GROWING BETTER LIVES

A) Legislation framework

The Mental Health Act (1983,2007), and Mental Capacity Act (2005) cover the rights, assessment and treatment of people diagnosed with a mental disorder. Natinal Health Service Mental Health Trust are responsible for providing the statutory services, which includes protecting the rights of inpatients, as well as service users in the community. The Care Quality Commission is the body with overall national responsibility for inspecting and regulating the operation of the mental health act by the regional trusts.

Services provided by Mental health trusts vary but typically include: Counselling sessions - one-to-one or in a group, self-help courses, resources such as booklets, psychotherapy (usually cognitive behavioural therapy), family support, community drug and alcohol clinics, community mental health houses – supported housing, day hospitals and day centres - short-term outpatient sessions with a psychiatrist, clinical psychologist or other mental health professional and drop-in centres for peer support and therapeutic activities. Trusts may operate community mental health teams, which may include crisis resolution and home treatment, assertive outreach and early intervention services.

The National Institute for Health and Care Excellence (NICE) is an executive non-departmental Public Body of the Department of Health in the United Kingdom, which publishes guidelines in four areas: The use of medicines, treatments and procedures, clinical practice (guidance on appropriate treatment and care), guidance for public sector workers on health promotion and ill-health avoidance and guidance for social care services and users. These appraisals are based primarily on evaluations of efficacy and cost-effectiveness in various circumstances. Identify main social actors

Public Health England is a governmental body linked to the NHS which has published guidance on physical health, well-being and physical activity (2018) and on the physical health of people with mental health problems. Also focused on the inequalities is “Psychosocial pathways and Health Equity” which maps the relationships between social determinates, psychosocial factors and health outcomes. Although these publications refer to the importance of physical activity in general, there is no discussion of sport.

B) Identify Social actors

Social enterprises and Community Interest Companies

A social enterprise is an organization that applies commercial strategies to maximize improvements in financial, social and environmental well-being—this may include maximizing social impact alongside profits for external shareholders.

A community interest company is a type of company introduced by the government in 2005 and designed for social enterprises that want to use their profits and assets for the public good. CICs are intended to be easy to set up, with all the flexibility and certainty of the company form, but with some special features to ensure they are working for the benefit of the community. They have proved popular and some 10,000 registered in the status's first 10 years. Growing Better Lives is a community interest company.

Sport in Mind is a charity which uses sport to help the recovery of people experiencing mental health problems and also, as a vehicle to bring people together to talk about mental health and raise awareness. By helping people to gain a greater understanding of mental health problems it aims to challenge the many negative stereotypes and help to combat the stigma associated with something that will affect one in four of the population each year.

Sport England is an executive non-departmental public body, sponsored by the Department for Digital Culture, Media and Sport. It funds and initiates projects which promote sport and actively promotes the involvement of people with mental health problems.

Greencare is a combination of a kind of “moral treatment” (how we treat each other) and environmentalism and sustainability. Although it does not promote any theological stance it accepts the relevance of spirituality and complexity in human affairs. It stands in contrast to the excesses of philosophical stances such as modernity, rationalism, materialism, industrialism, functionalism and positivism.

Greencare is also in line with attempts to find a better way then market managerialism, corporate greed and inequality. It goes beyond the purely economic and espouses an approach more in tune with nature, that acknowledges the limits to growth. (Haigh)

Training opportunities

Living Learning Experience

This consists of a 3 -day intensive experiential training course, taking place entirely in groups and run as a structured programme of activities. It is run on democratic and non- hierarchical lines. Participants explore the experience of working closely with others, and learn how to use relationship effectively in clinical practice. Growing Better Lives is involved in providing this training, which, although it does not involve sport, does promote a greencare approach and shares many of the values of those who are involved in using sport to support people in recovery.

Many Mental Health Trusts have minimal resources for staff who can provide opportunities to engage in a range of physical activities. Members of such groups do also often graduate to roles as support for others, although this tends to be on a voluntary basis. The local groups are involved in regular tournaments with other similar groups in neighbouring counties. The facilitators of these groups are usually either specialists in sports coaching, for example the staff of Sport in Mind, or health care professionals who have an interest in this aspect of recovery.

Title

GREENCARE

Country/Town

United Kingdom, Slough

Organisation

Growing Better Lives

(Historically, the term “institution” relates to segregated facilities and paternalistic systems of care and societal control. In that sense, therefore, our approach is opposed to institutionalisation. GBL is the organisation through which our democratic and non-hierarchical methods are applied.)

