Asylum

the radical mental health magazine

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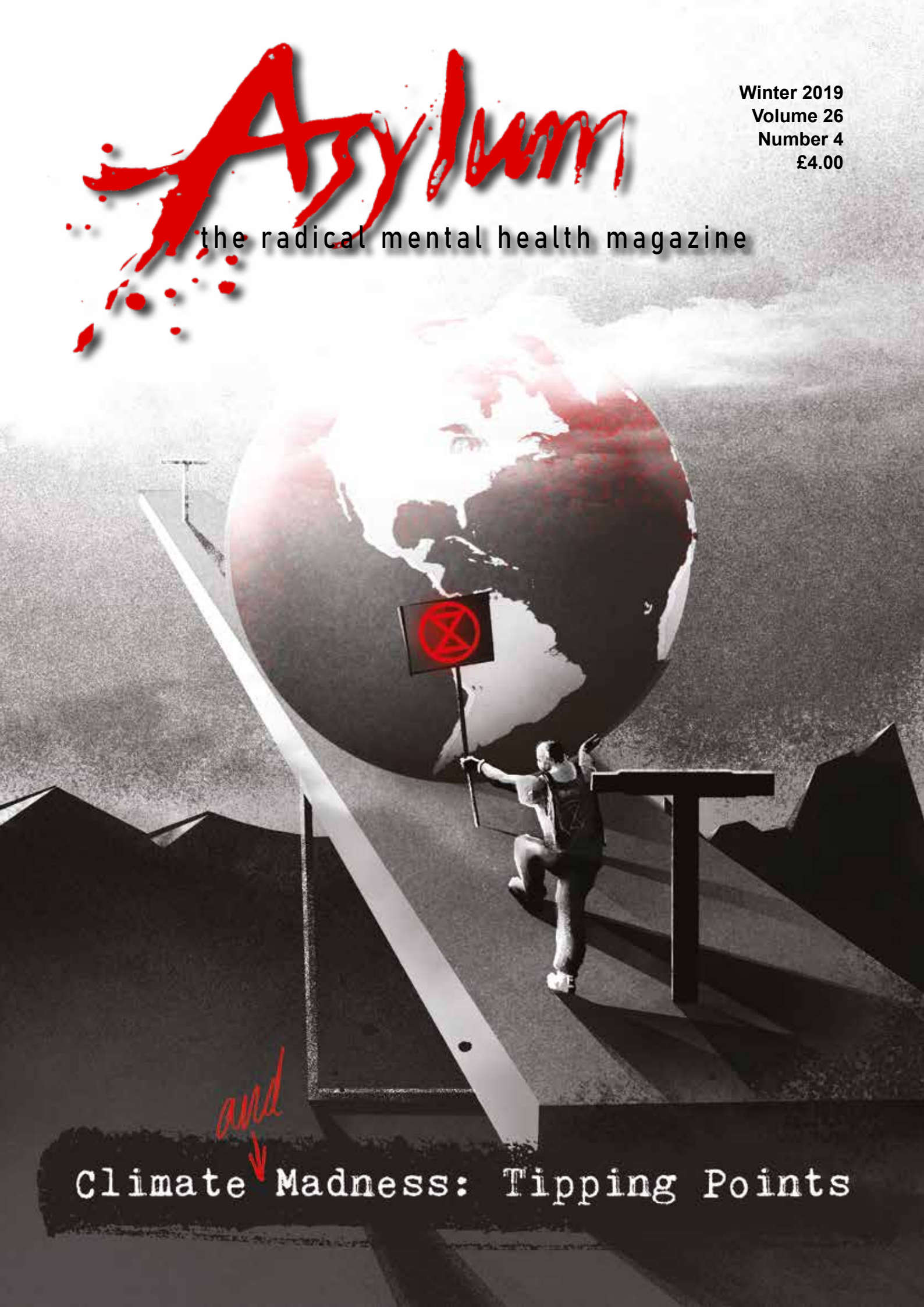


and

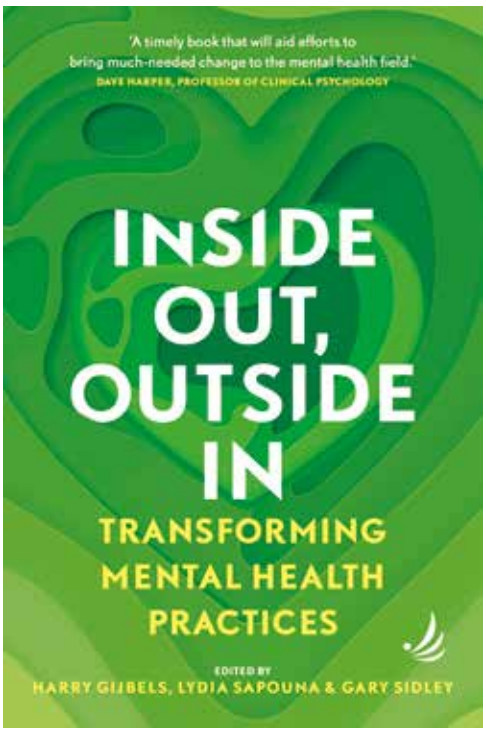
Climate Madness: Tipping Points

INSIDE OUT, OUTSIDE IN

TRANSFORMING MENTAL HEALTH PRACTICES

EDITED BY

HARRY GIJBELS, LYDIA SAPOUNA & GARY SIDLEY



Human distress has historically been understood and responded to almost exclusively either as a biological disorder or a psychological deficit. This has led to the development of powerful structures, 'mental health systems', that have dominated thinking and practice around mental health and been controlled by the psychiatric profession. Despite widespread recognition that such systems are often ineffective and can even be harmful, the bio-medical ethos, with its focus on 'mental illness' and primary use of drug treatments, continues to prevail in mental health practices.

This book showcases current projects that offer user-centred, context-informed, non-medical ways of helping people experiencing distress and overwhelm. The first section of the book includes projects located inside mainstream services that seek to influence change from within, including the education of future generations of practitioners. The second section describes projects that have established themselves as independent entities, outside mainstream structures and services, giving them the freedom to be truly radical in their approaches and influence by example. In a final section, the book looks at work aiming to challenge the wider societal influences that maintain the status quo and perpetuate factors that lead to mental distress and overwhelm.

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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.

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Editorial

'Is it just me, or is it getting crazier out there?' asks Mark Schwalbe in his film review of the Joker. Whatever the result of the UK election, it feels like we are at a turning point in history. If, as our feature article suggests, we have already reached an environmental tipping point, what does that mean for our individual and collective sanity, and the organisation of support and protest? Jonathan Gadsby suggests the Extinction Rebellion movement has not only put climate change on the agenda, but has also created a new kind of space for individual and collective support.

Dieneke Hubbeling's account of tick-box services, and our News and Reports section, certainly paints a depressing picture of established services. Nonetheless, Joy Hibbins' article offers hope that there are still services available which are proactively, and tenaciously, oriented to kindness and survival. We are always interested to hear from our readers about positive news stories and examples of individual or collective resistance.

In the meantime, what does it mean to look after *oneself* in a crazy world? William Park points to the need to value our inner life and, in the face of storms, to weave a personalised 'latticework of comfort'. To do so, we need to be alert to new ways of understanding responding to distress. Such alertness is often a feature of Asylum articles – such as ROYCURTIS' 'Waves of Fear' and Dave Barton's 'Experiences Beyond Consensus Reality'– and, especially, in our illustrations and creative writing contributions: James Walker's 'Shimmering Stone', for example, and Jessica Matthews' 'Zoloft Dreams'.

Sophie Watson's book review of *Mad Muse* points to the power of memoir to unsettle established understandings about mental health. Asylum has always made space for untold or unheard stories. For example, this issue includes Abraham Aamidor's powerful account of the harsh psychiatric treatment many Holocaust survivors received on arrival in America. Beyond telling stories, Phil Hutchinson asks whether we, as a community, should campaign for change. If suffering is, as Jonathan Gadsby suggests, our inner extinction rebellion, then what might we contribute to – or draw from – outward facing protests? Let us know your thoughts.

Extinction Rebellion: the movement of tipping points

Jonathan Gadsby

In the past four years, since the Paris Climate Agreement, the idea of linear effects caused by a linear increase of greenhouse gases has pretty much gone. Climate science is now focused on run-away effects and sudden or exponential change – *tipping points*. There are several key systems that are now vying for the top spot in a frightening conversation about an apocalypse. Scientists' models resemble games of Russian Roulette. The most downloaded scientific paper in history, 'Deep Adaptation' by Jem Bendell, is certainly worth a read. I'd summarise it like this: people are now divided by whether they have already understood, or are still yet to understand, the full meaning of a sign I first sat underneath on Waterloo Bridge last April; *We're Fucked*. Thankfully, Bendell sees this as the beginning of conversations we desperately need to have, rather than the end of them.

The genius of Extinction Rebellion is seeing that many of these tipping points are arriving at the same moment. Firstly, along with *climate crisis vs climate catastrophe,* comes each person's *personal* tipping point into this reality. For me, it wasn't the *We're Fucked* sign. It was more recently, when, a few feet from where I was standing in front of the Bank of England, the kneeling 77 year-old Rabbi Jeffrey Newman refused to move. Shortly after he was taken away, a woman from Cornwall I was talking with told me that whatever happened, good or bad, she just wanted to be able to look her children in the eyes. I have three children.

Another tipping point is towards more democracy – new togetherness, hugging strangers, collective grieving, people's assemblies, *accountability FFS* – or tipping towards fascism. The same moment I was outside the Bank, there were riot police deploying water cannon and pepper-spray in a terrifying attack upon Extinction Rebels in a city square in Brussels. Old people and young children lying on the cobbles with pepper spray in their

Every Single Being on the Planet: Fifty people, aged 7 to 70, converged on a beach in North West England to create a 110m diameter representation of the Extinction Rebellion Symbol. Organiser: Paul Speight. Photo Credit: Michael Swarbrick

faces, hands cable-tied. In Belgium. 2019. The chief of police was unable to conceal his enjoyment.

Extinction Rebellion shows us a tipping point towards new radical justice vs an accelerating dismissal of human and civil rights. Either we finally acknowledge and try to repair the legacy of colonialism or we carry on with more exploitation. One of the first acts of the October Rebellion was a beautiful lesbian wedding on Lambeth Bridge. As the registrant asked us if we would support the couple in the vows they had made before us many witnesses, we shouted 'we will!' and burst into applause.

'What is love, if not valuing life?' said a young middle-Eastern woman, reporting on 'XRTV' from Trafalgar Square the day after the police had announced that two of us gathering together was now an illegal assembly. We shouted 'We love you!' at hundreds of commuters taking videos from the steps of Cannon Street Station. The offices above looked like glass-fronted ants' nests, each suited worker with their own screen. The older woman next to me couldn't help but shout 'rebel!'. Three Amazonians spoke and sang in front of Blackrock, while bowler hatted activists sat at a dining table trying to eat money.

Sanity is another massive tipping point. This moment in history is turning everything on its head. What does it mean to be delusional at this time when business as usual is a suicide pact? What is generalised anxiety when they say my children may not grow old? What is panic when 'we're fucked' is good science? What is depression when I keep crying in the arms of strangers on the street? What is normal when grandparents are squeezing superglue onto their hands? What is self-harm when we have created an incredible food insecurity that means that crop failure thousands of miles away, which is already beginning to happen, could lead to empty UK shelves in a week? What is a stable upbringing when I'm looking through my diary to see which days this week I could get arrested and who will cover the school run? (And when the kids know why I'm doing it.)

Is there anything – *anything at all* – that suggests mental health services are the place to turn for these answers? Or for any kind of useful help? But then, are there any institutions left that can be trusted? Turns out I quite like the rule of law. Either we will tip back towards it and the judiciary will hold us up, create laws against Ecocide, hold the extractors and the polluters accountable, or we will tip away to God knows where.

I wandered away from Westminster. It was already dark and I was exhausted. Just a couple of streets away from a man clutching a photograph of his children and lying under a hearse, I walked into a very nice Italian bistro. I ate my *calzone* as four women on the table next to me laughed too loud at each other's jokes and

compared notes about the refurbishment of cruise ships. One of them told the waiter she hated Chardonnay.

Extinction Rebellion has done its homework. Many rebels love a core text by Joanna Macy that explores 'Deep Ecology'. She says that, whether we are conscious of it in this way or not, we *feel* because we are the Earth in pain. Our madness is the Earth's brutalised consciousness. Our health is the planet's health and the health of the superorganism is ours.

Back in Westminster, Well-being tents are put up to makes spaces to acknowledge grief and build the resilience that comes from being in truth and with others. *Extinction Rebellion is the newest mental health provider in the country*. With over 20 years as a mental health professional, I see no reason to prefer anything more established. I'll come and sit in your tent, I've got nothing else left.

