The Association for Pastoral Care in Mental Health

Being Alongside

Summer 2023

Setting free

Stories of hope from the inside

INSIDE: Launch of our new grant scheme
Remembering Andrew Sims · Befriending Networks

Being Alongside Summer 2023

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Association for Pastoral Care in Mental Health

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We are a faith-inspired, voluntary association of individual subscribers and affiliated groups who recognise the importance of spiritual values and support in mental health.

We have a network of supporters throughout the United Kingdom. We welcome and encourage people whatever their faith or belief system.

We are primarily concerned to promote and encourage 'being alongside' people experiencing mental or emotional distress.

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Professor Andrew Sims

We were saddened to hear of the death late last year of the eminent psychiatrist Professor Andrew Sims, who had been a patron of Being Alongside since 1995.

He became involved with us through the good offices of Stephen Sykes, who was a fellow pupil with him at Monkton Combe School in the fifties. Stephen, who became Bishop of Ely, was our patron from the early days of the charity, and inveigled his originally atheist pal into co-patronage.

The son of parents who were both doctors, Andrew studied Natural Sciences at Cambridge before pursuing his medical training at Westminster, followed by psychiatric training in Manchester and Birmingham.

He was appointed Professor of Psychiatry at Leeds University Medical School in 1979. His research interests included descriptive psychopathology, resulting in his 1998 book *Symptoms in the Mind*, which became standard reading for trainee psychiatrists. He dedicated it to his father Dr Charles Sims "who, more than anyone else, taught me to be observant."

Andrew became dean of the Royal College of Psychiatrists and then its president, from 1990 to 1993. A Christian since his Cambridge days, he became chair of the RCP's Spirituality Special Interest Group and wrote numerous books on the subject of faith and mental disorder, including a response to Richard Dawkins entitled *Is Faith Delusion? Why Religion is Good for your Health*.

His wife Ruth, a psychiatrist and Anglican priest, said: "Andrew chose to study psychiatry because he believed it was his calling. He was always full of energy, cheerfulness and compassion."

Choosing words that might stand as a fitting epitaph, Andrew wrote in 2007: "What I greatly respect in a spiritual person is the sense of yearning for a better world and a better self."

Portrait of our late patron by Michael Noakes

GRANT SCHEME LAUNCH

New money for new projects

Our chair Ben Wilson introduces our new grant scheme to offer seedcorn funding for local projects to 'be alongside'

We are very excited to be launching a new scheme offering a helping hand to local places of worship and other organisations keen to improve the care they offer to people experiencing mental health difficulties.

The Being Alongside trustees have agreed to give away up to £20,000 over the next two years, with the aim of expanding the number of drop-in café style projects and befriending schemes across the country.

Local organisers will be able to submit applications for up to £2,000 each to support the establishment of such projects, to help cover the costs of expenses like room hire, publicity and refreshments.

The grants could also be used to fund research into the needs of the local area, and how those with poor mental health could be best reached.

Since APCMH was founded almost 40 years ago, thankfully much has changed in our understanding of mental health and the value of holistic care.

There are now a far wider range of organisations working with churches and other faith groups, to address remaining stigma and offer training and good practice on helping welcome and include those with mental health difficulties.

But there are very few avenues for direct financial support to help get new schemes off the ground. I can think of fewer better ways of using our historic assets to achieve our charitable aims.

The trustees are particularly keen to encourage the organic growth of drop-in and befriending services because their value had been demonstrated so clearly by the work of Being Alongside's branches and affiliates, filling a gap left between statutory and other services.

Projects interested in applying for funding are invited to submit an application by completing the simple form on our website (**beingalongside.org.uk**). Applications will then be considered by a sub-committee of trustees on a quarterly basis, to avoid projects waiting a long time for a response.

We recognise that £2,000 is not a huge amount of money, particularly if there is any need to engage paid staffing, but the hope is that it may make all the difference

Being Alongside could help get your new project off the ground.

We will consider your project for funding if:

- It is hosted or led by an organisation which reflects Being Alongside's charitable objectives
- It is a new project, or a development that builds significantly on an existing initiative

Applications will be assessed against the following criteria:

- The extent to which the project will address a proven local need, and how the organisers will publicise the new service to potential users
- Whether the project plan is realistic, and how it will be governed and operated safely and effectively
- Sustainability of the project in terms of financial support and volunteers

in getting some projects off the ground—particularly if it can be match funded by other sources.

Being Alongside will stay in touch with successful bidders for funding and offer insights from past projects and initiatives. Over time, it is hoped that the scheme may lead to growth in the number of organisations affiliated to the charity.

Please spread the word about the new grant scheme! Details are available on the Being Alongside website or by contacting our Administrator (see p2). We look forward to hearing from you!

Thank you Miriam

John Vallat expresses our heartfelt thanks to outgoing trustee Miriam Reyes

Miriam was appointed as a trustee of Being Alongside on 17th May 2008. Under the new constitution and policy, which seeks to encourage new trustees and avoid anyone feeling committed beyond nine years, her trusteeship ended on 18th November 2022. In total, Miriam has served our association for a remarkable 14 ½ years. During that time there have been six different chairs and five different company/CIO secretaries. She outlasted all the trustees who were in office when she became a trustee as well as 13 others who came and went during her tenure! Until the impact of COVID-19, Miriam seldom missed a trustees' meeting, away-day or residential weekend at Turvey Abbey.

Miriam's working life has been spent as a carer, and she has always shown her great compassion for those who were struggling or in need. For some considerable time, she offered her own home in London as the venue for trustee meetings. She always gave a warm welcome and generously provided refreshments.

She has been a loyal and permanent prayerful presence among us in Being Alongside—a presence which has served as an example of "being alongside" to the other trustees and committee members: listening, non-judgmental, supportive, encouraging, prayerful, loyal and consistent.

In recent times, Miriam has been less able to attend meetings but she has still contributed with her emailed prayerful reflections, support and encouragement.

Thank you, Miriam. Your continued support will be greatly appreciated by the remaining trustees and wider Being Alongside family.

Miriam staffing our stall at the 2016 CRE exhibition (left), and with fellow supporters at Turvey Abbey (below)

Thank you Marissa and Stafford

In addition to saying goodbye to Miriam, we also wish to thank two other outgoing trustees for their service to the charity

Marissa Lawingco and Stafford Cunningham have both reluctantly stood down from the board of trustees due to changing personal circumstances, after serving around three and two years, respectively.

Marissa joined the national committee in July 2020 and quickly made a positive impact on our work, drawing upon her Roman Catholic faith and extensive experience in different healthcare settings around the world.

Marissa's contribution to developing a safeguarding policy was particularly valued, as was her prayerful support of the rest of the committee. New responsibilities in Marissa's job within the health service means she no longer is able to devote the time to Being Alongside that she would like, but we know she will remain a keen supporter of our aims.

In a similarly short space of time, Stafford has made a great contribution to the charity. At a committee meeting in 2021 he announced he thought we should hold a conference and pretty much went away and organised it, the speakers and a venue for us! Two more successful conferences followed and we know his legacy to Being Alongside will be to inspire us to continue to run an informative and thought-provoking conference programme. Stafford has brought us interesting speakers as well as use of a wonderful venue at the Charterhouse in central London.

