

WHAT DOES IT FEEL LIKE?

Medication: what, how, why and when?

Talking Therapies

Family Front

EAT YOUR WAY TO HEALTH

Taking Control

of your
Mental Health



Plus How is a Diagnosis Decided Upon? · Stigma and the Media · Knowing your Rights

Everything in this guide is directed by the idea of mapping a recovery journey for people.

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Shine. Supporting People Affected by
Mental Ill Health



Sebastian Kasciuk

Information Helpline

1890 621 631

Our information helpline is operated by trained volunteers.
It is a nationwide low call number based in our Dublin office at 38 Blessington Street.

The information helpline provides information, support and a listening ear.

WE ALWAYS NEED MORE VOLUNTEERS.
If you think you could give a little of your time please
contact Claire on 01 8601620





Shine Membership

Your membership is
very important to us.
It helps us keep you in
touch with information,
events and activities.

If you would like to become a
member please ring Elaine on
01 8601620.



Orla Rahill

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Introduction

For the last 10 years, our organisation has always had a publication that aimed to provide people with self-experience of mental ill health and their families with the most up to date and accurate fact and opinion available.

This new guide gives you basic information about mental ill health, recovery, the services and supports available and an introduction to your options.

It should be useful to people with self-experience of mental ill health, families and professionals. As far as possible, we have sourced the information from Irish policy, research and opinion. We have also included an extensive list of references that will enable you to continue to read, research and surf the web for more varied information and opinion.

Everything in this guide is directed by the idea of mapping a recovery journey for people. We hope this magazine will be valuable to all who read it.

John Saunders
Director

What is Shine?

Shine is the national organisation dedicated to upholding the rights and addressing the needs of all those affected by mental illness including, but not exclusively, schizophrenia, schizo-affective disorder and bipolar disorder, through the promotion and provision of high-quality services and working to ensure the continual enhancement of the quality of life of the people it serves.

What We Do

Shine supports people with mental ill health and their families and friends in a number of different ways.

Our information helpline **1890 621 631** is open Monday to Friday from 9am to 4pm and can provide general information, a listening ear and specific information about Shine services.

We have Regional Development Officers based in Dublin, Kilkenny, Cork, Ennis, Galway, Tullamore and Dundalk. The Regional Development Officers can deal with your questions and queries in person or on the phone and provide you with more detailed person specific information. They can introduce you to a suitable support group if you feel that would be helpful. The regional office will also have relevant and up-to-date information on local mental health services, information resources, training and employment services and other community resources.

In Dublin and Cork we have resource centres for people with self-experience of mental ill health, which are open from Monday to Friday. These centres provide a wide range of rehabilitation, personal development and social activities. Shine also has a Counselling service in Dublin and Cork.

In Dublin, Cork, Kilkenny and Galway we have the Ár nglór Advocacy service. The advocates work with individuals on single or multiple issues, which affect life in the community.

Shine has an online library called www.recover.ie

If you would like to talk to someone about your own experience as a person with self-experience of mental health problems or as a relative, please contact the Shine office nearest you or ring the Information Helpline.

Everything in this guide is directed by the idea of mapping a recovery journey for people.

What **is** Mental Ill Health?

Many people are frightened of the idea of mental ill health. The various diagnostic titles such as psychosis, schizophrenia, bipolar disorder and depression are seen as life long labels, which mark the person as different from the rest of society. The stigma associated with significant mental ill health is, for some people, almost as difficult to manage as the experience of being unwell.

MUCH HAS BEEN DONE TO REDUCE the impact of stigma by challenging inaccurate representations in the media and by humanising the real facts about mental ill health. It may never be possible to totally eliminate inaccurate and hurtful comments and headlines. It is, however, already evident that as people with self-experience and their families speak up and out about their experiences, people listen and many relate with empathy to those experiences.

All of us experience varying degrees of mental health. These are the normal ups and downs of life. Mental ill health is complicated and, like many physical conditions, the experience of it is unique to the individual.

Remember, what you feel and think and how you want to proceed towards balancing, regaining or maintaining your mental health is very personal.

No one approach or person will necessarily be sufficient to support recovery. You should seek a wide range of information and supports to assist you to negotiate your journey.

The concept of recovery from mental ill health has been the subject of much discussion over the last fifteen years. It is a wide subject, and each individual has to find their own entry point, and plan or map their own journey.

One central principle of the concept of recovery is that the person's own unique experience is the starting point for all actions. It is, therefore, very important, as you look for information and educate yourself, that you acknowledge your own feelings and experiences, identify your own needs and try to match your exploration of the information to those. Listen to what other people have to say, listen to yourself and what you want.

Then take action.

recovery is not passive; it takes work and courage

What does Government do about Mental Health?



A number of important things have happened in the last 7 years to improve the status of mental health in Ireland. The Mental Health Act 2001 introduced new procedures for the involuntary detention of people experiencing a mental disorder and established the Mental Health Commission. In 2005 the Department of Health and Children published "A Vision For Change." This document details a comprehensive model of mental health service provision for Ireland.

AT THE CENTRE OF THESE CHANGES is a clear focus on the "best interests" of the person (Mental Health Act) and the principle of recovery to guide and deliver those best interests for each individual.

The Mental Health Commission has published a number of very useful documents, including two on the process and delivery of a recovery oriented mental health service and a user's guide to the Mental Health Act.

MENTAL HEALTH ACT 2001

The Mental Health Act 2001 has been fully implemented since 1 November 2006. This means that from that date, the rules about admission to psychiatric hospitals and the rights of psychiatric patients changed. New procedures are being put in place for the monitoring and regulation of standards of care in psychiatric hospitals. Some parts of the Act have been in effect since 2002. The Mental Health Commission and the Inspector of Mental Health Services have been in operation for a number of years.

BEST INTERESTS OF THE PATIENT

The Mental Health Act 2001 makes sure your best interests are the most important aspect of mental health law. The Mental Health Act 2001 brings Irish law into line with international human rights standards.

The Act says that you have the right to receive good quality mental health care. Mental health services must be properly run and properly regulated. People working in the mental health services have to make sure that you are treated in a way that respects your rights as an individual. You should be treated with respect and dignity. (*Your Guide to the Mental Health Act 2001. Mental Health Commission*)

MENTAL HEALTH COMMISSION

The Mental Health Commission is an independent statutory body established under the Mental Health Act 2001. It has a dual mandate to protect the interests of any person admitted involuntarily into an Approved Centre, and to promote, encourage and foster the establishment and maintenance of high standards and good practices in the delivery of mental health services.

The work of the Mental Health Commission is underpinned by the core values of equity, accountability, dignity, respect and empowerment. It is committed to promoting and regulating quality mental health services for all.

The Mental Health Commission is responsible for maintaining a Register of Approved Centres. The in-patient care and treatment of persons with a diagnosis of mental illness or mental disorder may only be carried out in Approved Centres.

The Inspector of Mental Health Services, appointed by the Commission, monitors the standard of care provided in Approved Centres and in any other premises where mental health services are being provided, as he or she thinks appropriate. Mental health services means services, which provide care and treatment to persons suffering from a mental illness or a mental disorder under the clinical direction of a consultant psychiatrist



In the carrying out of its functions the Mental Health Commission is committed to respecting and upholding the best interests of any person who may be affected by the provisions of the Mental Health Act 2001.
(*Mental Health Commission*)

A VISION FOR CHANGE

A Vision for Change details a comprehensive model of mental health service provision for Ireland. It describes a framework for building and fostering positive mental health across the entire community and for providing accessible, community-based, specialist services for people with mental illness.

An expert group, which combined the expertise of different professional disciplines, health service managers, researchers, representatives of voluntary organisations, and service user groups developed this policy.

A broad consultation process was undertaken between the expert group and service users and providers, through invited formal submissions and through public meetings. The results of this consultation process were published in 2004, and critically informed the policy described in this document.

A Vision for Change builds on the approaches to mental health service provision proposed in previous policy documents.

It proposes a holistic view of mental illness and recommends an integrated multidisciplinary approach to addressing the biological, psychological and social factors that contribute to mental health problems. It proposes a person-centred treatment approach, which addresses each of these elements through an integrated care plan, reflecting best practice, evolved and agreed with service users and their carers. Special emphasis is given to the need to involve service users and their families and carers at every level of service provision.

Interventions should be aimed at maximising recovery from mental illness, and building on the resources within service users and within their immediate social networks to allow them to achieve meaningful integration and participation in community life.

This policy envisions an active, flexible and community based mental health service where the need for hospital admission will be greatly reduced.

You can view the full contents of A Vision For Change on the Department of Health and Children's website: www.dohc.ie/publications

"I never got it... 'insight'. Once I'm in it I'm totally in it. Mad or not, I can see them both, but not at the same time, if you get me"

What is it Called?

Below is a small selection of definitions of mental illness from various sources.

WHATEVER THE DIAGNOSIS - schizophrenia, bipolar disorder, depression, most people experience a huge amount of fear as well as some of the classic symptoms of the "diagnosis". At every stage, it is important to focus on the person and not the behaviour. If you are experiencing mental ill health you may or may not be aware of it yourself. You may be dependent on others to assist you to know what to do. The word insight is much used in these situations.

"I never got it, 'insight'. Once I'm in it I'm totally in it. Mad or not, I can see them both, but not at the same time, if you get me".

A big part of mental ill health is the fact that often people do not know that they are behaving strangely or out of character and demonstrating clear signs of ill health to all around them.

Insight only comes with time and experience. We are, at this critical point, very dependent on family, friends and mental health professionals. If you've been here before, planning, mapping and knowing your options is a great help in times of severe stress or crises.

Knowing and naming a person you trust who will steer you through times of crises, is a central factor in most personal stories of recovery.

If it is your first time, being able to avoid an endless cycle of cul de sacs or false starts is very important.

"Schizophrenia is characterised by disturbances in a person's thoughts, perceptions, emotions and behaviour. It affects approximately one in every hundred people worldwide and first onset commonly occurs in adolescence or early adulthood, although it can also occur later in life." (*Schizophrenia Ireland Handbook 2003*)

"Schizophrenia can be thought of in terms of experiencing episodes during which reality is perceived differently. This might mean hallucinating; seeing or hearing things that others do not, or having delusions where a person has unfounded beliefs that they are perhaps being persecuted or that they are famous." (*Rethink*)

"It is what is known as a psychotic illness, meaning that a person with schizophrenia may experience delusions, hallucinations and disordered thoughts. They may have little insight into their illness, and commonly do not recognise that they are ill." (*SANE*)

"Bipolar disorder, also known as manic-depressive illness, is a brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks. Symptoms of bipolar disorder are severe. They are different from the normal ups and downs that everyone goes through from time to time. Bipolar disorder symptoms can result in damaged relationships, poor

job or school performance, and even suicide. But bipolar disorder can be treated, and people with this illness can lead full and productive lives.

Bipolar disorder often develops in a person's late teens or early adult years. At least half of all cases start before age 25. Some people have their first symptoms during childhood, while others may develop symptoms late in life.

