feeling sad.

To try not to stay stuck in shitfulness, I:

- tell my friends. we laugh about it.
- tell myself, if I can't talk to friends. and I still laugh about it.
- practice shitfulness regularly.

IF YOU START FEELING STUCK IN SHITFULNESS, PLEASE TRY & ASK FOR HELP. IT'S HARD. BUT SHITFULNESS IS NO PLACE TO LIVE.

6

By Rin Flumberdank.
"Shitfulness" was first printed
as a zine in May 2017.
See <https://nooneaskedyoubrian.tumblr.com>

Survivors History:

Looking back and learning with Frank Bangay



Photograph by Nathalie Fonnesu

As part of an on-going project to honour the contribution of key figures in the psychiatric survivor movement, ANDREW ROBERTS, Secretary of the Survivors History Group, talks about the survivor activist and poet, Frank Bangay.

In May 2018 Frank Bangay addressed the memorial meeting for Philip Morgan (1965-2017), a fellow member of the *Survivors History Group*. Philip's historical theme was that we need to look back and recover our past if we are to fly forward. Frank commented that he did not know Philip very well "but wanted to learn more". He then recited some of his poems.

Much of Frank's poetry is about looking back and learning. In August 1996 he wrote "And We Can Learn", reflecting on growing up in a working class area of London during the 1960s and looking at what was going on around him. It is a poem about prejudices or stereotypes we learn to accept, but also about how we learn to move beyond them and know people as people. The poem and

a historical footnote were published in "*Naked Songs and Rhythms of Hope. An Illustrated Collection of Poems from 1974 to 1999*", which was published by Spare Change Books in 1999.

AND WE CAN LEARN

Children playing in the street
On the common
On the bomb site
Cowboys beating Indians with cap guns
Reading war comics
And the Brits always won.
But there was always one of us
Who never fitted in quite right
At an early age we learnt how to stereotype.

“Come in at once; your dinner’s getting cold.
Your father’s got something to say to you.
He’s going to teach you a lesson or two.”

“But we are not like those people
Who live down the balcony
You can hear their father shouting, oh so loudly,
As he beat his children
And they started screaming.”
Roger the Dodger sometimes seemed wise
With his philosophy on how to shirk and skive
But his father had a big moustache
A slipper in his hand
And his shirt sleeves rolled up.
No matter how he tried
There was one situation Roger couldn’t get out of.

The early 1960s
A new council flat
More room here to swing the cat
A bath with water running hot and cold
It will be a few years
Before the cracks start to show.

And though we came
Up from being poor
We harboured fears of black people
And considered ourselves unlike those people
On the other side of the wall
The mental people is what they’re called.

The mental people
The mental people,
I became one of them.

In a historical footnote to “And we can learn”, Frank wrote:

“This poem looks at the prejudices we learnt to accept. Many white adults of that period, having suffered through the Second World War, held the misguided view that they built this country up, so that people from the Caribbean could come over and take all the job opportunities (a view exploited by the racist parties), when in fact Commonwealth people were encouraged to come over by politicians like Enoch Powell, and used as cheap labour, as were Irish immigrants in the 18th

Century. Some people from the Commonwealth fought for Britain in the Second World War, a not very well-known fact.

“These prejudices were very evident at the Secondary Modern School I went to and the environment I lived in. On leaving school at the age of 15, I found this prejudice very evident at the Labour Exchange, where black people were discriminated against in work opportunities (crap as the work might be). At the same time, I faced a lot of contradictions because, despite a brief period in 1969 of being taken in by the snobbery of Progressive Rock (a lot of it soon became pompous), I liked the black music of that time, including the Ska/Reggae that came from Jamaica. At the same time I held the prejudice/fear that a lot of people had towards the Caribbean families who were moving into the area that I lived in In my early twenties, through looking for work I took on employment in the Health Service as a Hospital Porter, then as a Hospital Orderly. Here I worked alongside people from the Caribbean and got to understand how hard these people worked, thereby getting away from the myth I grew up with, that these people were lazy and scrounging off the Welfare State.

