Compassion not Compulsion

(published at Psychminded) Can we work towards a force free mental health service? As a society I believe we have a moral obligation to struggle for this ideal.

This is why on 14th of February (2005), I and many other former psychiatric patients and our supporters will be taking part in the ‘Kissit’ march (see www.kissit.org) which will rally at Whitehall and march past both the Department of Health and Parliament to Geraldine Mary Harmsworth Park (the ex-site of Bedlam).   Protesters will wear sticking plasters in the shapes of crosses on the seats of their trousers to bring the point home. A Valentine’s card will be given to Tony Blair that on the cover depicts a heart and a Cupid’s arrow, and when opened up shows the similar (but different) image of two buttocks being penetrated by a hypodermic syringe, with the message ‘Have A Heart’.

Originally conceived by the artist Aidan Shingler, the march humourously seeks to raise awareness of and protest against a serious issue; The widespread use of force in psychiatric hospitals (and soon to be extended into the community). ‘Psychiatric assault’ includes the use of physical restraint procedures, forced drugging (rapid tranquillisation), seclusion, and pain compliance techniques (where the person is hurt to encourage them to comply with the forced chemical or physical restraint procedure).

Many of us on the march will have experienced force in situations where we were not behaving violently. Many of us will have had our bodies invaded by drugs we did not want. Many of us will be workers or family members who have felt obliged to collude with practices we disagree with. The process of ‘Acuphase’ is one of the most common uses of force on the psychiatric ward. It is used to manage challenging behaviour. Forced Acuphase is where a person is pinned down undressed so that his or her buttocks are revealed. The person is then given a psychiatric cocktail (at present this is usually haloperidol and lorazepam). The NICE ‘Disturbed Behaviour Clinical Guidance’ (2004) draft guidelines suggest that all attempts to avoid forced treatment using de-escalation techniques should be tried prior to the use of force. There are however no structures to enforce this recommendation. If the government wanted a mental health service based on compassion it would commission an inquiry into the effects of force in psychiatric treatment and produce a whole set of guidelines on how to de-escalate challenging situations. This it has not done

In my experience at what point force is used on a psychiatric ward depends on the staff involved and the dominant ethos on the ward. In every hospital there are ‘hawks’ and ‘doves’. The often high numbers of agency staff tends to make the situation worse, as these staff are often less interested in establishing rapport with the people they are paid to care for. How force is used varies from hospital to hospital ward to ward and is influenced by which staff team members are involved on a particular shift and leadership styles. As someone detained in a secure ward described to his mother “At night the bouncers come on”. Under the present risk obsessed culture nurses are often persuaded that in order to avoid harm being caused, restraining and sedating patients early enough will avoid the risk of a harmful incident. This idea of preventive forced treatment (just in case things get difficult) is being most recently being advocated by the government in the form of Community Treatment Orders which psychiatrists will be able to renew every six months.

The long term harm caused by using these procedures is not looked at. I have written in some detail about my experience of forced treatment when I was eighteen years old, elsewhere (May 2002). My experience, conversations with other people who have been in-patients and practice as a clinical psychologist, tells me that the use of force has two main negative effects. Firstly it can set up in the person inflicted with force, a deep resentment toward health care workers. A fundamental trust is broken and the person is likely to be reluctant to seek mental health care support in future crises. Hence we have Assertive Outreach; whole teams set up to work with this group of dis-affected people and a growing market for secure hospital provision, to take the use of force to its logical conclusion, long-term internment. The second effect of the use of coercion if it doesn’t provoke outward anger and mis-trust is these feelings can be internalised so that the person learns not to trust themselves. They give up on their right to an active role in their life assuming a dependent ‘sick role’. One becomes institutionalised. Both scenarios have a negative effect not just on the person and the community as a whole. We lose out on the potential of people who have been psychotic to contribute to our society. We guiltily write them off and blame all the passivity or challenging behaviour on the ‘mental illness’.

One can feel like a radical writing about a peaceful and fair approach to mental health care. This is mainly because (since the mid seventies) there has been a lack of literature looking at it. When I facilitate self help groups in community and hospital settings I do not feel radical. In my experience in in-patient settings more than half of the people who receive treatment for psychosis and or self harm are in touch with and unhappy about how they have been treated and have good ideas about how they would like to have been treated. We need to listen to these testimonies.

Force denies the individual dignity and it damages the spirit. It is no surprise that one of the former Guantanamo Bay detainees recently released, now requires mental health care for severe mental health problems. This is the paradox, the use of force creates emotional distress and mental confusion yet in-patient services designed to care for such states regularly use coercive practice. One of my clients talks about her ‘secondary mental illness’, this is the one created by mental health services and the forced drugging she has endured. She describes it as a shadow in her mind. The NICE Guidelines on ‘Disturbed (violent) behaviour: the short-term management of disturbed (violent) behaviour in in-patient psychiatric settings’ are due out this month. The draft guidelines which came out last year, recommend that every time a person is forcibly restrained, drugged or secluded a review is desirable (but not essential) that looks at if any lessons can be learned. When the community (and I say the community because the hospital is part of the community) uses force against a distressed individual there are always lessons to be learned, amongst all parties. As a society we have to see the use of force as a failure of our abilities to carry out a compassionate approach to emotional distress. Where someone is actively violent restraint of some kind is at times necessary. However in my experience the use of force in the psychiatric system is often unnecessary and there lacks a culture of accountability when it is used.