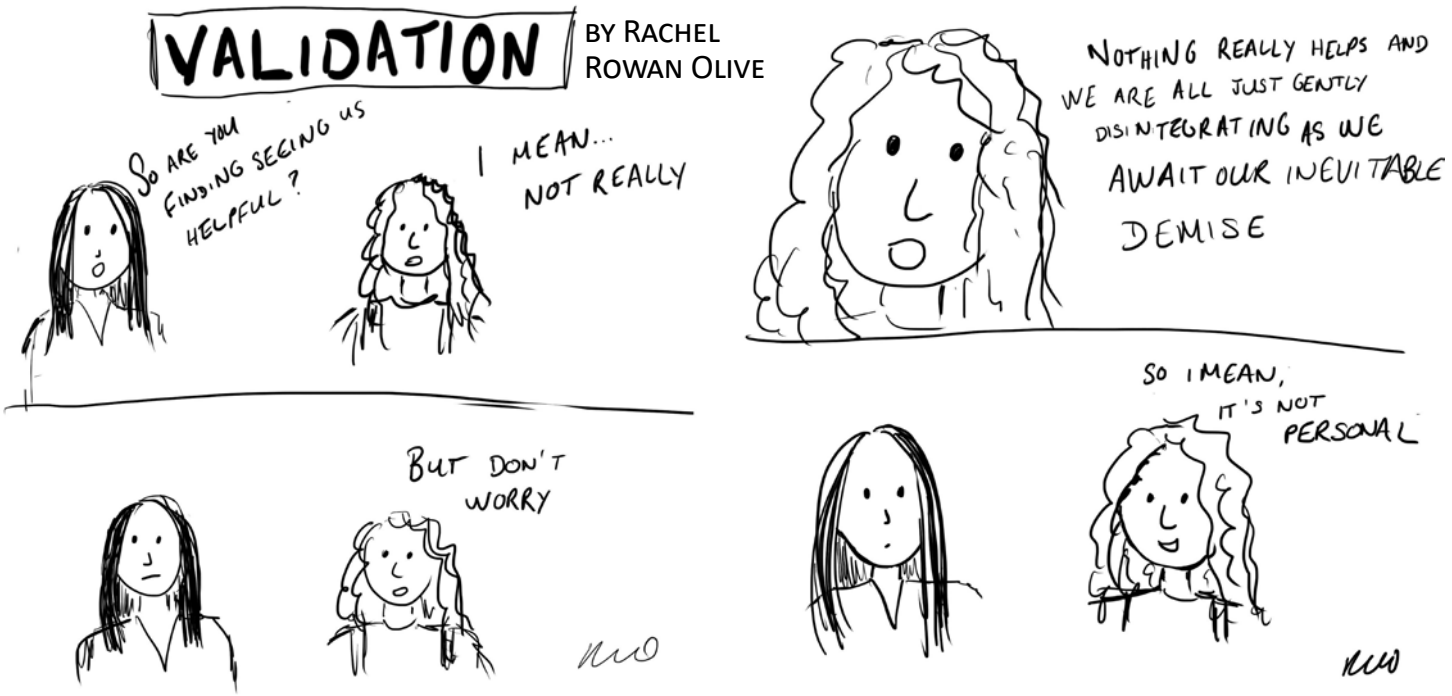
As I digest this new climate science of tipping points, it seems Extinction Rebellion's 'mental health service' is what I need. But their 'assessments' are a bit different. Their 'care plans' are too. When they say 'recovery' they mean ecosystems, you and me included. Their 'diagnosis' is that the planet is ill but those of us in acute distress about it are perfectly sane.

Our suffering is our inner extinction rebellion – why suffer it alone? Unfortunately, just like in the old mental health services, we also risk being detained. Police officers seem to be racing around everywhere, arriving in vans, one of them telling a fellow protester he was just glad of the overtime. In the old mental health services, the highest risk of violence and aggression is thought to be from black young men from the inner cities. In the new 'Extinction Rebellion mental health service' the most concern is about the risks posed by wealthy older white men working in the City of London.

What am I going to teach my mental health nursing students now? These days they are supposed to use the word 'compassion' all the time. They talk excitedly about it when I interview them to come on the course. It's one of the Six C's. OK then, compassion – literally, *suffering with* – that is what my classes will be about. They can all suffer with me.

Here is what I want to say to them: *Welcome to mental health nursing. The world is on fire. The trauma bar is being raised. We are all either acutely disturbed or superbly dissociated. Mental health services may become meaningless without notice because there is no mental health on a dying planet. I love you, by the way. At some point you may have to choose between starving in your house and violence at the shops. Look around you, it might be a very good idea to make some friends. Today's assignment is getting through your first breakdown.* ▪

Jonathan Gadsby is an Extinction Rebellion activist, co-editor of Critical Mental Health Nursing (PCCS Books) and editor of the Critical Mental Health Nurses' Network website.



ROYCURTIS, channelling Percy Perdurabo, presents:

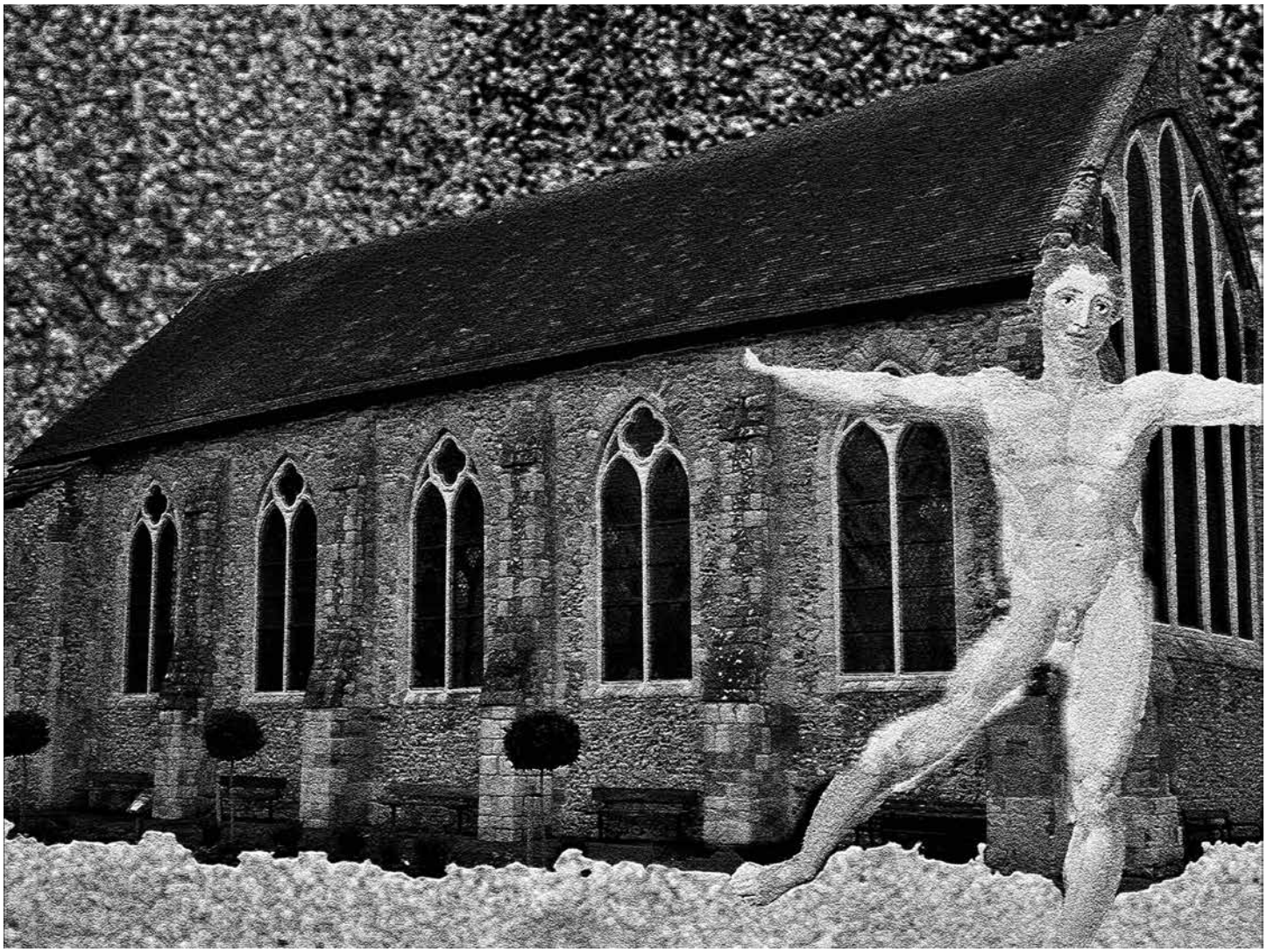
WAVES OF FEAR

"We know what happened to those who chanced to meet the Great God Pan, and those who are wise know that all symbols are symbols of something, not of nothing."
Arthur Machen, 'The Great God Pan'

It was a long time ago and truth moves with the now, covering the past so that it can only be retrieved as fiction, but I'm convinced that everything was basically okay as I made my way from Sheffield to Brighton on that sunlit autumn day. I'd successfully removed myself from the oppression and indignity of the benefit system. I worked for an income, and yet I retained the leisure time necessary to pursue my deeper interests (the accumulation of mystical experience, deepening awareness of religious truth, the penetration of the mysteries...) Let's just say I was happy to travel to Brighton, because it was a bright town, and it's always good to see the sea.

In Brighton he gained invisibility
by dissolving himself into light...

I'd been to the place before, heeding a TOPY summons, travelling through the soft South Downs at a leisurely pace to get there, popping into the photo booth on arrival to engage in ritual performance, thinking of a god as the flash fired four times, sending the resulting images into the world, giving the recipients extra reasons for living. That set the tone, and the brick built church down the hill looking left out of the station was the eidolon of my engagement. I saw it, and it was not there, a consummation of deeper reality. I went into a café and



'Albion Rose Again' by ROYCURTIS

asked the people who worked there to play the tape I had with me, and they complied because there was no reason not to. And I walked along the streets of the town and made everything mine in passing.

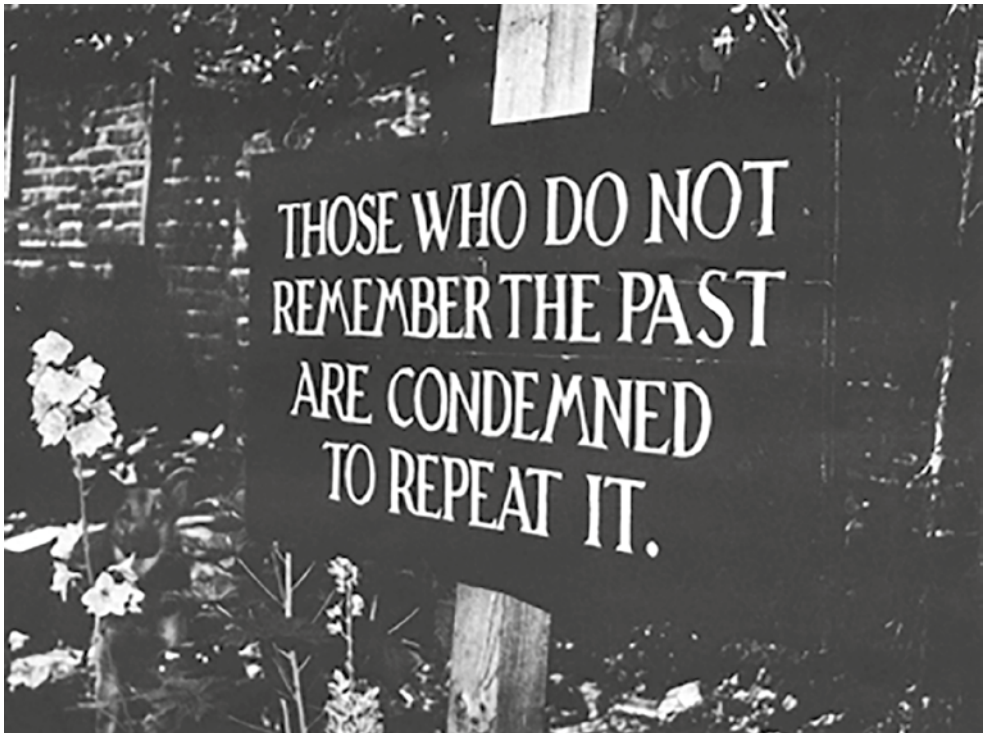
I still can't say for sure why dread hit me so hard on the pebble beach beneath the sun drenched sky. Perhaps it had something to do with an uninvited identification with the broad expanse of ye vaste briny ocean, which stretched before me without end. Perhaps the disorienting effect of the size and luxury of the hotel room I was staying in played a part. Perhaps the air of the conference hall I'd come from had been poisoned by the profusion of purple clad psychotherapists and other oppressive phantoms that ranged about the place replete with sickening self-regard (these mugwumps were certainly not my droogs). Perhaps there was something in my past experience that had primed me for panic and lurked within me just waiting for the opportunity to manifest. I'd swooned and shivered for months on end without knowing why after leaving home and moving to London at the age of 16. I vividly recall an out of body experience that came out of nowhere as I walked down a nondescript street of the capital city, in which all elements of my non-physical being suddenly left my corporeal shell to behold my body from a great height for a timeless eternity of I don't know how many seconds. Whatever the cause, I'd somehow entered another world. It wasn't just a question of perceiving space and time in a different way; everything outside and within me had been hideously transformed.

I left Brighton for Sheffield the following day. I endured an agonising train journey of fantastic duration (and the fantastic was in league against me). I tried to take comfort in the inwardly vocalised thought that home would provide a refuge but this desperate incantation could not prevent the growing intensity of the existential crisis I was subject to. As pain is the stimulus of pain, so fear is the stimulus of fear. My condition did not improve. I had embarked on a nightmare pilgrimage, which can be summarised by saying that I lived in continual fear of death, and knew with certainty that death would be just the beginning of my troubles.

I started to feel a bit better the following year but I was still very fragile. Somehow, I managed not only to attend a job interview the following spring but also to land the job. I found it somehow comforting to reflect that the inward desolation I was experiencing was not immediately apparent to others. The fact that "it does not necessarily show" has remained with me ever since. My new job involved a lot of travelling and I managed to battle through the agony as I explored the U.K.'s railway network. You could say that each individual journey, each night in a modestly comfortable hotel, each work related event I managed to push myself through represented a small victory.

