

CHAPTER ONE

Introduction

Overview

Topics in this section

- **How to use this Workbook**
- **Introduction to the Whole Life Approach**
- **Seeing Differently, Thinking Differently: Study Tours**
- **Mental Health as a Community Issue: Monaghan Mental Health**

Aim

Firstly, this chapter provides a detailed overview on how to use this workbook.

Following this is a history on how the Whole Life Programme came to be developed. The underpinning philosophies of the Whole Life Approach are also explained. Examples of multiple creative ways of working within mental health are explored by discussing innovative practices that are being used in many different mental health sites across Europe. Obstacles to using these new ways of working in England are raised, as are discussions around possible solutions.

Learning outcomes

By reading this section and completing the activities included you will begin to understand the following points:

- The main principles of the Whole Life approach.
- How and why it is important to create new mental health practices that consider the individual in the context of their Whole Life.
- How to examine our perspective on mental health and people with mental health problems.
- The perspective behind the Whole Life Approach motto: 'Change the thinking, change the practice, change the system'.
- Innovative ways of working with people who are experiencing mental ill health.

Introduction to the Whole Life Approach

by Tanya Kennard-Campbell

It is important to establish that there is a difference between the Whole Life Programme and the Whole Life Approach that underpins it.

The Whole Life Programme refers to a group of 11 localities who have signed up to the overall Whole Life vision and base of values. Historically, these sites and values have been supported by a range of study tours to different sites within Europe. These study tours have provided mental health workers the opportunity to see progressive ways of working in action. This, in turn, has stimulated alternative ways of viewing service delivery and has enabled the teams from the various sites to reflect on how thinking differently about the services we provide can significantly affect the client outcomes.

The overall aim of the Programme is to develop a strong network of sites that provides the opportunity to put the Whole Life Approach into practice. There are five specific principles that the programme advocates which are applicable across all care services as follows:

- a) A Whole Life Vision Ensuring that local mental health systems are united by a clear, meaningful, well-articulated vision based on a set of shared values.
- b) Putting Whole Life Values into practice Utilising these values and principles at every level and by all stakeholders involved in the planning, delivery and use of services.
- c) Whole Life Service Development Development of truly local

service models and systems that support practitioners to have the flexibility and creativity to apply these values in their day-to-day practice, for the benefit of the individuals that they work with.

- d) A Whole Life, Whole Person Approach Adopting a person-centred, individualised approach that enables practitioners to engage with an individual and to develop a partnership that facilitates the restoration of hope, optimism and 'Recovery'.
- e) A Whole Life, Whole Systems Approach An approach that ensures that local services actively promote the use of mainstream community resources in responding to the needs of individual service users and their families, and become much more integrated with the wider local community.

Each site takes on Whole Life in its own individual way. For some sites this has been the whole Trust signing up to the Whole Life Vision, while for others it has ranged from focusing on Recovery-based practice to developing truly integrated whole system community working. Through adopting the Whole Life Approach, it has become apparent that by changing the thinking about mental illness and about the people who experience it, leads naturally to changes in practice and systems.

The programme has also worked in partnership with a broad range of other national and international agencies, including The Sainsbury Centre for Mental Health, The King's

Fund, The London School of Economics and The Royal College of Psychiatrists Research Unit.

What has emerged are examples of 'what helps' in an individual's Whole Life journey and the role of services in supporting this journey. Good practice and examples of excellence have been communicated between sites through the exchange visits, stock-take events and the Whole Life Bulletin and Website.

The Whole Life Programme is supported by the Whole Life Approach which has developed a range of resources in order to share more widely the vision and value base. This includes the workbook, DVD, bulletin, website, CD/Well-being resource, leaflets and posters.

For further information about the sites and their contact details, please visit:

www.wholelife.org.uk

What informs the Whole Life Approach?

The Whole Life Approach has been informed by stories and experiences about 'what helps' as recounted by those who have lived with the personal experience of mental illness/distress and by those who support them. The Approach has also been influenced by examples set by colleagues around the world who have successfully shown how 'thinking differently' about mental health and people in the context of the whole of the rest of their lives can greatly effect their recovery.

Having reflected on the stories about what helps, both clinically and personally, we have used the underpinning principles inherent in these stories to inform the Whole Life Approach. This is reflected in the Whole Life logo which is about putting the individual's experience at the centre of everything we do.



We have also drawn on the lessons and truth learnt from historical approaches. Historically, mental health services have been formed around what is considered to be *clinically effective* in a person's recovery.

However, from a Whole Life Approach we take the perspective of prioritising what is *individually effective* in a person's recovery. To achieve this we need to be mindful of the individual's values, experiences, current frameworks and their stated individual needs. Often, this can be difficult to achieve for professionals and services who are used to working in more traditional ways that are generally based on the assumption that clinicians and services know what is best. The Whole Life Programme has discovered that, when talking about personal recovery, the most effective strategy is to enable the individual to find their own solutions, which requires creative and flexible support from carers, mental health workers and services.

Values underpinning the Whole Life Approach

The Whole Life Approach advocates a range of values that are found in the underpinning approaches of social inclusion, recovery, spirituality, choice, user and carer involvement, principle based approaches, the arts, equality, well-being, self-management, new ways of working, anti-stigma and anti-discrimination.

By drawing on these sets of values, we continue to see a range of practices and approaches that can help in maintaining or reclaiming a Whole Life. By putting the person's experience at the centre, as the driver for change, it provides a means of expanding on what helps in one's recovery and well-being.

