Sanpau Creative Wellbeing CIC
Create to express. Learn to develop.

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Sanpau is a Community Interest Company (CIC) that promotes creative and community approaches to alleviating mental distress wherever it may exist by developing innovative ways of promoting good Mental Health and treating poor mental health.

Our aspirational **vision** as an organisation, is to help promote a society which values our mental and emotional health, just as we do our physical health.

We challenge stigma and exclusion, and make the best possible use of community potential to educate, support and promote good mental health.

We aim to benefit all members of the community experiencing, or wanting to prevent, mental ill health.

**Terminology**

Throughout this document we use the term 'emotional distress' rather than 'mental illness', the term distress indicates to us that support may be required. We do not support the assertion that extreme distress always equates to illness as so much mental distress is initiated by social and environmental factors. Whilst we acknowledge that biological and psychological factors have a bearing we do not see one as being more important than another. People are a conglomeration of bio-psychosocial influences and it is most helpful to work with the whole person and their immediate environment.

Current mental health discourse refers often to a 'recovery' process; we prefer to think in terms of discovery rather than recovery. Following a period of mental distress we are unlikely to return to being the person we were, we emerge as a new, hopefully, improved version at which point we have to discover ourselves again.

**Current situation in mental wellbeing nationally**

- 1 out of 3 GP appointments is related to mental health issues (RCP, 2017)
- recent study suggests that 1 in 3 people will experience mental ill health (NHS Digital, 2016).
- In the UK 90% of people experiencing mental distress are managed in primary care (Mental Health Taskforce, 2015), with only a small percentage of people qualifying for specialist mental healthcare..

*'Mental ill health is the single largest cause of disability in the UK'*
(Department of Health, 2011 No Health without Mental Health)

Services in the UK are primarily available via primary care (IAPT services and medication) for those categorised as experiencing 'minor to moderate' mental ill health (Mental Health Taskforce, 2015). These are usually people suffering symptoms linked to depression and anxiety, which can be very disabling and seriously affect work and family relationships.

Secondary mental health services are available for those experiencing severe emotional distress but this accounts for only 3.4% of the adult population of England (CQC, 2017). The majority of people experiencing emotional distress fall between these two poles and, although there are variable pockets of provision nationwide, these are often short term and postcode dependant, nothing coherent exists to provide for this group.

The human cost of such minimal support for these people is as yet unquantified. However we do know that a recent OECD study estimated the overall cost to the economy of mental ill-health was £70 billion per year (OECD. 2014), and in 2017 the Institute for Fiscal Studies reported that half of all disability claims resulted from mental ill-health. The CQC point out in their 2017 report on the state of care in mental health services that:

- there is an increasing demand for mental health support particularly in primary care;
- there is a reduction in the number of trained staff able to provide support for those in mental distress, particularly nurses;
- the number of detentions of people under the Mental Health Act (MHA) has risen 26% between 2012/13 to 2015/16

- services provided across the country, both NHS and independent, vary considerably in terms of quality care and safety (CQC, 2017).

***We suggest that this is an unsatisfactory position that demands immediate innovative action.***

**What are Services For?**

To help contextualise our position it is worth considering briefly what services are for. The answer to this question is likely to differ depending on perspective. Few would argue that a primary purpose of mental health services would be to recognise mental health need and deliver care for people with mental distress (Shield et al, 2003). Pilgrim (2017), who could be considered a sociological observer of services, suggests that mental health services is a term used as a compromise label to describe services offered to, or imposed upon, people with a wide range of psychological problems. As a user of mental health services Beresford (2010) suggests that ideally services are there as a safety net, somewhere to sort out troubles and be cared for, but he suggests that very few actually experience services this way. This discrepancy between ideals/rhetoric and practice/reality is played out in multiple ways in mental healthcare.

The Mental Health Taskforce (2015) and the Department of Health (2011) agree that mental health is as important as physical health, however it is still the case that the service is vastly underfunded compared to physical healthcare as widely reported in the mainstream news in 2016/17. Also widely reported are risk events that may occur related to someone with a current or previous mental health issue, an action that contributes to the focus on risk management in society (Laurence, 2003) as well as an explicit desire to address the national suicide rate (Department of Health, 1999, 2011, 2023).

So whilst it may be hoped that mental health services are there to support people to recover from mental distress as idealised by Beresford (2010), in practice mental health services are often experienced as a form of social control with a focus on risk rather than recovery (ibid).