Bipolar disorder is not easy to spot when it starts. The symptoms may seem like separate problems, not recognized as parts of a larger problem. Some people suffer for years before they are properly diagnosed and treated. Like diabetes or heart disease, bipolar disorder is a long-term illness that must be carefully managed throughout a person's life." (*National Institute of Mental Health*)

"Severe depression is a serious medical illness. Unlike normal emotional experiences of sadness, loss, or passing mood states, severe depression is persistent and can significantly interfere with an individual's thoughts, behaviour, mood, activity and physical health." (*NAMI*)

"... a state of mind of a person, which affects the person's thinking, perceiving, emotion or judgement and which seriously impairs the mental function of the person to the extent that he or she requires care or medical treatment in his or her own interest or in the interest of other persons." (*Mental Health Act 2001*)

How is a diagnosis decided upon?

Across is a diagram. On the inside circle are the main diagnosis such as schizophrenia, depression or bipolar disorder. The outside circles contain different symptoms a person would need to experience. In order to receive a diagnosis, we must experience a number of these symptoms over a period of weeks.

IT IS ALSO IMPORTANT TO REMEMBER THAT YOU CAN EXPERIENCE ANY COMBINATION OF SYMPTOMS within the circles and not receive any diagnosis or be diagnosed with a schizoaffective illness (those diagnosed as having schizoaffective disorder may actually have schizophrenia with prominent mood symptoms). Or they may have a mood disorder with symptoms similar to those of schizophrenia. In the boxes below are simple examples as to why we get a particular diagnosis and what it involves.

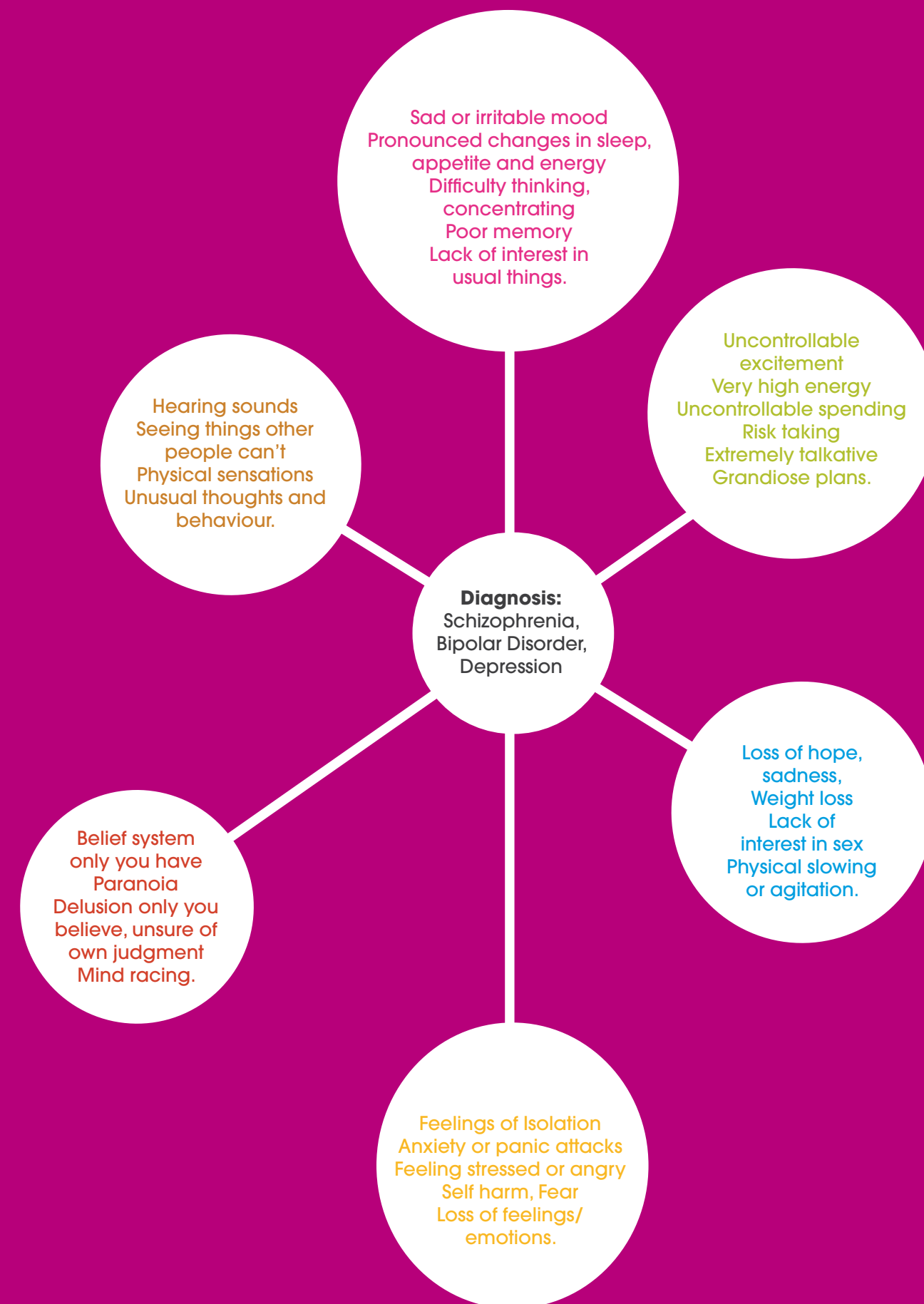
The diagnosis received is a general classification only, and a person will not experience all the symptoms. Most people, however, do have at least one prominent and difficult symptom, which limits how they live their life.

The diagram opposite is for demonstration purposes only. It is a simplified tool to aid understanding of how a diagnosis of mental illness may be arrived at.

If you are experiencing symptoms from the blue circle, which include: loss of hope, sadness, weight loss, lack of interest in sex, physical slowing or agitation and some from the yellow circle, such as isolation, panic attacks, self harm, loss of feelings, you may receive a diagnosis of depression.

If you experience symptoms from the orange circle voice hearing, or seeing images, plus symptoms from the red circle such as paranoia and delusions, as well as experiencing symptoms from the purple circle, you may well be given a diagnosis of schizophrenia.

If you experience symptoms from the green circle such as very high energy, risk taking behaviour, extreme excitement, aggression; and at other times symptoms from the blue circle occur, loss of hope, sadness, slowing down physically, isolation or lack of interest in sex, you may receive a diagnosis of bipolar disorder.



A Consultant Psychiatrist's View

A consultant psychiatrist often provides advice to general practitioners on the management of mental ill health. On some occasions, a general practitioner may request an opinion from a mental health service. The initial assessment usually involves a consultant psychiatrist or a junior doctor who works with the service user under the supervision of a consultant psychiatrist.

THE INITIAL MEETING WITH THE CONSULTANT psychiatrist provides an opportunity for the service user to discuss problems and identify recovery goals. It is also an opportunity for the service user to obtain information about what help is on offer from the mental health service. It can be useful to write notes and bring them with you to a first meeting with a consultant. It may also be helpful to ask a friend or family member to go with you. At a first meeting a consultant psychiatrist will usually ask about a person's life story and life plans. This helps the consultant to have a better understanding of the person as an individual.

The consultant psychiatrist may recommend that some tests should be done. This can include a brain scan or blood tests. These tests are often done because some symptoms of mental ill health can occur in other illnesses. Sometimes it might seem difficult to discuss some matters with someone you haven't met before, or you might forget something important. In these circumstances it can be helpful to write to the consultant or the team.

After the initial assessment, a consultant psychiatrist may recommend that the service user should meet another member of the team. A psychologist may help with advice on talking therapies, a social worker may help with housing problems, or an occupational therapist may help with advice on education

or employment opportunities. The consultant psychiatrist meets with the team and the service user to ensure that a comprehensive assessment has been done, a diagnosis is discussed and a plan is agreed with the service user. The overall plan may include several different phases.

The first phase involves working with the service user during recovery from an acute episode of illness. A consultant psychiatrist has special expertise in the use of medication and many people find medication to be of some benefit at this stage. There are many other treatments that work alongside medication and these should also be considered. The service user should be provided with information about the benefits and risks of each treatment option, so that he/she can make an informed decision about how they wish to proceed.

Once a person has recovered from an acute episode of illness, the next phase will involve making a plan to reduce the likelihood of an episode in future. The involvement of the service user in developing and managing their own health through this plan is very important. It is also important that recovery goals are identified, and that the consultant psychiatrist and the team work with the service user as he/she realises these goals.

As the person embarks on and sustains their own recovery, the consultant psychiatrist and the team will generally slowly reduce the level of support they provide. This is agreed with the service user, and allows him/her to manage and direct their own recovery.



Paul Kennedy



What does it feel like?

We asked a few people to describe their own experiences.

HEARING VOICES

"PEOPLE OFTEN ASK ME WHAT IT'S LIKE TO HEAR VOICES. IF YOU imagine somebody you know calling your name, you hear it in your mind not with your ears. Now imagine that voice taking on a life of its own, seemingly independent from you. Also, this voice is joined by others, mostly people you don't know, and they begin to talk to you in a very derogatory way as if they know everything about you, as if they can hear your every thought. Now imagine that when you are talking to somebody in reality or listening to the radio or watching television that this layer of voices overlaps the real sound, confusing and changing what you hear. That is what it is like to 'hear voices'.

As this developed I began to get paranoid about being spied on and plotted against. I could not understand how this worked — were there hidden cameras? I wasn't particularly religious but I began to think that this had a strong spiritual aspect to it and that maybe I was possessed by an evil spirit or spirits. Some of the voices I was hearing were people I knew; sometimes these people were in the same room. I began to talk back to them in my head, but it was mostly conversations about very personal things, and it was usually very negative and insulting. It was also very repetitive and it never stopped. If I was in a public place such as on a bus, in a restaurant or walking down the street, it seemed that everyone was talking about me.

It seemed impossible to me that what this doctor was telling me explained away the transformation in my life, but when he said he could prescribe medication that would stop this nightmare, a glimmer of hope appeared on the horizon. I was worried though about what this drug would do to me. Would it turn me into a vegetable, would I be

sedated to a state of numbness? He reassured me by saying it was a relatively new drug and that it was the best thing for me. He mentioned hospital saying I could go there, but I agreed to be treated as an out patient under my parents' supervision. He also gave me a prescription for side effects. The drive home with my dad was full of questions and talk of what this all meant, but I still kept my voices to myself. I had always sworn revenge on them some day, but it was early days yet. I took the first tablet when I got home and over the next few days I was very drowsy and slept a lot.

Looking back now I find it hard to believe just how all pervasive this experience had been. The effect on my life had been profound. My career as a designer had faded away. My long term relationship had finished. I had lost contact with family and friends. I was penniless and I felt totally isolated from society and the people I cared about.

The effect of the medication was to subdue the voices and delusions to a state where I could function to a relatively normal degree, but I found that I also had to be careful to avoid stressful situations. I had to eat, sleep and exercise on a regular basis. I also had to take the medication twice a day every day. If I didn't look after myself in this way the voices and delusions would rise up and start to interfere in my life again.