Many of these values will be expanded upon in the following chapters on Recovery, Social Inclusion and Well-being. However, the key principles underpinning the Whole Life approach are:

- Putting the person at the centre.
- Considering the person in the context of their Whole Life.
- Change the thinking, change the practice, change the system.
- A strengths focus.

Putting the person at the centre

Listening to stories of what helps the individual puts the person at the centre of everything that we do. This involves allowing the person's needs to lead service delivery, rather than the other way around. It also involves ensuring that the individual's values, culture, spiritual needs and goals are considered on an individual basis.

Equality has not been addressed specifically in this work book as there is a risk of applying generalised approaches based on gender, ethnicity, ability, sexual orientation or faith. Issues of equality are addressed on a personal and individual basis, as it is clear that issues relating to equality differ dramatically for each individual. It is easy to get distracted by a need to understand equality in all its diversity and thereby missing the individual in the process.

England has become a culturally diverse country with many new perspectives now available to us, and we cannot expect to truly understand in depth the diversity that now surrounds us. However, by remaining curious about the things influencing people's lives and the current resources they draw from, we are more likely to gain insight into people's worlds and begin to see how we can support people within the context of their whole lives.

This workbook includes many different perspectives about 'what helps' and what makes a difference in people's lives, from spirituality and ordinary

When we take the time to explore what the individual finds of benefit, we can begin to see how we best support them

everyday things that affect well-being, to stories of those who are living Recovery. These contributions offer insights into how we can begin the process of making people's experiences and needs at the centre of our care for them.

When we take the time to really explore what the individual finds of benefit, in the context of the whole of their lives, we can then really begin to see how we can best support them and can focus on what is currently of most importance to them.

CONSIDERING THE PERSON IN THE CONTEXT OF THEIR WHOLE LIFE...

Time and readiness

As we will see in the Recovery chapter and in 'change the thinking', acceptance is an important factor in Recovery, and it is important to be mindful of the individual's readiness to acknowledge what is happening to them, to support their needs and to be aware of the impact this has on their lives.

There is a need to acknowledge time and readiness in the context of someone's own process or journey, and it is important not to rush people as for some this can be a life long process.

An important focus of the

Whole Life Approach is to help people retain their place in their whole lives. Historically, services have removed people from their regular chosen life styles. If we seriously want to avoid segregating people, then we need to offer people support and services as close to those that everybody else would use irrespective of whether they have a mental health problem or not, rather than designing specialist support and services on the assumption that they will need particular specialist handling because they have a mental health problem.

There are times when it is clear that specialist expert intervention is necessary, but it is the role of services to ensure that this type of intervention does not disrupt people's place in their communities. In the past, provision of specialist expert services has lead to people drifting further and further away from their communities, and losing more and more confidence in being able to manage in the ordinary world.

Although it is essential to provide services that retain people's place in their communities, we are left with the legacy of services and systems that have drastically affected people's ability to develop and sustain meaningful relationships with their communities. It is important to acknowledge the responsibility we have in ensuring sensitive ways of supporting such individuals to reclaim their chosen roles within society, rather than having groups of disenfranchised and segregated individuals who are defined by their mental illness.

This involves services being honest about their roles and responsibilities in supporting people with mental health difficulties, and to no longer offer or provide services that create over-dependency.

For many complex reasons, current mental health services are often hard to access and sometimes even harder to leave. Entry into the service is based on an assessment of need, the criteria for access being for the person to be experiencing severe mental illness or to be at risk to self or others. This process is often traumatic for service users and tests their own

meaning of their experiences against rigid

To provide effective support, it is important to provide flexible and creative services that walk with people on their journey and move in and out of their lives as their needs develop

medically orientated criteria, which often does not fit with the individual's perceptions. Discharge from services is again based on an external judgement of need (clinical recovery), often based on perceived symptom elimination or stabilisation.

Considering the difficulties of entry into services, it is perhaps of little surprise that the concept of discharge can be a troublesome one for many.

Many individuals have remained users of secondary mental health services for many years, often with long periods of 'token' contact, based on the anxiety that, due to the 'nature of their illness', they may well experience a 'relapse' and require more assertive input in the future.

In order to provide effective support in the context of people's whole lives, it is important to provide flexible and creative services that walk with people on their journey and move in and out of their lives as their needs change and develop.

Change the thinking, change the practice, change the system

The Whole Life Approach believes that changing the thinking of individuals will lead naturally to changes in practice (behaviour) and a change in the system.

As we learn more about what makes a difference in people's lives and as people's needs change, it is inevitable that services need to change and develop to meet the needs of its 'customers'. There are already a number of initiatives intended to effect system change - and systems can be changed - but if people's thinking remains the same, the changes will have little impact on people's behaviour.

This is highlighted in the field of

stigma and discrimination. It has become unacceptable to discriminate against people from certain groups based on their race, gender or ability, and overt racism is no longer tolerated. But discrimination still exists and can be communicated in a look or gesture. Changing the system to advocate a zero tolerance approach is not enough as it could merely push the problem underground. People's thinking has to change.

Change the thinking

It is very easy to see the world from our own perspective, based on the series of experiences and views we have been exposed to. But if we want to gain a wider perspective of situations and the individuals we meet, we need to begin to ask the question, 'how else can I see this?'

The Whole Life logo can be perceived to mean different things, but one way of seeing the symbolism, is as the power of thought; how one little thought (or way of seeing) can affect everything we see and do.

In Whole Life we ask two fundamental questions:

- What do we think about mental illness?
- What do we think about those who experience it?

