# Module 2 - There is no health without mental health…

**Guidelines for Facilitators**

**You will need:**

- A flipchart and pens to capture the points made during the meeting.
- Sufficient copies of the fact sheets and testimonies for members of the group.
- Paper for sub-groups to record their thoughts.

**Aim of this module:**

To explore protective factors in mental health
To explore mental distress and the boundaries between mental distress and a formal diagnosis of mental illness
To understand where it might be necessary to signpost people to local services.
To reflect on how as a parish or deanery we can take this agenda forward.

**Length of Session:**

2 hours or a half day session if time permits

**Programme/Plan for this module:**

**Opening Prayer** (5 minutes). You may wish to compose your own prayer for this section or use one of the prayers in the Resources section of this toolkit.

**Introductions and Ground Rules** (10 minutes)

**Discussion 1 - What keeps us mentally healthy ?** Ask the group to list the factors which might keep us mentally healthy and put these on the flipchart.

Following your discussion, ask the group to consider particular issues, for example what keeps us mentally healthy in later life.

Distribute the fact sheet 'What keeps us mentally healthy' ? Ask the group to discuss the questions on the factsheet. (45 minutes)

**Tea/Coffee Break**

**Discussion 2 – Hearing the voice of people experiencing mental distress.** Ask the group to read discussion sheet 2 - 'Hearing the voice of service users' and Mary's story. What do we feel about her experiences ?
Ask the group to consider how we might better understand and be aware of those in our parish experiencing mental distress. How can the parish help to overcome the stigma of talking about mental distress ? List the points made on a flipchart. (30 minutes)

**Discussion 3 – From mental distress to mental illness.** You may want to have this discussion if your session extends to half a day. Consider inviting a staff member from the local Mental Health Services or a professional who is involved in your parish or deanery to provide input. Discussion Sheet 3 can be adapted to fit your local service provision. (45 minutes).
There are a number of issues you may wish to raise for discussion, for example how local resources such as counselling services or mental health helplines might be advertised on the Church notice board.

If you are organising a half day event you might wish to run the following as a parallel workshop.

**Discussion 4 – Suicide and self-harm.** Distribute Discussion Sheet 4. This is not an easy subject to discuss but is included because some people may want to discuss this subject more openly – they may have personal or family experience of suicide or self-harm. As part of the discussion, ask participants to read Edna's testimony (Module 6) which describes her experience in looking after her suicidal daughter. This also provides an opportunity to focus on the mental health needs of young people and how these needs can be better addressed. (30-45 minutes) Consider the points for discussion at the end of the sheet.

**Summary:** Ask the group to consider the implications of your discussions for pastoral and spiritual support offered by the parish or deanery. List potential action points Finish the session with a closing prayer. (You might want to use your own or you can find some suggestions in the Resources Section) (15 minutes)

**Discussion Sheet 1 – What keeps us mentally healthy ?**

***Keeping mentally healthy: Ask the group what are the factors which keep us mentally healthy…***

The Mental Health Foundation have produced a guide on tips in looking after your mental health. These include:

- Talking about your feelings
- Keeping active
- Eating well
- Drinking sensibly
- Keeping in touch with friends and family
- Asking for help when you need it
- Knowing when to take a break in our lives
- Doing something I am good at
- Accepting who I am
- Caring for others.

*Do the group agree with this list ? Are there other things you would wish to add, for example meeting our spiritual needs ?*

**Discussion Sheet 2 - Hearing the voice of people experiencing mental distress.**

For this to work, we need to be in touch with the experience of those who use services (sometimes described as service users, patients, clients in the official jargon). Clare Allan's columns in *Society Guardian* are a particularly helpful insight into the perspective of somebody who has a serious psychotic illness. In one article, Clare speaks about the shock of suddenly developing a paranoid psychosis after living a life as a successful and gregarious student, studying English at university (she has since published a novel partly based on her experiences: *Poppy Shakespeare*).

Clare talks about having a diagnosis by a doctor as helpful, as it meant somebody was recognising her illness and it wasn't just in her head. But the diagnosis was also limiting, in that diagnoses quite often tend to put people 'in a box', like it did for 'Rosie' at the beginning of this chapter. Clare also refers to the fact that at school she didn't remember any jokes about cancer or heart disease or a person's arm or leg, but children do make jokes about people who are 'mad', but perhaps because we need to define others as 'mad' so as to prove to ourselves that we are 'normal'. Many of us who have or experiencing mental distress in ourselves or in our families may experience some of these feelings.