Early this year another piece of my recovery jigsaw fell into place. I started receiving counselling from a psychotherapist on a regular basis. This has helped me to come to terms with myself on a practical level, and even though I believe it is early days in this therapy, I am hopeful that a lot of damage done to myself and others will eventually be resolved.

Noirín McCaffrey

“It does help to meet people. I’d love to be able to smile and laugh. I don’t have a family. Friends and family (if you have them) are very important. I’m looking for a step to take me into recovery. I write poetry and I do a bit of amateur acting. I enjoy that.”

(Anon. Written for this guide)

“Medication had a role to play in my recovery and I still take it today, but I feel my real recovery began last year when I started working in a job that values my lived experience. As a peer advocate my ability to talk openly about my experiences is a great help to people that may not have the confidence to do so. It is rewarding to have people who are suffering terrible anguish put their trust in you, and share so much of themselves, especially when you can see the results of helping them on a practical level. A little human warmth goes a long way.”



Noirín McCaffrey

SCHIZOPHRENIA

“Illusion to the sufferer, delusion to the psychiatrist; schizophrenia is identified as a split from reality. However, reality is only what the individual perceives, so if you are having delusions, that is your reality.

The extraordinary thing about being delusional is just how hard it is to translate this into language that conveys the experience to a clinician or family and friends. In my case the first time I talked to a psychiatrist about what I was really experiencing (I had already been a patient for six years); I tried to use the analogy of “Gulliver’s Travels” to explain just how powerful my experience was.

I was rewarded with the diagnosis “grandiose delusional memory”. To me there was nothing grandiose or delusional; it was a subtle and refined story that of course involved the wider world. It was all about a process of storytelling, of a spiritual life that I and my voices engaged in.

Now heavily medicated, I do not have nearly as much stimulation from my “grandiose delusional memory” but I adhere, as convinced to my belief in my experience, established over thirty years of my life. I still cannot say to a clinician with candour that I see people (very different people than you and I but still people) when I look at the night sky. I cannot describe them or relate the terms that they, as my voices, use.

I also see a variety of these people in everything I look at, be it the Sea, the Sun or the Wind. It is an extraordinary way to live and in my case I suppose the story is more coherent than most other patients. But then I think of all the other psychiatric patients ever interrogated for their initial assessment, and I wonder at the painstaking efforts to get out of them what they are really cogitating and just how belittling it is for them.

They too have a language barrier that is very hard to communicate across the divide, even with the application of what is a very sophisticated modern psychiatric assessment. It is established that there is a strong creative instinct in many people with mental illness. Perhaps this form of expression remains the best hope of clueing in to what those “split from reality” are really saying, with creative expression also being possibly; the best outlet for those of us with mental illness to express ourselves.”

BIPOLAR DISORDER

It could happen to anyone

“Ashamed as I am to say it, I’ve always “looked down” on mental health professionals. As a general nurse, I often thought that psychiatric nurses were people who had wanted to be general nurses but who hadn’t made the grade. It was such a biased opinion, one I wish I had never formed, but I carried it through life, both inside and outside of work. Thankfully, my recent experiences have forced me to completely reverse that opinion, both regarding mental illness and the people that help to support those with a diagnosis of mental illness.

For most of my life, I harboured some form of suicidal ideation, but didn’t understand why. I often self-harmed, but didn’t acknowledge that my behaviour wasn’t “normal,” even when I began working as a nurse and so knew more about mental health issues. I continued to brush my activities under the carpet, until just over two years ago, when I developed post-natal depression after the birth of my second child. My GP was quick enough to spot it, and wanted to refer me for a psychiatric assessment. I remember vividly the feelings I had when he suggested it. I genuinely thought that to be referred to the mental health services you needed to be experiencing vivid hallucinations or be out of control and not able to function properly. Despite my experiences of meeting people through my work, I had a picture of the “typical” psychiatric patient in my head, someone dirty and unkempt, a drug user, or someone shuffling instead of walking, with no comprehension of what was going on around them. I couldn’t possibly imagine that anyone with a mental health difficulty could look just like you or me, and carry their illness inside them.

I continued to refuse to be assessed, and also didn’t take the medication my GP prescribed for me. Eventually my husband was called in, and with both their persuasion I agreed to be seen. Even then I assumed that I would be seen and sent on my way, with everyone happy that I was “normal,” as there definitely wasn’t anything wrong with me, was there?

When I arrived at the Department of Psychiatry it was lunchtime, and the current inpatients were walking along the halls on their way to the dining room. As I watched them I still couldn’t believe that just about anyone could be affected, and even thought that the people I could see were putting on a normal appearance just for my benefit. After

talking with the consultant, she said I was very unwell and would like to admit me, but I remained in denial and refused to believe that it would be in any way possible for me to be mentally ill - surely all my symptoms were signs of a weak character, laziness and selfishness, not a genuine illness.

That first experience and realisation seems so long ago, and I have been on such a journey since then. Continued denial certainly didn’t help the situation, and when I was forced into hospital, my bigoted opinion of psychiatric nurses meant that I was convinced that my knowledge was better than theirs, as I was a “real” nurse, and I refused to let them help me effectively. It is only now with hindsight that I can see just how unwell I was and I am constantly mortified by my behaviour to the staff. Of course, we have since developed a very effective therapeutic relationship and I often apologise for my previous actions - which are dismissed, as mental health professionals continually draw a line in the sand and move on, only concerned with the progress that the client is making, rather than any regression. In my nine hospital admissions in two different hospitals, my opinions have been reversed due to the compassion, knowledge and integrity of the staff. I do not think I ever would have had the strength of character to do what they do, and have come to learn that, just as in every other category of employment, different people are suited to different sectors, different departments, and different divisions of what is described in general as the same job.

I have met so many people through my experiences, from various mental health and social care professionals, through to people that are experiencing difficulties just like me. I have had late night discussions with people from all social backgrounds, from many different countries, those who are married or unmarried, have children or are childless, are young or old, but who all hold one thing in common - they have experienced a mental health difficulty. They may have “labels” or diagnoses, or they may not. This may be a one off or reactive problem, or they may have a lifelong condition that they need to learn to live alongside. I have learned so much, even though previously I thought I knew it all, and my experiences can only serve to help me in my future work. I had often, as you may have also, heard the statement that 1 in 4 people will be affected by mental illness in their lifetime, but I assumed that it only happened to people with troubled backgrounds, with substance addiction problems or employment difficulties. Yes, mental illness affects many people with these problems. But it also affects many other people. I now finally believe it can happen to anyone, even nurses.”

DEPRESSION

"I had two life changing experiences. They were very traumatic. I think they set me back. I had lost my two main props. I became very isolated.

I would characterise depression as a feeling of joylessness. Everything is a struggle. Things that gave me pleasure no longer do. I am tired all the time. There is a sense of living disconnected from things. Life is going on outside.

I have struggled for 12 years. What helps? Well, I do some voluntary work with a number of different groups. I joined two walking groups. I have a number of good friends. These things help to contain the mood. My friends help me in practical ways, but mainly they are just people to share things with. These things give a sort of focus. I like music too and I go to the library. I'm not a great reader, but I browse.

The worst moment is when I first open my eyes. I feel wrecked. Getting up and getting washed is a real struggle. It gets easier as you get out and about. Very important to do that. Very important to interact with people. It takes the focus off yourself.

I take three types of tablet. I sleep well but I never feel refreshed. You're getting a form of sleep, but not of proper quality. There is no permanent lifting of mood. It's as if you are carrying a burden all the time.

My best friend says he doesn't know how I do it. He thinks I show great courage. I don't know if I've failed to take the right steps to get better or has the system failed me. I admire myself at some level. I feel the psychiatric services haven't given me the support I needed. I don't feel I'm being listened to. They talk at me, talk down to me. They have a cold bureaucratic approach. They change every six months. How are you supposed to make progress within that kind of system?

"It does help to meet people. I'd love to be able to smile and laugh. I don't have a family. Friends and family (if you have them) are very important. I'm looking for a step to take me into recovery. I write poetry and I do a bit of amateur acting. I enjoy that."



Why Me?

One way of thinking about this is called the ‘stress vulnerability model.’ Some of us will have a greater sensitivity to developing mental ill health and if a number of stressful things come along together, it can tip us over into poor or critical mental ill health.

“HAVE I BEEN MENTALLY ILL, SCHIZOPHRENIC, crazy, loony, loop-the-loop, out to lunch, not the full shilling? No. I have not. I have been subject to my experiences and have dealt with this to the utmost of my ability...” *(Speak for yourself. Women Together Network)*

“One of the features of my particular illness is that I can manage to work on very complex projects while I am psychotic, and nobody knows there is anything wrong, until I get so stressed out I can’t function anymore and need help immediately.” *Claire.*

It is frustrating not to be able to put a finger on the exact reason why you are unwell, but once you think or know you are, the next thing is to try (not easy we know) to focus on what you can do to get through it and get on with your life.

Family, friends, nurses and doctors are all possible partners to start working with you on recovery. Almost all personal stories of recovery tell of one important person who maintained a sense of hope at all times.

To have a recovery process, the main belief that only professionals can effectively contribute to mental wellness must shift to an attitude that respects the values and life experience of those with the mental health issues. The power and responsibility needs

to be shared and shared with effective and timely safeguards.

Recovery is about partnership. Partnership depends on each person taking responsibility for their “part” of the “ship”.

Recovery is not a panacea – rather it is a philosophy that respects the individual’s right to achieve wellness on his or her own terms, in his or her own time.

Recovery is just another word until people use it in a way that gives it vigour, and recognises a richer and fuller understanding of the enormity of the human spirit.

In practical terms, recovery can be described as two interdependent processes:

- 1. Spiritual recovery
- 2. Practical recovery

Spiritual recovery refers to a process of personal growth, self awareness and acceptance. It involves things such as:

- Ownership of the process
- Self determination
- Accepting strengths and limits
- Hope and optimism
- Sense of self and self worth
- Renewed values and purpose
- Belief and faith

Practical recovery refers to dealing with real life issues such as:

- Knowing about and managing one’s illness
- Discovering and saying what you want
- Being strong when you can and getting help when you need it
- Realistic goal setting
- Positive thinking
- Taking responsibility and control
- Seeking and using supports that are there
- Being prepared to meeting new challenges

(Adapted from Supporting Life. Schizophrenia Ireland)

The poet John Keats captures the important sense of “negative capability”. Being able to hold onto a sense of self, even in the midst of terrible disruption.

“Capable of being in uncertainties, mysteries, and doubts, without irritable reaching out after fact and reason.”
(John Keats)

So, take time when you can to think about what you want and need. Allow the positive things you feel to gain strength and space.

The following narratives are based on the situations and experiences that people have spoken about to Shine staff. Hundreds of individuals and groups meet and talk about these things. All of the stories are individual; yet, they reveal frequently repeated themes or events that are recognised by many. The purpose of this story is to share these sometimes painful, often wise and very human responses to the experience of mental ill health.

When you are reading this piece, it is important to remember the stories provided are a collection of peoples’ individual experiences and no one person’s complete experience.