The answers we give to these questions will greatly affect our behaviour, practice and the systems we design to support people.

How do we think about mental illness?

Some of the common myths are:

- It is a severe and ongoing process.
- There is something wrong with the person's brain or neuro-chemistry.
- There is no cure from mental illness.
- People have 'illness inside of them'.
- People need specialist help.
- Health professionals or experts are the only ones who can help.
- People will have to take medication or treatment for the rest of their lives.

If we believe or invest in this way of thinking, it is easy to understand why traditional services were designed the way they were. It was thought that people were unlikely to

To have true meaning and resonance with the person, it is important to consider their values, world view and life context

recover, would need protecting from society and life, and would need specialist, separate services to support them, most probably for the rest of their lives.

There are elements of truth in these statements, but each needs careful consideration and clarification in terms of what we mean by 'cure', 'severe', 'specialist', 'experts' and 'illness'.

However, these terms mean different things to different people and, as they are evaluative words, do require someone to make a judgement.

From a Whole Life Approach, it is important to consider 'whose values' we are considering when judging another's situation. In order to have true meaning and resonance with the person, it is important to consider their values, world view (framework) and life context.

Many people have found the concept of 'mental illness' and diagnosis a useful way of thinking about their experiences and, for some, this has led to the feeling of having their experiences validated and being given a language through which to then seek information and support.

This is summed up by the perspective of two individuals who were given a diagnosis, as quoted in *Strategies for Living 2000*:
"Yes, it made sense of all my symptoms, but I hadn't thought of it myself... It made sense, not sleeping, waking up early and not being able to get to sleep and not being able to eat, being constantly worried about what was going to happen, that sort of thing."

"At the time I was horrified... But I've realised since that that is actually true. But at the time I wasn't happy with it at all... But I've actually recognised that it is probably an accurate diagnosis."

However, when offering a diagnosis, it is important to be

mindful of its bedfellow - stigma. A diagnosis can often lead to personal (internal) and public (external) stigma and resultant discrimination, and these responses are greatly affected by the individual's current framework, value system and 'world view'.

It is also important not to assume that the dominant cultural view of mental illness within any given context is necessarily the 'right one' or is useful for the individual's understanding of their experiences.

For many, the labelling of their experience as a disease, illness or disorder is unacceptable and the use of these terms is becoming increasingly controversial, as described eloquently, in these following three statements:

"I don't think anyone's really comfortable with the term 'mental illness'. It's a kind of label and I dislike labels intensely. I mean, if you're termed as having a mental illness, it sort of sets you apart from the rest of society." Johns story, A Gift of Stories (1999)

"I just don't think I've got a mental health problem. I've got problems, which, um, things that have affected me. Made me the way I am. But it's because of things that have happened, that have made me who I am, not because I've got a chemical imbalance in my brain." Strategies for Living

"Don't ever use the label 'schizophrenic', because it contains many assumptions and maps out your life, obstructs full membership." Stephen Corran

The question is 'who does this diagnosis serve?'

According to the Whole Life Approach, individuals have the right to choose how they frame their experiences and symptoms. Some health professionals, or teams, have difficulty in accepting the individual's perspective, believing it to be a form of denial, and that to accept it, would be seen to be colluding with the individual's delusion.

However, this can often be a mistake on the part of the

professionals, as exemplified by Dave Williams who was diagnosed with 'bi-polar disorder' and who aptly sums up why he chooses to describe his experiences as a 'condition' rather than a mental illness:

"I don't believe I have a mental illness. I believe I have a condition because for me a condition fluctuates and comes and goes and mental illness is with you for the rest of your life. I can manage my condition without medication which doesn't make sense if it is an illness."

Once again, the Whole Life logo reminds us to put the person at the centre, their values, beliefs and frameworks. In terms of supporting a person's recovery, acceptance is an essential part of an individual's process of starting to take personal responsibility for their health and well-being.

Acceptance is more likely if the process of assessment, diagnosis and 'treatment' 'makes sense' to the individual's current frameworks and values system and does not result in disempowerment.

When we are forced to accept something that conflicts with our belief systems, resistance is a healthy reaction in protecting us from vulnerability, as described in the following quote:

"It just felt so wrong, so scary; it didn't make any sense to how I saw myself. Do I have to rethink who I am? It had so many implications, the scale of which seemed too big to handle." Anonymous

Insensitive use of diagnosis and insufficient discussion around what this means is clearly unacceptable. We need to remain mindful of what it is we are asking people to accept. Do we want people to accept they have a mental illness? Or that they have experiences that they need support and assistance to cope with?

Traditional Kraepelinian and 'narrow' medical approaches to 'illness' have been criticised for doing little to promote hope and self-determination because the 'power' inherent in the dynamic of diagnosing, prescribing and offering treatment options still remains

with the health professional.

We need to open our minds to the different ways of approaching mental illness and the multiple options available that can assist with recovery, rather than taking traditional narrow approaches based on the assumption that the professional knows best.

However, it is important to acknowledge that there are many skills and much expertise available in current mental health services, but there is

Many with a general medical condition would have a reasonable level of awareness about the dietary or physical factors that will contribute or improve their status. However, this is not the case for mental health

also a need to provide this within the context of a broader perspective on 'what helps' and what will provide long-term benefit to the service user.

It is well documented that being told that there is an illness inside you can lead to feelings of powerlessness, fear and loss of hope. This can leave the individual with little direction as to their role in regaining health over something that is perceived as 'out of our control'.