In terms of care for psychosis, force is at the centre of the state’s approach to treatment. Neuroleptic drug treatment (under the pseudonym anti-psychotic medication) is presented as the treatment of choice for people with unusual beliefs behaviours or experiences; Treatment of choice for those who have no choice. Most first admissions to psychiatric hospital are characterised by a ‘try this medication or if you don’t we’ll have to force you to take it’ approach. I am frequently contacted by families who choose to support people to manage their psychotic experiences without the use of forced drugging, they then get no support from mental health services. Maybe we should rename mental health services ‘psychiatric drugging services’! This use of neuroleptic drugs as a maintenance (long term) treatment occurs despite evidence that alternative approaches work. The Soteria project (see www.moshersoteria.com) and other similar projects in Scandinavia show that minimal or no antipsychotic treatment combined with a humanistic approach can be more successful than the traditional drug-based approach. Why aren’t similar (research) projects funded in this country? Is it the huge influence of the pharmaceutical industry on the medical profession and increasingly other disciplines (including the government’s own think to and policy spreader NIMHE)? This is a human rights issue, as democratic citizens we should have the right to a force free mental health care. Those of us who believe in compassionate approach to mental health need to come together to struggle for this vision.

Ten years ago I was told by my clinical psychology supervisor I was preaching to the converted, I disagree psychology (like other disciplines) is complicit in these arrangements. For example, if we look at the Early Intervention (for psychosis) movement, which is spearheaded by psychologists, what they are advocating is person centred but still neuroleptic drugs are at the centre of treatment. Is this pay-back for all the drug company funding of this movement? For example, one Early Intervention handbook on how to implement Early Psychosis services recommends that a person has to be ‘symptom free’ for a year, before professionals should consider cessation of drug treatment. The hearing Voices movement has shown that people can develop drug-free approaches to living with psychotic experiences. Despite the alternative evidence that is available, even the new Early Intervention services which pose as innovatory generally do not give people a choice of a drug free approach to their difficulties. This is how endemic coercive practice is in the mental health care system.

Aged nineteen, against doctors wishes I withdrew from my neuroleptic drug treatment I had to learn to manage my own psychotic experiences and recovery without medication. This is fraught with problems if you do it alone, to be successful you need a group of people who will support you (see Lehmann, 2002 for accounts of the withdrawal process). Part of the culture of coercion in this country is that there are no specific services that will support you if you want to withdraw off neuroleptic medication.

Over the last ten years I have had the privilege of supporting others to manage their disturbing experiences without the use of force, sometimes without the use of medication. Supporting people in a force free way through their spiritual and emotional crises takes resources. Not more resources, just a different emphasis in how they are used. Such an approach requires structural changes in society, I don’t deny this. Mental health crisis care needs to be based much more in the community and involve the community. We need to demand a society that assists a community based approach to emotional crisis. For example, in many cases family members or friends would be able to help more in the care and recovery process if they could take more time off work. We need employers to support this. Supporting someone through psychotic and or distressing experiences can be exhausting. One needs a whole team supporting the process. However in the long term creating this healing environment will reap rich rewards for everybody involved.

In a sense we are all institutionalised into accepting the status quo. A lot of good caring people end up colluding with practices in their hearts they know are wrong and counter-productive. I myself have at times chosen not to challenge practice I felt was unjust and violent. As a junior member of staff I feared repercussions on my career, if I rocked the boat too much. Many staff are in this situation every day. This is why the Kissit Campaign is so important (see the forthcoming special issue of Asylum magazine for detailed coverage). In this article I have tried to highlight some of the main issues involved. We need a public debate about this. The Kissit campaign is an excellent wake up call for all of us to become

more active in the struggle for a compassionate approach to different states of consciousness. We need to challenge the conventional approach to challenging behaviour. All the civil rights movements have had at their root the struggle against violence. Women, Black people, Gay people; all these groups have in the past, experienced state sanctioned violence, that at the time was seen as acceptable. The struggle for a mental health care approach that is not violent is just as important as these other egalitarian causes.

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If you share concerns about these issues, tell people you know about the Kissit campaign, spread the word, and if you can, join us on Valentine’s day!

References:

Lehmann, P.(2002) Coming off Psychiatric Drugs, peter-lehmann- publishing.com

May, R. (2002) Over Our Bodies Mental Health Today, August edition.