During this period, I also experienced depression and started taking tranquillizers, which later led on to a dependance on anti-depressants and seeing psychiatrists on a regular basis. This later led to a breakdown and hospitalisation. Through this I learnt what it was like to be prejudiced against and stigmatised. I started to meet more black people and while I don’t want to be idealistic, I started to see things differently.”

Frank has published his diverse perceptions in many forms including pictures, poems, prose and music in books, leaflets, blogs and CDs. “*Songs, Poems and Prayers*”, a CD with many childhood memories, appeared in the summer of 2009. This year (January 2019) Frank published “*The Adventures of Jack Frost*”, a colourful picture book drawing on the poems on the CD and relating his father’s gardens to today’s concerns about climate change.

For half a century Frank has been one of the most creative talents on the survivors’ scene. His work is well known to people who attend *Mad Pride*, *Friends of East End Loonies* (<http://friends-of-east-end-loonies.blogspot.com>) or similar events or who read *Poetry Express* (<http://www.thefed.btck.co.uk/Publications/SurvivorsPoetry>). Others may find it more difficult to find. The *Survivors History Group* is creating an archive of Frank’s work, some of which is listed at <http://studymore.org.uk/7.htm#Bangay> The list will continue to be updated and we recommend using it to find out how to share in Frank’s cultural legacy. ■

Creative Writing

To...who...

To the Policemen who handcuffed me, beat me and imprisoned me.
To the Policemen who listened to my story and promised to learn.

To the Nurses who held me down, injected me, restrained me, scarred me, broke more the broken.
To the Nurses who held my hands, held my tears as my trauma poured out on their big shoulders, loving and powerless in a broken system.

To the Psychiatrist who diagnosed me...
White, Female, Eloquent, Educated, can pass for Middle Class?
Bipolar!
Medicate as appropriate....
Lorazepam...Haloperidol...Olanzapine... Valporate....
Weight Gain, Tremors, Hair Loss, Nightmares:
Addicted.
Withdrawal. Hospital. Withdrawal. Hospital. Withdrawal. Hospital. Withdrawal...Hospital.
Failed, Shamed. Again and Again.

To the Recovery College who gave me Hope.
To the Recovery College who gave me Hypocrisy.

To the Peer Support Workers offering solidarity, support and care.
To the Peer Support Workers holding back tears, restraining others, retraumatized, asking is this what we signed up for?
Is this the dream?
I had a dream...

To the Activist who taught me Creative Maladjustment.
To the Activist who taught me that Righteous Anger can only take you so far.
To the Professor who told me my unsafe hands were only good for moving chairs not research.
To the Professor who gave me a job.

To the Researchers who patronized me; my story survivor porn; failed co-production; co-opted and tossed aside.
To the Researcher who held me on the stairs and promised together we will find a better way; a better system;
a better world.

To...who....
To...who....
To...who....

Who are you and what do you do?
What masks and roles do you choose?

How do they feel?

And what would you like to do?

Psychiatric cruelty. Psychiatric kindness.
Cruelty informing kindness.
I forgive you. I thank you.
For me. For you.

To the Recovered, the UnRecovered, the Awakened, the Traumatized, the Angry, Guilty, Shamed.
Who walk in my mind and my heart.

I have been all and none, with and without.
Lost in darkness and overcome by light.
Alone.

Battle.
Us and Them.

Compassionate Activism.
Us and Them.
United.

Bio: Dr Caroline Fox is a researcher at the University of Nottingham, she is a survivor, an activist, a reflector and an artist. She is one of many "Recovery Ninjas" battling in the shadows and in the light to reclaim the grassroots values of recovery and peer support in sometimes hostile and toxic environments.



