Reading Time: 31 minutes

Some people by this point must think that I have some weird obsession with Black Country Healthcare Foundation Trust. Like I enjoy complaining about them or something. Truth is, I only complain because of the quality of care I and others receive in terms of their acute mental health wards, and so much of it is hidden out of sight and out of mind, that it can be hard for real life stories to come out.

I actually have two new posts in the works; one is a deep dive into mental health funding in the UK, and how there needs to be a greater link between general hospitals and mental health inpatient services through ICBs, and the other will change the way you listen to my favourite Linkin Park album forever. Now I'm (almost) settled in to my new, permanent flat, I'm also getting ready to finally edit and upload the rest of season 1 of Breaking Down, Breaking Down, and getting ready with some ideas for season 2. Alas, I have to instead recap the events of the past week in relation to a friend.

Before I go any further:

- I want to make it clear that my gripes and complaints with Black Country Healthcare Foundation Trust (BCHFT) are based solely on their mental health services. I've been a recent user of their Adult Autism & ADHD services (AAA), and despite them cancelling an appointment on me, they've been fantastic. I've not used any of their other services nor know anyone who's shared their experiences with me, so it's solely mental heath services here, even though I will just shorthand BCHFT
- Because of the fact that the person involved is still an inpatient in an acute mental health ward in the BCHFT catchment area, I shall simply refer to them as a patient, and won't reveal any other information about them, including the exact hospital / ward they are on. Any misplaced reference to gender should be ignored, and I have referred to the patient as they throughout. If anyone from BCHFT wants to chase this up with me further, you know how to contact me by now.

Out of Hours Crisis Service

Our journey begins with the out of hours crisis service, which BCHFT maintain across their sites. If you call 111 (The NHS non emergency number) and select option 2, and confirm a few things via button pressing, you should end up talking to a duty nurse / healthcare professional. This however isn't always the case, and in the three times my friend tried the 111 option, we ended up either in a re-direct loop, voicemail, or call end situation. Each local authority in the Black Country has it's own out of hours crisis number which you can find if you can find a way of navigating the *horrific* website BCHFT use, or if you're lucky enough to have been provided it by a previous crisis call, CPN or whatever.

The purpose of a crisis service is as the name implies, to provide immediate support where possible to a patient in a mental health crisis, and provide signposting to services where possible. As an example, there is an out of hours, in person talking therapy service in Central Dudley, and there's options in some cases to arrange Home Treatment / other services where possible and practical. However if a patient is at risk of harm to themselves / others, the advice ***should be to call 999.***

This wasn't the case for my friend. Between 111 Option 2 and contacting their crisis number directly, he was just told to wait till the morning and play the GP lottery game by trying to get an appointment at 8AM in the morning. I've played the GP lottery game many a time, and trust me, especially on a Monday morning, you'd literally have better odds of winning something on a scratch card than getting through to a human being before 8:20AM if you called exactly at 08:08:00. Though they have a CPN, contact was sparse to them from the CPN, and in fact was due to be discharged from them. Regardless, the patient had no way of contacting their CPN; they could only do so through the Primary Care mental health team. That means waiting until at least 9AM, then a call back either from a duty nurse or if lucky, their CPN.

My friend had suicidal thoughts, caused by a mixture of fear of their living environment, and compounding voices in their head which they felt were trying to control them. They reached out to me as we had met previously in a mental health setting, and maintained contact as many people who meet in such settings do. In fact, I talk to more people who I've met in hospitals (General / Mental Health focussed) than I do anyone else many days of the week. I say in the same way that it only takes two people to have an informal AA / NA / etc meeting, it only takes two people who know each other to talk about their mental health. I encouraged my friend to come to my (still partial DIY site) flat, and we went out to get food, and have a good ol' chat.

