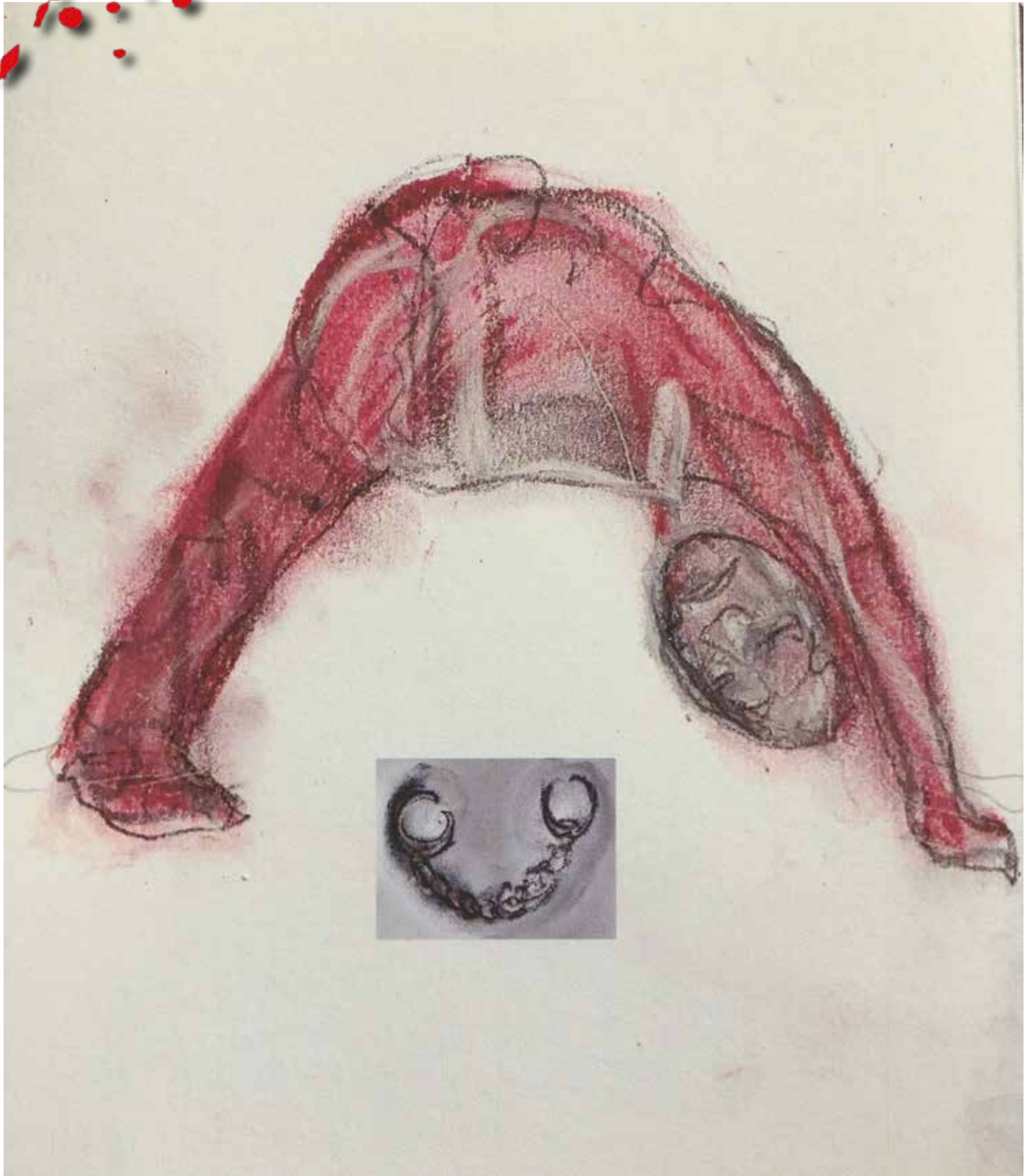


Asylum

the radical mental health magazine

Winter 2021
Volume 28
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who are we? and what do we do?

mental health
zine library

we are the **Mental Health Zine Library**, a small collection of DIY publishing around mental health and all that includes.

we work in partnership with the mental health charity Washington Mind, running creative workshops with young people and exploring how zines can be useful tools to sharing our stories and making connections.

our focus is on archiving personal stories and lived experiences to offer an alternative to the traditional medical model, and share a range of voices in order to capture **the diversity of mental health and it's histories**. whether that's a critical approach to mental health provision, perzines on addiction, poetry collections about anxiety or soft self care guides, we collect it all.

why is it important?

we've been making zines ourselves and running workshops under different projects since 2017, and recognise what a cathartic and healing process it is to put pen to paper and make something. but **hearing each others stories is just as important as writing our own**, and though making zines or being creative isn't for everyone, we think anybody can benefit from them if we make it accessible for those who need them the most.

anyone can submit their zine to our collection on our website, and we are always open to more contributions.

**"thanks for for doing this work of safekeeping our history."
- a zine maker submitting their zine project to our collection.**

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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 editorial group. Articles are accepted in good faith and every effort is made to ensure fairness and veracity. editors@asylummagazine.org

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The Trauma of Institutionalisation

JEROME SEWELL

When hospitalisation is discussed in the media, or in public conversation, it is usually framed as unstable people desperately needing help from the system. However, for many of us who have undergone the experience of being sectioned, we are acutely aware of the damage done to our lives and the suffering we underwent - whilst hospitalised. If recovery (under a new model of mental health care) is about increasing the quality of life of mental health patients, and if the age-old goal has been to facilitate recovery from an illness, we can no longer ignore the damage caused - to people's mental and physical health - by hospitalisation itself.

I write about this from a unique perspective. My experience comes from being in the forensic mental health system (the system that houses hospitalised ex-offenders). I am an ex-offender who was hospitalised whilst I was in prison and I have friends who are hospitalised and who live under section in the community. The forensic system's procedures are much more severe than other clinical services. Many of us have been left scarred and voiceless by the things that go on inside these hospitals. When I speak to my family about my experiences, they find it hard to listen and hear the hardship that exists in these places.

When you are on a forensic ward, you are stopped from leaving the building and seeing the light of day for a very long time. People can be stuck in there for years and years and never told how long it will take for you to be discharged and leave hospital. This can be very traumatic in and of itself. During my time inside I felt I was trapped for life. My mind and body were in a state of shock from the beginning of my admission to the end. I was never truly content or rested; knowing that I was chained and in bondage. I would even go so far as to say that this can induce symptoms of post-traumatic stress disorder. Once, whilst in hospital, I explained to a member of staff that they would never understand what it was like to be ripped away from everyone and everything you know and love and find yourself displaced, restricted and under severe control.

I thought 'whatever I do in here will determine whether I see my family again and whether I live life in a normal way again'. I will never forget when I heard a man shriek to the pharmacist: "I have gone five years without seeing my little ones. No, No!" Or when I saw nurses sitting with a man on the ward trying to calm him, telling him that it was good for him to speak. The only thing he asked was: "I would like to know when I am going to leave here?".

You may pick up the phone to your mum (as I did) and you tell her over the phone: "look mum I don't know when I am going to leave here". You cannot turn to a mother and say: "you may never see your son again" and expect her to contain that. Something unique to the trauma of institutionalisation is the lack of empathy professionals show to your loved ones; in my experience they show no compassion to the distress caused to families. They have said that they have a duty under the law to protect the patient from harm and protect others from harm by sectioning people but they fail to factor in all the other lives that are being damaged whilst this is happening.

Unless you have been there, you will never understand how it is to have your life and freedom taken away from you; for people to never tell you when you will be free, to feel so powerless and weak in the face of people who, you can only conclude, have no compassion for you or for your family. These people sit behind desks, never reflecting on themselves, but holding the keys to what you understood to be your right; to live freely. To not have control over yourself and have your self-determination stripped off you and to feel that your life will be taken over by the system and directed by it.

To only add insult to injury; imagine learning that your illness is biological and that you were born with this as it lay dormant. To find yourself trapped, punished and oppressed, not for the wrongs you have done in life, but for something you had no chance of controlling. To feel like an animal, caged by those who show empathy to you, not as a human being but only as a psychotic, dangerous criminal who deserves to be where they are. If you should show the slightest element of anger or frustration at this situation, you are told that they feel you need more medication, under the guise there must be something wrong with being angry about this.

One of the experiences I would like to highlight is the multidisciplinary meeting that is held on a fortnightly basis when you are in hospital, known as a ward round. During this meeting, the power dynamic is shown in its most dramatic form. When we speak of the trauma of institutionalisation, you may think of people having seizures in the room next to you or fighting, but the biggest struggle for me was to constantly have to fight for what I believed was mine; my self-determination and choice to do as I wanted with my life. The clinician across the table sits there and tells you they do not recognise they are acting under legal powers to restrain your movements and liberty and that they don't recognise that

they hold the keys to reversing a section of the mental health act that is keeping you caged. 'Section is modern day slavery', are the words of an anonymous patient (no doubt) who scribbled this in black pen on a post just outside the Royal Bethlem hospital grounds.

Imagine it: the nurse summons you: "the doctor wants to see you now". Then they walk with you into a room where four professionals are seated: a social worker, psychologist, a clinician and the ward doctor. Should you dare to challenge the so called 'wisdom of the forces that be'; if you choose to see things in a different way or maintain your own perspective, you were made to feel like you had no right to question anything. Should you dare to refuse any recommendation (such as extra therapy) or anything else, you are described as non-compliant, a resistor and an outright rebel. It is like they are thinking: "How dare you try to tell us what you should choose to do with your own life, how you think you should behave or how you think your treatment should go".

The self-determination of the service user is non-existent and crushed against the collective recommendations of the team. This abuse of power is so serious, that if you refuse to go for an assessment that they recommend, then they can refuse to discharge you, or let you progress through the clinical service, regardless of your mental condition, and without reference to whether it affects what they call your 'risk'. The power they have, to use even the smallest disagreement with them as a reason to keep you incarcerated, is an abuse of power. Nonetheless, this practice is enshrined in law.

It breaks my heart when I think of the oppression I felt. The way I had to put on a happy face, nod my head and sacrifice any sense of honour or pride I had in myself. To sit there and have to say "yes doctor, yes doctor, I agree doctor", sacrificing my own thoughts. To have my perspective, opinions and point of view suffocated. To

have my mind taken away and made docile and weak. But, when the doctor sees a patient who agrees and lingers onto every word they say; they conclude, "he is compliant, he is definitely recovering". It is as though the service user (because of their illness) forfeited the right to form an opinion that is different to that of a mental health team.

The level of demoralisation this represents is so intense that even your memories of it are enough to suffocate you with sorrow and pain. Imagine having to constantly fight to have your own mind and to constantly have to reaffirm that you have the right to hold your own opinions. Forget the physical confinement, it is the mental one; the thought that others wish to restrain your mind that damages you the most. Imagine, hundreds are released from hospitals each year; knowing they have had to sacrifice their right to choose how they should think.

I am from an island where slave masters told us, descendants of Africa, that we must believe what they tell us because we were lesser humans. This history gives some insight into how black service users can perceive expressions of power over us. It helps us understand why black people might experience sectioning as modern-day slavery. The black experience of institutions is different from other experiences, especially in forensic settings. Psychiatric hospitals are starting to realise this in light of the Black Lives Matter movement.

