Big issues identified by Covid-19 Requiring Fundamental Change in Mental Health

A Global and Local Action Plan

For Us All

Supporting Arguments, Experiences and Lessons

These contributions from coalition members have informed and supported our Action Plan.

National Reflections

1. The Impact on Mental Health from Covid - 19: Italy Reflection from World Association for Psychosocial Rehabilitation, Gabriele Rocca, President Elect of WAPR
2. Community Recovery:Experiences with Covid and response of people and communities in Italy, Fabrizio Starace, SIEP, Italy
3. Lessons From Argentina: Mental Health and the Pandemic, Alberto Trimboli, Immediate Past President. WFMH

4. Reflections from Brazil on Priorities relating to Covid - 19, Clarissa Mendonça Corradi-Webster, Ph.D., Professor, University of São Paulo, Brazil
5. A Call to Action for resetting an optimal balance between face-to-face, assertive outreach and digitally enhanced community focussed mental health services: Telehealth Mental Health Services for and beyond Prolonged Droughts, Extreme Bushfire regions, COVID19 & other likely Climate Change related adverse events, Professor Alan Rosen, AO, Chair Transforming Australia's Mental Health Service System, Inc, [TAMHSS]; Institute of Mental Health, University of Wollongong; Brain & Mind Centre, University of Sydney, Australia, October 2020.
6. The Situation in the Czech Republic relating to Mental Health and Covid - 19, Jan Pfeiffer, Psychiatrist, Czech Republic

International Reflections

7. The paradoxes and contradictions posed during the Covid pandemic for Mental Health,Roberto Mezzina, Regional Vice President for Europe, World Federation for Mental Health
8. Change the Thinking, Change the Practice, Change the System, International Mental Health Collaborating Network and Rob Warriner, CEO Walsh Trust, New Zealand
9. Service principles: Community centred work in mental health, Roberto Mezzina, Chair of IMHCN and Regional Vice President for Europe, World Federation for Mental Health
10. Transforming Mental Health, Rob Warriner, Walsh Trust, New Zealand
11. Lessons from the last 50 years: A Global "call to action"; making mental health services relevant to people who need to use them (not the people who need to deliver them!), Rob Warriner, Walsh Trust, New Zealand
12. The Need For Fundamental Change in Mental Health Requires Radical Rethinking of Global Mental Health, Benedetto Saraceno, Secretary General Lisbon Institute of Global Mental Health
13. Steps in Community Mental Health Development, IMHCN Library
14. Whole Person, Whole Life - Whole System Approach, John Jenkins, IMHCN

The Impact on Mental Health from Covid - 19: Italy
Reflection from World Association for Psychosocial Rehabilitation

Gabriele Rocca, President Elect of WAPR

The experience of the pandemic has highlighted in our country some contradictions of the health system on which it is necessary to reflect.

1. In Italy – as in many other countries – the facilities for aged turned into epidemic breeding grounds that lead to a massive death toll (WHO reported that half of COVID-19 deaths in Europe have occurred in elderly care facilities). Frequently these facilities hosted hundreds of beds where people were taken in because no longer self sufficient, while losing their fundamental bounds with their loved ones and the places in which they spent their all life. Large institutions full of sufferance, strict rules and patients who have lost a significant part of their own personal history confirm to be dangerous and pathogenic, just like the psychiatric hospitals. Moving on from this further evidence, we need to deeply question the tendency to institutionalisation of psychiatric patients, of elderlies and, in general, of disabled people.

2. We have seen how the capacity of an effective response to the pandemic was highly related to the “formal structure” of the health services – i.e. if a country has a public health system; if it relies mostly on few big hospitals; if it has a good ratio between ICU beds and ICU’s specialised doctors and nurses. This pandemic has especially highlighted the limits of an organisation focused on large hospitals and weakened in the primary care, the prevention and the community health system. In Lombardy, the Italian region most affected by the infection, the solely hospital care was unable to respond effectively to this major health emergence and General practitioners, for their part, made a great deal of individual effort but their work was thwarted by the lack of an adequate network of community health services. Consequently, the construction or reconstruction of a community system is an indispensable tool for people's well-being.

3. Patients with severe mental disorders have adequately addressed the various difficulties associated with the pandemic. In other words, they confirmed that the main therapeutic horizon is that of empowerment and autonomy, with the support of recovery oriented services. Within this network, peer support can play a crucial role by becoming the qualifying aspect of the full involvement of users and family members.

In conclusion, also on the basis of the recent experience of the pandemic, we can identify three key points of the Action Plan:

Deinstitutionalisation; Community Mental health Services: Users involvement in the care and programming of services.

Community Recovery:Experiences with Covid and response of people and communities in Italy

Fabrizio Starace, SIEP, Italy

Lessons From Argentina: Mental Health and the Pandemic

Alberto Trimboli, Immediate Past President. WFMH

It's undeniable that we're living in unprecedented, unusual, singular times. The virus has changed our way of relating to each other, our way of working, and our way of living. In the current context of this pandemic, we haven't just been forced to alter our habits and our routines, but also to bear witness to a series of novel incidents and situations.

The pandemic has shown us the necessity of implementing creative and swiftly enacted practices in order to confront, as best we can, the gravest health crisis of the past hundred years. It has also demonstrated that mental health is as important as physical health.

Before I move on to describe Argentina's situation as it relates to the pandemic, I'd like to call attention to something that has happened in a number of countries, including Argentina: the alarming resurgence of xenophobia and discrimination directed against certain communities, often incited by political leaders. For example, the president of a major power has referred to the "Chinese virus," and the president of a European country has blamed its spread on immigrants. We could make a long list of examples of this type, which is why, as representatives of the field of mental health, we have the responsibility of speaking up against these statements so that the stigmatization of these minorities, which include people who are affected by mental health issues, might cease.

In Argentina, in order to stop the spread of infections, the President decreed a program of obligatory preventive distancing that came into effect on March 20th of this year. The government decreed a total quarantine, leaving only the health system, food retailers, and other essential services open for business. This made it possible to check the number of infections and to strengthen the health system, increasing the number of beds in intensive care units and respirators available for future use. At first, society accepted the quarantine, but, with the passing of time, and urged on by some irresponsible political factions and certain journalists opposed to the quarantine, the quarantine became politicized and public demonstrations against the quarantine measures put in place by the government were held, which has increased the number of cases, although they still remain at a manageable level.

On a different note, it is important to understand the many issues that the pandemic has brought to light. Throughout the world, and also in Argentina, the issue of health in general, and of mental health in particular, has come to occupy center stage. I believe that is a unique opportunity to begin to establish a hierarchy of priorities through which health, life, equal rights, citizens and community solidarity might be made preeminent. As concerns the field of mental health, the pandemic has drawn attention to a series of issues. With regard to infections among people hospitalized on mental health grounds, we have witnessed the extent of the negative effects that the virus has had on mental health wards located in general hospitals: there have been almost none. In addition — to name just one example — in the city of Buenos Aires, not one case of contagion between patients has been reported, while in psychiatric hospitals, as in nursing homes, cases are counted by the score, which has shown that it is safer to be admitted to a general hospital than to a psychiatric hospital.

In Argentina, we are in the process of shutting down psychiatric hospitals, both public and private, as the law requires, which has unleashed a systematic attack upon this reform.
As for policies implemented by Argentine mental health authorities to cope with the pandemic, I want to mention several measures that were put into effect by the Argentine government so as to maintain physical distancing while at the same time providing psychiatric care:

a) Remote psychotherapeutic care through Zoom, Whatsapp, phone hookups, etc. in order to avoid contact between patients and therapists.

b) Digital prescriptions that psychiatrists can send to patients either through the mail or electronically.

c) The creation of protocols for hospitalization on mental health grounds.

d) The creation of a protocol to support hospitalized individuals during the final stage of their end-of-life care.

e) A right to access (through phone and the internet) for people who have been hospitalized so that might keep in constant contact with their families.

In closing, I want to say that we have much to do in the field of mental health. If the pandemic has taught us anything, it is, first, that in order to be mindful of preventive measures, one has to be of good mental health. Second, this pandemic has given us an opportunity to understand what it means to live while shut in. Now we can imagine, if only a little, what a person who is committed to a psychiatric hospital for a long period of time might feel.

Now, more than ever, we should assert that there can be no health without mental health.

Reflections from Brazil on Priorities relating to Covid - 19

Clarissa Mendonça Corradi-Webster, Ph.D., Professor, University of São Paulo, Brazil

Regarding the priorities needs, from our perspective, we would like to highlight 5 particular points:

1. The first priority would be to support the public services. Covid showed how our National Health System is important to attend the whole population and to guarantee the right to be cared for. At the same time, the Brazilian federal government is constantly attacking the public services, so we see that as an important issue for the action plan.

2. The second priority would be to strengthen the community care network. The expansion of community mental health services has been very slow in Brazil while the financing for beds in psychiatric hospitals has increased.

3. The third priority would be to focus on the centrality of social determinants in mental health. The new Brazilian police of mental health, established in 2019, reorganized the psychosocial network, with lots of emphasis on medical services, such as outpatient clinics

and hospitals. These types of services can reinforce the centrality of the medical discourse in the way suffering is comprehended and dealt with. In a country with so many inequalities, we think it would be very important to focus on the social determinants.

4. The fourth priority would be to highlight the protagonism of the experienced person. Even in community mental health services, the power of the medical discourse and the power of paternalism are still very strong. We have to open more space for collaboration and the protagonism of experienced people.

5. The fifth priority would be to increase the dissemination and training of recovery oriented practices.

A Call to Action for resetting an optimal balance between face-to-face, assertive outreach and digitally enhanced community focussed mental health services: Telehealth Mental Health Services for and beyond Prolonged Droughts, Extreme Bushfire regions, COVID19 & other likely Climate Change related adverse events.