I was more than happy for my friend to crash the night, then help them with their GP / CPN / Weekday crisis team the following morning. I didn't feel at risk of harm towards me, but I was becoming increasingly worried about the risk of harm to my friend, caused by themselves. There was a clear plan of action in their head, which became clearer when they started to look at the cost of Ubers to the place where they wanted to take their own life. Knowing mental health as I do, there becomes a point where the risk factors become too high, and having been told ***again*** by the crisis team to wait until morning (Without even doing a new assessment, or understanding the fact that I said that their health was becoming worse, and there was a clear risk of suicide), then the night nurse taking more than 45 minutes to even attempt to call back, I made the call and called 999.

Emergency Services & RHH ED.

My reasons for this were simple. This was a life threatening emergency, because there was a risk of death by my friend's mental health overwhelming them. Whilst there have been doctors who have told me to my face that if I wanted to really kill myself, there's nothing I can do to stop them, I disagree with the principle of letting them go 'and have a go'. The same way that tackling a small fire in your house can become something which necessitates the fire brigade, there comes a time when as someone who is both *cognis mentis,* and actually worried about my friend's wellbeing that I had to make the call. Were they happy that I did? Not really, but I know that the other options were worse:

1. If my friend decided to try and carry out their plan, I would have a civic duty to call the police. If found under the circumstances that they were attempting, they would likely have been placed under a Section 136, and taken to a 'place of safety'. This can be in a mental health ward, but not always.
2. If the police were not able to find them on time, there was a strong and real chance that the next time their family would see them is in a body bag, in a mortuary, or bits of body collated into a pile of sorts.

Depending on how life threatening an emergency is, you could be waiting minutes or hours for an ambulance. I was shocked that I was still on the phone to the call handler when the ambulance arrived. My entire call from calling 999 to paramedics being at my front door was less than 8 minutes. The paramedics were exceptional, and the complete opposite to the people on the crisis line. Despite not wanting to say much themselves, my friend allowed me to tell the story as I best understood it at the time, and the paramedics listened, emphasised, and engaged with my friend with kindness and most importantly **DIGNITY.** This is something which is so often missed when dealing with patients in a mental health crisis, and although it took some encouragement, eventually we were in the back of an ambulance, taking another trip to Russells Hall Hospital.

I've been in Russells Hall Hospital so many times that I can almost walk it blindfolded. I certainly know how to walk to the secret vending machines away from the Emergency Department when I was not in a fit state at all, and I can tell you not only where the Amazon Locker is, but where the outside gym and clothes donation bin is. If Squid Game 3 took place in Russells Hall Hospital, and I was a contestant, I would have survived, no issues. Being a frequent flyer at the hospital also means that I not only know the staff, but I know who to talk to when I need an update / chase someone up.

Unfortunately, someone had messed something up in triage, and rather than pinging the on call mental health team, we were forced to wait in a very busy, and very hot waiting room. It was only an hour in that after checking with the FOH triage nurse that this was noticed, but immediately she was on the phone, and quickly we were moved to a quieter area, something that I requested with the paramedics, but whom often have their hands tied. The hospital is undergoing an extension to build a new Resus unit, so a lot of the old 'quiet' spaces had gone. Even better, one of my favourite HCSWs was working the shift, and not only looked after my friend, but also provided me with my normal amount of hospital tea (A LOT). Most importantly here though, an error was identified, and it was resolved with efficiency and with an honest apology. Because in physical terms my friend was Medically Fit (MFD, MoFD etc), he didn't need to have observations, meaning he could have just spent a lifetime in the waiting room.

We Make Up Rules As We Go Along

Despite Bushey Fields and Russells Hall Hospitals being next to each other and directly accessible from one another, they are two distinct hospitals, under two different NHS trusts. *Techically*, the Matrons have no control over the conduct of the mental health staff that come to assess patients. I know this to be true, because I had to ask due to what happened at 3AM, then 10AM the following day.

In Russells Hall Hospital, you are always entitled to a chaperone. When having MDT meetings as an inpatient in a mental health ward, you are allowed to have a chaperone, or if under a Section under the Mental Health Act, an advocate. If you're in an Emergency Department at Russells Hall hospital and the duty nurse / doctor comes to see you however, 'We want to talk to to the patient alone, then we'll talk to you'. This is despite the fact that my friend wanted me to do the bulk of the explaining because he sometimes has difficulty articulating things themselves, and also because he has trust issues with BCHFT due to poor previous care, and wanted someone to be with them in case they fobbed them off.