If we must learn anything from institutionalisation, it is that mitigation of risk must not be in exchange for the service user's quality of life. I only came to terms with the true extent of the impact of institutionalisation when I left hospital and wrote a personal reflection to myself describing how I felt. For many, it will take a long time to find peace and it is about time we received some help with this. ■

Thrown into a dark room, stilled with the presence of the night,
 my arms are strapped behind my back, they surround me, needles plunged down,
 A rampage of chained ghosts erupt, trapped in my chest, tearing through my insides,
 I can no longer contain the weeping of my thoughts,
 tears and torment of loved ones scar my sheets,
 They say that the sacrifice of the Lord is a broken heart,
 and my soul has been smashed.
 Clinging for strength, I grab my pen,
 footsteps pass, window flaps open, they stare at me,
 witnessing the moments I first used my pen to cry,
 taking solace in weeping ink.
 As my destiny is decided by men in suits and women behind tables,
 I fight to keep hold of who I truly am,
 or become lost in the ignorance of a world that lacks understanding.
 The wound was chained once more, for the truth shall set you free.

Arm Tickling:

The mystery of subconscious self-soothing

BY JAMES COLLECTOR

I did it again last night. When the lights went out, lying in bed, both my arms raised toward the ceiling. My right hand began to gently graze my left arm, then vice versa. It's a slow, repetitive motion, this "arm tickling" habit of mine. I was almost completely unaware of it, until recently.

My partner attributes this behavior to subconscious self-soothing. She says it happens a few nights a week. Harmless enough—except the brushing noise. Sometimes, she firmly lowers my arms. Sometimes, it starts again. My subconscious doesn't give up so easily.

When I was a boy, my mother would rub my back to help me fall asleep. It felt good; it still feels good. But is it necessary? Do I need self-soothing so much that the responsibility is left to my subconscious?

At first, my partner's observations of my somnolent behavior made me uneasy. It felt embarrassing to be informed about my own actions. There is something unnerving in the realization that my conscious self, I, James Collector, is not the only one driving this body.

At the same time, I have to marvel at the benevolence of my subconscious. By tickling my arms at night, my subconscious is taking care of me—or us. To know that somewhere deep inside, there is a tendency toward self-care, is comforting.

At the same time, the necessity of subconscious self-soothing also suggests that my conscious mind may be pushing itself too hard. As soon as the lights go out and my ego is off-duty, my subconscious steps in and soothes. My mind has a mind of its own.

Psychologists often use a phrase: "Making the unconscious conscious" which describes the process of becoming aware of latent emotions and thoughts. The question is whether my arm tickling is a subconscious or unconscious behavior. Examples of *subconscious* behavior include breathing and typing without looking. Examples of *unconscious* behavior include the Freudian slip or other mental "knee-jerk" reactions such as bias or racism. So my arm tickling behavior seems to be subconscious, not unconscious.

To trust something we do not understand is to have faith. Faith in the subconscious – well, that's not a message we hear often. Instead, my research on this behavior turned up mostly alarmist concerns. For example, a post on reddit read: "I often wake up finding myself lightly brushing my fingers up and down my arm.



Credit: Photo by I.am_nah on Unsplash

No reason, but it feels really nice. My husband noted I did it this morning while dead asleep as well. I am just worried this is some parasomnia and it means there is some malfunction in my brain..."

For the record, parasomnia is a "sleep disorder" which usually denotes strange and self-destructive behavior while sleeping. Why the author of this post seemed to overlook the benevolent self-care of the behavior and, jump to the conclusion of a sleep disorder, I cannot say. Perhaps it's related to a general suspicion and distrust of the unknown, especially when the unknown dwells within us.

Our society tends to regard the subconscious as a sort of wild, untamed element beyond our control which could be dangerous if not understood. The subconscious is often blamed for "animalistic" desires. It is the source for bizarre artistic visions, a repository for demons, childhood trauma, etc. Basically, it is the dark closet of the mind. We expect skeletons to emerge. But in my

case, a kind and gentle hand reaches out to caress me.

When I described the arm tickling mystery to one friend, he explained that an ancient yogic practice is to activate the meridian lines in the arms by tracing one's hand down the inner arm and up the outer arm. Maybe you were a yoga master in some past life, he said. I laughed to think one person might be afraid of their own parasomnia while another might attribute the behavior to past life mastery.

Another friend, a psychologist, suggested that the arm tickling might be a trauma response. Did my raised arm resemble a gesture of setting a boundary, of pushing away? I pointed out that my wrists were usually quite limp, my arms outstretched like sensual noodles.

According to Stanford Health Care, sleep disorders involving abnormal behaviors during sleep are called parasomnias. These nighttime activities can occur at any age. The list includes sleep walking, sleep talking, sleep terrors, confusional arousals, REM behavior disorder, sleep paralysis, and nightmares.

None of these quite describes my benign arm tickling. However, I did experience "sleep terrors" around age 10. About an hour after going to bed, I would sleepwalk around the house with my eyes wide open, full of panic, terror, and dread. I could rarely recollect the incidents, even moments after awakening. Once, I woke up in a cold shower with my concerned parents looking at me like I had been possessed. These incidents were never explained, although research has shown that a predisposition to night terrors may be hereditary.

Recently, night terrors have been making the news with smart-phone footage of children crying and screaming. Thankfully, my parents never filmed me. Take my word for it: this is not a worthwhile Youtube search. Instead, try searching for this calming ASMR* video: "Nostalgic ASMR Triggers #5 | Back & Arm Tracing, Tickling, Tingly Rhymes." ASMR stands for Autonomous Sensory Meridian Response, a tingling sensation often triggered by whispering. In this example, a British woman recites rhymes as she tickles another woman's back and arms. The top comment is "Wow, I'm seven years old again."

As you can see, my research opened up a strange lens on human nature. We spend about one third of our lives asleep and yet dreams and nocturnal behavior are still poorly understood. After weeks of research, I was no closer to understanding my arm tickling.

Another study¹ published in *Frontiers in Human Neuroscience* focused on actual tickling during sleep (rather than caressing). The scientific paper used the following quote from Charles Darwin: "... from the fact that a child can hardly tickle itself, or in a much less

degree than when tickled by another person, it seems the precise point to be touched must not be known..."

The study goes on to conclude: "Our results, though highly preliminary, indicate that in the special case of lucid control dreams, the difference between self-tickling and being tickled by another is obliterated, with both self- and other produced tickles receiving similar ratings as self-tickling during wakefulness. This leads us to the speculative conclusion that in lucid control dreams, sensory attenuation for self-produced tickles spreads to those produced by non-self dream characters."

In other words, we cannot tickle ourselves while awake yet somehow we can while asleep.

A somatic therapist might ask: "What is the hand doing? Caressing the arm. And what is the arm doing? Being caressed by the hand." Therefore, part of me wants to caress while another part wants to be caressed. Plus, there is a part of me that seems to know when to self-soothe—while another part of me does not know but sincerely wants to understand.

Until I found an "answer," I decided to keep the search to myself. As benign as the arm tickling is, it's vulnerable to share. I'm a grown man who needs to be caressed—I at least want to know why before I broadcast the subject to my friends and family. Yet after months, I felt stuck. I ended up mentioning this essay to my mom over the phone. She laughed and said, "I used to do that too. Both my arms would go straight up. Your father thought it was spooky." She went on to explain that she hasn't done it since retirement. Without a job at the health clinic and kids to take care of, she has less stress. The absence of subconscious arm tickling is a barometer of relaxation.

So is the behavior genetic? Or is it learned? She did tickle my back when I was a little boy. My partner and I joked about running a natural experiment on our own children some day. Tickle one and not the other. I joked that the one deprived of tickles will turn out a stress-case or even a criminal.

After months of research and contemplation, it seems safe to conclude that arm tickling is a form of self-soothing. How and when my subconscious decides to self-soothe remains a mystery. Perhaps it always will—how does one interrogate the subconscious?

Instead, the important question may be: why I am not consciously self-soothing? The list of stress factors in my life is probably somewhere around average for a 34-year old adult with a busy job, leadership responsibility, significant commute time, and anxiety about climate change. Maybe I should spend less time peering into the cloudy mirror of my subconscious and more time walking in nature, stretching, playing music, exercising. A hot bath and cup of tea—deliberate self-care rather than relying on subconscious self-soothing.

After all, if my subconscious is looking out for me, so should I. ■

1. "Tickle me, I think I might be dreaming! Sensory attenuation, self-other distinction, and predictive processing in lucid dreams" by Windt, Harnkness and Lenggenhager (2014) in *Frontier of Neuroscience*.

A Tale of Two Losses

BY ELEANOR HIGGINS

Content warning: suicide

There's a kind of fracturing with traumatic grief, a severing, something ruptured beyond repair. When my dad died from cancer twelve months ago, a year after his diagnosis, I was bereft and in a state of disbelief, but it had a softness to it. It wasn't a raging against the fact that he is gone, though I know for some it is much more like that, and maybe that is still to come. It is a quiet, unfathomable loss. Periodically I catch sight of his photograph on the fourth shelf of the bookcase. It is at eye-level when I sit on the sofa, and I think "oh! It's you. You were such a good man, dad". But the feeling of sadness is momentary. My grief is fleeting though it was landing in me some months ago, like a weight in my chest having dropped anchor. I could feel the great presence of his absence. I was able to cry, I felt like curling up with the grief and holding it close like an old childhood blanket, nothing coming between us.

There is a necessary indulgence with grief. Even though being in a state of mourning will not bring them back, it feels like you are as close as it is possible to get to them. Nestling into memories of them, trying to imbibe them through the fabric of clothes they wore, listening to their music and reading their words, trying to see the world through their eyes. So that you might be able to capture something and say: 'Here, here they are! This is them!' Only nothing quite reaches that place of recognition because they are gone and they have taken that themness with them.

I am not spiritual or religious, but there is something about being with your friend's just-dead body that makes the concept of a person having a 'spirit' feel credible. A spirit that flees the scene after death, leaving just a shell of a person, the casing of them.

But the thing is, I couldn't tell if she was dead or not, if we had arrived just in time or just too late. There was a warmth to her skin that mimicked life, but an emptiness to her eyes that said something, the humanness of her had departed.

After she was down and I lain her on the landing as softly as I could, I realised I would have to release the pressure on her neck. Time slowed to the stillest I have ever felt it. Each thought felt like it wandered in my brain as I tried to think it, wasting precious time. If you had asked me to imagine such a moment I would think of

thoughts racing, but no. I'm told no time at all passed before the pressure was off.

I will never forget the violence written on her body. At some point I hear myself shouting: THIS IS NOT HOW THIS ENDS, repeatedly as I begin CPR. I am cheering my friend on as if she is running the egg and spoon race against the other mums in her kids' school sports day. I am invested in her always. This is no different. *This is not how this ends*, I pant. Chest compressions are exhausting and minutes later I have switched places and am holding her head still. I still think she's coming back but there's a flicker of recognition that if she is revived she may be permanently brain damaged. I keep cheering her on because I am too selfish to let her go.

My best friend dying does not fit the character of grief as I knew it up to that point. Suicide complicates things as it is, but finding her and failing to save her, seeing what we saw, that takes something of yourself from you. I don't know quite how to articulate something that is so beyond speech. It is probably still echoing in the screams I left in her hallway that my poor wife is haunted by. The images of that night were vivid but five months on they have become hazy and dissociated. Not because I have processed them but because I have detached myself from them somehow. I know this is a natural and self-protective mechanism that is just part of grief, especially of this kind. But, I say that from my head and not my heart. In my heart I am cold and callous. I clearly do not care for my friend if I can detach so easily from that night and from missing her.

It feels like I don't miss her most of the time, that I don't think about her enough. But I think of her everyday really, for example when I play music in the car. She is often close to my thoughts, but for very short periods and with little emotion attached. Sometimes I cry three or four tears and then they just dry up without effort. I want to feel. I feel like you do when you've had novocaine at the dentist and half of your face is numb. You can't eat or drink properly and you are aware all the time of the discomfort of numbness. You take to pinching yourself to check you really can't feel it, that it's really that deadened.