Names and locations have been changed and no one person’s experience is given in full. This is not an academic piece, it is written using peoples’ real experiences, which have been reshaped and when reading it, you may ask, is that me? The fact is it’s everybody’s and the experiences are very similar whilst being very different at the same time.

It is not possible to provide all the situations people go through, they are so diverse and individual; there is a selection of the most common experiences only.

A Journey from the Beginning - Childhood

When people with self-experience are asked how they felt as a child, often the reply is, “I felt different to other people, like I walked at a different speed or was out of step with other people”. However, if you asked anybody regardless of mental health status you would get the same answer. The simple fact is we are all different, we do live and exist differently to each other, even a set of identical twins will not have an identical set of experiences and if they did they would interpret them differently.

The obvious exception to this are people, who from an early age hear voices or have visual hallucinations, even elements of paranoia. Some hold beliefs only they feel are true and some also experience depression. Unfortunately it can be years before these experiences are addressed. It is important to know that you are not the only one who has had these experiences.

It is accepted that people tend to experience mental ill health from around the ages of 16 and upwards, or at least that is the age (with some exceptions) that they usually come to the attention of the services. It is misleading to suggest that these experiences began at the age they were diagnosed. It is clear that people often have a sense of “being different” for years before they are understood and their needs are met.

“I was 6 or 7 and I would be in my room playing, when suddenly Tom and Jerry would come to life and start talking to me. This was an enjoyable experience, as it was a kindly voice that would talk to me and tell me stories. It was only in later life as I began to get older 9 or 10, my voice would get sinister and start criticising me, calling me names, telling me to do things, which I knew were wrong. In fact I remember calling out to my mother; I can’t wake up from this nightmare help me.”

“I am 18 now. I was seeing things for about 4 years before I told anyone about the visions I was having, the Virgin Mary, Jesus and an evil spirit all telling me things. In the end, I got so confused I couldn’t tell which was which and who was good or evil. One day I plucked up enough courage to tell my parents some of what was going on for me, it got to the stage I was so paranoid and afraid of people that I stayed in my room and smoked hash 24 hours a day, the hash didn’t get rid of the voices or visions but somehow allowed me to endure them. Looking back on it now, though it is clear that the hash really messed my head up, it also reminds me of what someone once told me “people shouldn’t take drugs and some people really shouldn’t.”

Medication: what, how, why & when?

Medication is used to remove, reduce or relieve the main symptoms of mental ill health. Medication can reduce the impact of symptoms for a lot of people. However, it is not always the case, and some people find the benefits of the medication are outweighed by the consequences of the unwanted side effects. It is widely accepted that a combination of medication and other kinds of therapy is the most effective approach to recovery.

Glossary

1. A drug or medicine is described as 'a pharmaceutical product, used by humans in the prevention, diagnosis or treatment of disease.'
 2. An adverse drug reaction (ADR) is when a person receiving the normal dose of a medication experiences an effect from medication which is harmful and unintended.
 3. A side effect is 'any unintended effect (good or bad).'
- (Adapted from the World Health Organisation definitions)

There is little hard evidence that hash or street drugs will cause schizophrenia (or other forms of mental illness). There is evidence however, which suggests it can hasten the onset if the person has a susceptibility to developing it. It is certainly accepted that there are drugs, which can induce psychosis. The difference is, when you stop taking the illegal drug, the psychosis will stop. If you have symptoms of schizophrenia it will not.

MANY PEOPLE FIND IT VERY DIFFICULT TO keep taking their medication and frequently give it up. This can be dangerous and may not deliver the result you are hoping for. Never stop or adjust your prescribed dose without consulting your doctor. If you are determined to give up your prescribed medication, talk to your doctor, explain why, and make sure you have some other kind of therapy or coping strategy in its place.

Also, remember alcohol and street drugs have unwanted effects.

HOW DOES MEDICATION WORK?

Sometimes we can find it useful in understanding how medication works if we know a little about how our brain operates.

Our brain is made up of millions and millions of nerves which communicate with each other using what is called a neurotransmitter. However, sometimes these messages do not get where they are intended to go or are rerouted to somewhere else. When this happens, according to the chemical imbalance theory, we need to take medication, which redirects and smoothes out the path, which the messages should take.

The reality is that medication will work extremely well for some people, fairly well for others and very little or not at all for others. It is important to remember that if a medication is not working for you, as long as you are taking it as prescribed it is not your fault.

NEUROTRANSMITTERS

Essentially, they help deliver messages throughout the brain's nerve cells. These nerve cells, called neurons, are organised to control specialised activities. We each have somewhere between 10-100 billion neurons within our brains. Whenever we do anything, react, feel emotions, think, our neurons transmit messages in the form of electrical impulses from one cell to another. Nobody really understands the full workings of neurotransmitters and their effects on the brain.

SEROTONIN NOREPINEPHRINE DOPAMINE

Serotonin, norepinephrine and dopamine all work as biochemical messengers which regulate your mood in the brain. They are also associated with the sleep and wake cycle. If too much or too little serotonin, norepinephrine and dopamine are present it can result in too much emotion, over reaction to stress, and loss of sleep, appetite and interest in sex.

Medications are available that can reduce or increase the levels of serotonin, norepinephrine and dopamine. Other medications work on the other side of the scale and tackle depression by elevating serotonin and improving a person's mood.

DOPAMINE

Dopamine works in the brain helping it to regulate our movements. It also controls the flow of information from other areas of the brain, especially memory, attention and problem-solving skills.

When dopamine is released it provides feelings of enjoyment, motivation to do, or continue doing, certain activities. Dopamine is released by naturally rewarding experiences such as food, exercise and sex. Without enough dopamine, people can feel fatigued



Angelín Fanning



and depressed, making it difficult to get motivated about anything. With too much dopamine we may experience hallucinations or paranoia for example.

GLUTAMATE

Glutamate is thought to be responsible for mood fluctuation. Lithium and anticonvulsant drugs can help to stabilise mood disorders.

It takes a few weeks before lithium begins to relieve depression and mania in bipolar disorder. It works by bringing glutamate within a 'normal' range and over time it can curb both the highs and lows.

Excess inositol is another chemical thought to be involved in affecting bipolar depression.

TYPES OF MEDICATION

There are hundreds of different types of medication out there. We won't even attempt to list them. You may be lucky and find one that works for you very quickly or it may take a while to find the one that suits you best. Remember medication on its own is limited. You will need to combine mental, physical and spiritual resources as well, in order to give yourself a full chance of living your life as you want.

Medication can take time to work. Anything from days to months depending on the person's own chemistry.

Antipsychotics

There are two types - 'typical antipsychotics' which have been on the market for more than fifty years and 'atypical antipsychotics', which have been more recently developed. Medication can be administered by tablet, syrup or injection. Injections

can be beneficial for people who forget to take medication or for people who experience severe symptoms.

Mood Stabilisers

These are used to treat rapid and unstable mood changes. They can also be helpful in suppressing the swings between mania and depression for people experiencing bipolar disorder.

WHICH MEDICATION IS BEST?

Choosing a suitable medication is not always as straight forward as it may appear. Everyone reacts to medications in different ways. One medication may work well for one person but produce unwanted side-effects in another. It is therefore very important you insist that your doctor or nurse gives you as much time and information as possible, so that you can know what to expect. Together, you and your doctor can make a joint decision that suits you best.

At the outset, you should see your doctor often. This enables both of you to assess and monitor any side or negative effects you may notice and they can be addressed quickly. The doctor may suggest reducing the dose or finding an alternative medicine better suited to your needs.

Do not be afraid to ask for a reduction or an increase in medication if you think it might help.

Side effects

All drugs can produce unwanted side effects in various degrees. These will vary from person to person. Sometimes, but not always, they can disappear completely with a lower dose or by switching to another medication.

"From a medical perspective, the difficulty of treating a person who is misusing drugs or alcohol and is at the same time experiencing symptoms of mental illness is knowing where the unwanted effects of the alcohol and drugs end and the mental health difficulty begins. This is really very complicated."

"I know now Mary was using hash to self medicate, as she says herself. It also allowed her to live a life where she did not feel as exposed. Most of her friends in that scene had a chaotic lifestyle and she did not stand out as being different. It was only after a few years as her friends drifted back to mainstream living, did it become obvious to us that Mary was not a lazy waster, but something was going on for her which we could not explain."

It is well known that people self medicate with alcohol or drugs or both. For a lot of people the problem is the lack of control they have over the quantity of either substance used. Users report a small amount helps, but it is often too difficult to stop there. Frequently, people find themselves addicted and unable to stop at all.

So what we are saying in this group is that prescribed medication when it works throws a blanket over the experiences, which basically dampens them down to a barely audible level, leaving room for thoughts about living our lives as we choose. Alcohol or illegal drugs puts a net curtain over the experiences allowing us to interact with the experiences in a uninhibited way, not always good, and without either medication or alcohol or illegal drugs, we are left to the mercy of our own coping mechanisms, which at any given time can be bearable or terrifying.”

The main difficulties initially for people experiencing a mental health issue, is who to speak to? What to say? And if they do speak to someone, can they be trusted?

Can we trust we will receive their support? If there is even a small bit of paranoia or bizarre beliefs, can we be sure our relatives or friends or the authorities are not out to harm us? At the very least they might be colluding with the people we believe might harm us. It's a vicious cycle.”

Side effects can include:

- feeling drowsy
- having a dry mouth
- having too much saliva
- feeling restlessness

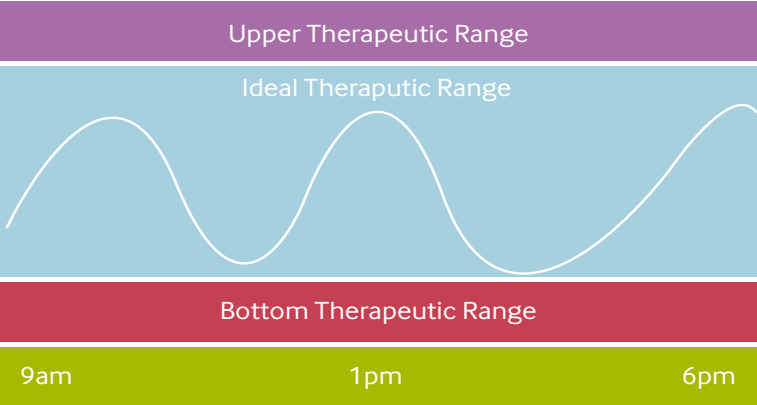
Some of these will settle down with time. If you experience severe body movements, stiffening up of your joints, facial movements that you cannot control or anything you are worried about, waste no time in seeing your doctor.

You can be prescribed a number of different medications, some to manage the main symptoms and some to manage the known side effects. It is always best to be on as low an effective dose as possible. It is also important that your medication is reviewed regularly, at least every six months.

Different drugs do not always work well together, so be sure to let your doctor know all the medications you are on.

WHY DO WE TAKE MEDICATION AT THE TIMES WE DO?

For medication to work effectively it has to remain within what is called a therapeutic range. The thick purple line below represents the upper line of therapeutic range. The blue area represents the ideal therapeutic range; the red line below represents the bottom therapeutic range. When you first take your medication it takes a while to build up in your body to a sufficient level for it to work properly. As the medication reaches the therapeutic range it begins to work, if you can keep it within this range and the medication is of benefit to you it will begin to work.