Professor Alan Rosen, AO, Chair Transforming Australia's Mental Health Service System, Inc, [TAMHSS]; Institute of Mental Health, University of Wollongong; Brain & Mind Centre, University of Sydney, Australia, October 2020.

We welcomed the first waves of mental health responses to the COVID-19 crisis from the National Governments, particularly in higher to middle income countries. Many largely focused upon the whole population through on-line or e-health information, triage, crisis counselling services, and telehealth, but much less so, if at all, on enhancing face-to-face and home visiting services. This resulted on rapidly "pivoting" many primary and specialist mental health care services from face-to-face to telehealth.

Although telehealth enhancement was often the sole or predominant response, it was often withdrawn too early, or extensions of these arrangements were often brief and discontinuous, or still too expensive and inaccessible for too many.

We also appreciated the unprecedented steps taken by Governments to preserve livelihoods through the crisis via various economic stimulus packages. The safety nets that have been established are crucial to prevent loss of jobs, which harshly impact on people with more severe forms of mental illness. However, such support was often too restricted or curtailed too rapidly.

There is now an urgent need to move the focus to people with moderate to severe, persisting and complex mental illness, and suicidality, whose numbers are swelling as further adversities unfold.

Key issues
The needs of people with moderate to severe mental illness were often poorly served prior to the pandemic, as evidenced by the prior low priority for funding of and many inquiries into mental health services. This represents a pre-existing crisis and makes the system in many countries extremely under strain and at risk.

Many people with mental illness and psychosocial disability were already existing on the margins of the economy and society, and are extremely vulnerable to the pandemic, associated economic recession, and high levels of unemployment. Many are isolated or living with families in need of support themselves and are at high risk of suicidal behaviour. At particularly high-risk are isolated or facility-bound aged individuals and those living with disabilities, Indigenous people, homeless people, non-citizens, and international students. Their need for acute care will swell during this crisis. A substantial rise in suicide risk is building, as in all economic recessions, and it will be more severe this time because of the scale and depth of the global disaster of COVID-19, including loss and grief. The suicide prevention field has been rightly emphasising the power of social determinants of suicide.

The impact will be difficult to counter or moderate in the medium term. Our response therefore must turn much more strongly to freely accessible expert clinical care.
In the shock of the initial phases of this pandemic, public, private and many NGO mental health services for people with mental illness saw a sharp drop in face-to-face care, and a withdrawal from home based and assertive outreach modes of providing such care, just when these are most needed for a wider range of service users who were more isolated than ever. In part this is related to a lack of availability of protection equipment and justifiable concerns about service-user and staff safety.

The system is weakest at a point where it needs to be strongest in the context of COVID-19, namely in its capacity to work upstream with timely community interventions to prevent excessive emergency department presentations, and hospital admissions of acute mental illness.

As with any disaster, and particularly the pandemic of the huge scale in which we are now immersed, there are emerging several delayed and overlapping surges of increasing demand and need for care.

Mental health services, including hospital facilities, are being overwhelmed when providers do not intervene early, and intensively, with people we know to be at risk of acute episodes and suicide.

It is also sometimes due to inconsistencies of clinical leadership and central policy direction, and to failures of role modelling by some senior clinicians, without age or disability related vulnerabilities, who have withdrawn to working digitally only from their homes and offices, and loss of in-person clinical back-up for NGO direct support services in the community.

Key Solutions
The key solution is to urgently deploy evidence based mobile pre-emptive active response community-based mental health teams, including home-based care with dynamic integration with digital on-line and telehealth platforms.
There are increasing numbers of published studies on telehealth use for mental health in recent disasters, but they are mainly descriptive, and often simplistic, implicitly encouraging public mental health teams to "pivot" almost completely to more sedentary

telehealth, without providing rigorous evidence of comparative effectiveness, nor adequate balance with face-to-face and outreach home visiting services, whenever possible and necessary, and with proper safety precautions. Some senior clinical leaders, even those not in designated vulnerable categories, role-modelled this by switching their work attendance to "virtual" only.

However, we need an optimal and adjustable mix of both, encouraging hybrid digitally enhanced face-to-face services (and vice versa) in all regions. The legacy of evidence and lessons from these disasters, extensive modelling algorithms on the basis of this evidence, and likely exponentially worsening climate change, for mental health services, are that we will need to stabilize and develop this balance further for the future, making these arrangements more equitable and ongoing. Government responses to ameliorating the continuing mental health impacts of trauma & prolonged economic consequences of these disasters, need to be sustained on an ongoing basis, not for just a few months at a time, nor without further and continuous Government commitment for the future.
We call on all Governments to ensure that national mandated policy guarantees an optimal balance between online and telehealth services, in-person mobile outreach community services, hospital inpatient services, and residential alternatives for community residential care with continuity of support. The focus of the next wave of policy and investment must shift to ensure the safety and optimal care of people with moderate to severe or complex mental illness.

Service managements must ensure safety and personal support of all service-users, clinical and NGO providers. Mental health providers must be assured that there will be no retractions of community staffing or their outreach capacity, with strong and compassionate management support, thorough safety training, adequate supplies of personal protective equipment, regular supervision and pastoral mentoring, in full consultation with their industrial representatives.

We must also now re-plan our mental health services for well beyond recent environmental disasters, including the current pandemic, in the light of our experiences of the effectiveness and deficiencies of different nations 'mental health responses to these disasters, We must do this also in anticipation of increasing demand for such services due to further escalation of climate change related environmental adversities, which will affect those with the worst greatest disabilities and social determinants first, but ultimately us all. This entails expanding early intervention and active response community based mental health services, while resetting the balance between more community and less hospital-centric services, as well as between digitally augmented and face-to-face and assertive outreach services.

References:

Rosen A, Gill N S, Salvador-Carulla L, The future of community psychiatry and community mental health services, Current Opinion in Psychiatry, 33: 4: 375-390, July 2020.

Rosen A, Telehealth Services for Fireground regions & COVID19 related mental health services: Hansard: Invited additional submission following testimony to the AUSTRALIAN SENATE FINANCE AND PUBLIC ADMINISTRATION REFERENCES COMMITTEE,
Updated September 29, 2020: Inquiry into lessons to be learned in relation to the preparation and planning for, response to and recovery efforts following the 2019-20 Australian bushfire season (& the COVID 19 Pandemic).

The Situation in the Czech Republic relating to Mental Health and Covid - 19

Jan Pfeiffer, Psychiatrist, Czech Republic

" ... on a national level a strong discussion is being held about the need to accelerate the process of deinstitutionalisation, both in health care social services as well."

In connection with the fact that institutional care (large psychiatric hospitals, social institutions) proved to be very risky for the possibility of rapid transmission of the disease, on a national level a strong discussion is being held about the need to accelerate the process of deinstitutionalisation, both in health care social services as well.

Large psychiatric hospitals have been tasked with creating facilities in some of their buildings for the eventual quarantine of their clients with corona virus infections if begin to appear in facilities. For this reason, and in order to reduce the risk by reducing the number of clients, a number of clients began to be discharged quickly from the psychiatric hospital. These were clients in an advanced stage of addiction treatment. There were also geronto psychiatric clients. These were also clients treated for psychotic illness. In previous debates on deinstitutionalisation plans, hospital management has argued that they cannot reduce their beds because all clients hospitalized here need their "treatment." It has suddenly been shown that bed capacity can be reduced by up to one third in one week.

We do not yet have a more accurate record of what is happening to the laid off clients. Most of them went to home care. Most of the discharged patients with psychosis passed into the care of community teams. Many hospitals worked with community teams to plan to release the group, and the release was quite safe.

However, there were cases when this was not the case. Clients could end up in various types of hostels, where community teams had to search for them themselves and find it more difficult to establish cooperation with them.

In some cases (rather sporadically), psychiatric nurses from psychiatric inpatient facilities began working part-time in community teams. This further strengthened the continuity of care for laid off clients.

The reaction of community teams to the current situation is different. Some have reduced their field work and communicate with clients by telephone or visual media. On the contrary, some have strengthened their field work. They replace dysfunctional outpatient clinics of self-employed psychiatrists. In the client's home, they apply depot medications, etc. Teams have also started to use Skype and other similar programs to communicate with each other (team sessions). Some teams are practically not in their hinterland, but are almost 100% of the time in the field.

Mobile media have become much more widely used to communicate with clients. Some clients react badly to this, some respond well, and even prefer this communication to personal contact.

Although unemployment has not risen dramatically yet, some clients report losing their jobs.

Web seminars have been used to a massive extent for therapeutic group sessions as well as for teaching and educational activities. The clients themselves also took part in this and organize a supportive, informative web meeting for members of their organizations or groups.

Many new crisis lines were created and hundreds of volunteers joined their operation. Hundreds of professionals are then available online with advice and supervision.
It turns out that smouldering domestic conflicts have escalated in many cases. It is estimated that domestic violence has increased. Many sectors have been involved in the protection and support of people at risk of domestic violence. A mobile application for people at risk of domestic violence was created. Postmen are trained in recognizing signs of domestic violence (when they get into their homes when delivering mail or parcels).

They are trained in the skill of open-ended questions and in supporting potential hugs to ask for help. Other delivery services (companies specializing in the delivery of ready meals or food, etc.) also joined the program.

Consideration is being given to how to re-establish the system of crisis interventions and how to strengthen the overall ability of the system to work with people with post-traumatic syndrome.

The government has decided to put more money into health insurance. At this step, it was also mentioned that the continuation of the reform of care for the mentally ill must be ensured.