This gap between rhetoric and actual experience has been upheld within our own sphere of practice via the Trialogues (Walker, 2018) which are facilitated open dialogue groups considering issues regarding mental distress. Common themes of these discussion were:

- Mental health services are not easily accessed
- Barriers to services cause problems. Services are currently part of the problem, not the solution.
- Early intervention is required to ward off crisis rather than having no support until crisis occurs
- Having face to face interactions with services is increasingly difficult. Less able to ask for help from an actual person with a move towards services provided over the phone or online. For example the increase in phone appointments from GP surgeries compared to trying to get a face to face appointment.
- Basic access is difficult. A lot is online and the GP is the gateway to everything. Creating an underclass of people who need help but can't access it. Not everyone has access to a computer.
- Mental health is still under resourced compared to the physical health drives we see.

**Our Philosophy**

Services/projects provided by Sanpau are based on certain assumptions:

- That people are capable and invested in their own wellbeing.
- That people are able to manage their own wellbeing and the professional role, if absolutely necessary, is to support and enable NOT to dictate, direct or impose solutions.
- Even in the grips of severe mental distress people are able to make decisions about their wellbeing.
- The route to mental wellbeing differs for individuals, there is no one size fits all response.
- The whole spectrum of emotions are part of human experience and therefore to be expected. Frequent negative emotion is not viewed as alien to the human condition.
- Open access principle is key, people need to remain in control of their own life course so self-referral is essential

- Creativity is good for us particularly as a means of self-expression where words are not sufficient or even possible

- Compassionate education of healthcare professionals is essential in order to help them to provide a more holistic and caring service for those in distress

These principles and tenets of service delivery do not differ from the policy language used by statutory mental health services, as discussed above. However, the delivery of these services, on the whole, does not always mirror the language, and patient reports often suggest that they experience paternalistic and oppressive treatment (Beresford, 2010).

To improve this situation, we want to see a fluid and responsive menu of options that individuals can pick from in order to create their own meaningful journey of discovery back to wellbeing.

**Mission**

By drawing on the availability of activities and courses through the Sanpau network , we will create a fluid and responsive menu of options. The individual decides on the activities/services that will best meet their current needs and feel most meaningful to them. Maintaining the lead in their own discovery journey helps to build confidence and self-agency and reduces reliance on statutory services. Additionally we will provide training for the workforce who provide care for those experiencing mental distress in order to improve the experience of the person using services.

**Practice Framework**

In projects which provide a service to people, rather than following the medical model as per much current mental health provision, we will utilise the Power, Threat, Meaning (PTM) framework (Johnstone et al, 2018) to underpin our interactions. This framework recognises that there is no one size fits all answer; that a mix of factors (biological, psychological, social and environmental) influence behaviour; and that a person's subjective experience needs to be taken seriously**.** It considers the operation of POWER within a person's life, that that power may pose a negative THREAT to the individual, group or community, the subsequent MEANING that those experiencing the threat make of it and the behaviour that may emerge as a response to that threat.

Four key questions are asked:

1. What has happened to you?
2. How did it affect you?
3. What sense did you make of it?
4. What did you have to do to survive?

In this way people can be seen to be actively engaging threat responses for protection and survival rather than suffering biological deficits they can do little to influence.

In our personal development work, as a code of conduct, we adhere to the principles of the Toltec tradition which includes the 5 agreements of:

- Being impeccable with your word
- Not taking anything personally
- Don't make assumptions
- Always do your best
- Be sceptical and learn to listen

These two approaches provide an excellent compliment to Sandy's Love Based mental healthcare model which we follow as an underpinning principle. There are many types of love in the world. CS Lewis suggested 4 types:

- **Storge** - liking someone through fondness or familiarity
- **Philia** - the love shared between friends
- **Eros** - romantic love including sexual love
- **Agape** - unconditional love, a love that is projected outward and is given regardless of circumstances.

In order for intimate relationships to thrive all of these types of love are necessary. Research shows us consistently that it is the relationship that exists between two people, in a counselling encounter for example, that really makes the difference and helps people to learn to overcome difficulty and flourish again. Patients of MH services who have a care coordinator have a relationship with the professional; within a patient/GP encounter we create a short term relationship in order to share a trouble and ask for help. In health care we are in

the business of relationship - whether it is explicitly noted or not. Love based MH care is simply making the love that exists within the caring relationship explicit within boundaries.