In contrast, many with a general medical condition would have a reasonable level of awareness about the dietary or physical factors that will contribute or improve their status. However, this is not the case for mental health and well-being and many people feel at a loss to know what role they can play in managing their own mental health and recovery.

This work book offers opportunities to explore the factors contributing to a person's ability to manage their own mental health. These factors are discussed in the various chapters and explored through exercises.

Mental Illness -- how we think about those who experience it

Some of the common myths are:

- People cannot recover fully from mental illness, or recovery is only available for some.
- People are damaged by

mental illness.

- There is fundamentally something broken, damaged or wrong with that person.
- People have something inside them that they have no control over.
- People with mental illness can be dangerous and unpredictable, need protecting from the realities of life, cannot cope with stress, will always need professional help and support, and are different from the rest of us.

Although it is important to acknowledge that people do experience distressing and often ongoing symptoms, this does not mean that they are unable to access full health, well-being and contentment in their lives (See Recovery chapter for greater insight).

Mental health exists on a

Whole Life principles would suggest that no one model could possibly suit each individual's needs, experience and journey and there is risk of focusing on the process or model and not the person. The main emphasis is the underpinning principles and values that inform practice rather than the model and approach used

continuum, and for some, this means experiencing what is beyond the common range of experience. The fear and distress accompanying these experiences is often due to a lack of understanding, a sense of isolation and the associated internal stigma. When we view others at their worst and at

It has become unacceptable to make generalisations about people based on their colour and gender, but we are slower to respond in terms of 'mental illnesses'. It is still too common to label individuals as schizophrenics or depressives

their most vulnerable and then take this view as defining that person, we have done them and ourselves an injustice. There is no doubt that such experiences change and shape us, but it is unacceptable to allow ill health or disability to be the defining

element of a person's character.

This is why, in Whole Life, we emphasise the importance of seeing the 'whole person' in the context of their whole life. For too long, mental illness and distress has been the focal point in people's identity, from mental health workers, services and the general public.

It has become unacceptable to make generalisations about people based on their colour and gender (for example), but we are slower to respond in terms of 'mental illnesses'. It is still too common to label individuals as schizophrenics or depressives, as shared by Paula Entwistle (from *Whole Life* DVD):

"I didn't want him disregarding me as another depressive person and the easy cop out was to give me medication."

As Kathy Smith (Chaplain, Cornwall MHP) puts it:

"I prefer descriptions to labels. Descriptions 'I' claim, whereas labels are applied."

What we all want, is to be treated as whole, unique, valuable and for who we really are, or really could be. The damage done to our sense of self cannot be underestimated when we are seen only on the basis of our faults, vulnerabilities and differences, as depicted graphically in the Bedlam Baby ward picture in the Resource chapter.

One common experience in Recovery is the process of the assault to the sense of self when we are first touched by mental distress and its implications.

Julian Bareham (Service user, *Whole Life* DVD) talks of the importance of respecting that 'we are emerging as different people' and urges health professionals to remember this sensitively in their practice.

If someone is concerned only with the person's faults, vulnerabilities and differences, it is natural that the new self may well take on these perspectives, even if we undoubtedly resist initially. If, however, these opinions are reinforced by 'the majority' and come from those

with credibility and authority, they can cement in a person's mind and create the reality from which we live. I think we can all imagine what impact this can have on someone, on their life, their hopes and recovery.

Strengths focused

The strengths-based approach, written about extensively by Charles Rapp, is a perspective familiar to many in the mental health care field.

This approach encourages focusing on the strengths, abilities and resilience of those who are touched by mental distress. As discussed earlier and reflected in many stories of recovery, taking a strengths-based approach to an individual's ability provides a positive foundation for recovery. The Recovery and Well-being agendas provide much hope, as health and well-being are seen as inherent human qualities that we all have access to, that we all have our own wisdom and are 'experts by experience' on 'what helps'.

This statement, attributed to Albert Schwietzer, describes this beautifully in another way:

"Each patient carries his Doctor inside him; they come to us not knowing that truth. We are at our best when we give the Doctor who resides within each patient a chance to go to work."

Each person is unique, as is their recovery. What is of use to one person is not necessarily so for another. Drawing out the strength, expertise and preferences of the individual and then using this as a basis of how to plan support, generally leads to more meaningful outcomes.

Many who come into mental health services do so at times of distress and confusion and are in need of assertive support. Many of us do not believe we have the skills or the control to influence what is happening to us, as when experiencing periods of distress it is natural to 'catastrophise' and to lose perspective of OUR strengths. It is hard to see anything else but the pain and fear that surround us and our desperate attempts to regain our well-being.

However, when we gain more

perspective and have the luxury of hindsight, we learn from these experiences and are able to see clearly the things we do

What is really useful is when those around us see our strengths and support us to believe in our own abilities in a caring way. By seeing people's strengths, abilities and talents, we reinforce the reality of them. By talking to the 'health' in the person, you draw the health out

have control over and the things we need support with. This is our wisdom talking to us and what makes a real difference is knowing that we have this wisdom. Most of us learn the hard way as to what our strengths are, through discovering them ourselves. But what is really useful is when those around us see our strengths and support us to believe in our own abilities in a caring way. By seeing people's strengths, abilities and talents, we reinforce the reality of them. By talking to the 'health' in the person, you draw the health out. In the Whole Life Approach, we see the person's strengths and abilities in context. The distress, illness or symptoms do not become the person.

Change the practice... A different way?