In summary:

- The spirit of cooperation and belonging has been strengthened throughout society.
- Mental health is proving to be an important factor to take care of.
- The current situation has strengthened cooperation between inpatient and community services and thus strengthened mutual trust.
- The advantages of community, mobile teams were shown and they generally gained more respect from other health services as well as from the local government
- The riskiness of large residential facilities has been shown and arguments to speed up deinstitutionalisation have been strengthened.
- Community resources have been mobilized, which have not yet been used for mental health care.
- In general, readiness for virtual communication has increased (even across borders), paradoxically, the availability of educational programs in the field of mental health care has increased (webinars, video recording, etc.)

The paradoxes and contradictions posed during the Covid pandemic for Mental Health

Roberto Mezzina, Regional Vice President for Europe, World Federation for Mental Health

Therapeutic relationships: when delivered online is compromised by the loss of physical presence materialised, however whilst remote connections cannot substitute for physical meetings completely they have shown to be useful in keeping human connection.

Social reconnections are diminished by lockdown and by the necessary lifestyle changes that people have been required to make.
Community-based services availability has been reduced (and outpatient care stopped in many places). Outreach work is mostly hindered (if not everywhere), whilst emergency care in hospitals is mostly preserved and protected.

Psychiatric institutions (and all forms of residential care, e.g. nursing homes, social care homes, especially of a large scale) are known to be sources of infection. Further, human rights have been compromised; people are staying longer in hospital ,and social contacts are limited.

Small scale (e.g. supported accommodation) is safer, where co-management and so-responsibility is practiced, both from a therapeutic and preventive point of view.
There is an opportunity to challenge stigma by developing a better understanding that we are all in this situation together. Everyone has experienced distress and trauma. Deprivation because of lockdown is causing social, ecological and economic problems. Mental health issues are now everybody's business.

Vulnerable people impacted by poverty, racism, ageism, homelessness, isolation and marginalisation, especially those with pre-existing Mental Health problems should be a priority. The response should e especially tailored to their life needs and social circumstances. Surprisingly those who required closer attention by community services did better, because of the trusting, collaborative relationship and support offered, and the investment in shared responsibility.

We don't know what the medium and long term effects will be on mental health in the general population. There is a danger that the detrimental impact of social determinants will have a greater impact than the pandemic itself.

As the adoption of more hygiene and health protection is necessary there will be an equal requirement there is for a robust social intervention. The restitution of the social body could be mediate through their active participation and being recognised as citizens. This is to address the issue of the subjectivation of the individual organic body (within medicine).

Solidarity (also at the community level) is needed, and has buffered the traumatic impact of Covid-19. However, this won't happen per se, it requires a catalyst role for community services. Comprehensive responses are proving to be more important than individual approaches, as integrated services respond to whole life needs of the person and the community.

The main question: what is an essential service in Mental Health?
A better integrated service?

Providing responses to basic needs?
Putting care relationships and social inclusion embedded in the total service response?

Change the Thinking, Change the Practice, Change the System

International Mental Health Collaborating Network and Rob Warriner, CEO Walsh Trust, New Zealand

Change the Thinking *that drives the practice, that creates the system, that shapes the culture.*

Whatever services are developed and then offered have to be primarily focused upon demonstrating “value” and “relevance” and “effectiveness”, to the people who need to use such services. To achieve this and to respond effectively and creatively to the distress experienced by people living diverse and sometimes complex lives, this will demand both integrity and engagement with the full complexity of that life – not just a medical diagnosis. This is a significant learning edge for GPs / medical centres, that is commonly minimised. In their current form, assumptions of their centrality to supporting contemporary community-based mental health and wellbeing are convenient, ill-considered and risk replicating, even reinforcing, diagnostically driven practice culture. A case of old wine in new bottles.

Effective interventions then have to be facilitated by a commitment to partner the individual and [commonly], a range of agencies / communities and resources, in developing an equally complex, but seamless array of service responses.

Change the Practice so that it is relevant to people living their lives
Mental health is now so much more than disease identification, treatment and then management. It is now time to take services to where people are, every day, in their lives, rather than passively waiting for them to arrive at “the clinic”. Practice must be led by social determinants of health, not on statutory roles in the health system. Such determinants must also include consideration of the impact of trauma, racism, violence, abuse and colonisation.

In 2020 it is time to move away from the paradigm of seeing medical problems with social implications to understanding that these are social problems with medical implications. Services must be active and intentional in their engagement and relationship with people and the community. Access to services will need to be available in people’s homes, offices, welfare services, public transport hubs, “marae”, sports facilities, education sites – and within health providers.

Change the System and the way it is organised and responds.
“Mental health” can no longer be regarded as solely a “health” matter and responsibility. Housing, employment, friendships, connections, employment, hope, safety… are all “mental health” matters. A seamless, coordinated experience must become the norm for people using services – and a key performance indicator for service providers.
Finally, in again recognising that mental health, wellbeing and addiction issues are driven and influenced by a wide variety of social determinants, the commissioning and funding frameworks have to reflect this - and be independent of service provision
As indicated by advanced experience like Trieste and other places worldwide, the changes outlined above will not just have to be good for people needing support with poor mental health and wellbeing, but they will also have to be good for staff and practitioners

Service principles: Community centred work in mental health

Roberto Mezzina, Chair of IMHCN and Regional Vice President for Europe, World Federation for Mental Health

Planning for the integration of community mental health whole system through:

Using methodologies and structures for co-planning and co-management of all services, approaches and interventions.

Mainstreaming: All mental health services should be an equal part of the general health care system and delivered at a local community level.

Co-production: The participation and empowerment of service users and carers (both past and present) is necessary in the planning, management and evaluation of services. The energy for successful service transformation comes from the knowledge of those who use the services based on their whole life needs.

Equalities and Participation: The participation of all stakeholders in decision making and self determination is essential for a co-production approach.

No coercion: All levels of involuntary and imposed treatments must be limited and considered a last resort after having possible alternatives. These practices based on human rights include having open doors, open access, no seclusion, no restraint, no compulsory treatment. These should be enforced legally and through shifting the power balance between the service user and the professional promoting a culture of positive / shared risk taking and developing specific training opportunities.

Work towards reducing the use of secure beds / units means recognising that institutional forms of limiting freedom are contradictory and need to be addressed. We also need to manage the contradictions of sanctions within the prison system

No long term psychiatric hospitals: The process of de-institutionalisation and closure of large psychiatric institutions is the foundation of community based mental health services. They should not coexist as this undermines the quality of the care and support in the community and peoples human rights.

Proximity: Services should be offered as close as possible to people homes and in neighbourhoods known to the person. Person / group / network / local community / institutions / society: this is the progression from the individual to the collective and social dimension

Community based services must be small scale, accountable, responsible, accessible, mobile, flexible, not only physically located in the community, including utilising social media, apps and other internet based supports. These must be accessible 24 hours a day, seven days a week with multidisciplinary staff also providing home treatment and respite beds as alternatives to hospitalisation.This should have the aim and the capacity to care for people with severe problems.

The Holistic approach: to all aspects of life (health and social determinants) does not separate the mental health condition, life experiences and the vicissitudes of life as they should be understood and responded to in relation to the whole life needs of the person. This approach should apply to every organisation, system and interventions in many respects. This approach is antithetical to biomedical reductionism and therefore should be central to the new paradigm.

Evidence based ethics: The adoption of ethical, bioethical, rights-based values must be founded upon a person centred approach. This requires the development of participatory, dialogical, dialectical, multilateral relations between services, citizens and communities.

Lessons from the last 50 years: A Global "call to action"; making mental health services relevant to people who need to use them (not the people who need to deliver them!)

Rob Warriner, Walsh Trust, New Zealand

Why?: We know all about the climate crisis, but another crisis is also happening. A human crisis; our human resources.

We have designed and created empires of services with needs, expectations and demands that respond to the problems they are presented with. But they are increasingly separated from people living lives. A diagnosis suggests we know something; it allows a selection of treatment options to become available and be offered. Loneliness, anxiety, poverty, homelessness, social exclusion, discrimination, trauma, relationship breakdown... can struggle to fit into our consideration of a person; to become a priority. So too a person's talents, uniqueness, qualities, dreams, aspirations, and potential.

Human resources are like natural resources; they are not just lying on the ground waiting to be picked up. You have to search and dig for these; and sometimes dig deep. You have to create the circumstances, the environment where they will show themselves.

For people, more often than not, this is in the community; at work, at play, in their homes with their family / whanau (Maori gathering place), with people they love and care about. And you might imagine that this is where mental health, well-being and support services concentrate their work, their knowledge and resources. It's not.

Every mental health service in the world is working through, most struggling through, a process of reform. It's not enough. Reform is of no use, because all it is doing is trying to fix a broken model. What is needed is not change, but in fact a revolution. Services have to be transformed into something else; a transformation that in fact challenges if not re-defines our common sense.

And this latter idea highlights the core of our problem. How do we overcome the “rule” of common sense; the things we take for granted, that we think, “Well it can’t be done any other way...”.

Places like Trieste (in Italy) have shown that things can be “done another way...”; that common sense can be changed. An absolute commitment to upholding people’s human rights, that recognises the therapeutic value of freedom... these infect the bedrock of services in Trieste – and are a pre-condition of care. As a result services in Trieste can boast some of the lowest uses of compulsory treatment, seclusion and restraints in the world – and by some measure.

We too can re-define common sense. It isn’t easy or simple; in fact it means doing things differently, that we find hard.

We too can re-define common sense; because it’s been done before.

Responses to poor mental health must now be reoriented to ensure that everything they do is based in the belief that all people have a right to a sense of self- worth, and the potential to live a rich and fulfilling life that holds personal meaning and purpose.

