reVision

A radical voice for change in mental health

Revision News Winter Edition 2021 Tim Wilson

all the best for 2022 – let's hope people can safely get out and about more

IF anyone has got any news, events, park walks any articles please contact me: t.j.wilson@liv.ac.uk

Introduction

1. This edition begins with a very powerful and important article by Mary O'Reilly – Trapped, enslaved to a monstrous Mad regime – this terrific piece depicts the dangerous, cruel, wrong and iatrogenic nature of modern psychiatry.

2. This followed by lovely sounding serenity integrated mentoring (SIM) its anything but, just more disturbing, discriminatory diabolical contemporary mental health services.

3. Next is a newspaper report by David Batty, illustrating more breaches of human rights in mental health – surveillance gone too far.

The fourth feature is an extremely salient article by Mick McKeown and Jonathan Gadsby for the critical mental health nursing group – Mental health nursing and conscientious objection for forced pharmaceutical intervention – any comments and discussion on this,

please email Mick (see email at beginning of article, Mick would welcome comment.

5. I follow with a quick response – please disagree or make comments. The sixth paper is one seen before – Kinney and Wilson – putting the politics back into the psych.

6. This followed by a recommendation to read activist Don Weitz resistance matters - please download it free

7. Next a piece I wrote in 1995 on health and education part of one chapter in a paper I called the ontology of humanness.

8. Followed by more information on corrupt drug trails and its reporting.

9. Follows a public health piece, on how to protect yourself from coronavirus and how medicine went wrong 150 years ago – from a Wilson perspective

10. Lastly what revision is about, its philosophy and vision of change

any comments or critique please get in touch

"New" wonder music therapy - Erroll Garner 1953, cheek to cheek; good for dancing movement and brain.

Trapped - Enslaved to a Monstrous Mad Regime

Mary O'Reilly

I've always wanted to write in the style in which I so easily speak. Turn it all into a joke. Life as a performance piece. Entertainment. I remember years ago becoming openly upset over some stupid, systemic, ugly rule or regulation. 'I don't like you this way - I prefer you when you're funny' was the immediate embarrassed response from the health service manager involved. I couldn't disagree. I too prefer the funny version of me. But it's hard to hold on to humour in a madhouse.

This is not what I wanted to write. But the blank page won't play the game. Won't provide humorous backdrop. Stubbornly withholds the jester's hat. Will not facilitate comic performance. Demands truth. And the truth is that my life has always been endangered by a vulnerable mind space where deadly depression lurks.

Mental distress and torment is terrible. But it is the rancid, coercive regime appointed to its containment and control that is diseased. I am easy prey to the deadly alliance of Psychiatry, Big Pharma and the Mental Health System - a murder of predatory crows.

We are never safe from ourselves. I was trapped at conception. Branded at birth by temperament, by particular sensibility, by a familial way of being. Genetic inheritance. Blighted bloodline. Destined to revisit and relive a particular tortured, tormented state of mind over, and over, and over, all my life long. Always caught unawares by the sudden inevitable deadly, dangerous unsignposted detour. Tracing, in retrospect, its devious tactics, its treacherous trajectory. But never aware in time. Never alert or armed to divert from its ruinous path. Always too late. Time becoming an enemy. The clock’s forward movement demanding function, engagement with the world - the very thing that is disabled in me. Existence a shameful apology. Sorry, sorry, sorry......that my sense of myself and connection to the world fragments like a crystal glass smashed into a thousand shards. Hope, belief, self-confidence, self-esteem, self-respect sucked into a vortex of murderous negativity. No matter how often I achieve the bloody, tortuous task of repair the fault lines remain, the glass will shatter again.

Sleep, the one possible transient escape from tortured, relentless, fragmented thought is haunted by images from other times when this state has ripped my life apart. Anger and despair that this recurring state leaves me subject to definition and damage by a monstrous regime that I have grown to despise. Every personal resource for survival undermined not only by mental distress but by fear and loathing of its alleged care and support system.....

Chorus of Hell - Inferno Ward

Assault by the day shift

A feral flock of

Screeching marauding macaws

Replace night terror and neglect with

Garrulous shrieking gossip and

Static crackle of transistor radio

Monstrous swooping seagulls

Stalk ward window ledges

Tap savage predatory beaks on glass

Hideous counterpoint to

The hellish cacophony of

Crude callous raucous

Systemic care

Introibo ad altare Dei

Lunchtime on the ward. Victim rises, extending his arms outwards and sideways in the manner of a benediction.....or a crucifixion. At first, I wondered if he might have been a priest. How describe the terrible sight of him at mealtimes. Propelled to a table. Seated and draped in flimsy see-through blue plastic apron. Food plonked in front of him. Admonished to 'eat yer dinner' and abandoned to drooling, futile, hopeless slow motion attempts to transfer food from dish to mouth. Care Goblins sit at a nearby table ticking boxes. Victim rises and is shouted at - 'sit down!'. A passing Goblin wipes Victim's drool - 'it's not nice, ye're sittin' with other people'. Victim rises again, weaves and staggers towards the garden. Ex-bouncer Goblin - a hard-faced thug - attempts to get him back to the table. Fails. Gives him an ice cream tub and plastic spoon and abandons him. Job done - lunchtime nutrition box ticked.

I don't see him for a couple of days. Then I hear that he was taken away for more ECT but is now back on the ward. We're herded in to lunch and there he is - seated, aproned and abandoned in front of a bowl of soup. We encourage him verbally but cannot be seen to help. He used to be a music librarian and a violinist but he cannot orchestrate the score from bowl to spoon to mouth. There are no Enabling Elf Carers present. An haranguing Nasty Goblin replaces the soup with a plate of vomit coloured chicken curry and a futile knife and fork. Victim obviously cannot manage. I fetch him a spoon. The Goblin, who's been observing, hand on hip, from the doorway, sees this and says she's already asked if he wanted a spoon and he said no. I suggest that he needs help. 'I can't take away his skills' she snaps. Nasty, cruel creature of a savage system.

Introibo ad altare Dei ......I will go unto the altar of God. (the opening words of Roman Catholic Latin Mass in the Old Form – now called Tridentine

Curtain Up.....

Random Scenes From The Theatre Of Cruelty

The Writhing Queue Jerking, grimacing bodies wait for the next shot of a drug that renders them grotesque.

The Contorted Girl
Neck, trunk and arm spasms propelling her bizarre drug-driven movement through the ward. This has been the case for months.

The Mother Raising money to pay for cosmetic surgery in an attempt to repair psychiatric drug damage to her daughter's face and eyes

The Father Banned from any further meetings with hospital management because he dares voice his opinion that treatment of his son is not fit for a dog.

The Asylum Seeker
In the MRI Department. Undergoing investigation of brain lesions - damage caused by medication - enforced 'treatment' while he was incarcerated here ten years ago following his arrival to the city as a traumatised 15 year old. Through the window he can see the Psychiatric Unit in the distance. Grey, raw, rainy, hopeless afternoon in April....

The Health and Safety Manager
'Language Mary!' he exclaims rising from behind his computer to the dizzying heights of his incompetent mediocrity. He has scheduled regular ear splitting, nerve wracking testing of the hospital's alarm system at a time that disrupts, distresses and utterly sabotages patient recovery group meetings. This has been repeatedly reported together with suggestions for more appropriate testing times. Nothing has changed...... 'I have access to five languages - English, Irish, French, Spanish, Latin - which would you prefer? Because the message is the same in any of them - this situation is an 'effing disgrace'.

The Funeral He was a lovely, gentle, funny man. He loved to sing. He used to come to the recovery group and voiced distress and fear at being forced to take weekend leave in order to free up beds for emergency admissions. He never returned from leave. He hanged himself, unsupported and alone in his flat. The opening song at his funeral service is The Boxer.......

My story's seldom told....I have squandered my resistance.....For a pocketful of mumbles......Such are promises......All lies and jest.....

Final Curtain....

What Do You Expect - This Is The NHS

Ironic, defensive, inappropriate quips from ward staff do not laugh away the reality of damage done. It is far from a joke. For two weeks I was administered a drug that compounded already significant eye damage caused by previous psychotropic medication. Withdrawal of the drug did not reverse the damage.

I'm aware that the Hippocratic oath has fallen out of fashion. But I'm wondering if perhaps I've missed something in my reading of the College of Psychiatry's Code of Ethics or the General Medical Council's Good Medical Practice Guidelines. I may have - my sight is unreliable. So perhaps I've missed the get-out guideline that endorses craven denial and abrogation of responsibility for harmful practice. For two decades I have been subject to evasion, cover-up, closing of ranks and withholding of information from both psychiatric and eye specialists regarding prescribed psychiatric drugs that have caused devastating permanent damage to my eyes and sight. My natural distress has been responded to with appallingly inappropriate, patronising, insulting, insensitive comment.......Well you're not blind......You're lucky it's not glaucoma ....You won't pass a driving test now.....You're too high functioning - you expect too much....You're very intense.....What do you expect? This is the NHS....

Drapetomania

Why is the mental health system not referenced in discourse on modern slavery? Surely it's the perfect paradigm - enslaving, coercing, disabling and victim-blaming. Drapetomania was conjectured as a mental illness in 1851 and hypothesised as the cause of black slaves fleeing captivity. The remedy for this disease was to make running a physical impossibility by prescribing the removal of both big toes. I think Psychiatry has missed a trick in failing to reinstate Drapetomania as a diagnosis. It would surely be the ideal diagnostic weapon against those of us attempting escape from hellish psychiatric treatment. No longer any need for toe amputation. Psychotropic drugs keep us in our place and enable the obscene profits of the master - Big Pharma

Mental Health Training..... I have learned to dread the phrase - and it's consequences. A large part of my work and life experience has been in and around Health and Education Services. I have witnessed both degrade into commodified, instrumental, depersonalised business models in settings toxic with repressive training.

Training is not education. Information is not knowledge. Education opens and expands the mind, it facilitates learning and enables the development of critical thinking and the capacity to question, challenge and grow. Training limits and shuts minds down. Dogs are trained to fetch sticks, likewise sea lions to balance balls on their noses. Army and police forces are trained to conform, obey, control - and kill. That's what training does for you.

Mental Health staff training produces unthinking Pavlovian automatons in a system controlled by hubristic psychiatry. Heads are stuffed with rules, regulations, policy and procedure. Staff interaction with patients is conditioned, dictated and damaged by diagnostic labelling and medical modelling. Intimidated and overwhelmed by defensive, controlling, risk averse, bureaucratic procedure they have no time, space or encouragement for thought or reflective practice. In such an

environment those who are naturally kind, compassionate and empathic are shackled, disrespected, damaged and inhibited. The potentially decent and useful are desensitised, rendered heartless and indifferent. The dangerous and sadistic are disinhibited and enabled to grow more bullying and brutish. It is a barren, malignant environment. Initiative stifled. Creativity suffocated. Challenge crushed. Spontaneity forbidden. .

The Mental Health System is dysfunctional, fear filled, self-referring, incestuously inward looking and inhumane. The culture in services is brutish and brutalising to both patients and staff. It is fundamentally flawed and rotten and simply not fit for purpose - unless that purpose is abuse. Its most urgent and immediate need is root and branch cultural reform and adequate interdisciplinary staff working with - not against - each other, to deliver compassionate patient-centered care. Multi-million pound vanity projects - trophy buildings warehousing neglect and abuse - simply relocate but do not reform it. It is toxic with layers of mediocre, inept management and staff who are groomed, brainwashed, shackled, controlled and fearful or incapable of exercising authentic professional judgement

On Safari

This is the tale of an NHS Foundation Trust. It is controlled by a Board of Corporate Executive Goblins. It cultivates the image of a caring, compassionate, person-centred, user-involved, recovery-focussed, allsinging, all-dancing, good-egg sort of organisation. It is actually A Monstrous Mad Regime. Well financed and slickly manipulated public relation techniques, a mutually sycophantic relationship with local media and highly skilled, devious and expensive legal representation enable its local and national benign image. The perverse incentives of a malign accountability system create mile high scaffoldings of policy and procedural paperwork protecting a corrupt core and rotten foundation and enabling the Regime's avoidance of accountability for damage done.

The Executive Medical Director is The Goblin of Psychiatry and guardian of the medical model of mental health. He presides over The Big Locked Hospital for Mad Criminals and The Local Locked Centres for Mad Community Members. His coercive control is granted by The Government and confirmed and endorsed through a social control law - The Mental Health Act.

The Executive Goblin of Accountancy ensures that the Regime's books not only balance but show considerable profit. This is achieved by systemic staff reduction and witholding of essential, compassionate care and support to the mentally distressed who are enslaved to the Regime's abusive practice. Financial profit enables the Mad Regime to expand its power and prestige by voraciously hoovering up any weak, ailing, vulnerable services in its reach. Ever increasing corporate ambition and greed has extended this reach beyond Mental Health to Community Health Services. To borrow the idiom of our time - this is the superspreading of a virus that will result in exponential damage.

The Mad Regime is awash with Goblin Managers ad-hocking their way through to their pensions. Devious ducking and diving maintains their fitness. The particularly fleet of foot occasional ascend the greasy pole to promotion. An MBA provides a useful route to the top.

The Chair-Goblin, Chief Executive and a ragbag of other Sundry Executive Goblins accompany Government Ministers, Royal Visitors or Popular Celebrities on publicity safaris to their Jungle of Mental Distress. Armed with map, compass and weapons of patronising claptrap, acronyms, sound bites and weasel words they bravely travel to their Outposts of Madness. Today's target is The Great White Elephant. It is a multi million pound trophy building where the mentally and emotionally distressed are incarcerated and warehoused subject to the same old abusive understaffed regime of coercive psychiatric treatment repackaged and marketed as 'Specialist Mental Health Care'. It is a holding tank of drugged distress without adequate psychological, social or occupational support.

The object of the Safari is publicity - nourishment for The Twitter Beast. It is also an ideal opportunity for Executive Gnomes to practice and perfect their most important and necessary skill - speaking simultaneously out of both sides of their mouths while lying through their teeth - after the fashion of their political masters.

The Safari also provides cheap material and photo opportunities for Couldn't Care Less the Mad Regime's glossy magazine. A back issue of this publication carries the eye catching front page tag line **KILLING ME SOFTLY** with a photo of the two main female characters from the TV drama 'Killing Eve'. A four page centre spread includes a glamour shot of the 'chic assassin' with the tag line **KILLER QUEEN - DO WOMEN PSYCHOPATHS REALLY EXIST?** Two of the Mad Regime's mental health professionals - a psychiatrist and a psychologist - contribute glib, trite soundbites on psychopathy.

Featuring a deranged, murderous character explicitly defined as a 'psychopath' in trivialising tabloid style would appear to be the regime's strange, twisted representation of support, dignity, care and respect for mental distress. They consider it appropriate for two of their consultants to engage with such crass enterprise. Perhaps affording inappropriate gross publicity instead of challenge to this particular label is empirical evidence of symbiotic identification. The Monstrous Mad Regime shares a lot of the characteristics associated with the label - grandiosity, impaired empathy, impaired remorse, disinhibited egotism, superficial charm, lack of conscience or guilt, and refusal to acknowledge the consequences of their actions.

If genuine improvement in care mattered surely they would be at the forefront of reducing harmful medication, increasing - not limiting - occupational and psychological therapy, developing and supporting respite centres, challenging the increased use of ECT, and challenging - instead of grossly and inappropriately publicising - labels such as 'psychopath'.

What the Monstrous Mad Regime with its proudly proclaimed £573M Turnover actually has to offer is shameful failure, abuse and neglect writ large on its in-patient wards. In its vaunted community hinterland **OF MORE THAN 11 MILLION** in North West England and beyond the mentally distressed languish on waiting lists for psychological help and die and despair in the absence of adequate crisis service and real support. This is the **'Specialist Mental Health Care'** that they aspire to market to an even wider clientele - a model of greedy, corporate, commodified, instrumental care.

Abandon kindness and compassion. No place for that on a spreadsheet. Forget about honesty, integrity or genuine care. No scope for that in the culture and language of Corporate Portfolios, Turnover, Acquisition, Group Models, Merger Models, Novel Network Modelling - Corporate Greed. The Health Service Journal laps it up - it showers them with awards. Government honours their champions and leaders with CBEs and MBEs. That's the name and aim of the game - award and publicity for duplicitous, slickly contrived false image. A Monstrous Mad Regime

SIM - stands for **Serenity Integrated Mentoring** – which all sounds lovely but it's most definitely not

Courtesy of Mary O'Reilly

SEE this website for more details : https://stopsim.co.uk for more details

Mental health patients turned away by NHS under controversial scheme

EXCLUSIVE NHS whistle blower tells i that he had to refuse care to a woman who attempted suicide on multiple occasions, because of rules adopted by mental health trusts

By Patrick Strudwick

Special Correspondent. https://inews.co.uk/author/patrick-strudwick June 15, 2021 8:07 pm (Updated June 16, 2021 12:26 pm)

It was the police who brought Sally into A&E the night she tried to kill herself in her hostel. Staff at the hospital were used to seeing her. There had been several previous attempts.