In a recent book on people experiencing mental ill-health and their journey to recovery: *Voices of Experience* (Basset, T. and Stickley, T. Ed, 2010) quite a number of people speak of the importance of faith in their journey, their pilgrimage, towards better health.

**Mary's story**

'Mary', a sprightly woman in her mid 70s, was walking back from the shops when she bumped into 'Rosie', the 21 year old daughter of a friend in the local parish. Mary was fond of Rosie, because when Mary lost her husband through cancer six years before, and had also been bedridden after breaking her ankle, Rosie and some of her school friends had been a great help in coming round, getting in the shopping, making tea, cheering Mary up and generally seeing that she was all right.

Mary said to Rosie: "Hello Rosie, how nice to see you, I haven't seen you for ages". Rosie looked shy for a minute, and then responded: "Well, I've been away… I'm not telling everybody, Mary, but I've been in the local psychiatric unit. I've been very ill, I'm a schizophrenic". Mary paused and looked kindly at Rosie. She reminded the young woman how helpful Rosie had been to her at a time when she had been distressed, and invited her to come round at any time if she could be supportive to her. At the end of the conversation Mary took Rosie's arm, looked her straight in the eye and said: "To me Rosie you are not 'a schizophrenic', or actually 'a anything', to me you will always be Rosie".

**Discussion Sheet 3 - From mental distress to mental illness.**

One in four people are said to suffer from mental illness at some point in their lives. This percentage may well in fact be higher, because of the problems of stigma and our reluctance to say that we have experienced mental ill-health. A distinguished scientist, Dr Lewis Wolpert, writes that because he has spoken publicly of his mental ill-health, nearly everybody he talks with has either experienced a mental illness or knows a family member or close friend who has. Interestingly, Dr Wolpert is an atheist, but he talks about his depression as "soul loss", thus using spiritual language to describe this very human experience (quoted in Gilbert, 2011)

**'Low level Mental Health Problems'.** Recent work has demonstrated that 'low-level mental health problems' such as mild depression, stress and low self-esteem, has a negative effect on the lives of three in five women and girls. Recent work has also been carried out on the particular issues for men and mental health, where men may hide their ill-health, and perhaps act out their symptoms in substance abuse and aggression, meaning that their problems can easily be overlooked or misdiagnosed. Men often see admitting mental distress as a 'weakness'. The recent economic crisis, stemming from the credit crunch of 2008, has clearly adversely affected a number of people. Almost half of young people without a job say that unemployment has compromised their mental health. Unresolved loss and bereavement is also a particular risk factor in developing mental health problems later.

**From mental distress to mental illness.** Many people might be thought of as having a mental illness when they might be going through a transient phase of mental distress. For this reason clinicians use clearly defined diagnostic criteria and in general practice the most commonly used criteria is DSM IV. This means that a specified number of symptoms have to be present before a diagnosis can be made. GPs should follow diagnostic protocols before deciding on treatment and where possible mental illness is treated within primary care without recourse to specialist services. There is clear guidance to GPs on the way in which a mental illness is diagnosed as well as its severity.

Some of the diagnoses which we come across are:

- Depression
- Psychosis
- Dementia
- Autism
- Dual diagnosis including mental ill-health caused by substance misuse.

**Specialist (or secondary) Mental Health Services.** Specialist Mental Health Services are often organised through Community Mental Health Centres, or through a presence in Health Centres. There will often be an intake team, with responsibility for assessing urgent situations, and a team with responsibility for working with people with more enduring mental health problems. In addition there may be specialist teams organised on an area wide basis, such as crisis intervention and home treatment teams, Assertive Outreach Teams, Early Intervention in Psychosis Teams, and specialist teams dealing with drug and alcohol related problems.

Specialist services for young people are often known as Children and Adolescent Mental Health Services (CAMHS) and are comprised of staff from a number of disciplines. Specialist Teams for Older People with Mental Health Problems often function alongside teams for younger adults and often (but not always) offer a Memory Service for people with early signs of dementia as well as support for carers.