Responses to poor mental health must achieve this through understanding, responding to and supporting what it is that people are trying to achieve and the difficulties they may experience. They must empower and communicate people’s worth and potential so clearly that they are inspired to see it in themselves”.

Finally responses to poor mental health must provide a range of quality, community-based, mental health support and well-being services, that are connected to and partner with community networks, expertise and other resources. These services must be provided by a range of skilled and dedicated staff - the skills of many will be enhanced by their own personal experience of over-coming adversity in health and/or life.

“We cannot simply scale-up existing models of treatment to meet the current level of mental health need. We have to change the paradigm from treatment and containment to prevention, early intervention and sustainable recovery – and we have to shift resources accordingly.”

The following articulates a roadmap for transforming global responses to poor mental health and wellbeing. It is grounded in key service principles. These service principles must be breathed into life by the following human values: courtesy, respect, integrity and kindness.

The roadmap is presented in the context of three core challenges and objectives; these are:

Change the thinking
Why does this need to happen?
What will it look like / achieve
How will it achieve its purpose / reason for being? What values and principles will drive this?

Change the system[s]
Why does this need to happen?
What will it look like / achieve
How will it achieve its purpose / reason for being? What values and principles will drive this?

Change the practice
Why does this need to happen?
What will it look like / achieve

How will it achieve its purpose / reason for being? What values and principles will drive this?

Ethical, or bioethical, or rights-based value horizon must be combined with the recognition of the person and his centrality.

If this happens, once again through a passage of power, it becomes an alliance, an a priori dialogue and collaborative position, which cannot fail to influence the results (it is intrinsically therapeutic).

When reality breaks from us: COVID-19 and lived experience

Ana Florence, PhD and Larry Davidson, PhD, Yale Program for Recovery and Community Health, November 2020

In April of 2020, after the WHO characterized COVID-19 as a global pandemic, a Yale Program for Recovery and Community Health research team led by Ana Florence convened three listening sessions over a virtual platform to gather information, views and
personal accounts from 24 people with lived experience with the psychiatric system related to the current COVID-19 pandemic. Several areas of priority were identified by this group. They are: 1) recovery framework; 2) challenging notions of normality; and 3) health inequities. The group identified a useful conceptual framework in the recovery tradition highlighting the importance of understanding moving through distress as a non-linear process. Counter intuitively, many of our group felt well prepared to deal with high degrees of uncertainty brought by the pandemic, and hopeful for the future because of previous experiences of extreme states, breaks with reality and restoring meaningful lives in their journeys of recovery.
A second priority is related to the understanding of distress and suffering outside of the pathologizing framework. The collective experience of a reality break caused by the emergence of the virus can be an opportunity to revisit notions of normality and

pathology and reframe them as life experiences that affect whole persons rather than a series of symptoms to be medically or psychologically addressed and eliminated. This framework should inform how systems of care mount responses to this public health crisis. Issues of employment, financial stability, access to food and housing, and access to health should be prioritized.
Finally, from a health inequities perspective, specific groups have been disproportionately affected by the virus, such as Black/African American and Latino populations in the US, incarcerated people, individuals living in congregate facilities such as psychiatric hospitals and ageing population. Providing psychological services to mitigate the distress of loss of job and income, of food insecurity, of challenges related to parenting while schools are remote would be a tragic mistake. This reinforces the lifestyle drift and locates the issue within the individual rather than addressing the structural causes of distress and suffering. COVID-19 is not the great equalizer, the pandemic has highlighted and magnified long standing social problems, it is our hope that this crisis will bring new equity.

Transforming Mental Health

Rob Warriner, Walsh Trust, New Zealand

There are places in the world where fundamental change and transformation have taken place. Philadelphia transformed their mental health services during a decade, from 2005-2015. The following is an amalgam of elements that were seen to contribute to such fundamental change.

The elements were:

Engagement - they listened to multiple constituencies.

They **“role-modelled”** an approach that was to infect both the transformation itself, as well as the consequent structures, processes, culture and practices that evolved.

The multiple constituencies obviously started with the individuals and their families served, and individuals and their families who need[ed] but have not received services. However also included was the widest array of community interests and perspectives and responsibilities. Increasing the “listening stance” was a good start; however the main challenge and opportunity was to encourage all the parties to come together as a listening / learning system of care and support, and influence.

They conducted an inventory of system relationships
This was a second “listening” process. It was a compilation described as a “searching and fearless” inventory of the existing system relationships. People (regardless of their role) were asked to share their experience of being within the system. The stance of of those assigned to listen was not to defend, rationalise, deflect, blame or correct. It was purely to listen and record as accurately as possible.

They created a vision of a transformed system of care
Utilising the above, they developed a shared vision that was based on an understanding of both mutual limitations and collective strengths. The core message mirrored the

experience of many recovering from illness / trauma: “We can achieve together what we couldn’t achieve alone”.

They developed a consensus on the need to move from “power over” to a partnership-based, relational model

Through the listening processes, prevailing relationship patterns became clearer. Power-based relationships, that were governed by real or implied threat and control, pervaded the system from top to bottom. An underlying tone of paternalism, disrespect, and, at times, outright contempt were quickly revealed. The care question raised in this collaboration process was “How do we best move from this atmosphere of power-based relationships towards one marked by deep and sustained respect and collaboration?”. The answer was pivotal in the conclusion that “...we all need to recover – individually and as a system of care.”

They developed new values to guide system relationships – against which all partners / parties would commit to being accountable

To support the need for healing and renewal of the systems of care, they developed and modelled values that led to more supportive relationships between and across service constituents. For example, just as people were encouraged to share their recovery stories (how things were, what happened, how things are now...), people working within the systems were likewise encouraged to emulate that story-telling by creating a parallel story of how things were for the service systems. This created a story of how a wounded system can itself be in a recovery process.

They began the transformation and partnership process internally to model commitment to new values

A key principle guiding a transformation is that the organisations leading the process must also begin those change processes internally (ie. “being the change you want to see”). Activities that supported this included: internal focus groups, education and training about recovery, community representatives/ service users included in internal committees and work groups, activities located in “everyday community settings” (not a hospital or clinic), recovery plans for specific units / teams, leadership training...

They created partnership planning and advisory structures against which new partnerships were initiated and sustained

It was recognised that recovery and well-being systems transformation process required a fundamental reconstruction of all relationships within and across the service systems (including health, housing, education, welfare and social services, justice...), . This required structures whose function was to effect, oversee, and provide leadership to the relationship reconstruction and embedding processes. Resourcing the “transformation” process was essential; it cannot be achieved alongside of, or as an add-on to “business as usual”.

They created a transformative blueprint that defined goals, roles, and relationships

This was critical. The large number of activities generated by the transformation and the system development / maintenance functions have to be coordinated to occur simultaneously. Without effective coordination, these can threaten the transformation process by creating overload and a sense of chaos.

1) Seven areas could be prioritised: community inclusion/opportunity,
2) Holistic care,
3) Peer culture / peer support / peer leadership,

4) Family inclusion and leadership,
5) Partnership,
6) Extended recovery support, and
7) Quality of care / support.

Given that a "systems transformation" is a long journey, efforts were made to ensure that celebrations of progress were included in meetings / activities.
They ensured tools, resourcing, and contingencies (rewards) to support and incentivise movement towards partnership models
Early responses to systems transformation within the recovery advocacy and treatment provider communities went from resistance to scepticism to commitment at a conceptual level.
Fears continued about what this would all mean.
Treatment providers feared a loss of status and a potential loss of resources that would be diverted to support these other initiatives. Those fears and pockets of continued resistance were addressed by:
1) developing consensus on precisely how service practices would change within a recovery-oriented system of care,
2) providing concrete tools to help implement those practices,
3) providing incentives (acknowledgment and funding enhancements) for recovery-focused practice alignment and innovation, and
4) providing technical assistance to organisations having difficulties with the shift in philosophy and practice.

A transformation of this magnitude cannot occur by decree, nor without a long term commitment to achieving an end point, nor without dedicated resourcing.
They actively and deliberately celebrated the "fruits of transformation" and the new partnerships that were created through the transformation process
Restructuring mental health and addiction care systems, goals and relationships is demanding, time-consuming, methodical work requiring commitment, determination, and still more commitment. Progress – let alone achievements – could at times feel incremental - even for those closest to the activities and initiatives intended to achieve transformation. Everyone – from people using services, to people providing support, managers and administrators, community agencies, employers, local politicians… needed to see and celebrate the fruits of the system transformation.

They created institutional partnerships that were not dependent on only a small number of key people
Transforming complex human service systems, is not an overnight process; a common tendency can be to dramatically under-estimate the time required. Key institutional relationships cannot be built around a small number of key individuals. The new partnerships between organisations needed to be built from the top down and across organisations so that they are institutional relationships rather than person-dependent relationships.

They developed ways to measure partnership, recognizing that partnership development will take sustained time and effort and will develop in stages across multiple stakeholder groups

With many simultaneous activities occurring with the system transformation it is difficult to evaluate what progress, if any, is being made. Within each partnership structure / initiative, it was important to determine how they would know if a

particular activity was showing success. One of the most useful initiatives introduced to support the Philadelphia experience of transformation, was the development of a series of “Tools for Transformation” documents. These enable staff, people using services, service providers…etc. to evaluate themselves and their progress related to a particular strategy.

They recognised that partnership development will take sustained time and effort and will develop in stages across multiple stakeholder groups
The stages of personal recovery are well-known to most practitioners. The stages very much approximated the stages of system transformation in Philadelphia as experienced by service providers.