This time, there was a new psychiatrist on duty who looked at her case notes revealing a lifetime of sexual abuse and knew that she needed to be helped. But he was stopped.

Sally had been tagged under a relatively new, little-known scheme that enables emergency services to turn away some of the most vulnerable mental health patients. It's called Serenity Integrated Monitoring, or SIM. It meant that Sally (her name has been changed) was discharged that night.

The psychiatrist, working on the frontline of Britain's mental health crisis, today turns whistle-blower after speaking exclusively to i about the controversial system that overruled his attempts to help Sally.

"You've got people who are coming in with acute distress, saying, 'I don't know what to do, I'm feeling overwhelmed.' And rather than being dealt with in a compassionate way, you're pushing them away again," he said.

"This isn't about helping the person, it's about rubber stamping this person as 'difficult' or branding them 'resource heavy users' and then you can kick them out."

It was designed to enable police and A&E services to cope with patients who regularly phone 999 or arrive at hospitals having self-harmed, attempted suicide, or threatened to take their own life. When tagged under the

An NHS doctor told i that he had to turn away a woman who had attempted suicide on multiple occasions

because she had been assigned to the SIM scheme. He considered resigning as a result. He said: "I would expect there to be trials to demonstrate safety, efficacy and

cost effectiveness, but I’m not aware of any trials

The purpose of SIM is to help patients with high mental health needs to better manage their behavioural

responses to distress and therefore reduce the impact on emergency services. Once referred to the scheme, individuals are assigned a police mentor who contacts them twice a week to forge a plan for managing their symptoms. Proponents of the scheme say that it decreases the number of calls to 999, and admissions to

As part of the ongoing treatment plan, some are encouraged to sign up to a written protocol agreeing that if

The Royal College of Psychiatrists has issued a statement highlighting its concerns over the potential

“human rights” implications after a grassroots campaign by mental health activists, called the StopSIM

The SIM scheme, which has been implemented in nearly half of England’s mental health trusts since its

inception in 2013, was designed to manage mental health patients who frequently use the emergency services, either by phoning 999 or arriving at A&E.

Often they are suicidal or self-harming, and many have complex psychiatric diagnoses such as borderline (also known as emotionally unstable) personality disorder, bipolar disorder, or PTSD.

Patients assigned to the scheme are given a police mentor who works with them weekly and are flagged on emergency services systems when the patient presents at A&E or phones the police.

Some have been subject to criminal proceedings for suicidal behaviour.

Campaigners also say it is used as a way to withhold treatment from perceived “time-wasters” who actually need support for complex mental health problems.

Many, said the psychiatrist, are women who have been serially abused, and for a scheme to be developed that can deny them help is a form of institutionalised misogyny.

He said: “The whole thing is reliant on a misogyny because we are dismissing the distress of abused women, by its very nature. It is set up to discount the anxieties and cries for help that come from women who have been systemically, serially abused.”

Campaigners call SIM cruel; clinicians are now asking where the evidence is for it, and questions are being raised about how it came to be implemented so widely by the NHS.

SIM has even enjoyed royal approval after Prince William met with the founder of the scheme, former police officer, Paul Jennings, in 2017 and gave a speech commending police on their efforts around mental health patients in crisis. A&E. Serenity Integrated Mentoring, or SIM, has been adopted by 23 NHS mental health

trusts in England What is Serenity Integrated Mentoring?

But this week, the SIM service fell into disarray as the company behind it, the High Intensity Network, disappeared online and a domino effect of mental health organisations, charities, and professional bodies issued statements condemning SIM.

They have called for inquiries, and asked how a system that was not devised by psychiatrists or psychologists could have been implemented by the NHS.

Tim Kendall, the NHS National Clinical Director for Mental Health, and Claire Murdoch, NHS England's Mental Health Director have now written to participating mental health trusts asking them to review their use of SIM.

In a statement to i an NHS England spokesperson said: "NHS England does not mandate the 'SIM' model and has asked Trust medical directors to review its use to ensure it is being provided in line with NHS Long Term Plan ambitions to expand community services for people with complex mental health needs and to provide care in line with NICE guidance."

When asked if SIM has been suspended and if so what will replace it and when, a spokesperson for NHS England said he did not know.

Individual mental health professionals this week began sharing their concerns on social media.

Consultant psychiatrist, Dr Nuwan Dissanayaka tweeted: "Lessons surely need to be learned not just at Trust level but also within NHS England.

Sally had previously been discharged from hospital after a one-day admission where she had presented to A&E, very suicidal, having taken an overdose. It's what she frequently does. They discharged her the following day with no follow-up. She was vulnerably housed, working as a sex worker, and with substance

Two days later, she attempted to kill herself in her hostel. She was sent to A&E, brought in by police.

When I arranged for a mental health act assessment we became aware that she was assigned to a SIM

service and [so] the plan was: discharge her. I was saying, "I'm really worried, there is clearly not a clear plan

Other staff kept saying, "She's under drug services." But substance misuse services were saying she wasn't

SIM is supposed to be catching those people but it's not, it's just saying: you can discharge this person and

send them home. So I said in A&E: "Someone needs to do something because this woman tried to kill herself. That's serious." And they were saying, "No, it's a gesture…there's already a plan in place." So she

And in the most robust intervention, The Royal College of Psychiatrists called for an "urgent and transparent investigation" and published a lengthy condemnation of SIM

on Monday.

It claimed the scheme had been implemented on the basis of its “impact on service demand, without considering clinical benefit”. I was overruled. was let out.

The statement raised “concerns about the professional duties of psychiatrists and human rights considerations” and warned “there is a risk that this can lead to diversion from established, evidence-based approaches to clinical treatment of mental illnesses.”

The College expressed particular concern over the criminalising of people in crisis.

The statement added: “Where people remained unwell and continued to self-harm, attempt suicide or report suicidality, in some cases they were prosecuted and imprisoned or community protection notices were applied which required them to stop self-harming or calling for help, with imprisonment as a potential sanction if they breached the notice.”

The Royal College of Nursing and the Centre for Mental Health echoed these concerns, along with the charities ReTHINK and Mind.

In a rapid turn of events, the company behind the scheme, the High Intensity Network, went to ground, removing its website, leaving patients, staff and campaigners in confusion about the future of the scheme. Its social media presence had already been wiped.

When the i approached Jennings, its founder, the email bounced back, saying: “The High Intensity Network is now closed permanently. Thank you to everyone who supported our amazing 8 year journey and to the service users who made such great progress and were such an inspiration.”

In a previous interview he defended SIM as “positive risk management”.

But what marked this fall as particularly unusual was that it wasn’t professionals who prompted it but mental health patients themselves.

A network called The StopSIM Coalition, comprised solely of volunteers with their own histories of mental illness, had in just eight weeks raised a petition with over 50,000 signatures, lobbied organisations and clinicians behind the scenes, fired off Freedom of Information requests revealing that the very data on which SIM was introduced was questionable — and prompted the Royal College of Psychiatrists to credit them for exposing what was happening.

In one redacted email from 2018, which was brought to light by an FOI request to Hampshire and Thames Valley Constabulary, someone in the force involved in assessing SIM was already questioning the scheme.

“I have raised significant concerns about the data being used to sell SIM around the country,” the email said. “The raw data is not remotely accurate in a number of ways and is then being presented in a way that is just not ethical.”

While the identity of the individual and respondents was obscured, the subject line was “NHS colleagues”.

In another email, seemingly to a senior manager, the employee wrote: “I have made it clear that having seen the raw data on ‘police incidents’ that he is using to measure the success of SIM; that Hampshire Constabulary cannot support these figures. They do not accurately reflect the number of calls we have received. I have asked him to remove all references to ‘police incidents’ from any of his slides and he has agreed to do so.”

After pointing out numerous other inaccuracies in the data, as they saw it, the employee wrote: “Sir – I would like to update the College of Policing regarding the above. As you know I have been fielding a number of calls about this for some time and [redacted] would appreciate an update.”

Funding for local authority spending on public health in England has suffered as a result of cuts over the last

decade. Planned spending by councils was £3.3bn in 2019/20 – down 15 per cent on a like-for-like basis

Despite this, the King’s Fund charity said spending on mental health services has increased over the past

Andy Bell, the deputy chief executive of the Centre for Mental Health, told i that funding for NHS mental

“It is currently rising because of the NHS Long Term Plan but this hasn’t always been the case. And while

funding levels have wavered, levels of need have steadily increased, especially among young people. This, combined with years of austerity cuts in other local services, have put ever greater pressure on mental

Mr Bell added: “Waiting times for mental health support vary widely. For some services, people can be seen quickly when they need help. But for others, waiting times are long or the help isn’t there at all. And there remain too many gaps in mental health support for people who don’t fit easily into the types of service that

All the emails came from FOIs submitted by the StopSIM Coalition. In an exclusive interview with i, three

representatives of the group said they while were “incredibly pleased” that reviews will be now be carried out many questions remained unanswered.

“How did this happen?” said one StopSIM spokesperson. referring to the NHS mental health trusts adopting the scheme. Another added: expressed further concern that clinicians and those involved in management or policing did not speak out more. “Why has it taken us doing this [raising the alarm] rather than the people involved in the roll-out?”

All three who spoke to i expressed concern about what happens now to SIM patients.

A spokesperson added: “The same flaws in the system that are currently present that allowed for SIM to be rolled out leaves the door open for similarly concerning interventions to be supported in the future.

“What we want from this is for lessons to be learned to protect patients going forward and make sure that this doesn’t happened again. The other part is making sure patients who have been on the SIM teams are properly supported and get the compassionate care and treatment they deserve.”

A supporter of the group, Dr Laura Richmond, also called for an independent inquiry, rather than a review by individual mental health trusts, as NHS England has requested.

She said: “NHS mental health trusts cannot be relied upon to mark their own homework in this way, especially when there have been failures in due diligence in assuring that any new intervention has a robust evidence base and will be safe and effective for patients.”

She called for a separate investigation into how any of this could be allowed to happen.

The campaigners, along with the psychiatrist who blew the whistle, described SIM as emblematic of wider cuts to mental health services, particularly for the most at-risk patients. People with a personality disorder diagnosis “have been particularly poorly served”. health services.” Government plans £500m mental health funding after pandemic Earlier this year, the Government ringfenced £500m for its Mental Health Recovery Action Plan in response to the pandemic. Covering a range of illnesses, patients will benefit from greater access to talking therapies and better joined up support between primary and secondary care. The Government has pledged to offer mental health patients more choice over their care and ensure they are treated as individuals. It comes after ministers commissioned an independent review of the Mental Health Act, which sets out when people can be sectioned, in 2017. The Government also plans to ensure people are detained for shorter periods of time. The NHS Long Term Plan in England promises to spend at least £2.3bn more a year by 2023/24 on mental health care and increase funding for services for children and young people.

“I think it’s very clear what this is. They’ve cut personality disorder services,” said the psychiatrist who spoke to i.

“There are swathes of these patients now being left flailing around in distress without proper support containment. They have been having to access acute mental health services. They’ve been going to A&E. And this [SIM] is in response to that.”

An NHS report describes how police in Surrey who were using the SIM scheme in partnership with the local NHS trust chose not to detain one vulnerable woman under the Mental Health Act.

Officers took her home and left her there, and soon afterwards, she intentionally overdosed and had to be admitted to an accident and emergency department for treatment.

According to the report, the Independent Office for Police Conduct concluded that the officers had no case to answer for misconduct “because they followed due

procedure according to the clinically endorsed care plan”.

The psychiatrist continued to discuss Sally, his patient. After arguing with other staff in A&E, because she was tagged as a SIM patient, he was not able to admit her to the hospital despite his many years of experience — and despite her fragility. She was sent home.

“I was furious,” he said, and added that he considered resigning on the spot over what SIM is doing to patients. “This is an outrage.”

SURVEILLANCE GONE TOO FAR

NHS trusts criticised over system that films mental health patients in their bedrooms

Oxevision system, used by 23 NHS trusts, could breach privacy rights, charities say

Twenty-three NHS trusts use the Oxevision system in some psychiatric wards to monitor patients' vital signs.
David Batty
Mon 13 Dec 2021 13.39 GMT

NHS trusts are facing calls to suspend the use of a monitoring system that continuously records video of mental health patients in their bedrooms amid concerns that it breaches their human rights.

Mental health charities said the Oxevision system, used by 23 NHS trusts in some psychiatric wards to monitor patients' vital signs, could breach their right to privacy and exacerbate their distress.

The call comes after Camden and Islington NHS foundation trust (C&I) suspended its use of Oxevision after a formal complaint by a female patient who said the system amounted to "covert surveillance".

The Oxevision system allows staff to monitor a patient's pulse and breathing rate via an optical sensor, which consists of a camera and an infrared illuminator to allow night-time observation.

It includes a live video feed of the patient, which is recorded and kept for 24-72 hours, depending on the NHS trust, before being deleted. Oxehealth, which created the system, said it was not like CCTV because staff could only view the video feed for about 10-15 seconds during a vital signs check or in response to a safety incident.

The system, which is also installed at Exeter police station custody suite and an Oxfordshire care home, can alert staff if someone else has unexpectedly entered a patient's room or if they are in a blindspot, such as the bathroom, for too long.

Alexa Knight, associate director of policy and practice at Rethink Mental Illness, said: “While we appreciate that the motivation for putting surveillance cameras in people’s bedrooms stems from the need to protect them, to do so without clear consent is unjustifiable and this pilot should be suspended immediately.”

Camden Borough User Group and other service users have raised concerns with C&I that patient consent was not being consistently obtained.

The trust’s patient information leaflet about Oxevision states that rooms are monitored by an optical sensor but does not mention that patients are being recorded.

A spokesperson for C&I said the trust acknowledged that patient consent for Oxevision needed to be tightened, including the option to opt out of the system. “While the [patient] leaflet advises that the system monitors service users 24/7, we are not confident that the video element was always made clear,” she said, adding that the trust was conducting a review into whether to resume using the technology.

Rheian Davies, head of legal advocacy at mental health charity Mind, said: “Being videoed without consent in your own room is a dreadful thought and could add to the distress someone is already feeling.”

Davies, a former psychiatric nurse, said: “We urge any mental health trusts considering trialling, or trialling, this technology with their patients without consent, to pause and reconsider, because of the legal, ethical, and clinical questions it raises.

“Even if you are detained under the Mental Health Act you do not lose all your legal rights … and blanket use of surveillance raises issues of privacy, which is protected under the Human Rights Act.”

Of the 17 other NHS trusts that Oxehealth said it could disclose as piloting the system, another five revealed patient leaflets with similar descriptions to C&I’s: Derbyshire Healthcare NHS foundation trust, Midlands Partnership NHS foundation trust, Pennine Care NHS foundation trust, Rotherham Doncaster and South Humber NHS foundation trust (RDaSH), and West London NHS trust.

All five trusts said patients were informed by staff about how Oxevision works, and RDaSH added that its leaflet was under review.

NHS app storing facial verification data via contract with firm linked to Tory donors

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Leaflets provided by three trusts – Central and North West London NHS foundation trust, Cumbria, Northumberland, Tyne and Wear NHS foundation trust and Surrey and Borders Partnership NHS foundation trust – explicitly mention that Oxevision incorporates a camera or records video footage. Several other trusts did not clarify whether their leaflets did so but said patients were informed about the system.

Mary Sadid, policy officer at mental health charity the National Survivor User Network, said: "Oxevision is playing out in some settings as blanket surveillance with questionable attempts at informed consent.

"The Care Quality Commission does not authorise the use of 'covert intrusive surveillance'. What we have heard about Oxevision so far, including possible breaches of right to privacy, points to a potential need for an investigation by the regulator. The suspension of blanket surveillance and surveillance without consent should be an immediate priority."

Oxehealth's own research, with up to 78 patients from five mental health trusts, found that 80% agreed the system provided a better sense of safety and two thirds agreed it provided a greater sense of privacy.

A spokesman said: "We take patients' privacy rights very seriously and Oxevision is fully compliant with all the laws that apply to it. It is a service that is only used where necessary and it is only used for patient benefit. Oxevision offers significant patient safety benefits and allows clinicians to measure pulse and breathing rate without disturbing the patient."

Case study: Lily's story

Lily, not her real name, who has schizotypal disorder and autism, became acutely distressed after discovering that she was being recorded by Oxevision at Camden and Islington NHS foundation trust.

The 26-year-old was admitted to the Rosewood Unit, based at St Pancras Hospital, which is dedicated to treating the trust's most vulnerable female psychiatric patients, in mid-July, after she "became incredibly unwell and a danger to myself".