Personally he has had a long career in the healthcare sector, most recently managing care for the residents of the Charterhouse. Needless to say, recent years have been exceptionally tough in his sector due to the impact of the Covid pandemic. Stafford leaves us and his job in London to return to Ireland to take a little time out and to spend more time with his family.

The remaining trustees and other supporting members will miss both Marissa and Stafford, and the immense but quiet contribution they have made. A heartfelt thank you to you both, and all best wishes for the future.

Could you help guide Being Alongside?

If you, or someone you know, might be in a position to consider joining our board of trustees to succeed Miriam, Marissa or Stafford, we would be very keen to hear from you. Please contact Ben or Lucy via the contact details on page 2 of this magazine, to arrange an informal conversation.

Befriending Networks

In the second of this series on organisations with similar aims to ours, we meet Befriending Networks

Befriending Networks (BF) was founded in the late 1980s and currently brings together over 370 new and established befriending services throughout Britain and Ireland. Among those is one of our affiliated groups, Battersea Befriending Network.

Based in Scotland, BF's primary aim is to ensure that people receive high quality service from befriending organisations. It recognises that befriending services are often small and can be geographically isolated, so it's valuable for their co-ordinators to be able to share good practice. It also works to promote the work of its member organisations and to raise the profile of befriending to national and local government, commissioners and funders. Its website features a befriending directory which enables you to search for organisations by keyword, region, theme and age group. That ability to narrow down your search is very useful, as member organisations are by no means all specifically focused on mental well-being, but also include services aimed at specific user groups such as carers, homeless people, refugees, lone parent families, ex-offenders and older people.

Winners of BF's Quality in Befriending Awards

Also freely available on the site is a wealth of other resources including good practice guidance and briefings for people running or looking to start a project, as well as a library of reports gathering together research from around the country on befriending, loneliness and social connectedness.

BF runs a range of training courses for befriending services at affordable rates, including vital skills for staff, topical training, good practice training, with focus areas on bereavement, dementia, and engaging volunteers. Member organisations pay reduced fees for courses, and have access to networking events for manager and other staff, and a full volunteer training toolkit.

Larger organisations such as volunteer centres, CVSs, health boards, social work teams and national voluntary organisations are also able to engage BF's expert staff for consultancy services to help with tasks like project evaluations, in-house training and organisational reviews.

Just a table

‘Official’ drop-ins are great, but we can find ways of being alongside in less formal settings too, says **Lucy Roose**

I’d like to tell you about a table. A simple rectangular solid pine table. Nothing unusual about it as a piece of furniture. There must be thousands of others like it in church halls and community centres up and down the country. But for me, this table has come to signify something rather special, as you will see.

I write as the part-time administrator for Being Alongside, but also as a Church of England priest with a passion for compassion and good pastoral care for all those facing mental health challenges. I am currently serving my curacy in a rural village setting on the Hampshire/Surrey border. My two “roles” sit well together. This article is written with the objectives of Being Alongside in mind, and I particularly hope to encourage others to consider what living out the charity’s aims and objectives might look like in their context.

Being Alongside is keen to promote “drop-ins” and befriending set-ups for those who struggle with their mental health. But this will look different in different places and contexts. For example, over the past three decades in London the wonderful volunteers who have powered our local branches and affiliates have focused on running drop-in sessions and befriending relationships.

For me as a curate who will move on from my church at the end of my training, I have to be mindful of only setting up things that can continue to run without my input when I move on in a year or two.

In my village context, and in terms of the volunteer hours available to us, we haven’t felt it appropriate to run anything very formal in setup, but that is not to say we don’t have our eye pastorally on those who might be struggling. After all, for clergy that is part of our role. We were concerned about having sufficient volunteers (certainly a post-pandemic issue) and mindful of needing to be robust in our safeguarding responsibilities, particularly with a view to anyone who might come to us in crisis or need further support at the end of a session. And so I offer a description of what we are doing to show that churches can provide welcome and

support to those facing mental health difficulties without necessarily offering a formal framework.

One of our villages has a very successful church-run community café, offering good coffee and cakes two mornings a week as well monthly soup lunches. It is run by volunteers and delicious cakes are made by a bank of volunteers (from the church and the community) and bought for a suggested donation. It thrives in terms of cakes, staff and providing income for other community projects as well as being a hub within the community. It occupies an attractive building opposite overlooking the church which has converted into a comfortable café with small round tables and chairs and brings the village together. At one end there are comfy sofas, books and toys for children, and in the corner as you enter there it is—this simple pine kitchen table.

I have come to love both this pine table and what it represents and spend at least part of my Friday morning every week drinking coffee at it. A community minded non-churchgoer sits here for the whole morning most weeks. She has a coffee, usually a cake and always brings some knitting, crochet or other craft activity. If nobody joins her, she just knits; if they do, she chats as she knits. Currently she is knitting poppies for a remembrance display but often she is knitting socks or scarves for a homeless charity she supports. It could be called “Chat Café” or “Knit and Knatter” but it is less formal and yet more profound than either.

The other tables in the café are occupied by people who come in with friends to socialise. This pine table has forged its own purpose and mission. It has become a place where those looking for company or who

Lucy enjoying coffee and a chat at the pine table

might be struggling in some way can sit. It also offers a way to have an informal chat with the clergy. We have one person drop by who we know often struggles to leave her house. Somebody else whose mental health has meant a change in circumstance has gained the confidence to drop by now and again.

Another regular guest, diagnosed with bipolar affective disorder, comes every week and sits and knits. She will chat if you chat to her but is perfectly happy in quiet company. Some found her challenging when they previously got "stuck" at a table with her. Some find it awkward to sit without chatting. But her husband is grateful that she has found this change of scene, and the fact she returns week by week suggests she values the space we have created.

We might have a school-mum drop by, someone who wants to catch up on their knitting, or someone who wants a chat and some perspective. We put the world to rights, we chat, we build relationships, we might talk one-to-one about personal challenges; we walk together and support one another. We offer company, compassion and understanding.

"In one sense it has become a drop-in; in another it is nothing more than a table where people can sit to share time or conversation"

God is at this table too. In one sense it has become a drop-in; in another it is nothing more than a table where people can sit to share time or conversation. Certainly we don't advertise it—and nobody would recognise it—as a mental health drop in. It has more of the feel of sitting round a dining table in fellowship.

And yet because of our intention to "be alongside" those we sit with, it has become something more. The troubled can find compassion, we can keep an eye on those in our wider flock and when they are or are not in evidence. Without the need to set up formal rotas, book room hire or advertise an expectation of what it might entail, this pine table has developed into exactly the simple drop-in that is appropriate for our setting and Being Alongside's mission to walk alongside people. It doesn't offer crisis management or anything more than informal signposting if it comes up in conversation.