In the graphic above the wavy white line represents the amount of medication in your system. It will be at the bottom red line when you wake up in the morning.

When you then take your medication it rises through the range to just below the upper therapeutic range.

As the day progresses the level will begin to dip down until you take your medication again and it will increase.

If you do not take your medication or you miss a dose, it will drop out of the therapeutic range into or below the bottom red range and be of little use.

If this happens do not be tempted to take a double dose to catch up, just revert back to the prescribed dose and time. Consult your doctor if you are worried.

If you do take a double dose by mistake or you are prescribed a dose that is too high, the positive effect of medication may not increase, but the side effects may cause more harm than good.

A consultant psychiatrist is usually the person who prescribes medication and develops a treatment plan. He or she leads a multidisciplinary team (MDT), all of whom will have a role in working with you and your family members towards the goal of good mental health.





**there is a real sense
of fulfilment when
'team work' works!**

A Multidisciplinary Team

Multidisciplinary team-working is central to a modern mental health service. This means that a number of professionals with different expertise work together to support a person through times of ill health and into recovery. The make up of teams can vary from place to place but they generally include a consultant psychiatrist, social worker, community mental health nurse, psychologist and occupational therapist.

MOST PARTS OF THE COUNTRY NOW HAVE FULL TEAMS working with people. MDTs are used in hospitals, in day services and in the community.

We asked a few mental health professionals who work as part of a team to describe, in their own words, what they do and how they support people experiencing mental ill health.

Rehabilitation and Recovery Multidisciplinary Team:

A CONSULTANT PSYCHIATRIST'S VIEW What is my job?

As consultant psychiatrist, I am the leader of the team and responsible for the treatment and standard of care for each service user. I oversee the junior doctors and direct how other members of the team carry out their work.

In the past the consultant was seen as the person who had the final say in all decisions, but in the modern mental health service the consultant works together with other professionals (nurses, occupational therapists, social workers, psychologists, art therapists, care assistants, etc) in a more democratic way to make sure that the person's needs are met to the best of everyone's abilities.

This is how a 'multidisciplinary team' works. This means that I accept that I may not always have the right knowledge or skills to ensure recovery in all service users. For example, a nurse or psychologist with the necessary training in talking therapies may have a better plan, or the occupational therapist or social worker may be the most suitable professional to work with the service user on their recovery journey. Usually, the best solutions come from service users themselves and sometimes from others who are not mental health professionals at all. Part of my job, like the work of the team, is to find the means to make these solutions work.

How do I work with people?

It is absolutely necessary to listen to what the service user wants if I am to treat their psychiatric, psychological and social problems.

Along with all the other professionals on the team and other significant people (such as family members, advocates), I need to ensure that everyone is working together with the service user (and not working 'on' the service user) to achieve what recovery means for that person.

This way of working is effective for most mental health problems; it is particularly important for those with severe and enduring disability. In my experience it is also the most rewarding way of working. The rewards come from seeing real changes in peoples' lives, often despite their mental health problems, like finding a place in society, having control over how or where to live, having a relationship or a job. There is a real sense of fulfilment when 'team work' works!

On the other hand it is frustrating when the team doesn't work so well or as quickly as I would like: then there is a need to be flexible, to find out where the problem lies, to listen more and to remind myself and others what the purpose of our service is and who I am employed to serve".

COMMUNITY MENTAL HEALTH NURSE

"The CMHN is part of a multidisciplinary team, which includes medical and nursing personnel, an occupational therapist, psychologist, consultant psychiatrist and social worker.

The community mental health nurse usually has the role of key-worker to service users.

I engage with the service user and, with their consent, their immediate family. It is a partnership approach, which aims to improve the person's immediate wellness and enhance their future quality of life. The partnership is collaborative in nature, with the expertise of both the nurse and the service user's self-experience influencing the plan of care.

The relationship is based on trust borne of a deep respect of the right of choice and self-determination of the individual, along with an appreciation of the person's uniqueness, individuality, personal experience together with their dreams and hopes. These are the underlying guiding influences in creating a therapeutic relationship, which will promote recovery. The CMHN will focus on your strengths

Surprisingly a lot of relatives find themselves in the same cycle of fear and confusion, not knowing what is real, what is right or who to turn to.

and advocates with you for your needs, to ensure you get a good team recovery package of care.

Probably the most important fact is that we will believe in you and share your dreams and hopes. We will be honest with you, working to establish realistic goals.

I see the role as partly that of coach or mentor, empowering the service user to enable them to make informed, positive choices that will underpin and sustain their long-term wellness. I provide information and education to the service user and their families in respect of the illness and the various treatment options. Highlighting the link between stress and illness can help to normalise the experience, reduce stigma and increase the likelihood of the service user taking more control of their own situation, ensuring greater personal responsibility.

The CMHN will focus on an individual's strengths and seek to avoid labels. An important function of the role is the identification of the needs of the service user that can be fulfilled by the assistance of various members of the multidisciplinary team. It is the role of the CMHN to engage the relevant disciplines to meet these needs, and liaise regularly to ensure success. The CMHN communicates regularly with the GP and other primary care clinicians regarding the service user's progress or physical needs, ensuring a holistic package of care.

Service users are encouraged by me to take a proactive role to support fellow users by sharing their experience and getting involved in further therapeutic education and support groups. All service users are encouraged and facilitated to develop their own Wellness Recovery Action Plans (WRAP) and a copy of the crisis plan is placed in their medical file and adhered to as far as possible should a relapse occur.

Service users are encouraged to involve their family. Education and support is offered as acknowledgment of the caring role well performed. Family members are encouraged to join the local relatives' support group, which is facilitated by the CMHN and to participate with the service user in a representative role involving service planning.

The role while very challenging is also very rewarding in so far as one can witness the great beneficial transformation that it can bring to a person's wellbeing and quality of life.

The role privileges the nurse to travel and witness recovery on a daily basis".

OCCUPATIONAL THERAPIST

The Occupational Therapist works in collaboration with the Community Mental Health Team to contribute towards a holistic approach. Following a referral from any member of the team, the O.T. will arrange to meet the individual in hospital, home or Community Mental Health Centre. An assessment is completed which will help identify their needs. Using this and by listening to the individual, goals of treatment are identified. These may focus on work, domestic activities, leisure or self-care, to promote optimum function and a balanced routine. The treatment

programme aims to provide support, practice and education to develop self awareness, responsibility, motivation, interest, confidence and endurance.

The O.T. can also help people to develop skills to cope with anxiety, low self esteem and to address time management issues. Together the O.T. works with the individual at their pace, to enable them to resume fulfilled roles and healthy habits. On some occasions when the individual is ready, they may be asked to join a group of people with similar needs. If appropriate, treatment may also involve community related activities.

Should you feel that you would benefit from the input of an O.T, inform your doctor or another member of the Community Mental Health Team

SOCIAL WORKER

"I love my job as a mental health social worker, I get to meet lots of interesting people and no two days are ever the same!

I work with individuals, couples, families and groups. My role is to provide counselling and support to service users and family members, in addressing problems and making changes in different aspects of their lives.

Referrals can come from Primary Care, other members of the multidisciplinary team, and self-referrals from service users or family members. I am based in a community mental health centre, and I also meet people in their homes, the hospital or other places in the community.

Social workers take a holistic view when someone is experiencing mental health difficulties.

Often the problem is located in the person's environment and the intervention that is needed is to change the system (for example when people are being discriminated against or being treated unfairly because of stigma, or when there are problems in the family).

Other times, people may be in distress because of relationship difficulties, financial concerns, legal issues, housing conditions or worries about children. Some people want to explore employment, education or training options. It is important to assist people in identifying their

passions and strengths, and to talk about what has helped in the past. Having a solutions-focused approach gives a positive focus to the work.

"Who do you turn to when it happens to you? We knew since John was about 6 that he had amazing energy; he would be climbing the walls. He was disruptive in school; he had been expelled from 2 schools. We brought him everywhere, looking for a solution to his behaviour. Attention Deficit Disorder appeared hopeful for a time, you might think it is funny to want your child to have something like that, but we were at our wits end, and were seeking any straw to grasp. We felt that if we had a diagnosis we could cure him or something. As he got older he gravitated towards a group of young people who drank a lot. He embraced this scene with a passion, so much that we had to bring him to an alcohol addiction centre by the time he was 17. It was only then it came to light that he may be experiencing a mental illness."

An important part of the social work role is to provide relevant information and education to people and to link service users and family members with services in the community. Good social supports are a key part of recovery. There is no substitute for being able to connect with other people who have had similar experiences and who can provide hope of a positive future.

We are lucky to have a vibrant peer support centre in our area that is run by service users and is home to many different types of support groups and activities, such as the Phrenz group. I facilitate the SHINE Family Support Group that meets monthly at the centre.

Another part of my job is to support the development of new services that are needed in the local community. I am involved in interagency initiatives to address domestic violence, suicide in young people, and homelessness. I am also working in partnership with service users to develop self-advocacy initiatives, mindfulness groups, and WRAP (Wellness Recovery Action Planning).

The best part of my job is having the opportunity to accompany a person part of the way on their recovery journey. It is fantastic to see people making positive changes in their lives, especially when they are able to give themselves the credit for making those changes!"

CLINICAL PSYCHOLOGIST

"Clinical psychologists are trained to recognise a breadth of influences that lead to mental health difficulties.

There are as many pathways to the diagnosis of schizophrenia as there are individuals with this diagnosis.

For those people who experience significant mental ill health, extreme distress or disturbance in their normal life, a difficult and challenging process of recovery may lie ahead. This path is often unclear and what helps someone travel along this path can vary dramatically from one person to the next.

The clinical psychologist is one of several mental health professionals who help to try and understand the best help that each individual may require along their road to recovery. Clinical psychologists work within a multi-modal framework, drawing on a wide-ranging array of theoretical models. They tend to rely on the 'stress vulnerability' and 'bio-psycho-social' models of mental health.

Put simply, clinical psychologists recognise the fact that each individual is unique and that several factors may be involved in leading a person both into and out of mental ill health.

More specifically the clinical psychologist helps to develop an understanding of each individual's psychological needs and the nature of the difficulties they are experiencing. This may involve a focus on current symptomatic difficulties, long standing personal issues, early traumatic experiences, difficulties with thinking, memory or attention, emotional or familial difficulties. An assessment of these needs may then lead on to a psychological therapy.

Psychological therapy can take on a variety of forms, ranging from brief problem or symptom focused interventions, to longer-term in-depth therapeutic interventions. For many individuals, coming to some understanding of what is happening inside them is absolutely essential in learning to cope with the extreme experiences being endured. Aiding someone to make sense of hallucinatory experiences, extremes in mood states or deeply held fears of threat is often the goal of a psychological therapy.