I long to feel the pain of the loss of her. My twenty-two year friendship just gone seemingly has no tangible impact on me. I want to be floored by it. It feels only right that this should take me down. But I have a life to live, madness has ebbed from my life and I need to live. I have

now survived three close friends' deaths and I sometimes wonder, why do I get to live?

Don't get me wrong, I am glad to be alive and to *want* to be alive. I have built something from the wreckage, somehow (with a lot of privilege). Rather than sinking under the weight of survivor's guilt, I feel the best way I can do justice to my friends is by taking care of myself – by showing myself the understanding, compassion and acceptance they showed me during our friendship. But there is something in that that enables me to bypass mourning, to give grief the run around, to set myself onto autopilot. The trouble with that is I end up being somewhat absent in the rest of my life.

If there is one thing I am learning about my grief and my relationship to loss it is that I have to consciously make space for it in my life. Not only inviting it in, but putting aside time to let it stay for a while. I think it also needs some boundaries so it does not render me incapable of functioning (even though lying on the pavement and refusing to move an inch feels like the most appropriate response to the situation).

The violent death of my friend has also paused any mourning for my father. I am in a state of limbo, neither here nor there. I exist in the moment but I'm not altogether present in it. I'm also not in the past or the future, I am just a bit vacant. It's like being emotionally constipated and I feel I should be able to process my feelings better by now but I'm not. It's hard not to judge yourself for the way you do, or do not, seem to be grieving. Little I have read about grief and loss has resonated.

Suicide leaves a wake of questions that will never be answered. In the case of other friends who have died by suicide, I have been rageful towards services who let them down. But this time, she didn't give anyone a chance to help. She decided on a course of action and meticulously executed it. It has made me say the most ridiculous things that would anger me if anyone else said them. Such as, "but you loved the tennis, why didn't you hold on until after Wimbledon?" *I know*. And other such gems as, "but you'd bought a book to read yesterday!" *Yes, really*.

The aftermath is horrific. The hardest thing is that I don't believe it was inevitable. I believed in her with my whole heart. But also, if she could have stayed alive, she probably would have. I have to respect her limits. And yet, I will never stop hoping for or believing (in) people who say they cannot live anymore. Because maybe they can live, with help? I have said those words "I can't do it anymore, I'm done". I was given up on a number of times and I gave up on myself even more times. My friends, however, never did.

Friendships can be the most painful loss. We don't talk enough about the death of our chosen family. I'll likely never wrap my head around the fact that she chose to leave. Suicide feels like a personal attack sometimes, like the rest of us weren't enough, even though it doesn't work like that. If love could have saved her, she would be immortal. ■

Eleanor Higgins is a queer survivor of madness and trainee counsellor living in the Midlands.

Digi-Summons: A new way to collect Council Tax debt.

I work in a mental health setting in London and one of the people accessing our centre came in crying and fearful. She showed us a letter she'd just received from the council. Accompanying the letter was this notice: what I call a 'digital' summons. I decided to investigate this situation. I discovered that the Government has allowed Councils to increase Council tax rates by up to 5% a year, to try and plug the gap left by severe austerity measures. Citizen's Advice estimate that more than 3.5 million people now have council tax arrears. In addition, during the pandemic, 281' 380 households were referred to bailiffs who have the right to remove personal property and sell it, to 'recover' debts. Some Councils now begin this process of 'recovery' digitally. You don't need to imagine the impact on people's mental health, it's horrendous. Digi-summons must be deleted. ■

Mark Bertram



IT STARTED IN 2013
ON DAVID 'BREXIT/
LOBBY-BOBBY'
CAMERON'S WATCH

AND IT INVOLVES ----->



SERENITY INTEGRATED MENTORING we are embedded police we ensure serenity is maintained as cheap as poss. So here's our advice, glum friend, hack away at your hair, not your arms. Then ring an hairdresser. Can you see where this is going - yep, you foot the bill. That's called being a good citizen.



YOU WON'T GET HELP FROM THE MENTAL PROFESSIONALS TODAY BUT HOORAY WE'RE HERE AND WE WE ARE GOING TO ASK YOU TO ASSUME A YOGA POSITION - FOR YOUR SERENITY - AND THEN WE ARE GOING TO HANDCUFF YOU INTO THAT POSITION - FOR YOUR HEALTH - AND TAKE YOU DOWN THE NICK. To be honest I'm fresh out the mounted division and more used to horses

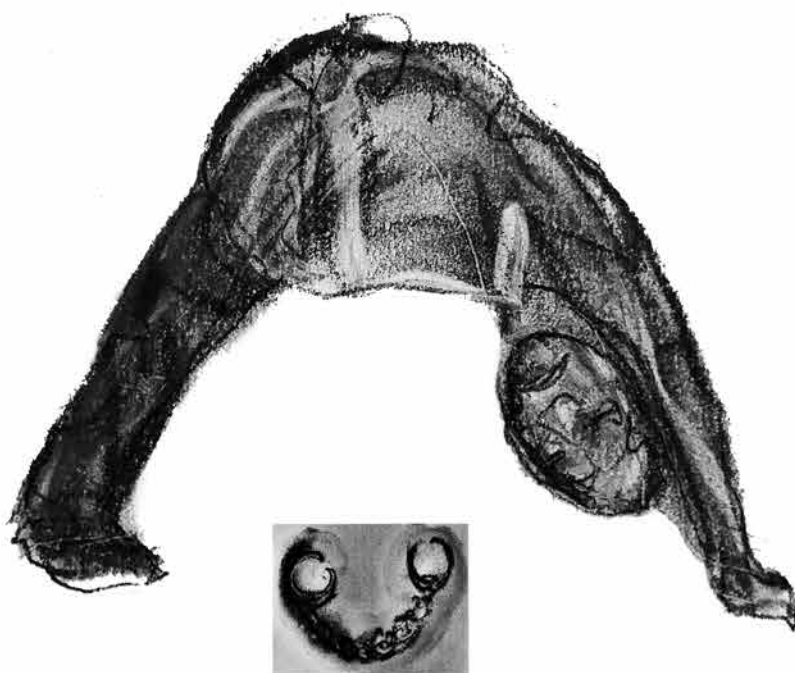


I REPEAT, THIS IS FOR YOUR SERENITY. DO YOU HAVE SERENITY NOW? GOOD, CUFF 'EM

When the steel friendship bracelets come off we will make a wish that you are no longer a pain in the arse.



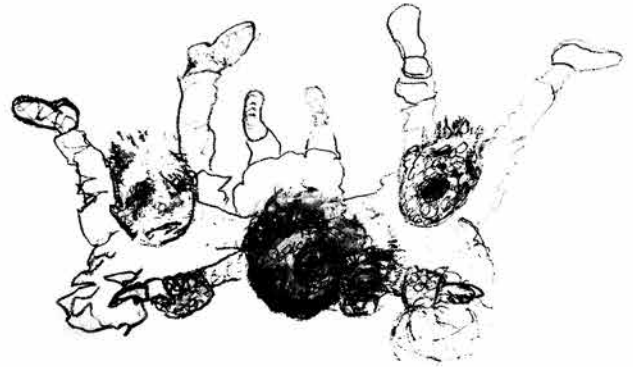
Come on, sunshine, that's just sitting-cross-legged with your hands on the floor



I am PC Calm and this is PC Placid. How about a spot of mindfulness, eh? Want some guided imagery?

Yeah, righto, you imagine you turn around and you trot back where you came from and you hope when you get back that someone's cleaned up all the sodding mess cos you're still dripping, incha? This sign is A for Accident and not I for 'I intended to do it'. You in the moment now? I know I am.

Here's what we'll do if you loiter, PC Placid and myself will take you low-altitude skydiving



How about a replay?

Look at those spacemen go...



This Has Been
A Brief But Necessary Satire on SIM -
Serenity Integrated Mentoring
By The Ornamental Hermit

Which way is Mecca?

Being a Somali Refugee in UK mental health services

MUSHTAG KAHIN

Imagine being on a psychiatric admission ward, surrounded by complete strangers and professionals unable to communicate. You want to leave, but are stopped by staff, and you do not know why. The only halal food options are curries which are not part of your cuisine, mundane and too spicy for everyday meals. You want to order food, but you cannot verbalise this to staff. It is the middle of the pandemic and your family are not allowed to visit. You miss your children whom you only can speak to through the airlock window. You do not know which direction is Mecca to pray your five mandatory Islamic daily prayers. You are forced to take psychotropic medication, but you do not know why, nor can you verbalise the side-effects you are experiencing. Not only are your freedoms taken away, but also your dignity. You have to cover up at all times as strangers check on you every hour, including nighttime. You feel lonely, bored and do not know how to switch to the hospital Wi-Fi to speak to your family.

There are no words for depression in the Somali language. There are no psychiatric diagnoses and little awareness of mental illness in general. In Somali people with serious mental illnesses are often locked up or chained for rest of their lives. You are perceived as either “sane” or “crazy” with little chance of recovery. Your first contact would be with spiritual healers as you may be possessed by Jinns (spirits). There is hardly any psychiatric care and therapy is non-existent and unheard of. Coming to the UK as a refugee you might not know about mental health services and that the first point of contact is through your GP. Somalis often come into services when they are at crisis point or via criminal justice. Mental health services are not equipped to deal with the needs of Somalis and there is a lack of Somali mental health professionals, especially therapists, in the UK.

The pandemic has highlighted structural inequalities in society. There were higher numbers of deaths amongst ethnic minority people and staff working on the frontline. Brent, where there is a large Somali community, was hit very badly by COVID-19. It was only after awareness-raising by Somali-British journalists in the Guardian that NHS funding went into the community to tackle inequalities, information and awareness.

Somali is an oral society and Somali people are known for being storytellers and poets. As a clinician, when I work with Somali people, I do not see ‘patients’

but people with untold stories. Listening to their stories is a privilege that I do not take for granted. To be let into expressions of vulnerability is sacred. Because Somalia is an oral community, the literacy rate is often low. Therefore, information should be shared orally in our native language.

I remember once being told that a Somali patient was doing “unusual activities” when they were washing their feet in the sink not knowing they were performing ablution. I also heard about a middle-aged Somali woman confined to her bedroom who was left untreated in the community for 7 years whilst her ex-husband and her relatives brought daily food to her and her young child. Mental health professionals were rebuffed at the door and did not make extra efforts to safeguard her. Eventually, her ex-husband was advised to contact a tailored Somali mental health project worker who advocated on his behalf. They arranged for a Mental Health Act Assessment and the woman was sectioned and diagnosed with schizophrenia. She and her family did not have to suffer like this if mental health services had not failed her.

There are no in-service transcultural services in London and NHS leadership has not addressed this yet. This is even more worrisome when Black people are 4x times more likely to be sectioned under the Mental Health Act. There are hardly any BAME mental health advocates on wards and membership of Mental Health Act panels lack diversity. Finally, there is a lack of BAME people in leadership roles – there are only two ethnic minority CEOs in London (one was appointed this year due institutionalised racism).

Transcultural training should be mandatory in Universities and Trusts. There should be transcultural workers in every Trust and yearly anti-racism training for professionals, leaders and students. Specialist services need to be community centred, culturally and spirituality sensitive. Service providers need to implement trauma informed practices and interventions. Interpreters and Somali professionals should be trained in mental health awareness and translators should be employed by Trusts. We need to acknowledge Islamophobia and its impact on mental health. Communities are not “hard to reach”, services are. ■

Mushtag Kahin is a Somali registered Nursing Associate and Community Engagement Practitioner in London

A Crisis of Identity

BY JANE FISHER

It was 2015. I was sitting in a community mental health team waiting room. I stared down at the floor and fidgeted awkwardly in the standard NHS plastic pale blue chair. I heard nurses come and go, confidently punching in security codes. I sensed their hidden stress. They looked at their watches and attempted to navigate a key code and their heavy, useless, bag of psychiatric interventions. They desperately searched for their car keys and an outdated NHS-issued mobile phone. This was most likely filled with messages from their patients - "You are late. Should I wait in for the rest of the day?" A receptionist muttered last minute urgent messages in convoluted mental health nurse code.

