War and Propaganda - Mental Health Services

A Report from the Frontline in Liverpool

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There is a file on my computer recording my engagement in twenty years of mental health activism. This file was initially entitled *Mental Health*. But I have been driven to rename it. It is now entitled *The War.* I do not use the term lightly. I have long attempted to engage respectfully in reform of a system that has degraded into instrumental abuse. Over the past ten years I have witnessed the decimation of mental health services.

The headlong, lemming-like drive to Foundation Status with its deeply flawed and utterly unprofessional version of business modelling destroyed so much. User/Carer involvement, once supported by some authentic well intentioned commitment by services to inclusive, consultative, humane care, became no more than an instrumental, tokenistic, tick-box exercise. Mental health executives and managers tweet, text and self-promote on social media while dangerous, neglectful, edgy, understaffed services provide little other treatment or support than medication and custody. Funds are squandered on trophy buildings within which regimes of commodified, instrumental *care* continue to be administered by a mental health nursing profession dedicated to nothing more than medicating, feeding, custody and paperwork. Services have been subjected to systemic brutalisation.

During the past year, as a result of major depression and two suicide attempts I have been a patient on two different psychiatric wards for two separate ten week periods. My first hospitalisation was in Adult Services. The second was in Elderly Services. My route to both was via General Hospital A&E - the only mental health crisis service available.

On the first occasion, prior to accessing Adult Services, I spent ten days on a general ward. I was *the Psych Case in the corner bed* ignored but talked about by most staff and recipient of the odd humane gesture from the few not yet desensitised by the system. Four of the beds on this eight bedded female ward were occupied by dementia patients in states of terrible confusion and distress. Day and night they called for nursing attention and assistance. This attention was random and seldom, if ever, immediate. On many occasions these women left their beds and wandered out of the ward unsupervised and undressed. During the night it was also a regular occurrence for male dementia patients from an adjacent ward to find their distracted way into our ward. Buzzers to summon staff to such incidents were rarely responded to.

The level of night-time noise created by the anguished cries of distressed patients and the raucous voices of nursing staff made sleep a virtual impossibility. Nightly chaos and neglect was replaced at daybreak with the arrival of a day shift of Health Care Assistants (HCAs) who could only be likened to a flock of feral marauding macaws. Their loud, garrulous presence was accompanied by the static torture of pop music blaring from their tinny transistor radio. They went about their business of caring i.e. bed making and ward cleaning, with all the delicacy and empathy of a butcher processing sausages while exchanging loud vacuous gossip over and around their victims.

After ten days in this hellish setting, a bed was found for me on a female ward in a local newly built £25 million Mental Health Hospital boasting I*n-Patient Single Rooms Throughout and En-Suite Bathrooms.* This trophy building offers, in reality, nothing more than the medical model of psychiatric care in a costly setting. The propaganda created around it gushes with grandiosity - *Perfect Care and the Pursuit of Excellence* -

State of the Art Care - Specialist Service - Continuous Improvement - Dignity - Respect - Enthusiasm - Zero Tolerance Approach to Suicide.....

My first experience of *State of the Art Care* and *Specialist Service* was on the day following my admission. Still in an extremely distressed state I was summoned to meet with a glib, polished specimen of psychiatric consultancy. Within minutes of our first meeting and having expressed neither interest nor curiosity in my condition or personal history, other than with reference to previously prescribed drugs, he pronounced ECT as his treatment of choice. Aware of the worrying increase in the use of ECT on older females (data from a group of NHS trusts in England between 2011 and 2015, found that, on average, two thirds of recipients of ECT were women, and 56% were people aged over 60. The 2016-17 annual dataset release by the Royal College of Psychiatrists reveals that 67% of patients receiving acute courses of ECT were female, as were 74% of those receiving ECT to prevent relapses – so-called "maintenance ECT') I was also aware of my vulnerability in the coercive environment of a psychiatric ward. The possibility of enforcement of a treatment that invariably causes brain damage, memory loss, and cognitive malfunction increased my already traumatised state but also determined me to evidence mental capacity. I refused to see this consultant again and requested another psychiatrist.

There was no programme of recovery, rehabilitation or activity in this S*pecialist Mental Health Service.* Harassed nursing assistants occasionally organised a Bingo or Karaoke session or opened, for short periods, a disorganised and seldom used Activity Room to oversee patients colouring in - *State of the Art* therapy. The ward did not have an Occupational Therapist and Psychological provision was limited to one hour per week for those fortunate enough to access it at all.