About a year after my experience in Brighton, I found myself smiling as I read 'Head On', the Dionysian autobiography of the musician Julian Cope, on the train from Sheffield to Birmingham. This was a real breakthrough. Since freaking out on that pebbled shore, I'd been unable to concentrate for long enough to read a book (through the necessity of devoting most of the power of my mind to the certainty of imminent catastrophe). Whatever his failings, and you could argue he has many, I've felt a fondness for Cope ever since.

A fellow by the name of Thighpaulsandra played keyboards in Julian Cope's band and he was also a member of the group of explorers of the psychedelic multiverse that went by the name of Coil. Jhonn Balance (may he be bathed in perpetual light) was the singer in Coil, and he was also a renowned collector of the art of Austin Osman Spare. Spare is commonly identified as the progenitor of Chaos Magic, and the foundation texts of Chaos Magic are 'Liber Null' and 'Psychonaut' by Peter Carroll. In 'Liber Null', Carroll states that altered states are the key to magical powers and that sensory overload in the form of fear can result in one pointed consciousness, or gnosis. I certainly didn't



'Those who do not remember the past are condemned to repeat it' from the cover of 'Live in Astoria' by Psychic TV (2003).

associate my time of tribulation with gnosis, or anything remotely positive, but Carroll's remarks offer a means of attributing positive value to what had previously been fixed as negative experience. There is great value in any work that enables the possibility of re-evaluation. I'm particularly interested in the idea that the most striking experiences that one might encounter during the course of a lifetime do not possess fixed meaning and can be seen in a radically different light as a result of encountering clarifying information many years later.

Of course, there was a diagnosis attached to my experience, and treatment followed diagnosis as surely and relentlessly as day follows night. To my mind, the diagnosis does nothing to reveal the meaning of what I went through but rather diminishes it, and I remain entirely unconvinced that the medication I was prescribed did anything to ease my plight. William Blake described his condition as 'Nervous Fear', and this makes more sense to me than any modern diagnostic category, although the somewhat comical resonance of Blake's term is at odds with the horror I knew.

All of the stories we tell ourselves in our attempts to make sense of our experience have to end somewhere. When all's said and done, I'm glad that I went through what I went through (admittedly, this sense of gladness can only exist because I'm no longer in that state). It wasn't a breakdown, or an illness, or the result of a chemical imbalance in my brain; rather, it was a revelation. It's necessary to realise that you're confined in an arid desert before you can ever hope to find your way out.

IO PAN! ▪

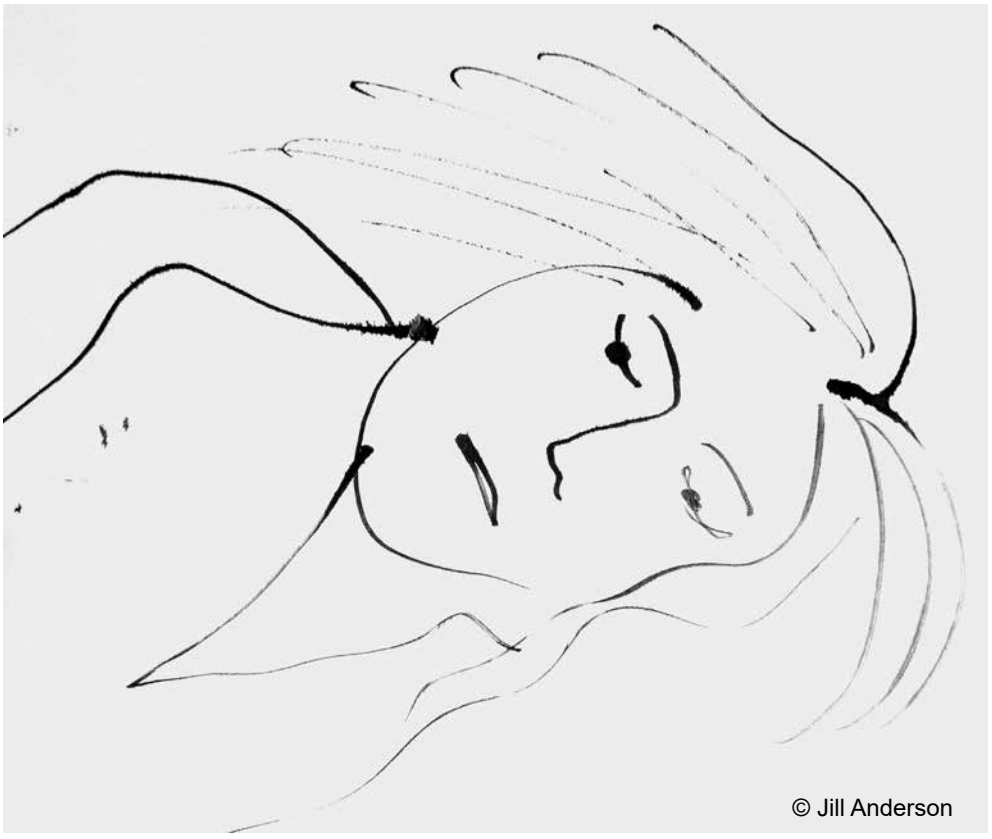
Percy Perdurabo

'Waves of Fear' is the stand out track from 'The Blue Mask' by Lou Reed. The lyrics of the song, and the spiky guitar lines courtesy of Robert Quine, provide a fair approximation of the panic experience for those with an ear for avant-garde popular music.

Zoloft Dreams

Jessica Matthews

When I wake up
I'm not sure what is real.
The pressure in my skull pushes
Through to my eyebrows
And out comes the daze
From Zoloft dreams.
Sometimes I don't know if
I'm awake.
Is inception a side effect
Of selective serotonin?
I feel dull
Most days,
But my nights are
Wild, unpredictable,
And haunting.
Whatever happens,
I can't tell;
Are these memories?
Or even closer,
Did this just happen?



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Jessica Matthews is a Technical Writer who also enjoys writing creative pieces.

Does box ticking ensure good care?

Lessons from good art

Dieneke Hubbeling

Managers in the NHS nowadays assume that good health care consists of many boxes being ticked on an electronic patient note system. As a mental health professional, I am instructed to ask specific questions. For example, every service user not known to the trust is asked: 'Are you renting your house?' and, if the answer is yes, there is a mandatory follow-up question: 'Do you rent it from a private landlord, from the council or a housing association?'. Of course, I also must enter the answers on the computer. Managers do check whether it is done, and they also compare individual practitioners and teams on performance criteria derived from the electronic note system, in other words how many boxes are ticked by each mental health practitioner and by teams. The question is whether this checking really improves care.

I have been informed that managers in the NHS are told by commissioners that they must check whether all the necessary boxes have been ticked. Apparently, if they do not produce the performance data, commissioners may decide to put a service up for tender and let the care be provided by a third-party provider. This has happened quite frequently especially for addiction and IAPT services (Improved Access Psychological Therapies).

But do you really receive the best possible care, if all the boxes are ticked? And is the care you receive always bad, if only a few boxes are ticked? In my view there is an analogy with identifying good paintings.

Komar and Melamid were interested in identifying 'most wanted' paintings. They arranged surveys in various countries and asked participants which elements of paintings they preferred. In the Netherlands in 1996 they surveyed 949 participants. The preferred colours were blue (31%), green (19%) and red (13%) and the Dutch people in 1996 preferred an abstract painting. Combining all the findings gave a picture consisting of red, green and blue parts, which can be seen on their website (http://awp.diaart.org/km/)[1]. This picture is not a nice painting. Other Dutch paintings such as *The Night Watch* by *Rembrandt* or, if one prefers abstract paintings, various works by *Mondriaan* are actually much nicer to look at. To my knowledge no similar study has been done in the United Kingdom, but Komar and Melamid did organise a survey in the USA in 1993 with 1001 participants. This resulted in the favourite colour being blue (44%) and a preference for realistic paintings with historical figures. Combining all the results gave a picture with George Washington in the middle, which can also be seen at Komar and Melamid's website. Again, the overall picture is not particularly appealing.

Combining preferred elements does not necessarily give a good painting.

Maybe people will say that this is entirely predictable. It is an overall judgement whether a painting is good, some specific elements can be dreadful, and the overall painting can still be very good. However, when it comes to mental health care the assumption seems to be that it consists of a number of specific elements and nothing more.

I often wonder whether the need to include the pantheon of 'most wanted' RiO elements such as social inclusion data (is somebody living in rented accommodation or not), HoNOS (Health of the Nation Outcome Scale) score[2] and clustering, smoking cessation data, the myriad of questions in the risk assessment, even if not obviously relevant, is really offering good care to service users?

In the Komar and Melamid study participants were asked which elements they considered important in a nice painting. The situation in mental health is even worse. Service users have not even been asked about the items which need to be covered in an initial assessment. It is highly unlikely that a question such as 'Do you live in rented accommodation?', would be selected by service users.

This process of checking whether certain boxes are ticked must stop. It is not only that questions are often irrelevant; it also leaves less time to talk about what really matters. One should only allow maximum 5 minutes to check boxes and the content of the mandatory questions should be agreed by service users. ▪

Dieneke Hubbeling works as a consultant psychiatrist for the NHS in London

1. For copyright reasons this picture and others cannot be reproduced here.

2. It has been suggested that HONOS scores can be used to establish costs. However, this idea is not well supported by empirical evidence. See for example Utility of the Health of the Nation Outcome Scales (HoNOS) in Predicting Mental Health Service Costs for Patients with Common Mental Health Problems: Historical Cohort Study by Conal Twomey et al. PlosOne (2016).

JUST ANOTHER HOLOCAUST STORY

Using personal, biographical and archival material, ***Abraham Aamidor*** suggests many Holocaust survivors were misdiagnosed and received harsh treatment in the psychiatric system when they arrived in America.

The psychiatric literature on mental illness and Holocaust survivors is mixed – some studies suggest that mass trauma PTSD would be the likely diagnosis today for those who were pegged as schizophrenic after the war, while other research says diagnoses of schizophrenia were routinely *missed*. My brother, Yehoshua Chaim "Sidney" Rosenberg, who died by suicide at age 24, and my late father, Rabbi Joseph Rosenberg, both Holocaust survivors, were treated for mental illness in the years following World War II. I recently began a search to fill in my understanding of just what happened to them, yet privacy laws in America make it impossible to obtain a complete picture.

My search began with an inquiry, then an entreaty, to the high school at Telshe Yeshiva in Cleveland, Ohio, from which Yehoshua graduated in 1954. Being from an Orthodox family, re-establishing a strict Jewish lifestyle was paramount after the war. I wrote to the current Yeshiva administration twice for details of my brother's life in Cleveland, but they were unresponsive. What I know is that Yehoshua joined the United States Air Force two years later, in 1956, when he was aged 19.

From my late mother's files, I discovered a letter from the Jewish chaplain at Warren Air Force Base, where my brother was stationed. The following is an excerpt, written by Chaplain Philip Silverstein, 1st Lt., USAF, dated 7 May, 1956.

"Sidney had been coming regularly to the services here on base and we got to know each other very well.

"He is an intelligent boy but he has been suffering from a mental illness which began prior to his entering the Air Force. It was on these grounds that he was discharged and I'm afraid it cannot be reconsidered. I have spoken to the psychiatrist at lenght *(sic)* about him and I could only urge that he begin treatment in civilian life.

"I am very much concerned about him and I hope that he will adjust to civilian life. I can see by your letter that you have tried to help him but I'm afraid that it is not in our hands. He should see a doctor."

Nothing in the letter is really a diagnosis, of course, and part of it counts as a legal disclaimer – *Sidney was ill before we ever saw him, Mrs. Rosenberg* – but I'll go so far as to acknowledge that my brother was troubled prior to his enlistment. Yehoshua (he had been renamed "Sidney" by relatives on our father's side who'd arrived in America before the war and who wanted to Americanize the name, but we never called him Sidney) had received a General Discharge and left the service after six months. It's not a dishonorable discharge – it just means things didn't work out.

It was a psychiatrist in Chicago, where we moved after my mother and father divorced, who declared that Yehoshua was a paranoid schizophrenic. Yehoshua never agreed with the diagnosis. "Insane is the sane man in an insane world," was his favorite quote, and "Mother, don't take sides," was a common injunction he would utter to her. I initially recalled Yehoshua's Chicago psychiatrist only by his last name – Dr. Hilkevitch – but I now believe he was the locally well-known Aaron Hilkevitch, a Russian-born Jew, a University of Chicago graduate, and a past member of the Abraham Lincoln Brigade, which was a group of Leftist and often Jewish volunteers that fought on the Republican side in the Spanish Civil War (1936-39). This is somewhat speculative on my part, but my mother worked at the Park View Home for the Aged in Chicago for many years; she worked with a social worker named Milton Cohen who also was a well-known former member of the Abraham Lincoln Brigade. It's not a stretch to think Cohen referred her to Hilkevitch.

As my mother worked at the Park View Home, a project of the Chicago Jewish Federation, she asked for a subsidy to the psychiatric ward at the city's old Michael Reese Hospital, which was much closer to home and also connected to the Jewish Federation. Part of her reasoning was that Michael Reese served kosher food, which still mattered to Yehoshua, but there also was the issue that my mother trusted Jewish institutions in America.

