Westminster Mental Health Approach

> **A community is not essentially the building but the belonging – a shared commitment, a pooled accountability, a common language or approach. (Al-Khudhairy)**

By creating the Westminster Mental Health Approach we are developing a shared way of thinking that we will apply across the whole service. This will be a common way of working that will provide a consistent experience for clients and external stakeholders. It will be a guiding framework for all staff with a shared language, theoretical approach, and way of acting and behaving. We will use it in our recruitment, training, supervision, appraisal, reflective practice, building design and service delivery. This will fit within the organisational Recovery Approach but be more specific in terms of mental health support.

Medical Model:
Traditionally most mental health services, both statutory and voluntary, are based on the medical model. This is the idea that psychosis, distress, hearing voices or having unusual beliefs indicates a **mental illness** and result from a problem in the brain, genetics, DNA, or a chemical imbalance i.e. there is a biological cause. Doctors, nurses and psychiatrists are trained in this model. It uses a language of diagnosis, medication and symptom management. People are thought to be unlikely to recover without long term medication but these treatments don't address the underlying root of people's distress.

Our position is that mental health is a contested area. Some people find it helpful to think of their problems as an illness but others do not. The experiences that are sometimes called schizophrenia or psychosis are very real and can cause extreme distress, but they can also be viewed in alternative ways. We should not promote any one view or suggest that any one form of help such as medication or psychological therapy is useful for everyone. Interventions from a range of theoretical models would be consistent with our approach.

Alternative approaches:
Open Dialogue – this Finnish model involves exploring multiple perspectives on what is happening to cause a person's distress. A series of open 'network' meetings including the person themselves and their family, friends and professionals are held to discuss a range of explanations with the aim of placing the experiences and feelings in a meaningful social context.

Hearing Voices Network /Paranoia Network – this peer support approach attempts to normalise and de-pathologise the experience of hearing voices and paranoia. People are encouraged to find their own way of understanding and managing their experiences. Peer-led meetings create a space where people can learn from each other and build social connections.

Recovery Approach – the focus is on an individual's process towards recovery. This involves establishing their own goals and aspirations and developing the skills and resources to cope with the effects of distress to enable them to live a full life. This requires us to work in a way that promotes and respects hope, choice and individuality.

Person Centred Approach – this counselling model emphasises the importance of empathy, non-judging approach and genuineness in helping relationships. It is a 'non-expert' model which promotes equality, choice and control within the recovery environment and the belief that with support each person has their own resources to achieve meaningful solutions for themselves.

Trauma Informed Approach – this model focuses on mental distress as a reaction to life events, trauma or abuse. The people we work with are all likely to have one thing in common - that they have experienced events, to different degrees, which have been traumatising. A traumatic event is something which causes someone to feel terrified, helpless and out of control. The earlier a trauma occurs, or the more often it's repeated, the stronger the impact. Most clients have experienced multiple or complex traumas including abusive or absent parents, violence or neglect, child sexual abuse, torture, war or being a refugee, damaging relationships, discrimination, poverty, relationship breakdown, bereavement, sleeping rough, being in prison, using drugs, drinking to excess or sex working. People have experienced a staggering amount trauma in childhood and as adults which simply wasn't tolerable. This will impact on how they behave and relate to the world and others, this is how they have adapted to cope

In the Westminster Mental Health schemes we are committed to working as **Psychologically Informed Environments**. We are trying to create mentally healthy environments that avoid re-traumatising people. This involves thinking about how we understand and react to behaviours and how we offer support. If we accept that many people have experienced trauma then we can attempt to understand why someone is doing something instead of labelling it as a symptom of psychosis. Challenging and distressing behaviours, and unusual experiences and beliefs may have roots in trauma.

We will help people by:

- Providing staff teams who are safe, consistent, honest, warm and empathic.
- Offering safe and predictable environments with team approaches, clear and consistent rules and consequences.
- Being open, transparent and collaborative - involving people in all conversations, planning and decision making relating to their needs and support.
- Supporting people to understand that the difficulties they are experiencing are normal and trying to help them to manage their anxieties.
- Listening to and helping people make sense of their experiences and find their own meaning
- Asking: 'What has happened to you' rather than 'what is wrong with you?'
- Focusing on an individual's strengths and positive behaviours to build self esteem and motivation rather than support needs, risks and trying to get them to change.
- Focusing on their goals and working toward these, rather than our expectations of what they should do.
- Openly talking about hearing voices and visions, paranoia and unusual ideas, emotions and feelings, and risky behaviour.
- Supporting people to make informed decisions about medication and advocate for it to be used when needed, at a minimal dose for a limited time and reviewed frequently.
- Looking for opportunities to talk, negotiate, collaborate, make social connections, be more transparent, creative, trustworthy and share decision making.

Using a shared language:

Fear, suspicion, sadness, confusion and distress are understandable parts of being human. Once they are transformed into the medical language of depression, anxiety, schizophrenia, diagnosis, symptoms, and disorders this confirms people's 'illness', and cements the divide between 'them and us' the 'well and unwell'. If we use this language of we continue to accept this approach. The language we use is important because it reflects, reveals and shapes the way we think about things.

In the Westminster Mental Health service we will try to use non-medical language by just using everyday English. In this way we enable people to define their own experiences and avoid imposing our own ideas on them. We will use the language of 'hearing voices' or 'believes things others find

strange' or 'has suspicious thoughts' or 'appears out of contact with reality'. These terms and descriptions are as neutral as possible and do not imply that there is only one way of understanding these experiences.

Our Approach:
There is increasing evidence that even the most severe mental health problems are not the result of faulty genes or brain chemicals. They are a natural and normal response to the terrible things that have happened - **Bad things happen and can drive you crazy.** This way of thinking makes people's experiences more understandable and enables us to empathise more. Hearing voices, believing things that others find strange, or appearing out of touch with reality can be understood in the same way as other emotional or psychological problems such as anxiety, confusion, fear, sadness - as something **normal** we all could experience to some degree.

If we can make people feel safe and in control, validate their concerns and talk about their feelings then we can find out their strengths and work with them to meet their goals. We need to concentrate on helping each person to make sense of their experiences of madness, find the support that works for them and maintain the hope of recovery and we will work in a normalising, non-medical, trauma informed approach.