The building is provisioned with expensive S*tate of the Art* gym equipment which cannot be accessed regularly as staff are untrained in its use and dependent on a local charity to provide supervision. The underfloor heating in my S*ingle En-Suite Room* did not work for most of my ten week stay, the shower regularly provided only cold water. During weeks of fruitless requests for an extra blanket I resorted to covering my bed with a dressing gown and coat for warmth. For the majority of my stay my bedroom window which overlooked a public pathway had only one inadequate, gaping curtain. My request for the missing second curtain was routinely ignored. The community dining room did not provide adequate seating or table space to accommodate all eighteen patients and was also the cramped public setting in which detained patients were obliged to receive visitors. A thoroughfare for continual distressed trafficking back and forth through its glass doors to the outside garden, it was also a setting for the public enactment of frustration and despair by many patients.

Having succeeded in dismissing the advocate of ECT I was assigned another psychiatrist. She prescribed medication the side effects of which were migraine, visual disturbance and chronic bowel incontinence. After six weeks I had lost 9.6 kilograms in weight and suffered a severe and excruciatingly painful bowel blockage. My physical health had deteriorated to the point of tottering weakness and I was confined to bed for several days. Only at that point was it agreed to change my medication but there was never admission or acknowledgment as to the damage done by the previous drug.

Never the truth, just endless duplicitous propaganda *.....As part of our commitment to Perfect Care and the pursuit of excellence we have made a commitment to eliminate suicide for all those in our care.....*The mentally distressed have no choice, no option, no help other than compliance with an instrumental, medically modelled mental health system that inflicts unacknowledged damage and distress with its only treatment - toxic psychotropic medication. In order to eradicate the blemish of suicide, which they ***will not tolerate***, on their record of accountability they will incarcerate the defenceless in a holding tank of despair to endure the living hell of mental distress along with the destructive side effects of enforced medication. The erection of multi million trophy buildings in which to administer this torment is portrayed as evidence of S*pecialist Care.*

Costly bricks and mortar without the cement of integrity to hold them together. Holding tanks of abuse and neglect stripped of the psychological and occupational expertise and support so necessary for mental recovery. Such a building is a monstrous white elephant - a monument to psychiatric abuse.

Following a month of medication somewhat less toxic I was discharged from the embrace of *Perfect Care.* I returned home with no continuity of psychological support, one of many on the long waiting list for an inadequate and under resourced service. Psychotropic medication continued to cause me chronic bowel problems. Two months later a community psychiatrist's brusque response to my desire for support in tapering off the drug was to bark that I could stop taking it altogether and do as I wished. She referred me to community services and ended the consultation. I had a subsequent visit from a brisk, abrasive community nurse who did not want to listen to my concerns. When I voiced concerns to my GP practice regarding their lack of mental health support and the general overprescribing of anti-depressants the response was to remove me from their list. This to a patient of seventeen years recently discharged from hospital following a suicide attempt. I no longer had a GP.

The many headed Hydra of the system continued to wage war. A letter from the DWP informed me that the Disability Living Allowance (DLA) that I had been awarded for life because of *severe and enduring mental illness* was to be withdrawn within the month and that if I wished to continue to claim benefit I would need to apply for a Personal Independence Payment (PIP) assessment within that time.

Once again I descended into hopeless despair. My second admission - this time to Elderly Services - followed a thirty six hour wait on a chair in A & E. No ward orientation occurred upon arrival to the ward or thereafter. I had been an inpatient for a month before being given the *Welcome - Useful Information for Service Users* pack which contained no information relevant to that particular ward. Patients were not verbally advised about their situation or their rights, or assisted to access advocacy. The overall impression was that such conversations were avoided by ward staff and information wilfully withheld.

I was assigned a *Named Nurse* who was on two weeks leave when I arrived and was the nurse in charge on consistent night duty following his return. Even if *Named Nurse* and C*are Planning* were anything more than a fictitious tick box concept how could he possibly be expected to carry out the role? He was responsible for supervision and medication on night shifts with dangerously inadequate staffing levels. And how *Co-Produce* a *Care Plan* in a self proclaimed *Specialist Mental Health Service* aspiring to *Perfect Care* that has no specialism to offer other than feeding and medication?

Elderly Mental Health Services were a sad and shocking revelation. A corrupt, distorted social model combined with a vulgarised, crude, inhumane, reductive medical /nursing model abandons distressed, traumatised, vulnerable people to a confusing, unexplained environment through which they are expected to find their own way unaided. Misrepresentation of terminology and concepts such as *de-skilling* and *functionality* leaves vulnerable elderly patients unsupported in basic care such as organisation of their bed space / room / belongings or dressing themselves.

The ward had an alarming number of admissions, from general hospital, of patients who had been plunged into critical mental distress because of abrupt withdrawal from psychotropic medication prior to surgery. I witnessed patients perceived as *difficult, challenging,* or *attention seeking* ignored and unsupported for long periods while suffering severe bowel incontinence. This appalling disregard for dignity and respect left the afflicted patients lying in their own feces with soiled communal bathrooms and pervasive fecal odour distressing all patients for several hours and, in one case, overnight.