She was denied. My mother claimed she was told that since she had a job she could afford to pay for her son's treatment, but private pay psychiatric treatment was expensive and, anyway, Yehoshua already was 21 by this time and he did not have a job. He was simply a Holocaust survivor, a United States Air Force veteran (albeit truncated service), and a very troubled young man. He was referred to the Galesburg Research Hospital in Illinois by Dr. Hilkevitch, who should not have been indifferent to his patient's history. Yehoshua had bounced around the country from Memphis, where the family had originally settled after the war and where I was born, to New York to Chicago to Cleveland repeatedly by the time he was 16, and he had *been bounced* from Poland to Lithuania to Shanghai to port in San Francisco by the time he was 10. My parents and Yehoshua were refugees during the war and were never interned in a concentration camp, but my mother's parents and her 10 siblings all perished.

Was my brother schizophrenic? Was he suffering from mass trauma PTSD? I don't know, but I want to float a certain hypothesis as to my brother's treatment, that sending him to a state-run psychiatric hospital may have been an expression of his doctor's deliberate contempt for Orthodox Judaism and Holocaust survivors and, as such, an example of the notorious *countertransference.* I can only think of Bruno Bettelheim, the discredited Jewish psychiatrist who claimed to have personally known Sigmund Freud and was reported to have physically abused children into submission at his famous Orthogenic School on the campus of the University of Chicago – it was Bettelheim who had argued most forcefully that Jews didn't resist the Nazis, i.e., were cowards and complicit in their own genocide. Hilkevitch, too, according to his obituary, was a Freudian psychoanalyst and surely would have known the once-famous Bettelheim during his own University of Chicago days and later, life-long residence in the university's Hyde Park neighborhood.

Privileged Communications

I wanted to obtain some records from the now-demolished Galesburg hospital – precise dates of admission, treatment protocol, maybe even prognosis. After a few false starts, I was referred to Anthony W. Vaupel, the associate judge who handles petitions for psychiatric matters in the relevant jurisdiction. Here is what he personally wrote to me after reviewing my request.

"Disclosure of records through the Illinois Mental Health and Developmental Disabilities Act is intended to be prohibited except for a few people or entities. While I understand why the statute is written the way it is, it seems to lack common sense exceptions, such as your situation. … I understand this letter must surely be disappointing, especially when I can think of no societal interest in precluding family members from records nearly 60 years after death. I am required to follow the law, even in those situations where I disagree and it is for that reason I must deny your request for an order."

Judge Vaupel's letter was respectful, clear and final. I have no quarrel with him. But, I do note the irony of the relevant statute that says, for example, had I been suing my late brother's estate for any monies he might have left, oh, well, in that case I *would* have had access to his records! I think it was Karl Marx who wrote that all law is really about property rights; you don't have to be a Marxist to see he had a point.

I do have one original document from Galesburg, though. It's a letter that Yehoshua wrote to our mother while he was committed there; she kept it all the years of her life.

"Dear Mother, I want to come home," he wrote. "I promise to be good." That's it. The note is written on a half-sheet of paper and his handwriting is slow and scraggly, much like a schoolboy's. He was a Holocaust survivor, a world traveler and an Air Force veteran, yet he was reduced to promising to be good like some 7-year-old in sit-out.

Manhattan State Hospital, Ward's Island, New York City

Now, my father: I cannot say I knew him well because I only met him twice after my parents divorced, but he, too, was committed to a mental hospital, in this instance the Manhattan State Hospital, Ward's Island, New York City, in 1950. He was living with his older sister in New York at the time, yet my parents were still married and officials in New York wrote my mother for permission to begin a certain treatment. I quote from a letter written by John HL Travis, MD, Senior Director, addressed to Mrs. J. Rosenberg and dated Nov. 19, 1952.

"Dear Madam:

"Your husband, the above-named patient [Joseph Rosenberg, #124308], was admitted on Nov. 17, 1950. He is suffering from a chronic form of mental illness and has had extensive treatment in the past. I regret to say that so far he has failed to show any appreciable improvement in his mental condition.

"In our opinion he might be benefited by modern brain surgery known as Topectomy and Lobotomy. This form of treatment is widely used on patients suffering from the same illness as your husband and the results have been very encouraging.

"Before performing this operation we need your consent. Will you please sign the enclosed 'permission blank,' have it witnessed and return it to me at your earliest convenience."

I copied the full letter (with my father's patient number) and mailed it to the Manhattan Psychiatric Center, as it's now known. The reply was Orwellian in some of the language it used, which I quote now:

"We are in receipt of your request seeking information from the records of Joseph Rosenberg, who, *you believe* (emphasis added), was a patient in our facility and is now deceased. … The New York State Office of Mental Health does not allow either (*sic*) confirm or deny that the individual received treatment in our facility for the purpose of genealogy or *interest* (emphasis added)."

Well, my mother signed, the operation was performed, and I was told by older family members who knew my father better than I did that he was never the same person again. Joseph managed to evade the Nazis only to receive the cure, as it were, here in America. He even got his own number. ▪

Abraham Aamidor is a former long-term reporter at *The Indianapolis Star.*

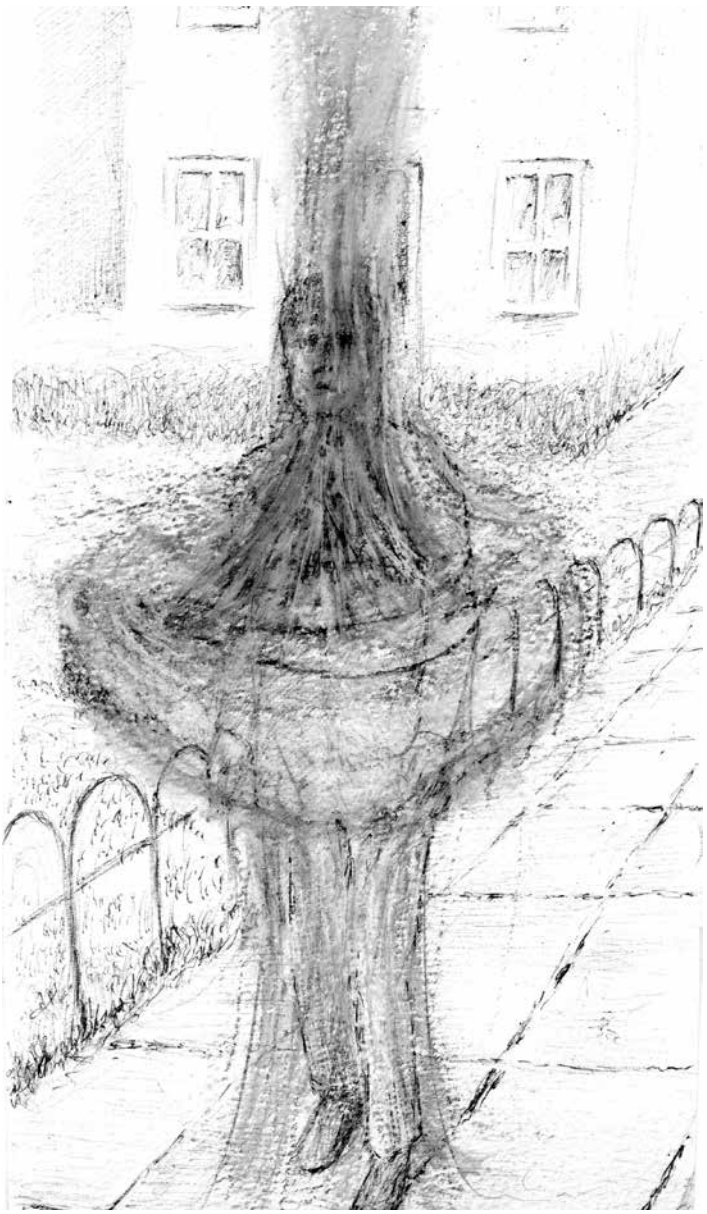
Psychiatry and experiences beyond consensus reality

Dave Barton

This article begins with two of my experiences of extreme inner states. It goes on make some observations about psychiatry, psychiatric training and wider culture. These experiences could well have led to me being put in the loony bin (as it used to be called):

1. I was returning from Europe by myself when I was 17 (in the early 1970s). I landed at Heathrow airport late at night. Knowing I could not travel home to Bristol at that late hour I was just going to wait for public transport to start up again in the morning. During the early hours I started to play chess with a young man who was also waiting for the public transport. The last thing he did before we went our separate ways was to light a joint which he offered to me to share. Being naïve and curious, I took a total of four puffs before he departed, and I was left alone and scared at the way my mind was rapidly changing. Completely confused and imprisoned in my own psyche I lost any sense of what other people were about and how they would react to me as a person. I could not think straight at all; even adding two numbers together was beyond me, let alone working out public transport well enough to get myself home. I avoided all eye contact in case someone could see what a very weird person I had become. I could not trust myself to speak; who knows what would come out of my mouth and how people would react! I was terrified the police would haul me in, and that my fear and confusion would last for ever. Fortunately, the effects of the weed eventually wore off and I was able to find my way home. This experience could be called “Paranoia”.

2. Three years later I was walking down Whiteladies road in Bristol. I was just my ordinary self, not affected by any drugs or psychological influences when, with great power and authority a voice in my head said “Fly!” and I started to be pulled out of my body. Energy came pouring in – tearing me upwards and outwards – and I knew that as I left my body it would go smack on the pavement. Not wanting that to happen I desperately fought by pulling downwards hard and, losing the battle, I wordlessly and emotionally prayed for assistance with my entire being. A tremendous tension followed, energy pulling me out and energy holding me back, like super-conducting magnets fighting with each other. The force lifting me out suddenly left, and I returned to my everyday self.



'Fly' by Dave Barton

I do not associate the voice that said “Fly!” with myself, it did not have the same handwriting my own thoughts have, and I have no power to tear myself out of my body when I am awake! This experience could be called “Dissociation” (a bad fit into a diagnostic category).

Observations

I think it very likely that if I had talked to psychiatrists about these experiences forty-five years ago, they would have said I was mad. These experiences were clearly outside the consensus of what reality is, and therefore the label of mad was justifiable. They would say I was mad because they did not understand the experiences, and the situation is not much better today. Professional practice, backed up by the legalities of the Bolam defence (1957 to the present day), would require that I be diagnosed as suffering from a psychiatric disorder and medicated. This “treatment” would doubtless have made it extremely difficult to participate in life: to develop inwardly and outwardly, and to work. Effectively the psychiatrist would have contravened the Hippocratic oath of doing no harm.

Many psychiatrists work helpfully with individuals who have had extreme experiences. Individuals who have extreme experiences are often grateful for psychiatric support and treatment. One psychiatric skill frequently seen is the ability to get a manageable balance between the benefits and the drawbacks of medication. However, psychiatrists rarely receive unmixed appreciation: frequently individuals do not feel listened to, or understood. The background to why we are not listened to and understood has many strands to it, but I suggest that their ability to provide informed and authentic listening could, and should, be improved. Psychiatry also seems to have been blinded by its own self-importance, as it appears very reluctant to seriously consider the nature of unusual experiences. The range of the psychiatrist's understanding could well be expanded, to include useful first hand perspectives on what it is like to disconnect entirely from everyday life. Powerful insights about the nature of, and the pros and cons of these experiences are easily available from a range of individuals, and they need to be read, discussed, and internalised with care and respect.

These experiential accounts are not integral to the psychiatrist's training which is mainly informed by psychiatric practice and research. The training does not adequately inform psychiatrists about human consciousness and this can be clearly seen in the content of the latest curriculum (on the Royal College of Psychiatry website). The most promising heading I could find was: “Describe the various biological, psychological and social factors involved in the predisposition to, the onset of, and the maintenance of psychiatric disorder” (intended learning outcome 2). This does not indicate material leading to a thorough understanding of the kind of experience I describe above. This inadequate psychiatric training could, however, be the main understanding that the psychiatrists apply throughout their career.

The research that is undertaken is usually funded by major funding agencies, which all have criteria that the research proposal must meet. For instance, the Medical Research Council (MRC) defines research as: “The attempt to derive generalisable or transferable new knowledge …”. The difficulty with this is by concluding research with *generalisable* statements the nature of individuals’ unusual experiences is unlikely to be revealed. This is because the research and also the generalisable conclusion is based on an ontology (philosophical position) founded on measurement. Extreme states are unique and not measurable, even though there can be some very useful commonalities between them. General understandings gained through this usual form of research are unlikely to work well for any unique individual. In the National Framework for Mental Health Research, neither in ‘Basic Science’, nor in the section on ‘Discovery Sciences’ (part of section 5.3: Translational Research), is there any indication of support for exploring the nature of unusual human experiences.

Additionally, most psychiatrists’ understanding of their own inner nature does not appear to be much better than anyone else’s understanding of themselves. There is no compelling evidence that most psychiatrists understand the further realms of human nature in a particularly thorough way. Both understanding their own nature and unusual experiences are important in psychiatric practice when working with individuals who have had, or are experiencing, extreme states. Because trainees’ awareness has usually been restricted to ordinary states of consciousness, there is no experiential learning about, especially, unusual states. Psychiatric training does not require that trainee psychiatrists explore their own nature, through counselling or meditation, for instance. This lack of awareness is a severe deficiency in their professional training and development.

In our culture the authority of good reasoning and professional expertise is still a powerful influence on our behaviour and experiences. There are cracks appearing in this dominance though and new approaches are gaining ground. It would be helpful if the wisdom of an informed and intuitive support, which acknowledges and respects the full scope of human individuality, becomes an influential part of psychiatric practice. ▪

The need for a fundamental change in the way services respond to people in suicidal crisis

Joy Hibbins

In a year where the number of people dying by suicide nationally has increased, there is a need for a fundamental change in the way in which services respond to people in suicidal crisis.