Photograph by Bob Sapey

Reaching Out For The Intangible: Victim Of Love

I suspect you know
to grasp the nettle by the neck
Standing on a shore, when the sea's out
Struggling and bleeding on my cross,
Jumping through your hoops sideways on,
In pursuit of the unanswerable question,
The reading of a page-less book.
When will people like you learn?
My best interests are unknown.
It's not me you're helping.
But I was wronged by a heart
protests, he crossed the line of deceit
the affair, as I began my penance
inconsolable, incarceration.

an end to ideas above my station.

how hard it is for me,
when the nettle is out of reach.
and never returning to scenes of yesteryear.
made inglorious by my own doing
twisted by your design.
or filling a bottomless vessel.
A faceless clock, just a wooden block.
Your best interests are not mine.
So when you say you're helping,
I'm not you. You are not me.
I thought was true. Despite my
with his married name. There ended
for his shame. Each day I languish
This mill girl lost to his game, put

Mark Schwalbe

The Ocean's Song

I once was the sound of ululating waves,
An eternal but transient stream,
That through the crash of waves on rock and shore,
Being rubbed to dust by the rhythm of the tides,
Making music like an undulating song,
The sun falling,
Gold transformed to the ocean's green,
Until all perishes and becomes extinguished,
Let slip the mooring.

Ben Gray

Dr Ben Gray is a voice hearer, academic and researcher who has published several poems. He is diagnosed (or rather labelled) with schizophrenia and depression. Ben lives in Wivenhoe, a small coastal town that was once a fishing village and thriving port, but is now better known for its community of artists, writers and academics. The Ocean's Song is about death and rebirth, following the bereavement of his step-father, Mark. It is also about letting go of the pain of mental illness, moving on and recovering.

POEMS

by Henry Bladon

I stand on **THE HILL** and scream at the clouds.
I watch the balloons rise in August.
I can see the bridge - its lights are pretty at night.
Sometimes I just feel lonely.

Hollow

Hollow knee
Hollow cheek
Hollow brain
Hollow week

Colours

When the world is blue you have to look for other colours

Recovery

I swallow the shadow of my past
And whistle through the cloud
The windy aisle of
Broken memory
Is a fading tempest
Consigned to the pages of another tale

The Tree

You walk to the tree, where we used to be
Together in life, entwined and alive.
The carved names acted as a call to hearts
In summer skies and winter winds.
Now, I have the distant feel of your fingers.
The warmth of your lips.

What's the difference between a wolf in sheep's clothing and a snake in the grass?



*In the context of large mental health organisations making claims about 'co-production', **ROY CURTIS** suggests the reality is somewhat at odds with the rhetoric.*

There is a big event about co-production in mental health services coming up soon. It's been organised by a national strategic body for workforce development and the local mental health hotshots in my town (let's call them Organisation F) are making a presentation.

About a year ago I made a commitment to challenge people and organisations who talk about co-production when what they really mean is low level, tokenistic, user consultation. So I'm duty bound to pass judgement on Organisation F.

The core aim of co-production is to develop more equal relationships between people who use services and service providers and professionals. Organisation

F is in no position to support this aim, as it's basically an offshoot of the local mental health Trust. Although the Care Quality Commission (CQC) has rated the Trust as requiring improvement, Organisation F says and does nothing to criticise it. You wouldn't think the Trust was rated amongst the bottom 20% of service providers in the country to look at Organisation F's website. It presents a rosy picture of recovery-oriented services providing all the support that local service users could ever want or aspire to.

This mealy-mouthed support of the establishment status quo is not surprising when you consider that the chair of the Organisation F board is a former Executive Director at the Trust and that the other main decision-maker is a university academic, who has enriched himself through arbitrary appointments as a consultant on numerous Trust supported projects. They like to stress

their credentials as a person with 'lived experience' of mental health problems with a radical new vision for mental health. However, there is little evidence of any involvement with the many independent user and survivor-controlled organisations that have operated in my town during the past 25 years. Her 'radical vision' reads like a watered-down version of selected ideas generated by user/survivor organisations in the mid-1990s. She might be a person with lived experience, but she operates as an establishment endorsed mental health professional.

The core principles of co-production are accessibility, diversity, equality and reciprocity (or getting something back for putting something in). So, how does Organisation F rate in relation to these principles?