Ironically, fobbed them off is what they almost did. I hate to say this, but the lucky dip I mentioned about getting a GP appointment, this is only amplified when it comes to mental health nurse assessments in Russells Hall's Emergency Department, especially at night. I have had the experience of having an assessment by the same nurse as my friend did, and though I can't say for certain, the doctor that was with her looked strikingly similar to the lead consultant for Bushey Fields Hospital. In the same way that the crisis team wanted to pass the problem on to another day and another set of staff, this is pretty much what the duo tried doing in talking to my friend, suggesting home treatment / moving forward an outpatient appointment. Throughout, they seemingly decided to ignore the immediacy of the situation, and the fact that frankly, had my friend be discharged, I'd be waiting for Birmingham Mail to report on some 'tragic situation' the following day.

Perhaps more frustratingly, that 'Then we'll talk to you' bit? Didn't happen. They saw me, walked past me, and disappeared into the night. I had to track down the aforementioned HCSW and nurse to work out what the next plan of action was, and in effect, what decision was made. Eventually (Things get blurry after time, but it was before 6AM), my friend was moved to a specific room that's used for non violent patients whilst awaiting another assessment by the day team. The only reason why I know that it was pre 6AM is that I was on Greggs Sausage Roll and cigarette duty by this time, as my friend was allowed out for a cigarette so long as I was with them, but not allowed off hospital grounds for slightly obvious reasons. I'm certain that there should have been a CSW / Nurse doing 1 – 1 observations with them all the time, but when I'm not a patient but a 'friend' of a patient, I think the staff trust me enough not to fuck about, or allow the patient to do so. I had to go for a telephone meeting with my employer (Of sorts), and there was a CSW parked outside his door whenever I wasn't there.

Instead of two, it was a trio of mental health staff who came later on in the morning. Again, chaperoning wasn't allowed for the same stupid reasoning, but what gets me is why they don't ask the patient alone if they wanted a chaperone / anyone to sit in on the conversation. Surely this must be a right, especially as my friend wasn't under a section, and therefore had no deprivation of liberties (DOL). I can understand that there can be times when a patient can talk more freely outside of the grasp of their friends or especially family, but openness in communication works in multiple directions. Sometimes a friend can be a comfort blanket, helpfully filling in the gaps or providing a clearer context to what a patient is trying and sometimes struggling to get across. I know for certain that if I needed someone else in the room I'd be kicking off until this happened, though alas because it's a different hospital, trust and circumstances, the rules are neither made clear, or just made up as they go along.

Waiting For A Bed

There's a time when being in ED as a physical and mental health patient has some form of similarities. It's that arduous process of waiting for a bed. For physical health patients, this normally involves s journey through the Acute Medical Units (AMU), then either onto a general / specialist ward as needs and bed spaces require. For a mental health patient however, it's awaiting a bed at one of the mental health hospitals in your 'local area'. For BCHFT, this could be in Dudley, Wolverhampton, West Bromwich / Walsall. There is often an assumption that if you go to say Russells Hall Hospital, you'd be moved to Bushey Fields hospital as it's next door, but this isn't always the case. In most cases, you'll be placed where a bed becomes available, which can create a disparity in terms of wait

times for men and women, as there are significantly less female wards than male in the Black Country.

I know of patients who have had to wait in the same room as a friend for a week or more. The room doesn't have a bed as such. It's a sofa like chair with an extension so you can lay down, but it's certainly not comfortable. I have seen occasions where there's been a bed moved in there, because frankly, if you're mental health is shit, the last thing you need is a cocktail of pain and insomnia to add to your list of conditions. The beeping alone is enough to drive someone up the wall over time. I was lucky the last time I was admitted into Bushey Fields Hospital, where I was moved to AMU where things are *slightly* more comfortable. I don't know if this is because of a shortage of beds in ED, if I wasn't fully MoFD (You can't be moved to a mental health ward until medically fit from a physical perspective), or if it's because the staff in ED were sick and tired of me. Who knows.