NHS services and charities often focus on "respecting the right" of a person to end their life. Mental health services may go even further than this, frequently telling patients "It's your decision" or "It's your choice" to end your life, if they are not detainable under the Mental Health Act. A mental health crisis team member said this to me when I was having suicidal thoughts. I now run a Suicide Crisis Centre and many of our clients report having been told the same thing. I felt that it validated the "decision" to end my life – it made it sound like a reasonable, lucid decision on my part.

At our Suicide Crisis Centre recently a young woman under mental health services told me she was having strong impulses to end her life. She said she felt there was no point seeking help from mental health services because "They tell me if I want to die, it's my decision." This approach can mean that people disengage, and stop seeking help.

When services say "It's your decision", I wonder if it really demonstrates an understanding of what it's like to be at the point of suicide. The person's ability to think clearly is likely to be compromised at that point, either by high levels of distress, or by mental illness, including depression or post-traumatic symptoms. Few people in that position are making a clear, carefully thought out decision. My ability to make decisions was influenced by the post-traumatic images which flooded into my mind. However I was judged to have the "mental capacity" to end my life.

If we take the view that most people's ability to make the decision to end their life is compromised in some way, then we should surely be pro-active in trying to protect their life. We should take active steps to intervene and help them stay alive.

Crisis teams will often emphasise the need for patients to "take personal responsibility" for contacting services when they are in a crisis. When we feel that someone's mental health is deteriorating, and we ask the crisis team to contact them, they will often tell us: "the person is welcome to call us". The crisis team has at times told us that they may be "intruding on their privacy" if they call the person without their expressed consent. They have even said it may amount to "harassment". Surely contacting someone in the context of having concerns about their risk of suicide should not be viewed as potential harassment.

At our Suicide Crisis Centre, we sometimes get asked by professionals, family members or friends to call someone they are concerned about. We always do. In my opinion, the important issue is that someone's life may be at risk. That overrides our concerns about intruding on a person's privacy.

We have seen some of the consequences of expecting people to "take responsibility" for contacting services. This has become evident in the witness testimonies at inquests, which we have attended as part of our research into deaths by suicide.

For example, at Jay Bailey's inquest, his mother Elaine described how she contacted the mental health crisis team during the final weekend of his life. She urged the team to contact Jay because his mental health had deteriorated significantly and she felt there was a real risk that he would end his life. The crisis team told her that Jay knew their number and was welcome to call them. Elaine felt that Jay had become too mentally unwell to contact them, and they needed to be proactive at this point. The crisis team maintained their position. Tragically, Jay took his own life early on the Monday morning.

Surely the "learning" from this is the need to respond pro-actively. We cannot always expect someone in crisis to be able to contact a service. They may be too distressed or too mentally unwell to do so.

Clients sometimes report that being told "It's your decision" made them feel that clinicians didn't care whether they lived or not. This was often cited as another reason not to contact the crisis team, or to disengage from the service.

The "clinical distance" of staff can add to this. It is so important clients and patients feel that professionals care about them and that their survival matters to them. You can openly care about clients without it breaching professional boundaries.

A person who is at the point of suicide may withdraw from everyone around them. They may detach emotionally from everyone they love or care about. Sadly, that may happen as a person starts to detach from life, and moves closer to the point of suicide. In that disconnected place, we need to work actively and tenaciously to reach them. Kindness and a caring approach are much more likely to penetrate those barriers.

I wonder whether many mental health clinicians have a fear of letting clients know that they care. Indeed, some have openly expressed a fear that it might breach professional boundaries. It doesn't. It can make the difference between someone surviving or not.

The approach we take at our Suicide Crisis Centre is that we do "everything we can for each individual to help them survive". We work proactively and tenaciously to help our clients stay alive.

We have been actively keeping in contact with the young woman who is having strong impulses to end her life. We do not feel that letting her know "she can contact us" is enough.

We have been providing services since 2013 and no client has died by suicide during the period in which they have been under our care. I feel that this should send a powerful message to services about what needs to change, to ensure that more people survive under their care. ▪

The author would like to thank Elaine Bailey who has given permission for me to share information about the circumstances of Jay's death, in the hope that it will help other people.

Joy Hibbins is the founder and CEO of Suicide Crisis, a charity which runs a Suicide Crisis Centre with a zero suicide achievement: www.suicidecrisis.co.uk

An evening

By John Gimblett

I spent an evening suicidal.
Knowing I needed to do something
but not knowing what I should
do. Having no-one to call; no-
one who would perhaps be
interested enough to break
or spoil their own routine to
come here and hold me.
Words wouldn't suffice; it was going
to take an imprisonment of
elbows keeping me from movement.

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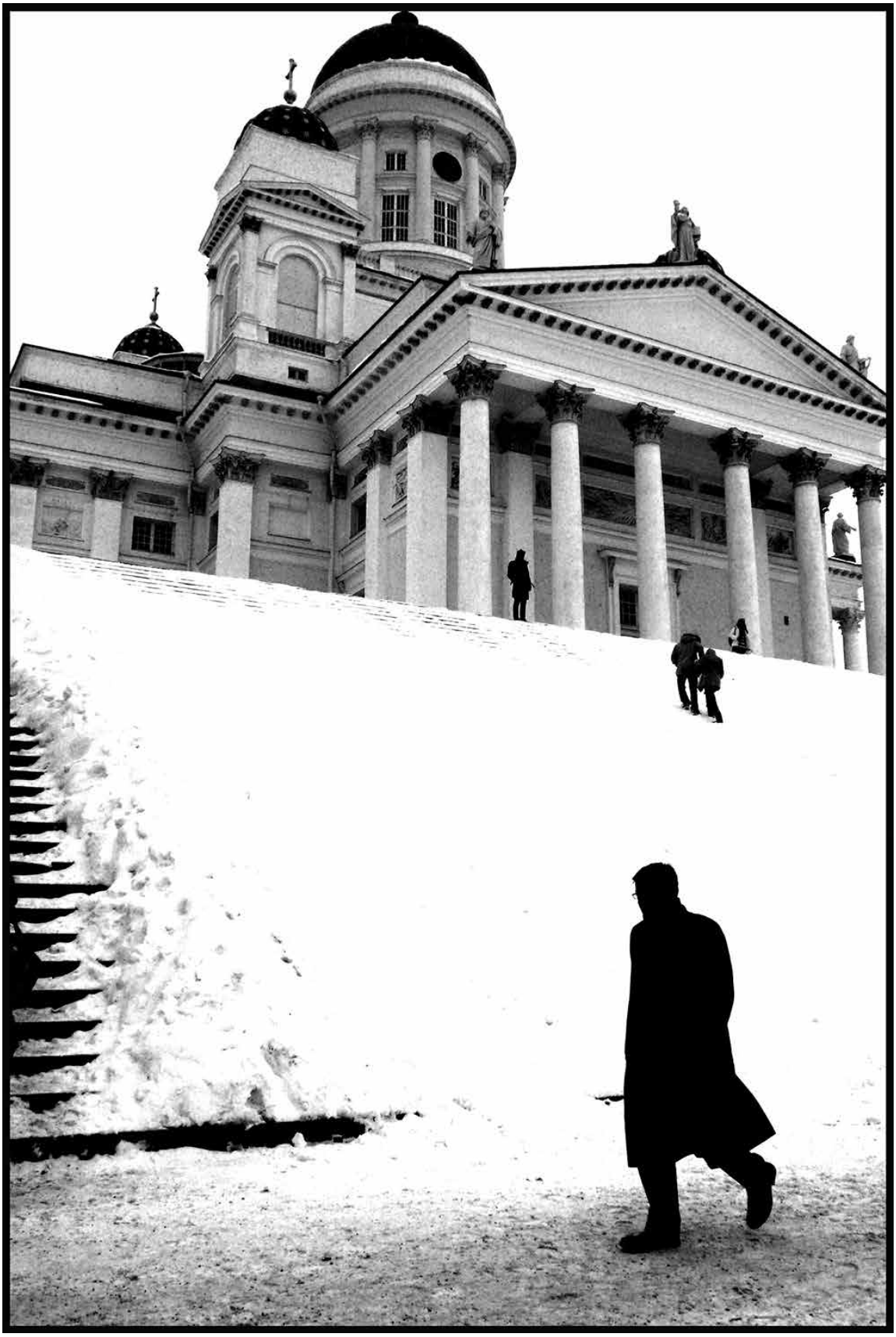
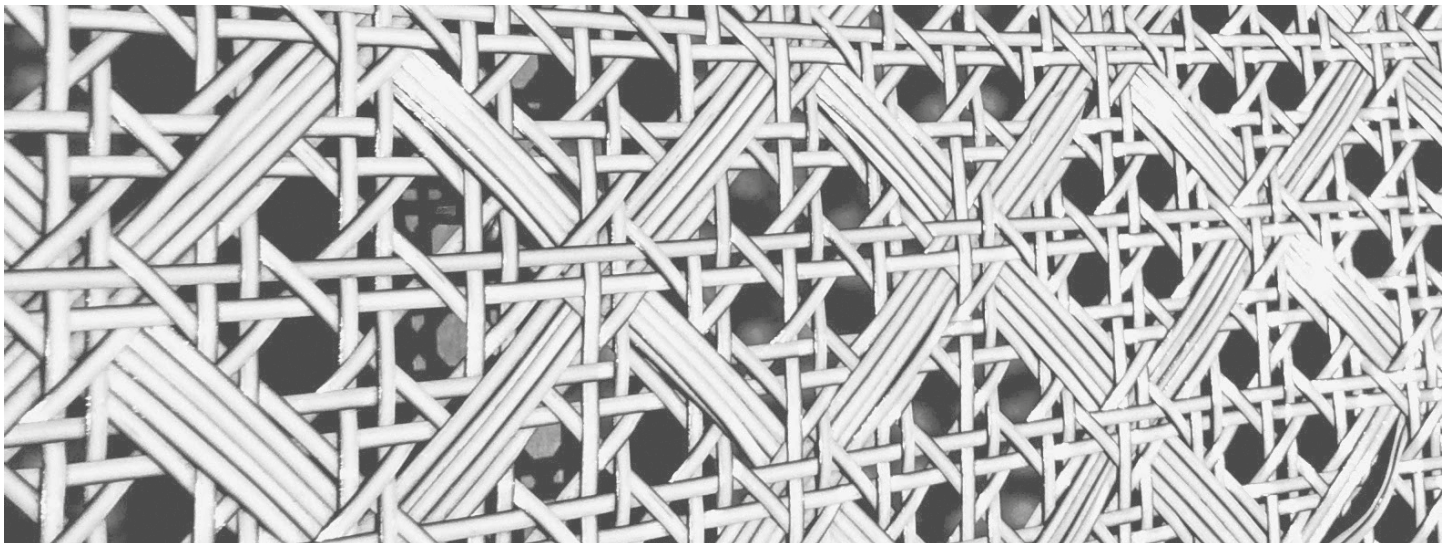


Helsinki, Winter – by John Gimblett

PERSONAL LATTICEWORKS:
an introductory idea

By William Park



I think imaginative/mental 'disturbances' are part of the yet-unidentified patterns of the outer limits of cognition. These patterns can eventually result in achievements – for example in the arts or sciences – if we're lucky.

I'm interested if any writers, musicians, artists, philosophers or practitioners have investigated the areas I briefly describe below [areas which have correlations with the concept of 'resilience'].

However, I hope this doesn't sound too much like the 'mad creative genius' conclusion, because I largely don't agree with that [I mostly follow Albert Rothenberg's views in *Creativity and Madness*].

Disturbances, oddities, apprehending beyond the mundane, are a world away from mental confusions and damaging delusions.

This is not to evoke an interest in 'hearing voices' as such; although this is no doubt valuable. I'm more concerned with domains of artistic/poetic/ and sometimes audio-visual perception [rather than 'voices']. I'm suggesting these are precursors of creative breakthrough, but beginning quietly, remaining dormant – for periods – in the mind.

Some strands of this idea are similar to my earlier idea of 'Creative Suicidal Anxiety' which I posited at the beginning of this decade. This connects with Colin Wilson's explanation that manufacturing urgency and crisis are significant to increase the likelihood of connecting to our highest powers.

In terms of creativity, 'looking after oneself' is not always the best option I've found: reduced sleep or food can promote ways of thinking which are positive, unusual, and new, if the strong and resourceful centres of the mind are activated. This can be done through egoless, enthusiastic, efforts of will.

I'm not interested in disturbing the senses through drug-taking, or alcohol, though. These are uncontrolled, explicit, forced distractions – cul-de-sacs – eradicating the chances of authenticity.

Nor am I suggesting some kind of supernatural dimension… though it might involve synchronicity.

Without even exploring deeper levels, I can cite the following advantages as a consequence of valuing one's inner life: being open to fortuitous coincidences of information or meeting people; having an alertness to balderdash and hokum of all kinds; and being less concerned with conventional approval.

I'm interested in promoting detoxified experiences through concentrated periods of thought, exposure to the arts [including music] realising the importance of inner awareness over basic needs, along with a wholly individualized physical [exercise] programme. For instance, using the kind of rigour or self-determination once characterised by Gurdjieff and his followers,

There could be a tendency to want to 'translate' these experiences into known metaphorical lexicons, rather than present or understand them as uncategorizable manifestations. I recognise there are different 'languages' for expression anyway – other than the written word – art, drama, body 'language' [dance] can surely fruitfully be a part of such explorations.

I find some resonance with the work of the poet Herbert Read: his view of the importance of art – as an

aspect of educational enrichment – is pertinent here.