"People would be saying, "your brother is mad, he is great crack", yeah, right to you maybe. For me I was incredibly embarrassed about him. I was ashamed and sometimes would not acknowledge him as being by brother. All I wanted was a normal older brother who would play with me and stick up for me. My reality was a home, which was disrupted and angry all the time. My parents spent so much time looking out for John that we may as well have been invisible; I hated him. Looking back on it now, I feel sometimes guilty knowing what he had to go through. But hey, I was a kid and I thought like a kid, all I could see was the stress and strain my parents were under because of him. Wishing for the umpteenth time, when he ran away that he wouldn't come back and we could be a normal family. If there is one thing I have learned as a result of my brother's mental health difficulty, it is that he is my brother and as the song goes "he aint heavy, he's my brother" and I love him very much. Even if I am still a tiny little bit resentful of the time and attention my brother got, and I still can't listen to that phrase, "he needs us more."

In many ways the psychologist lends the person their thinking, when thinking becomes muddled or difficult.

When emotions become intense or confusing, when experiences seem bizarre or unusual, when the world does not seem to share your view of what is happening to you, it is vital that you have someone to talk to about these experiences.

The sense of being overwhelmed and alienated, that is so common amongst people who experience serious mental health problems is something best shared. It is a psychologist's job to help people in these ways to understand and cope with their experiences, sometimes in great depth, in lending their thoughts and supporting each person's efforts to come to terms with their experiences".

- The advertised route to accessing the mental health services is:
- You have a problem
 - You attend your GP
 - The GP listens carefully
 - He or she suggests you attend a specialist and writes you a letter of referral
 - You attend the specialist. He/she listens carefully
 - He or she suggests you go for counselling, take medication, or that admission to a department of psychiatry is necessary, where you will receive all of the above
 - After a number of weeks you leave hospital with a multi disciplinary team supporting you in your community
 - You recover and live a full and happy life

The above scenario is what many people experience.

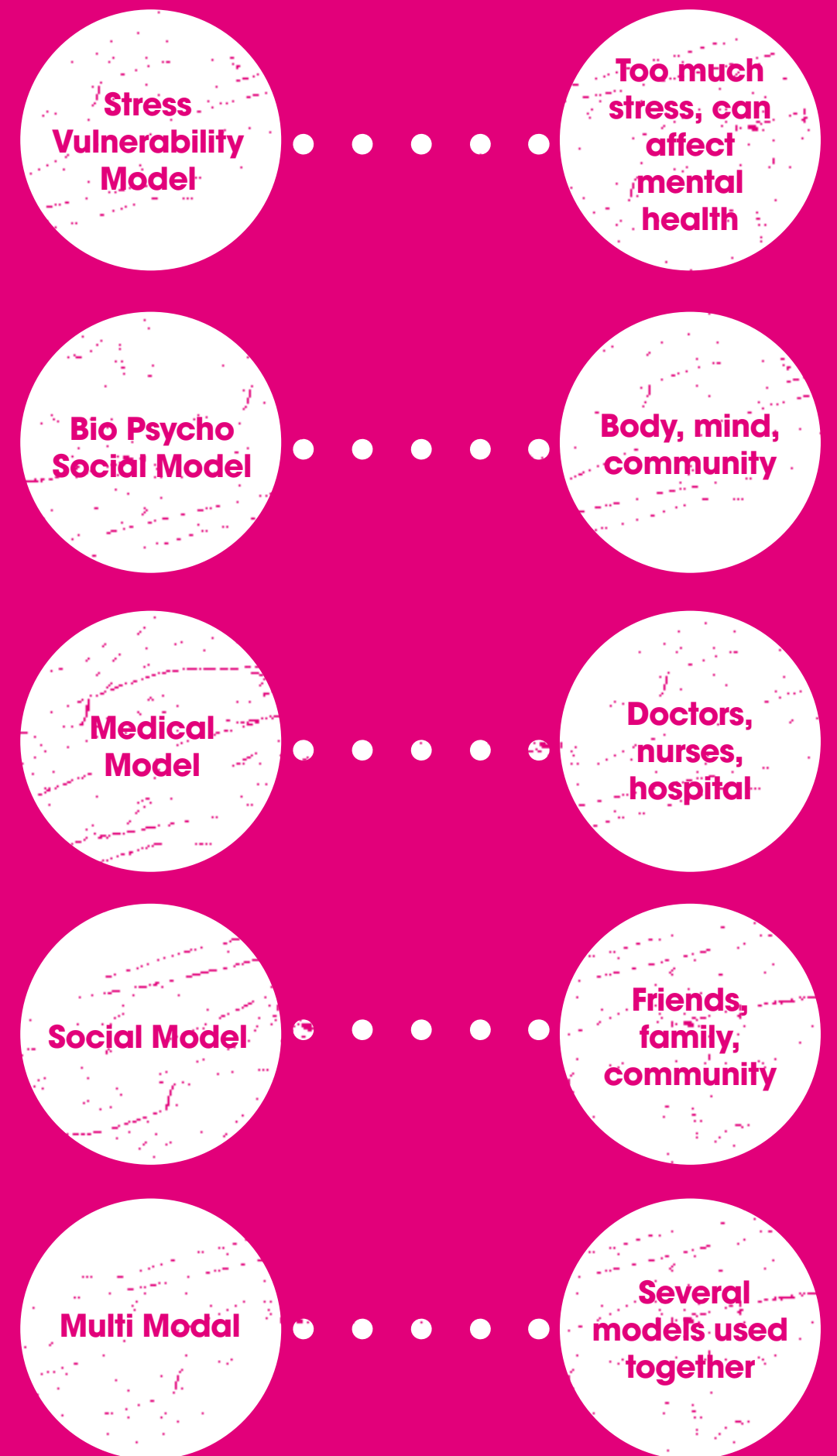
Managing “models” to best effect

You will frequently hear the word model being used to describe an accepted approach to understanding or managing health issues.

Stress Vulnerability Model	- too much stress, can affect mental health
Bio Psycho Social Model	- body, mind, community
Medical Model	- doctors, nurses, hospital
Social Model	- friends, family, community
Multi Modal	- several models used together

The problem with all such models is that while they do now recognise that no one size fits all, there is still an expectation that the person will actually fit under a number of the labels used.

All you need to know is what works best for you and get the models working with you.



Respondents sometimes felt their own lives were sometimes “put on hold” due to the demands of their caring role.

*The Unknown
As we know,
There are known knowns.
There are things we know
we know.
We also know
There are known unknowns.
That is to say
We know there are some things
We do not know.
But there are also
unknown unknowns.
The ones we don't know
We don't know.*

- Feb. 12, 2002,
Donald Rumsfeld, Department of
Defense news briefing

This quote above, while the source of
much amusement at the time, puts
it quite well. Actually knowing what
you need to know is not easy.
Families need a wide range of
supports. Information plays a
big part. There is a lot out there.
Sometimes too much.

Family Front

FAMILIES NEED Information

Most asked questions include: What is
happening? What happens next?
What about medication?

Education

I can't cope with his/her behaviour. The
doctor won't talk to me. I feel I have lost
my child.

Support

Knowing I wasn't alone was a great help.
Having a place to talk about my
own needs. Sharing the ups and downs.

"I think there definitely should be something
that we should, as a family, go to. We don't have
to be individually seen. Because we're not sick
people, we just want somebody, psychologists
or counsellors or whatever, somebody that will
talk to us and explain to us what's happening
and which we didn't get, we didn't get any of
that information till much, much later and a lot
of it I asked for myself. And a lot of it I found out
about on the Internet and by reading books
and seeing movies on television and things like
that you know". *(Family Support Study. Health
Research Board 2006)*

"So the help was there, but one had to be very
much on the ball" *(Family Support Study. Health
Research Board 2006)*

"Three mothers noted that they had received a
lot of written information about schizophrenia
and it was too "drastic", and upset them even
more because of the stigma associated with
the word schizophrenia. The importance
of personal contact and moral support was
highlighted by these mothers" *(Family Support
Study. Health Research Board 2006)*

A group of parents and carers in Waterford
undertook a research project into the needs of

families caring for a family member with mental
health difficulties. They note:

"Respondents indicated that they required
assistance in understanding what the
information meant and how it would help them
in their caring role. "Knowledge is power" is only
true if people know how to interpret and make
best use of that knowledge"

And

"Respondents sometimes felt their own lives
were sometimes "put on hold" due to the
demands of their caring role.....It also highlights
the crucial need for targeted supports to be put
in place for carers as part of the development
of a comprehensive community model of care".
*(Every Mother's Son. Waterford Parents and
Carers Research and Advocacy Project. 2007)*

A FATHER'S VIEW

"In starting, I would like to acknowledge the
context in which all of us concerned with
mental health operate, that is, within a mental
health service that is historically under-
resourced. Now I'd like you to read a few lines,
from one of my favourite poems – Milton's
Paradise Lost

*Round he throws his baleful eyes that witness
huge affliction and dismay
At once, as far as angles ken, he views the
dismal situation
Waste and wild.*

*Regions of sorrow, doleful shades, where peace
and rest can never dwell:
Hope never comes that comes to all but torture
without end.*

This is what being in hell is like. I would suggest
that this is what being in the grip of mental
illness is like.

Our own family journey started with:

Confusion

Throughout his childhood years our son was a happy, loving boy. We could not understand what was happening as things began to change. Between the ages of 12 to 21 our confusion and bewilderment grew. His behaviour changed radically, this led to difficulties in school, disturbed sleep patterns, sleeping all day, awake all night, angry tirades, blame and accusations. We began to believe that drinking and drugs were at the root of the problem. Cars and cheques vanished. Trouble with the law followed, with policemen at our door.

Our efforts to get help for our son throughout this period saw us travelling the length and breadth of Ireland. We spoke to our GP, brought our son to counselling and attended family counselling over many years. At the same time we were holding down jobs; caring for our other children and trying to hold on to our sensitive and gentle son in what felt like the middle of a hurricane. There were many false dawns during this time.

He spent his 18th birthday in the Rutland Treatment Centre. We were heart-broken yet hopeful. He completed the treatment. There was no breakthrough - no diagnosis.

Our son moved out of home. We helped him get a series of rented flats. He tried to work. Looking back now, we can see the fallout for other family members. The cost was high, both financially and emotionally.

A series of hospitalisations led to a revolving door of treatment followed by discharge - often into homelessness. We got used to waiting for hours on end in busy A&E units. Sometimes our son was loud and angry, sometimes distraught and weeping. At first we were self-conscious and embarrassed both for ourselves and for the other patients waiting to be seen. We tried to engage with medical staff, looking for information around treatment and around care plans. Our son was now over 18, and information was hard to come by.

This long period of confusion eventually led to:

Comprehension

A final breakthrough came with the diagnosis of the illness. It took ten minutes in a psychiatrist's office. He told us he had no doubt at all that our son was suffering from schizophrenia. We were shocked. We couldn't understand how through all the years of seeking medical help - this diagnosis had never been made.