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Target Group/context

People with lived experience of mental health problems. These methods can be helpful for a range of people and labelling them on the basis of negative characteristics is avoided as far as possible. Having said that, GBL is often asked to work with people in distress whom the statutory services have failed to help. Specifically, people with personality disorders have benefited from this approach.

Colin Godfrey and Trevor Lowe have applied the principles of non-competitive sport to groups whose members had been diagnosed with a variety of disorders, many of which would be described as serious mental illness, although the supporting operatives do not necessarily have detailed knowledge of those disorders or of the clinical history of the participants.

These methods can be applied to groups of almost any number but they are essentially group based because they involve the exploration of relationships, and testing of reality, which can only be experienced through interaction with others.

Content/Learning outcomes

Examples of Good Practice – Growing Better Lives

It is not particularly helpful or informative to reduce the approaches of GBL to discrete, concrete practices but the following is an attempt to divide the various components into three distinct categories. An attempt has also been made to use examples which are relevant to the current project, where possible.

It should also be borne in mind that contact with nature, therapeutic environments and an emphasis on relationships in general run through each category as unifying threads and are essential to the application of this approach.

GBL has not previously been involved in sporting activities per se, although there are many parallels with the approach of those groups who have. Additionally, two members of the GBL team (Trevor Lowe and Colin Godfrey), co-opted for this project, have extensive experience of non- competitive sport in a therapeutic/educational context in the UK and abroad.

An attempt has also been made to use examples which are relevant to the current project, where possible. This therapeutic approach fits very well with an educational paradigm, as it represents an alternative to more clinical approaches, concentrates on autonomy and learning, and has a normalising and anti-stigma effect.

Working, planning and being together in supportive environments

In practical terms, this might include preparing meals, walking, looking after animals, gardening, and sport. Doing these together has many benefits, for example it can be used to develop a culture which is non- judgemental and very different from the “us and them” clinical atmosphere of formal settings. In these informal activities people feel more inclined to talk about their real concerns and they also benefit from the sense of well-being which is engendered by communal task sharing.

Using these ordinary, incidental occasions as a way of getting to know each other and as learning opportunities, dissipates much of the mistrust, suspicion and self -doubt which would otherwise get in the way. This is because formal treatment protocols tend to create their own tensions and when these are not present it can be much easier to approach difficult issues. Trust grows, along with acceptance and a sense of belonging. Concerns often move away from the self and on to a more empathetic relation to others. The task for helpers is not to "do" something, but to create a supportive psychological environment.

Meeting the Challenge

How can facilitators approach their roles in these processes? In order to grow, members inevitably have to confront their own insecurities and this is not easy. The main stream approaches are often symptom focused, whereas ours is more concerned with identifying and reinforcing the positive attributes of our members, for example what they enjoy and what they are capable of. So, when difficulties arise, perhaps in a challenging undertaking such as a long hike, it can seem that often surprising role reversals will occur with previously diffident individuals starting to grow in confidence and becoming the helper rather than the passive recipient of help. On the other hand, workers must also learn when to make demands on a person and when to give up them some leeway, some space. They must also know how to deal with their own and members' failure, all of which depends on the development of trust and mutual respect.

A related issue here is raised by the notion of non-competitive sport. We are aiming to help people to get into, or get back into, things that give them pleasure and/or things that they are good at. This means promoting achievement and of course, it may be easier to have good team spirit if the team is successful! However, it is also crucial that members should be accepted and included, regardless of their level of ability. For example, does a football team make a substitution to give someone the chance to play, even if it could cost the team the game?

Additionally, not all relationships between members, or for that matter within any group, are positive and supportive all the time and the and the point is to provide an environment in which such differences can be managed and resolved. This leads on to third theme.

Feedback and resolution

Meetings of the whole community take place at the start and end of every day and are a way of checking in and checking out, for everyone to share how they are feeling and to ensure that any "unfinished business" is resolved. This is where the culture of belonging is introduced and also where it is reaffirmed. It is also where the involvement and inclusion are

seen in practice and the sense of containment can be experienced. It is the return to a place of safety and security, where each person is acknowledged and recognised as having value. Finally, these practises are not distinct, but are part of a cycle with beneficial outcomes. So, we move from openness in communication, through attachment and containment, to a sense of safety and inclusion. All this is supported by the therapeutic nature of the learning environment and by other people in the group.