Another consequence of inhumane interpretation of *deskilling* and *functionality* was the spectacle of catatonic pre-ECT and disabled post-ECT patients abandoned, unencouraged and unsupported at meal time, confronted by plates of food which they could scarcely see let alone cope with. I have a particularly poignant memory of a dazed gentleman, who had just returned from ECT, being handed a knife and fork and abandoned at a table in front of a plate of fish, chips and peas. Half an hour later he was still hopelessly chasing the food round the plate while nursing staff stood around the dining room wall ticking boxes.

Desensitised, demoralised staff regularly resorted to inappropriate humour or disrespectful, bullying behaviour as a form of self defence and self preservation. The following are direct, and not unusual, quotes -

What do you expect? This is the NHS.....

That's stupid. You can't do that.

Take yer dishes back to the hatch. Yer becomin' de-skilled !

You're well able to walk now aren't you! Pity you couldn't find your feet this morning when you nearly broke me back!

It was relentless yesterday and we're not having it again today if you have diarrhoea.....

Come back in the dining room. We can't be runnin' after everybody. We're short staffed.....

The ward reverberated with utterly inappropriate and nerve-racking levels of noise caused by door banging and shouting - this behaviour from staff, not patients. Genuine communication with patients was scarce. People need to be spoken to. Notices - frequently months out-of-date - are no substitute for verbal communication. Mental distress causes confusion, poor concentration and poor memory. A common side effect of psychotropic medication is blurred vision. A third of the population of this city have literacy difficulties. Notices on walls are neither sufficient nor authentic communication - although they may enable the duplicitous ticking of a *task done* box. Communication between members of staff was equally poor. Sloppy, careless, unprofessional office procedure with no proper diarising or recording resulted in messages not reaching patients and inadequate briefing of staff on handovers.

As was the case in Adult Services there was no structured programme of activity, recovery or rehabilitation on the ward. Neither was there an Occupational Therapist or a Psychologist. It took five weeks of relentless pressure from myself to source the psychological support that I needed. I eventually achieved the miracle of having a psychologist and a psychiatrist present at my ward round in an MDT (Multi Disciplinary Team!!) room. It took a similar amount of pressure to achieve some semblance of occupational therapy - an Activity Worker was seconded from another site for two day's a week. She was, however, almost immediately withdrawn because of some sort of idiotic managerial dispute. Elderly patients with no physical activity or mental stimulation, and rendered comatose by medication, spent their days slumped in armchairs in front of the TV. Their only access to psychological support was from The Jeremy Kyle Show!

The hospital is situated at the edge of one of the most beautiful public parks in the country. The mental and physical benefits to wellbeing of nature and exercise are indisputable yet the opportunity of getting off the ward for a walk in the park was something that was rarely offered to patients. Inadequate staffing levels and the dearth of OT and activity workers enable an easy dismissive assumption that '*they don't want to do anything'.* The ward's only accessible outdoor spaces - two courtyard gardens - were in a state of deplorable neglect containing little more than weeds, dead plants and shrubs and dirty, worn out, rotting seating. One of these gardens is also the site of an annual wasp infestation - the wasps nest in the rafters overhead and not only inhabit the garden but access the ward through windows and ventilators. This is an annually recurring

problem but nothing has been done to properly address it. After weeks of sustained pressure from myself and other patients a solution was achieved with the installation of plastic hanging wasp traps. This is something that could have been done years ago.

Institutional inertia afflicted and suffocated all ward business. It took several weeks to replace a broken toilet seat and the acquisition of a replacement TV remote control appeared to be beyond the capacity or ability of management. During my ten weeks on the ward the TVs in two separate lounges were reliant on one remote control handset. This caused ongoing confusion, aggravation and bickering among patients. The solution was simple - buy a replacement handset at Argos for a cost of £8.99. Surely a small investment to maintain one of the few 'treatments' available on the ward - TV. Access to the women's lounge - the only quiet, comfortable, pleasant place for women patients to sit is restricted by the same institutional inertia. There is a problem with leakage through the lounge's roof if there is heavy rain. The ward solution to this is to lock the area off. This has been an issue for *a long time* and *workmen* have attended on several occasions but the leakage persists. Heavy rain is a regular occurrence. Ignoring the problem will not make it go away but it will continue to deprive women patients of a comfortable refuge.

Mealtimes were reminiscent of wartime rationing with consistent shortages ..... Juice - Vinegar - Salt - Marmalade - Fruit - Serviettes - Paper Cups - Cutlery - especially spoons - always a radical shortage of spoons. There was a day when the only fruit on offer was a collection of rotting oranges and four cooking apples. Shortages were always blamed on somebody else - *They* hadn't placed a proper order - *They* hadn't loaded the trolley properly - *They* had lost the spoons. Who are *they* ? Could it possibly be *them* .....?