For this service it is twofold:

- Self-love - this incorporates all of the levels of relationship indicated above. A sense of fondness for ourselves as people, being our own best friends, having a healthy sexual relationship with ourselves and loving ourselves unconditionally regardless of our size, health, difficult behaviours etc.
- Agape - Unconditional love for others and an acceptance of who they are where they are. This love does not mean that behaviour that is destructive or illegal is accepted, it means being boundaried and clear without judgement. This is the sort of love that people who care for others show - teachers, nurses, doctors, parents. It used to be called 'unconditional positive regard'.

Somewhere along the line, research suggests, we have lost sight of that love. The individual practitioners within health care may not have lost it, but the service has. In MH care staff leave in their masses, burnt out from not being able to care for people in a system that has lost its way, or been led astray by decades of consistent underfunding and political meddling. A system that can be actively damaging - leading many of those who have used services to describe themselves as survivors. This is a thing of shame for any service that holds itself up as a caring organisation. In 2011 Crawford and Hallawell wrote an editorial asking where is the love in healthcare? They called for NHS and private companies to build services that are conducive to humane and compassionate care. Let's call a spade a spade though - compassion is a form of love.

**Past, Current and proposed projects**

Sandy was a founding member of the Good MH Cooperative (now retired) and previous projects have been documented elsewhere www.goodmentalhealth.org.uk

Current projects include:

- Therapy provision - EMDR (inc Flash) and Equine Assisted Therapy is available
- Workshops - At least one creative workshop each week on varying topics
- Training - Primarily for healthcare professionals and also for members of the public on key mental health related topics

Proposed future work:

- Therapy - a wide range of therapy provision to be available with sliding scale payment
- Workshops - summer programme and seasonal offerings
- Exhibitions - artworks created via workshops to be shown publicly once a year
- Grant building for targeted projects

## References


Barber C., (2013) The Layperson's Guide to Good Mental Health, Lulu Enterprises Ltd.

Beresford P (2010) *Being A Mental Health Service User.* Ross-on-Wye. PCCS books

Care Quality Commission (2017) *The state of care in mental health services 2014 to 2017.* London, CQC

Department of Health (1999) *Safer Services. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.* London. Department of Health

Department of Health (2011) *No Health Without Mental Health* . London. Department of Health

Emmerson , Joyce R, Sturrock D. (2017 *Working-age incapacity and disability benefits*. Chapter in IFS Green Budget. Accessed 15/05+2018 https://www.ifs.org.uk/publications/8888

Johnstone L. & Boyle M with Cromby J. Dillon J. Harper D. Kinderman P. Longden E. Pilgrim D. Read J (2018) *The Power Threat Meaning Framework: Overview.* Leicester: British Psychological Society.

Laurance J (2003) *Pure Madness. How fear drives the mental health system*. Oxon. Routledge,

McCrone P, Dhanasiri S, Patel A, Knapp M, Lawton-Smith S. (2016) *Paying the price: the cost of mental health care in England in 2016*, London Kings Fund

Mental Health Taskforce (2015) *The Five Year Forward View Mental Health Taskforce: public engagement findings*. London, MH Taskforce

O'Brien, Sir Stephen and Greatley, Angela and Meek, Liz (2015) *The mentally healthy society: The report of the taskforce on mental health in society. Discussion Paper.* London, The Labour Party.

Public Health England (2017) *South East Suicide Prevention Resource Briefing*, London, PHE

Mental Health Foundation (2017) Surviving or Thriving: The state of the UK's mental health. London, MHF

Mental Health Foundation (2015) *Fundamental Facts about Mental Health*, London, Mental Health Foundation

NHS Digitial (2017) *Survey shows one in three adults with common mental disorders report using treatment services* accessed 15/05/2018 https://digital.nhs.uk/news-and-events/news-archive/2016-news-archive/survey-shows-one-in-three-adults-with-common-mental-disorders-report-using-treatment-services

OECD (2014) *Mental Health and Work: United Kingdom*. UK, OECD

Pilgrim D (2017) Key Concepts in Mental Health. London, SAGE

Royal College of Physicians (2017) *NHS reality check: Delivering care under pressure*. London, Royal College of Physicians

Shield T, Campbell S, Rogers A, Worrall A. Chew-Graham C. Gask L. (2003) Quality indicators for primary care mental health services. *BMJ Quality & Safety* ;12:100-106.

Walker S (2016) *The Recovery College Phenomena* blog. Accessed 15/05/2018 https://nihrclahrcwessex.wordpress.com/2016/10/10/the-recovery-college-phenomena-sandy-walker/

Webb D. (2016) Thinking Differently about Suicide. . in. Russo J. Sweeney A (2016) (eds) Searching for a Rose Garden: Challenging Psychiatry, Fostering Mad Studies. Monmouth. PCCS Books