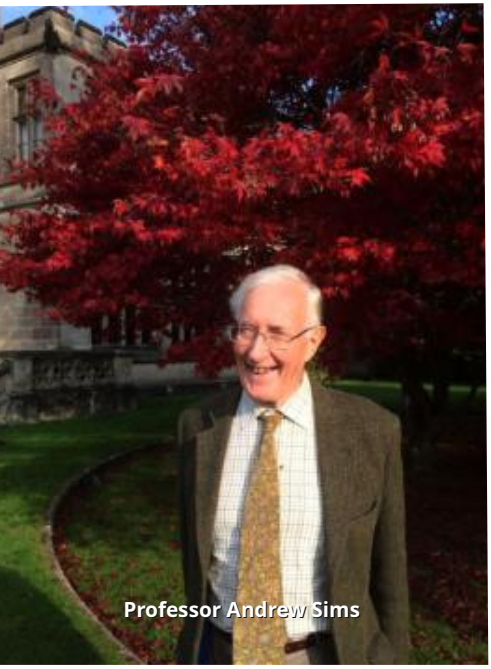
But as author Shauna Niequiest says: "The heart of hospitality is about creating space for someone to feel seen and heard and loved. It's about declaring your table a safe zone, a place of warmth and nourishment."

And this is how our table works as a hospitable space. For those of us who are driven by our faith, this is incarnational ministry; for others it takes a more secular, community perspective. Either way it is offering welcome and love to those in our community who often find themselves marginalised.

Said Jesus: "Truly I tell you, whatever you did for one of the least of these brothers and sisters of mine, you did for me." (Matthew 25:40)

Reflections on Andrew Sims

Jamie Summers reflects on a thought-provoking afternoon spent with our late patron


Professor Andrew Sims

I had the pleasure of meeting our late patron Professor Andrew Sims in April 2016 at his house in Shropshire. He and his wife Ruth, herself a psychiatrist and latterly also a vicar, kindly treated me to lunch in the local community hall which convenes several open drop-in sessions each week in addition to its café operations.

We together chatted about the issues of patients, psychiatrists and priests. Fortuitously enough there was one of each in the house! Perhaps we all have our roles to play in the current and future treatment of the distressed.

When I touched on my own painful personal experience of psychiatry in the early nineties, Andrew winced at hearing of the cocktail of neuroleptic drugs that came close to killing me at that time. And I learned that he too had tussled with Virginia Bottomley to little avail in his time as president of the Royal College of Psychiatrists (RCP) between 1990 to 1993.

Andrew was far from being an outsider in his profession. His 1988 book *Symptoms in the Mind: An Introduction to Descriptive Psychopathology* quickly become the standard text on the subject for trainee psychiatrists in the UK and many other countries. And of course one does not become president of the RCP without the support of many colleagues.

But what did set Andrew Sims apart from the majority of his profession was his faith. In 1993, at the end of his tenure as RCP president, 73% of psychiatrists reported no religious affiliation. One suspects even lower percentages of belief would manifest today in our increasingly secular

society. But many were and are still believers, and Andrew worked with some outstanding examples, including the late Dominic Beer, a leading light in the reform of psychiatric care at the turn of the century, and Andrew Powell, founding chair of the RCP's Spirituality and Psychiatry Special Interest Group.

A notable product of his collaboration with Andrew Powell, together with Chris Cook of Durham University's Department of Theology and Religion, was *Spirituality and Psychiatry*, a 2009 collection of essays which they co-edited exploring the nature of spirituality, its relationship to religion, and the reasons for its importance in clinical practice. Also in 2009 Andrew published *Is Faith Delusion? Why Religion is Good for your Health* (Bloomsbury) as a riposte to the Richard Dawkins hypothesis *The God Delusion*. He was kind enough to give me a signed copy of this when we met.

In *Is Faith Delusion?*, Andrew wrote somewhat critically of the recent history of his profession: "Psychiatrists have not increased the credibility of their speciality in the first three-quarters of the twentieth century by posing as the universal experts on the experience of life and how it should be led. Expert knowledge of the abnormal does not preclude ignorance of the normal and the psychiatrist can never generalise from the sample of people selectively referred to him to the whole of mankind. As we shall see, there has historically been an unnecessary conflict between psychiatry and religion."

He also offered a critique of the profession of journalism, pointing to its lack of interest in covering the findings of research in this area:

"The advantageous effect of religious belief and spirituality on mental and physical health is one of the best-kept secrets in psychiatry and medicine generally. If the findings of the huge volume of research on this topic had gone in the opposite direction and it had been found that religion damages your mental health, it would have been front-page news in every newspaper in the land.

"In the majority of studies, religious involvement is correlated with well-being, happiness and life satisfaction; hope and optimism; purpose and meaning in life; higher self-esteem; better adaptation to bereavement; greater social support and less loneliness; lower rates of depression and faster recovery from depression; lower rates of suicide and fewer positive attitudes to suicide; less anxiety; less psychosis and fewer psychotic tendencies; lower rates of alcohol and drug use and abuse; less delinquency and criminal activity; greater marital stability and satisfaction ... We concluded that for the vast majority of people the apparent benefits of

"We concluded that for the vast majority of people the apparent benefits of devout belief and practice probably outweigh the risks"

devout belief and practice probably outweigh the risks."

Another quote I treasure from *Is Faith Delusion?*: "The grace of God is for everyone ... the seriously distressed person with acute psychosis and the supposedly hopeless neurotic."

Andrew opined that the word 'delusion' in modern speech always implies the possibility of psychiatric illness but he stressed that the study of 'personal experience' is fundamental to psychiatry. Hear what the patient is saying and empathise with understanding. He referred to Leo Tolstoy's 1885 short story, *Where Love is, God is*, in which Tolstoy tells the tale of Martin, an old shoemaker living in extreme poverty, for whom everything had gone wrong throughout his life; in his despair, 'he began to complain of God'. He had always been a good man, 'but in his old age he began to think more about his soul and to draw nearer to God'. After reading the gospel, Martin hears in his sleep the voice of Jesus, telling him that He will visit him the next day. Martin lives in a basement and recognises the people passing his workshop by their boots, many of which he has repaired. The day after his dream, he is sitting by the window, looking up into the street rather than working. During that day he speaks with five people, on each occasion telling them of God's love. He gives hot, sweet tea to Stepánich, an old soldier who has not enough strength even for his casual job clearing away the snow. He feeds, warms, clothes and gives a little money to a young peasant woman with a crying baby, both of them dressed only in ragged summer clothes. He reconciles an angry old woman with a boy who had stolen an apple from her basket. The expected revelation of Jesus never comes ... Until the evening, when he hears footsteps and each one, Stepánich, the woman with the baby, the old woman and the boy, say, 'Martin, Martin, don't you know me? It is I' ... and steps into his room. After they have gone, Martin's soul grows glad. He reads the gospel again: 'I was hungry and you gave me something to eat, I was thirsty and you gave me something to drink, I was a stranger and you invited me in'. 'Truly I tell you, whatever you did for one of the least of these brothers and sisters of mine, you did for me'. (Matthew 25:35,40). Why Christians care for people in need is encapsulated in Tolstoy's story, the whole of which is a paraphrase of that gospel passage of Matthew.

"If the huge volume of research on this topic had found that religion damages your mental health, it would have been front-page news in every newspaper in the land."