We were given a bleak prognosis, which we were initially unable to take in. There was no support and little information

"Yeah it was hard, but it was brilliant there. I was in hospital and I felt safe, safe from myself and safe from others. Everybody was so nice, the staff, the other patients. It was comforting to know exactly what time meals, medication and the cups of tea were at. I attended whatever programmes were available on the ward. I had loads of visitors. All in all I was there about six weeks. The other patients used to joke that I was the one who "got away", that is, I never took up smoking!"

available to us. We struggled to come to terms with the nature of this life long illness. We began to realise that we were essentially on our own. It dawned on us that we would have to help our son cope with this illness for the rest of our lives. A slow and uneven process began, whereby our son gradually came to accept his illness. We in turn began to have some understanding of the measure of his suffering.

A major breakthrough occurred when - at our lowest point and in a moment of pure crisis - we contacted Schizophrenia Ireland. We were introduced to a carers' group. Comprehension about the nature of this illness began to sink in. We were and continue to be - greatly helped by the experience and support offered by other carers and parents in the group.

The relief was immense that after years of searching we found:

- We were not alone
- We were not the only ones struggling to understand this devastating illness
- We were not the only ones going over the past, trying to find out where we went wrong

At the carers' group it is possible to say it like it is. We experience acceptance, friendship, discretion, wisdom, shared experience, a wealth of information and sound advice. This contact, we firmly believe, has been central to our recovery as a family.

Compassion

As our understanding of this terrible illness grew - we came to understand the suffering endured by our son and all who struggle with the symptoms of schizophrenia. With this understanding came compassion and acceptance. We embrace the challenge with hope and decide to fight back. Our journey has led us through stages of confusion, comprehension, compassion and finally to commitment.

Commitment

By commitment we accept the responsibility and challenges of supporting our son as he fights his way through the maze of schizophrenia. We accept the setbacks. We are learning at last to distinguish between the illness, it's cruel symptoms and our own unique and loving son.

"You need the success stories. It keeps you going in this job: I love it when someone comes into hospital, responds to treatment and leaves. You might meet them down the town, they may or may not wave at you, stigma I think is a reason they don't, but they would always give you that invisible nod of the head or look in their eye, one of gratitude. You know you have made a difference. Sometimes people will be back in a year later or whatever. It's really tough for them and their families. It is. It's very hard to stay well sometimes. We all know that, it's hard for everyone, but for people with big mental health problems they need a whole lot of support. Mostly we can do that. You get to know what helps. A lot of the time it's really simple stuff."

We are committed to supporting him in every way we can. We continue to campaign for his rights and the rights of all with a diagnosis of mental illness - to proper treatment and best practice - long promised but much delayed.

Co-operation

At all times we as carers are more than willing to share our experience and knowledge of the illness. We seek to work in cooperation with the Mental Health Services, GPs, Voluntary Bodies, Shine, FOCUS, the Gardai, Statutory Services and all others working for change and improved outcomes for service users and their families.

Conclusion

Milton's vision of hell with which I started, sums up for me the anguish of mental illness. To some extent I live, in my mind, the life that my son lives – social exclusion – in society, but not part of it – with few friends – trying to achieve goals that without professional help – he will not be able to achieve – stumbling from day to day – full of aspirations and hope one day – hitting rock bottom the next. I have come to understand how hopeless and powerless his symptoms leave him. I have come to see how overwhelmed he can be by terror and fear – with little help except from his family and his medication. I am saddened that I cannot do more to help him.

I am full of admiration for his determination to work, his immediate response to the offer of a day's work, even a Sunday job, his fierce desire is to build a better life for himself, a normal life.

After 11 years on the housing list our son has at last succeeded in getting a suitable local authority apartment of his own. A miracle! This meeting of the most basic human need for shelter and security has helped his wellbeing and self esteem enormously.

I am full of admiration for his courage in facing each day. I struggle with my own anger at the shortfalls in the system,

- the underfunding
- the neglect
- the lack of support
- the absence of structured care and recovery planning
- the absence of follow up
- the failure to include carers as active partners in the recovery of their loved ones
- the failure to deliver joined up services to those whose lives are affected by mental illness."

The Mental Health Commission undertook a consultation into what might constitute a quality mental health service in Ireland in 2004. Below is a summary of their findings on the needs of families, parents and carers.

It is important to acknowledge the good experiences people have when they access the mental health system. Unfortunately, not all experiences are as good as others.



The Mental Health Commission has established three important themes, which reflect the needs of families. What constitutes a quality service for families, parents and carers?

Theme 7: Families, parents and carers need to be empowered as team members, receiving information and advice as appropriate

Families, parents and carers want to be part of a solution-focused approach to treatment, and to play a constructive part in the team, aiding the person who is experiencing mental health problems. There were clear differences of view between families and service users about the level of involvement that families can legitimately expect to have in relation to knowledge about the person's illness, information about treatment, planning and decision-making.

Theme 8: Effective family support services need to be in place to reflect the important role that families, parents and carers play in a person's healing

"We didn't know where to turn to. We could not get Shelia to see the GP and when we tried to talk to the GP, he said Shelia is over eighteen and she would have to come in of her own free will. On Thursday, May 14th, Shelia was running around the town spending money like water, she couldn't sit down for two seconds. Every time we tried to speak to her she would become angry and suspicious and accuse me of trying to control her, I don't know where she got the energy. When she wasn't out she would pace up and down the floor for hours, all night sometimes. We tried everywhere for help. Eventually things got so bad that on Sunday June 25th Shelia consented to see the GP."

Families need a range of support services for themselves at various stages in their family member's illness and recovery process. The main areas of support needed by families in a quality service, in the view of the stakeholders, are:

- Information, advice and being part of the team
- The family being empowered as team members
- Provision of a continuum of support services for families

Theme 9: As with people who use mental health services, families, parents and carers need to experience understanding, empathy and respect. Families, parents and carers expect understanding and empathy, and a respectful service. They want to be listened to carefully, and have their views respected. They want to be treated as equals with professionals and be shown respect, and be kept up to date with what happens to their relative.

They go on to comment; families highlighted the provision of information and advice as their most pressing need from a quality service. In the first instance, they need factual information about what services are available, how the services work, and how to access them, especially in a crisis. Information about support groups for carers, workshops about mental illness run by health boards, and peer support groups where people can exchange views were found by families to be particularly helpful to them.

Families accept the need for client confidentiality, but express a great deal of concern about its impact and about the way providers operate the provision. Essential information, for example in relation to discharge planning, may be withheld from families on grounds of client confidentiality. On the other hand, a skilful professional can help a person to understand the benefits of sharing information with their family.

Families need support at every stage in the person's illness and recovery process. In particular they highlighted the need for

counselling and therapy to help them to deal with pressures on their own mental health, arising from stress and anxiety. Family therapy is needed to help to rebuild family relationships, and to give support to siblings of the person who is ill.

As was the case with people using the services, families expect understanding, empathy and "a shoulder to lean on" in a quality service. They want to be listened to carefully, and have their views respected. They want to be treated as equals with the professionals and be shown respect, while being kept up to date with what happens to their relative. (*Quality in Mental Health. Your Views. Mental Health Commission 2005. You can view the full document on www.mhcirl.ie*)



John Surdival

No matter how unwell or distressed we are as a person, it is only when we hit our own crisis point that we seek help, regardless of anybody else's opinion. So remember, crisis points are individual to you. That's why some of us will endure more than others. We all have our breaking point. The trick is to try to recognise when we are heading for a crisis early enough, so that the crises diminishes or even disappears.

"Although we were relieved she consented to see the GP, it was Sunday and our family GP was closed. We then called Care Doc, (an out of hours service, for emergencies). After a few brief questions the Care Doc decided they were not familiar with my daughter and they could not see any reason to refer our daughter to the local department of psychiatry. She sat there as polite and pleasant as anything. I felt the Care Doc was looking at me as if I was the one with a problem. But she gave me a letter for the local A+E department anyway. Now I thought, we are going to get help. Sheila was becoming a bit agitated again, and I quickly presented the letter to the receptionist.

BROTHERS AND SISTERS

'Sibling relationships... outlast marriages, survive the death of parents, resurface after quarrels that would sink any friendship. They flourish in a thousand incarnations of closeness and distance, warmth, loyalty and distrust'. (*Erica E. Goode, "The Secret World of Siblings," U.S. News & World Report, 10 January 1994*)

Dr Jo Smith, a consultant clinical psychologist in Worcestershire has taken a special interest in the needs of siblings. As part of her presentation at the Recovery and the Family Conference in Wexford in 2009, she outlined some experiences reported by siblings.

- Alterations in their relationship with the affected sibling and other relatives
- Adverse impact on emotional wellbeing
- Neglect of personal needs
- Difficulties in maintaining friendships
- Decreased academic performance
- Increased responsibility at home
- Ignored by psychiatric services
- Low awareness of genetic vulnerability
- High levels of involvement in caring for the affected sibling

Common Sibling Experiences

- Siblings struggle with the changes they observe in their brother or sister or their relationship
- Siblings lack knowledge and experience and can find it very difficult, distressing and frightening at times when someone in the family is psychotic
- Siblings may feel their parents are preoccupied and they do not get as much attention as the person who is psychotic
- Siblings feel for the sibling who is unwell
- Siblings may have anxieties about their own mental health and risk for psychosis
- Siblings rarely get information or support from services

If only my husband was alive he would know what to do, maybe Shelia would not be like this, maybe it is my fault she is here. My thoughts were cut short when I heard a porter tell my daughter she can't smoke there. She told him to f--- off and she could smoke where she liked. Everybody in the waiting area perked up at a bit of entertainment. I rushed over stammered out an apology and caught Shelia by the elbow and steered her outside. When we got out there I lost my cool. I didn't care who heard me, I called her a selfish little b----, a lazy good for nothing and asked her what her father would say if he could see her now, he would be ashamed I told her. Just then Sheila's face scrunched up and a large tear appeared at the side of her eye. She cried and said, "I am sorry mam" in a voice so soft I barely heard. My heart broke in two, but all I could say was "where the hell is the doctor", I turned around and walked back in.

A Sister's Experience

"I was 16 when my brother first became unwell. He came into the house telling us all he had driven his car through some bollards and terrorised a learner driver. We went outside to look at his car and found that this was not the case. Needless to say we were all confused at what he was saying. The first time my brother became ill his behaviour was so bizarre I don't think any of us knew what was going on. Me and my brother had always had a stupid sense of humour so it took us a few moments to realise he was talking rubbish for no apparent reason.

I think the hardest thing to come to terms with was how quickly my brother became ill, it literally was overnight. There was no time to get used to the way he was, we had to start managing straight away. We all handled him differently and at times one of us would be more impatient and this would cause conflict amongst us all. I was often shocked with some of the things he would come out with and when he would say something strange we would say "Well that's what you think at the moment, but we don't think that." Often he would leave me speechless and I felt so helpless that I could not wave a magic wand and bring my brother back.

I think before I fully accepted what my brother was suffering with we were already in the thick of it. I remember one of the worst evenings where I watched my brother literally crawl the wall; it was like a scene out of the exorcist and a side effect of his medication we had not been warned of. The four walls of our house had never seemed so small. I quickly learned how uncomfortable it made people, for me to talk about my brother's illness, and soon learned it made others more at ease to say he had suffered a break down, rather than mention anything to do with his mental health.