When my distressed mind allowed me to raise my head, a nurse attempted a smile. But I dropped my gaze in shame and fear. I was at their mercy. I felt powerless. They held my future in their hands. Would they help me? Or would I be sent away to find my own cure? I could not meet the eyes that held such authority. Instead I locked eyes with another vulnerable occupant of a pale blue chair. They smiled in a knowing way, alluding to the fact we were both at the mercy of these nurses. Whilst my mind was in chaos, this brief smile made me feel human again.

We waited patiently to bare our soul to a stranger (for a maximum of thirty minutes). If we didn't live up to this expectation, we would be accused of not wanting the limited support on offer. If we were lucky, we would leave with a folded piece of NHS-branded paper. Our names scribbled on the front to make us feel important. A safety plan they will call it. It tells us what to do in a crisis. Vague instructions we are supposed to follow before we even dare to contact mental health services. As an added extra we might hear about the magical healing power of a warm bath and a walk. Obviously, we had never thought to try this as a cure for our insanity.

Eventually my name was called.

This was it.

My chance for hope.

Later the same year I entered a similar waiting room. This time I had no chance to sit on the plastic pale blue chair. I had a heavy bulging bag to carry, a key code to remember, car keys to locate and an outdated NHS issued mobile phone. It was brimming full of frantic messages. "You are late. Should I wait in for the rest of the day?" I

attempted to control my rising stress levels, whilst hoping I had something remotely useful in my overfilled bag for a patient in crisis. I received last-minute urgent messages from the receptionist and muttered encrypted mental health nurse code in return.

Despite my dash to exit the building, I noticed someone in the waiting room. I smiled, whilst wondering what inner turmoil they endured. They couldn't quite look me in the eye. I sensed their shame and fear. I recognised this mental torment like an old familiar friend. I hoped they would be able to bare their soul in thirty minutes. If not, I feared the outcome.

No folded branded NHS piece of paper could even begin to heal their brokenness. Nor touch the depth of despair. A name hastily scrawled on the front did not make anyone feel seen or heard. The same NHS-branded papers I had in my bag suddenly felt toxic. This feeble piece of paper was no guarantee of safety or help. Yet we would hold its owner to ransom if they dared not follow the 'agreed plan.' Agreed by us. We offered very little in return for this expected compliance and obedience.

I looked at this defeated, desperate person and saw a mirror of myself. An echo of my own brokenness. I saw distress personified. I saw myself. Yet they looked at me and saw authority, power, and judgement. I had the power to offer or withdraw lifesaving treatment and care. Few other health care providers could legally or ethically offer and withdraw such treatment on a whim. Few other specialisms would willingly expect patient's loved ones to do their job.

Sadly, I left this mirror of myself waiting patiently for some hope.

I continued my day. I did not mention a warm bath or walk. I listened. I tried to understand. I talked about hope. I looked deep into eyes, rather than my bag, for meaningless tokens of support. I saw distress personified. I sat with despair. I held out hope. I saw. I listened. I smiled. I cared.

I carried my own fragile mind with me along the way. I took it six miles home at the end of every day. Here in this parallel universe I handed it to another mirror image of myself. An echo of my power and authority. Each time desperately hoping they would look after it with care and compassion. Each time feeling the shift of power from nurse to patient. Then back again.

This was it.
 My identity crisis.
 My search for hope.

In 2015, whilst on maternity leave, I had dramatically become a mental health patient overnight. I consumed my personal cocktail of psychiatric medications. I travelled hopelessly through the full quota of mental health teams in my local area. Caught between the rhetoric of either 'too complex' or 'too well.' Six miles away I was simultaneously employed by mental health services and working as a community psychiatric nurse.

People not connected to mental health services might be naïve enough to assume a mental health nurse with a mental 'illness' would receive the best possible care from 'their own.' How wrong they are. For other professionals this may be the case. But why not mental health? Why is there so much stigma attached to mental health professionals having a mental illness? Or mental health patients becoming mental health nurses? Perhaps mental health systems are built on an outdated notion of illness versus wellness. Nurse versus patient. With nothing in between. I can be a nurse. Or I can be a patient. Not both simultaneously. There seems to be no option for integration in my parallel universe of mental health care.

There is limited value and acceptance for mental

health professionals who live with what is called mental illness. Our current options are limited. We are either perceived as an impaired professional, a wounded healer or simply a liability. Can I truly identify or be accepted by psychiatric survivor movements when I am simultaneously a psychiatric nurse? Am I part of the problem or solution? If I need therapy to address the trauma of accessing mental health care as a mental health nurse, surely there is something fundamentally wrong with the organisation and delivery of mental health services.

I am a nurse. I am a patient. Maybe I will always be both. I should be accepted for all that I am. I cannot separate these identities. I should not be expected to. We are all human. All subject to stress and illness. All entitled to a career in mental health nursing. And all entitled to access mental health care.

I refuse to be ashamed of living with a mental illness. And I will always be proud to be a mental health nurse. I can't change the fundamental errors in the systemic organisation and delivery of mental health services. But I can encourage individuals within the system to care. I know this is a drop in the ocean but it's my drop in the ocean. And when someone is treated with care and kindness, despite the limitations of service provision, that one drop in the ocean is worth me telling my story. ■



Photo: TO Walker

A Healthy Escape – Finding Freedom Through Music

CAYLEY BLAIR-STEELE

‘The person is not the problem,
the problem is the problem.’

These were words written on a mental health hospital bedroom wall in Canada. Sleeping in the bed next to them is Lucas. He’s been living at the hospital for the last three years. The hospital is over one hundred and fifty years old. Their practices and beliefs are also dated, but these resources are often the only option for people like Lucas.

The words on the wall suggest a new way of thinking. The problems Lucas face include isolation, lack of freedom and control over his own life. Even though he is an adult, he has very limited choices. For example, he can choose whether to spend the day in his bedroom alone or outside in a fenced off field by the parking lot. At times, even that small freedom is taken away. However, there are people in his life starting to listen and trying to make changes. His mother, Julie, hired me to do Recreation Therapy with him a few times a week to attempt to improve his situation at the hospital.

The quote derives from narrative therapy, a respectful, non-blaming approach to counselling and community work. It centers people as the experts in their own lives and views problems as separate from people. Seeing that quote on my first day set the tone for my work at the hospital.

When I started working with Lucas, Julie introduced me to Open Dialogue. This is an approach to mental healthcare where there is an ongoing conversation with everyone involved in a person’s mental health crisis, including family, friends, and the person themselves. It was started in Western Lapland in Finland and even though the hospital is not yet using the approach, I began educating myself on it. Open Dialogue teams help those involved in a crisis situation to be together and to engage in dialogue that is relevant to the healing of the person involved. The idea is that if the family and the mental health team can tolerate uncertainty and bear the extreme emotion in a crisis situation, in time healing becomes possible. It has become an internationally renowned approach that has had a remarkable success rate for those experiencing psychosis and other mental health crises. Open Dialogue is not the norm in Canada but we are working to change this. I learnt that implementing it is a challenging task. However, a good way to start is to examine which elements of the approach are already present and then find which ones you can do more of.

Being a Recreation Therapist really helped me grasp

the value of Open Dialogue because Recreation Therapy is focused on the interests, thoughts, and feelings of whoever you are working with and these are also the foundations of the Open Dialogue approach. Listening to who you are helping seems like a simple and obvious strategy for healthcare, but it is often at the bottom of the list for practitioners. This is often because healthcare professionals have so many guidelines, pressures, and rules in place for how they should be conducting their treatment. When these obstacles are in place a patient-oriented approach gets pushed down to the bottom of their priorities.

Julie told me Lucas’ strengths and interests were music, the outdoors, and people. These were all things he had barely any access to and so I was actively tried to find ways to increase opportunities for these activities in a meaningful way. While sitting and talking with Lucas on a regular basis, I learned that he often listened to music that reminded me of a local band, ‘Salem Creeps’, who play self-described gucci rock/alternative music. One day I played some of their songs for him and asked him what he thought of them. Lucas’ default response to most things is ‘no’ and so when he told me he liked their music I took it seriously.

This sparked an idea. I decided to reach out to the band and see if it would be possible to organize a personal concert for him. I got their email address from Instagram and wrote to them explaining the situation and asking if they would be able to come and play a few songs at the hospital. To my surprise they replied a few hours later and agreed to put on a full rock concert for us. Their response was a best-case scenario and the next step was to put the plan into action. Lucas has access to a fenced off outdoor space in the back of the hospital which I decided would be a perfect place to hold the concert. I discussed the project with Julie and she quickly agreed that it was a good idea.

I searched the grounds of the ancient hospital for an outdoor outlet where the band could plug in their amps. Because the outlet was far away, I bought a one hundred foot extension cord so that it reached Lucas’ outdoor area. As Lucas and I would be the only people present to watch the concert, I asked the band if the performance could be recorded to share with his family afterward. They agreed and so I rented an audio recording device from the music store in town. The video of the concert was recorded on the guitarist John’s iPhone.

I waited until the day of the show to ask the psychiatric unit if it would be okay if the show went ahead. I knew

this concert would be special and would have a positive impact on Lucas, but I didn't want to slow the process down by having to wait for considerations and approval from the hospital. The universe took care of us and when I called the nurse on duty that day she was happy to hear the show was happening and trusted that it would be a positive thing for Lucas and the rest of the hospital.

This concert was a very unusual event at the hospital. It was beneficial for Lucas and exciting for the other patients, especially because hospital life is usually so mundane and uneventful. However, one of the patients did get distressed from the commotion of the concert. Therefore, if I organized an event like this again I would inform the hospital staff in advance. Although the majority of the staff and people at the hospital were thrilled to see the concert occur, I want to ensure that I am creating space for positive experiences for everyone involved.

Isolation is a real issue for Lucas. Being able to feel a connection to the outside community, especially the music community, and to the music he loved, was a powerful experience for him. The entire concert was around forty minutes and Lucas stood with me and watched the entire show with great interest. His communication is limited but his body language and the fact that he stayed and watched the entire show indicated that he enjoyed it. I asked him a few times throughout the show if he was okay and liking the music and he confirmed he was and gave myself and the band a thumbs up a few times.

Three months after the concert, band members Tim and John did an interview reflecting on their experience of the performance. Considering their music could be perceived as loud or abrasive I asked them why they thought it had a calming effect on some people, including Lucas. John, the guitarist of the group, replied "when you really listen to music and really love it then it's like an escape...but a healthy one." I personally enjoy this type of music as well. While watching the show I was definitely excited it was happening, but nervous that something would go wrong.

Tim, the guitarist and singer, said something that intrigued me: "music is just intrusive thoughts written down...you hear someone else saying these kinds of personal things that maybe some people would be ashamed of admitting that they've thought about or felt like. I don't know, I guess it just makes you feel okay."

This brings to mind a quote from an article in the Summer 2021 edition of *Asylum Magazine* about heavy metal therapy where Kate Quinn wrote, "our emphasis on turning towards rather than away from intense feelings, as a coping strategy puts our approach in direct odds with some of the ideas that are common within mainstream mental health awareness and public mental health resources." These quotes suggest that music can help us face intrusive thoughts, reflect on them and maybe even move past them.

The Open Dialogue approach is a stepping-stone to a new and effective mental healthcare system. It is not

an easy solution that is going to solve all the problems that Lucas and other face at the hospital. Neither is Recreation Therapy or a concert. However, these are all valuable tools that can be used to make real changes. There is no magic cure to a dated and flawed health care system but there are ways to change it and improve it that are attainable when you start looking at the situation in a new way.