Accessibility: Organisation F presents itself as a community owned resource. Community ownership extends to allowing select individuals to share their 'constructive and respectful' stories on the organisation's website, or to apply for a volunteer position as a 'creative content producer' or 'digital ambassador'.

Diversity: Organisation F has prospered due to alliances with establishment authorities, primarily the local mental health Trust and council. As Organisation F has secured support from these and other grant makers (through reflecting their values), user-led organisations have suffered or disappeared, because their access to funding has been denied. Organisation F is a key element and beneficiary of the parochial and paternalistic monoculture that dominates mental health provision in my town (any town?) today.

Equality: From time to time, Organisation F holds meetings, collects the ideas of people with lived experience (an image of vampires flashes through my mind), and goes away and thinks about how it might monetise them. It then looks for funding and delivers what it can in accordance with its self-promoting ethos.

Reciprocity: People with lived experience are not paid for their contributions to Organisation F. Some individuals who have become involved with the organisation have had their ideas taken over by their host and then been cast aside, due to their lack of 'professionalism', in favour of other people who will not rock the boat. Generally speaking, people with lived experience of mental health problems do not benefit from their association with Organisation F, save as passive recipients of its condescending self-regard, or as unpaid content providers to an online resource that is so unchallenging, sickly and sentimental that it's not really worth engaging with.

Organisation F represents (default) style over substance. It is best understood as the Amazon of mental health in my town; as it prospers, so other groups go to the wall. The main differences between Organisation F and Amazon are that there is far less on offer from Organisation F and it can't deliver what it promises.

I don't think that's the message that will be relayed to the people at that vacuous shindig next week... ■

Note: any similarity between Organisation F and other organisations living or undead is purely coincidental. Roy Curtis is a pseudonym



LIFE AT THE COAL FACE:

AN INSIDER'S ACCOUNT OF WORKING IN MODERN MENTAL HEALTH SERVICES

NINA BRADSHAW



Image: 'Broken Trust'
By Lane Erickson

I worked in a Home Treatment team for almost 2 years. I took the job reluctantly, after deciding to give the NHS another chance. I had previously worked for the NHS in various roles for 12 years. Most recently I worked for a team that provided support for people diagnosed with Personality Disorder (PD). The service ran a therapeutic community (TC) and the team was basically run along TC lines – with a flattened hierarchy; regular team support (weekly supervision); collaboratively working alongside the service users; and with a relatively high-risk threshold. This meant we tried to work with people and their distress, recognising that the way of expressing their distress might sometimes mean taking massive overdoses or putting themselves at risk in other ways, and trying to contain people and help them find ways to express their pain rather than act on it. But in a patient way. We tried not to coerce people into stopping their risk taking through such measures as, for instance, enforced treatment. It didn't always go as planned – how could it? There was one time I was so worried about a service user that I thought a long-stay, properly funded,

therapeutic in-patient stay would be preferable. But overall, team support was in place so that practitioners felt supported in what they were doing, not constantly under threat of punishment if a service user 'went too far'.

This service also had two 'add-ons' – diagnosing and treating Adult ADHD and Autistic Spectrum Conditions (ASC). These were things the commissioners wanted, and they were in the National Institute of Clinical Excellence (NICE) guidelines. However, these elements were not seen to fit anywhere else, so were tacked-on to a specialist team for clients diagnosed with PD. Over the course of the service, the commissioners began to realise that adult ADHD and ASC services were lucrative and wanted to 'sell' them to other local NHS trusts. The PD part of the service was closed and me and my colleagues were asked to take on assessment and diagnosis of ASC (no treatment or support, just assessment and diagnosis) and some supportive work with the more troubled ADHD clients (the main 'treatment' for ADHD being stimulant medication, of course).

I left this job as I had taken the job originally because I had a particular interest in working with people diagnosed with Personality Disorder. I felt quite disillusioned with the NHS at this point, so returning 2 years later was a big step for me. I wanted to train in psychotherapy and needed a decent income to fund this. I had worked for the voluntary sector for a short while in the interim, but funding and wages in that sector is fairly grim.