Andrew Sims had the distinction of being quoted, in 1997, by the then Archbishop of Canterbury, George Carey, in an article for the British Journal of Psychiatry entitled *Towards wholeness: Transcending the barriers between religion and psychiatry*:

"As Andrew Sims commented in his Presidential valedictory lecture three years ago, when speaking of this task of the psychiatrist: 'One needs to know both about the shared assumptions of the religious group and the unique self-experience of the putatively disordered individual. In the past, talk about religion was a prominent symptom of many mentally ill people resulting in the notion of religious mania; too much religion, like genius, was thought to drive you mad. Both hypotheses are, of course, fallacious.'

"As I have already said, individual patients can gain greatly when there is close cooperation between psychiatry and religion in general, and psychiatrists and the clergy in particular."

Carey continued: "There are intellectual questions that still need to be debated. You may find that the Churches are in better shape these days to handle these issues without fear and insecurity getting in the way of serious dialogue. But while that debate is still going on, we can work from what we have in common for the good of those we seek to serve. We are united in our commitment to people, for their mental and spiritual health and for a mature and responsible society. I believe with all my heart that a healthy religion has much to offer to community, to the psychological security of individuals, and to the well-being of society as a whole. For me, faith is not the religious equivalent of a nuclear air-raid shelter but an invitation to a pilgrimage with a God who is always going before us and who is always surprising us with his ability to transform the bleakest moments in human history. Healthy, secure religion, which is open intellectually, has much to gain from closer contact with psychiatrists either as individuals or as a body of professionals. With temerity I suggest that you have something to gain from us too. Perhaps, deep down, we are all aware that those who make the best therapists, like those who make the best pastors, are people who are humble enough to acknowledge their own limitations; people who know that their interventions are beyond their capacity to understand fully and that their work, however successful, contributes only one element to a person's progress.

"A partnership is needed, and it needs to flourish. Andrew Sims concluded that lecture by saying: 'For too long psychiatry has avoided the spiritual realm, perhaps out of ignorance, for fear of trampling on patients' sensibilities. This is understandable, but psychiatrists have neglected it at their patients' peril. We need to evaluate the religious and spiritual experience of our patients in aetiology, diagnosis, prognosis and treatment.'"

Following Andrew's conclusion with his own, the Archbishop signed off: "It is my view that closer cooperation could make both Christianity and psychiatry far stronger as 'forces for the future'."

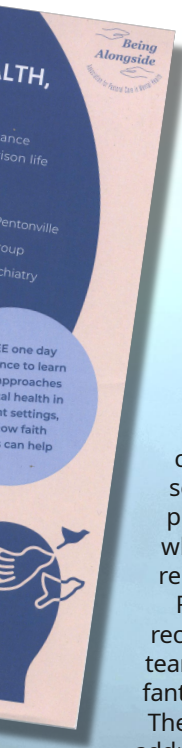
I believe it would be difficult to find a better example of such co-operation than the life and work of our late patron.

As I was leaving Andrew's house at the end of my visit, he said: "You know, I find myself grounded on these two great pillars of our society, the two institutions of the Church and psychiatry." I responded: "Choose the church". As if he needed telling.

Setting free

Photo of The Charterhouse by Dominic Alves. Licence: CC-BY

‘Setting Free’, our third conference since 2022, focused on the inter-related topics of addiction, prison life and mental health



More than 40 delegates gathered at The Charterhouse in central London to hear a range of expert guest speakers explore and explain topics surrounding incarceration, addiction to substances and harmful behaviours, and recovery.

Delegates heard from experienced psychiatrist Dr Paul McLaren about the current medical approach to major substance addictions—chief among them, alcohol dependency—and about recent updates to the international classification system produced by the World Health Organisation, which guides healthcare professionals in making diagnoses. We also heard about the remaining gaps in medical knowledge about the nature of addictions and their treatment.

Our second speaker, Tess, focused on the long standing work of Alcoholics Anonymous, introducing the audience to the 12 step programme and other founding principles of the movement’s approach.

In the afternoon, we heard from the Revd Jonathan Aitken and custodial manager Neil Fraser, two professionals working in the prison service, on their experience of mental health and neurodiversity among prisoners. Jonathan and Neil highlighted a project at HMP Pentonville which is actively seeking to better support inmates with autism and other related conditions.

Feedback from delegates suggested the conference was very well received. The trustees would again like to express their gratitude to the team at The Charterhouse for their hospitality in granting use of such fantastic facilities for the day.

The following pages present edited transcripts of the speakers’ addresses, which you can also listen to on our website.

Addiction: an overview

Priory Group psychiatrist **Dr Paul McLaren** opened with a medical view of the latest analysis and trends in the area of addictions

When I'm asked what I do as a psychiatrist, I usually say I do two things. One is keeping secrets, and the other is walking with people in hard places. So I like the phrase "being alongside". This is my first experience of the charity, but I'm impressed with what I've heard, and have no doubt of the value of the human connectedness that is so often lost with mental illness and addictions. I was asked to say something spiritual in my talk. That's not my *forte*, but it made me think about the spiritual element in what I do, which is particularly significant I think in the area of addictions. But first I will give you an overview, and a quick summary of some of the new issues we face in the addiction field.

As psychiatrists we struggle to pin down what we mean when we talk about a particular illness. The International Classification of Diseases (ICD) is a World Health Organisation enterprise to try and make psychiatric diagnosis reliable across cultures and across countries. It's just been revised, which is very exciting for us psychiatrists, because it distils and summarises our thinking, and the latest research in these areas. ICD 11 has simplified the addiction construct. Within it, the problems with addiction follow a common structure. I'm going to go through what the disorders are for alcohol, but you could substitute cocaine, opiates, cannabis, for that, and the criteria would be the same.

"Harmful pattern of use of alcohol" is the category in ICD11. It refers to a pattern of alcohol use that causes damage to a person's physical or mental health, or has resulted to behaviour leading to harm to the health of others. The pattern should be evident over at least 12 months. That doesn't mean that you couldn't have been drinking for less time than that, and not still have a problem. You clearly can. And if the use is continuous the minimum is a month. And harm to the individual occurs either through behaviour leading to intoxication, domestic violence for example; direct or secondary toxic effects of the substance, eg liver disease, brain disease; and a harmful route of administration.

ICD11 doesn't talk about "alcoholism", which is essentially a 12-step construct. Alcohol dependence from a medical point of view is now regarded as a disorder of regulation of alcohol use arising from repeated or continuous use of alcohol. The characteristic features are: impaired ability to control use; increasing priority given to use (so it starts to come before work,

before family, relationships, before your physical health); persistence of use despite harm (relationships breaking down, losing jobs, drink-driving convictions, but you're still drinking); and a subjective sense of urge or craving to use alcohol.

You may also have physiological features of dependence, but that's no longer given the priority. It doesn't mean that you have to have physical withdrawal symptoms. You may do. but it's recognised that these other psychological and behavioural processes are more important.

Moving on to some of the behavioural addictions that we encounter these days... there are those in the domain of sexual behaviour; there's shopping; there's gambling, which is a huge problem and getting bigger; video gaming; food; and then other problems that are on the borderline of addictive behaviour, such as self-harm, or compulsive and repeated plastic surgery.