One of the issues being sat in ED for so long is that your food options are… Limited. Due to the fact that most people in ED are there for a short period of time, perhaps because visitors are allowed 24/7, and also perhaps there's not even enough space for those horrible hospital table like things, full meals aren't provided. It's soup, dry sandwiches, chips, or jacket potatoes most of the time. I learned whilst at the QE hospital that if you're in ED for more than 24 hours, then you can get a voucher to go to the on site restaurant, which is something I would suggest to Russells, even though the main hot food area's opening hours are bordering on part time at best.

In total, I was with my friend for 24 hours in ED and the like. The nurses and CSWs were great, and kept me as informed as possible. It's ironic though that within 15 minutes of me leaving to get the last bus back home, my friend was moved to a mental health hospital, which as mentioned at the top, the name of which I'm not disclosing at this time. It doesn't matter if you're going next door or across the Black Country (Or as was the case for me from London twice), you get bundled into transport for your and others' safety. I had actually gone back the following morning with Greggs and soft drinks in hand to find out that they'd been moved. This was where communication and patient care started to break down.

Inside A Mental Health Ward

Moving from ward to ward in a general hospital can be a bit of a pain, especially if like has happened to me so many times, this happens at 2AM. You have to complete forms, remember what possessions you have on you, get your observations done (again), and so on. This however is nothing compared to the arrivals process on a mental health ward.

This is one of those times that the less you have on you in terms of possessions, the better. That's because any bags that you have with you will be taken to a nurses office, and *eventually*, someone will find time to go through it all with you. That's of course after you get told what room you're in, and given a key to it. Even though there's a bed waiting for you, sometimes this process can take hours, leaving you to either sit in the communal area, smoke yourself into an early grave, or be like Stephen A. Smith and play another game of solitaire as you've got nothing better to do. Just remember that you're not allowed a lighter, so every time you want to smoke, you have to find a Healthcare Assistant (HCA), or nurse with a lighter to enable you to give up 5 minutes of your life to a cancer stick.

Why you go from having CSWs to HCAs by literally going out of a back door between Russells Hall Hospital and Bushey Fields Hospital is beyond me. The role is essentially the same, but this is more on Russells Hall being Russells Hall in this particular instance, as most hospitals I've been to refer to HCAs as... HCAs. One of the only advantages of having several mental health hospitals in the Black Country is that they have the same job roles, procedures and policies, or at least on paper. For example, on one ward at Bushey Fields Hospital, you're allowed to have charging cables below 15cm in length. Same at Dorothy Patterson Hospital. But on another ward at Bushey Fields Hospital, no chargers allowed outside of a secure locker room. I've tried asking for explanations as to why, but no answer. No one knows, because rules are seemingly made up at random.

I talk a lot about onboarding in the letter which I'm currently half way through writing for BCHFT, which got moved back on my priority list due to a move, being in hospital with my diabetes, then another move. I'll post it in due time, but the onboarding process isn't exactly welcoming. So often patients are in a state of limbo as set out above, and if (Like happened to my friend) you get moved just after meal time, your only option for food is any snacks you brought with you, or stale cereal and touched up bread for toast. You can't just go to bed even if you do get your room key, as you're waiting for a duty doctor to come and see you which could be at any time day / night, and your medication? Well you can't have that until you've seen the doctor, even though you'd likely leave the general hospital with TTOs which you literally could have taken in the car / ambulance or before you enter the ward. The funniest thing here is that most mental health medication comes with a warning not to stop it without first consulting a doctor, but if you miss your medication time being stuck in limbo, you're going to miss at least one day of said meds, which pausing may make a patient even worse.