In the Home Treatment team, the picture was very different from the TC job. We were inundated with patients presenting in crisis who were highly distressed and highly risky. Colleagues were terrified of 'ending up in coroner's court' or losing their 'PIN'¹ (these were daily comments). The service was supposed to have a maximum caseload of 60. Yet it wasn't uncommon for there to be twice that number 'on the boards' (written up case-loads on whiteboards). When I arrived, I asked about supervision. It turned out most of my colleagues didn't have any, whether case management or clinical. My colleagues were so burnt-out they thought this was acceptable. In fact, supervision was seen as a luxury. When I did find my own supervision, I had to sneak out of the office to take the time to discuss the distressed and distressing people I was working with.

We had no way of keeping our caseloads down. Senior management often coerced us into taking on more clients. The result was a team rife with splits, paranoia and we felt totally un-contained. The anger was taken out on each other with in-fighting, and on the clients with excessive use of labelling, over reliance on medication, and the over-anxious use of coercive measures. One client I went to see told me that a colleague had said to her 'Don't kill yourself or I'll lose my pin'. The police were used regularly to 'chase' people who had not been seen for a few days. For instance, if someone rang in distress saying they felt like killing themselves, the most common response was not to talk to them – to find out why they were feeling like that – but to call the police to get them to check up on them. This was a complete waste of resources and further alienated clients who were already in a lot of distress.

The whole atmosphere of the place was high-octane anxiety and paranoia. There was no time or space for thinking. When I tried to flag these issues up with my manager, I was seen as a trouble maker, or 'too sensitive'. NHS machismo was winning the day. It impacted on me to such an extent that I felt suicidal at times. I was also working through my own stuff in

therapy, having had a history of depression, and it is a requirement of my psychotherapy training, but the distress I was carrying as a result of working in the team massively amplified my own stuff. Another colleague did attempt to end their life. Again, this was due to a mix of personal issues and work stress, but no support was put in place for colleagues even after major incidents like this. When a patient ended their life, the team became even more defensive and risk averse, convinced that punishment was imminent.

The final straw was when the team was forced to undergo major changes, to come in-line with standards from another NHS trust that had taken over running the service. These changes had far-reaching implications. There had been a 'consultation' exercise for a few months but myself and most of my colleagues did not feel we had time to attend, as we were so snowed-under with the day-to-day work. Besides, the consultation was really only lip-service as the changes were pushed through anyway. In the space of a month, almost everything about how the team operated changed. The process was managed so poorly. In fact, I would say it wasn't really 'managed' at all.

One of the major changes in staff contacts meant going from working days and evenings to working nights. If I had wanted to 'opt-out' of this contractual breach (on behalf of the trust), I would have had to go through Occupational Health to mark myself out as 'ill' – the implication being that if you can't cope with such massive changes, there must be something wrong with you. In addition, the 'qualified' team members would now be mainly carrying out assessment work – to gate-keep the service, or access to a hospital bed – rationing in other words. The minimal case-work with clients was relegated to a sideline, or largely carried out by support staff. It was not much of a service at all really. So I left, even though I didn't have another job to go to. I felt there must be a better way to do this.

Writing this now, I had not realised how caught up I was in the overwhelming sense of despair and hopelessness. It felt like it must be something I was doing (or not doing) that caused me to find the work so difficult. I also feel extremely angry. The patients were treated like shit, and the staff equally so. I am a skilled and experienced mental health worker, and I left feeling inadequate, ill-used and that there must be something wrong with me. Writing this has been cathartic, to some extent, as I am able to see how mentally warped this service was, and sadly still is.

It makes me so angry, sad and frustrated that so-called mental health services can disregard the needs of its workers so massively. What does this say about the way the service users are thought of or treated? ■

1. A PIN is a nursing registration number. The threat was that staff could be de-registered from the Nursing the Midwifery Council (NMC) and thus 'lose their PIN'. It was a very medical team. Social workers don't have PIN numbers, but there were far more nurses in the team.