Description of the process

The setting is as natural as possible

People may have been marginalised and disadvantaged but in this setting, they should be able feel safe and secure and be able to participate on equal terms with others.

Success/outcomes should be measured by the extent to which people are engaged and involved in social activities, not in terms of symptoms or problematic behaviour.

The learners/members are given a “breathing space” away from the claustrophobia of consulting rooms and are encouraged to look outwards at their environment as well as inwards

“Checking in” at the beginning and end of each day ensures that conflicts are resolved

“Reality checking” promotes an open atmosphere where suspicions and hostility are less likely to fester

The situation may sometimes be challenging as negative emotions arise as well as positive ones

The following principles/developments are promoted:

Core values	Attaining a healthy attachment to the group
Containment	Feeling safe and secure in one’s environment
Respect	Mutual respect
Communication	All behaviour has meaning, we communicate constantly
Interdependence	Well-being relies on relationships based on mutual need
Relationships	The quality of relationships determines the quality of other aspects of life
Participation	The ability to have agency and influence one’s environment
Process	The need for reflection rather than immediate reaction
Balance	Acknowledgement that we all have both positive and negative experiences
Responsibility	Mutual responsibility with others

Resources needed

Adequate staffing depends on a number of factors, including the experience of the helpers, the level of dependency of participants and their stage of recovery, and the need to liaise with other agencies which may operate a more hierarchical model. With these provisos, then for most situations, a ratio of 3:10 is acceptable. Facilities would include the availability of suitable environments in which the participants can involve themselves in activities, whether it be sport or greencare, including access to natural settings, meeting areas, sports fields and equipment, and facilities for the preparation of meals.

Evaluation of the Methodology

The following are examples of evaluation:
(at: http://growingbetterlives.org/growing-better-lives-social-futures/)
Planticons; The Greencare Way of measuring how we feel.
Choice and Engagement Research
Green Therapies for Personality Disorder: Research and Evaluation

Haigh, R. (2012), "The philosophy of greencare: why it matters for our mental health", *Mental Health and Social Inclusion*, Vol. 16 No. 3, pp. 127-134.

Haigh, R (2013), "The Quintessence of a Therapeutic Environment", *Therapeutic Communities: The International Journal of Therapeutic Communities,* Vol. 34 No. 1, pp. 6-15.

In addition, the custom of holding regular group meetings at the beginning and end of each day provides an immediate and direct way of evaluating the methods as well as taking care of the well- being of the participants.

Appendix 1: The process of recovery

It is important to avoid giving the impression that there is one royal road to recovery, but it is possible to see some patterns and common features in the stories of people who are on the road of recovery.

The aftermath of an experience of mental health breakdown has been described as like post- traumatic stress disorder and certainly the initial phase of recovery can be a period in which the person still feels very vulnerable and sensitive. This is for some people a time when they feel the need to take stock and they may feel very isolated, but at the same time will often recognise a basic human need for contact. One person spoke of a drop- in centre as being "welcoming, but not *too* welcoming" and others have described periods of up to a

year during which they regularly attended a day centre without wishing to mix too much or really get to know anyone else there. At this stage, people sometimes describe also being emotionally dampened down by medication, which might serve to increase the sense of isolation. Even for people in this position, it is often important that some kind of contact is available throughout the day, but it can be a matter of having someone around rather than having too many demands made.

As people emerge from the initial phase, they are often coming to terms with what happened to them and struggling to come to an acceptance of it, acknowledging the damage done. At the same time those who have moved on in their recovery may talk about having made a decision to “get up and fight”. This decision may be described as arising spontaneously, or it may be linked to other factors, such as realising how family members have suffered by seeing them so unwell and unhappy, or thinking of their children and the effect on them. They may start positively wanting to see other people and having “the energy to be with other people”. They may also decide to start imposing useful and healthy rules on themselves, such as routines which ensure that they get out of the house and start to become more self- motivating.