All being well, let's assume that all of this happens on the same day; you see the duty doctor, you get your bedroom allocation, and the HCAs document what belongings you have. What next? This is where one big disparity lies between the nurses who see you in a general hospital, and the reality of being in a mental health hospital. If you have been sectioned under the Mental Health act, it's largely a given; you're not leaving the ward any time soon, unless you are granted Section 17 leave, which normally is long enough only to get you to the nearest shop and back. If however you are a 'voluntary' or 'informal' patient, you are, in theory allowed to leave the ward at any time, though the nurses & HCAs must ensure that you are fit and well enough to do so. The process for BCHFT is known as the '5 C's', though no one I've ever spoken to knows what the 5 C's actually are, only what they have to check, which includes:

- What clothing you're wearing
- Where you are going
- When you plan to return
- What to do in an emergency
- How to contact the ward if needed.

I fully appreciate that you can't just let a voluntary / informal patient off the ward just because they ask, however the thing that's missed out often is that between your duty Doctor review and your MDT (Multi-Discipline Team) meeting which could be up to a week away, most wards and nurses won't let you off of a ward, because 'You've not been fully assessed yet'. This means that if you turned up with just the clothes on your back, unless you had a relative come and see you, you had no change of

clothing, no snacks, no cigarettes / vapes, nothing. On some wards some staff do ‘shop runs’, but this is literally to the closest shop (Which is normally an off-license), and depending on who’s working that day, you can either give them your bank card to pay by contactless, or you can, if lucky toddle on down to said shop with them.

Even after your first MDT meeting, it can still be a game of roulette to see if you will actually be allowed off of the ward, and in what capacity. One ward I’ve been on actively encourages patients to leave the ward in pairs / small groups. Another actively ***DISCOURAGES*** this, under the guise that it will promote more risky behaviour such as drinking, taking drugs etc. The issue here though is that the policies seem to be blanket, rather than tailored to patients, which either leads to patients not wanting to go out if they have to do so alone, or have to use partially deceptive practices in order to have a friend / other patient meet them by going out one at a time.

I was talking with my friend yesterday about something that they like to refer to as ‘support in the community’ within BCHFT. This is in short making a case that a patient is better off in the community, and that a wider range of support can be provided there. Being on an acute mental health ward however can open a patient’s eyes to some aspects of community living that may prove to be a partial trigger, as has been the case for both my friend and I over the years. Something such as going to the local shop, or going to buy groceries, or grabbing a coffee may *seem* trivial, but can cause a wide range of triggers. There are medications which can help with panic attacks / social anxiety situations, but how can you know if they work in real life scenarios unless you actually place yourself in them? To this end, when I was an inpatient at Bushey Fields hospital in both 2023 and 2024, I always put forward a 5 point scenario as to how ‘safe’ I felt leaving the ward, and how I was if § mitigating my own potential triggers:

1. I felt comfortable being alone off the ward, either due to a pre-defined activity / feeling safe within myself.
2. I would feel comfortable off the ward if I were to be with another patient, or was meeting someone else (a visitor), to go off the ward with. This would provide me an avenue for immediate support if I were to have a turn for the worse either physically / mentally.
3. I would only feel safe / comfortable off the ward if I were to be with a staff member, for a specific, pre-defined activity, such as going to the local shop / chip shop. I would want to be within close proximity to the ward in the event that I were to have a panic / anxiety attack.
4. I would not feel safe going off of the ward, and would actively communicate this to staff, so that I would not make an excuse to go off the ward to potentially cause harm to myself.
5. I did not feel safe in myself at all, and would try and remain in a public space on the ward such as the smoking area so I can be observed without adding to the number of patients on enhanced observations.

Whilst my friend *should* be allowed off of the ward as an informal patient following his MDT meeting, there could be a chance that the doctor deems them to be too high risk to do so alone, which is something which as a non professional but advocate and friend, I’m inclined to agree with. However without considering option 2, the only ‘off ward time’ my friend would have would be limited to the

same shop, the same times, every day it was possible for a staff member to accompany them. This is where it's so important to listen not just to what a patient says in relation to their immediate health, but also about how socio-environmental circumstances impact them, their behaviour and mental health.