In the domain of sexual compulsions, we have some recent data from a student clinic in London. The research was focussed on addiction, but about a quarter of students were presenting with problems with compulsive sexual behaviour—almost exclusively men had experience of exposure to pornography at a young age. ICD11 has a category for compulsive sexual behaviour, defined as a persistent pattern or failure to control intense repetitive sexual impulses or urges resulting in repetitive sexual behaviour and distress. That could lead to criminal behaviour, but more often it's the individual that suffers the harm.

There's an increasingly common phenomenon in metropolitan areas, particularly in London, Birminghma and Manchester, which is called chemsex. This is where compulsive sexual behaviour is combined with problematic drug use, particularly sedatives. People will advertise that they're available for sex encounters plus drugs, and will offer to bring drugs with them. The individuals are usually male, and usually homosexual but not always. The main drugs in use in the UK in this context are methamphetamine (crystal meth); GHB, GBL, which becomes GHB within the body, they they are intimately linked; and methodrone. In other parts of Europe it's more associated with use of ketamine, and novel psychiatric substances such as cannabinoids like Spice.

Gambling disorder is included as a separate condition within ICD11. It's defined as a pattern of resistant or recurring gambling behaviour, which can be either online or offline, and there are categories for both. It's manifested by impaired control; increasing priority given to it; continuation or escalation despite negative consequences; sufficient to cause significant impairment (personal, family, social, educational, occupational, or other important functioning); and it may be episodic or permanent.

"I have no doubt of the value of the human connectedness that is so often lost with mental illness and addictions"

So, some of the new drugs that we're encountering, particularly in London, and which you may encounter in your work, particularly if you're involved in the criminal justice system: methamphetamine, as glorified in Breaking Bad; GHB and GBL; and Spice. They each have their particular problems and negative consequences.

Crystal meth is white in colour as crystals. It's smoked, snorted and injected. When injected it's referred to as "slamming", and produces acute increased arousal, disinhibition, and difficulty sleeping. The harms that come from it are: agitation; persecuted delusions; auditory hallucinations; ultimately physical consequences including heart attacks and strokes; depression; and persistent psychosis. The acute psychotic reactions are severe, and will often end up with people being sectioned and treated against their will. The most severe psychosis I've seen has been methamphetamine-induced. It can be terrifying and extremely dangerous to the person suffering and to those around them. It's a very dangerous and destructive substance. It's attractive to the user because of the speed of onset and the intensity of it, but that's what creates the problems with it.

"The most severe psychosis I've seen has been methamphetamine-induced. It can be terrifying and extremely dangerous"

GHB (gamma-Hydroxybutyric acid) is a substance that works on the GABA systems in the brain that alcohol works on. It's like a very intense, concentated alcohol effect causing euphoria and disinhibition—hence its attractiveness in the chemsex context. So, it causes rapid disinhibition and an intense euphoria; and muscle relaxation, changing very quickly into sedation and coma. There's a very narrow dose range between where you get the high and where you get sedation, which makes it very dangerous. I have seen a number of senior professionals employed in the City of London who have ended up in intensive care repeatedly as a result of its use. It can lead to intensively severe physical dependence and withdrawal symptoms. There's an effect of intoxication that's described as "going under" that people crave and find attractive because of what it feels like just before you go unconscious. The toxicity can vary very widely in clinical severity. Effects can vary with the amount you ingest. The preparations are produced with different concentrations, and if you're used to taking one and then take a different one, it's very easy to overdo it.

Used together with other sedative drugs the effects can be unpredictable. They can rapidly lead to neurological, psychological and cardiovascular depression, which can be life-threatening. There's no antidote. So it's not like heroin where you have an antidote like naloxone which will reduce the effects immediately. You just have to offer support to breathing and to heart function while the effects of the drug on the body start to wane. It has high dependence potential associated with tolerance and withdrawal, and that can

lead to multiple doses a day being taken, and some heavily dependent people may have to dose every hour, keeping themselves topped up.

Those of you working in the criminal justice system will be aware and have a lot of exposure to spice, and I've certainly encountered it most frequently in patients who've been in prison. It's a synthetic cannabinoid, so it acts on the THC system, the active ingredient in cannabis. It's more powerful than THC. It's not a single substance, so it's different chemical structures that all have a similar effect. First identified in 2008, it's manufactured in China and exported to Europe, where it gets mixed with plant material, creating a substance like cannabis in appearance. The active ingredients are dissolved in methanol on the plant material which is then dried, packaged and sold either as an incense for burning or as smoking mixtures. By 2015, 40 different sub-families had been identified. The law lags behind the chemists as they construct different formulations. The particular formulation isn't critical, but it's about how much is dissolved and put onto the plant material. It's much higher potency than cannabis, and you can get a hit from a few milligrams. It can be overpowering, producing panic and inco-ordination. You may have seen videos of homeless men in New York staggering around the streets unable to walk properly. That's usually Spice intoxication. It can cause extreme numbness and loss of sensation, and then collapse. Continuous use can result in psychosis. Most reports of severe mental health and addiction problems and violence associated with it are in the prison system and the homeless. It's a dangerous, horrible substance that I think is becoming endemic in the prison system.

Thinking about how addiction behaviour interfaces with mental health, we think of it in terms of vicious circles. The Priory is associated with rehab services, and you'll hear more about those from Tess. But a lot of people come for help come not just because of their addiction, because they may be in a position where they've been active in addiction for a long time, but often because they've developed serious depressive symptoms or anxiety disorders. Some will have depression as a secondary effect of the substance they're taking. Depression and addiction are both common problems, so with a proportion of people it'll just be those two common things occurring together in the same person. When people go and do rehab and finish the 28 days, if they've come in with depression, probably about half of them will no longer be depressed, and you can work out retrospectively that their mood problem was secondary to their alcohol use or their cocaine use.

"For a high proportion of people what they need to do is abstain, and their anxiety symptoms will settle"

Similarly with anxiety—people get into a vicious circle if they have anxiety disorder, so if they have generalised anxiety or panic, then they self-

"The greatest challenge we face in the addiction world is still alcohol"

medicate with alcohol, and then the alcohol becomes a problem in its own right, and then they try and stop drinking and then anxiety gets high and then they continue drinking. So again it's important when one's trying to support people in coming off that you recognise that you may have to treat an underlying disorder. But for a high proportion of people what they need to do is abstain, and their anxiety symptoms and their disorder will settle.

Intoxication can as you know produce acute behavioural problems usually related to disinhibition, and that can lead to offending, violence, in a domestic setting and elsewhere, and sometimes intoxication, as we were saying, with Spice and methamphetamine, can lead to direct psychotic illness. That's not saying that it inevitably causes schizophrenia, but it can do, and heavy regular cannabis use can trigger schizophrenia in people who have a family history and a vulnerability.

The other presentation, particularly for chronic cannabis use, is amotivation and demotivation symptoms in young men. These are young men in their late teens or early 20s who should be out doing the sort of things that young men do. But they they're not. They're sitting in their room, staring at walls. The cannabis keeps them there and undermines any motivations they have.

And then there's the direct toxic effects of substances on the brain. The greatest challenge we face in the addiction world is still alcohol. Alcohol is poisonous. It kills off nerve cells, it will produce chronic organic brain syndrome, and it's one of the things that can lead to dementia, but before that it can produce many other serious physical complications.