By changing our thinking about mental illness and the people who experience it, we naturally change the way we support them.

By taking a more holistic appraisal of an individual's situation, we are able to understand in depth the

We need to question whether traditional interventions allow the level of flexibility needed to promote recovery. Therefore, we need to acknowledge the difficulties and tensions that exist in this process as systems have to balance the needs of the service user against the needs of the communities

challenges an individual faces and the strengths they bring with them. We do not exist in isolation, but within social systems that give us a sense of place, meaning and purpose

and are a source for developing and exploring our values and beliefs.

By changing the thinking about how we provide services, we need to remember that by putting the individual's journey at the centre, we are less likely to lose sight of the meaning implicit in that person's journey.

There is no one Whole Life model

We have remained clear that there is no one Whole Life model.

Although traditionally people have looked for the most effective model for mental health practice, within Whole Life there is no such model. According to Whole Life principles, no one model could possibly suit each individual's needs, experience and journey and there is very real risk of focusing on the process or model and not the person. The main emphasis of Whole Life is the underpinning principles and values that inform practice rather than the model and approach used.

If we truly want to provide recovery orientated, socially inclusive services, it requires a fundamental shift in the way we currently provide these services.

The emerging themes from stories of recovery and working with teams on 'recovery-based practice' clearly indicates that there are many barriers that currently exist within systems to working in this way. These barriers often centre around frustrations such as bureaucracy, paperwork, red tape, rigid systems and a fear of getting it wrong – the last of which can lead to defensive practice and care.

It appears that traditional systems do not wholly allow the level of flexibility required for recovery orientated practice. Therefore, we need to acknowledge the difficulties and tensions that exist in this process as systems have to balance the needs of the service user against the needs of their communities.

A good example of this tension and need for a flexible working environment is provided by a clinician who was working with an Afro Caribbean woman who heard a combination of voices. The woman wanted to retain the positive voices and diminish

the influence of the negative voices. She felt medication affected both types of voices and this in itself was an unsatisfactory solution for her. She felt part of her recovery was to gain more control without the use of medication. The dilemma for the clinician was that, when distressed, this lady believed her neighbour to be spying on her and the voices encouraged her to seek retaliation. This clearly had consequences for her, her neighbours and the team.

In the end, what helped the individual and the neighbour to overcome this situation, was the team's ability to work creatively and flexibly by remaining mindful of the long-term gain in this approach. This long-term solution enabled the woman to manage her symptoms and to be aware of her triggers and vulnerabilities - thereby enabling her to seek assertive intervention and support at times of need.

This scenario involved a team appraisal of risk versus potential long-term gain which involved gaining wider support and responsibility for risk taking. Risk-taking is an essential part of making changes that support recovery. However, the word 'risk' is a semantically loaded and over used term. We exist within a risk averse society with the threat of legislation.

Feedback from study tours often reflect on how certain services do not allow risk to become a barrier to practice. For example, within the services at Lille, individuals in an acute phase of their illness are offered placements within an artist workshop which provides open access to saws, knives and many other sharp tools. This is not considered to be of major concern to the providers of this service and they have not had any untoward events occur. This type of service provision is challenging, at the very least, when considering how we approach risk within our current settings.

There is a need for a robust discussion about risk around the topics of 'whose risk?' and how this can be worked within a creative way, without it being a hindrance to an individual's recovery, and the need for the recognition that taking calculated risks is seen as a

essential part of recovery.

New ways of working

As people's need change, services need to change and develop with them. This is recognised by government policy and investment in new ways of working. The way services are delivered has changed drastically in recent years, with new teams being able to expand and extend what they can now currently deliver.

These teams include early intervention, assertive outreach, crisis intervention, home treatment and community mental health workers. From initial feedback, it appears these teams are less restricted by the bureaucracy and red-tape processes that have restricted practice in the past.

For example, Assertive Outreach teams have less paperwork and can work with a client for up to five years, and the Crisis Team does not have to deal with regular bureaucracy. New teams seem to have the capacity to truly respond to individual needs.

These new approaches give greater opportunity to involve a range of stakeholders to support service delivery and this enables the flexibility to harness the unique contribution that communities can make.

However, there is still a need to reconsider what we mean by 'teams' and 'systems' with a readiness and willingness to include families, service users, carers and a wider community as part of the wider team.

Expert care

Service users and carers are requesting clinical expert care within the context of care and compassion. This clearly appears to improve outcomes for service users and carers with the added benefit of supporting staff in ways truly reflecting their skills and satisfying the vocational reason why they entered the job in the first place.

Conclusion

The Whole Life Approach advocates that organisations and systems should be clear about their purpose and that they should have a clear vision and value base to reflect this.

To fully appreciate the values that inform the Whole Life

Approach it is important to listen to the meanings and values behind the words found in the following chapters.

What is clear is that as people's needs change, so do the things that help. In order to 'go with' this ever changing process, it is important to remain creative and flexible in the way we provide support if we truly want to benefit people's lives.

The challenge for us is to critically appraise the role we all play in changing the thinking, changing the practice and changing the system.

Seeing Differently, Thinking Differently

by Anna Stenning

“Study tours challenge you, and encourage you to bring good practice back.” Study Tour Participant.

Participants in the Whole Life Programme undertook a series of specially arranged study tours around Europe. The tours offered opportunities to experience innovative, community-focused mental health care in other European settings as offering progressive services. Participants were encouraged to focus on the values and principles underpinning what they saw.