NEWS & REPORTS

PIP DISCRIMINATES AGAINST MENTAL HEALTH CLAIMANTS

New research in the UK shows discrimination against benefit claimants with mental health conditions. The research analysed government data on 327,000 people with either physical or mental health conditions switching from disability living allowance (DLA) to personal independence payments (PIP) between April 2013 and October 2016. 32% of those with a mental health condition had their disability benefit taken away; this was double the 16.4% of those with diabetes or a neurological or musculoskeletal condition. The authors highlight concerns that few PIP assessors are trained in mental health.

Campbell, D (2019) Mentally ill people more at risk of losing benefits, study shows. *The Guardian* 22 Jan

MENTAL HEALTH WORSENS AMONG THE YOUNG

The biggest UK study of young people's mental health for 13 years revealed that mental ill health is on the rise among young people. Overall, in 2017, one-in-eight of those aged 11–19 and 5.5% of children aged 2–4 were found to be diagnosed with some kind of mental health condition. Distress appears to be particularly common in late-teenage girls. A fifth of girls aged 17–19 had self-harmed or attempted suicide. Almost one in four girls of that age was diagnosed with a mental health condition, mostly anxiety or depression. Figures for boys aged 17–19 showed one in 10 boys had self-harmed or tried to kill themselves.

Jemima Olchawski, of Agenda (campaigning for girls and women at risk), said "The sexualisation of girls, pressures they face around sex, and particularly the alarming levels of sexual and other forms of violence they experience, must be a key part of the conversation." Sue Rogers, of Action for Children, commented: "Some very young children are struggling with sleep disturbance, behaviour issues, excess crying and eating difficulties. Due to central government cuts, vital services such as children's centres, health visitors and family support services have been reduced, cutting off an important lifeline to families who need to seek early help for their pre-school children's mental health."

London was found to have the lowest rates of mental ill health among young people, whereas the East of England the highest. The highest incidence of mental ill health was observed among white British children, whereas the lowest incidence among Asian/Asian British young people. A markedly higher incidence of mental ill health

was observed among young people who identified as non-heterosexual, compared to those who identified as heterosexual.

Campbell, D (2018) Fifth of 17 to 19-year-old girls self-harm or attempt suicide. *The Guardian* 22 Nov.

HIGH LEVELS OF MENTAL DISTRESS AMONG LGB YOUNG PEOPLE

A study, carried out with young people in and around Bristol, found that young lesbian, gay and bisexual (LGB) people start getting depressed and self-harming from the age of 10. 34.9% of 14–19 year olds identifying as lesbian, gay, bisexual or with another sexual identity were found to have been diagnosed with a mental health condition, compared with 13.2% of those identifying as heterosexual. LGB 16–21 year-olds are four times more likely to feel depressed, harm themselves and think about suicide. The researchers believe that feelings of being different from heterosexual peers lead to self-harm and other mental health difficulties in LGB young people, and that the higher risks are linked to the discrimination, stigmatisation, bullying, abuse, as well as the feelings of loneliness, social isolation, shame or fear of rejection some young people experience due to their sexuality at home or at school. These results should prompt health professionals to consider the sexuality of the young people they try to help overcome depression or self-harm.

Campbell, D (2018) Study finds high levels of depression among LGB teenagers. *The Guardian* 12 Dec.

MENTAL HEALTH SERVICES FAIL UNDER-18s

In a survey with a random sample of 1000 family doctors across the UK, 99% of the GPs said they feared under-18s coming to harm as a direct result of the long delays to see specialists and of the rationing of vital care. Only 10% said health and social care services for young people with anxiety, depression, eating disorders and other conditions were "adequate" or "good", while 90% said they were either "extremely inadequate" or "very inadequate". Many of the GPs said that the NHS child and adolescent mental health services (CAMHs) could not respond adequately to the recent sharp increase in demand for care. CAMHs providers were "overwhelmed", delays could be as long as 18 months, and many young people were denied treatment and had to be potentially suicidal in order to be seen.