"A nurse came into my room while I was using the toilet and said: 'Oh you're in the bathroom, I couldn't see you on the camera.' When I asked what camera she meant, she claimed she misspoke. I was later made aware of a poster and leaflet that had been placed next to the nurse's station but neither of these mention a camera.

"It was a few more days before a nurse showed me the monitor they have in the office. It fed into my delusion that staff were intentionally keeping patients unwell … I tried to cover the cameras but staff stopped me, and I became so distressed that the response team was called. They nearly injected me.

"Staff still told some patients that Oxevision only took their blood pressure and heart rate, and denied the existence of the cameras. So a lot of patients thought that I was having psychotic delusions.

"To be under surveillance 24 hours a day is incredibly distressing and dehumanising. It is a violation of privacy and dignity. This constant monitoring can make people who struggle with paranoia or psychosis even more unwell.

"I rely on staff to tell me if a thought is rational or delusional. I can no longer trust them to do this. I told the staff that the system was unethical and required consent."

Hi Tim
Hope you are well
I'm keen on getting a discussion going re this article attached

And related links to critical mental health nursing network webpages for frequently asked questions https://criticalmhnursing.org/2021/11/09/conscientious-objection-to-forced-pharmaceutical-interventions-faqs/

And recording of presentation at Critical Voices Network Ireland Conference November 2021 https://cvni.ie/2021-2/

All the best
mick

Any reply to this most important issue please email Mick Mckeown at

MMckeown@uclan.ac.uk

Mental Health Nursing and Conscientious Objection to Forced Pharmaceutical Intervention

Jonathan Gadsby & Mick McKeown
Nursing Philosophy, DOI: 10.1111/nup.12369

Abstract

This paper attempts a critical discussion of the possibilities for mental health nurses to claim a particular right of conscientious objection to their involvement in enforced pharmaceutical interventions. We nest this within a more general critique of perceived shortcomings of psychiatric services, and injustices therein. Our intention is to consider philosophical and practical complexities of making demands for this conscientious objection before arriving at a speculative appraisal of the potential this may hold for broader aspirations for a transformed or alternative mental health care system, more grounded in consent than coercion. We consider a range of ethical and practical dimensions of how to realise this right to conscientious objection. We also

rely upon an abolition democracy lens to move beyond individual ethical frameworks to consider a broader politics for framing these arguments.

See further discussion here - https://criticalmhnursing.org/.

Introduction

Forced treatment using drugs is arguably the most ethically suspect and least defensible of a range of coercive practices deployed within psychiatric services. It is often accompanied by other use of force, such as physical restraint, adding to its objectionable status. These practices can be seen to cause distress and trauma for both service users and mental health nurses. As such, we contend this enforcement of pharmacological treatment represents an affront to a progressive and positive nursing identity and recognition of this opens up the possibility to object as a matter of conscience.

In this paper we make the case for mental health nurses to have recourse to a conscientious objection to such forced treatment and frame this within an argument informed by theorising and activism relating to abolition democracy. In a general sense, a conscientious objection is a formally recognised right, grounded in conscience, to not be involved in a practice or activity felt to be morally objectionable. In history, the most obvious example is when citizens express a conscientious objection to involvement in warfare, typically under conscription. Nurses do have conscientious objection rights in different international jurisdictions, most usually concerning faith-based objections to involvement in interventions to terminate pregnancy. Interestingly, at times of conscientious objection to militarism conscientious objectors have been both compelled to work in psychiatric hospitals and on occasion been psychiatrised themselves.

Abolition democracy refers to a panoply of ideas and activist interventions for progressive improvements to society which have their roots in the movements to abolish slavery and provide for a more just post-abolition settlement. Coined by W. E.

B. Du Bois, taken up by Angela Y. Davis in the context of critique of the US prison-industrial complex and re-energised in the Black Lives Matter movement, abolition democracy offers a radical lens through which objectionable and unjust social systems, relations and practices can be criticised and potentially transformed. It is our contention that forced pharmacological treatment of the mentally distressed is one such objectionable practice and that abolition democracy ideas represent a useful tool for considering the value of a right to conscientious objection. Both abolition democracy ideas and conscientious objection can be seen as deeply compatible concepts grounded in a morality of social justice. In the context of a desire to be an evidenced-based profession, evidence alone is unable to untangle the difficulties that many mental health nurses have with forced pharmaceutical intervention. An intolerable inner conflict may be the inevitable consequence for nurses attempting to uphold the values of their codes of conduct and of the demands of degree-level education to engage practices in a critical manner.

Background

Possession of a conscience can be an asset for nurses, driving attention to positive practice or sensitivity to patient needs and key moral, ethical and social concerns (Jensen & Lidell, 2009). The fact that matters of conscience exist for nurses is reflected in generic professional literature, acknowledging psychological stresses arising from conflicts of conscience occurring in practice (Glasberg et al., 2006; Juthberg et al., 2007, 2008) that may be resolved by claiming a conscientious objection (Cleary & Lees, 2019). The notion of conscientious objection, however, is much less visible in the literature, despite many international regulatory jurisdictions allowing for nurses to raise a conscientious objection (Dobrowolska et al., 2020; Lamb et al., 2019). Commentary and scholarship on conscientious objection rights exercised by nurses has focused on matters of conceptualisation/definition, ethics, and the practical circumstances within which nurses wishing to act on a matter of conscience can be supported by nursing leadership and organisations (see Catlin et al., 2008; Davis et al., 2012; Dickens & Cook, 2000; Ford et al., 2010; Lachman,

2014; Lamb et al., 2019). Nurses in the UK currently possess such a right regarding abortion and fertility issues only; with criticism of the tension between rights of nurses to object and patients to choose (Fiala & Arthur, 2014; Kane, 2009; McHale, 2009). In the mental health context, the stress of conscience has been found to be a key element of overall occupational stress (Hanna & Mona, 2014). Furthermore, of all forms of coercive practice, forced pharmacy is viewed by a substantial proportion of nurses as the most ethically problematic (Jarrett et al., 2008). However, despite substantial attention to the moral, ethical and practical dilemmas of forced psychiatric treatment and the extent to which this troubles practitioners, seldom is this linked to demands for conscientious objection.

In mid-October 2018 the UK based Critical Mental Health Nurses' Network (CMHNN) hosted a three-day open online discussion about conscientious objection to forced treatment[1]. Despite potential for the subject matter to be viewed as somehow rebellious it was striking that participants expressed attitudes and language steeped in nursing traditions, referring to the UK Nursing and Midwifery Council Code of Conduct, ethical consideration of rights, evidence and scholarship, professional and personal reflections, nursing duties and person-centred care. The saliency of notions of 'values-based practice' (Morgan et al., 2016) or trauma informed approaches (Sweeney et al., 2018) were noted amidst moving testimony from service users and nurses. It seems right to say the conversation reflected a situation in which *aspiring to be a good nurse* was driving problems of conscience for mental health nurses, rather than a feeling they were turning away from, or were unsuited to, nursing. This is an important theme in all that follows.

A number of important questions require attention. These include whether:

1. enforcing pharmaceutical interventions is a matter that may be described as 'of conscience' and not simply 'of evidence';

[1] The discussion is available to read and for people to continue at https://criticalmhnursing.org/.

2. in a service including a spectrum of coercive and custodial elements, it is possible to single out this particular use of force for attention;
3. conscientious objection should be conceived as an identity or as an act, contingent on circumstances;
4. existing mechanisms to support nurses reporting concerns about enforced pharmaceutical interventions are sufficient, rendering a separate right of conscientious objection unnecessary;
5. exercising this potential right could work practically, especially considering employment protection and changed relationships within teams;
6. within a profession subject to various demands for reform, the issue of a possible conscientious objection to enforced pharmaceutical interventions should be prioritised;
7. this issue is specific to mental health nurses.

A matter of conscience and not merely of evidence?

Radical nurses have long argued matters of conscience should be at the heart of any nursing interest in emancipation and social justice (Kagan et al., 2010). Moreover, nurses recognise a complex blend of evidence-based *and* moral or value-based questions concerning the issue of forced pharmaceutical interventions. This is entirely consistent with both the nursing profession more generally and ways in which issues of conscience are typically framed. For example, Paterson and Duxbury (2007) have written about the ethics of physically restraining distressed, disturbed and aggressive individuals.

Appeals to ethics may or may not delimit consideration of politics – both having a moral dimension – but we do need to be alert to such limitations. McKeown et al. (2019a) note the pitfalls of nurses framing use of coercion as a 'last resort' or 'necessary evil' only in terms of ethical frameworks or ethics informed clinical guidelines (e.g. Luciano et al., 2018). This risks neglecting consideration of a politics

of legitimacy: specifically, how shibboleths like 'last resort' can blind us to routine applications of force and epistemic forms of violence, and can be used to socialise 'good' nurses into accommodating themselves into a system they feel uncomfortable in. Interestingly, notions of legitimacy can also be predicated on appeals to evidence, raising the same dilemmas concerning the somewhat equivocal nature of the evidence-base for various interventions.

The idea of evidence in this context ought to encompass more than just the supposed efficacy of medication and extend to inquiry into the short and long-term impact of forced treatment (and alternatives). That said, here we focus on the contested field of evidence for psychotropic medication. Writers such as Robert Whitaker (2010) lead nurses to question the reported efficacy of these interventions and Peter Gøtszche (2013) and Ben Goldacre (2009; 2012) prompt disquiet about the influence of pharmaceutical industries in development, testing and dissemination. Critics such as Joanna Moncrieff (2009, 2020) further contest the evidential justifications for medications – that they are a 'treatment' at all; raising serious questions about the harms associated with long-term use. Moncrieff argues persuasively that practitioners should be more honest about the actual effects of drugs, rather than become distracted, and perhaps deluded, by supposed models of action. Then nurses might be in a better position to support service users in choices to take drugs or not.

Extensive philosophical work in recent years, such as brought together in the recently-published 'Power Threat Meaning Framework', suggests the very models on which mental health services and mental health professions rely are contentious and not politically neutral (Johnstone & Boyle, 2018). Although the politics and over-simplicities of Thomas Szasz have been repeatedly exploded, fundamental questions about the failure of diagnostic categories to 'self-vindicate' remain. This is only important for this issue in the extent that diagnoses may provide an argument for a 'known' future deterioration of mental state linked to decisions surrounding enforced interventions and a background acceptability of the notion of such interventions being regarded as 'treatments'. Criticism issued by the UN Special Rapporteur leaves mental health nurses with some very serious questions about collisions between

human rights, disability rights and mental health law (United Nations, 2017). Together with additional scholarship from authors such as Kate Pickett and Richard Wilkinson (2015) this suggests mental health services are missing important data, perspectives and approaches for public health, which, again, invites uncomfortable questions about political neutrality.

There is also disquieting evidence, especially in light of Black Lives Matters activism, of longstanding international anomalies in the detainment and treatment of ethnic minorities and indigenous peoples, including being disproportionately subject to higher doses and forced medication and extension of obvious harms up to and including death in custody (Aiken, 2011; Anthony, 2016; Gone, 2007; Gudjonsson et al., 2004; Keating & Robertson, 2004; Prins, 1993; Razack, 2015; Sivanandan, 1991). To sustain the case for a conscientious objection, it is not necessary to attempt to resolve evidential contestation. Indeed, it is in part the inability of *anyone* to satisfactorily settle these contests and incommensurate ideas that makes this an issue of conscience. 'Evidence' does not necessarily win debates so infused with ideology, leading authors interested in the importance of both values and evidence in mental health to describe a preferrable 'dissensus' of views (Morgan et al., 2016). It is therefore enough to notice that such contests are serious and wide-ranging and quite reasonably can be considered grounds for a degree of personal and professional crisis for individual mental health nurses. They may leave a nurse with a sense that core paradigmatic understandings of mental health services may be overturned, especially, perhaps, the supporting evidential and ethical frameworks of pharmaceutical interventions. We note that a recent response from the English Hearing Voices Network to proposed reforms of mental health law (Hart & Waddingham, 2018) argues for an end to enforced pharmaceutical intervention without arguing for an end to all detention. In line with the aforementioned UN Report, this would see a wedge driven between detention, viewed as legitimate, and enforced pharmaceutical interventions, viewed as unsupportable. For our purposes, the key understanding is that 'the evidence' does not resolve itself into a clear legitimation of pharmaceutical interventions and that connection to these areas of contestation may be found through

professional education and pursuit of the critical thinking and reflective practice required of registered nurses (Grant & Gadsby, 2018).

However, there are further factors that may make it reasonable that mental health nurses find the issue of forced pharmaceutical interventions a matter of conscience. A range of critical thought undermines reliance upon widely used justifications of ‘last resort’, ‘best interests’ and ‘no alternative’. To these are added programmes such as Open Dialogue (Seikkula & Olson, 2003), Soteria (Mosher 1999), Trauma Informed Approaches (Sweeney et al., 2018), the insights of the Hearing Voices Movement (Romme & Escher, 1993) and more general forms and ideals of co-production (Dzur 2019); all very much concerned with democratisation of service provision. If we leave aside questions of co-option and adulteration of these ideas, then we might also pose questions of compatibility with coercion; coercive care seemingly the ultimate oxymoron. Ultimately, from this perspective, forced treatment is the factor that will derail efforts towards democratised therapeutic relations.

Such differing ideas may lead a mental health nurse to view the lack of alternatives to be a service-driven feature and not a service-user-driven feature (not integral to the mental or behavioural state of service users). Given the physical realities and well-established non-therapeutic effects involved with pharmaceutical interventions, anything undermining the credibility of ‘last resort’, ‘best interests’ and ‘no alternative’ justifications may reasonably be predicted to generate intolerable difficulties of conscience for some nurses in regard to enforcing pharmaceutical interventions.

One further related problem concerns the notion of psychiatric ‘insight’. ‘Lack of insight’ is a phrase used to suggest that, due to illness, a person does not have the capacity to consent to or refuse pharmaceutical interventions: a capacity that they would have were they to accept pharmaceutical interventions, perhaps. This has always been a difficult and somewhat circular argument, along with concerns about professional power. Additionally, it certainly stands on a large degree of confidence in the ‘treatment’ model of psychotropic substances that many now view as problematic. First person accounts of being subject to forced treatment, even in a context of

cooperation with services in every regard other than a refusal to take medication, undermine ethical justifications (McKeown et al., 2019a). The establishment of 'drug free' beds in some Norwegian psychiatric hospitals (Whitaker, 2017) and the development of alternatives such as Philadelphia Houses or Soteria using minimal or no medication compare favourably with the mainstream. Despite variations in the methods and extent of implementation, such examples serve to highlight two points. Firstly, mental health professionals in other places are already seeking to divide involuntary hospitalisation and involuntary pharmaceutical interventions. Secondly, the 'there is no alternative' mantra has geographical boundaries.

A mental health nurse does not need to argue that alternative interventions would be effective for every recipient of mental health services to find that they cannot always say they are acting in the 'last resort'. There is some evidence in the study of physical restraint that these interventions are applied more to certain (misunderstood) groups, such as people diagnosed with personality disorder or who practice self-harm (McKeown et al., 2020). The untruth of last resort is also obvious in the practice of planned restraint associated with administration of forced medication (McKeown et al., 2019a). Research studies and practice development initiatives focused on minimising the use of physical restraint have also remarked upon the propensity for levels of coercive practices to correlate with resource and funding cuts, with specific attention to safe staffing complements; staffing shortfalls are also implicated in undermining efficacy of the very initiatives introduced as remedies (McKeown et al., 2019b).

Is an objection to enforcing pharmaceutical interventions simply a signal that a person is not suited to the realities of the profession?

Crucially, in no way does critical consciousness of any of the above difficulties suggest that mental health nurses lack a clear vocation for the care of people with mental health problems, including that given in acute services. Such concerns do not make them less committed and skilled; in fact, we contend that they are likely to be motivated, professional and caring. The notion of professional identity does,

however, offer scope for deepening the case for considering forced treatment a matter of conscience. Arguably, aspects of nursing's professionalization journey are intensely problematic; being bound up with an archaic notion of professionalism and riding the coattails of bio-medicine. This is especially true of the advancement of mental health nursing from roots in the occupation of asylum attendants in the 19th Century. Feminist nursing scholars blazed a trail in suggesting possibilities for deconstructing and reconstructing notions of nursing professionalism (Davies, 1995). A new model professionalism could be more person-centred and less attached to violence (opening up critical reflections on epistemic enmeshment of psychiatric power with for example, colonialism, neo-colonialism, free-market capitalism and toxic masculinity).