Some people who are at risk to themselves or other people are admitted to hospital under the provisions of the Mental Health Act, 2007. The most common types of admission are under section 2 (admission for assessment for up to 28 days) and under section 3 (admission for treatment for up to six months). During this period in hospital, pastoral support from the parish can be particularly important, especially as those involved often return home on leave for the weekend.

Under the Mental Health Act a person can also be subject to a 'Community Treatment Order' which requires them to see a psychiatrist or another Mental Health Professional when required. Health and Social Services Authorities have a duty under section 117 of the Mental Health Act to provide aftercare – and spiritual needs should be seen as an important part of aftercare. Any person subject to the provisions of the Mental Health Act has a right to an Independent Mental Health Advocate (IMHA).

The voluntary sector is very active in Mental Health Services and often is responsible for the delivery of community services as well as day services and advocacy services. Some nationally based organisations include MIND (www.mind.org.uk) and Rethink (www.rethink.org.uk)

**Personalised Mental Health Services:** Over the last few years there has been a trend towards services which are tailored to the needs of service users with more enduring mental health problems.. Staff are encouraged to work with the service user as an equal partner in identifying what services might be of help, for example provision of a personal assistant or help with pursing a particular activity or hobby. This is sometimes known as 'self-directed support' and involves the use of an individual budget which is paid directly to the service user. Local authorities normally take the lead in providing this service alongside NHS colleagues. Over time it is planned to develop this approach to cover other directly provided Mental Health services.

**Focusing on dementia.** You may wish to explore the issue of dementia further in response to the increasing numbers of people with dementia in our parish communities. Over recent years there has been much interest in the pastoral and spiritual needs of people with dementia and in particular a person-centered approach to their support and care. Caritas Social Action Network has produced a DVD 'Its still ME Lord, which looks at understanding and meeting spiritual needs in care settings as well as in the community. Further details available from Caritas Social Action Network – www.csan.org.uk

**A useful resource.** The DVD: *Hard to Believe* issued by Croydon Mind in 2005, is an excellent resource for looking at the spiritual needs of people suffering from mental distress; and how faith communities and mental health services can work more effectively together.

Most of the research around the values of religious belief and practice in respect of mental health is based on Christian and Jewish communities in the USA. Very little research has been undertaken in the UK. The USA research demonstrated that, in 70% of the studies reviewed, religion has played a positive role in well-being, recovery and resilience in mental health.

## Discussion Sheet 4 – Suicide and Deliberate Self-Harm

Suicide is an experience which some of may have encountered in friends, colleagues or family. As a Church, we still regard taking one's own life as objectively wrong. However, nowadays, we recognise that, when a sufferer has serious depression, such as a bipolar sufferer on a "low", takes their own life, it's caused by their illness and so we can't hold them fully responsible for their actions.

Suicide is an issue of major concern is most industrialised societies. The group most at risk are males under 45 more at risk than the older age group. At the same time men are less likely to seek help for mental health problems, particularly depression. Risk factors include long term unemployment, social isolation, as well as recession and poverty. Alcoholism, as well as a major depressive illness and also a chronic physical condition are also significant causes of suicide.

Deliberate self-harm (DSH) refers to behaviour where are harm is intended but which does not result in suicide. It needs to be taken seriously because 10-14% of people who harm themselves ultimately die by their own hand. There is a variety of motives for DSH, including a wish to die, a cry for help, and a response to unbearable physical symptoms.

The spiritual aspects of suicide and DSH are complex. Coghlan and Ali (2009) point out that religious thought content, particularly distorted ideas about sin, can be problematic. Just as our faith can be a source of strength, some people can be weighed down by 'tyrannical religious views' resulting in self criticism and self loathing. The journey to recovery through the love God gives us can seem a very distant reality

Read Edna's story (in the module 'Caring about Carers' for a powerful account of the experience of her daughter's suicidal behaviour. Details of her book are in the resources section of this toolkit.

***Point for discussion:***

- *How might we look for signs in someone who is suicidal and in need of professional and pastoral help ? Do we know where we might 'signpost' them to for further assessment and support ?*

- *How, in our parishes, do you think all of us involved in the funeral of such a person, such as priests, deacons, those involved in a lay ministry and ordinary parish members, can prepare sensitively for the funeral? How can all involved minister sensitively to the relatives and friends?*