A person in recovery may at this stage may decide to do something different, perhaps to go back part time to work if employed, or to return to old skills and activities. However, while some people feel a strong inner impetus, others who are gently coaxed and encouraged may eventually find themselves pleasantly surprised at how helpful it has been to have a positive role and some interesting activity. The more active and positive aspects of an environment become increasingly important, the person starting to seek out others who can provide emotional support and to take opportunities to express their feelings, perhaps by talking about some of the more difficult things, weeping or raging, but also through laughter and finding pleasure in the company of others. The concern for family members can become a more positive affirmation which may include a resolve to enjoy their children and have fun as a family

Being trusted by others to do things is an important catalyst during this latter stage and other important factors are for example finding good role models and support from people who understand and do not adopt a position of superiority

As things progress, the recovering person may feel able to take more personal responsibility for maintaining their burgeoning sense of well- being and become more expert at spotting the patterns in their own cycles of emotional states, responses to events, experience of stress and at the same time, more skilled in knowing what to do to avoid the potholes and stay on the road of recovery. They may begin to consciously see themselves as part of a

social support network or system, with a positive role as helpers as well as recipients of others care and, in the process, becoming more outward looking and less consumed by old feelings of low self- worth and guilt. They may start to feel like and strongly need to give something back, becoming more focused on matters outside their own preoccupations and drawing emotional energy from identification with the group. Continuing to work through the things that have happened in the past, they nevertheless become increasingly optimistic and positive in outlook and often free themselves of the sense of being unhelpfully identified with and labelled by a particular diagnosis.

Naturally, there are many variations on these themes and some contradictions, in particular recovery may not progress in the above idealised sequence, things may develop in a different order and people may be knocked back by inner or outer events; some may find the journey a continuing struggle, others are more fortunate, for example by finding new and fulfilling relationships along the way, resulting in an easier passage to greater stability and happiness.

Appendix 2: What is needed from workers (operators)

Lack of optimism and hopefulness, in the sense that helpers do not believe in the possibility that people have who have experienced serious mental health problems can change and make progress, is a barrier to successful helping. The belief that people can change and belief and trust in a particular person, is in itself an agent for recovery. This goes along with an ability to organise things in such a way that each person can make a contribution and reach their potential, also to inspire and reinforce positive achievements.

Self- belief and self- esteem are damaged by the experience of mental health problems and their consequences and there is usually a loss of confidence and the esteem of others. To some extent, the recovery of self- belief and self-esteem can be seen to come from increasing self -maintenance as well as the ability to regain independence and the opportunity to have a say in one's own recovery process. The sense of belonging and having a clear identity appears to develop alongside confidence and self- esteem and its presence among the members is an indication of a learning to trust others again, or even for the first time. Feeling that one is trusted oneself is also very important. For some, learning to trust can be about being able to accept advice or praise and feeling trusted is an important part of building up self- confidence.

Another aspect of building up confidence can be to do with realising that one has skills and strengths and having that acknowledged by others. It should be pointed out that the underlying values and attitudes of recovery focused work have to be absorbed and reflected on with sincerity and perseverance. Optimism should not become a *mantra*, which is

imposed in a mechanical way. If it is perceived to be completely groundless, it can be unhelpful and damaging.

Another theme therefore could be broadly categorised as flexibility. This includes acknowledging people as experts in managing their own life and electing to work alongside them. Also, taking risks whilst at the same time working at the person's own pace. This is so much easier when the groundwork of trust, mutual respect and security has been established.

There are a number of aspects of the relationships between helpers and members which demonstrate the importance of attitudes and feelings in supporting recovery. When such relationships are good, they are often characterised as open and honest, and members feel that the fact that they are trusted and believed in is crucial. Going along with this and with high expectations, a good relationship makes it possible for people to challenge each other as well without jeopardising friendship and mutual respect.

Another related factor which should be strongly emphasised is actually talking to people and finding time for them. Quite a lot can be made of the importance of people getting to know each other and the related need for consistency in the helper. Maintaining contact is also vital and it is clear that the dependency issues which are regarded as so problematic in most mental health organisations are more likely to be somehow resolved if the level of support needed is carefully monitored and adjusted appropriately. Probably this is because, for the most part, needs are met and there is an understanding that everyone has some degree of dependency on others. For this to take place, helpers should find opportunities which are available during ordinary activities, rather than demanding that the person is open and confiding, only when it is convenient for the organisation.

Sometimes however, quite basic things are done for people and decisions made for them, which they are quite capable of doing for themselves. This can be problematic for some helpers who feel that if they aren't doing things for the members, they are not being useful. The emphasis can then become defensive and risk averse and over-concerned with meeting regulations. It then becomes difficult for some helpers to recognise and accept that people might have different standards and that people should have a choice in such matters.