'The person is not the problem, the problem is the problem'. Lucas is not the problem I work with when I visit him at the hospital. The barriers faced is where my focus is. His diagnosis and struggles are simply factors, not the whole picture.

Since the concert, I have formed a friendship with the band members, and they have returned to the hospital to play for Lucas and another full concert is being planned. Julie and I are continuing to push for Open Dialogue in the hospital. She is acutely aware of the challenges but says "the most important thing to know is that if you don't push for it, it's not going to happen." Staff who work with Lucas are now reading the 2021 book *Open Dialogue for Psychosis* (edited by Nick Putnam and Brian Martindale) to expand their own understanding of the therapy. The goal is to have Open Dialogue meetings where Lucas is present and heard by the people in charge of his care at the hospital, as well as his family members and close inner circle. Lucas is still at the hospital, but his situation is starting to change. Music is a tool for change.

The interview and concert can be found on Youtube. ■



It Pains and It Roars

ALICE LANGLEY

Who are we?

We are invisible, but we are among you. We are everywhere. We are the adults who self-harm.

Some things you leave behind in your teenage years, others you take with you. Some behaviour you occasionally revisit. Some people might stay up drinking – albeit better quality booze now – until it gets light. For me, it has been self-harm. I believed I had left it behind, like PE and Claire's Accessories. But it remains, lying in wait. Hidden in the shadows until you are vulnerable, until you have started to hollow out, and then it will creep back in, to fill the void with darkness and evil thoughts

I made it five years. No long sleeves in too-hot weather. No excuses about cat scratches. No squirrelling away sharp objects.

As a teenager, depression crept through me, along every vein, until I felt like the only way to let it out was with a pair of scissors. I spent hours in the PE teachers' office while they called my mother. My Chemistry teacher had spotted the thread-like scratches on my thighs.

No one expects it of adults. You're meant to have your shit together. You survived your teenage years and now, like soldiers returned from the front, it's supposed to be over. No more drinking in parks beneath the swings. No more being dragged out of bed to go to school in the mornings. Now you have to get yourself up and brush your teeth, unprompted. No more homework. No more rules. No more self-harm.

But it crept back in. At thirty years old, I am ashamed that this seems to be the way I am holding onto my youth.

People barely notice the scars, criss-crossing my forearms and legs. A few know, but not many. I have discovered that bruises are far more innocuous than a myriad of scratches. No one notices a bruise, even if they do, the excuses are limitless.

I banged it on the door frame

I don't know – so weird

People don't question. They don't realise that the greeny-yellow patch on your arm is from where you stood staring into your blank, overflowing eyes in the mirror, repeatedly hammering your arm bone against the rim of the sink. That same mirror you meet your husband's eyes in when you brush your teeth together. Like I said, really, you're too old for this. A brief internet search (I try to avoid looking up self-harm on the internet) led to a solitary article about adults that self-harm. We are a hidden pocket of society.

We don't want to die, to stop existing. It isn't that. Like everyone else, we eat greens when we'd rather have

pizza. Stop smoking. Don't drink too much. It isn't even that sway on the train platform - the *will I won't I* wonder of that moment in between being and not being everyone has from time to time.

No. It's pinning ourselves **HERE**. Like butterflies to cork. To feel present, to reappear. We attach ourselves to the world, with scissors and knives. Razors and pins. Matches and lighters. Yet, this brazen act of visibility results in our disappearance.

It rains and it pours and it pains and it roars. Not one single voice telling you that you are worthless. It's a cacophony. Won't be, **never have been** good enough. A blistering snarl shrieking, louder and louder, pushing forward memories of every failure, every hurt, every grievance. Amplified in technicolour until it is blinding. A howl that is too loud, too painful to be contained within, so you take it outside. You smash your arms into walls, against doorframes. You slash. You tear at your hair until it comes away and you scratch at your face until it is slippery with tears.

And this. This is the irony of it.

IT DOESN'T HELP.

IT DOESN'T HELP.

IT DOESN'T HELP.

There will be a moment. A brief silence so profound your ears ring. But then the roiling turmoil begins again.

What is the alternative?

Self-harm literally makes a tiny puncture, letting out a fraction of that poisonous cloud within.

just enough to diminish it to a manageable level

a level that you can ignore

carry on with your day

smile

be nice

and all along you're holding in a whole tsunami and god knows what would happen if it was released

if you just ...

Let...

go

No.

It must be better to keep it within, contained inside the shell of your own skin as it slowly eats at you from the inside out.

One of the huge problems with having poor mental health is that it seems your choices are limited. That, all around you, doors are closing and the only path you can take is the one you're already on, wearily putting one foot

in front of the other without any change, any hope, as you gradually fade.

It doesn't have to be that way.

Finding a light, a torch, to shine into those dark places and discover another path, an alternative, isn't easy. But it is possible.

What if...

The thought is terrifying.

What if, instead of fading, you chose to stay. What if there was another way. To become visible again. Slowly withdraw the bolt from the bathroom door and come out.

Unlock yourself, a little at a time.

You are not nothing.

You are not nothing.

You
are
NOT
NOTHING

You are made of magic and all magic spells have the potential to turn dark. But good always wins in the end.

Talk to someone. They may listen. They are stronger than you think

Go outside. Howl at the moon, at the stars. On the cliffs where the waves crash below

Shop on the internet

Take medication

Don't take medication

Hold handfuls of ice cubes (that never worked for me, but this is your spell. Your power)

Get a cat

Fight to be here. Force yourself to appear, part by part. You may not be whole again. There will be fragments missing, like lost pieces from a restored vase. But you will be you

Be kind. You don't know what lies beneath someone else's shell

Don't compare. Our lives are bubbles, gently bumping against each other. Press too hard and one of us will burst

It rains and it pours, but the sun will shine again. ■

Alice Langley is a writer and theatre maker based in Glasgow. Her previous writing has been published in Second Chance Lit, Not Deer Magazine and Pot Luck Zine.

RACISM AND EXCESSIVE USE OF FORCE



On 27th October 2021 I attended a webinar entitled 'Lived experience Co-production, race and

restrictive practices' organised by the Collaborating Centre for values based practice in health and social care, based at St. Catherine's College in Oxford. The main focus of the webinar was police brutality, institutional racism and excessive use of force on black people (mainly black men) within psychiatric settings.

The testimonies of Ajibola Lewis and Marcia Rigg constituted the most powerful and moving moments of the webinar. Ajibola Lewis is the mother of Olaseni (Seni) Lewis and Marcia Rigg is the sister of Sean Rigg. Seni was a 23-year old black man, who died after being restrained in the prone position for 45 minutes by 11 police officers at Bethlem Royal Hospital in south London in 2010, having checked himself in voluntarily for a mental health episode. Sean was a 40-year old black man, who – whilst having a psychotic episode in 2008 – suffered a fatal heart attack in Brixton police station (south London), following police officers restraining him in a prolonged prone position. Both men's inquests asserted that 'excessive, unnecessary, unreasonable' restraint by police contributed to their deaths. The police officers involved were never punished; on the contrary, both cases were characterised by police cover-up and complete lack of accountability, whilst pointing to failings of mental health services on multiple levels.

Both Marcia Rigg and Ajibola Lewis highlighted that police brutality and the use of excessive force on black men is a global phenomenon which does not confine itself to mental health settings and reflects deeply entrenched institutional racism. Both women are very actively involved in the *United Friends and Families Campaign* (<https://uffcampaign.org>), a coalition of those affected by deaths in the hands of the state, including police, prisons and psychiatric custody.

Notably, Rigg drew links to the case of Sarah Everard, a 33-year old woman, who was kidnapped, raped and murdered in London in March 2021 by Wayne Couzens, a Metropolitan police officer. Couzens, who burned Sarah Everard's body to try to hide his crimes, received the rare whole-life term sentence, as his crimes involved him abusing his position as a Metropolitan police officer to kidnap Everard (it is likely that he utilised Covid-19 powers to trick Everard into a car, using his police warrant card and handcuffs to restrain her).

The webinar highlighted that in order to combat institutional racism and achieve a reduction in the use of excessive force and restrictive practices in mental health services change on multiple levels is needed – legislative change; change in organisational cultures and staff mindsets; change in the domain of resources; as well greater involvement of the families and communities of mental health service users in their care. ■

Dina Poursanidou is member of the Survivor Researcher Network CIC and the Asylum editorial group

Mad Studies: Setting the Tone

ALEX DUNEDIN

“...I’ve written and published such and such, blah blah blah.... It would be very valuable to me personally to be a part of the Mad Studies course as it would provide me with important opportunities to bring together my collected thoughts on mental health and continue to be a part of a vibrant critical mental health movement.

I feel that I could bring to the programme my lived experiences as someone who has contended the psychiatric system as it is and as someone who is angry about the injustices which are recreated in culture and through pernicious myths. I would also bring to the programme scholarly skills, research experience and my passion for analysing complex problems relating to how people’s behaviours are perceived and to institutionalised structural violence.”

This is the tail end of the personal statement I made to get on the Mad Studies MSc course which Queen Margaret University are running; the first in the world I am led to believe.

As someone without formal academic qualifications getting this personal statement right has been very important. Language matters, the words matter; sticks and stones may break my bones, but names encourage people to hurt me. The uses of the word ‘Mad’ I contend with. It is a word that is loaded and used as a weapon, a word that condemns people to pre-conception even in the face of alternative evidence.

To me, Mad Studies means anger, an emotional reaction in response to injustices. My approach is based on the standpoint that equity should be the highest principle of the legal system which society creates to settle disputes. I am Mad-angry because of the lack of equity-equality in the structures of our society and in how people are met when something ails them.

Rubric bound systems have negated the voices, knowledge and experience of people who are perceived to be the targets of the dominant medical system. People have been traumatised by the way they have been treated by the apparatus established by other human beings. It boils down to inequality of treatment – how one person is treated unequally to another, which contravenes the human rights of certain individuals.

I take no fixed position on matters of well-being for mind and emotion and think it is problematic to do so. If we are not open to new information, or to exploring perspectives which don’t accord with our own view, we are set adrift

from the tools which help us navigate complexity. There are no categoricals that hold true on close scrutiny.

There is something important to be found in the accumulated information of the medical model of mental ailments. For example, there is little doubt that mercury poisoning affects psychological well-being; and there is something equally important to be found in the social model of mental ailments (there is no doubt that bullying affects mental well-being). Exposure to mercury disrupts the normal functioning of the nervous system; social predation causes psychological maladies. Surely we need to respond in complex ways to complex situations?

People are locked into policies and peer group responses that fail to take on new information. Camps form and people feel compelled to agree with pre-packaged positions that do not represent their experience and knowledge. We lack the skills and practices to help us act appropriately where there are disagreements.

It seems that emotional reactions to financial impoverishment are met with powerful, debilitating and life-shortening drugs but only those which come via the prescription pad. Alternatives, like cannabis, are met with criminalisation. Mention some natural molecule which cannot be patented, and we are met with the shunning silence of specious orthodoxy.

In psychiatry, we seem to be no further forward than tautological accounts of well-being – ‘they’ are psychologically incompetent because ‘they’ have a biochemical imbalance in the brain; however, we are offered no account of what a biochemical balance looks like or how to achieve it. Counterbalancing this is the perspective that ‘it’ is all psychologically-based, but this fixed position takes no account of an aberrant food chain or toxic environments that disrupt neurotransmitter systems, endocrine function and physiological well-being.