The stages were:
Pre-contemplation (eg. “Everything is fine; treatment works…”) through
Contemplation (“There are problems with the current design…”),
Preparation (eg. We are committed to making major change…”,
Action (eg. We are making major changes…”),
and **Maintenance** (eg. “We’ve come a long way, but still need to catch ourselves when we slide back into old ways of thinking…”).

Each stage was explored under 3 headings:
1) attitude towards overall systems transformation,
2) attitudes towards partnership development, and
3) the core strategies that were utilised.

As with individuals in recovery, it was not unusual for systems to cycle these stages multiple times before achieving a sustained and successful transformation process.

They were courageous and went “deeper and broader...”; measuring system relationships as part of the larger evaluation of system transformation efforts.

This element of the transformation became more pronounced at around year 4. The “deeper” reflected the need to move the change process and the existing newly formed partnership relationships from areas that generated rapid consensus, to areas that touched on areas of greater threat to vested ideas and interests.

“Deeper” also implied that the building of partnerships / forming relationships was not a task with a defined beginning, middle, and end. These partnership relationships had to be valued and regularly nurtured and deepened or they would wilt from lack of care, and in-attention.

The “broader” suggested that inevitably (with the benefit of reflection and hindsight) not all community stakeholders were equally engaged in the transformation process. Consequently, there was a need to strategise how those groups can be engaged, to bring them into and adding value to the transformation process.

Guiding principles:
Principle 1: People / family centred
Principle 2: Community-led
Principle 3: Uphold Te Tiriti O Waitangi ..
Principle 4: Achieve equity

Principle 5: Protect human rights
Principle 6: Work together
Principle 7: socialised

The Need For Fundamental Change in Mental Health Requires Radical Rethinking of Global Mental Health

Benedetto Saraceno, Secretary General Lisbon Institute of Global Mental Health

Addressing key unanswered questions

To address the "Need for Fundamental Change in Mental Health" a radical rethinking of the notion of global mental health (GMH) is needed.

To do so, we should consider a set of unanswered questions that are matters for serious debate.

Is GMH really global or rather Western?

Is GMH too unbalanced towards a biomedical model?

Is GMH concerned enough with modifying social determinants?

What is the real impact (if any) of GMH in low-income countries?

What are the consequences on the human rights of people in psychiatric institutions of the almost exclusive emphasis given by GMH on common mental disorders and on primary care level?

Are people with severe mental disabilities living in institutions once again at risk to be forgotten?

The Executive Board of the Consortium of Universities for Global Health defines Global Health as an "area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide and emphasizes transnational health issues, social determinants, and solutions". In other words, Global Health goes beyond medical paradigm and introduces the key notions and goals of improving health and achieving equity in health using a comprehensive public health and developmental approach.

The public health approach focuses on populations rather than on individuals, puts emphasis on prevention and not just on care and stresses the goal of equity and justice.

But if all this is true for Global Health cannot be true for Global Mental Health as well? In other words, why global mental health should be reduced just to making psychiatric medical treatments available to more people? Are we not accepting reductionism rather than joining the ambitions of global health?

Global Mental Health therefore, should be seen as an approach to international technical cooperation between countries where best practices in mental health policies, programs, service organization, care delivery and treatments are promoted and locally supported.

We all have enthusiastically endorsed the notion of reducing the gap between untreated and treated and therefore the urgent need of scaling-up mental health care.
However, we need to build the content of the scaling-up: what do we actually want to scale-up?

If we do not put a clear content to this process for sure we will get an easy and generic consensus about scaling-up and closing the gap but that consensus may be too easy and too generic. In scaling up mental health care are we scaling up:

i) outmoded psychiatric hospitals (as some psychiatrists seem to wish);

ii) compulsive hospitalisation with different rules and rights depending on the gender of the patient (as some psychiatrists would like to do);

iii) unmodified electroshocks “exceptionally allowed” (as some psychiatrists seem to recommend);

iv) finally, are we scaling-up the unacceptable influence of Industry on psychiatric prescribing practices (and all related international congresses and conferences)?

Of course, the answer would be: **NO,** we do not want scaling-up all this, but we should say that more clearly and make any effort to scaling up care more comprehensive, innovative and human rights driven mental health systems of care, prevention and promotion.

We need a more trans-disciplinary approach and opening dialogues and collaborations with service users, we need to look at national legislations and their coherence with international covenants on human rights, we need to look at the social and economic rights of people with mental disorders and disability as recommended by the UN, the Inter American and the European charters and conventions.

In other words, we cannot simply try to export treatment packages even if they are of good quality and evidence based: this is no longer enough.

We should be concerned about an increasing tendency of global mental health thinkers in reducing the notion of scaling up just to treatments as it would be possible to provide treatments in a vacuum instead than in a well-defined service/policy framework. We should be extremely vigilant to avoid that technical cooperation with countries (mostly with low income countries) is reduced to the transfer of treatment packages.

In other words, the term “global” should be seen not as just a geographical extension of the number countries treated as passive recipients of technical cooperation in the narrow area of psychiatric treatments but as the global support to local provision of comprehensive mental health policies and care.

What are the priorities for the next ten years of policy activity in global mental health

Firstly, we should qualify the notion of policy. Indeed, we need prioritising the re-orienting of mental health services organisation rather than the policies. If we generate a new policy, even if it is innovative (or maybe because it is innovative) in most of the cases it will not be implemented. On the contrary, if we re-orient the organisation of service we may eventually and more realistically generate a good mental health policy accordingly.

Secondly , we should designing clear and effective mechanisms to assist policy makers in countries to reduce the hegemonic role of psychiatric hospitals: when I was young, ministers used to ask, “why should I reduce number and size of psychiatric hospitals”; now they ask “how can I do it”. The key issue now is designing detailed mechanisms and processes for effective deinstitutionalisation.

Last but not least, we should promote sustained commitment to empower users in conceiving, planning and contributing to providing mental health services

What are the priorities for the next ten years of research in global mental health?

The first priority has not to do with a specific topic of research but rather with a research-policy issue. Now a day there is a broad consensus on the need to develop implementation science and the efforts to scale up mental health interventions provide an important opportunity to embed scientific research alongside the implementation of programmes. However, to develop implementation science the contribution from mental health research generated in LAMI countries is fundamental and vital. Research from those countries is needed for policy development and the establishment and expansion of clinical services

In 2003 the WHO Department of Mental Health and Substance Abuse called a meeting attended by 25 editors who signed a joint statement about “Galvanising mental health research in low-and-middle-income-countries”. Sixteen years later we are still quite far from the ambitious goal of promoting research in LAMIC.

Going into the topics of research we should consider as priority we may choose three main topics:

i) Understanding how genetic, neurodevelopmental and social risks and protective factors interact across the life course influencing mental health and mental disorders

ii) Given the brain’s plasticity, the perinatal period and early childhood are critical periods for healthy development and later mental health, my second priority would be promoting research on young children’s development

iii) Finally, implementing a comprehensive monitoring and assessment system to understand how interventions addressing social determinants of mental health have an impact on clinical outcomes and social functioning

Finally, should policy, implementation and research be given similar relevance or, rather, should any of the three activities be given priorities over the others?

The three activities should always coexist but depending on the country they should receive different degree of relevance giving priority to implementation over policy and research in many LIC but giving priority to research and implementation in many MIC.

Steps in Community Mental Health Development

IMHCN Library

The general community development process can be described in the following 10 basic steps. However it is important to recognises that community development is an organic process, so that while the "steps" are presented in a logical order, in reality they may not follow sequentially and some steps may either be skipped or carried out simultaneously with other steps.

10 Steps to Community Mental Health Development

1. **Learn about the community** Whether you want to be an active member of the community, an effective service provider or a community leader, you will have to be familiar with its issues, resources, needs, power structure and decision-making processes. Your initial orientation could include reading your local newspaper regularly, attending community events, reading reports and familiarising with available services as well as community projects and activities. Close observation of the community as you interact with it will also provide significant insights into the strengths and weaknesses of the community.

2. **Listen to community members** You won't be able to learn everything you need to know by reading and observation. You will need to talk to others about their interests and perceptions to put it into context. You can contact community members through formal channels, such as joining a local organisation, or informally by chatting with people that visit the library or that you encounter in other situations, such as shopping at local stores or attending school activities. By listening to the community you may identify an area in which there seems to be a common interest in making a change.
Health organization staff need to maintain regular contact with the community to collect enough information to make sound recommendations and decisions on health services and priorities and to identify important community issues.

3. **Bring people together** to develop a shared vision Once you have identified that there are some common interests among community members and you have identified a few individuals who seem willing to work on a community development initiative, the next step is to hold a community gathering. In some circumstances it may be appropriate to invite representatives of specific organizations or sector to attend, but more often it would be a public event for a neighbourhood or, for other types of communities, for all the identified members. The purpose of this gathering would be to develop a shared "community vision"; i.e., through imagining their ideal community and discussing their ideas together they will determine arrive at a common vision and some broad strategic directions that all are committed to working towards. You may also use this gathering to ask for support for the initiative, elicit community input or invite members to join a steering committee or help in other ways.

4. **Assess community assets and resources**, needs and issues To be able to work effectively in a community development context, you will need to gather some information about your community. It is extremely helpful to undertake a comprehensive community assessment which will collect both qualitative and quantitative data on a wide range of community features. Unfortunately, often time and budget restraints will necessitate choosing between methods and limiting the assessment to particular areas of interest.

Deciding what and how much information to collect may be aided by a SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis of the community, which may point to particular areas being higher priorities for action.

