

# Mental Health Chaplaincy in Cambridgeshire

*promoting spiritual health, recovery and well being*



**DON'T  
MISS  
THIS  
FILM!**



The Devil and Daniel Johnston is an astonishingly accomplished journey through 20+ years in the life of the American singer, songwriter, and artist (he draws all the time) in the title. It is by no means certain that he will survive the torment in his head; for in there is a wickedly poisonous concoction, made up of the Christian fundamentalism of his childhood and teenage years, the temptations of Satan, his longing and need to BE someone, and to have his love for his obsession (a woman called Laura, who married someone else) requited. He is sectioned a number of times, for his own safety, and that of others. In one incident he frightened an older lady so much that she jumped from a first floor window, breaking both her ankles. He was, he claimed, driving her demons out; and anyway, it was the demons that pushed her. Especially moving is the sequence in which his father recalls a time he was flying Daniel home following a concert when he grabbed the ignition key and threw it out of the plane. Then, grabbing the controls, took it into a spin. Dad prevented a stall and landed in high trees, just as he'd trained to do. Daniel found the whole thing thrilling. On his way to hospital, the ambulance passed a church: on its poster board was the following (I paraphrase): "The Journey with God is a bumpy one, but the landing will be calm."

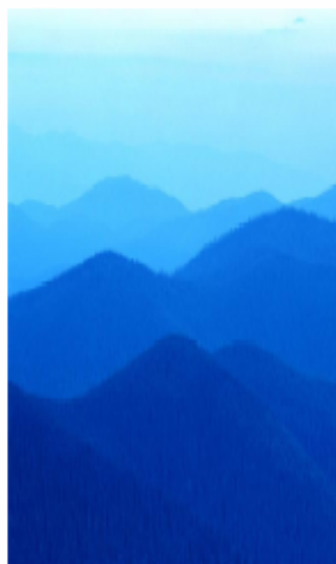
What I appreciated about this film was its eloquence and raw honesty. Daniel Johnston is a tormented soul, but the love and care he receives from those closest to him is clearly very deep and has forgiven him many things many times over. It IS a story of recovery, but it is not pretty. It IS a story of hope, but there are no smooth edges and neat endings. What balance there is in his life is precarious and precious. Left to his own devices, and without medication and a load of other important, helpful factors -especially love - Johnston may already be dead; or alive, yet gone forever.

*The film is available on DVD (I've got a copy too, if you want to borrow it).*

**John Nicholson**

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## Coping With Coming Off...



... psychiatric drugs

**FREE day workshop in  
CAMBRIDGE  
22nd March 2007**

**The Meadows  
Community Centre  
1 St Catharine's Road  
Cambridge CB4 3XJ**

- A day to raise awareness of the possibility of coming off psychiatric drugs within the context of recovery
- A day to promote confidence for people thinking of coming off psychiatric drugs and their prescribers

**Cambridge Women and  
Homelessness Group  
1 Corona Road, Cambridge,  
CB4 3EE  
Phone: 01223 369125**

**Email:  
corona\_house@yahoo.co.uk**

### PRESENTATION

JIM READ will present the findings of the research undertaken by Mind into the experiences of people trying to come off psychiatric drugs.

### GUEST SPEAKER

RUFUS MAY will discuss what professionals need to know in order to support people coming off psychiatric drugs.

### PANEL

Individuals describing their own experiences of coming off a variety of psychiatric drugs

### WORKSHOPS

A key part of the day will be facilitated small groups providing an opportunity for discussion and reflection.

### The Chaplaincy Team

*Here for you*

We offer the human touch and a personal presence. We take a non-clinical, confidential, non-judgemental approach, and are here for you, whether you have a religious faith or not.

### Who we are

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## Newsletter 4

### *A different view*

*A letter from TONY MADEN, PROFESSOR OF FORENSIC PSYCHIATRY, IMPERIAL COLLEGE LONDON in The Independent, 18.01.07*

*Sir: In The Big Question (9 January), you ask whether inquiries into killings by the mentally ill support law reform and answer in the negative, based on the Barrett inquiry.*

*John Barrett was exceptional because, at the time of the killing, he was subject to mandatory supervision, but the report said of his earlier violence that the only way of securing compliance would have been a community treatment order and that such an order would probably have been effective (page 211).*

*Numerous homicide inquiries over the last 20 years have called for the introduction of a community treatment order. Many inquiries also conclude that homicides are a consequence of poor treatment, and the most damaging myth perpetrated by the Mental Health Alliance is that risk management and optimum treatment are in opposition.*

*In truth, good treatment is safe treatment for patient and public alike. Fifty homicides each year by the mentally ill is too high a figure; similar collateral damage associated with any other form of medical treatment is unthinkable.*

*We should welcome reasonable and proportionate measures that will make it easier for services to offer good treatment.*

## Risk, violence & treatment by force

*As the Government is proposing to improve public safety through increasing the scope of compulsory powers and bringing people into compulsion even if they do not gain any therapeutic benefit from it, we wanted to explore the assumptions behind the legislation. So, here are the views of the Mental Health Alliance, and [below left] a somewhat different slant from Tony Maden.*

There is a widespread perception amongst the general public that mental ill-health, particularly in its most severe forms such as schizophrenia, is linked to violence, and that it is a rising problem, caused by the introduction of 'care in the community' and 'loopholes' in the current Mental Health Act.

**None of these assumptions is supported by the facts.** The facts are: • In 2002/03, the latest Home Office figures show, there were 873 homicides in England and Wales. Of these, less than 4% (i.e. about 35) involved suspects with a mental illness. • The number of homicides by a person with a mental illness has stayed constant for many decades: the number has not risen since community care began in earnest in the early 1990s. • Mental illness is not a predictor of violence although for the small percentage with psychotic illness there is a modest increase in levels of violence. Being young, male and of low social status are far more important factors than psychotic illness.

**The inquiries that take place into each homicide by a person with a mental illness show consistent results. They frequently find that tragedies happen when:**

- Services communicate poorly with one another;
- Community service provision is inadequate or early intervention does not occur
- Overstretched professionals fail to heed warnings from patients or their families;
- Care planning is poor or not implemented properly;
- The Mental Health Act is misinterpreted by practitioners (i.e. the law is not inadequate; it is just inadequately used).

**This approach is based on the wrong model** – on the basis of individual tragedies rather than a public health model. The belief that it is possible to predict who, out of a population of people with a history or violence, will commit a violent offence is false.

**Safety, in relation to mental health services, is primarily achieved by:**

- Increasing the number of better trained staff and more beds, particularly at medium security.
- Making the wards much more therapeutic with less violence, and activities other than smoking available for patients.
- Much more research into the aetiology of mental disorders and their treatment, and into risk assessment. It is worth noting that 50% of 'sections' are to detain patients who initially agreed to informal admission to hospital.

**Mental Health Alliance briefing**

<http://www.mentalhealthalliance.org.uk/aboutus/index.html>

*The Mental Health Alliance is a coalition of 78 organisations [user groups, psychiatrists, social workers, nurses, psychologists, lawyers, voluntary associations, religious groups, research bodies, and carers' associations] working together to secure better, fair and workable mental health legislation.*

**To contact Chaplaincy: ☎01223 218598**