Take, for example, organophosphates. They are used as nerve gases during war and post-war put on crops to kill insect life and boost yield. When raised as a valid issue I am denoted as ‘conspiratorial’ and ‘out of touch with reality’, despite citing peer reviewed science. When opioids and petrochemicals, which are known to affect normative neurological functioning, are added to foodstuffs, triggering cravings and affective disorders, nobody wants to know. We hear about positive psychology, but not about the crippling poverties of a toxic society.

I’m angry about the fact that the planet’s apex predator – homo sapiens – has turned on itself and all other forms of life. I’m angry about the natural world being turned

to foodstuffs or yoked as a pleasure toy. I'm angry that this goes unacknowledged, but I am called mad and problematic for raising it. I am silenced because I raise such issues when asked what pains me. I am deemed mad not to be party to this.

But I don't want to fight. I don't want any more violence. I want peace. I want to be left alone in my difference, to be....

Asylum, grant me asylum. I call to the weather, the rain, the re-configured homelessness, for I am effectively stateless...

"I don't have to tell you things are bad. Everybody knows things are bad. It's a depression. Everybody's out of work or scared of losing their job. The dollar buys a nickel's worth. Banks are going bust. Shopkeepers keep a gun under the counter. Punks are running wild in the street and there's nobody anywhere who seems to know what to do, and there's no end to it. We know the air is unfit to breathe and our food is unfit to eat, and we sit watching our TVs while some local newscaster tells us that today we had fifteen homicides and sixty-three violent crimes, as if that's the way it's supposed to be. We know things are bad – worse than bad. They're crazy. It's like everything everywhere is going crazy, so we don't go out anymore. We sit in the house, and slowly the world we are living in is getting smaller, and all we say is: 'Please, at least leave us alone in our living rooms. Let me have my toaster and my TV and my steel-belted radials and I won't say anything. Just leave us alone.' Well, I'm not gonna leave you alone. I want you to get MAD! I don't want you to protest. I don't want you to riot – I don't want you to write to your congressman, because I wouldn't know what to tell you to write. I don't know what to do about

the depression and the inflation and the Russians and the crime in the street. All I know is that first you've got to get mad. (shouting) You've got to say: 'I'm a human being, god-dammit! My life has value!' So, I want you to get up now. I want all of you to get up out of your chairs. I want you to get up right now and go to the window. Open it, and stick your head out, and yell: 'I'm as mad as hell, and I'm not gonna take this anymore!'"

This speaks to me, but it is on the TV. It is fiction, drawn from people's lives, and leased back to us. It is from the 1976 film *Network* with Peter Finch and Faye Dunaway. It is a parable of our iatrogenic times – I want to stick my head above the parapet and say how mad I am about the mind sickening culture that has been created. I am angry and scared because I know how critical speech is reacted to if you don't take the shilling to be silent.

I wrote this piece to record how I go into this Master of Science on Mad Studies. There was no space in the digitised application process to record what it really means to me. I'm going into the institution with hope because I've not sold my silence for a shilling. We are a people divided from our selves – estranged from our authentic possibilities – betrayed by the response to our suffering.

We are made crazy through being starved of the things we need – food and social relations; we are maligned for taking drugs which blot out the modern and technocratic forms of cruelty and impoverishment; and we are disturbed that evil is banal and in every day actions. I am left with the final dignity of speaking the truth to this dread filled culture of deference. This is part of my final dignity that I share. ■

Alex Dunedin is an independent researcher who works with the community education project, *Ragged University* and *Asylum* magazine.



International Mad Studies Journal

Founded by a psychiatric survivor in Australia, and developed by like-minded people from around the world, the IMSJ is a platform for the sharing of Mad knowledge and alternative perspectives on mental health. In addition to peer-reviewed articles, it seeks out unique and unheard voices presented in creative ways through comics, fiction, poetry and other forms of artistry.

imsj.com

MADNESS IN MOTION

CASEY CLABOUGH

“I can calculate the motion of heavenly bodies, but not the madness of people.”
– Isaac Newton

Schizophrenia is madness in motion. When I am psychotic – when I see and hear things others do not – it seems as though the buzz of atoms, the molecular bonds that hold things together, reveal themselves as tiny humming grains beneath the appearance of my surroundings.

It took me a while to learn my illness isn't like other ways of being sick: it knows everything I know. It uses my brain against me and the more active and operational one's brain, the more powerful the disease: the more tools it has at its disposal. When I learn new coping methods so does the disease, which in turn seeks to undermine them. As I say, it knows everything I know. That is why a lot of the time I choose to blunt my brain: with drugs, with alcohol, with sleep.

For a long time, I existed in a dysfunctional zombie-like haze before I learned to manage a rough, teetering balance between sedation and awareness. I don't take the full dosages of the drugs I'm prescribed, but neither do I totally go off them. Without them I'm insane, yet the full dose deadens my ability to feel—to write, like I'm writing to you now. Even cutting back, it's not within my power to write with the same intensity of feeling I used to; the meds and the disease won't let me. Maybe if I went totally off the drugs I could, but then I'd be crazy and with that there's always the chance I could hurt myself or, worse, someone else. It hasn't happened yet, but I'd be lying if I claimed it hasn't *almost* happened.

Mornings generally are the hardest for me. I awake with songs in my head: stupid catchy songs, rendered in different voices with ridiculous alternating accents that play themselves over and over. I shuffle around anxious and unable to concentrate until my meds kick in. Then I can focus for a while, maybe thirty minutes: long enough to crank out a few sentences; not long enough to work a job.

None of this is ideal, but I have managed to remain more grateful than dissatisfied. That's because I've been



a lot worse off: utterly dysfunctional, suicidal, locked up against my will with people a lot sicker than me. And I think of those people if I begin to feel sorry for myself: homeless, living in halfway houses, quietly vegetating on wards or in prisons. It's as much for them as for me that I try to be productive: to eke out what I can from what damaged gifts remain. The people I think about have lost their voices, but not their lives, and because they cannot speak, I try to do so for them. So, when I write about my condition it sounds in my head not like a single voice, but a chorus. We're writing schizophrenia. It is insanity channelled, bound with brittle bonds.

It is madness in motion, held in check, but spilling out a little onto the page through one of its many victims which, here – in these pages – just so happens to be me. ■

Casey Clabough teaches in the *Etowah Valley Writers MFA* at Reinhardt University and this is an extract from her unpublished memoir about the experience of schizophrenia.

CoVid 19 and Castles in the Sand

HENRY BLADON

Talk about fake news. There's no room for doubt in dogma. The sacred religion of psychiatry is like any other belief-system imbued with false confidence. But, stand back and admire the total commitment to the cause, the credo delivered in unassailable fashion. The medicalised version of reality means that the bar is set so low that everything becomes a problem. Eventually, even the simple act of blowing your nose could end up being added to the list of diagnosable 'illnesses'. This may sound ridiculous but stop and consider what it is people are attempting to diagnose. In an effort to sound scientific, classification is category creation, providing a sense of permanence, to fathom the unfathomable. This self-serving process will spew one unwelcome label after another until we have a fat reference book to prove to the world that, at last, you know what you're talking about. Oh, wait. We already have one of them and it's supported by wild assertions of chemical imbalances that have been so successfully pedalled

to the public that they (in the most part) are happy to accept the psychiatrist as the 'expert' who must be obeyed.

A perfect example of this process in action is how psychiatry has attempted to appropriate the pandemic. The epidemiological lexicon got unleashed, warning about an epidemic of illness spreading like 'hysterical contagion.' Talk of a 'tide' of mental health issues is nothing new, but this didn't stop the psychiatrists. Like a kid in the candy store, they rushed to stake their claim, describing newly invented syndromes. Among them was *coronaphobia*, a 'classification' for the 'psychiatric ramifications' of the coronavirus pandemic, the symptoms of which include 'compulsive hoarding of groceries'. Honestly, you couldn't make it up.

Only, they did! ■

Henry Bladon is a writer, poet and mental health essayist based in Somerset in the UK.



Hundreds of people from all over the world have been taking part in an international Soteria and Peer Respite Summit. Soteria House and Peer Respite models are both ways of supporting individuals experiencing distress and/or life-interrupting challenges. Both allow individuals to stay voluntarily in a homelike environment, providing 24/7 safety, support, and affirmation from non-clinical staff as they go through whatever they are experiencing. Despite not requiring psychiatric medications, both models support individuals and help them avoid hospitalisations.

It was truly a historic event, hearing from people all over the world, sharing their experiences of setting up and running such projects. Each session included

presentations and discussion, many people staying on-line for hours after the official end time to continue discussions. Sometimes discussions weren't easy – this, is after all, extremely difficult territory – but the organisers ensured that discussions were facilitated compassionately and inclusively.

It is not too late to join a worldwide community of people who share a passion for justice and equity in mental health. A network providing connection and learning opportunities, mutual support, and a resource repository for developing compassionate alternative approaches to supporting people experiencing life-altering distress. Collectively, we have the power to build supportive and inclusive places that value self-determination in every community in the world, replacing the use of force and coercion in the mental health system.

<https://www.alternatives-conference.org/> ■

Creative writing

In Retrospect...

BY SAMANTHA J. LINDERER

I sit motionless in a waiting room chair

My father sits across the room
Watching me like one stranger watches another
Silence engulfs us
And he breaks it first
“How do you feel right now?”
I laugh inside of myself
At a memory of him looking me in my eyes and saying
“Some days I feel like you choose to be sad.”
When validation was the band aid
He told me to rub some dirt on it
“I feel nothing.”

Is that what you wanted me to say Dad?
Was that easier for you to hear?
But the truth is I did feel nothing
Not the kind of nothing you wanted me to feel
I was numb from the inside out

I sat emotionless in a waiting room chair

The magazines are boring to look at

My mother sits across the room
And her eyes cannot bear to meet mine
Silence engulfs us
And she breaks it first
“I just don’t understand why you do it.”
I laugh inside of myself
At a memory of you slamming your fist on the wall
Your voice rising and shaking with rage
Because I wrote what I felt on the skin of my thighs
And I’d forgotten to bury the evidence
“It doesn’t mean you’re a bad parent.”

Was that the right answer Mom?
Is that what you needed to hear?
You didn’t want to know why
You never actually asked
You just wanted to know it wasn’t your fault
The magazines were all you would look at

My fingers dance to a nervous song

A psychiatrist sits across the room
And she surveys a patient health questionnaire
Silence engulfs us
And she breaks it first
“We’re going to up your dosage.”
I laugh inside of myself
At the thought of you being able to understand
The weight of what I felt on a scale of 1-5
In a window of 15 minutes
“Whatever you think is best.”

Did I get it right Doc?
Did you get me in and out on time?
A little overmedication wouldn’t hurt her
And you couldn’t be bothered with specifics
You had 23 other group members to see

My fingers danced as a side effect

It’s as if I am living to die

A therapist sits across the room
And I stare at her lifeless and wounded
Silence engulfs us
And she breaks it first
“Just try to see the positives in life; it’s as if you’re living
to die.”
I laugh inside of myself
At the ways my seams have ripped, trying to hold on
Unable to appreciate the good in the bad
Because the bad was desolate; lonely
“I suppose I hadn’t thought of it like that.”

Am I the ideal patient?
Is that really what you hoped I would say?
You couldn’t see how desperately I was trying it your way
But there’s no healing in avoidance
And I the walking wounded
Couldn’t you see I was dying to live?

Poetry

A lot has changed for me since the last issue and the poems coming into Asylum have been a reassuring and grounding presence. While many wonderful poets have sent us their work, those whose work found a home in this issue use language as a way of relating to and defining identity. They ask what happens when language cannot encapsulate experience, and boldly demonstrate the freedom that can be found in the expression of self. From the unyielding tongue of the mother in Ornamental Hermit's DRY TONGUE to the gentle exchange of sounds rather than words in Maija Haaviasto's 'Bad Fake', the following poems work in a dedicated and dirty handed way with language.