As an informal patient, there are Occupational Therapists on wards, who do activities 5 days a week. These can be mundane, but provide *something* to do that doesn't involve watching yet another episode of Homes Under The Hammer, Bargain Hunt, Tipping Point / The Chase. There's no activities at weekends, however to make up for it perhaps, patients are allowed to order takeout on weekends. There are hot meals provided twice a day (Which I used to refer to as slopp o'clock), but aside from that, it's the stale cereal and heavily handled bread in a communal kitchen. The bread is the one which caused me the biggest issue, as patients with no money but a nicotine habit would partake in something known as 'nubbing', where they would go and pick up partially finished cigarettes to get re-lit, or deconstruct to make into a new cigarette. Same people however often would fail to understand the fact they are picking things off of the ground, then touching fresh food items, and would forget that washing hands would help a lot in reducing contamination.

They're Fine, They're Not Fine, Etc.

One of my biggest griped with mental health hospitals is how closed off the observation / notes systems are. I had to complete a Freedom of Information (FOI) request to even get my discharge summaries, and my notes and observations were bundled into this. If I were to be reviewing and agreeing them in real time, I would have had a major issue, as so many of them were frankly either copy / pasted or just full of shit. There was a chilling article on BBC news last week about how a patient had apparently eaten breakfast 4 days after committing suicide on a mental health ward in North East London, and frankly, I feel some of the observations done by BCHFT's HCAs are about as accurate accurate. Especially when there are agency staff on shift, sometimes they just ask 'What room number are you', as even though they have iPads, there's no patient photos on there!

In the time between seeing my friend in ED at Russells Hall, and visiting them on the mental health ward, I constantly tried to get a clear update and understanding of his situation, care plan and state of play. Although I'm neither a parent nor a relative, I was asked if I could be their emergency contact due to ongoing family issues around his mental health which ironically makes his situation worse, not better (The phrases 'man up' and 'just deal with these issues' came up at least 4 times in his conversation with them whilst in ED). Rather than being able to get a clear answer, what I received was generic bullshit, with the nurses getting angry with either me / them when I called to alert them to the fact that their suicidal tendencies / paranoia was getting worse.

The first time I called , I was just told 'They are fine, they've been on the ward, visible', etc. Great. That means nothing if you're not actually talking to the patient. The only way to get slopp o'clock food, get your daily set of observations done, receive your medication and have a cigarette is to be on the ward, so all of this means little to nout. When I called the ward following a conversation with my friend when they said that they were feeling worse and that they didn't think that anyone was listening to them, the nurses simply said there's nothing they can do until their MDT, which is utter bullshit, as there is always a duty doctor on call in case of a crisis.

More annoyingly, after I called the ward after my friend had called me saying that they felt suicidal and just wanted to end it all, their attitude was both blasé and frankly rude. I mentioned that it may be a good idea to move them up on the observation scale, to which the response was 'We're monitoring them and if we need to we will do so'. It's worth noting that the scales for observations are generally as follows:

1. L1: Observations once an hour. If in your room, the staff will just open the privacy glass on your bedroom door, check you're *alive*, and carry on. Most patients are on L1 observation, especially after seeing the duty doctor for the first time, unless they are at risk of harm to themselves or others.
2. L2: Observations once every 15 minutes. This is because a patient is deemed to be of higher risk, and therefore needs to be observed more closely, but does not need constant 1 – 1 support. Patients are on L2 observations until seeing a duty doctor for the first time.
3. L3: A staff member has to be within eyesight of a patient at all times, and if in their bedroom, a member of staff is to sit outside the room, normally with the door open. Patients on L3 and above are deemed to be of significant risk of harm to themselves / others.
4. L4: As above, but with one member of staff within reach, and one within eyesight. There are higher levels, however this is for the most severe cases of patients in need of observation, support, or potential restraint.