Similarly, the dream-analysis I've been doing – identifying various patterns of visual experience and 'word-play' which often occur in [my own] dreams – is part of my ongoing informal study.

In the realm of mental health, moods, atmospheres, emotions are particularly important… the pre-language, beyond language life… thus the tenor of my suggested approaches swings away from the temptation to swiftly package responses into easily digestable answers or formulas for 'living' [or indeed, thinking].

Mood often accompanies certain dream scenarios [with the amygdala probably involved]. But that's just one aspect: I'm not necessarily over-enamoured with exploring 'dreams' as a priority.

What's important – I believe – is being mindful of the subconscious elements interacting with waking life; these, on occasion, can produce recognisable phenomena [such as 'scintillating scotoma', a form of migraine attacks which I experienced in record amounts last year, though mysteriously they have now died away].

My hunch is that these phenomena and abilities to access inner worlds are rooted and hardwired into brain physiology; but learning to evoke and adapt these experiences is partly a matter of compassionate self-monitoring of everyday thought patterns or physical habits.

The overall psychological contribution I'm suggesting is: *to identify and develop a personalized latticework of comfort* to surround and interact with inner storms and difficulties. The creative tension can lead to a form of individual resilience.

I believe this comfort may be created through charting/noting one's own unique emotional and mental landscapes… then eruptions, shocks, subsidence can co-exist with protective self-made signposts and fortifications.

This personalized landscape – I suggest – can be mapped with words, sculpture, painting, images, diagrams, sounds, action, sensory immersion of all kinds, or conversely silence … whatever the individual finds most enriching.

Developing concentration and mindfulness [which I'm working through, though not particularly following modern 'Mindfulness' guidelines] concerning mood and change is also very important.

Eventually, this may lead to what I conclude are the two most significant questions a person can ask [free of 'doctrine'] whether one is watching a sunset, or has a knife to one's throat [or both]:-

Are you fully present? Are you fully yourself?

With that state of mind and existence, an individual will be most able to report authentically – with the closest union of beauty and terror – to one's own inner being, or to others. This is a state of 'self-actualization'.

The tone and flavour of what I'm really into is, in all honesty, a lot less grand than that.

I suspect there is no ultimate meaning in anything; or if there is, we won't be able to know it.

But it's perfectly worthwhile to give oneself answers which are rewarding for the short space of time we are alive; and who knows, others might take comfort from one's personal latticeworks too. ▪

Dear Asylum,

I wanted to offer some thoughts of the last issue of Asylum. I valued the piece by Keir Harding giving valuable insight into realities of front line work as part of CMHTs alongside the report of massive amounts going out of the NHS budget to private companies with no incentive to care beyond a basic level, let alone develop critical or innovatory practice. It made me wonder whether we – a community of experiencers of services, academics, practitioners, professionals of all disciplines and members of professional bodies and unions – could exert pressure on the Department of Health and the NHS to significantly increase the personnel and resources of CMHTs and to end contracts to private companies.

We are a community of Asylum readers and contributors, a collective which carries some credibility. Letters discussed, drafted and agreed, with co-signatories to national media outlets and the relevant Government Secretaries of State and Ministers can make us an active part of campaigning to improve services.

Henry Bladen's conclusion to his article also prompts us to campaign for clarity and redefinition of a Psychiatrist's role, if there is to be one at all. Again it can be viewed as a question of resources. It can take a GP less than 15 minutes to decide to make a referral to a CMHT for assessment and then further working with a person including crisis intervention and short stays in a hospital. This could support the argument for a campaign to expand CMHTs, and axing contracts to the "care" home pirates.

The coverage given to the Whittingham Lives project was also important in its remembrance of how things have been in the past, giving perspective on where we are now and where we might take things further and for the better of us all.

Thanks and let's keep Asylum going.

Phil Hutchinson

Mad Memoirs

Mad Muse: The Mental Illness Memoir in a Writer's Life and Work
By Jeffrey Berman, Emerald Publishing Limited, 2019

Book Review by Sophie B. Watson

For anyone interested in the writing life, the world of therapy and treatment, and the relationship between the writing craft and illness, *Mad Muse: The Mental Illness Memoir in a Writer's Life and Work* offers a master class. Author Jeffrey Berman is a Professor of English at the University of Albany in the States and the author of more than a dozen books dealing with the intersection of writing and well-being. His impressive body of work feeds this impressive study of madness memoirs.

As a self-declared literary detective Berman uses his skills in literary criticism and biography, and his extensive knowledge of psychology, psychiatry and psychoanalytic culture, to illustrate how madness memoirs situate themselves in the context of a writer's body of work *and* life. He takes us on an epic roadtrip through the worlds of seven different writers, their lives, their works, and their memoirs.

Examining their memoirs alongside their other works contextualises and illuminates their various paths towards writing their madness memoir in the first place. Berman has done a vast amount of work to curate his analysis: highlighting, and then interrogating, the literary and societal value of madness memoirs. His intertextual philosophy offers a holistic view encompassing the author, the mental illness and the work.

Berman writes with fluid clarity and his empathy shines throughout as he goes behind the scenes of the construction of madness memoirs. Along the way he unearths disturbing information that reminds us that non-fiction is not without its filters and frames. His meticulous examination of what it means and what it costs memoirists to write about their own mental illness, to self-disclose as much as they do, is fascinating and it fundamentally shows their invaluable contribution to de-stigmatizing mental ill-health.

Berman's deep investigative journey examines not only the author's works one by one, but also their reviews, biographies, letters, and interviews. It is also a close reading, not just of their books, but other parts of their lives he accessed, through interviews, letters and diaries. The seven memoirists have suffered from extreme depression, manic depression/bipolar disorder, and/or schizophrenia, and they all have passionately different views of psychoanalysis, psychiatry, hospitalization and medication.

Proceeding largely chronologically, William Styron is the first author Berman studies. His *Darkness Visible* is regarded as the first big memoir about depression. "No memoir has played a greater role in educating the public on the dangers of untreated depression." (p23) As a much-lauded literary writer, Styron's contribution to illuminating the condition was seen as especially valuable. We learn through Berman's reading of Styron's daughter's memoir, of what he chose to omit from his story (for example, his apparent fear of a scandal emerging out of his extramarital philandering with a much younger woman). I was startled to learn too of the reoccurrence of his illness towards the end of his life and even of his suicide letter to future readers of the book. *Darkness Visible* had a vast readership and legions of readers wrote him letters, sharing their own stories of depression which he apparently devoted a great deal of time and care to answering. Styron is also credited with essentially creating a guidebook of sorts for other writers, giving them permission to write about their mood and thought disorders.

With Kay Redfield Jamison whose work *Touched by Fire: Manic Depressive Illness and the Artistic Temperament* marries her interest in humanities and science, we meet an Assistant Professor of Psychiatry who hides her own struggle for years before coming out with her personal story of dealing with manic depression in *An Unquiet Mind*.

Berman discusses how Kate Millett's *Sexual Politics* and her other works which condemn totalitarian patriarchal controls contributed to her anti-psychiatry views. She waged a long battle with friends and family and psychiatrists over her contested sanity, eventually declaring herself victorious when she gets off lithium at the end of her memoir *The Loony-Bin Trip,* but we learn that in a subsequent edition she admits to needing to go back on a small dose after all.

Intergenerational madness is the subject of much of memoirist Linda Gray Sexton's work. Sexton's writings

of growing up with the famous poet Anne Sexton and becoming her literary executor after her suicide make for harrowing reading as her discoveries in her mother's archives reveal details of the poet's sexual abuse of her daughter.

We meet memoirist Lauren Slater who transmutes from patient to psychotherapist and Andrew Solomon whose writing life speaks to the powerful possibilities for writing as catharsis as we learn that his memoir and epic study of depression *The Noonday Demon* "largely cured his sadness". (p 281) Finally, Berman studies Elyn R Saks who advocates for better mental health policies as a law and is a psychiatry professor who suffers from paranoid schizophrenia herself. Saks' story is perhaps one of the most remarkable as she manages what many consider to be the most disabling of all mental illnesses, with medication and prolonged psychoanalysis several times a week for years, while writing extensively about her therapy.

Berman suggests there has been a positive shift in readers' perceptions of this kind of personal writing. For example, F. Scott Fitzgerald had three essays republished together posthumously in 1945 as *The Crack-up.* They were initially dismissed as written by someone who had lost his talent and was embarrassing himself but are now recognized as a "minor literary masterpiece". Berman also suggests that writers such as Doris Lessing, DH Lawrence, Norman Mailer and Hemmingway use writing to explore, and sometimes exorcise, their demons. At the same time, he explores the limits of the writing cure and the talking cure.

Why do authors choose to lift the veil of fiction and produce memoir when it is perhaps the most exposing genre of all? Berman explores many answers to this, including the idea that memoir is perhaps more appropriate for capturing the essence of madness than fiction could be.

In conclusion, Berman shows us how these memoirists demonstrate a commitment to truth telling as wounded storytellers writing/righting wrongs, countering shame, and offering their vulnerability to readers as a precious gift. Ultimately, he suggests that "mental illness narratives are survival stories, strengthening our hope and resilience, showing us how to persevere in the face of adversity." (p337) ▪

Sophie B. Watson is currently studying for a PhD in creative writing and is writing a memoir about her experience of anxiety.

January

Kristen Shea

January, wither, waste;
Barren, inescapable darkness
Where life wavers on a breath.
All life wavers, disintegrates.

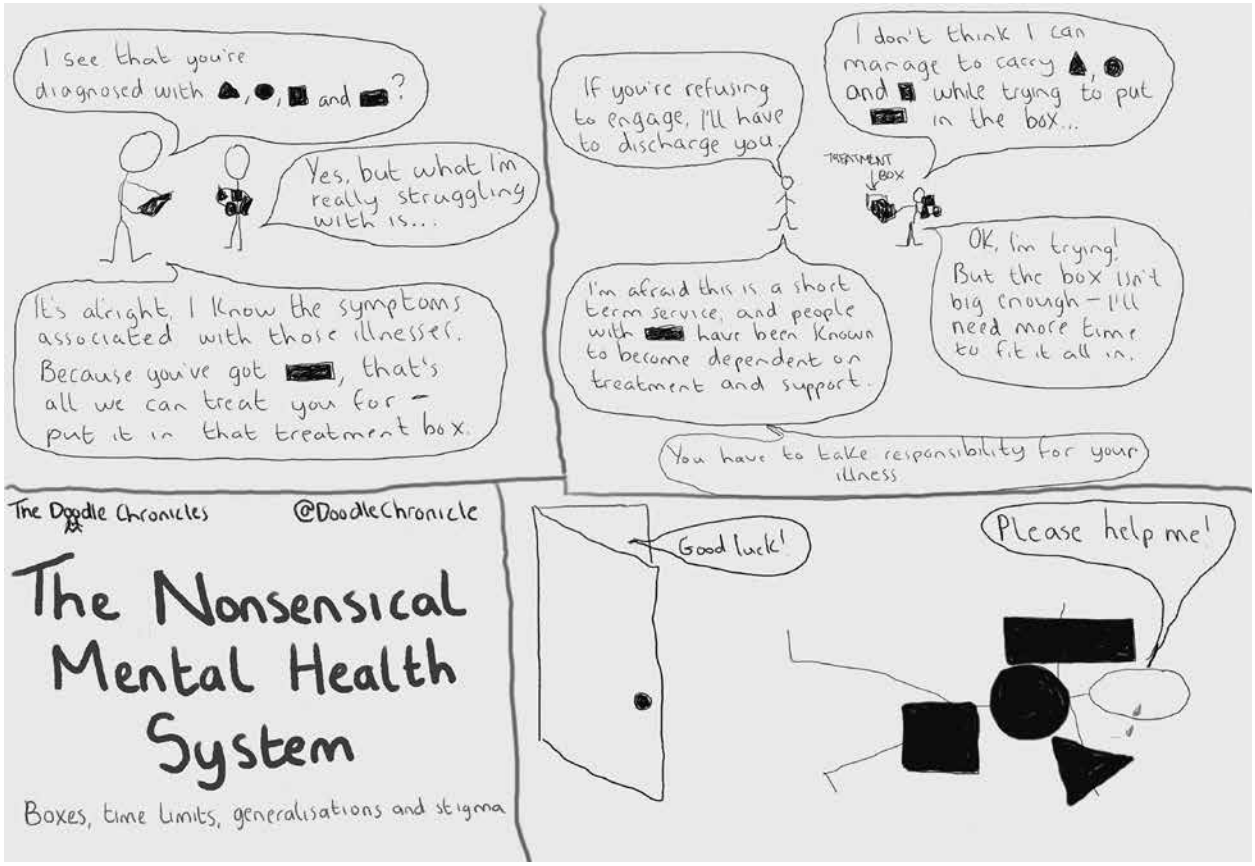
January, gaping, gray;
Starved, fissured ground
Where the Daffodil is born.
The doomed Daffodil buds, struggles.

January, unforgiving, unchanging;
Freezing, asphyxiating air
Where blossoms dare to dream.
The Daffodil blossoms and *breathes*.