If you are interested in having your work featured in future issues of Asylum, or would like to tell us about some poetry that you think deserves some extra recognition, please send up to 3 poems, or up to 500 word poetry book review, to Adrienne Wilkinson at adrienne.asylum@gmail.com.

A song about that thing you get on medication...

No Words Escape Her

Ornamental Hermit

My Mother has a DRY TONGUE
every morning a DRY TONGUE

no tastebuds rest in a spit sarong
no call and response, no ding then dong
her plosives sprawl all flat and long
fricatives wander where they don't belong

my mother has a DRY TONGUE
every morning a DRY TONGUE

tongue like a bell, old nut in its shell
like extreme heat-shrinkage in the pit of hell
tongue like a tuft in a dried-up well
prayer or expletive you just can't tell

My Mother has a DRY TONGUE
every morning a DRY TONGUE

Like the tide's gone out on a stranded song
like the furred ferule that dukes the gong
piped choux pastry baked too long

like the push-up bollard in a parrot's beak
like the thing that makes the staircase creak
terracotta gewgaw bunged in her cheek

a sun-dried slug that's not quite dead
some old growth that Autumn's shed
all sounds compacted into zed

submarine that's sunk below
a missile docked in its silo
an afterthought, an undertow

if I catch what she says I'll let you know

Seed

Fred Gerhard

My life is male but not masculine – often
as not-my-life is woman – but not woman

This – none of it identifies who I am –
that is no mystery

The turning fuchsia hang from
my porch in autumn noon light

bright yellow leaves are there – were not
yesterday

and I watch them from the music room's
plush floral sofa

because I am cold – my fingers
even as I write this – seek warmth

in words from a crystal pen
curiously free from ideas engendered

There is simply me and – next
like dancing fuchsia

in my half-spin – the label
peeled from the pot long ago

when I was a seed suspended in
black soil

Bipolar Messiah

Anne Marie Brian

I can ...
Fly like an angel
Across the sea
And love everyone
Even if they hate me
I can ...
Smell the sun
On the trees
And instantly put you
At your ease
Or listen to the grass
And feel the running feet
Of ages past
I can ...
Look into your eyes
And see your ancient soul
And hug you
Until you feel completely whole
I can ...
Catch the moonlight
On the lake
And tangled cobwebs
Made of lace
To weave an Elfin gift for you
I can ...
See the world
In a single flower
And stop you picking fruit that's sour
And taste it first
So you don't thirst
can ...
Catch a rainbow
For all to see
And dance in the light
That follows me
And in my mind's eye perceive Prophets of old
In raiments of gold
I can ...

See God in the faces
Of people I meet
Especially the poor ones
On the street
And, feeling the love
They badly need
Try to protect them from
This world of greed
I can ...
Let down an onion
Into your hell
And as I chant my ancient spells
A kindly spirit
In my heart
Beckons me to take your part
I can ...
Write a Sonnet in sixty seconds
And play a tune
As if fame beckons
Or dance in the nude
And make you laugh
Until you ache for solitude
I can ...
See the face of Jesus
In an ordinary window
And breathe
The changing seasons
Like a silver minnow
And imagine the world
Through the eyes of a fly
And
Climbing higher
Walk into the sky
What am I?
You call me "Bipolar"
But
In days gone by
I am Mage, Soothsayer, Auger, Shaman, Prophet,
Witch, Saint, Madonna, Joan of Arc,
And
Messiah

Bad Fake

Maija Haavisto

when sunlight was icy
and burned my skin like
spirits in an open wound
someone turned it off
just like that
without making a fuss

when I tossed around in bed
unsure if I was asleep someone
went and hung up nets for the
harsher falls

I'm not sure if it was you
or if I did it myself and forgot
I have forgotten so much
but not the chilling cool
how you hushed me
and it made things okay
how the nets weren't real
yet it still helped
the sun was a bad fake
but at some point it changed
from the wan fluorescent blue
back to its nuclear blaze

To bear witness

Bethany Walker

I am the keeper of your secrets.
The whispered calls, the hateful acts, the violent ends.
I am the balm for your scars.
The moments that broke you – cut you – shattered you
to where you never thought you would come back together again.
I am the witness to your pain.
I sit with you in the silence, soaking in the weight of the words as they tumble out.

It's a privilege and a burden,
To hear the worst of humanity and the victims they have taken
To see the strength of resilience and the hearts that can mend.

I'm often the first.
The first to hear how he hurt you, your childhood ended too soon
The first to know the words that turned to knives in your heart
The first to see the lines from the times you tried to no longer exist

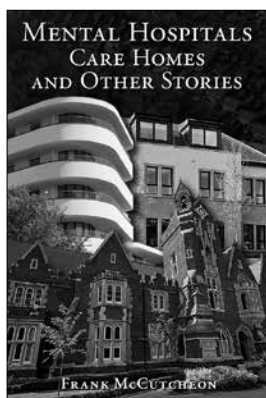
At times I'm the last
The last place you expected to find yourself
The last Hail Mary attempt before you drown
The last time you'll be able to say "I've never told anyone this"

I will listen.
I will hold your pain.
I will let you exhale it all
So your lungs can fill enough to breathe
I will bear witness as you see yourself return

Book review

Mental Hospitals, Care Homes and Other Stories

by Frank McCutcheon
Fulmad (2021). 252 pages
£19.99



REVIEWED BY PHIL VIRDEN

Served up in 138 easy-to-read bite-size segments, *Mental Hospitals, Care Homes and Other Stories* is a selection of the memories and reflections accumulated by a former mental health nurse after working in the field for forty-five years. Most of the book consists of stories of everyday situations and incidents inside the psychiatric system. As it says on the cover: 'Frank McCutcheon lifts the lid on what happened – and is still happening – in mental health in-patient facilities and care homes.'

Mental Health and Care Homes have become a surprisingly popular topics over the last few years, and this book should prove absorbing reading to interested members of the general public as well as to patients (aka clients), former patients (aka survivors), residents, and current or prospective workers in any of the 'caring professions'.

To support patients' interests, the author was already a MIND volunteer before starting his career in mental health. As a student nurse, and in good faith, he willingly signed up to the conventional 'medical' wisdom. This enthusiasm lasted until awareness of the systemic inhumanity gradually dawned on him. Actually, 'Frank McCutcheon' is a pseudonym the author employs to protect the anonymity of those he writes about - especially the patients and ex-patients he wishes to protect from embarrassment, stigma and even the risk of vindictiveness from functionaries who might recall some of the events.

This might sound ominous, but in fact the overall tone of the book is not dispiriting. The author applauds the good intentions and dedication of some admirable mental health workers. He also offers a smattering of humorous anecdotes (some a bit 'dark'). But unfortunately what mainly sticks in his mind is all the woeful maltreatment. Most of his tales are therefore instructive: by exposing the pernicious effects of a routinised and minimal 'care', doled out indifferently and according to the bigoted misapprehensions of the dubious medical model, they

add up to a stark warning of how care should *not* be practiced.

In the preface, the author warns that he had actually seen worse: 'Some stories involving cruelty and untoward death were too horrific to mention; and given their high-profile in the media at the time, would be too easy to pinpoint.' For this reason, his stories mostly illustrate varieties of habitual staff prejudice, carelessness and poor practice, the niggling pettiness, the failure to respect patients, demoralising humiliation used as means of control, and casual but too frequent neglect and abuse. And running through the whole mental health enterprise is a predictable, wearisome, deadening inertia. On a psychiatric ward (or in a unit), nearly every worker with any authority at all would consistently prioritise their idea of the smooth-running of the organisation over the needs the patients. Whenever staff dealt lazily with 'difficult' patients, this principle was confirmed among them by mention of the joke acronym: AFQL - Anything For a Quiet Life. In general, it seems that genuine 'best practice' so far only has a foothold in some of the community-based services.

You could say the author gets rather too painfully honest when he reveals some of his own iffy nursing decisions. Most were when he was young, and he puts them down to inexperience, being taken in by the medical model, and having to follow orders. In time, he came to see right through the medical model and the generally oppressive nature of 'care'. He was also able to step up into management and make some changes for the better.

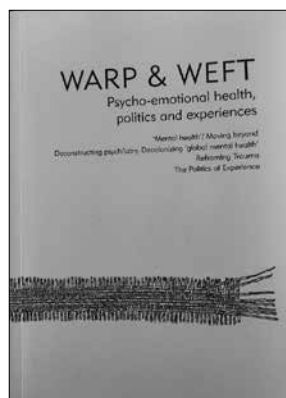
At the front of the book is a helpful glossary of technical terms, acronyms and jargon. At the back is a brief discussion of the issues raised, followed by some recommendations. These refer to routine malpractices which could so easily be addressed. For instance: iatrogenic harm from psychotropic medications; changing meds without informing the patient; high-handed, condescending, disrespectful and stigmatising staff behaviour; name-calling/labelling patients, (e.g., 'manipulative' uncooperative', 'sociopath'); taking away patients' possessions; lack of privacy/invasion of patients' personal space; excluding patients from information and decisions on their own care and treatment; making patients feel watched; staff 'forgetfulness' (i.e., they regularly fail to keep the promises they make to patients); keeping patients waiting at their appointments with the psychiatrist; the team's deference to the psychiatrist despite their own well-considered collective opinion; evasive responses to patients' requests to leave or be discharged; a distinct lack of talking therapy - conversations with doctors and nurses are only seen as inconsequential 'chats'.

Not a lot to ask, you'd think. Surely a start could be made on this list? Ah, but there's always AFQL... ■

Book review

Warp & Weft: Psycho-emotional health, politics and experiences

by Lisa Fannen
(2021). 438 pages



REVIEWED BY JOY M ROONEY

This book is an up-to-date synthesis of Lisa Fannen's views about "psycho-emotional health" (how we feel, what happens to our body and soul, not just our head, mind or brain). Fannen is a radical health activist, bodyworker and community herbalist. She moves beyond and breaks down psych/iatry (meaning: soul/ medical treatment). She considers changing (decolonising) global mental health through global North, South, East and West interactions. Trauma is reframed through broadening out from the individual to the collective, considering social trauma. The politics of experience is considered in its widest sense by superseding the pathologising of our consciousness, distress and struggle away from biomedicine into a social and spiritual context. Ideas are provided at the end of each of the four sections for group/collective conversations

While this is not designed as a self-help book, it may be of assistance to those who wish to study alone and certainly I learned lots from it. It includes many original, practical exercises for release, rest and reconnection in an appendix.

The scene is set by examining past and present thinking in biomedicine and "mental health". It includes so much information it is difficult to pick out what learning stood out for me. Possibly it was her critique of the de-stigmatisation of mental health campaigns. She believes we really need to talk about "the impact of the alienation of most work structures and the division of labour, of class inequality, the injustices around economic and social resources, intergenerational trauma, structural racism, the violence and meaningless of consumer capitalism and the grief of environmental damage" (p. 64).

The book forces the reader to re-think what they know about psych/iatry, its history and global imposition. Psych/iatry often supresses indigenous understanding and healing approaches to distress, struggle and/or variable consciousness. For me, the idea that psych/

iatry is associated with individuals, rather than society, politics and cultures was new learning. Healing is seen as restoring balance with the self through relationships with others in the environment, using holistic integrated approaches.

In part three, trauma is considered using an alt-biomedical model – a biomedical model plus alternative/progressive mainstream ideas that look inside us. Then Fannen looks outwards into the experiences of distress, in all its forms, and tends to it there. Collective, rather than individual care, is the starting point for resolution in radical compassionate and embodied ways. Her alt-biomedical model considers things like "how do we reset, rest, renew, reconnect, re-associate?" and "how do we respond and reimagine?".