5. **Help community members** to recognize and articulate areas of concern and their causes In any community development process, it is the community that is in the driver's seat. Community members will define the issues and the process for resolving them, which might be quite different than what would be proposed by an external "expert". However, it is the community members that are most familiar with the situation and, in many cases, have knowledge and wisdom that an external "expert" lacks. By providing tools, resources, meeting space and facilitation, community developers empower the community to start to take ownership of the issues and the development of solutions.

6. **Establish a 'vehicle for change** In most circumstances it will be necessary to create a "vehicle for change" for an organizational change, which in most cases will start as a steering committee. Depending on the circumstances, this nature of the group could range from a few unaffiliated individuals or a coalition of organizations and institutions. In time, the steering committee may evolve into or be adopted by a community organization. There is a wide range of activities that the steering committee will need to undertake to ensure that it will be able to plan, organize, implement and evaluate the initiative effectively, including developing a charter or terms of reference, establishing governance policies, obtaining sufficient resources to carry out the work and identifying potential partners who can contribute to its success.

7. **Develop an action plan** Assuming that the community as a whole has set the strategic directions for the initiative, the steering committee will now develop the action plan. Depending on the size of the group and the complexity of the initiative, there may be other steps between setting the strategic directions and the action plan. You may want to create a comprehensive strategic plan containing long, mid and short-term objectives, and mid-level plans for communications, resource development or human resources. In addition, if there are a number of activities or events to plan, you will need a separate action plan for each one. The point you need to arrive at is a well thought out plan that is easily comprehended by community members, clearly links activities with objectives and indicates responsibilities, time frames and resources required.

8. Implement action plan This is the heart of the initiative, in which financial and human resources, including volunteers and community members, are mobilized to take action. This may take many different forms. Perhaps the community has decided to establish a coalition against homelessness and is working to ensure all organizations that come into contact with homeless persons are able to provide referrals to appropriate sources of assistance. The actions might consist of:

- working with community workers to identify needs and appropriate services;
- developing informational brochures;
- eliciting support from targeted organizations;
- distributing the brochures to the organizations; and
- meeting with organizational representatives to provide further information.

In addition to implementing the various action steps, it is important to ensure that the factors that are required for the success of any community initiative are in place, such as:

- shared vision and purpose
- concrete, attainable goals and objectives
- sufficient funds, staff, materials and time
- skilled, participatory leadership
- clear roles and policy guidelines
- mutual respect
- open communications, including both formal and informal method
- recognition that there are "process" people and there are "action" people; ensure there is a variety of ways of participating in or contributing to the initiative
- time and resources management; don't take on more than you can handle at one time; set priorities
- conflict management; don't let problems slide - address them in an open, honest and timely manner
- good record-keeping; e.g. financial reports, meeting minutes, successes
- celebration of successes
- fun; don't forget to celebrate your successes - even small ones!

9. **Evaluate results of actions** Traditionally, community development workers have relied more on their own experience, anecdotal evidence from others to guide their practice rather than formal evaluation procedures. Often it is difficult to find reasonable and appropriate measures in terms of the cost and time involved, especially when the desired outcomes, as is often the case with prevention and capacity-building initiatives, may not be seen for several years. However, there are many reasons why it is important to evaluate your work. Most importantly, you may need to demonstrate that you have not caused any harm to others through your actions. Other reasons to evaluate may be to demonstrate the effectiveness of the initiative so that it will be continued, to satisfy funder requirements and to provide information that will be useful to others or to subsequent initiatives. Evaluation plans may be formal or informal and tailored to the needs and resources of the group. IN community development, a participatory evaluation method is usually conducted in addition to or sometimes in place of more traditional method. Participatory evaluation involves program participants and/or community members in the evaluation design, data collection, and the analysis and interpretation of results.

10. **Reflect and regroup:** Allow time for the group to catch its breath before embarking on the next initiative. Thank everyone that contributed and make sure there is good follow up communication with media, partner and funders. Celebrate your successes and reflect on any disappointments that might have occurred. Discuss how well the organisational processes and structures worked and identify areas that need some attention before the next rush of activity occurs. Also, it is important to provide a space for participants to reflect on their personal development as a result of being part of the group. When the

group is ready to tackle a new initiative, they might want to revisit the community assessment information and the strategic directions and decide whether either of those steps need to be repeated.

14. **Whole Person, Whole Life - Whole System Approach**, ***John Jenkins, CEO, IMHCN***

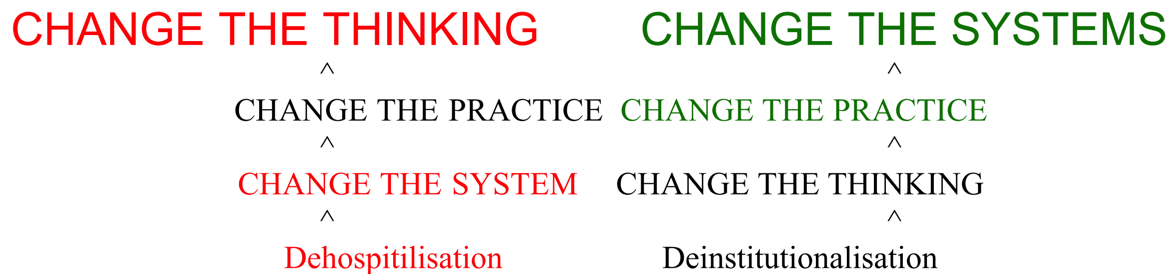
Whole Person, Whole Life-Whole Systems

Recovery and Discovery Approach

Social Determinants of Mental Health

- Whole Person
- Whole Life
- Recovery, Discovery into Practice
- Whole System Development

3 Tenets of Whole Person,Whole Life-Whole System



Worldwide, most new initiatives have come from the bottom up through people developing new initiatives in the field:

- 1870 John Bucknill in Devon, community hostels1923 Tavistock Clinic, treatment and training in psychotherap
- 1936 143 Outpatient clinics developed across the UK
- 1940 Cassel Hospital, Henderson Clinic, Dingleton, Therapeutic Communities
- 1946 Establishment of MIND
- 1954 Community Nurses ,Warlingham Park, Moorhaven, Plymouth
- 1950's day hospitals,social rehabilitation, welfare benefits and antipsychotic medication, the beginning of the decline of beds in institutions
- CMHC's USA 1960's, UK, Paignton,1979, Italy,Trieste 1978
- Home Treatment Teams, Boston, Amsterdam,Vancouver,Denver,
- Birmingham,Madison,Sydney,Montreal, in 1960's and 1970's
- Assertive Community Treatment Teams, Madison,Birmingham
- Comprehensive Whole Life Community Mental Health Services, Trieste,Lille
- Host Families, Madison,Boston, Belgium,Lille, Hertfordshire
- Recovery movement, USA,UK, France,Australia,New Zealand and many other countries
- User run services, acute alternatives, Cornwall, Birmingham, Colorado
- Self help, Prato, Italy
- Peer support, France,USA,UK
- Social cooperatives/ firms, Trieste, Brescia,Italy,UK

Whole Person, Whole Life-Whole System Approach

Developed in 2000 in NIMH(E) to implement policies since 1975 and the National Service Framework

Approach to bring together;

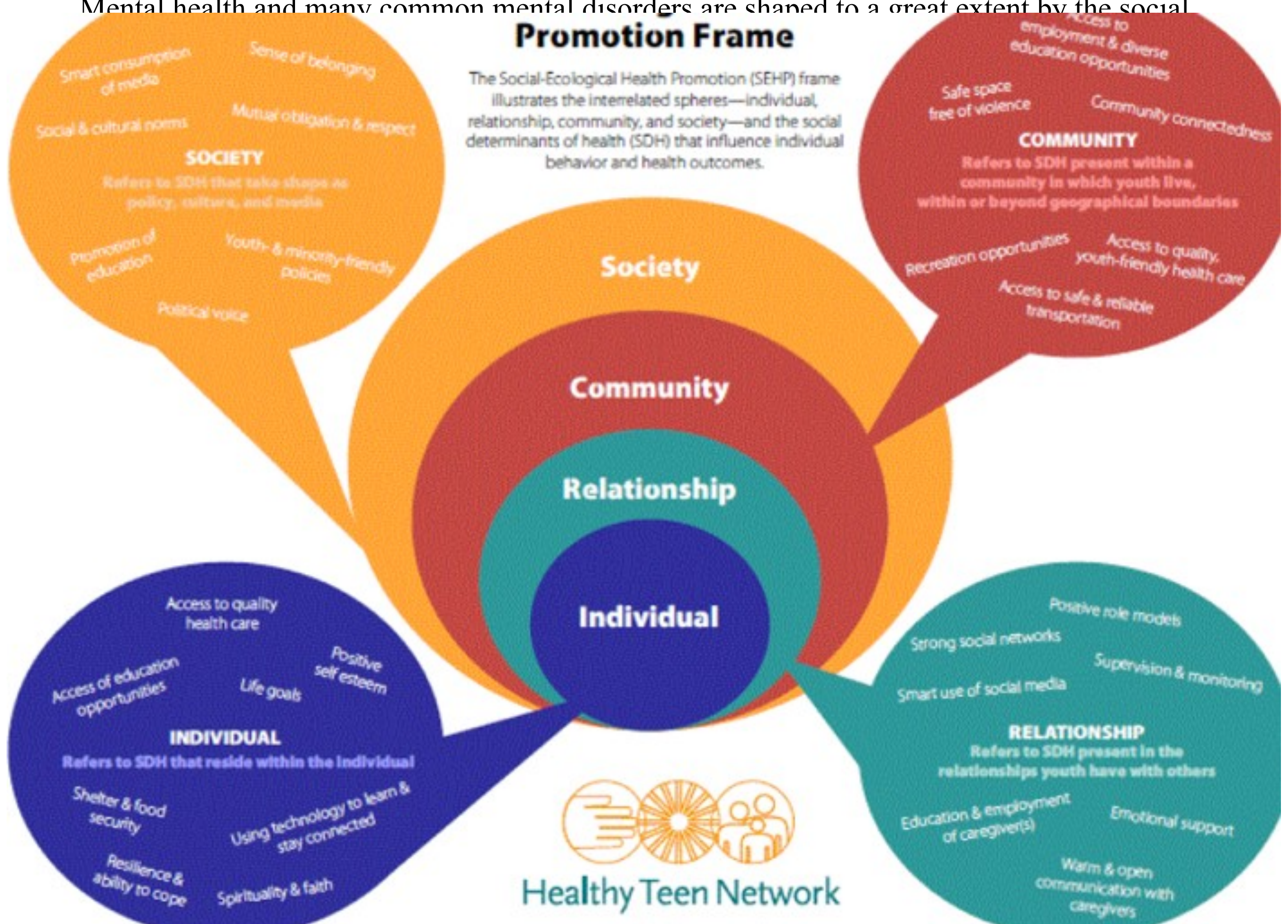
- Biological
- Psychological
- Social determinates of Health and Mental Health
- Anthropological, Meaning and Culture
- Philosophical, Critical Thinking. Dialogue
- Whole Life, Recovery Paradigm
- Whole Systems Thinking and Development
- Education and Knowledge,Sharing and Learning from International best Practice