The feedback from the study tours (below), and the principles made explicit by the service providers, reflect different ways of looking at recovery, having genuine community involvement, consistency of care, and a person-centred approach. Participants in Whole Life study tours have included managers, clinicians of all professions, social care staff, (including support workers), service users and carers. Visits have taken place in Italy, Spain, Sweden, Ireland and France.

MONAGHAN, Ireland

Between 1995-1998, Cavan/Monaghan agreed a new service model, based on local research and a review of relevant models abroad.

New services were founded on the following principles:

- The centrality of patient's needs and rights.
- Specialist services for specific patient groups.
- The delivery of individualised effective treatment packages in the setting of home and family.
- Minimum use of inpatient beds.

The aims behind these services



were:

- To enable patients with severe and persisting mental illness to reach their highest possible level of functional independence.
- To provide the level of care and support to such patients that is appropriate to their disablements.
- To provide the informal carers of such patients with the knowledge, skills and support necessary, to assist them in their caring role, and to minimise the stress associated with that role.

The philosophy that underpinned this was to provide individualised care programmes for patients and carers, based on identified need and implementation, as much as possible, in a non-institutional setting.

The model would provide:

- One point of access for all acute referrals to General Psychiatry.
- Multidisciplinary assessment of all referrals.
- Individualised care plans.
- Allocation of Key Workers to patients.
- Integration and shared case management.

- Close working relationships with GPs.
- Liaison with voluntary organisations, self-help groups, carers' groups and community groups.
- The development of a home-based acute nursing service as an alternative to the use of admission beds.

TRIESTE, Italy

Franco Basaglia began working at the Trieste Psychiatric Hospital in August 1971. He believed that in order to provide care in a humane way, it was necessary to:

“redefine relationships, discover new spaces, make the subject emerge.” (Dell'Acqua, 2001).

The motivations behind the 'humanisation' of the services in Trieste included the following:

- Shutting down the psychiatric hospital as a criticism of the practice and culture of clinical psychiatry.
- The construction of a network of services.
- 'The person, and not the illness' situated at the centre of the search to create therapeutic, rehabilitative, and emancipatory processes.

Today, the Mental Health

Department in Trieste offers four mental health centres, (equipped with 8 beds each, and open around the clock), plus the University Clinic, a service for rehabilitation and residential support (11 staffed group homes), a day centre including 6 creative workshops, 13 accredited social co-operatives (see below), and a small unit in the general hospital service, for diagnosis and care.

According to the World Health Organisation:

"The Italian city of Trieste has created an impressive network of community-based services, protected apartments and co-operatives employing mentally ill persons. These centres provide medical care, psychosocial rehabilitation, social assistance and when necessary, treatment of acute episodes. A number of protected apartments providing a 'non-medical' and friendly environment for the most severely and chronically ill were created. Finally, work opportunities have allowed many patients to secure substantial integration into community life." Extract from Stop Exclusion 'Dare to Care' (2001)

LILLE, France

Here, the general philosophy is to provide treatment and accompaniment. The facilities and services on offer include:

- The Maison Antonin Artaud, which deals with emergencies.
- There is a municipal social welfare centre also providing mother-and-child care consultation, sport health consultation, and a social welfare service.
- A branch facility in the Centre Medico-Sportif (sport health centre), in the swimming-pool premises in Ronchin, and another in a medical centre in Mons en Baroeul. A third is to be opened in a social welfare centre.
- A therapeutic workshop in the Centre Frontières in Hellemmes, which is linked to a contemporary art gallery which opens onto a busy street in the town. This opportunity is used as an option for those in 'acute

distress'. The art gallery is subsidised by the Regional Authority for Cultural Affairs

- Via workshops in the fields of plastic arts, aesthetics, computing, sport, dance, music, singing and video, the aim is to diversify the offer, and to open up to leisure activities. The groups are led by artists and supervised by nursing staff. For activities organised by the school for self-expression by movement in Villeneuve d'Ascq and the dance association in Lille, groups are mixed, in that they cater for psychiatric users alongside people from the general population.
- Inpatient facility - ESPM Lille-Metropole in Armentieres.

Many of the participants on the study tour to Lille were impressed by the 'therapeutic family stays scheme,' whereby members of the community opt to host people with experience of mental illness/distress in their homes. The scheme involves families accommodating stabilised patients in the long-term, and other families providing accommodation and support as an alternative to hospitalisation. In the latter situation, the patient is experiencing an 'acute episode' and directly after consultation, or in a secondary strategy after hospitalisation, remains with the family from a few days to a few weeks. The instructions given to the family are to take the person into their homes, not to provide care. A nursing and educational team care in the course of home visits (management of treatment, organisation of therapeutic activities, consultations in the sector). The families are full partners in the care team.

STOCKHOLM, Sweden
"Good psychiatric care , on the basis of the needs of the individual, from a holistic perspective. A fundamental principle of care is to be the maintenance of continuity in the treatment of the patient. Great importance is to be attached to a method and approach which integrates outpatient and inpatient care ..."
Psychiatric Care (1999)

ASTURIAS, Spain

Mental Health reform started in 1983 from a regional psychiatric hospital with 1,000 beds. The reform process was made

following the principles of community psychiatry.

Today, Asturias has a network of community services: 15 mental health centres that take into care all the mental health referrals from primary care. It is completed with 4 specialised teams in child psychiatry, 5 community units to treat drug addiction problems, 6 day hospitals, 4 therapeutic communities (halfway houses), 5 acute psychiatry wards in General Hospitals, 2 detoxifying hospital wards, 2 day hospitals treating eating disorders, 1 hospital ward treating eating disorders and a residential unit in the old psychiatric hospital with 90 beds. It also has a network of labour and job education and rehabilitation programmes.