For several decades mental health nursing has aspired to be a profession 'in our own right'. It may be that a right to conscientiously object from enforcing pharmaceutical interventions adds a new and initially uncomfortable boundary to our close relationships with medical colleagues. As a profession 'in our own right' this is to be carefully and sensitively welcomed. This request for an extended and revised right of conscientious objection need not be an explicitly 'anti-psychiatric' initiative. Indeed, many psychiatrists share grave concerns about the evidential and ethical context of their work and some key relevant texts are written by critically minded psychiatrists (e.g. Middleton and Moncrieff, 2019; Bracken and Thomas, 2010). To be mature professionals in our own right is to belong to an educated occupational group that prizes critical thinking rather than a potentially oppressive culture that student nurses are socialised to dutifully perpetuate. We see this issue of conscience as a predictable consequence of our professionalisation trajectory.

Is enforced pharmaceutical intervention something distinct from other forms of force, coercion or detention?

Mental health nurses provide many services existing on a spectrum of force, coercion and detention. Indeed, separating out forced pharmacological treatment for particular objections may raise some challenges to the apparent selectivity. These may have

implications for building alliances with radical service user/survivor groups or other activists – who may struggle to see the point of separating out one set of coercions over others. Similarly, resistant or indifferent staff may use the same argument. Hence, a closely argued case needs to be made. Nurses seeking to claim a particular conscientious objection need to establish whether enforcing pharmaceutical inventions is a meaningfully separable element.

We contend that for an individual nurse to have a conscientious objection to enforcing pharmaceutical interventions it is not necessary to enter the many arguments about the morality and use of mental health law more generally (e.g. Pilgrim & Thomasini, 2012; Sidley, 2015). Given the difficulties already described, it is possible to conceive of circumstances in which a nurse could argue for a person's detention under mental health law while conscientiously objecting to them receiving enforced pharmaceutical interventions; preventing life-threatening self-harm for example.

Therefore, a nurse who conscientiously objects to enforcement of pharmaceutical interventions may yet be required (and choose) to take part in the trained application of force; these situations themselves may not be viewed as a difficult matter of conscience (and this is not duplicitous behaviour). To put this another way, one could imagine a conscientious objection to enforced pharmaceutical intervention in which the nurse remains wholly within the values and principles of the mental health nursing profession while objecting to all uses of force, or to mental health law more generally, has wider and more problematic implications. It is likely that a mental health nurse who objects to enforcing treatment will have views on wider use of mental health law around, for example, utility of diagnostic categories, forced feeding of a person with anorexia, or enforced seclusion. We would want to encourage well-informed and frank discussion about all those issues. However, while we may be concerned about many of these when they are non-consensual, it is not clear to us that a mental health nurse can or should be afforded a right to conscientiously object to any of these at this time. Arguably, there are already opportunities to think about (and work towards) the possibilities for more consensual alternatives and preventative

approaches.

The mechanisms allowing for appeal against applications of mental health law already provide nurses and nursing teams some opportunity to present the contested nature of detention for individuals in their care. Nurses can already contribute their views about these issues and we believe it is right to say that there has long been widespread, tacit and under-discussed informal support for mental health nurses conscientiously objecting to assisting with Electro-Convulsive Therapy[2]. If a service user, having had an open and informed discussion about the therapeutic and non-therapeutic effects of pharmaceutical interventions, chooses to take them as prescribed, it seems then that the same issues of conscience do not apply; mental health nurses already have a role (indeed, it is specifically required by our Code of Conduct) in monitoring and discussing non-therapeutic effects of pharmaceutical interventions and are able to influence their prescription in this way.

An identity (i.e. 'I am a conscientious objector') or a case-by-case decision?

This is an important area of debate for conscientious objection more generally, but within the CMHNN discussion there was a consensus: if such a right were to exist it should be exercised on a case-by-case basis. Conscientious objection was recognised as less of a personal attribute or general moral stance and more of a thoughtful response to individual service-user circumstances, which may be highly nuanced. Perhaps this lack of contention was more likely because of the network being committed to criticality; critical thinkers are generally sceptical towards 'blanket' positions. Other mental health nurses may feel that the form of their own conscientious objection is more intrinsic to them as a person, but they would still be served by an extension to the existing provision for conscientious objection on a case-by-case basis.

Is conscientious objection an individual focus to problems that might be better

[2] For the purposes of our argument it seems sensible to treat ECT as a sort of pharmaceutical intervention; despite its very different nature, it suffers from some similar issues of evidence and ethics.

discussed at a team-based or wider systems level?

In addition to questions about whether a focus on enforced pharmaceutical interventions is meaningfully distinct from a spectrum of coercive practices and legal frameworks, conscientious objection can be queried as a meaningful idea when those involved do not work alone but with many colleagues within a complex of interlocking professions and systems. Certainly, it seems that some parts of those teams and systems may be failing when the collective work may cause an individual member such difficulty. However, the idea of collective refusal is equally difficult. As already stated, part of the reason for thinking that this is an issue of conscience is precisely because evidences are so complex and incommensurate; finding whole-team or whole-system agreement is unlikely (and, arguably, risks replacing one universal solution with another). For us it is correct to view this as an issue of individual conscience *and also* as a matter that should become a team or systems problem. We wish to avoid the pitfall that, if conscientious objection is viewed as a 'symptom' of a system that sometimes requires nurses to act against their individual understandings and values, then that same system is capable of viewing conscientious objection as an individualised problem rather than a voicing of the trouble inherent within overarching systems of thought and practice. This means that great thought will be required to protect individual nurses who choose to conscientiously object. It may need to encompass staff training, employment law and possibly more. *If a right of conscientious objection were allowed, it would need to be introduced within a context supporting more robust discussion, more team work, a greater sense of nursing cohesion and mutual support, less individual anxiety and trauma and, ultimately, a more person-centred and thoughtful experience for service-users.*

One further question raised is how such change might appear to service-users and survivor groups. It would be wrong to attempt to guess their views, but it seems fair to note that while potential exists for teams or systems to vilify or sanction an objecting individual, it is very possible that service-users may sanctify her or him. This understandable response may be unhelpful for the objecting nurse; and it may cause non-objecting colleagues to be described as immoral (by comparison). If this

becomes the case, then the trauma of the controversy over enforced pharmaceutical interventions will have effectively created further harm to a nursing team and individual nurses in ways unlikely to be viewed as an improvement (even where the existing situation is understood to be problematic).

Arguably, no initiative is adequate without taking into account views of people with lived-experience of mental health difficulties. Yet we also recognise conscientious objection is also in many ways an issue for discussion within the mental health nursing profession, concerning our personal experiences and issues of conscience and how these can translate to collective demands. Just as with the views of our multi-disciplinary colleagues, we are keenly interested and yet feel there is something important here about mental health nurses primarily addressing our own practices.

An extension of existing provision for conscientious objection, or a revision?

The current UK provisions (NMC, accessed 2021) make for interesting reading. Two significant elements raise questions about whether provision can be merely extended, or whether it must be revised.

Firstly, the relevant portion of the NMC website states there is 'a currently statutory right of conscientious objection for nurses, midwives and nursing associates in two areas' before detailing the basis for both, in abortion and human fertilisation legislation respectively. As mental health nurses have become more educated and increasingly employed as autonomous practitioners, able and required to consider complex and contested ideas in their decision-making, it should be understood that in a contested field there will be legitimate and significant diversity of opinion. Under these circumstances it is inevitable the question of further provision for conscientious objection will arise. The current regulatory stance is difficult to defend from accusations it is less about enabling objection and more designed to prevent it.

Secondly, our mental health nursing values, our commitment to critical thinking and reflective practices such as clinical supervision lead us to the view that the emotions and deliberations of a colleague should be expressed, supported, explored and form part of team decision-making; and yet the stated requirement for the conscientious

objector to find a replacement suggests that the team should remain untouched by the thoughts of their colleague and the issue seen as merely idiosyncratic, or as a resource-management issue. Conversely, conceiving alternate (perhaps more democratic) work processes, wherein teams are perpetually engaged in learning and reflection, ideally inclusive of service users would seem preferrable.

The requirement to arrange for a substitute is certainly not a condition of the legal right to conscientiously object from military service and, indeed, within the field of conscientious objection more generally it is questionable whether sending another in one's stead is a meaningful objection. Once again, the suggestion seems to be that the current provision for conscientious objection must not be allowed to interfere with the smooth provision of the service's status-quo. Perhaps this is understandable in the complex interplay of rights found in fertility and termination issues where opposing views tend to be driven more by personal and religious conviction than debate over incommensurate evidence. Objections to forced treatment may also reflect faith standpoints, and an interesting question might be why the religious conscientious objectors who oppose abortion do not dissent from the violence of psychiatry. Answers may cycle round into the powerful systems of socialisation and legitimation bound up in psychiatric systems.

Is this issue a priority?

Mental health nurses have to make complicated decisions every day that may involve compromise, for example due to constrained resources, resulting in a service that is less than their personal ideal. Many would argue for reform of services through reduction of coercion and minimising reliance upon medication, the introduction of alternative interventions such as those mentioned above, or describe their hopes to work in increasingly 'psychosocial' ways. What, then, makes the idea of a conscientious objection to enforced pharmaceutical interventions a priority?

Two main factors render this a priority. The first is the seriousness of the experience for all concerned. Enforcing pharmaceutical interventions is viewed by many service users as a physical assault and is variously described as shocking, degrading and

humiliating; being frequently life-changing for service users (and nurses). Physical injury may occur. Post-traumatic symptoms for service users and for mental health nurses are not uncommon. Given that such force may be precipitated by service-user behaviour (taken as indicative of 'mental illness'), it is inevitable that themes of deviance and punishment may at times be prevalent, even if unintended. Service users may scream or shout and for both them and staff alike there may be a very uncomfortable sense of sexual assault, exacerbated by the unconsented exposure of a person's buttocks, together with penetration with a needle and an unwanted substance. Even the required training (a post-qualification separate training) impacts in some of these ways for mental health nurses. When student nurses talk about their first experiences of acute mental health wards, such experiences understandably preoccupy them. Nurses work hard to debrief themselves and each other following forced pharmaceutical interventions, but such processes can collapse into self-deception and justification (Chapman, 2014).

Given the extreme nature of these interventions, it seems right to describe them as unlike any other kinds of nursing procedures. In fact, they arguably challenge the very identity of 'nurse' for mental health nurses, tarnishing them in the eyes of service-users who may come to see them singularly as custodians, carrying the threat of conflict and force. These frequently voiced criticisms and mental health nurses' own troubled relationship with enforced pharmaceutical interventions may contribute to estrange mental health nurses from a positive self-identity. Being a mental health nurse can feel like something for which to apologise, unlike other fields of nursing.

A second factor is the apparent absence of leadership about pharmaceutical interventions. One difficulty mental health nurses face is that, while controversies about pharmaceutical interventions are highly present in scholarly literature, these do not possess the same urgency within mental health services. Arguably, many nurses who feel they have a conscientious objection to enforced pharmacy would be less anxious if such debates were visibly present at the highest level of the profession with the intention of informing decisions about care. Instead, the justifying rhetoric often evokes the most simplistic acceptance of medical treatment narratives (e.g. 'It's like

insulin for a diabetic' or evocative care narratives about amelioration of distress and preservation of dignity) that can make a nurse seem foolish or immoral for raising questions and concerns. New scholarly engagement in this area would likely alleviate concerns. Arguably, the strongest case for creation of this new right is that *the mental health service owes the people tasked with this most serious of procedures much more than the current level of debate.* Additionally, individual mental health nurses and nursing teams with skills in prevention of the perceived need for enforced pharmacy would be more clearly seen as examples of good practice. It is hard to imagine this being brought about with the appropriate urgency by other means.

Vote with your feet?

We recognise the argument that mental health nurses already have a means to excuse themselves from the enforcement of pharmaceutical interventions; they can leave acute wards and work in other roles. We believe that this has always been a key motivation for nurses to leave acute wards (and other places where forced pharmaceutical interventions occur, such as prisons and secure units, children's homes and other residential settings). However, we would argue that this is inadequate provision for conscientious objection.

Firstly, it implies that acute wards and other psychiatric spaces must necessarily involve enforced treatment as a status quo. In fact, as mentioned above, there is a large variation in its use, something that this proposed revision of the right of conscientious objection may make more visible and instructive.

Secondly, it locates the problems of evidence and ethics within the individual nurse who may be considered (or consider themselves) 'not cut out for acute settings'. This probably masks and delays the proper engagement by our profession of the evidential and ethical challenges already laid out.

Thirdly, it removes critically engaged nurses from acute wards where they might be influential, perhaps promoting service-user rights and more reflective practice. Moving the conversation about the use of force away from the clinical context probably has a negative impact on the quality of that conversation. It may also

contribute to a divide between community and hospital nurses, and perhaps between academic nurses and nurses working in clinical areas. Despite our roles as nurse-academics, the CMHNN strongly recognises that such debate is poorer when not part of the pragmatism of practice focused nursing work.

Fourthly, a situation is possibly created wherein care of individuals most acutely in need is left to those holding a less diverse range of nursing views and moral instincts. While experienced nurses often have more autonomy and more ability to voice opinions, it is more difficult for newly qualified nurses to speak up. This proposed right might correct that problem a little, given the possibly greater proportion of more recently qualified nurses in acute settings.

Fifthly, when leaving is the mechanism of objection, refuseniks may find that enforced pharmacy remains an issue in new roles. Being a community mental health nurse does require consideration of hospitalisation at times and the mental health nurse who left the ward due to reasons of conscience may find this part of their new role no less difficult. The prospect of Compulsory Treatment Orders (CTOs) with medication administration in clinics, holds an implication that refusal returns one to compulsory admission.

While mental health nurses in general do not have the right to conscientiously object, there may be great inner conflict for the community nurse who feels they are 'handing over' service users at a time when they are vulnerable to a group of other nurses prepared to do the 'dirty work'. This situation does not serve any relationships well and still does not resolve the issue of conscience. However, the knowledge that they were recommending hospital admission for service-users under their care to a ward in which reflective nurses have the option to exercise a right to conscientiously object from enforcing pharmaceutical interventions might feel different; there would be the reasonable expectation that discussions take place about the issue of enforced pharmacy in an atmosphere in which the team have had to prioritise a skill set designed to prevent it.

Finally, community nurses have increasingly been required to give long-acting 'depots' to *detained* service-users in the community. Even consensual depot

medication represents a strange hinterland of coercion and mistrust, complicated further by CTOs. Although this is not conducted under direct force (instead, facilitated by the legalised threat or memory of such force) it is a further example that changing roles and 'voting with your feet' is not a satisfactory way for mental health nurses to relieve issues of conscience about enforced pharmaceutical interventions.

How would conscientious objection to enforced pharmaceutical interventions work in practice?

If there are evidential, ethical, professional and personal grounds for this right, then its practical application will be a matter of employment law, policy, clinical supervision, team discussions, service-user information and nursing education. These highly important considerations would be a prerequisite of the establishment of that right. The CMHNN would wish to be involved in the very cautious consideration of all of the practical issues involved in taking this potential new right forwards. Survivor groups and nursing trade unions are likely to be valuable contributors.

Any future argument that agrees in principle with the view that mental health nurses should have the right to conscientious objection but then argues that it cannot be granted in practice is in effect saying that mental health services are not currently able to employ nurses ethically.

Is this issue specific to mental health nurses?

It may be case that other professions would wish to be part of this discussion and care will be needed to consider how, and to what extent, they may contribute. The enforcement of pharmaceutical interventions implicates a multi-disciplinary set of interactions, including hospital managers, even though it is nurses who are typically charged with carrying it out. It is occasionally the case that a medical professional is involved, but this is rare (and only extends to the administration of the pharmaceuticals and not the more obvious use of force). Medical professionals have their own registering body and their own provisions for conscientious objection. Further discussion will need to consider the rights of Health Care Assistants, who

may also be trained in the use of force as part of a team with mental health nurses. Indeed, in the UK there are contemporary moves to formalise 'professional/occupational' regulation of HCAs.

Always, the question is not 'what do we know to be correct?' but 'is it reasonable that a mental health nurse could suffer unbearable issues of conscience in this context?'. This and other associated issues raise the possibility mental health nurses may experience post-traumatic symptoms if required to be involved enforced pharmaceutical interventions. The fact that nurses may also be traumatised may cut little ice with potential survivor allies, who undoubtedly bear the brunt of psychiatric harms. Acknowledgment of such possibilities allows for our arguments to connect with longstanding identification of alienation within nursing labour processes and, in turn, alienating technologies of care (Fromm, 1968). From this perspective, nursing involvement in coerced medication represents a profound existential threat to conceptions of 'being a nurse'. Hence, nurses become estranged from a positive identity, and service users are appalled that nurses would act this way, associating nurses with custody, control, conflict and violence rather than care and compassion.