IMHCN

The social determinants of health (SDH) are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems. (WHO)

Social Determinates of Mental Health
(World Health Organization and Calouste Gulbenkian Foundation. Social determinants of mental health. Geneva, World Health Organization, 2014)

Mental health and many common mental disorders are shaped to a great extent by the social



Technological Paradigm

The currently dominant paradigm, or framework, through which we understand mental health problems.

When we experience anxiety, depression, voices, suicidal impulses or states of disorganization, we are encouraged by family, friends and the media to see a specialist, get a diagnosis and a prescription for medication or therapy.

Mental illness is seen primarily as a technical challenge. It is understood as something that emerges from faulty processes in the brain or the mind, something that can be modelled with the same sort of models that we use in the rest of medicine, as when we grapple with endocrine problems such as diabetes.

Such models are developed by experts in psychiatry or psychology, and innovation in treatments are understood to emerge from university departments or research laboratories.

In this paradigm, patients can do things to help themselves but this is adjunctive to the main work that is provided to patients by experts of one sort or another.

While the non-technical aspects of mental health (relationships, meanings, values) are not ignored, they are of *secondary importance only.*

Empirical research on where mental health problems come from, and on what actually works to get people well, overwhelmingly points to the primary importance of relationships, meanings and values.

If we are to be truly evidence-based in our approach, we will have to face the challenge of questioning the dominant paradigm and effectively reversing our understanding of what should be at the heart of our work.

This has echoes of that other great paradigmatic reversal in history when Copernicus asserted that the earth revolves around the sun, not the other way around.

Recovery Paradigm

In fact, mental health service users have already started to do this. What is known as the ‘recovery approach’ emerged directly from service users challenging the understanding of their problems that they had been given by professionals.

In the past 20-30 years, many people who were told that were suffering from schizophrenia, or some other form of serious mental illness, and told that their best hope was simply to ‘keep taking the tablets’ and passively accept the guidance of the professionals

Many managed to find ways of changing their lives substantially
Many found that they were able to exit mental health services altogether.

Some did so with the help of therapy or medication but others found paths that led them to a reality of recovery that did not involve mental health services at all.

Work, relationships, the creative arts, recreation, peer support, religion and spirituality and a range of other pursuits have all provided the encouragement and support that people needed.

Some found that services got in the way of their recovery and a number argued that they had been damaged by their involvement with psychiatry and the other mental health professions.

A substantial group of these individuals have written about their journeys and now provide inspiration to their peers.

The recovery approach has emerged directly from this literature and the movement that has grown around it. Its essential message chimes with the results of empirical work on how professional interventions actually have their beneficial effects.

It does not represent a new model as such but instead involves an interrogation of all professional models and an assertion of the centrality of empowerment in the process of recovery

About the Whole Person

People want to be regarded as individuals and citizens and not to be identified or labelled by their diagnosis or pathology.

- People want to be in control of their recovery journeys and assisted by services in an equitable and empowering way.
- All too often people have been slotted into an illness paradigm that disempowers and maintains people within mental health services.
- Professionals and services need to recognise and harness the capabilities and assets of people with mental health problems.
- People with mental health problems need to take personal responsibility for their own recovery journey.
- In this way an individual can take the power to ensure that their unique goals, strengths and needs are harnessed, are fully recognised and acted upon.

Whole Life And Well Being

- A person with a mental health problem has the same basic human Whole Life needs as anybody.
- This is how to develop and lead a life that is full of purpose, interest, recognition, contribution, value and reward.
- A whole life comprising of these needs and aspirations is what most people with a mental health problem are seeking for themselves.
- Access to health, education opportunities, vocational training schemes, work, volunteering, social networks, sport and leisure and art and culture activities are all important in enabling people to have a whole life opportunity to assist them in their recovery and well-being.
- The IMHCN Whole Life approach promotes this by applying a Whole Systems methodology in the design, planning and implementation of a comprehensive integrated mental health system.
- The Whole system has to have an agreed common purpose and

objectives negotiated and owned by all community stakeholders.

- In this way the components of the System are interdependent with each other and have themselves a well defined contribution to the Whole System.
- The Whole is the most important and not each component on their own.
- It is a discipline for seeing WHOLES not HOLES.
- In mental health, recovery does not always refer to the process of complete recovery from a mental health problem in the way that we may recover from a physical health problem.

What is the Recovery, Discovery Approach

- For many people, the concept of recovery is about staying in control of their life despite experiencing a mental health problem.
- Professionals in the mental health sector often refer to the 'recovery model' in a different way, changing the name of things without the meaning!
- Putting recovery into action means focusing care on supporting recovery and building the resilience of people with mental health problems, not just on treating or managing their symptoms.
- There is no single definition of the concept of recovery for people with mental health problems, but the guiding principle is hope – the belief that it is possible for someone to regain a meaningful life, despite mental health issues or serious mental illness.
- Recovery is often referred to as a process, outlook, vision, conceptual framework or guiding principle.
- The recovery process provides a holistic view of mental health that focuses on the person, not just their symptoms
- It believes recovery from severe mental illness is possible
- It is a journey rather than a destination
- It does not necessarily mean getting back to where you were before
- It happens in 'fits and starts' and, like life, has many ups and downs
- It calls for optimism and commitment from all concerned
- It is profoundly influenced by people's expectations and attitudes
- It requires a well organised system of support from family, friends and professionals
- It requires services to embrace new and innovative ways of providing new services and practices

- The recovery process aims to help people with mental health problems to look beyond mere survival and existence.

It encourages them to move forward, set new goals and do things and develop relationships that give their lives meaning.

- Recovery emphasises that, while people may not have full control over their symptoms, they can have full control over their lives.
- Recovery is not about 'getting rid' of problems. It is about seeing beyond a person's mental health problems, recognising and fostering their abilities, interests and dreams.
- Mental illness and social attitudes to mental illness often impose limits on people experiencing ill health. health professionals, friends and families can be overly protective or pessimistic about what someone with a mental health problem will be able to achieve.
- Recovery is about looking beyond those limits to help people achieve their own goals and aspirations.
- Recovery can be a voyage of self-discovery and personal growth.
- Experiences of mental illness can provide opportunities for change, reflection and discovery of new values, skills and interests.
- Especially during a crisis.

What supports recovery?

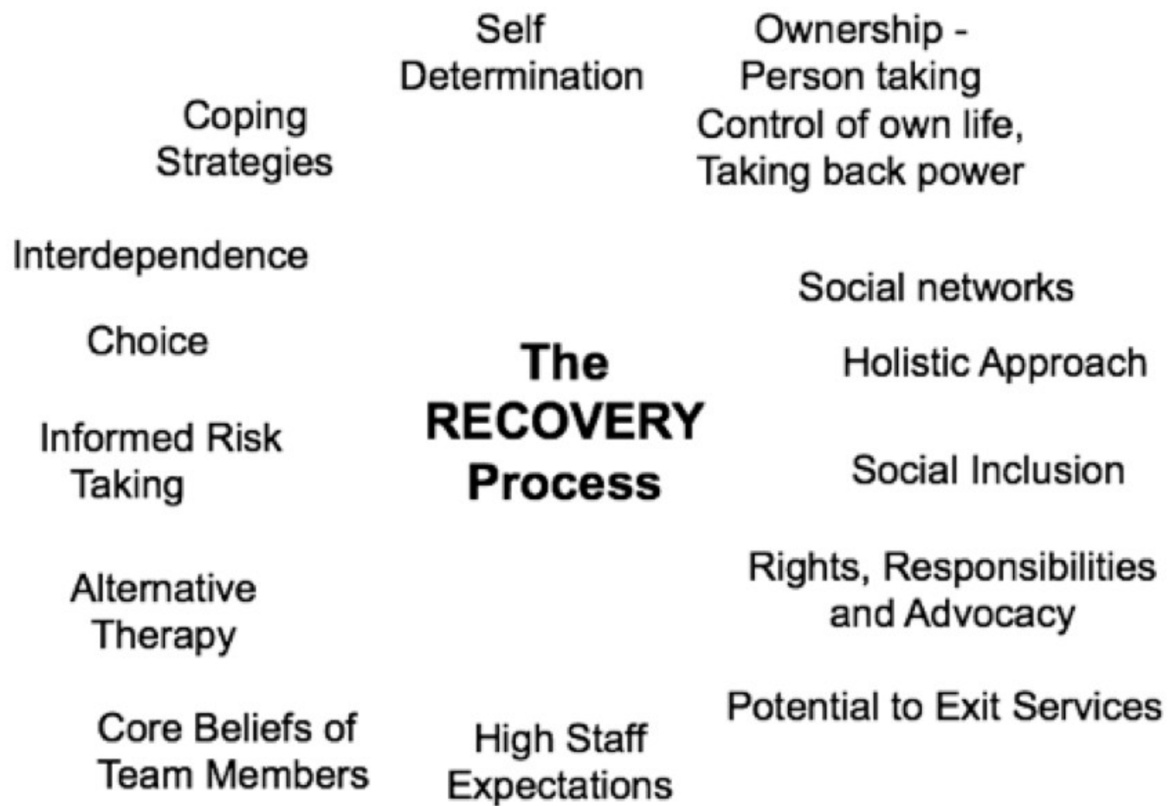
Research has found that important factors on the road to recovery include:

- good relationships,
- taking responsibility,
- shared responsibility
- financial security, satisfying work,
- personal growth,
- the right living environment,
- developing one's own cultural or spiritual perspectives,
- developing resilience to possible adversity or stress in the future

Further factors highlighted by people as supporting them on their recovery journey include:

- Developing a trusting reciprocal relationship with professionals
- being believed in
- being listened to and understood
- getting explanations for problems or experiences
- having the opportunity to temporarily resign responsibility during periods of crisis.
- The importance that anyone who is supporting someone during the recovery process encourages them to develop their skills and supports them to achieve their goals. HOPE

Maintenance Model


IMHCN
Self Determination
Ownership - Person taking Control of own life, Taking back power
Coping Strategies
Interdependence
Social networks
Choice
The RECOVERY Process
Holistic Approach
Informed Risk Taking
Social Inclusion
Alternative Therapy
Rights, Responsibilities and Advocacy
Potential to Exit Services
Core Beliefs of Team Members
High Staff Expectations

Recovery Resources and Materials

These are intended to provide practical help in a person's journey of recovery and how professionals and others can assist. In this way we can inform and motivate each other in improving the practice of recovery, whole life and well being for people. These will include:

- Recovery Stories, books in CPT, HPFT, Lyngby provided by individuals
- Whole Life-Recovery good practice guides
- Recovery Tools and instruments, WRAP, SHIRE, PATH, Recovery Star, THRIVE, etc
- Self Help, management manuals, Psychosis,self harm,depression, Bipolar
- Recovery and self injury workbooks
- Hearing Voices, exploration and understanding, voice dialoguing
- Recovery journeys by individuals
- Whole Life-Whole System Programs
- Well-being programs
- Psycho-educational techniques, stress management, positive thinking, interpersonal communication
- Nutrition and Diet
- Managing my medication
- Returning to work after mental health issues(NHS Choices)

WHOLE LIFE-WHOLE SYSTEMS

- This is to incorporate the Recovery Approach for individuals with whole life- whole systems community development, for them to have a whole life full of wellbeing and purpose
- This is to develop a community wide common purpose and responsibility and commitment through partnerships with local community organisations and groups.
- It is important to move away with the ever increasing preoccupation with security and risk
- To find ways to improve the effect of social determinants that are key causal and aggravating factors to a persons' mental health and the opportunities for their recovery.
- A common purpose of understanding and action for improved mental health and wellbeing of the population needs to be developed in communities and by communities(For the People of Plymouth by the People of Plymouth)
- This should use a Whole Systems developmental approach and process by engaging with all community organisations that have real or potential capacity to provide housing, employment, volunteering, art and culture, sport and leisure and education, etc.
- A Whole Systems process of developing community common purpose and responsibility has been developed by the IMHCN www.imhcn.org
- Plymouth Whole Life-Whole System Strategy

A WHOLE LIFE IN ALL RESPECTS

- **Where you live** The place you live in should meet your individual needs. You should not have to worry about having to move out, and it should not be too out-of-the-way. You should be able to come and go when you want, be alone when you want and not be harassed by the people you live with, by staff or by neighbours.
- **Money** You should have enough money to pay bills, stay out of debt and not miss meals. You should not have to feel isolated or cut off from society because of lack of money. Help with finances Many people find that they need help with claiming benefits, filling in forms and working out how to manage their money.You should get as much help as you need to do these things.
- **How you spend your day** You should have the opportunity to spend your day in some form of regular and meaningful activity. This could be working, studying, training or going to a day centre.
- **Family and friends** Mental illness can affect a person's relationships with the people that he or she cares most about. You should be able to maintain good relationships with the people closest to you.
- **Social life** You should have the opportunity to mix with people and form new friendships and relationships. To make this possible, you should have enough money, access to transport if you need it and the use of a telephone.
- **Information and advice** You should be given as much information as you want or need about the services and treatments available to you, about the Mental Health Act and how it works and about the mental health system generally. Some people find it helpful to have someone like them (such as another service user or a member of the same community) to explain things to them. The information you are given should be clear and easy to understand, and should be available as and when you need it.
- **Access to mental health services** You should be able to get help from your local mental health services when you need it, throughout the week, at any time of the day or night.
- **Choice of mental health services** A range of services should be available to you, and you should be able to choose those that closely match your needs, including complementary/alternative therapies, counselling & psychotherapy. You should have a choice about the mental health workers you meet with regularly (for example, being able to choose their gender or ethnic background) and be able to change workers.
- **Relationships with mental health workers** Doctors, nurses, social workers and other mental health workers should create reciprical trusting relationships, show you respect, be honest with you and discuss things with you in a way in which you can understand. They should keep information about you with you, confidentiality should be jointly determined and ask your permission before passing it on to others. If they pass on information, it should be accurate and save you from having to repeat yourself to new mental health workers.
- **Consultation and control** Mental health workers should not pressurise you to do anything that you do not want to, or take decisions on your behalf without getting your permission first. Even if you have been ‘sectioned’, people should show you respect, listen to you and take your opinions seriously.

- **Advocacy** You should be able to put your views across to people in authority. This can be difficult for several reasons, such as the effects of medication, if English is not your first language or if the situation is frightening or intimidating. If you want, you should have somebody (an advocate) to help or support you, or speak for you. You should feel that this person really understands what you want and genuinely represents your views when he/she speaks on your behalf.
- **Stigma and discrimination** You should feel safe and other people should not harass, exploit, victimise or be violent towards you. You should not experience stigma or discrimination at home, at work or from mental health workers, police or any other section of the community. People should not discriminate against you because of race, culture, religion, gender, sexual orientation, physical or mental disability or for any other reason.
- **Your medication/drug treatment** Medication should be given only to relieve the symptoms of mental ill health and to reduce your distress. All medication can have unwanted effects, but these should not cause more disruption to your life than improvement.
- **Access to physical health services** You should be able to get the treatment and care that you need for your physical health when you need it, whether you are in hospital or living at home. You should be able to be registered with a general practitioner and have regular check-ups from a dentist. You should have access to other types of care, such as opticians, chiropodists, physiotherapists and so on. Relationships with physical health workers The people who give you physical health care should listen to you, show you respect and take your condition seriously.

CHANGE THE PRACTICE

There has been a revolution over the last two decades in our understanding of what promotes recovery from mental illness. This evidence comes from various sources, from many different cultures, involves both health and social care perspectives and is based on various methodologies. This includes the individual testimony of service users and families, practice based evidence as well as the results of more scientific randomized controlled trials.

Research and clinical best practice points to several key areas underpinning contemporary ways of providing effective care & treatment.

These include:

- Care and treatment should be provided closer to the individual's home in normal settings chosen by the person themselves
- Services must be accessible and available when and where the person needs it, that is on a 24 hour / 7 day a week basis
- Detection and intervention must happen at an earlier stage in the development of the illness
- Care and treatment must be person centered and based on individual need and choice
- Increased access to individual talking or psychological therapies, such as CBT
- Access to family interventions and support, such as Psycho-educational and behavioural approaches to family support
- Effective recovery oriented Care Coordination in the context of Multi-disciplinary Team Work, which promotes access to effective services, continuity and coordination
- Greater promotion of client self-management and peer support approaches

- Integration of effective vocational interventions into everyday practice to support greater employment opportunities
- Improved access to effective modern medications
- Users require very often a variety of interventions and certainly choice about what they think works for them ,based on a trusting and therapeutic relationship with their psychiatrist, psychologist, nurse or social worker.How the intervention is applied is just as important as the content of the intervention. How Practice is Practised

Challenges for Services

- Many people in mental health services have ***lost hope for the future***
- The system has ***focussed on problems and disorders*** and has ***eroded aspirations***
- There is a ***culture of low expectations*** that effects people who use services as much as those who provide them
- **Austerity,** a time for **reflection and whole system change**
- **Focus** on the **Needs of Users** and not only on the **Needs of Organisations**

Some Examples of best services and Practices in Changing Thinking and Practice

24 HR Community Mental Health Center with Guest Beds - Trieste

Host Families, Madison, Lille, Hertfordshire

Crisis Houses, Birmingham,Cornwall, Leeds, Hertfordshire, Rethink

Social Cooperatives, Social Firms, Italy, UK

Recovery Houses and Communities, Italy,
Scotland, Australia Critical Psychiatry

www.criticalpsychiatry.co.uk Europe

Intentional Peer Support Is a way of thinking about purposeful relationships, Many countries

The Open Dialogue Approach, Finland,Denmark, UK, USA
Trialogues, Austria, Germany, Ireland

Soteria Houses for people with Psychosis experiences, USA, Europe