Photo credit: William Park

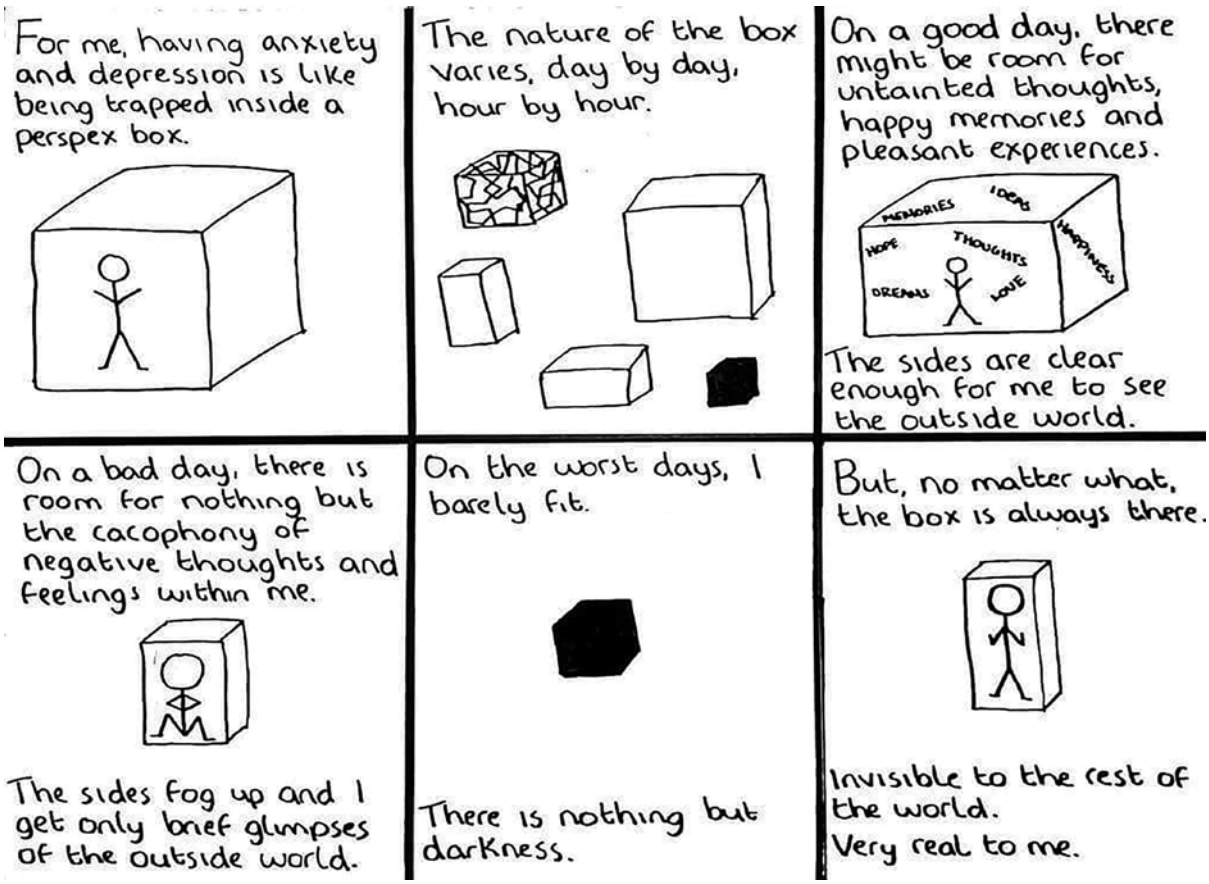
The Nonsensical Mental Health System

BY MOLLY @ DOODLE CHRONICLES



Life in a Box

BY MOLLY @ DOODLE CHRONICLES



‘IS IT JUST ME, OR IS IT GETTING CRAZIER OUT THERE?’

… Joaquin Phoenix’s character in Todd Phillips’ ***JOKER*** (2019) asks his social worker, as he sits in her office. She appears somewhat self-absorbed in the process of her role, as she replies – ‘It is certainly tense. People are upset; they’re struggling, looking for work. These are tough times. How about you?’ Despite ***Joker*** being set in the early Seventies, there is a contemporary feeling amongst the cinema-going audience that little has changed in the Twenty-first century. Gotham City’s elite shows more than a little disregard for its more disadvantaged citizens, who ultimately rebel and protest, turning the streets into a nightmarish landscape (like real life examples, Toxteth & Lambeth in the early eighties). It certainly has historic resonance to real life societal unrest in a Post-Millennial, neoliberal world.

Ironically, it is Arthur Fleck – a ‘mentally ill’ misfit – who becomes the symbol of the people, challenging authority and industrialists like Thomas Wayne, who has nothing but scorn for those citizens, he condemns as ‘clowns’. This statement comes back to haunt him, as Arthur’s party clown, who has killed three of Wayne’s corporate young workers, is embraced as inspirational.

Is Wayne so dissimilar to Donald Trump, a real-life Wayne, whose self-styled corporate success and presidential standing, mirrors Wayne’s political ambitions to be the next Gotham Mayor? By marketising society and health care, the ‘mentally ill’ are further socially isolated through the process of ‘individualisation’ which neoliberalism brings with it. Further, more people become disadvantaged in the workplace, economically through occupational pressures to work harder for less, zero-contracts and unemployment, relinquishing the skills they suddenly find redundant in an ever-mutating workplace and polarised population.

When Arthur writes in his diary, ‘I just hope that my death makes more cents than my life,’ I wonder whether this is a simple spelling mistake, a Freudian slip or one of writer/director Todd Phillip’s many allusions in his fictional narrative to our world. Auteurs have become the ‘gate-keepers,’ those cinematic monitors, regulating real and historic issues of injustice and contemporary politics which affect every last one of us. I have previously mentioned to the editors of this magazine that there is much to be gained by engaging with ‘Cinematherapy,’ a term coined by Dr Gary Solomon (if not others, before and since), in his 1995 ‘*The Motion Picture Prescription.*’ That is why, cinema consumption, despite taking away the originality of literary imaginativity, creates an arena of character/plot dynamics we can engage with and relate to. In many cases, the portrayal of traumatic events can send the message that ‘we all suffer.’ This simple phenomenon is vital to individual coherence and sense of community.

I was particularly taken by the depiction of Arthur’s life and how he ultimately evolves into his nefarious alter-ego. In a marketised, corporate society, which disempowers and disenfranchises him, he becomes a relatively manufactured and resurrected ‘empowered’ product. What had been Arthur’s personal failure to communicate his situation to authority, as well as to the public – with his misinterpreted hyenical outbursts – is portrayed as a growing sense of frustration, tension, and despair. He declares that all his life he felt blamed for having a condition and that his life is ‘Comedy, rather than a Tragedy.’

He informs his social worker, that until recently, ‘no one ever noticed me, I didn’t know if I existed’ and asks, ‘Why don’t you listen to me? You just ask the same questions.’ Arthur states that he always has the same negative thoughts, before his social worker reveals that it’s the last time they will meet, as the city has cut funding and the offices are being closed down. ‘They don’t give a shit about people like you Arthur, and they don’t give a shit about people like me.’ One is left wondering, as a public servant, whom is she sorrier for?

When the finale comes, Joker is laid reverently upon the police car, almost like Christ extracted from the tomb. Resurrected, discarding his old persona, he rises reborn, arms outstretched in mock-crucifixion, an Anti-Christ or Anti-hero, saviour and voice for the Masses. Okay, I got the point Mr Phillips and that it was probably cathartic for Joaquin, who has suffered personal trauma, leading some experts in psychiatry to speculate whether he has mental illness himself. But will Johnson and Trump understand the important message the film sends out: a timely mirroring of illness, exacerbated by a lack of adequate health care and a society which perpetuates both? Or is ‘reality’ simply even more of a sick joke for us ‘clowns?’ ▪

Mark Schwalbe

frankenstein's cutlery

Frankie Konieczki

dishes are piled on three surfaces in my apartment
my dresser, my table, and every kitchen counter
there are cups of watery cranberry juice that i mixed up from concentrate
poured several days ago
most of them three quarters of the way drunk
i have been sober for a month longer than a year
and i have been progressively, decreasingly disorganized this time around
since i got sober and back on my meds
i polish off one of the cranberry juices on the table
stopping first to remind myself, "that's paint water," when i look at the fullest cup
i usually go for the fullest cup after inspection when i am overwhelmed and thirsty
i open the refrigerator and see a lot of food that's nauseating
i focus my green eyed laser vision on some leftover macaroni and cheese
i doctored it up with okra, real parmesan shavings, and pepperoni
i ate all the pepperoni out in the first sitting
i remove the red lid and shovel some mac and cheese into my mouth
without a single utensil because all my dishes are dirty
lost shell shaped noodles hit the floor
it tastes unsatisfying without protein so
i open the fridge and search for bacon bits
i pour bacon bits onto my Frankenstein meal
i almost start to shovel to my mouth bare handed again
but get anxious and squint since my glasses aren't on my face
i'm making sure i did not drop the silica gel pack
into my creation before using hands like ladles
to get the remainder of cheese pasta into my mouth
at last bite i panic thinking i see white fuzzy mold
my heart rate increases
but i squint again and hold my heart in relief
as i realize it's just an okra seed
gratitude comes in small doses and although i am not yet restored to sanity
by the definition of most people
at least i know i embarrassed myself into washing spoons tomorrow

Shimmering Stone

By James Walker

I know where Visions live….

13th floor high – the walls crumple, dissolve. I feel my angel wings suspended in the sky. Floor melts – I could even fall through it, but am kicked back with a crack of matter, with a crack of fact.

Alleyway. Eyes glow – Infra-red. Vision in the dark. Red beams lighting my trail for every stranger to see. I run down the passageway – lit up. Dead-end. That's when I see shimmering stone. Bloom – blossom from the brickwork. I try to scale the wall, but all I find are abandoned back-yards.

Driving through midnight

My Mother comes – take me to safety. I stand in the petrol station signalling the new Messiah, descending if he can from a vessel in the sky. Calling, summoning, a second landing on Earth.

Time stands still – evaporates. Earth stops spinning, plunged. Eternal darkness in space. Planet in free-fall. Frozen black Armageddon

Driving. City lights. Microscopic town. Tiny, twinkling, exciting, inviting. Car slows down in the tide. 'O to reach this sparkling micro-city'

I beat out a pounding tribal rhythm on the dashboard. Primal. My mother shakes – close to tears, draws the car to a halt

Insiders

The man says 'You're Sectioned'. I know that now, but all I see are sketchbook flowers bursting from the table. Animated before my very eyes.

I see friends' corpses lining the corridors. Deflated – drained of life, a tragic blur. Hazy room – I pick up a bag I think is mine. Take my place in the hallowed halls of this cartoon heaven.

The freezing hulking Devil and his demons grip my hand. Pulling me down. 'Rescue me please from this abode'. Raven swoops – pecks my skull to liquid. I see its reflection in the spoon – gnawing at my brainstem.

Watching the dead faces in the breakfast room. The ghouls – the lost souls…. I eat to save the starving African children. All I eat is transmitted…. The ghosts and the ghouls just stare. Men bereft of life with crooked rabbit eyes.

Thick as Thieves

Sitting in a circle on the ward. Flash me your bright gas lighter. When they let me out I'll buy my own. Today I escaped and stole a razor from the supermarket. They say I I'm not safe to shave. So I do so, secretly.

Signalling to each other in secret codes. Watching each other… tuning in – every gesture, meaning – symbols pour from every corner. We the chosen, we the special, we the prisoners.
Enchanted friendship.

Sacred Space

In the night the beds are islands. Between them swim my sacred friends – saviours. Please swim to reach me. Save my soul. You – the holy people – the ones who love me.

I hear dead singers on the radio, speaking from beyond the grave. Speaking to me of hope. The holy elders sit – gentle – surrounding the quiet Christ. Soft love. Soft matter. Soft understanding. Forgiveness. Healing. Saving me. Saved me.

Make a coffee, make a coffee, make another coffee. The mugs here defy gravity – they won't shatter (Suicide Watch). We have a ward-meeting – I ask if everyone here is a captive like me. They say that is 'private'. I hear helicopters. The nurse says I'm 'psychotic'. Something I can't understand (yet).

Sickly medicine flows sticky down my throat. Nails my feet to the floor, makes me tremble – a walking corpse. The nurse moves my stiffened limbs. He has a needle. I resist – I fight. They say if you ever want to leave this place, you'd better surrender.

Discharge

"Discharge" – the most holy word in the hospital vocabulary. Get the hell out of here and don't come back. (Recovery starts at home). The nurse says 'I don't ever want to see you here again'. (Cruel kindness.) Mind how you go… mind how you go…
Resolution

All this – years ago – yet somehow
As close as yesterday

Industrial

Sarah Jake Fishman

She spends her days telling herself she is strong
And her nights wondering if she is bad

She gives herself whiplash worse
Than your mixed signals ever did

She is a factory
Churning out personal rewards
And punishments
Exhausted but eternal

She awakes in the morning
With a hard hat on her heart
And builds walls around her soul

But the sun sets
And the walls crumble

Daggers forged from her own debris
Stab at her over and over
Until she is a heaving
Bloody mess

She is a cycle
A habit
A rat that never learns

She is hypocritically sad
Recoiling from a blow to her ego
But her knuckles are bloody too

She is a villain
She is a victim
She is sorry

NEWS & REPORTS

Human rights abuses of learning disabled children in psychiatric hospitals

Children with learning disabilities and autism are enduring "terrible suffering" in psychiatric hospitals, where their human rights being widely breached, a damning new report has found. The UK parliament's Joint Committee on Human Rights outlined appalling examples of poor care and abuse suffered by patients. It warned that it had "lost confidence that the system is doing what it says it is doing" and that "the regulator's method of checking is not working".

One child had his arm broken by hospital staff while he was restrained and a 17-year-old girl, kept in solitary confinement for years, was only allowed to talk to her father on the phone by lying on the floor and speaking through a gap under the door. The number of disabled children detained in hospitals has more than doubled from 110 in March 2015 to 255 in July 2019. The committee of MPs and Lords has now called on the government to take action, blaming "a lack of political focus and accountability to drive change" as a key barrier to improving the system.