Action for change

Davis' (2005) espousal of abolition democracy identifies her as the consummate critically engaged academic, seamlessly connecting insightful scholarship with necessary activism; showing health care practitioners amongst other citizens paths to radical agency and praxis as alternatives to a more passive professionalism, complicit in social injustices by remaining on the sidelines (Roberts, 2006). Indeed, the provocation for Davis of the atrocities of Abu Ghraib is mirrored in the recognition that, however virtuous any clinical rationale, many people will experience forced psychiatric treatment as a traumatising violation (Jarrett et al., 2008). Of course, abolition democracy involves more sophisticated demands than simple root and branch dissolution of systems, rather it calls also for upstream action focused on underlying causes of systemic injustices, or the causes of the causes. Recent protests focused on police brutality and structural racism have resonated with radical

healthcare practitioners. For example, Iwai et al (2020: 159) remark:

> *Abolition medicine is a practice of speculation, of dreaming of a more racially just future and acting to bring that vision to fruition. It is to recognise that the Hippocratic Oath to "first, do no harm" requires those working in health care to dream radically and act structurally. This is the possibility of abolition medicine: to renarrate and re-envision justice, healing, activism, and collectivity.*

The history of critique and activism in and against psychiatric systems has reflected various tensions between outright abolitionist demands and more nuanced calls for reform or imaginative shaping of alternatives. The notion of a wild and fluid undercommons is helpful in pointing to a difference between calling for the end of an institution or social structure such as modern psychiatry, replete with restrictive practices, and the end of the standpoint from which such institutions and practices are seen as legitimate or make sense (Halberstam**,** 2013; Moten & Harney, 2004).

Inspired by such critique, radical nurses urge recasting nursing professionalism towards critical consciousness of shared history, the wider political context and politicised nursing action (Dillard-Wright et al., 2020; Dillard-Wright & Shields-Haas, 2021; McKeown 2019; Smith, 2020; Smith & Foth, 2021). A starting point might be radical influences upon nurse education, where a commitment to critical pedagogy engenders more critically thinking nurses. Such explicit connection to criticality and a critical/inquiring professionalism could be foregrounded in the necessary dialogue and debates to establish a conscientious objection principle and this, in turn, can open up the space for wider critical thinking about the role and function of psychiatric systems in the neoliberal state. In this way, agitation for a conscientious objection to forced treatment may be as much a means towards progressive change as an end in itself. We might consider this as one of many possible activist challenges to the power of psychiatry and, following Davis (2005:

125), consider 'the best way to figure out what might work is simply to do it'.
The articulation in formal policies, or indeed in the current statement of principles for reforming the UK Mental Health Act, of commitments to 'least restrictive practices' and the more colloquially professional rhetoric of 'last resort' and 'necessary evil' can be seen to exemplify what Sara Ahmed (2006) has referred to as nonperformative speech acts. From this perspective, such language appeals to a morality of progressive change and action but blinds us to the actuality of nothing being done or nothing changing. By such means radical ideas and ideals can become neutralised or co-opted into the mainstream without effecting meaningful change.

Despite these ever present threats of incorporation or neutralisation of critical ideas and alternatives within contemporary psychiatric systems, there are some grounds for optimism regarding the fate of this call for a right to conscientious objection. The entrenched power of psychiatry and its broader functionality for neoliberal governance systems and social control (Rose, 2016) suggests a certain obduracy to revolutionary or abolitionist transformations. A more nuanced or tactical abolition democracy might, however, be advanced via a prefigurative politics (Springer, 2016). Following, Sedgwick's (1982) seminal *PsychoPolitics*, we have argued elsewhere that, supported by cross-sectional activist alliances, prefigurative conceptions of alternative approaches to care may be achievable within the interstitial spaces of the psychiatric system; in effect operating in the places where a controlling, neoliberal gaze is not always looking (Spandler et al., 2016; Moth & McKeown, 2016). Arguably, activism for a right to conscientious objection might be catalytic in this regard, challenging the mainstream and raising the potential for alternative forms of care. Recognising that radical service users and survivors may be reluctant to enter into alliances with elements of the mental health service workforce, we have also called for grass-roots processes to repair the hurt and harms presently and historically caused by psychiatry (Spandler & McKeown, 2017) and to sincerely apologise for these (Williams et al., 2018).
Notwithstanding our commitment to alliances, we feel that any campaign for

conscientious objection should be led in the first instance by nurses themselves. This will serve a purpose of establishing an authenticity to nurse activist appeals to be considered in solidarity with service users, refusers and survivors of psychiatric care. It will also firmly locate the endeavour as part of taking control of our profession and reshaping professional identity along radical and progressive lines. Raised firstly as an internal issue between nurses and the regulatory body, the issue is reinforced as a matter of personal and collective conscience. Finally, lived experience of mental health problems has always been a possible motivating factor in people coming to the special vocation of mental health nursing, meaning uncritical and divisive 'us and them' binaries are also open to contestation. Eschewing binary positionings, on this or other contestable matters, represents a more constructive pathway for radical movement building (Spandler & Poursanidou, 2019).

Conclusion

The ultimate value of a campaign to enact this right to conscientious objection might be to open up the discursive space for a meaningful and constructive debate within the mental health professions regarding the detriment caused by forced treatment amongst other coercive practices and embolden moves to seek more consensual alternative forms of care provision. Moreover, such critical dialogue within services should signal to external critics, including survivor activists, a favourable basis for political alliances to further advance action for change. Following Moten and Harney (2004) this may be less about the complete abolition of psychiatry as we know it than abolition of the perspective from which an essentially coercive psychiatry makes sense: thus requiring a transformed society where forced psychiatric treatment can no longer be imagined.

Critical Mental Health Nurses' Network Draft Position Statement

The Critical Mental Health Nurses' Network believes that it is timely and proportionate to request that the United Kingdom Nursing and Midwifery Council extends and revises the current provision for conscientious objection to include the

right for nurses to conscientiously object to enforcing pharmaceutical interventions and Electro Convulsive Therapy within mental health services. This reflects the changing relationship between those practices within mental health services and their evidential and ethical context. We believe that this request is wholly consistent with our commitment to the values and principles of our Nursing and Midwifery Code of Conduct, the scholarship required by our degree-level education, the ongoing critical reflection required of us as a profession in our own right and our practice experiences.

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Ref mental health nursing and conscientious objection to forced psychotropic Drugs – quick response Tim Wilson

I sincerely hope this important moral and ethical objection is successful in its campaign, and hope it will transform the practice of mental distress care. Hopefully this objection to giving psychotropics drugs and Electro-shock and other harmful practices, will also be given to also to medical doctors who call themselves psychiatrists. I am sure some doctors have a conscience? But obviously -action speaks louder than words. There is much evidence (loads) that psychotropics so called anti psychotics and so-called anti-depressants and others are causing harm and not being on drugs has better outcomes particularly in terms of functionality and daily living interactions.

Personally, while the totally faulty (the lack of evidence) diseased bio- psychiatric, medical model of "mental illness" holds the power. And the fabrications of diagnosis and the guilds of the American Psychiatric Association and its equivalent psychiatric body in UK hold power; and corruption of big pharma, I have reservations. Someone will always dish out the drugs – but let's be optimistic I hope this reform if it comes about will transform practice.

Equity is a moral, social justice, human rights and fairness issue, and inequities are the causes of the causes they cause inequalities in health and much mental distress. I favour abolition democracy being extremely critical of particularly the lack of science, the corrupt research, the fabrications of diagnosis, the abuse and coercive nature and violation of human rights and harms to people by psychiatry and colluding professions. This is legitimisation of abuse, past crimes and present psychiatric crimes including fitting in with the last forty-two neo-liberal years. I am only doing my duty, just following orders is no justification for harms and abuse in my eyes, everyone has free will and a choice. I also want being highly critical of nearly every aspect of psychiatry to abolish it as a medical speciality. Some people will say I am not being nuanced, that's their opinion. The elephant in the room where some nurses are concerned is psychiatry. I am advocating not less resources for mental distress but lots more but a different approach, definitely not the same old same. There are many alternatives of which there are many great examples, just a few HVN, Soteria, none drug wards, dial house Leeds, open dialogue, power threat and meaning and many others – we need more resources, more doctors, more critical nurses, more critical public health, more mental health/distress prevention and services, more upstream public health/mental distress provision - also reverse the last 42 neo-liberal years, end the crippling privatisation in the last 40 years of health and care provision – I don't think many changes are likely to occur in mental distress under neo-liberalism; but I may be wrong. Have upstream public health, proper resourced public services promoting the common good, prevention, get rid of the IAPT, see Davies (2021); mental health first aid, psych compulsion and all the other individualistic westernised psychotherapy and medicalisation. Individualistic concepts like resilience, as if it's a personal defect, surely children brought up in love care safety nurturing, good income

environment will have a good start in the game of life– there is such a thing as society, Thatcher was very wrong.

I may have missed a trick but surely evidence and actual practice does influence conscience. There are no chemical imbalances but lots of power imbalances. Ideology like psychiatry, pseudoscience and neoliberalism do rule, when humans bury their heads in the sand and due to the ideology power, process and practice become passive. Yes, as Gramsci says everything must change. What definitely urgently needs to change is the inherently discriminatory and racial Mental Health Acts. Discriminatory in sense everyone is treated under the Acts, as if they have no capacity, which is diabolical and they are racial.

The most important person in any health care system is the person using the system – not the Guilds of psychiatry, not the corrupt drug corporations, not the state and definitely not the needs of neo-liberalism or any other ism's – professionals should do no harm, they should speak out, come to voice, advocate for the person so no harms occur. Sadly, the reality is that this isn't the case, iatrogenic practices are pandemic, particularly in psychiatry but also in other forms of medicine, many miracle cures in heart health, cancer and dementia with natural inexpensive products, have been hidden; suppressed by the medical model and corrupt big pharma.

These issues are an urgent priority, trauma, long term harms and abuse, violations of human rights are pandemic for people who have and who are experiencing psychiatry and also some people actively participating in the practices of psychiatry. All health professionals need to be exposed to critique and be critical of every aspect of "knowledge" they are taught – particularly critical of reality - actual practices. There are many different perspectives and difference should be valued. Yes, what is knowledge is important and also an ontology of humanness.

I strongly support the right of conscientious objection to enforced pharmaceuticals and giving of electric shock- I would also like this the right of objection to be given to any pharmacy (Drugs) and procedure that we know causes harm because giving drugs or shock in this way even if the person doesn't object to having it – is in my mind just as harmful – sometimes it's not what we do in life that matters -but what we don't do. As Don Weitz would probably say resistance does matter.

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Putting the politics back into 'psycho': grass-roots consciousness raising in Liverpool

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key words psycho-politics • mental health • revisionists • oppression • consciousness

Introduction

This article will reflect on the work currently being undertaken by reVision, an activist group in Liverpool, the town of Sedgwick's birth. The primary focus of the group is to raise awareness of the unquestionable impact of social factors on mental health and the wholly inadequate medically driven responses to these. We are also contributing to the multiple conversations and campaigns that are seeking to change the very nature of current service provision, a mission that we believe Sedgwick would have approved of, even if we take issue with some of his arguments. We, like many other groups, assert that to understand why mental distress occurs requires an explicit understanding of the socio-political context of these problems.

Without this, the 'psycho' becomes meaningless. The correlation between all significant social issues within our society and inequality and oppression is now irrefutable
(Wilkinson and Picket, 2011). The medicalisation and pathology of mental health is a convenient political way of denying this and is perpetuated by largely apolitical professional groups who do not realise that they are more often a part of the problem and not the solution. reVision assert that the use of chemicals and poorly defined/ applied psychological therapy within mental health services often does more harm than good.

Background

reVision is a child of austerity. It was born out of the sweeping welfare cuts of the

current Conservative Party, which, among many destructive policies, all but silenced the independent voice of people who actually use mental health services. In Liverpool, our precursor group was called the 'Joint Forum'. With no more available funding, the group conducted research and deliberated on how to continue its work. The key conclusion was that its effect in mental health services had, at best, been marginal and had, like many other similar groups, been a victim of the neoliberal consumerist ideology that catered for superficial 'consultation' rather than meaningful change.

This was nothing new or surprising and is reflected in a continuing debate about the very nature of service user involvement in organisational culture (Beresford, 2013).
We decided that what was needed was a broad alliance of critical voices based upon anti-biomedical theories. This approach is very similar to some of the movements created prior to the Thatcherite-inspired Community Care Act 1990 (Barnes and Bowl, 2001) – although, hopefully, more democratic and radical.

Raising consciousness

One thing that neoliberalism has done very well is to severely constrain meaningful political discussion. Yet, paradoxically, the effects of neoliberal policies also provoke radical dialogue and resistance, with the emergence of critical groups like reVision. Tony Blair consolidated a neoliberal agenda via an ideologically bankrupt New Labour experiment that was, in many respects, the unholy love child of Thatcherism. This destructive ideology has continued to be built upon: first by the Liberal Democrat–Conservative Coalition and then through the subsequent unfettered brutalism of singular Toryism.
It is not difficult to sustain an argument that the current crude austerity-fuelled economic policies are literally killing thousands of people a year, for example, by reading many of the harrowing narratives of people whose loved ones have committed suicide (Russell, 2009) in the most horrendous circumstances. This is reinforced by evidence that directly correlates austerity with increased suicide rates (O'Hara, 2015). In this context, the subjugation of significant critical reflection and action is deeply depressing. This is not, however, to devalue the work and struggles of many groups who oppose these policies. The fight is still definitely raging around us. However, the danger is that, as Noam Chomsky (2002: 43) so poignantly stated, 'The smart way to keep people passive and obedient is to strictly limit the spectrum of acceptable opinion, but allow very lively debate within that spectrum'. Within mental health, any challenge to the current system reflects this political context and is reinforced by institutional processes that appear to offer opportunities for meaningful inclusion but, in reality, are playing a tick-box game that perpetuates current services and powerful vested interest (Kinney et al, 2013). reVision seeks to challenge this and draws heavily on activist consciousness-raising traditions. We use, for example, the ideas of Freire (1970), who helps us to understand the centrality of education and effective communication in bringing about individual and broader social change. For example, we strive to create safe spaces for open, critical dialogue.
Creating opportunities for this is not always easy and can often feel like 'preaching to

the converted'. However, we do have an expanding and diverse membership that reflects a wide range of experience and engagement with mental health issues. Some examples of our consciousness-raising events include:

- critical reading groups;
- bimonthly public talks;
- the use of film and arts to generate discussion and critical reflection;
- presentations at conferences; and
- the creation of a manifesto for change.

Putting the politics back into 'psycho'

All of these are intended to be provocative and challenging. For far too long, the medical approach has had an almost imperialist hold on mental health resources.
Very worryingly, this is now also being exported, with massive vigour, to all parts of the globe (Fernando, 2014). Pharmaceutical companies are at the forefront of this expansion and have whole new markets to sell their 'medicines', or, as many would assert, 'poisons' (Breggin, 1993, Davies, 2013). Our hope is that our activity will help groups and individuals to challenge the continuing dominant use of pharmacological interventions in mental health services and to recognise the alternatives to these (Stastny and Lehman, 2007).

Developing a *mental health manifesto for change*

We live in a strange world where the premise that underpins much of current mental health service delivery is discredited and essentially false. As Crossley (2006, p 112) recognised, scientific paradigm shifts, such as a move from the medical model must necessarily involve significant political change, as this would invariably: 'challenge the authority and legitimacy of an old guard, who have invested a great deal in the existing paradigm.' This paradigm shift at the theoretical level has all but occurred and was started by, among others, Laing (1960). It is worth acknowledging at this juncture that Sedgwick was dismissive of Laing's later work, but not so critical of *The divided self* (Laing, 1960).
He was also quite taken with Laing as a person once he met him (Proctor, 2016).
Laing encapsulates the futility of labelling madness in an insane world. His attack on the very nature of an alienating society was deeply philosophical and political.
It was also much more than this as, along with other 'revisionists', he demonstrated that people can and do recover from mental distress without medication and labels.
Since the heady 1960s, these ideas have grown and many others (Stastny and Lehman, 2007) have shown a plethora of contemporary ways to provide non-medical services. Some of the best of these are service-user-led initiatives, for example, the Leeds Crises House (Dial House, 2016).
Mainstream politics is continually seduced by the biomedical approach and has historically deferred to the doctors and pharmaceutical industry, who give them seemingly logical answers to complex problems. The recent shift in the Labour Party to the Left has given a possible opportunity to challenge this entrenched situation.

For example, the recent shadow minister for mental health, Luciana Berger (2016), was at least trying to advocate for preventative socially based services. However, the language employed is not threatening to the same old powerful interest groups, implying a traditional defensive stance to welfare cuts. reVision recently met with Luciana and discussed how this approach needs to be challenged. She did agree that what is required is to carefully reflect on what is actually required by communities and individuals so as to sustain good mental health. There is an interesting intersection with this standpoint and Sedgwick's call for more and better services, and his fears that certain radical critique could be adulterated to make the case for dis-investment in welfare.