The final section is about the politics of experiences, named after the title of a book by R.D. Laing, a leader in the anti-psych/iatric movement. It honours the use of diagnosis but critiques the classifications of experiences of consciousness or distress. Symptoms may be considered as protests against oppression. Diagnostic labelling is set aside for a broader, more accurate and useful language of experiences with collective care.

Warp & Weft is an assured read on psycho-emotional health, trauma and the politics of experience. This book is companion to her feminist health book *Threads* (2018). Both books are available at www.threadsbook.org for free, however, they are also in print through www.actedistribution.org at £8-91 and £4.75, respectively. They are published creative commons and not-for-profit. ■

Dr Joy M Rooney is a researcher, who also teaches models of health and the complexity of psycho-emotional distress to OT and nursing students at the University of Worcester.

Book review

The Zyprexa Papers

by Jim Gottstein

REVIEWED BY DON WEITZ



Activist and lawyer Jim Gottstein is a hero, and his book *The Zyprexa Papers* is a bombshell. In this exposé, Gottstein shows how and why he took on and exposed Big Pharma giant Eli Lilly, the manufacturer of Zyprexa (generic name olanzapine). Over 10 years ago, Lilly was convicted and fined hundreds of millions of dollars for misinforming the public and hiding the many risks of another of its best-selling drugs: the suicide-inducing “anti-depressant” drug Prozac. With the courageous help of Dr. David Egilman and *New York Times* reporter Alex Berenson, Gottstein decided to go public with the awful truth. Not only does Zyprexa, a huge money-maker for Lilly, cause diabetes and other life-threatening medical disorders; but Lilly was deliberately and criminally covering up these serious risks in secret documents.

The book reads like a gripping detective story. Gottstein gives blow-by-blow accounts of his many legal protests and courtroom strategies against Lilly, and documents several obstructionist tactics by lawyers for Lilly and the Alaska Psychiatric Institute (API).

The *Zyprexa Papers* also documents Gottstein’s unyielding and courageous defence of psychiatric prisoner Bill Bigley. After some 80 or more “involuntary commitments” and years of forced drugging with numerous doses of Zyprexa, Bigley died at 59, despite Gottstein’s awesome and relentless fight, in and out of court, to save his life. Gottstein does not specifically say this, but I will: psychiatry, and its forced drugging, killed Bill Bigley and thousands of other victims. You won’t find this damning fact in any coroner’s report or medical journal.

Unfortunately, there are many thousands of Bill Bigleys. My long-time friend, the anti-psychiatry activist Mel Starkman, was also prescribed Zyprexa for many years. I’m damn sure his doctors never warned him about diabetes and other “side effects.” I sometimes wonder if Zyprexa, which suppresses the gag reflex, contributed to his choking death last year in a Toronto

nursing home that covered up the circumstances surrounding his death.

The *Zyprexa Papers* should serve as a worldwide alert, a wakeup call about the pandemic of health crises and deaths caused and covered up by Big Pharma giants like Lilly, as well as Glaxo and Pfizer (the manufacturers and promoters of the “anti-depressant” drugs Paxil and Zoloft, which, like Prozac, are known to cause suicides, among their many other dangerous effects).

We need many more class-action lawsuits and independent investigations against these and all the other pharmaceutical mega-corporations that produce and promote these. As well as “antipsychotic” drugs (neuroleptics) These drugs are unethically and fraudulently marketed as “safe and effective medications” and approved by the U.S. government’s complicit Food and Drug Administration (FDA).

The Zyprexa Papers shows us why we need more advocates and courageous whistle-blowers like Jim Gottstein, who will not only fight for the freedom and human rights of psychiatric prisoners, but fearlessly expose the lies and crimes of Big Pharma and psychiatry. Silence is not an option. ■

Don Weitz was a psychiatric survivor and social justice activist. He died in Sept 2021, at the age of 90, after a lifetime of activism. Don co-founded the *Ontario Mental Patients Association* in the 1970’s and *Phoenix Rising: the Canadian antipsychiatry magazine* in 1980 (which ran until 1990). He co-edited (with Bonnie Burstow) *Shrink Resistant: The Struggle Against Psychiatry in Canada* (1988) and wrote *Resistance Matters: the Radical Vision of an Antipsychiatry Activist* in 2018 (free to download from the internet).



Don Weitz (1930-2021)

Ms Benn, pretend journalist, interviews Miss Diagnosis



Ms Benn caught up with Miss Diagnosis one Friday night and asked for an interview.

Miss Diagnosis was quite taken aback as she's only been around as a real character for six weeks; but Ms Benn was adamant about getting an interview in case she vanishes.

Are you aware of dissociative amnesia Ms Benn?

No, tell me about it.

There's not a lot to tell. That's the point.

Oh, well let's chat anyway and see what comes out. Why did you go on stage Miss Diagnosis?

Well, it all started when I wrote an article about the case for trauma-informed social change in the Spring 2021 edition of Asylum. After it was published, I gave what was supposed to be a serious presentation, to six medical staff in my GP surgery. This was encouraged by my Social Prescriber and Doctor. I realised after doing this that the likelihood of me becoming a professional speaker was about as likely as me shopping from Amazon ever again. Not likely!

So, if you can't do something, you create something else to focus on. Useful strategy eh? What did you do next?

I did some guerrilla advertising for Asylum and wrote about it for the Autumn issue. I combined a little stint of walking around the streets of Tower Hamlets in the summer wearing a pair of gardening gloves and carrying a sign saying, 'Free Gym. Pick up litter. Get fitter.'

Then I had an idea for an improvised show, 'Britain's Got Nutters', and took it to Dan at The Backyard Comedy Club. He did not share my excitement which was a bit of a downer; but Dan being the encouraging chap he is, suggested I go on an improvisation course.

I got home, and straight away, did an internet search, and in the next hour was taking Stand Up Comedy 101 on Udemy for £17.99.

Somehow all this evolved into Miss Diagnosis as a real character doing stand-up lunacy.

I've even got a new T-Shirt, advertising Asylum Magazine and my list of Disorders. There is a very serious reality to being called Miss Diagnosis, after all.

I'd like stand-up lunacy to be a new genre. I'm sick of having to fit into socially acceptable categories to make my mental differences understandable to neurotypical people. I'm a lunatic and that's that. In any other lifetime mad

experiences would be honoured. Even criminals honour their own. So I'm consciously and politically honouring myself and advocating for my voiceless counterparts. We are the experts and socially acceptable as we are, not because neurotypicals feel more comfortable when we are artists or writers or musicians or WTF.

You seem very skilled, Miss Diagnosis, at covering over reality with your creativity. What I'd like to know is what is going on under the bonnet?

Chaos. Terror. The four Fs: F. Off, Flap, Flip, Flop

I get the feeling Miss Diagnosis, you're not going to say much more.

Look Ms Benn, the reality is, don't ask me such normal questions. I don't know what's really going on under the bonnet. I do know I'm sick of seeing mad arts on the fringes, as if in some sort of estranged ghetto. Even if my stand up-lunacy is rubbish and only ends up on a digital rubbish or Kreatiff Krapp YouTube channels, I'm still advertising Asylum magazine at a mainstream open mic comedy club. The personal is political and I'm sitting there whopping and hollering to encourage freedom of speech. At least I can state, I may not be Woke but I am Awake and advocating Liberal Awakeness. After all, if you are not Woke or Awake, WTF are you?

[Miss Diagnosis pauses to take an anger management breath].

I'm ready to take my imaginary sledgehammer to smash the coercively controlled glass ceilings and glass walls which separate us from the rest of the world. I've had enough of the ghetto and it'll take neurodivergent individuals to make this journey. Whatever follows, who knows? Insider/Outsider gets on my flipping nerves. There is room at the inn because it's getting a makeover and by the time I've finished there will not be an inside and outside, just one big space where we all live together as one.

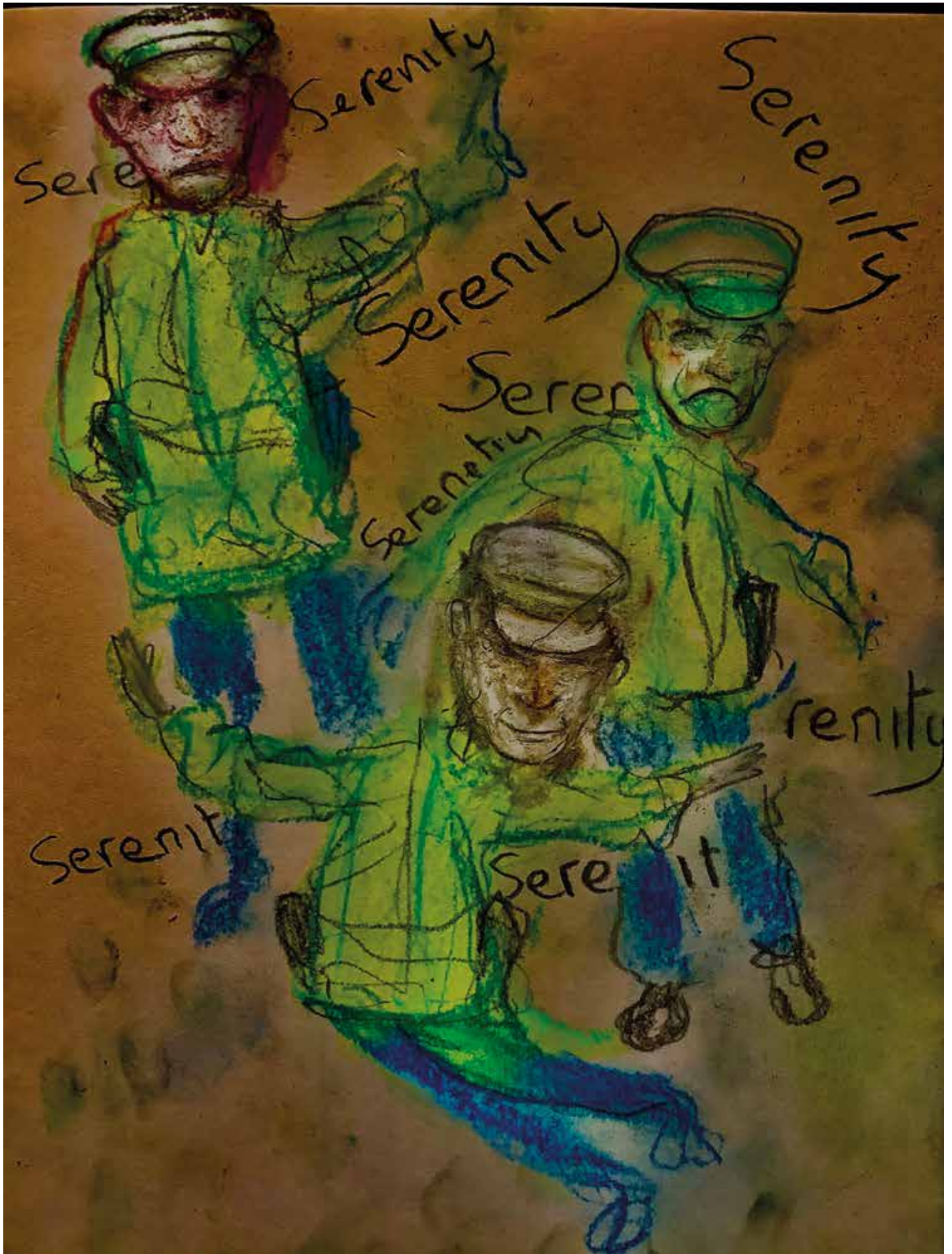
And Ms Benn I've had enough of this interview.

Miss Diagnosis, stand-up lunatic, leaves the building.

Over and out.



Miss Diagnosis is on YouTube and Instagram (kreatiffkrapp)



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