The nurses on duty at this time did not seem to understand the fact that although my friend would make attempts to speak to HCAs and nurses, if they didn't feel as though they were being taken seriously, they would stop talking to them, and contact me instead. This should have been in their care plan from the outset, as it was what was discussed with paramedics and ED staff, however it wasn't passed on. Perhaps if the mental health nurses and doctors at Russells Hall had spoken to me, this could have been articulated and then included as something to follow up on.

Visiting Times & Care Plan

Visiting a patient in a mental health hospital is not the same as in a general hospital. You can't wait until 11AM, stroll in and sit with the patient until 8PM, bringing in whatever you like. You have to make an appointment, and in some cases you can only have a 1 hour slot, in case there are too many people on the ward. That's not an issue with me at all, and makes total sense. If a fight or incident were to occur, there needs to be a staff – patient & visitor ratio that keeps everyone safe. What is an issue is when you call to make a visiting time slot, be given a time, then be told a day later that you can't visit until an hour later.

To be fair, there are a number of little bits of laminated paper outside the ward's 2nd entrance which sets out the visiting times. I would check on the website, however the website page with welcome information and the like hasn't been updated in years. BCHFT, if you need someone to help with this, just let me know. This meant having to spend over an hour not getting stabbed whilst walking around a derelict town centre. These days everything either seems to be a charity shop, a vape shop, or a bookies. It did however mean that I got to speak to the Nurse in Charge (NIC), where I asked some basic information about my friend's care which I knew they hadn't received, such as:

- Their named nurse & HCA. They should meet these at least once a week, as this feeds into the weekly MDT to provide a more complete context of the patients' wellbeing outside of BS observations.
- Their care plan, which I told was done and just need to be printed, which then was being typed up, by which it was being copy and pasted from another document. This happens all the time it seems.
- Their consultant and MDT day & time (The latter if possible; things change). The MDT given to me on my visit was one day, then another day was mentioned to the patient a few days later.
- The medication they are on, and new medication added. Nurses had apparently just said 'here are your pills', without explaining what they were, what new medication was added to the drug chart, and what PRN medication was available.

This isn't designed to deliberately catch anyone out. This should be done as a priority once a patient is on a ward, but not in this case it seems. Even when speaking to one of the nurses to get this information once I was on the ward with my friend, there were constant back and forth to find out key information, and the sheet of paper which I had written this on along with key points to include in a care plan was taken to the office, and never returned to my friend, making much of the exercise futile except for the fact that I took a photo and sent it to my friend. I don't know what it is about patients and data in BCHFT mental health hospitals, but even trying to access information about your care is a nightmare. And in this circumstance, not only in my friend paranoid that something bad is going to happen to them, the constant back and forth, not being fully listened to, and being treated with disdain when I'm having to speak to the nurses to alert them of their 'in play' state of mind isn't in my opinion conducive to recovery. This is exactly the same as what happens often in the community, and why according to their CPN they are 'fine'. Of course, the NIC avoided me like I had bubonic plague, I'm assuming because of the fact that they knew that I knew that the patient's care wasn't being looked at efficiently.

The front page of the care plan raised a concern, in terms of the Next of Kin (NOK). My friend made it clear in ED, and when being admitted onto the ward that they did not want any contact with their parents, and for no information about the care being provided to be relayed to them. Yet the NOK on the care plan still showed their mother, which was not updated in line with the patients' wishes. This ironically has happened to me in the past where my ex wife was included as my NOK, whom was then contacted whilst I was in an MDT as they 'couldn't find me'. Even though I explicitly stated no contact with her. This isn't just a cock up, it's a massive data protection & GDPR breach, which shouldn't be happening at all. All information about NOKs, whom can be contacted / allowed to book visits etc should be discussed and confirmed with a patient, not just 'rolled over', as I'm certain there's a data protection policy which explicitly forbids this.

In a funny twist of irony, either because of the notes I took and passed to the nurses, or perhaps because I simply foresaw how things would be with my friend, a number of the comments I made have now actually been actioned. Being on L2 observations compared to L1 isn't an inconvenience to my friend, unless it's 1AM and the HCA turns the room light on from the outside and forget to turn it back off. They've been allowed to do the glorious walk to the local shop for cigarettes. Whilst they've not yet (at time of writing) met their named nurse, they have had multiple meetings with HCAs which has led to both of the above, and unless someone changes their mind whilst I'm in an Uber, they will

be allowed a chaperone for their MDT on Tuesday. I've already made it clear to my friend that they now owe me a Starbucks!