The State of Health and Social Care in England: mental health and learning disability

The Care Quality Commission's (CQC) annual assessment of the state of health and social care in England shows that, whilst the overall quality picture for the mental health sector, which includes community mental health services, remains stable, it masks a real deterioration in some specialist inpatient services. That has continued after 31 July 2019, the cut-off point for the data included in the report.

As at 30 September 2019:

- 10% of inpatient services for people with learning disabilities and/or autism were rated inadequate, as compared to 1% in 2018
- 7% of child and adolescent mental health inpatient services were rated inadequate (2018: 3%)
- 8% of acute wards for adults of working age and psychiatric intensive care units were rated inadequate (2018: 2%).

Difficulties in accessing the right care can mean that learning disabled or autistic people end up detained in unsuitable hospitals. Although inspectors have seen much good and some outstanding care, they have also seen too many people using mental health and learning disability services being looked after by staff who lack the skills, training, experience or support from clinical staff to care for people with complex needs. The majority of mental health inpatient services rated ' inadequate' or 'requires improvement', lacked appropriately skilled staff.

Poor post-natal mental health provision

Looking after a baby can be overwhelming. GPs are supposed to identify postnatal depression, anxiety or any other birth-related condition, and mothers should be asked about their health - including their mental welfare – six weeks after giving birth. A National Childbirth Trust survey found that a sixth of the respondents had been given no time at all to talk about their health at these appointments, while 31% had been given less than three minutes. Of the 1,025 women polled (all having given birth within the previous two years), one-quarter had not been asked anything about their emotional or mental wellbeing. The NCT is now campaigning for standalone NHS appointments for new mothers to discuss any physical or mental health problems.

New mothers' mental health problems going undetected, says charity. *The Guardian* 5 Sep 2019.

Lack of support for vulnerable adults in custody

Since 1998 there has been a duty for all children in police custody to be supported by an appropriate adult – a parent, social worker, or someone with whom the suspect is familiar. But there is no such statutory duty on local authorities for those over 18 and deemed in need of help.

A survey by the National Appropriate Adult Network (NAAN) found that during 2018 the police in England and Wales detained and interviewed vulnerable suspects at least 111,445 times without an appropriate adult present. This failure to provide assistance, chiefly to those with mental illness, autism or learning disabilities, put them at risk of miscarriages of justice.

Report raises alarm over police detention of vulnerable suspects. *The Guardian* 31 May.

Homeless women sent to prison, and rise in prison suicides

According to the Prison Reform Trust, 7,745 women were sent to prison in England and Wales during 2018, and 3,262 were recorded as of "no fixed abode". This number is up 71% from 1,909 in 2015.

Christina Marriott, chief executive of the Revolving Doors Agency, said: "These shocking figures show a system that punishes already disadvantaged women. Prisons cannot and should not pick up the pieces where society has failed to provide an adequate safety net. Sending homeless women to prison for a short spell embeds the disadvantage, and we know many will simply be released with nowhere safe to live yet again. Many of the women being sent to prison will not only be homeless but will also have addictions, mental ill-health and have been victims of domestic violence. This revolving door has got to stop."

Meanwhile, in England and Wales, 27% of prison deaths in the year to the end of March 2019 were self-inflicted up 23% to 91 (there were 74 in 2017–18).

Self-inflicted deaths rise in prisons in England and Wales. *The Guardian*. 10 Oct 2019

Number of homeless women sent to prison doubles since 2015. *The Guardian*. 3 July 2019

CAMHS appointments – rise in cancellations

Mind has published data showing that from August 2018 to July 2019 Child and Adolescent Mental Health services (CAMHS) in England cancelled 175,094 appointments with vulnerable patients; this is 25% more than the 140,327 cancelled during the same period in 2017–18. GPs also complain that too many young people referred for mental health support are rejected by CAMHS services on the grounds that they are not sufficiently distressed. The number of under-18s referred to CAMHS in England increased from 343,386 in 2017–18 to 405,479 last year – up 18%.

NHS cancellations of child mental health sessions jump 25%. *The Guardian*. 11 Nov.2019

Mental health crisis summit

In September 2019 an emergency Mental Health Crisis Summit was called. Service users and their families, workers and trade unions spent the day together imagining what a good mental health service might look like. From a social model of mental health, to organising low paid workers, they started to develop the first stage of a mental health campaign. This summit included speeches about the politics of mental health by: veteran radical film director, Ken Loach; Denise McKenna from the Mental Health Resistance Network, Kevin Courtney from the National Education Union, and Elizabeth Cotton from Surviving Work. You can read more about the summit on the Keep our NHS Public website: https://keepournhspublic.com/campaigns/mental-health/

Critique of neo-recovery launched at nursing conference

Recovery in the Bin (RiTB) have spent over half a decade critiquing and satirising recovery. The user-led collective call themselves the UnRecovered: which includes survivors, service users and supporters. On 13th September 2019, they delivered their keynote address at the 25th International Mental Health Nursing Research Conference. They presented a survivor-led conceptualisation and critique of NeoRecovery: recovery policy and practice under neoliberalism. The focus of their critique is based on collective members' experiences of the way recovery is currently understood, researched and implemented, especially in relation to people who have severe and long-term mental health conditions It went down a storm.

You can find full details of the talk, associated podcasts, etc on the RiTB website https://recoveryinthebin.org/ .

We hope to include an article about NeoRecovery by RiTB in the next issue…

Randomised Controlled Trial (RCT) of Clozapine for people diagnosed with BPD criticised

Clozapine is an antipsychotic licenced for people who have been diagnosed with 'treatment resistant' schizophrenia. It is associated with severe, and sometimes even fatal, side effects, and therefore requires extensive routine monitoring through blood tests, particularly in the first 6 months (when the most severe adverse effects are likely to occur).

The CALMED trial is a Randomised Controlled Trial (RCT) of Clozapine for people diagnosed with Borderline Personality Disorder (BPD). In the CALMED trial 111 people will receive clozapine and 111 will receive a placebo for 6 months.

In October 2019, Recovery in the Bin (RiTB) published a blog: 'The CALMED Trial: A Black Box Warning', raising several criticisms of the trial including:

a. The CALMED trial investigates the use of Clozapine for people diagnosed with BPD, whereas UK National Institute for Health and Care Excellence (NICE) guidelines state that medication (including antipsychotics) should not be used for the treatment of BPD. Given that psychosocial interventions are considered the most successful and clinically appropriate interventions for people diagnosed with BPD, the trial appears to diverge from established clinical practice.

b. The CALMED trial was funded in response to a National Institute for Health Research (NIHR) commissioning brief for an RCT to investigate the effectiveness of clozapine for a specific 'sub-population' of people diagnosed with BPD i.e. those diagnosed with severe BPD who are inpatients, typically in long-term secure units. However, the CALMED trial is not limiting recruitment of participants to this specific 'sub-population' of people diagnosed with BPD. People with a diagnosis of mild, moderate and severe BPD, who are admitted to non-secure, short-term mental health wards, including general acute wards, are currently being invited to take part in this trial. The CALMED Trial is thus conducting a RCT in a population other than that envisaged in the initial brief.

c. The CALMED trial is not using clozapine as a 'last resort' intervention in accordance with established clinical practice associated with the use of clozapine. Inclusion criteria for the trial does not ensure participants have been offered and have declined, or have failed to benefit from, NICE recommended individual and group psychological therapies. In addition, the trial was amended to enable people to take part as outpatients. There is a caveat about extensive monitoring in the community. However, the RiTB blog poses the question 'Who will monitor these participants in the community at a time when community resources are already stretched too far?'

d. Lastly, the blog asks: to what extent is it feasible to obtain free informed consent from potential trial participants when people diagnosed with BPD are 'frequently [neglected and] not provided with NICE recommended psychosocial interventions, and [hence] may be desperate for any potential intervention to alleviate their suffering'.

Austerity fuels mental distress

After conducting an international survey for the UN's Human Rights Council, the special rapporteur on health, Dr Dainius Pūras, concluded that social justice is more important for mental health than therapy and medication. In his view, austerity, inequality and job insecurity are bad for mental health, and measures to address inequality and discrimination would be far more effective in combatting the rising prevalence of mental illness than the emphasis over the past 30 years on medication and therapy.

Pūras calls for reducing inequality and social exclusion through better early-years and school programmes, rapid interventions to support those suffering adverse childhood experiences, stronger workforce unionisation and better social welfare. He criticises "the outsized influence of pharmaceutical companies in the dissemination of biased information about mental health issues". He calls for governments to focus more on prevention than on biomedical cures, concluding that "we need to target relationships rather than brains."

Austerity and inequality fuelling mental illness, says top UN envoy. *The Guardian*. 24 June 2019

Air pollution linked to poor mental health

A recent study by researchers in the US and Denmark has found a link between air pollution and increased risk of mental health problems such as bipolar disorder, schizophrenia and personality disorder.

For example, researchers looked at air pollution exposure for the first 10 years in the life of 1.4 million individuals born and living in Denmark between 1979 and 2002. Levels of 14 pollutants were considered and used to provide a measure of overall air pollution exposure over those years. The team then explored subsequent mental health diagnoses up to the end of 2016.

Once factors including age, sex and socioeconomic status were taken into account, rates of four mental disorders were found to be higher among those with a greater exposure to overall air pollution during childhood. With participants split into seven equal-sized groups based on the air they breathed until the age of 10, the bottom seventh (who experienced the worst air) had 29%, 148%, 51% and 162% higher rates for bipolar, schizophrenia, depression and personality disorder respectively than the top seventh (the cleanest air).

Animal studies suggest mental health may be affected by air pollution: by triggering inflammation in the respiratory tract, leading to inflammation across the body, including the brain. Some researchers suggest that inflammation may be a major contributor to mental and physical health problems, especially depression (see The Inflamed Mind by Edward Bullmore)

However, these research findings do not prove that air pollution drives the development of these conditions, and the studies did not consider many other factors known to affect mental health, e.g., family psychiatric history or bullying.

Growing up in air-polluted areas linked to mental health issues. *The Guardian*. 20 Aug 2019

Strong link between domestic abuse and poor mental health

A Birmingham University study finds that women who have been abused by a partner are three times more likely than other women to be diagnosed with depression, anxiety or conditions such as schizophrenia or bipolar disorder. At the same time, women who have seen their GP about mental health problems are three times more likely to report domestic abuse at a later date: nearly half of those who report abuse have already had mental health problems.

Domestic abuse victims more likely to suffer mental illness. *The Guardian*. 7 June 2019.

Impact of cuts on police mental health

A study involving 17,000 serving police officers and frontline staff from across the UK found that 90% had been exposed to trauma, and nearly one in five suffer from post-traumatic stress disorder (PTSD) – a rate five times higher than that for the wider population.

More than half of the respondents said they had insufficient time to process incidents before being sent back out on the next call. Campaigners say the lack of a unified approach has created a 'postcode lottery' in the support for traumatised officers, and call for a national policing mental health strategy to combat a "clinical and public sector crisis… Without resources in place, the cost to policing and public safety will just mount up."

From 2001 to 2009 the average number of police suicides was under 17 per year, but from 2010 to 2017 (the most recent data) this rose to 23 per year.

One in five police officers in UK suffer from PTSD *The Guardian* 9 May 2019.

Labour calls for review into police welfare as suicide figures revealed. *The Guardian*. 10 Aug 2019.

Risks to residential care workers

In the five years to March 2018, residential care workers experienced 6,034 violent attacks resulting in serious injury and reports to the Health & Safety Executive (statistics obtained by the GMB union). Almost all were perpetrated by residents in their care, many of whom had mental health conditions.

Of the total, 5,008 were so seriously injured that they had to take at least seven days off work (with a resulting loss of pay), while 1,026 suffered a "specified" injury – a category including fractures, loss of sight, brain damage, loss of consciousness, asphyxia, or amputation. One carer died.

"Our members often tell us about the abuse they face at work" said Rachel Harrison, GMB national officer. "The statistics are the tip of the iceberg – they only include the most serious injuries". "The only time you hear about carers in the news is when they attack residents," one injured carer said. "Most homes are chronically understaffed. On average, there are three carers to 20 residents and I've even known it to be two carers. It's not a safe number".

Revealed: 6,000 residential care workers suffer violent attacks. *The Observer*. 9 June 2019.

Mental health workforce falls by 10.6% in ten years.

The Royal College of Nursing says the mental health nursing workforce has fallen by 10.6% since 2009. This is despite commitments by successive prime Ministers to boost resources for mental health services.

Overall, there are 40,000 nursing vacancies in England, and while the number of mental health nurses may have grown in some areas (e.g., community care), they have fallen elsewhere. Numbers are down by a quarter (25.9%) in acute care and inpatient care – with mental health nurses' numbers dropping by more than 6,000 over the decade. Meanwhile, applications for nursing degree courses have plummeted by 32% since bursaries were scrapped in England in 2016.

There are also warnings of a postcode lottery for mental health care, with some regions having little more than half the resources of the best-funded. According to Mind, the average annual spend on mental health services per head of population is £124.48 in parts of Surrey, compared with £220.63 in South Yorkshire.

NHS England loses 6,000 mental health nurses in 10 years. *The Observer*. 19 May 2019

Bad News by Jamie Squire

Send letters, comments and submissions (including artwork, images etc.) to: editors@asylummagazine.org

Send creative writing and poetry submissions to: william.park@talk21.com

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