I'll give just a couple of thoughts about spirituality, which I stress is not my forte. It's very clear from working in the addiction field that the impact of science and scientific knowledge is still very limited. You know, no one has developed a drug that cures alcoholism. Nor do I think we're going to. And in terms of treatment interventions, CBT [cognitive behavioural therapy] has revolutionised psychological treatment. It's evidence based, time limited, focused, very effective for depression—the treatment of choice. But in the field of addiction its impact is really very limited. And 12 step recovery is still the strongest intervention that we have. So rehab services, as you'll hear from Tess, are about giving people a strong introduction to 12 step principles that they will then be able to go out and use. The people who manage to effectively learn to live with alcoholism or other serious addictions are basically the people who learn to use 12 step recovery.

The other area that I guess touches on the spiritual is mindfulness, which is increasingly used within psychological treatment—particularly CBT. CBT is very effective. It teaches people how to deal with negative maladaptive self-defeating thinking patterns that pop up and make their lives more difficult. But it doesn't stop them popping up. So the impact of those thinking patterns can be less, but they're still there. Mindfulness is something that, added to the

sort of cognitive and the behavioural intervention, can help people to distances themselves from the noisy brain and the upsetting thoughts and feelings that are the core of mental illness.

The term mindfulness was first coined in 1881 by a British magistrate in Sri Lanka called Thomas Davids, as a translation of the Buddhist concept of Sati. Many years later Jon Kabat-Zinn, who was a physician at Massachusetts General, set up a stress clinic there. He was dealing with in-patients where he recognised that chronic pain becomes primarily a psychological problem, even when people have bones crushing nerves and critical processes that are leading to pain. The longer pain goes on, the more important psychological processes associated with it become. Kabat-Zinn set up a mindfulness based stress reduction programme, and then in 1991 he published a book called *Full Catastrophe Living*, which was adopted very quickly by the medical community and also by the psychologists who were developing CBT at the time, and incorporated it. The key elements are paying attention to something in the moment on purpose and with open curiosity. That's essentially what it means. And it's been fairly widely incorporated into CBT practice.

So, to summarise addiction... There's so much we don't know, and science has had only a limited impact. The more I learn from my patients, the more important one sees that relationship and connectedness are in terms of supporting people and helping them move forward. We recognise also from psychotherapy research that whether you are doing CBT or psychodynamic therapy or client-centred therapy, probably the most important factor in terms of outcome is the quality of the therapeutic relationship—the connection you have. Among therapists, there are people who will connect. Whether they're using CBT or they're standing on their head in the corner of the room, they will make a connection with the patient that has therapeutic impact. And if you don't have that, you can be brilliant with technology and understand all the theory, but the likelihood is that your intervention will be limited.

Certainly with addiction the most effective interventions are the people-based ones. Tess will say more about 12 step I'm sure *[see p24]*. Smart Recovery is a secular version. The idea that some people avoid AA because it's a sort of God thing, a religion thing that they don't pine for. So Smart Recovery was established in 1994 in the USA as a secular way of trying to distill the behavioural and practical aspects of AA into a group peer support structure, and now operates around the world. People have found it helpful, although it hasn't had the depth and the very long tradition of AA. In terms of long term outcomes I think its impact still remains to be seen.

"Probably the most important factor in terms of outcome is the quality of the therapeutic relationship - the connection you have"

The amazing fellowship

Tess told us how AA enables her to be a better person, and what rehab owes to AA

My name is Tess, and for the last 20 years, I have been working as an addictions counsellor. I think of myself as an alcoholic, but actually I haven't had a drink now for over 25 years, and I owe my sobriety to the interaction which I've had with the fellowship we call Alcoholics Anonymous.

I'd like to talk to you a little bit about how attending meetings of Alcoholics Anonymous can be helpful to somebody who's got an alcohol problem. And also how rehab using the tools and philosophy of AA can help. The same tools and the same philosophy also apply to the other addictions that Dr McLaren has mentioned. So even though I may talk about alcohol, the same may hold true whether you're facing an addiction to other drugs which might be cannabis, cocaine, heroin or crystal meth. And it also can help people with behavioural addictions of the type which have been mentioned.

In AA I met the most amazing set of people, and those people wanted to help s upport me in not drinking. They introduced me to some suggestions which would specifically help me not drink, but also some of the suggestions were a pro gram of living, and that's where the spiritual element comes in with AA. It's not just about not drinking. It's like when you play Monopoly... when you first get yo ur car or your hat and you put yourself in that slot that says Go,
well that's the equivalent of putting down a drink. the rest of my journey for the last 25
years in AA has had nothing to do with alcohol. I don't care about alcohol. But I c ontinue to to AA after all these years probably for the same reason some people might go to a fellowship that is a church. Because there's something that happe ns to me as a human being when I go to that fellowship that makes happier to b e me, because it makes me a better version of me, and I li
ke being the better version
of me. I'm aware that if I let go of that fellowship, I may well drift back into being the individual that I used to be. that individual wasn't a terrible person, but she was a bit self-centred an
d a bit blinkered towards how other people felt about what I did and how I beha ved. I couldn't see
it. everything was from the absorbed situation. so my going to this fellowship ha s been about this spiritual journey.

Only some of the suggestions that are made in AA are to do with how to stay

off alcohol. The remaining ones are about how adjust my attitude and how to allow me to live a more spiritual, more dignified, better life, for other people and for myself. so they are guides towards a more spiritual way of being.

And these suggestions completely transformed how I saw myself and my behaviour, and how I impacted others. since being exposed to these insights into how I behaved and how I affected others I continued the practice of observing myself, and I try to catch myself before I become spiteful, or over-reactive.

I didn't become a saint! You might see me swear when I bump my toe, or get irritated with somebody because my coffee was served cold. It still happens. But I have become motivated to become the best version of myself. Luckily in AA they reassure us by saying "it's progress, not perfection".

So what motivated me to keep going to these strange meetings? Well, when I went to my first ever meeting, I found to my surprise that I liked people there. And they seemed to quite like me back. They were welcoming and astonishingly friendly and easy-going. And they were very contrary to my expectations. You think "alcoholic" and imagine somebody sitting on a park bench who smells seriously bad, at least in part because they have wet themselves, right? I was expecting to see people who looked dirty and unkempt and shuffly. And actually the opposite true. I was struck by the dignity of the crowd of people that I met and their professionalism. If I showed you an AA meeting, there is nothing that you would be able to see that's different from the group of people sitting in front of me today.

I was relieved to find that people were talking in a relaxed way about stuff that they had done which was similar to stuff that I may have done and that I had shame about. Some of that stuff may have been something fairly lightweight about the way that I had spoken in public and that I made a fool of myself, or came across as unpleasant. Some of the things were a little bit more sensitive. But either way there were people in that room that talked openly about areas of their shame and distress that made me go, OK, they've done worse, or even *much* worse than me, and they were comfortable admitting what they had done, so I became less ashamed of what I had done. I thought, if this AA weirdo business works for them, and they've done worse things than me, then in theory it should work for me.