Participants were asked to consider the following themes when offering feedback on the Study Tours:

- Experience of the service users, including the contribution of the service to their recovery process.
- Interface with other local services.
- The vision, philosophy and culture of the service.
- Clinical and social outcomes.
- Operational practice.
- Examples of positive practice.
- Obstacles.

COMMENTS FROM STUDY TOUR PARTICIPANTS:

On Monaghan

"I've worked for many years in mental health and it's the first time in years I've felt there's a real change occurring."

"I noticed that teams responded quickly and intensively to crisis, there were smaller case-loads, and that they worked as a team – they weren't protective of their roles."

"There's more community and family support than here."

"Differences I noticed included a real enthusiasm ... [they were] better staffed, [had] good working relationships, were very relaxed and practical, and they engaged well with the community in general. [They] weren't encumbered with paperwork – good service-user group – hospitality was

great and they were very supportive of their nurses."
 - Rob

"Despite having clinical teams that are predominantly Medical/Nursing in content, [at Monaghan] there is a real focus not only on excellent medical and psychological treatments, but also on valuing user views and real social integration into local communities."
 - Paul Smail (2005), Devon Partnership Trust

On Trieste

"I found I needed to really listen to what was going on and drop all thoughts and judgements to be able to understand the concepts behind their work."

"Truly enlightened services."

"What stood out was the way the psychiatrist we were with treated one of his patients who turned up unexpectedly. He greeted him warmly with a friendly hug and slap on the back and they went on to joke with each other, taking the mickey out of one another. No hierarchy here."

"They had a creativity that they nurtured and grew..."

"They threw the Mental State examination out the window - instead they have a conversation and listen to stories. Much more person centred."

"The suicide rate was very high. This has been tackled through family and community work – support lines give a true partnership and this has resulted in suicide rates dropping in three years."

"The buildings are not institutional; they are welcoming, ordinary, clean and modern."

On Lille

"Fantastic, loved it."

"What struck me was making services 'nice to know'. This has directly influenced what we have tried to do here, we have made contact with the local museum and Barnfield college to put on a

combined exhibition. We've really thought of how to use local community in terms of making us nice to know; we've turned it around and encouraged the community to come to us by improving networking and establishing good relationships. We've shifted where we want to go and are now putting energy into a service that is progressive."

"They weren't scared by risk, e.g. [by saying] 'you are absolutely responsible for your behaviour.'"

"Over here risk seems to be about how it affects me and my registration and very little about the service user."

"In France they openly declare they are a mental health service, but here you wouldn't know, we hide what we are. They have a premise that we all have a mental health issue, the degrees are relevant."

"They take an artistic approach to mental health. Art draws out the health to help heal."

"There's a vast difference in the use of medication."

"What amazed me was their minimal use of medication. When I asked how many patients would use medication in their service, the answer is 8-9 out of ten. But when I asked how many people who had a diagnosis of 'Schizophrenia' used psychotropic drugs, they said maybe 1-2 out of ten. Now that is astonishing. In England I'd hate to imagine how many are on meds, but to hazard a guess it would be 9-10 out of 10. It made us all think about the different attitude we have."

"What really struck me were the host families, they had to have no qualification or experience in the mental health or social care field, a totally different approach to believing what helps."

On Stockholm

"I recently had to admit a client to the local unit. It was dark, dank, unclean and there was not even a curtain to separate his bed from the next. My heart broke for him. In Stockholm it was

very homely it felt like a place you could go and sit, you had your own room, privacy and personal things. As a result of this study tour, we now put funds towards what clients want on the wards."

"They take care of their people, with one clinician all through their process. We now think about encouraging family and friends to come along to the assessment."

"They seem less disabled by paperwork."

"It's so simple to treat people well."

"One of the most interesting things that I found about Sweden's services was that they were so focused on the 'whole client'...they were followed by the same team throughout their involvement with the services... keeping track of clients' care and establishing one set of notes that were kept in one place may not seem like much, but with our services our clients have assessments from each and every service they link into. This can be very disheartening for them as it is a regurgitation of the same information, and this can happen many times over."

"Another plus is that when a new patient comes into the emergency service the staff member who saw them is the staff person who will follow them through their treatment period whether long or short term."

"A person's surroundings have much to do with the rate at which they recover. In this area we are sadly lacking. It was evident in all of the facilities we saw that they put a lot of emphasis on the support, comfort and wellness of the client."

"Overall the experience in Sweden was an eye-opener and something that we can look at as a good example of mental health care."

"Well organised, with military precision. There is a clear, strong focus on recovery. Continuity of care, the Key Worker is present all

the way through."

"Tremendous sense of calm and hospitality, and the quality of the building is outstanding. There seems to be respectfulness in the relationships, with a clear split between the social services and health services."

"Evangelical, passionate leaders ..."

"There was a real accessibility of the service, providing ease of discharge and admission."

"Always being available, not fearful about resources, and didn't waste energy on who does what – instead it flows fluidly." Recovery is respectful and shows real equality and continuity."

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Further stories and comments from participants in Whole Life Study tours are featured on the Whole Life website.
www.wholelife.org.uk

Mental Health as a Community Issue

by Margaret Fleming

Introduction

The Cavan & Monaghan Mental Health Services have been recognised nationally as a service of excellence winning two prestigious National Awards, the Health Service Innovation Award 2005 and the Taoiseach's Award for Public Service Excellence in 2006.