Campbell, D (2018) Lack of NHS mental health services puts under-18s at risk, say GPs. *The Observer* Dec 30.

MUCH HIGHER RISK OF SUICIDE FROM ABUSE IN CHILDHOOD

A study, the biggest of its kind, showed that those suffering sexual abuse in childhood are three times more likely than others to try to kill themselves, while the risk for those neglected or abused physically or emotionally were two and a half times as great. One-in-three adults were found to have been abused during childhood. The research analysed 68 previous studies on the topic, based on the experiences of a total of 216,600 adults in countries including the US, Canada, Italy and the UK. Men and women were equally likely to think about suicide or act on suicidal impulses, and risk of suicide grew as the person got older. Having no contact with mental health services posed the greatest risk. Ged Flynn, chief executive of the charity Papyrus, which works to prevent youth suicides, said: "Around 70% of calls to our helpline cite childhood abuse of various sorts, some of which are still current. This can include sexual, emotional, and financial abuse, as well as neglect."

Campbell, D (2019) Childhood abuse increases risk of adult suicide, finds research *The Guardian* Jan 9.

STAFF SHORTAGES SCUPPER MENTAL HEALTH SERVICE REFORMS?

Under its new Ten Year NHS Plan, the UK Government says there will be "the largest expansion of mental health services in a generation". More specifically, about 2 million more people who suffer from a mental health condition such as anxiety or depression will benefit from at least £2.3bn extra funding invested in the sector by 2023–24. Over the next five years, an estimated 350,000 more children and young people will be treated, and 380,000 more adults offered access to talking therapies. Crisis care, a serious weakness, will be improved by people of all ages being able to ring the NHS 111 helpline and be directed to support 24/7. Moreover, in July 2017, the then health secretary, Jeremy Hunt, said that by 2020–21 the recruitment of 21,000 extra mental health nurses, therapists and psychiatrists would help the NHS treat a million more people with mental health problems, and offer 24/7 care. However, NHS Digital workforce figures now show this target is very unlikely to be met: a year after Hunt's pledge, Mental Health Trusts in England had together employed only 1,524 extra personnel!

Campbell, D (2019) Mental health: target to boost staff numbers by 21,000 set to be missed *The Guardian* Jan 1. Campbell, D (2019) The NHS 10-year plan: what we already know *The Guardian* Jan 6.

EUROPE-WIDE MENTAL HEALTH CRISIS

A recent Organisation for Economic Co-operation and Development (OECD) report found the whole of the EU struggling with 'the burden of mental ill-health', which affects an estimated 84 million people – one in six. In 2015, 84,000 Europeans died due to mental illness or suicide. 'Anxiety disorder' affects more than 5% of the population, 'depressive disorders' affect 4.5%, while 11 million have

'alcohol and drug disorders', and 5 million have severe mental health conditions such as 'bipolar disorders'. Finland, the Netherlands, France and Ireland have the highest rates of mental ill health with more than 18% of people affected, whereas the UK follows with 17.7%. The report suggests that enhancing people's mental health should be a Europe-wide priority, and identifies improving mental health services, as well as promoting interventions in schools, as ways to help those of all ages with mental health problems.

Bosely, S (2018) Mental illness costs UK £94bn a year, OECD report says. *The Guardian* 22 Nov.

CARERS AT HIGHER RISK OF MENTAL ILL HEALTH

According to a recent Office for National Statistics (ONS) survey, the UK's 1.3 million carers for children and older relatives are at a significantly higher risk of mental health problems than the general population. One-third of those caring for children and a vulnerable relative for more than 20 hours a week reported anxiety or depression. This disproportionately affects women mostly aged 35–54.

Booth, R (2019) People caring for older and younger relatives at higher risk of mental illness. *The Guardian* 14 Jan.