After a couple of days of their encouragement I no longer was feeling quite so sick about how embarrassing or unpleasant I had been when I was drinking. I started to feel slightly relieved about that self-loathing. As time passed I started feeling a growing sense of pride. I started counting the days. I've had two weeks without a drink now! In actual fact I wasn't a daily drinker. My pattern was more of binge drinking. I wouldn't drink for a week or two and then I would have a bit

of a blowout. I was more of a dancing on tables kind of person rather than drinking on my own behind net curtains. Two weeks became three weeks, and that was a bit more unusual for me. Then when I got to a month I felt I was doing quite well. So I started feeling good about counting my days. And then I started seeing new people coming into the room, people that were newer than the one month I had been sober for, so they might have had a drink that morning. They're known as newcomers. And I found myself offering them encouragement. you look as if you might like a cup of tea. Do you want to sit over here. Are you new? Just basically making them feel less self-conscious and less uncomfortable. A lot of them would say I'm not sure if I'm an alcoholic but I thought I'd come and listen. And we'd say oh that's great, you don't have to be an alcoholic to come here. Just come along and see what you think.

So I gave them encouragement, and they showed that they were grateful to me for doing that, and they would sit next to me. And then after a while they would ask me questions, so I told them about what had happened to me, and how it was going for me after a month. And they were expressing their gratitude to me, and congratulating me about how I was getting on! I felt OK before, having been a month sober, but now I felt even better, because to my surprise people were seeing me as their role model! So my self-esteem was growing.

I got helped by talking to other people. They encouraged me to talk to the newcomers, which I did, and then I encouraged those newcomers to talk to newer people as well. And so I see AA as sort of being this grand pyramic scheme. It is! You pass it on. But it's got nothing to do with money. It's just about love. I was given love and encouragement and I was able to pass on that love and encouragement.

So the AA programme is more about connection than alcohol. It's about the connection with yourself. You come to stop hating yourself, you start seeing the good in yourself and start realising that the behaviours you got engaged in aren't representative of who you really are. And you start connecting with the world, with other people. You gain a sense of belonging and a sense of purpose and meaning.

So, how do we use the 12-step programme in a rehab? How do treatment centres tap into the clever stuff of AA? Well at the place where I work we look at the first three steps, and even rehabs that don't link themselves to 12 steps actually use the same principles. They just change the language, but it's the same thing. Every rehab or treatment centre is going to provide a safe, encouraging social environment for a group of alcoholic addicts together—people at the same level—to explore how their drinking caused them problems. And thus they gain insight from sharing with their peers. Very different from just sharing with a single counsellor in a one-to-one situation, because there you've got a disparity in power. The alcoholic may not open up fully to their therapist. Or they may and not open up with their peers. But either way, it's not the same thing as opening up to somebody on the same level, and getting reinforcement from the other person opening up about their shame. And they become able to admit how messy and disastrous their life had become. Recognising and

admitting unmanagability, that's step 1. And they explore how their belief that "I should be strong enough to stop on my own" just doesn't work. Again, this is step 1. And the rehabs encourage them to support each other and allow themselves to be supported and guided. Rehabs discourage isolating behaviour, and encourage them to reach out to each other. That's steps 2 and 3.

In our centre we introduce people to the physical fellowship of AA at the first opportunity. They go to meetings in person. They are encouarged to speak to people they see there, to exchange phone numbers, to make friends. We also let them know about online meetings because they can use those at time when they're sick or they just can't make it somewhere.

So, what is actually happening? What is the therapeutic explanation? How does it work? People imagine that AA is somehow so spiritual that there's no science behind it, that no real therapy happens in AA. Well actually it does. In therapeutic language what happens in an AA meeting, and in rehabs, is this:

shame reduction;
installation of hope;
practice of human interaction;
connection at depth;
receiving social support;
reinforcement of abstinence goals;
identifying triggers and vulnerabilities;
learning tools for abstinence when triggered or tempted;
learning tools to deal with low frustration tolerance;
a structure provided that is conducive to living an abstinent life;
gaining a sense of purpose in life;
guidance for rebuilding relationships;
gaining insight of one's behaviour, for continued better relationships;
trauma resolution;
understanding of cross-addiction;
creating new neural pathways by repeat actions—a new response to triggers, which extinguishes the automatic addiction response;
learning gratitude as a psychological tool;
non-violent communication;
recognising your authentic self;
dealing with failure and disappointment;
commitment to self care;
altruistic living;
discerning between appropriate and inappropriate responses to perceived insults; and
motivation to be a productive member of society.

This is what we do in our rehab facility, and this is what happens in all 12-step fellowships. There are other 12-step fellowships. It's not just AA. There's also Narcotics Anonymous, Cocaine Anonymous, Gamblers Anonymous, Marijuana Anonymous, Sex and Love Addicts Anonymous, Debtors Anonymous, Crystal

From prisoner to prison chaplain

Revd Jonathan Aitken, a chaplain at HMP Pentonville, talked about what he has learned since he became the first cabinet minister since Tudor times to be jailed

I have no medical qualifications. But I have on the other hand had a ringside seat on the prison world and a particular focus on prison mental health for over two decades. Some of the seats haven't been very comfortable, the first of which was of course being a prisoner myself.

When I arrived at the gates of HMP Belmarsh in handcuffs I did not have the slightest idea that there were any mental health problems in prisons, until I was tapped on the shoulder within the hour by a prison officer who said: "Aitken, your turn to see the prison psychiatrist." The psychiatrist asked a number of standard questions, and then asked: "Does anyone other than your next of kin know you are in prison." Recalling all the TV news satellite dishes outside I responded: "I dare say, yes, about ten million do!" He then scribbled something into his form, looked up at me and asked: "Have you ever suffered from delusions?" Well, that was the comedy...

When I first arrived in prison I was bumping around, getting on with the sort of regime that HMP Eton had trained me for. And then I had an enormous stroke of luck. A young prisoner asked me to write a letter for him, to help him not be evicted from his council flat in Lambeth. Having done eviction cases for 25 years as a back-bench MP in my constituency I knew exactly what to write, and he did succeed in his appeal. Anyway, having written the letter, this chap announced to the rest of the wing: "Hey guys, this MP geezer of ours, he's got fantastic joined-up writing!" And this very effective advertisement fell on the ears of a very receptive audience, because so many people in prison can't read or write. Lo and behold, I had a queue of people every night of my sentence wanting letters read and written for them. As a result my social circle

Revd Jonathan Aitken addressing our 'Setting Free' conference

expanded beyond the horizons of my imagination, I got to know this community really very well indeed.

A few things stood out to me. The first was just how many of these people had spent at least part of their youth in care, and so some had never had someone who can say "Well done son" or "I love you." I was really stunned by the coldness of the upbringing of so many. Second, I saw there was quite a lot of talent around. There were bright people who had gone wrong for one reason or another, and so many of them had potential.

The third thing was that for one reason or another, so many were just ordinary people who were somehow out of kilter. And if you started to dig into their family backgrounds, a lot of them had had trauma early on in their lives, and seen things like their mothers raped or knife fights in the kitchen, and this had traumatised them.

When I was moved to Standford Hill prison, I had a cellmate whose name was Mickey Aguda, who alas has died now. He became a tremendous friend, and remained so even after we both came out of prison. Mickey was autistic, and if you had asked me before I went to prison what is autism I wouldn't have had a clue. With Mickey I got to know what being autistic meant, and I got quite skilful at stopping him losing his temper when his toothpaste ran out or something. I just said "borrow mine". If you spend any time with autistic people you soon realise how suddenly a quite normal event can blow up into something quite wild and even dangerous.