Health Services Innovation Award 2005

Cavan & Monaghan Mental Health Service is a rural community-based service which lies on the border of Northern Ireland. It serves a total population of just over 118,000 and covers an area of just over 3,000 sq.km.

The purpose of the Cavan & Monaghan Mental Health Service is to provide an integrated, comprehensive, high quality, recovery orientated, individualised system of care and supports which meets the needs of people. The values and principles of the service are:

- Centrality of service users' needs and rights
- Delivery of individual effective treatment packages in the setting of home, family and community
- Responsiveness
- Empowerment
- Participation
- Partnership
- Citizenship.

The values and principles of the service are underpinned by the national policy document 'Quality and Fairness, A health System for You 2001', the Mental Health Commission publication 'Quality in Mental Health, Your Views 2005' and the National Policy document, 'Vision for Change 2006'. The Cavan & Monaghan Mental Health Service has a long history of commitment to research and evidence-based practice which informs service developments.

Research by Shepherd (1994) suggested that service-users place greater emphasis on the social and practical aspects of life in the community. The provision of services to facilitate recovery requires more than a healthcare system. It requires a coordinated, interdependent whole systems approach, which includes multi-sectoral collaborative alliances.

Pickin *et al* (2002) identified a number of best practice approaches that enable partnership working between community and statutory organisations. One approach identified was 'whole systems working'. The Cavan & Monaghan Mental Health Service moved from a closed systems approach to an open systems approach to transform the philosophy into a reality to meet the needs of service-users.

Wherever a group of people exist, a system exists. The medical model is a closed system. The flaw of the bio-medical model is that it does not include the service-user and his/her attributes as a person. It is based on dualistic thinking; that is, the right way and the wrong way. This dualistic thinking has created the expert (professional) and the patient. Closed systems are not collaborative as they do not interact with the wider context. They are set and predetermined and service-users are seen in terms of their diagnosis rather than as individuals and become passive recipients of care.

The open system approach, on the other hand, takes into account the individual, relationships, family, friends, community, culture and society. It is based on multiple discourses and the equality of each voice. It does away with

the concept that there is one way of knowing and embraces the concept that there are multiple ways of knowing. It focuses on the whole person and places greater emphasis on the uniqueness of the individual. It is collaborative and autonomous but remains connected. It promotes independence, personal growth and achievement of personal potential. It sees the service user as the expert, where they become, an active participant.

The Cavan & Monaghan Mental Health Service views mental health as a community issue and works in partnership and collaboration with the local community in promoting, developing and establishing social capital. McCulloch (2001) suggests that people with low social capital have an increased risk of having mental health difficulties. Research by Cooper *et al* (1999) also recognises that living conditions and socio-economic status are strong predictors of mental ill health. Therefore, the importance of building bridges within the community to develop an ecological approach and promote and facilitate recovery is a core principle.

The Cavan & Monaghan community-based model has at its foundation housing, work, education, income and other basic elements of citizenship, rights to equality of opportunity, economic security, justice, respect, freedom of speech, freedom of choice, the right to be an individual and the right to self determination. The focus of the service is person centred, needs led, family supporting, recovery oriented, clinically competent and flexible and working in collaborative partnership with the local community. Recovery involves full membership of a community

and that equates to citizenship. The service embraces the belief that people with mental health difficulties are, foremost, citizens with rights.

Research by Miller, Duncan and Hubble (1997) identified relationships as accounting for 30% of recovery; relationships based on mutual trust, respect, dignity and understanding. Franz Anton Messmer (1734-1815) believed that healing becomes impossible in the absence of rapport. They also identified 40% of recovery can be achieved by tapping into the person's own world and incorporates resources from that world, such as family, friends and community. Their research also confirms the importance of hope and expectation in recovery and accounts for 15%.

Watzlawick (1986) suggests that the key to instilling hope is the attitude the "professional" assumes. This involves working with service users with the attitude that they are capable and possess the strengths and resources necessary to solve their problems. This in turn creates a context of empowerment for service users. Empowerment emphasises rights, abilities, strengths, resources, rather than inabilities, weaknesses, deficits etc. In attempting to understand the process of empowerment, we took empowerment and viewed it from a circular perspective and coined the phrase the "reciprocal process of empowerment".



Members of the Cavan & Monaghan Mental Health Services with Taoiseach Bertie Ahern



Whole Life Study Tour Group visiting services in Monaghan

Taking empowerment from this circular perspective demonstrates the participatory nature of the process. This is a poem by a young woman, following her contact with the service.

Homebase

*There is a time, in someone's life
Where life seems just a doubt,
There is no need to carry on
And love is not about.
There are people out there,
Though they're always in the few,
Who use their gifts
of tender love,*

To cure their patients fears.

*They always treat you with respect,
That's what they're there to do,
They ease our troubles there and then,
Onto that endless queue.
They send out vibes of comfort,
On every angle known,
Consideration always granted,
They banish our souls of woe.*

*They never mess with our emotions,
No, they never do,
Just put them in their places,
Now then, as good as new.*

*So if you are uncomfortable,
Or stressed because of life,
Homebase will be there for you
To sort your troubles out.
Thank You Homebase.*

Taoiseach's Award

The Cavan & Monaghan Mental Health Services have been honoured to host a number of NIMHE study tours from different services across England and have gained a wealth of knowledge and friendships through this partnership. Above are some study tour participants in Monaghan.

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