Conclusions

Remember that phrase 'Too many cooks spoil the broth'? There's a bit of it here. In effect, there are five different teams in play here, whom either are unable to transfer data between themselves due to being in different trusts with different systems, or because it's not seen as a priority, despite being central to patient care.

Whilst my friend is struggling with his mental health, the man on the Clapham Omnibus would agree that they have enough capacity to be a contributor to their care. Yet you can't do that when you have no idea what your care plan is, until your friend / mental health advocate volunteer / bona-fide arsehole calls up and asks where the hell it is. HCAs & Nurses won't know how to best engage with a patient unless they are provided with information about suggested strategies and actually action it. To be fair and clear here, I'm not saying that the nurses are doing a bad job specifically here, but lectures and seminars only teach so much. It's once you've walked a mile or hundred in someone else's shoes that you can tell the difference between idle ranting and a serious situation. I would never have called 999 unless I thought at that time my friend was at risk to themselves, and wouldn't have spent *x* hours in A&E unless I truly believed they needed help.

I've seen patients frankly abuse the system in the past, and I know that there is a massive shortage of mental health beds nationwide, not just in BCHFT. I know that discharge planning and community support will be on my bingo card for the MDT, however consultants need to be aware of the perils of early discharge; both from the potential of risk to life, and what I call the revolving door syndrome, which costs the NHS even more money by having to repeat the process. I can say hand on heart that I never walked out of a BCHFT mental health ward with a full set of medication and a discharge summary. In fact in one case I was kicked out so quickly I couldn't retrieve my Nintendo Switch on time (Which is likely now in a Cash Converters), or my glucose sensors, which were still in a cupboard in the medication room 3 months later.

My friend isn't sectioned, yet the nurses have seemingly treated them as he was on a number of occasions, and this starts by ignoring or not taking seriously their current state of mind. I explained it frankly and clearly that this could change in a matter of minutes, and whilst they may be OK say at mealtimes, could change over the course of a cigarette due to the compounding voices they have in their head. The easiest way to explain this is like having EUPD / BPD on steroids, yet the 'euphoric highs' that some with such conditions face is being 'normal', and the lows are a very dark, very dangerous place for themselves. This is why I'm glad that they either finally listened to me or came to their own conclusions that they should be on L2 observations, and the fact that HCAs are spending more time talking to them to actually understand how things are in more detail. Frankly, if that 999 call didn't happen, there's a good chance that my friend would have been sectioned, first under a S136 to a place of safety, and likely under a Section 2, but the fact that despite delays, waits, poor information transfer and the feeling that they were being investigated like they were going to 'trip up', they clearly both need and **WANT** help, which is perhaps the most important thing.

I was throwing up copious amounts of gunk the day I was supposed to meet BCHFT's team to discuss

some of my prior concerns. Though I won't name the patient directly, this is yet another example of poor care in a mental health setting within BCHFT, and it shows a pattern of poor direct patient care which can't just be fixed with refurbishments, more FT staff and the like. It requires an entire culture shift to place the patient at the heart of their care setting, through listening and engaging, providing practical and meaningful advice and support to provide a thought out return to community, and an appropriate package of care which is more than a tick box exercise *(Even though the patients CPN didn't even do a PHQ-9 Questionnaire or similar before wanting to discharge the patient out of their care, amounting to less than a tick box exercise?)*. In any sense, just because a patient is on a mental health ward doesn't mean that they should be treated differently to others. Patients still have needs, feelings, fears and in most cases a desire to get better. That can only be achieved through honest and meaningful engagement.

I'm certain that this won't be the last time that I rant about BCHFT's mental health services, but for now, it's back to your regularly scheduled programming.

Peace, Rage And Love xx