Two other incidents come to my memory, to illustrate the variety of mental distress I came across. One was a man who said he recognised me from all the movies I did. I thought it was maybe because he remembered seeing me in news bulletins and so on, but no, it turned out he thought I was General Custer. Yes, he was absolutely delusional. Another was when I was going into the showers, and there was a man there with tremendous scars all over him, pretty recent ones. He told me not to worry about them, because he did them to himself. I asked why. He said: "Usually I have this medication that stops me wanting to cut myself. But then when I feel good, I throw the medication away." And this happened quite often.

I saw many similar scenes on that wing. So you can see that I was getting interested in the whole issue of mental health in prisons, which is bigger than I had ever imagined possible. After leaving prison, I took a new career change in my life, and went to the one institution that had worse food and more uncomfortable beds than prison. This was an Anglican theological college called Wycliffe where I spent three happy years. The one thing of which I was totally certain at the end, having got a degree in theology, was that I was totally unsuitable to enter the church. Well, as you can see, things change.

They took a long time to change, actually, but finally it seemed to be that I should be a prison chaplain. I had been going in and out of prisons as a volunteer, both here and in America. and the chaplaincy was always over-stretched. I thought about that, and then thought no this isn't for me. I'm too old. I'm past it, and would be no good at it. But then somebody said: "You should read what the cricket player C. T. Studd wrote."

Studd played for England in the 1882 match with Australia at The Oval which was the origin of The Ashes. He was a national hero like Stokes, and he was a Christian. And he is attributed with this verse to explain his later decision to become a missionary in China, India and Africa: "Some want to live within the sound of church or chapel bell; I want to run a rescue shop within a yard of hell." As soon as I read that, I thought yes, maybe I could be a prison chaplain.

It is really ministry at the sharp end. Everything going wrong. Fascinating challenges every day. And although the spiritual side is enormously important, I would always keep in mind a saying quoted in a song by Johnny Cash: "Don't be so heavenly minded that you're no earthly use." You've got to solve a lot of practical problems. And one class of problems in Pentonville, as everywhere, is mental health problems. As a very old prison, Pentonville is one of the grottiest in terms of its infrastructure. But it's strangely one of the most imaginative prisons right now in terms of being willing to try to do new good things, in mental health and otherwise. We have an abstinence wing, and a programme for young gangland people, very well run. But what CM Neil Fraser and I have come here to tell you about today is the neurodiverse unit (NDU) wing that was set up last year. Over to you, Neil...

The calmer landing

Custodial Manager **Neil Fraser** introduced us to the innovative Neurodiverse Unit at HMP Pentonville

I'm the custodial manager of the Care and Supervision Unit (CSU) and the new Neurodiverse Unit (NDU) we call G1 at Pentonville. The CSU is made up of 14 cells of all the prisoners who cause trouble and violence, get caught with phones and that kind of thing. They get adjudicated on, sometimes with the involvement of the police, and all the serious cases go there.

An overview of Pentonville.... It's a 180-year-old Victorian prison. It's got six-foot thick walls all the way round. The infrastructure is appalling. The electrics, the plumbing, all showing its age. So it's really difficult to put new things in place. We're an inner london cat-B local, meaning that we receive prisoners from the north-east london courts. Capacity of 1300, with about 1200 currently in occupation. About 50% are from ethnic minorities, 25% are foreign nationals, 69% are unsentenced, 27% are

CM Neil Fraser

under 25, only 40% have accommodation on release, 55% have drugs issues, and 75% have mental health issues.

The NDU was born out of the need to try and look after prisoners who have the likes of autism, attention deficit hyperactivity disorder, learning difficulties, learning disabilities, that kind of thing, who struggle on the main wing. The governor, Ian Blakeman and managing chaplain Jo Davies had the idea to set this up. The idea was to take people with these conditions off the main wing and put them in an environment where they can get more support.

What people say about the NDU

Neil then showed delegates a presentation about the NDU, explaining the features which set it apart from the other areas of the prison, including a higher staffing ratio, giving officers more time to spend with people; special activities such as social communication and occupational therapy; a physical environment that's designed to reduce anxiety, including plain walls to avoid visual clutter, and noise absorption panels and ear plugs; and even visits from therapy dogs. The presentation included interviews with prison staff, volunteers and prisoners themselves. Here are a few excerpts from some of those...

"It's so good to come down to a landing where you have time, to talk, to deal with people's issues, to deal with their problems, so you're not going home at the end of the day thinking about all the things you didn't have time to do. It's so much nicer as an environment when you can help people and get stuff done."

"I think the most significant difference for me was that I felt that my mental health was taken a bit more seriously. I felt like before on the other wing things got brushed under the carpet a bit more."

"Everybody has a chance to do some sort of activity, job, education, which usually on a bigger wing way less guys would be able to take part."

"On the other wing I used to get in a lot of fights, causing trouble. I honestly feel like on G1 I'm more calm now, more positive, less negative. no fights and stuff like that, and working with the staff properly. That's about it. It's been a perfect experience so far."

"On the main wing I'd probably know their name, whether they are waiting for a visit or not, but not much more than that. On the NDU I can tell you people's family members' names, I can tell you who likes the taste of spaghetti but not the texture of it, whose door I should knock on three times before going in because otherwise they would have sensory overload if you just burst into their cell. Things like that. I know them in a completely different way, because we have the time to care about them and support them. It's a different ball game down here."

"A lot of them only see dogs when their cells are being searched. For some prisoners the visit by a therapy dog is the highlight of their week. Also when Dobbie's running around being petted and fed crisps, you are able to come and sit with some of the quieter ones and listen to them."

Listening

You are not listening to me when…
You do not care about me;
You say you understand
before you know me well enough;
You have an answer for my problem
before I've finished telling you what my problem is;
You cut me off before I've finished speaking;
You finish my sentences for me;
You find me boring and don't tell me;
You feel critical of my vocabulary, grammar or accent;
You are dying to tell me something;
You tell me about your experience,
making mine seem unimportant;
You refuse my thanks
by saying you really haven't done anything.

You are listening to me when…
You come into my world and let me be me;
You really try to understand me
even if I'm not making much sense;
You grasp my point of view
even when it's against your own convictions;
You realise that the hour I took from you
has left you a bit tired and drained;
You allow me the dignity of making my own decisions
even if you think they might be wrong;
You do not take any problem from me,
but allow me to deal with it in my own way;
You do not offer me religious solace
when you sense I am not ready for it;
You accept my gift of gratitude by telling me
how it makes you feel to know you have been helpful.

Image by Sebastiaan ter Burg. Licence: CC-BY-NC

You can find this text with slight variations doing the rounds on many mental health-related websites, but its origin is obscure. This isn't the first time we've printed it, apparently. Frieda Wilson got in touch to say she found these words neatly clipped from some unknown publication in her late father's possessions. The text ended with "Reprinted, with permission, from the newsletter of the Association of [sic] Pastoral Care in Mental Health." Anyone know who actually wrote it? (Ed.)