Despite this, it is clear that defending what health services we have is the political opposition's starting point – with seemingly little understanding of the damage these have caused, both historically and contemporarily (Scull, 2015). It was ironic that, soon after our meeting, Luciana was in the local press with the Labour leader, Jeremy Corbyn, looking around the latest £25 million psychiatric unit in Liverpool. This is another classic example of vested interest replacing one type of institutional care with another. Was that really the best way to spend such a huge amount of money?

It does not take a degree in accountancy to work out that this could have bought at least 100 Leeds-equivalent crisis houses. Yes, the new unit is much prettier and comfortable than the old one, but it is run by essentially the same staff and based on the same old policies and procedures. It appeared that Luciana and Jeremy were very impressed and without an understanding of mental health history, theory and social context – why would they not be. This begs the question: what change is possible within the current political context?

reVision recognises that Sedgwick's (1982) *Psycho politics* is hugely important and informs the need to develop strong critical alliances to resist welfare cuts. He helps us understand the need for a more sophisticated and nuanced approach to challenging the inadequacies of current service provision and, at the same time, attempting to preserve, maybe despite inadequacies, services that many feel are important to them.

No easy task! For many of us within reVision, however, Sedgwick's reluctance to drop an illness concept and trenchant dismissal of 1960s'/1970s' revisionists can be hard to stomach and does not sit easily with members' personal experiences of treatment and medication.

In their increasingly influential 'Mental health charter' (SWAN, 2014) the Social Work Action Network (SWAN) explore this conundrum by not only challenging welfare cuts at every turn, but also exploring 'alternatives' to crude biomedical services. Sedgwick's affinity for prefigurative imaginings of alternative futures chimes in with this stance, and it is unfortunate that he did not live to see more of the emergent possibilities that are available to us now.

What reVision has attempted to do is to add to this work by critically reviewing current services and to consider practical, 'real' improvements or alternatives to these.

What we do know is that more doctors and nurses, within current systems of working, are not going to stop the seemingly unstoppable increase in mental health problems.

Via public consultation and discussion, we have developed a *mental health manifesto*

for change (reVision, 2015).
In summary, we have identified seven visions for a better understanding of mental health and service delivery, these are:

1. To move from a 'diseased' bio-psychiatric model of 'mental illness' to a social model of mental distress/health. We strive for a different approach 'grounded' in social fairness, listening, equity and social justice.

2. To stop using all psychiatric diagnostic and classification systems.

3. To recognise what we need to achieve good mental health: income, family, friendships, a safe home, opportunity, work, leisure, the arts, spirituality – plus many more that should be defined by individuals and communities themselves.
Recognise oppression in all its forms and develop strategies to combat these at the individual and structural level.

4. To assert that medication does not and cannot 'cure' mental distress.

5. To work towards socially orientated and democratically accountable types of mental health service provision.

6. To stop coercion – abolish Community Treatment Orders, ban electroconvulsive therapy (ECT) and urgently review all mental health laws.

7. To challenge the current crude neoliberal economic system that creates a fertile environment for ever-increasing mental distress.

We also call for a complete rethink of what it means to be a mental health professional and assert that:
Mental health workers will be located and fully integrated into the communities they serve. They will explicitly know these communities and seek to improve the conditions which foster good mental health. They will be visible in: schools, church halls, GP surgeries, gyms, libraries, work places, housing departments, and supermarkets – or in sum all the places you find people. (reVision, 2015)
The manifesto goes on to consider the detail of training that mental health workers will require to undertake their work and the plethora of non-medical alternative types of services already out there that offer much better opportunities for recovery.

Conclusion
At the heart of any psycho-politics has to be understanding of the economic and social processes that create the conditions for mental distress. We are currently in the eye of what feels like a perfect storm of neoliberal austerity, global oppression and bankrupt mental health services – bankrupt in the sense of ideas and resources. The challenge for all progressive groups is to raise awareness of these issues and fight for meaningful change. Given the persistent and enduring power of the pharmaceutical companies and

psychiatry, this is undoubtedly a massive challenge.

1. If you would like to join our group please email: revisionmentalhealth@gmail.com

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Don Weitz was a psychiatric survivor and a social justice activist – he recently died at the age of ninety which is usually in itself for a survivor of psychiatry. HE founded many activist groups and activist magazines and wrote resistance matters (many pages)
I urge all members to look this article up (Resistance Matters : the radical vision of an antipsychiatry activist in 2018 free to down load from the internet about 160 pages).

Health and Education - Tim Wilson – **written in 1995** from Wilson's ontology of humanness

According to R.D. Laing (1978) a child born today in the UK stands` a ten times greater chance of being admitted to a mental establishment than to a university. This can be taken as an indication that we are driving our children mad, more effectively than we are genuinely educating them (perhaps it is our way of educating them that is driving them mad).

"Give people the right to speak, regaining the voice of the oppressed is the fundamental condition for human emancipation" Freire (1974)
It is essential that education is grounded in human narratives, human emancipation and social justice. We produce history in our thinking and in our dialogue and actions with others. People need a language of hope but more importantly an actual hope. According to Freire present education has more controlling than emancipatory aspects. It is important to shift from the teacher to the student. There must be a shift in power, students must be involved thorough praxis in controlling their own education. Praxis according to Freire means political practices informed by reflection. Students need to transform structures so they become beings for themselves. Teachers are frequently recruited from the elite and

unwittingly perpetuate dominance through teaching. Although policies impact on the freedom of educational methods.

Education represents both a struggle for meaning and a struggle over power relations. There are deeper beliefs about what it means to be human to dream. Education reproducers the nature of the dominant culture and how it maintains a culture of silence e.g., reductionistic discourses. The oppressed internalise and thus participate in their own oppression. We need to work with people's real and actual experiences. All men and women are intellectual. There is a need for community solidarity around issues and language which oppress, people must learn together from each other's stories and realities. History can be made and re-made; the silenced voice must be heard. The dependent society is by definition a silent society. The voice is not an authentic voice but merely an echo of the voice of the dominant ideology. We require the transcendence of the dichotomy between manual and intellectual labour and a form of education that does not reproduce capitalistic neo-liberalism, were talent is mistaken for privilege.

Universities are not the seat of learning. Traditional education orientates students to conform to follow authority ~ (comment from 2021 now fees/massive debts has entrapped students to conform even more in neo-liberal society). People need an epistemological relationship to reality; they need an anthropological appreciation of their own culture. An understanding of what a human being is now. Freire 1993 confronts the white man's theory of paternalism and capitalism and centres on the ontological vocation of human beings to be fully human. Reflection is crucial, life is a process of becoming; of changing the political, economic and social environment. Unfortunately, the dominant elites lose their humanness: we live in alienated culture.

Classrooms die as intellectual centres when they become delivery systems for lifeless bodies of knowledge. In banking education, the teacher silences students. There is an urgent need for listening, dialogue, action and reflection. The whole activity of education is political in nature, politics is the subjects chosen for the syllabus and those left out. Medicine is dominated by big pharm, corrupt drug research; capitalistic individualism; it seriously lacks an epistemological and ontological critique. Politics reside in the discourse (claim to truth) of the classroom, school and universities construct people year by year. Students must question the system they live in and the knowledge being offered to them, to discuss the kinds of future they want. Elites impose culture and values on people.

Curriculum is controlled from above as a means to impose the dominant culture on each new generation. Uncritical citizens who deny their own intellect and blame themselves for their own failures are the easiest to control. Decision making must be shared, and people must never be taught how to speak- never let any other human define you own reality or existence.

Ontology of increased humanness
we only live authentically when we engage in enquiring and the creative transformation of the world. Consciousness is intentionality towards the world, to exist: humanly is to name the world, to change it. It is in the interests of the oppressors to change the consciousness of the oppressed i.e., getting them to fit into an obnoxious environment rather than to change the situation that oppresses them. The more the marginal people can be brought to adapt to the existing order, the more completely they can be dominated and denied their ontological vocation. Banking education controls and stops people asking questions. Critical consciousness cannot exist outside the praxis that is outside the action reflection process.

Sensationalism but terrible poor "corrupt" drug science Tim Wilson

Ref anti-depressants channel 4 22/02/18 - your piece was bias didn't give Moncrieff a chance to explain criticisms of it - seemed to swallow spin about effectiveness of these not benign drugs - I have now read the Lancet reported study - appears still no difference between any anti-depressant and Placebo control - still we don't know all the negatives drug companies found only have to get two positives - don't know enough detail of actual research in meta - analysis - eight weeks is extremely short term, no mention of effects of these drugs - addictive - can cause aggression agitation suicidal thoughts lots of shooters in USA on anti-depressants, can have effects on people change in thoughts and behaviour , body tries to reach homeostasis by reducing serotonin receptors - not a benign situation - theory behind anti-depressants flawed can have low serotonin and never feel down, high serotonin levels and feel down. Myth of chemical imbalance must ask what is cause that cause the cause to become a cause see Brown & Harris research 1970/80s on the social origins of 'depression see Hari 2018 - see 100s of meta - analysis by Kirsch and colleagues and other researchers saying anti-depressants no better than placebo which again was replicated in this Lancet study see all the links these researchers have with pharmaceutical industry - anyone can produce a person who thinks the drugs are wonderful - we have lost connections restoring them with a social upstream public health and community model are the best anti-depressants - not a pill for ever ill, not an individualised approach not any discussion about how society arrangements causes people to feel down.

Issues with so called anti-depressants media hype research published in February 2018 praising AD – Flaws - still little difference between drug and placebo,

Don't know details of actual research, how many negative finding are detailed or revealed – unknowns,

What about the results of all the other meta-analysis by Kirsch and colleagues,

Side effects of AD,

Study only very short term eight weeks,

Vested interest and links of researchers with drug industry

Trail not double blind everyone knows who is on anti-depressant due to side effects,

Say improves serious depression but drugs given for slight 'depression'

The coverage was almost universally uncritical and said very little about the adverse effects that some people will suffer taking AD or trying to get off them.

Often people who have been on AD are taken off them very quick and placed in placebo group – off course they will suffer from withdrawal effects and artificially make AD look good this is unethical

Calling for more AD to be proscribed will cause wide spread harm – iatrogenesis

Human misery will not be cured by psychotropic drugs – alienation will not be cured by psychotropic – but will turn social and political issues into individualised medical issues (medicalisation).

Antidepressants have been in the news recently. The general feeling seems to be that although they are being overused and may have some unpleasant side effects, they certainly 'work,' at least in some people (1).

So what is the evidence that antidepressants 'work'? If you compare them with a dummy tablet or placebo in a randomised trial, (not double blind because everyone knows who is on anti-depressant because of side effects) scores on rating scales that are meant to measure depression sometimes go down a few points more in people taking antidepressants compared to people on placebo. But what does this mean? Well, firstly, the differences are small. The commonly used Hamilton Rating Scale for Depression has a maximum score of 54 points and across studies differences are less than two points (2). A two point difference is unlikely to have any real (clinical) significance. Whether these scales actually measure a complex emotional state like depression is another question. They consist of lists of symptoms that are sometimes, but not always, associated with depressed mood. A two point change can occur because someone is sleeping better and may have no relation to the individual's underlying mood.

But the real problem is that placebo controlled trials are not a level playing field. See (http://joannamoncrieff.com/2013/11/21/models-of-drug-action/) antidepressants are psychoactive substances. They make people feel different, both physically and mentally. The older 'tricyclic' antidepressants, such as amitriptyline, were profoundly sedating. There was no mistaking

that you were taking them. The psychoactive effects of the newer antidepressants like fluoxetine (Prozac), paroxetine (Seroxat or Paxil) and venlafaxine (Effexor) are more subtle, but nevertheless present. They seem to make people a little drowsy sometimes, and lethargic. They reduce sexual drive, and in some people they produce a state of emotional detachment or indifference. Some people experience unpleasant feelings of tension or agitation (3).

The psychoactive effects of antidepressant drugs can affect the results of placebo controlled trials in two ways. Firstly, they may directly affect scores on depression rating scales. The emotional detachment produced by selective serotonin reuptake inhibitors (SSRIs) and similar drugs may reduce or blunt negative emotions, so people will rate themselves as less depressed. The sedative effects of the tricyclic antidepressants can improve sleep and reduce anxiety. Since these factors feature prominently in depression-measuring scales, these effects will produce an apparent improvement in depression, despite the fact that there may be no change in the individual's actual mood (although of course feeling less anxious and sleeping better might improve one's mood too).

Secondly, the mental alterations produced by psychoactive drugs, alongside their physical effects, may also affect depression ratings in randomised trials by signalling to people that they are taking the active substance rather than the placebo. This is what has been called the 'amplified placebo effect' (4). We use placebos in randomised trials because we know that the expectation that the drug will make you better increases people's chances of actually getting better. Using a placebo is meant to guard against the role of expectations, but if people can guess whether they have had the active drug or the placebo, then this safeguard no longer operates. We know that people can usually guess better than chance whether they are on the active drug or placebo in randomised controlled trials of antidepressants and other drugs used in psychiatry (5).

If this is the case, people taking the active drug will have greater expectations of success than those on the placebo. So people in the placebo group get the ordinary placebo effect of *thinking* they are taking a drug, but people in the antidepressant group get an 'amplified placebo effect' because they don't just think they are taking a drug, they have evidence (in the form of subjectively detectable drug-induced alterations) that they really are. An 'amplified placebo effect' is especially likely to occur if people enrolled in the study have a bias towards drug treatment in the first place.

Since people who don't want to take antidepressants would usually not take part in a drug trial, this is likely to be the case.

The direct impact of the psychoactive effects of antidepressants, together with the amplified placebo effect, mean that we cannot interpret the differences between antidepressants and placebo that occur in some randomised controlled trials as evidence that antidepressant drugs have 'antidepressant' effects. In other words, these differences do not demonstrate that the drugs reverse part of the underlying mechanism that leads to depressive symptoms. They only show that the experience of taking a drug with psychoactive effects is different from that of taking a sugar pill.

Consistent with this view, almost any type of drug with psychoactive properties has been shown to have 'antidepressant-like' effects in one study or another, including stimulants, benzodiazepines and antipsychotics (6). Substances without noticeable psychoactive or physical effects have not (7). The fact that antidepressants come from a wide range of chemical classes, and produce an enormous variety of physical and mental alterations, also supports the idea that it is the presence of these alterations and not any specific chemical mechanism that produces the effects seen in placebo- controlled trials.

Drugs might be useful in depression, however, even if they are acting through their psychoactive effects and not reversing an underlying pathology. The sedative effects of the older tricyclic antidepressants and some of the newer ones might be useful in facilitating sleep and reducing agitation. The emotional detachment or indifference produced by the SSRIs may come as a relief to some people who are deeply distressed. The widespread promotion of the idea that depression is caused by a chemical imbalance and that antidepressants help put it right means that most people do not expect the drugs to work in this way, however. Indeed, there is so little coverage of the psychoactive effects of antidepressants that it is likely that most doctors are only dimly aware of them.

Moreover, the psychoactive effects of the drugs we call 'antidepressants' do not come cost free, of course. SSRIs cause high rates of sexual dysfunction, including reduced libido which is probably an aspect of the emotional indifference they produce (3). Occasionally they seem to precipitate suicidal thoughts and inclinations and there are also withdrawal effects to consider. A minority of people have severe and prolonged withdrawal reactions (8).

Using psychoactive substances to cope with negative emotions is a longstanding human response, but also one that is fraught with difficulty. Although drug-induced effects may bring temporary relief, they may also hamper people from finding more lasting solutions to their problems. If people do want to go down this route, however, there seems no reason to restrict the repertoire to drugs currently called ‘antidepressants’. This raises all sorts of thorny questions, of course, about why some psychoactive drugs are legal and others illegal, about what sort of drug use society approves of and what it doesn’t, and why the legal dispensation of many drugs is restricted to doctors: subjects for many future blogs!

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The Body is the Hero Alternative public health report

How to combat coronavirus

The danger is from an immune system
that can't protect you
And that's where we're making a DEADLY mistake.

*Let me explain…*Yes, the COVID-19 coronavirus is highly **infectious**.

It spreads extremely easily. But it's not especially *deadly* compared to some others…

Look at it this way…Over the past couple decades, we've seen **2 other smaller-scale coronavirus pandemics**.

One was from **SARS** in China in 2002. The other was the **MERS** outbreak in the Middle East in 2012.

Now, the COVID-19 coronavirus we're dealing with now seems to kill about **3%** of those who get infected. **SARS was much more deadly**… killing about 10% of the people who got it.And **MERS**? Well, MERS was *incredibly* dangerous… **killing 34% of those who got infected**.

That's 1 out of every 3 people who got sick... **died***!*

(And MERS hasn't even been eradicated – it still pops up occasionally.)