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Managing Editor

Helen Spandler

General Editor

Phil Virden

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Members of the Asylum Editorial Group

Jill Anderson

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Sonia Soans

William Park

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Administration & Distribution

PCCS Books, Wyastone Business Park
Wyastone Leys, Monmouth, NP25 3SR

Subscriptions (see below for rates)

www.pccs-books.co.uk sales@pccs-books.co.uk
01600 891509

**Back cover image 'Clown Seduced by Rake' (2018)
by Thomas Draven**

HYGIENE FAIL: MENSTRUATING ON A PSYCH WARD

BY SARA ARENSON, WINNIPEG, CANADA



It seemed an innocent enough request. I asked the elderly Gift Store volunteer if they had any super absorbency tampons. I was holding a \$1.99 package of “heavy overnight thin” pads, the only alternative to simple panty liners. The only tampons on the shelf were in “regular” absorbency, far too weak to get me through my day.

A long blank moment ensued. The woman, who had seemed nice a moment ago, just stared at me, offering nothing. Perhaps, I wondered, this was simply not in her training.

There were no drug stores in sight. The bathroom had an antiquated pad machine that choked up when I tried to feed it a quarter’s worth of nickel and dimes. Contrary to our vision of Canada as a generous and kind society, none of the women I approached had a spare tampon.

So, I went back up to my ward. From the 5th floor of Grace Hospital, I surveyed the options. I could continue to stuff toilet paper up my you-know-what. I could ask my doctor for a better “pass” so I could exhaust myself walking outside to the Shopper’s Drug Mart, remembering I have no mittens with me in my room. Or I could always bleed all over my clothes. A classic option.

The ward did have very basic and not too absorbent

pads which were bulky and annoying. Even the nurses thought they were lousy. Then I remembered that a few days ago I had pulled a super-absorbency tampon out of my purse in a moment of inspiration, offering it to a friend when it was her period.

I sat down on a couch in the patient lounge, and searched my purse in earnest. Voila! 1 single tampon, super-absorbency. It was a little like a Hannukah miracle. But it came a few days too late, and one tampon will not last for 8 days and nights.

This is a non-denominational hospital with a very Christian name and even a large chapel beside the gift shop that has such a lousy selection of hygiene products. In Grace Hospital, the Spiritual Care Workers aren’t allowed to reveal their own personal religions, and they offer Reiki but no priests or rabbis. No one from my congregation has visited me in the psych ward yet. Perhaps no one has thought to contact them since organized religion means little to Grace. Or perhaps my congregation is writing me off because I confused a few congregants for Nazis the other day, and went storming out, brave and terrified, declaring we have a security system. I thought our lives were in danger. On my way out, someone asked if I was off my meds. It took 3 tries for the police to take me seriously, and even then, who knows. Later I declared on an unrelated e-mail list, “We should have a wall and armed guards around every synagogue, if it will prevent Pittsburgh from ever happening again.” Instead the synagogue opened itself up to even more threat with a giant vigil.

And I’m the crazy one. The one who will soon have blood on my pant(ie)s.

I doubt that the Winnipeg Regional Health Authority (WRHA) would stand for a shortage of bed pans, needles, or pharmaceuticals in its hospitals. But somehow, not only the medical ward itself, but the entire institution of Grace Hospital, has conspired to make feminine hygiene impossible for its guests.

I don’t think this situation is confined to psychiatry, which makes it even more neglectful. In a country where psych wards are essentially internment camps for weird or unwanted people, places that offer pills, beds and very little else, it’s unsurprising that Mother State neglects our hygiene needs.

Such a profoundly misogynistic attitude cannot be allowed to continue. This should not be a matter of personal embarrassment. This should be fixed. Yesterday. ■

Author’s Note: In Dec 2018, the Grace Hospital psych ward was shut down to be amalgamated with several other wards. The staff and patients were transferred to Victoria General Hospital. In a series of trips on the “short bus”. I jokingly called this migration “our personal trail of tears”.

Editor’s note: In the UK, the British Medical Association (BMA) have recently argued that sanitary products should be provided for free, and readily available to all in-patients and easily accessible by hospital staff. This followed FOI (freedom of information) requests to all UK trusts and health boards revealed serious shortcomings in the provision of sanitary products for in-patients.

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T. DRAVEN
2018