Shortly before leaving the ward I witnessed an attempt to discharge an elderly patient four days prior to the date she had previously agreed and felt would be safe. She was informed by her psychiatrist that he was discharging her immediately as *her bed was needed and there were those in greater need than herself.* Shocked, distressed and upset she explained that she could not leave alone as she would not feel safe and was depending upon the support of her son on the already agreed date. The psychiatrist and nurse attending then told her that she would have to go to a hotel until the weekend. She left the meeting in a distressed, emotional state. Her weeks of recovery were totally undermined by what can only be described as insensitive, heavy handed bullying. Her distress was further compounded by the appearance of a member of staff sent to deliver plastic bags to speed her packing and departure. It took several hours of resistance, urgent appeals to the Ward Manager and, very probably, the fortuitous presence on the ward that day of a CQC inspector, to reinstate her original discharge date. Hardly surprising that the door to readmission rapidly revolves. If patients are prematurely discharged while feeling unsafe and against their judgement and wishes relapse is hardly surprising.

My negative experience of treatment with psychotropic medication continued. My body is a sixty year evidence base for the damage caused by such drugs. I now refuse to take any that have damaged me in the past. This leaves psychiatry and it's medical/pharma model with very few options in my treatment. On this occasion the first drug prescribed had, within two weeks, caused considerable and significant damage to my eyes and sight. Withdrawal from the drug did not reverse this damage. (Three months later, as I write this account, I am due to visit an eye specialist to investigate whether the damage is permanent.)

Following a two week moratorium on medication, psychiatry came up with a drug of last resort which would - hopefully - do me no further harm. I had been drug free for over two weeks and was already benefiting from the psychological support that was at last in place. I had also, perversely, been energised by sheer anger against damaging psychiatric treatment and the negative ward environment. It was therefore with great reluctance, trepidation and some distress that I was obliged to comply with yet more medication. The

immediate effect of the new drug was a worsening of depression. There followed tinnitus, visual disturbance, fine tremor, migraine and nausea. These side effects lessened with time but I continue to experience tremor, tinnitus, intermittent headache and raised blood pressure.

I survived. I have recovered. I am home again. This, in my opinion, is due to the passing of time and good, ongoing psychological support. I can evidence and add to my record the negative aspects of yet another psychotropic drug. I am currently caught in the psychiatric trap of compliance with medication that is damaging to take but potentially dangerous to discontinue. I have neither conviction nor proof of its efficacy and no faith in a profession that offers me little else. I have already stipulated that I wish to be supported in its discontinuation after some months.

I am fortunate that lifelong exposure to psychiatry has not damaged my mental capacity or ability to fight back. I am blessed with supportive family and friends. My experience of and activism around the mental health system has armed me with the insight and knowledge to confront bad practice and insist on adequate care. So many service users have no such advantage and are abused and destroyed by the system, by the war.

Mental health services, driven and enabled by the perverse incentives of a malign accountability system, have lost sight of the community they were created to serve. Inept, dysfunctional business modelling and commodification of both patients and staff has resulted in services managed by spreadsheet and bereft of humanity. An environment damaging and abusive to both staff and patients has been created. This damage is writ large on wards where under-staffed, under-resourced, disrespected, demoralised and desensitised staff deliver a crude, vulgarised, often abusive and disrespectful, medical model of care. It is a miracle that some small number of nurses and nursing assistants still succeed in maintaining integrity and humanity in their practice.

Occupational Therapy's place in services has been abused, marginalised and eroded and Psychological services are likewise disrespected and under-resourced. Psychiatry is enabled to continue relatively unchallenged despite so much evidence demolishing the medically modelled myths on which current services and government policies are based. Leadership and management is increasingly remote, indifferent, poor and, in some instances, downright disrespectful and abusive. Ward managers are not supported or empowered to improve quality. They are on constant firefighting duty to plug holes on dangerously understaffed wards.

How should we view the shocking and disastrous inability of a health system to communicate with either staff, service users or carers in an equal, respectful way? It is so deep rooted in delusion and denial that it will not see the irony and cruelty of espousing models such as Recovery, Co-Production and Peer Support which are founded on core principles of respect, equality, authentic relationship, honesty, support and hope, while practising in a manner opposite to all of these principles.

Service users are in the hands of a fear filled, self-referring health system, incestuously inward looking and dysfunctional, with a malign, bio medical view of mental illness. It is most afraid of what it most needs - new blood, creative freedom, thought, imagination, risk taking and a workforce with the courage and freedom to think, challenge and deliver real, courageous, meaningful care. Psychology is a major part of what it most needs and fears.