Now, **COVID-19** *is* **dangerous**, of course.

Especially for **seniors** or the immune compromised.

But, generally, most people get only mild symptoms – *or none at all.*

And children and young adults have almost **nothing** to fear from COVID-19.

Why? Well, the very likely cause is this…

Because they have robust, powerful immune systems.

And…

Studies show a strong immune system can help STOP a viral infection before it takes hold

But seniors… and those with complications like diabetes… **are dying at a much higher rate**. **Because they have weaker immune systems.**

Let me tell you…*The virus is nothing.*

The immune system is EVERYTHING.

In fact, I'm about to tell you **something that almost no one knows**…

...probably not even your own doctor. **We've made a HUGE mistake when it comes to viruses.** And it's related to the litre of milk in your fridge right now...

Remember **Louis Pasteur** from science class?

The French scientist Dr. Louis Pasteur is famous for our understanding of microbes or "germs"…

which are **tiny organisms like bacteria and viruses**.

He invented **pasteurization** – the process that makes milk last longer by superheating it to kill the germs.

Now, Pasteur had a professional **rival** at the time…

The scientist **Dr. Claude Bernard.**

This guy was an absolute **genius**.

Harvard University's Dr. Bernard Cohen called him, "**One of the greatest of all men of science**."

Now, Louis Pasteur and Claude Bernard were actually **good friends**…

…but the 2 great scientists differed on one **HUGE** *point.*

Pasteur believed people get sick and diseased because of germ attacks from **outside** our bodies…

Bernard believed that **germs are always inside us**…

…and we only get *sick* when **our immune systems become weak**…

…and allow dangerous viruses or bacteria to take hold.

The thing is, in my public health experience…

Pasteur was wrong.

Dr. Bernard was right.

And even if modern medicine has failed us (I'll explain why in a moment), **the latest science now agrees.**

And so do I.

The science I've seen now **PROVES** Dr. Bernard's theory.

And this is the KEY to preventing and destroying virus attacks.

Let me explain…

Our bodies are already FILLED with viruses, including coronaviruses.

This will shock you, but…

You have more virus cells in your body
than you do your own cells

It's true. *By a long shot.*

You have about **37 trillion human cells** in your body.

But that's NOTHING compared to how many VIRUS cells you have in you right now.

For every human cell in your body – **you have about 10 virus cells.**

That's right… **you have over 370 TRILLION virus cells in you <u>right now</u>**.

We all do.

In fact, humans have been home to so many viruses throughout history that…

...**8% of our DNA is now made up of ancient virus DNA.**

This is absolutely true.

It's known and accepted medical science.

But I bet no one has mentioned this to you before...

I also bet they never mentioned how a study found, at any one time…

…**the average person is carrying 5 "HARMFUL" viruses**… *without even knowing it.*

The fact is: We are full of both harmful and benign viruses (and bacteria and other germs) **<u>all the time</u>**.

And if Pasteur's theory – that we get sick because of **external** germ attacks – was correct…

…we'd be permanently sick.

But we aren't…

Because…

Thanks to something called "antibodies"…
our immune systems are GREAT
at preventing disease

Viruses, bacteria, and other microbes are in us and around us **all the time**.

And our immune systems keep us healthy…

But when you do get a viral infection (like coronavirus)…

…that's actually a **symptom of an immune system <u>out of balance</u>**.

Even famed modern microbiologist Rene Dubos **agreed**:

"Most microbial diseases are caused by organisms [viruses and bacteria] **present in the body of a normal individual.**

"They become the cause of disease when a disturbance arises which **upsets the equilibrium of the body."**

This was Dr. Bernard's theory in a nutshell…

The germs aren't important.

It is the "environment of the body" – including your immune system – that matters.

Bernard was **right** about infectious disease…

<u>Dr. Louis Pasteur was wrong</u>.

And, in fact, even **HE** finally realized it…

On his deathbed, Pasteur is purported to have uttered, "*Bernard was right*…"

"*The microbe is nothing…*
The environment is everything"

But, sadly… this is where the **huge mistake** was made.

And we are all victims of it to this day.

You see, **Pasteur's theory won out**.

And medicine has stumbled down the wrong path ever since...

But why did we embrace the **WRONG** *theory?*

Well, for one thing, **Pasteur was very popular**.

He was a **hero** for inventing the pasteurization process, among other things.

At the time, he was practically a **celebrity**.

Another reason?

Well, call me a conspiracy theorist if you want, but…

…there's **no money** to be made by boosting our immune systems.

Especially when the best ways to do it involve **natural** substances (*that can't be patented*)…

But you can make BILLIONS creating drugs to "treat" the **symptoms** of disease.

And that's exactly what happened.

Though, it does make you wonder, if all the **countless millions of research pounds and dollars** Big Pharma has put into *drugs*…

What if that money had instead been spent on studying ways to **strengthen our immune systems…and alternatives to psychotrophic drugs.**

Especially those of the elderly, *where most disease happens*…

Would we still die of infectious disease?

Would ANYONE die of viruses?

Is it possible that, if we could **UNDO** medicine's big mistake, almost…

No one would need to die of coronavirus
or any other viral infection?

I know one thing: Despite Pasteur's admission, **mainstream medicine STILL doesn't get it.**

That's why they rely on immunizations and drugs to try to keep viruses **away**… *and fight them off.*

How's that working out lately?

It's pretty clear from COVID-19 spreading devastation across the globe… **we need a BETTER solution.**

That's why I practice and advocate alternatives to the dominant medical model of disease.

Our immune system.

There is a handful of almost **unknown immunity superheroes from around the world**…

…one of which **killed 99.9% of 14 common viruses** in testing...

...plus 4 other immune boosters that are **also super potent**.

I want to help the immune compromised, and anyone else build a **supercharged** immune system…

…to help **destroy** viruses, bacteria, candida (yeast) and other microbial pests…

…BEFORE infection takes hold in the body.

And, if a patient *does* get infected, a minor tweak to this same method **helps their own immune system DEFEAT the infection.**

It's designed to help the immune system become **SUPER STRONG…**

You know how a champion bodybuilder **pumps up** his muscles by lifting weights…

This was developed to PUMP UP your immune system to help fend off viruses and bacteria

Immunity enhancement

A strong immune system is the BEST way to beat infection and disease…

…and to SURVIVE any viral and microbial infections.

So, if you want to create a superhero immune system… to **pump it up STRONG**…

I

Not only that, **it can be done from home** – without a prescription.

I'll show you **exactly** how it works in a moment…

First, why are those of us in our "golden years" in **more danger** from viruses?

Well…

The bad news is that immune response DECREASES with age…

…so older folks are especially vulnerable to infections and disease.

Even if you're a healthy senior, you're more likely to contract viruses and infectious diseases than younger folks…

…and more likely to DIE from them.

That's why respiratory infections – the **flu, pneumonia**, and now, the **novel coronavirus** – are some of the TOP causes of death of people over 65.

But why does this happen?

There are many theories…

…including an age-related decrease in **T cells** and the other infection-fighting cells that make up your immune system's defensive arsenal.

Plus, many older folks eat less food than they used to – and often eat much of the same thing every day.

That can cause them to be deficient in many **essential vitamins and minerals** that are *critical* to keeping your immune system healthy.

Itf you use carefully selected natural virus-fighters to help build up the immune system to **prevent** dangerous infection…

…including **the breakthrough ingredient that killed 99.9% of 14 common viruses** in in vitro testing…

And then it includes an additional **trio of virus assassins** ready at the first sign of any infection or sickness…

Ok, let's start with how to **supercharge the immune system**…

…to help **prevent** viruses or microbial pathogens from taking hold in the first place…

The first part of the Immunity Pump method
is a specific combination of
5 potent immunity boosters…

Now, your doctor likely has never heard of any of these…

…but they are **the most powerful immunity boosting breakthroughs**

And I believe they're **the key to "pumping up" the anti-viral response** of your immune system to help prevent infection.

Here are the first 3...

1. **Monolaurin**: The natural substance that killed 99.9% of 14 common viruses…

…by stripping off their protective armor, leaving viruses "naked and afraid"…

2. **Transfer Factor**: A super immunity "download" from mother's milk…

3. **Elderberry**: This most potent antioxidant builds a bulletproof immune system…

…that obliterates viruses and bacteria in vitro <u>before</u> they take hold.

Have you ever wondered why – at the start of the coronavirus outbreak – everyone and their brother was telling us to **wash our hands for 20 seconds**?

Well, the reason is because viruses are sometimes called "**bad news wrapped in protein**".

Meaning… the virus itself has a **protective "shell"** made of protein and fats.

And, when you wash your hands, the soap helps **break down that protective shell**, stripping it away…

…and deactivating or "**killing**" **the virus**.

Well, I've discovered an astonishingly **powerful anti-viral weapon** *that does the SAME THING…*

…except it works **on a cellular level**.

<u>And no one is talking about it</u>.

It's called <u>**monolaurin**</u>.

And **monolaurin** is <u>the first part</u> of my Immunity Pump Protocol.

I'll explain exactly **what** it is in a moment.

But first I thought I'd show you how incredibly **potent** monolaurin is.

An in vitro scientific study found that…

Monolaurin was more than 99.9% effective in KILLING 14 common – and often deadly – viruses…

…including one type of **coronavirus, pneumonovirus, influenza, measles, cytomegalovirus, Epstein-Barr, and herpes simplex virus 1 and 2.**

With all 14 viruses, **monolaurin disintegrated the virus's protective shells,** *destroying them…*

And this study was done by no less than the **Centers for Disease Control's (CDC) Respiratory Virology Branch** – so you know it's the real thing.

So what is it?

Monolaurin is actually a **combination** of 2 all-natural substances, each a potent immunity booster on its own…

The first is **lauric acid**.

And lauric acid comes from a surprising place…

It's the main antiviral and antibacterial substance in human breast milk…

In fact, you could call it *baby's first antibiotic.*

Lauric acid was discovered when scientists studied breast milk to understand how it protects infants from viruses and infections.

They found that <u>lauric acid</u> **safeguards newborns from serious respiratory tract viruses**.

But as powerful as lauric acid is on its own… it's actually a building block of something that delivers **an even BIGGER antiviral punch.**

You see, when the lauric acid combines with another natural anti-viral substance – **glycerol** – in your body…

…it forms **<u>monolaurin</u>**.

And in a case of the sum being **MORE** than its parts…

...**monolaurin is an antimicrobial DYNAMO**...

When it comes to **killing viruses***, monolaurin leaves lauric acid in the dust.*

But not JUST viruses… monolaurin has been proven to help wipe out various strains of **bacteria and fungi** in vitro as well.

Fact is…

Monolaurin can be <u>your secret weapon</u>
because it's an antiviral hero

You see, **monolaurin ATTACKS the protective shell around the virus**…

That kicks off a chain of events that **KILLS viruses.**

In fact, in vitro studies show that monolaurin gets to work destroying viruses in **3 key ways**, including…

- **Disintegrating the virus's protective "shell", and deactivating the virus inside**
- **Preventing viruses from entering and binding to host cells**
- **Disrupting viruses' ability to replicate (make more viruses)**

And that's making scientists *very* excited.

The Centers for Disease Control's (CDC) Respiratory Virology Branch conducted an in vitro study that showed...

…monolaurin was **more than 99.9 percent effective in KILLING 14 common viruses…**

…including **coronavirus,** pneumonovirus, influenza, measles, cytomegalovirus, Epstein-Barr, and herpes simplex virus 1 and 2.

Well, it didn't stop there…

Another clinical trial provided insight into how monolaurin works.

It found that this potent compound **BINDS to the virus's protective shell**.

That PREVENTS viruses from *entering and attaching to your cells*… **making infection and replication IMPOSSIBLE.**

And additional studies have provided even MORE clues to **how monolaurin keeps viruses from taking hold...**

Some studies have linked monolaurin's anti-microbial effects to its ability to **INTERFERE with virus maturation and replication.**

And additional research has shown that when monolaurin binds to the virus's shell, it makes **viruses MORE recognizable to your immune system –** *so it can destroy them***.**

But **monolaurin** *still has a few MORE tricks up its sleeve...*

As I told you, it doesn't just make short work of viruses by breaking down their outer coatings…

It can ALSO do the same for harmful <u>bacteria and fungi</u>.

Monolaurin is a safe and effective treatment – without the side effects of antibiotics and other dangerous drugs

You see, antibiotic resistance is a growing health crisis – and folks are DYING from common infections that used to be treatable.

But monolaurin is a NATURAL bacteria-killing *hitman***.**

In vitro studies have shown it can **destroy many common bacterial strains**.

Monolaurin uses the <u>same</u> mechanism on bacteria that it uses to destroy viruses…

…it penetrates the fatty coating of bacterial cells and basically *dissolves* them.

That prevents bacterial cells from attaching to the host cells – stopping bacteria from replicating and spreading…

…and making it easier for your immune system to destroy them.

And unlike some pharmaceutical drugs… bacteria DON'T seem to develop a resistance to monolaurin.

But that's still not all monolaurin can do… it's also a powerful **antifungal**.

A study published in the *Journal of Food Safety*, found that monolaurin inhibited the growth of 16 different groups of fungi, **including** *yeast* **(candida albicans).**

So, with all of the mounting in vitro evidence of **monolaurin's antiviral and antimicrobial superpowers**…

…why ISN'T mainstream medicine sitting up and taking notice?

Friend, once again, it all comes down to **the almighty pound and dollar**.

As I told you, monolaurin is a derivative of **lauric acid** – which you'll find in breast milk and coconut milk.

Well, until Big Pharma can patent coconuts or breast milk, *you're not likely to hear much about this antimicrobial wonder.*

Going next to **Part 2…**

A super immunity "download" from our Creator

Remember how I mentioned that lauric acid – a building block of monolaurin – was found in **breast milk**?

Well, you're going to start thinking there's a theme here – *and I suppose there is…*

Because the second step in my protocol involves *another* **substance found in breast milk**.

There's a reason for this.

For the first weeks after birth…

…a mother's milk is absolutely packed with **the most potent immunity boosting substances** on God's green earth.

And this next one is positively mind-blowing…

Did you know that mother's milk contains an extraordinary substance…

…called **Transfer Factor (TF)**…

…that *passes along immunity* to the viruses, bacteria, and pathogens the mother has already faced?

It's truly incredible.

It's like **Transfer Factor "downloads" all of a mother's immunity to her baby**… *passing it along for generations.*

It's no wonder I call Transfer Factor the "**brains of your immune system."**

And here's the very good news…

Yes, "mother's milk" is LOADED with the stuff… but you don't have to be a baby to reap its benefits.

TF can give its protective power to **anyone** who needs it – even *folks with weak immune systems.*

When TF is **transferred** from the donor to someone new…

…it <u>teaches</u> the new cells to recognize harmful pathogens – like **viruses, germs, bacteria, fungi, and parasites**.

But transfer factor doesn't just pass along the *memory* of those threats from when they were encountered in the past…

Transfer factor (TF) passes along
IMMUNITY to them

That means YOUR immune system can react **instantly**…

…fighting off dangerous viruses and bacteria as soon as it encounters them.

And while most doctors don't know much about TF, pioneering scientists have finally taken notice…

For example, a study published in *Folio Biologic* called "*Transfer factor: An overlooked potential for the prevention and treatment of infectious diseases"…*

…showed that **TF can successfully treat a variety of pathogens** (disease-causing microbes).

The scientists made several compelling discoveries, including that **TF could prevent infection from the dreaded herpes virus…**

And that TF doesn't just KILL viruses – **it keeps them from TAKING HOLD in the first place**.

Can you see why **I consider TF so vital for defending against virus attacks?**

And why I made a specific dose of TF **Part 2** of my Immunity Pump Protocol?

Transfer Factor is available as supplement – *if you know where to look.*

In a moment I'll share with you how to get the details on **where to find the TF supplement**…

…and, most importantly, **the specific dosage someone could take**.

The 3rd part involves a potent purple berry that helps BULLETPROOF your immune system

A berry?

Well, this isn't just **any** *berry…*

Imagine an **all-natural medical marvel** that's so PACKED with *immune-boosting, virus-fighting power…*

…a major U.S. university created an annual 6-day international symposium **dedicated ENTIRELY to its healing superpowers.**

I'm talking about the humble **elderberry**.

It all began when a group of brilliant scientists from the **University of Missouri**…

…discovered what may be **the world's next** *super immunity booster* was hiding right in their own backyard.

The first **International Elderberry Symposium**, held in 2013, was billed as…

…"the world's first gathering of international scientists studying all aspects of the **elderberry**, and its use as a food and dietary supplement."

And thanks to **growing scientific evidence of elderberry's healing powers**, the event has been held *every year since*.

Elderberries, which grow in late summer along Missouri roadways, have long been a favorite in jams and wines...

But now a **growing mountain of evidence** points to them as FAR more than just a palate pleaser.

And it's backing up a **healing tradition** that dates to 400 B.C. when ancient healers used the purple berries to battle colds, flu, arthritis, and other diseases.

In fact, some medical experts now say that elderberries could hold the key to building a **bulletproof immune system…**

…the ticket to **helping your body** *battle viruses and other pathogens*.

You see…

Elderberries are LOADED with antiviral compounds that can fight viruses at various stages of infection…

…including the EARLIEST stages, when the virus tries to enter your cells and replicate.

But elderberry practically puts a "**Do Not Enter**" sign on your cells – and ENFORCES it.

And if you DO get sick, this potent purple berry could make your symptoms **MUCH less severe…** and help you **recover a LOT faster.**

I'll tell you more about that in a moment.

But first, let's talk about what gives elderberries their **immune-boosting power**.

Well, most researchers agree it's likely their **unique** nutritional profile…

…including their **off-the-chart antioxidant levels**...

…some of the **HIGHEST** of ANY edible berries.

Scientists measure antioxidant levels using something called an ORAC value.

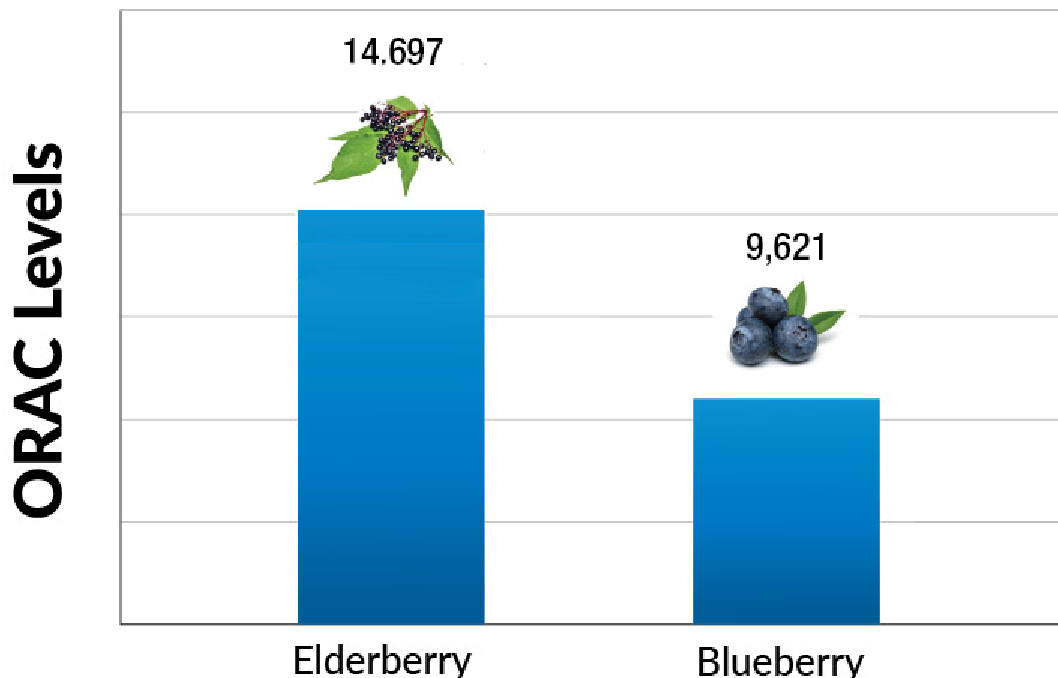
Take **blueberries**, for example.

These antioxidant-rich berries are often touted as *superfoods* and praised for their nutritional benefits – as they should be.

The ORAC value of blueberries is **9,621** — an impressive measurement, to be sure.

But that's **NOTHING** compared to elderberries…

…which smash the scales with an ORAC of **14,697.**



Here's why that *matters*.

During a typical day, we're all exposed to a mix of chemicals, pollutants, and other toxins, like radiation, pesticides, and tobacco smoke.

These interactions kick off a chemical reaction in your body called *oxidation*.

A by-product of oxidation is the production of harmful *free radicals*.

Free radicals are *unstable* molecules that damage the cells and tissues they come in contact with, **including your immune cells**.

This is bad news.

In fact, that damage – called "**oxidative stress"** – is linked to nearly *every* major illness and condition we face today…

…from nasty viral infections, to **cancer**, Alzheimer's disease, heart disease, *and even the aging process itself.*

On the other hand, **antioxidants** – like those found in elderberries…

…**PROTECT your cells against damaging free radicals.**

And, as a I mentioned a moment ago…

…**elderberries are loaded with so many antioxidants** *they're practically off the chart!*

But those long-term disease-fighting benefits aren't the *only* way **antioxidants help to keep us healthy…**

Elderberry's antioxidant power *can keep you from getting sick every day*

You see, antioxidants are a *critical* part of your body's natural defense system against **harmful bugs, including the viruses that cause colds, flu, respiratory infections, and more.**

Not only that, elderberry is packed with additional vitamins and nutrients **that give your immune system the boost it needs to stay healthy.**

But what's most exciting to me is how elderberry SLAYS viruses.

Sambucol – a specialized elderberry extract – was shown to be effective *in vitro* against **10 different strains of the influenza virus**.

Flu viruses KILL hundreds of thousands globally every year, *especially older folks like us.*

But mainstream medicine doesn't have much to offer you if you're battling a nasty bout of flu.

Elderberry to the rescue.

This all-natural treatment could **get you back on your feet a LOT** *faster*.

And it can do it without *any* of the troubling side effects of pharmaceutical drugs.

In a double-blind, placebo-controlled study (the gold standard), published in the *Journal of International Medical Research…*

...researchers investigated elderberry's effects against the flu.

The participants included 60 adults who'd been battling influenza for less than 48 hours.

Half the group was randomly given a **15 ml dose of elderberry syrup**, which they took 4 times a day for 5 days.

The other half received a look-alike placebo syrup, which they took on the same schedule.

So what happened?

Let's just say that the elderberry BLEW the placebo out of the water.

Folks who took the *real* elderberry got better an average of 4 full days sooner
Not only that… FAR fewer members of the elderberry group needed a rescue med inhaler.

According to the researchers, "a complete cure" was achieved by a whopping **90 percent** of the elderberry takers *within just 2 to 3 days*.

The placebo group wasn't quite so lucky – they didn't recover for **7 to 8 miserable days**.

That led the researchers to conclude that **elderberry could be an "efficient, safe and cost-effective treatment for influenza"…**

…though I bet your doctor hasn't mentioned it, right?

But elderberry doesn't just kick **flu viruses** to the curb…

…the **common cold virus** may have met its match as well.

A study published in the journal *Nature* revealed the extract might be able to **reduce both the length of colds AND the severity of the symptoms.**

With **elderberry extract, TF, and monolaurin** you have the first 3 powerhouse ingredients of an Immunity Pump *Prevention*

1. **Monolaurin**: The natural substance that killed 99.9% of 14 common viruses…

…by stripping off their protective armor, leaving them "naked and afraid"…

2. **TF**: A super immunity "download" from mother's milk…
3. **Elderberries**: This most potent antioxidant builds a bulletproof immune system…

…that obliterates viruses and bacteria before they take hold.

And the other 2 antivirals that make up the the 5-part prevention …

includes coryza forte…

…

The "Prevention" for preventing virus infection in the first place…
And the "Acute" protocol for **beating a viral or microbial infection**…

I

1. **Monolaurin**: The natural substance that killed 99.9% of 14 common viruses…

…by stripping off their protective armor, leaving them "naked and afraid"…

2. **TF**: A super immunity "download" from mother's milk…

3. **Elderberries**: This most potent antioxidant builds a bulletproof immune system…

…that **obliterates viruses** and bacteria before they take hold.

: Viruses and microbials are all around us.

And, as you learned, they're also **INSIDE** us. *Trillions of them.*

Our Vision:
A society in which the social causes of mental distress are understood and treated with socially based solutions that improve individual lives and bring about wider social change
Our Aims

- *• To be an alliance of critically aware thinkers, such as academics, voluntary sector workers, students, social workers, service users and other community activists who are committed to promoting the social model of mental health*
- *• To empower communities and individuals through research and education on issues relating to the social causes of mental distress*
- *• To be a strong voice for change, locally and nationally, on issues that affect people's mental health and well-being*
- *• To enable differences in the experiences and needs of people who experience mental distress to be heard, respected and acted on, and make connections between individual experiences and structural oppression and disadvantage*

If you want to join us email t.j.wilson@liv.ac.uk or and state that you agree with our aims.
reVision is affiliated to Asylum, the Magazine for Radical Mental Health
What makes us different to (most) other mental health organizations
Why we are called reVision
We have chosen the name reVision to reflect the revisionist ideas of critical thinkers in the 1960s and 1970s - anti-psychiatry - who were critical of the bio-medical approaches embodied by most psychiatric thinking and practice.
We are an alliance
Our key strength is that we are an alliance, which means that we can draw on a wide range of skills, experience, knowledge and ideas in order to further our common goal of promoting critical understandings of the social causes of mental distress. We seek to develop a radical voice for change, which is fundamentally different to most other mental health groups in Liverpool and beyond.
We are critical
We exist to critique psychiatry. Our aim is to challenge the dominance of psychiatry and to expose its limitations, and the harm it may do, in relation to treating mental health problems.

We are political
Our research, education and critical commentary have political foundations and political aims. We make connections between individual experiences and structural oppression and disadvantage and raise awareness of how these wider structures impact on the mental health of individuals and on community wellbeing.
We understand difference and diversity
We are united in our diversity. We understand that achieving equality requires an understanding of difference in terms of needs, experience, and social location. We have an informed, unwavering commitment to effectively meeting different needs, and to facilitating collective empowerment around issues relating to power, social inequalities and their connetions to mental distress.
We speak truth to power
We are critical of community involvement and consultation activities which do not encourage critical thought and dialogue and that do nothing to address the social, cultural and economic power structures that are the cause of much mental distress. We aim to offer an alternative, critical voice and to empower people to question and speak out against the medicalisation of inequality. **reVision –**

We are asking the membership to help with this new revision news – so please send (on any mental health/public health issue) any articles, any thoughts, any critique of articles , writing, poetry or (what's on particularly regular events) to the email above
Revision value the opinions, views and visions for future mental health services from the membership. We are asking how we can better make connections with you and finding out what type of activities events speakers they would like.

Anyone willing to explain their experiences of "lock-down" positive and negative learning any new skills etc.

With this in mind we have enclosed a small questionnaire – please return to **revisionmentalhealth54@aol.com**
Q. what types of events, activities would you like?
Q What are the most convenient times and locations e.g. early evening, Saturday morning or any other preferable time please list
Q do you have any suggestions for public speakers, events, discussion

groups etc. Q. what are your views on the Seven aims of the manifesto for change?
Q. any other ideas, suggestions, critiques
Why called revision
We are named after the "revisionists". They were also known as the "Anti - psychiatrists", but in reality some of them given this label didn't consider themselves anti-psychiatrists e.g. Szasz, but all were critical of aspects of Psychiatry- so maybe critical psychiatry is a better term. They were an important movement in the 60s and 70s. More contemporary many people are critical of the scientific basis of psychiatry and many critical thinkers are concerned about the harm's psychiatry does. And how social societal issues are medicalised as an illness. This can lead to the social, political, economic, and environment (SEPE) issues to conveniently disappear from the arena of debate and action to change. It can also lead to a disappearance of mental distress and its causation (what has happened to people), it can make their narrative disappear and the potential for change to be curtailed.

Our Vision
A society in which the social, economic, political and broad environmental (SEPE) causes of mental distress and physical distress are understood and treated with socially based solutions that improve communities and individual lives and bring about fairness, equity, social justice and wider social and radical changes to the present psychiatric and mechanically CBT dominated mental health services, including societal change. Revision advocate a social model of mental distress and health.
We are an alliance – of people from all walks of life.
People with lived experience of emotional or mental distress,
People who have and continue to experienced mental health services,
Carers of people with mental health concerns,
Community activists, Professionals in the field
Family, Students, community groups, discriminated people, bullied people
Anyone interested in mental health who maybe also wants to change the system.
People who have been through a spiritual crisis
We are independent of Mersey-care and any other mental health service, and any funders who might prevent us from saying what we think and believe.

Our aims are to –

Challenge psychiatry (inherently discriminatory), and the inherently discriminatory and racialist mental health laws, some members feel that psychiatry should be abolished. Unite – form alliances with others to improve and reduce mental distress
Empower – people can only empower themselves forming alliances but having resources, connections and support does help.
Support others – provide listening, ask, 'what has happened to you' – help people to make connections with other people and groups, value difference.
Speak out, 'come to voice' break the culture of silence assisted and supported by empathy confidentiality and skill development
Work with others to bring about a new type of mental health provision, promote autonomy, control and social support,
Advocate prevention of mental distress including 'up stream' public health strategies and social policies for mental health. Repeat: Revision advocate a social model of mental distress and mental health.
We believe that everyone has gifts and valuable ideas and qualities. We want to discover a way forward together.

Activities:
We have held talks, discussion groups, art events, film showings followed by discussions, published articles … Sometimes we do things as a group. Sometimes we support each other in our different projects.
It's all about seeing how what individuals are suffering is part of the bigger picture, Many perhaps all people are suffering from alienation.
The value of community and forming connections is important.
Inequality, poverty and discrimination make people very unhappy. There are no chemical imbalances but many power imbalances.
We say there is nothing wrong with peoples' brains. "Chemical imbalance" is a myth.
Safe Space
In our meetings, we try to be a safe space for each other. Anyone can develop mental health issues, at any time in their lives, if put under enough stress. Who is really "well "and who is really "ill"? Are these just labels? We believe in people defining themselves rather than other people doing that.
Groups linked with reVision – please come along!

All the below have temporary been cancelled due to pandemic but it may be possible some are using technology like zoom.“REVISION CAFÉ - discussion and Reading group –when first Saturday in month, time 10.45 a.m. – Next session - ???? at 10.45 a.m. venue, VGM Victoria gallery and Museum, Ashton street , Brownlow Hill, opposite to Harold Cohen Library near University square, Liverpool University.

NEW GROUP

MEN'S TALK LIVERPOOL At the Brink 21 Parr St, Liverpool L1 4JN

A new group has started at The Brink. It's, birth has been prompted by the alarming stats that continue to rise, regarding men and mental health. A new group which offers a space for men from all walks of life to share a space, talk, listen, be heard, support and be supported. We are aware of the growing numbers of men having hard times with negative mental health, depression or suicide. Having a non-judgmental space to be in and share has worked in other places with similar groups so we’re doing one here. Donation based group. There seems to be few spaces that allow men to share, listen, be heard, support and be supported with their life and personal issues. A men's group has been tried in other cities and seems to work really well for those who attend, so we are setting one up here. The simple act of talking can work wonders it seems!

EVERY WEDNESDAYS 6.30-8.00PM - donation based group.

Quiet Space is a regular hearing voices group who meet every Thursday 1.30-3.30 pm at The Umbrella Centre on Mount Pleasant, Liverpool.
www.hearing-voices .org
This group member of the Hearing Voices Network (HVN)

Women’s only hearing voices group
The Third Friday of each Month
Between 11.00-1.00 pm
At PSS: The Umbrella Centre, 111 Mount Pleasant, Liverpool

The Spiritual Crisis Network local group meets the 1st Monday of each month at the Umbrella Centre from 11am-1pm. The Spiritual Crisis Network believes that spiritual crisis & mental health difficulties often overlap & that experiences that may seem unmanageable "can be deeply

transformative, offering the possibility of breakthrough rather than breakdown".

Café Psychologique provides a space to discuss life in an open equal way. It is free and takes place in The CASA on Hope Street, 6.30-8 pm on the last Wednesday of each month:
https://www.facebook.com/cafepsycholiverpool

check that the above (cafe psychologique) it is using zoom

*** New Cultural vitamin' event Liverpool Jazz club first Wednesday of every month at the Pen Factory, Hope street, Liverpool 8.30 pm -**

A new Liverpool council run service

- **Liverpool Light - Providing Mental Health Crisis Support**

Liverpool Light - Providing Mental Health Crisis Support
Description
A preventative out-of-hours mental health crisis service.
It has been set up to provide a safe place for people who are experiencing or at risk of a mental health crisis.
This space will alleviate the demand on A&E departments offering a more suitable environment to de-escalate and recuperate.
We will also be able to refer to our partner organisations if there are any other issues such as debt, risk of homelessness, benefits and welfare advice, domestic violence refuge, refugee support and substance misuse.
The Liverpool Light is a partnership between Creative Support (click) and Liverpool City Council.
Service Details
Locations:
181 - 185 London Road, Liverpool, L3 8JG
Liverpool City Council