I didn't know anyone else that had the same or even a similar situation to me and I remember feeling very alone and resentful to the people around me who were genuinely happy and not just putting on a brave face as I had to.

Eventually a man approached us and asked us to follow him. I asked him if he was a doctor. "God no" was the reply "no such luck, I am a psychiatric nurse". He led us down a corridor, led us into a small room, asked us to sit and told us that Dr Johansson would be with us in a minute. I tried to move my chair back a little but it didn't move. I looked down and saw it was bolted to the floor. I glanced over at Sheila and could see she was very upset and scared looking. I reached out to her and squeezed her arm; she jumped as if she was shot. Just then the doctor walked in. A good-looking young man in a white coat, he introduced himself. I barely understood what he was saying; his accent was so strong. "How are ye to day" he asked. The funny thing is, I said, "we are fine", and so did Sheila. Doctoritis, I think."

Very few people understood what I was going through and I became less sociable. This was partly to do with the guilt of going out and leaving mom and dad to handle my brother, but also I just did not have the energy and enthusiasm that I used to have for socialising.

Unfortunately my brother became ill around Christmas and so this usually very happy season was ruined. This was very difficult to deal with and we were very isolated at a time that would usually be crammed with family and friends. We were cautious of my brother being around young cousins because of some of the odd things he used to say. My brother was so unpredictable, very angry one minute, very anxious and frightened the next.

He experienced very vivid delusions and thought he was our late grandfather, thought he needed a wheelchair and thought he could talk to God. On many occasions when I or my parents had planned to use public transport, my brother would become obsessed that there was a bomb on it. None of us could put the television on as my brother experienced voices and thought that he was being sent messages through the TV. Needless to say this made trying to live our lives as we had before my brother became ill, an impossibility.

Unfortunately amongst all of this my pet rabbit died, and my brother in his confused state thought he had killed him, this meant I was unable to grieve for a truly treasured friend. My brother spent two periods of time in hospital, one from which he escaped and we had to receive a very distressing phone call to inform us of this. I never went to see him in hospital; I just could not cope with seeing him there. Now I feel riddled with guilt as he often requested me to visit and it is something I have never forgiven myself for.”

My Feelings

At the time, I felt very neglected by my parents as all their time, energy and thoughts went into my brother. This was not without the understanding that my brother’s needs were greater than my own, but at times important things for me were not acknowledged. At my brother’s worst, he would only sleep in my bed with me, however, this was very fidgety disrupted sleep and he would be up early needing mothering and reassurance. This was extremely physically and emotionally draining. Although my brother was very draining for the majority of his illness, we would laugh at some of the things he did and said, because that was our way of coping. I know that I owe a lot of my coping ability to the fact that I had and still have an extremely supportive boyfriend and I know that things could have been very different without him with regards to finishing my degree for example. I would have greatly appreciated the opportunity to have talked with other siblings in a similar situation, as I know my main struggle was feeling like I was alone.”

The Sibling ‘No man’s Land’

The UNAFAM study highlighted a ‘no man’s land’ for siblings where they face a number of paradoxes: (Davtian, 2003)

- They have too little information yet they know too much
- They are often involved but without a defined role or knowing what is expected of them
- They experience difficulties but asking for help may risk making themselves more vulnerable
- They often find themselves in the dilemma of choosing compassion or abandonment

There are virtually no services available for siblings in Ireland. As noted above, the needs of brothers and sisters simply do not come up for discussion. The “No Man’s Land” above describes very well the often silent and lonely journey that sisters and brothers have to face.

Useful and appropriate information and knowledge can help family members to improve their navigation of the process. As in all stressful situations, it is very important that everyone gets the chance to talk about how they are feeling. Too frequently emotions are ignored, or buried and then burst out in anger at the worst, or maybe not the best time.

It is easy to loose sight of the ordinary, everyday things that keep us ticking along. People talk of putting things on hold, feeling that they are walking on eggshells all the time.

If a family member is very unwell, it may be that everyone has to find a way to re-imagine their role and develop new and different personal responses.



Orla Rehill

AS A WIFE

“My husband has a diagnosis of bipolar disorder. Maybe! I have good supports. It feels good to be sad and angry and frustrated instead of putting on a bloody happy face all the time, I am ditching that! It has been a long journey. At this point I try to be with my husband when he is withdrawn. Just to sit with him, even if he is saying nothing. I don’t feel angry with him anymore. That may be part of my recovery. There have been many very bad times when I have been afraid and did not know where to turn. I went to our GP to get some answers. He said that psychiatrists did not like to diagnose too quickly.

My husband has been hospitalised a number of times, some for long periods. I thought he would be ok.

I was still completely ignorant and did not understand anything that was going on. I was trying to support a loved one experiencing a severe mental illness, yet I knew nothing about mental illness.

Some time ago I came by some booklets. I shoved them under my coat so no one would see them, and that evening just before I decided to bin them all, as this still was not happening to me, I opened a page of one of the booklets and became engrossed. I read every page of those booklets that evening and cried as I realised that this was happening to us. It was like reading our life in written form. This was the day that I received the information I needed to start my recovery process.

I have attended a support group for relatives, which was a very hard step as it made everything very real. I had such similar experiences.

I feel very passionate about information being out there and available to relatives and people with self-experience. I think it is unacceptable that I had to come across the information almost by accident.

Through my experiences I have grown and developed as a human being, I have matured and gained so much confidence. Recovery is not just something that people with self-experience need, even though it is vital, but families need support to recover too. The impact of struggling to support a loved one through their own journey of mental illness is so hard and extremely complicated. Relatives need information, support and education too if they are ever going to be able to support their loved ones and themselves on the road to recovery.

Struggling to support a loved one experiencing mental illness can in itself cause physical and mental illness in relatives, so it is vital that supports like free counselling, advocacy, support groups, family education courses, a helpline and plenty of information are accessible to relatives also.

I do not feel that the mental health services provide adequate supports for anyone, I also feel very strongly that people using these services and their relatives must be informed about organisations outside of the H.S.E. and this can be as simple as providing a simple telephone number. It is not rocket science.

Everyone needs to look outside of our own areas so that everyone involved in mental health in one way or another can come together and join forces. You cannot possibly support anyone if you do not have



Barry Walshe

support yourself. When you are in a crisis you do not always see the things that you should see, sometimes you have to be told that they are there, as your mind is elsewhere.

So to end, it is my feeling that the only way that families’ needs can be met, is if everyone involved in providing services in the area of mental health, put aside what they feel is right or wrong and concentrate on what families ask for and want, as people with self-experience and their relatives are the real experts on mental health, as they have lived what professionals learn from books. Nothing can compare to lived experience and everyone’s experience, although similar, is an individual experience, so must be treated as such. Individual experiences must be included and listened to. It is about a fundamental human right to information, education, support and most of all choice.”

Talking Therapies

Many people with self-experience and their families speak of the need for counselling or psychotherapy to help them make sense of their experiences. Gaining access to talking therapies is difficult in Ireland for a number of reasons. Most therapists practice outside the HSE and thus, there is a financial barrier. Many mental health professionals believe that only a few specific therapies can benefit people with significant mental ill health. Very few recognise the importance of such support for family members.

“EVEN AS PHARMACOLOGICAL TREATMENTS IMPROVED the management of symptoms, those with self-experience of schizophrenia and other psychoses attending mental health services, often reported a profound sense of alienation in their interactions with mental health services.

People attending services, struggling with their experiences, could not find anyone to help them articulate their experience and try to make sense of what was happening to them.

Within a biologically oriented treatment paradigm, the particular individual experience of psychosis is not of clinical significance, being simply a manifestation of the illness process and therefore to be medicated away and hopefully forgotten as far as possible, rather than being integrated into the sense of self. Psychologists and psychotherapists were not, by and large, available within mental health services to people with a diagnosis of schizophrenia and requests for such were dismissed as inappropriate.

In more recent years the biological model has been superseded by the bio-psycho-social model, and a multimodal approach to treatment, taking account of the biological, social and psychological dimensions of psychotic illness is now favoured (NICE, 2003, A.M.A., 1997). The development of a strong service user movement, of which Shine is a part, has provided practical support and, perhaps more important, validation, companionship and a voice to those experiencing mental health difficulties. The service user movement accords a high degree of importance to personal narratives, such as people's personal accounts of their illness and journey towards recovery.

This has provided an outlet for the articulation of feelings of personal alienation and invalidation of experience, which had unfortunately been part of many people's experience of treatment services.

The recovery movement or recovery approach to mental health, endorsed by A Vision for Change (2006) as a guiding philosophy for our

mental health service, has provided an ideological framework for the development of user-friendly services.

User-friendly services respect the individual's experience, recognising that, while psychiatric diagnostic systems focus on similarities in clinical presentations, the personal experience of psychosis is an individual one and touches on the very essence of the self.

Additionally, the development of cognitive behavioural treatment protocols, which have a good deal of success in tackling positive symptoms of psychosis, such as delusional thinking and auditory hallucinations, have also refocused attention on the value of working with the individual's experience through some sort of “talk” therapy. These developments have been accompanied by a renewed interest in the development of new and better-targeted models of counselling/ psychotherapy and psychological therapy as part of treatment packages for psychosis. These models tend to draw on insights from psychotherapy and psychoanalysis, psychological theory, cognitive behavioural theory and family therapy. Interventions are grounded in a stress vulnerability model or its updated version the ‘stress vulnerability-cognitive model’, and benefit from a deeper understanding of the nature of psychotic experience and of the phasic nature of schizophrenia. They are, therefore, better targeted and, the research suggests, more effective. These newer approaches require highly skilled and well-supervised practitioners with high levels of personal flexibility. Fenton (2000) talks about “the therapists capacity to ‘shift gear’ flexibly and change roles with all patients based on changing circumstances, always holding the goal of helping the patient accept, learn about and self-manage what may be a chronic and devastating illness” (Dr. Anne Byrne Lynch, Principal Psychologist, HSE. *Talking about Talking Therapies. Schizophrenia Ireland*)

“Traditionally, talking therapies have been considered to have little role as an intervention for psychosis. The prevailing view has been that

psychosis is purely a medical issue. Service users and their carers often ask for counseling frequently, wanting to talk about their distress, their problems, their psychotic experiences. They are often informed that counselling would not be good for them, indeed that it would be likely to cause a deterioration in their condition. They are often told that therapy may be considered well down the line, but in practice this rarely occurs. In my opinion, this is a misguided view, one which needs to be revisited. The obvious benefits of medication, particularly in the acute stages, do not negate the role of talking therapies.”

Talking therapies can play an important role in enabling the person to live well, understanding themselves and their symptoms, to work towards living the life they want to live, a safe place and space to begin rebuilding their sense of self and interacting more effectively with the world.”

(Terry Lynch. *Talking about Talking Therapies. Schizophrenia Ireland*)

“I would far prefer to learn about myself and what makes me tick, especially, what makes me tick the wrong way and how to fix it. Who knows you best, but yourself, what you need to know is how to deal with other people assertively, but illness and hospital makes you lose confidence and belief in yourself and your own abilities.” (Brendan. *Talking about Talking Therapies. Schizophrenia Ireland*)

THE PROCESS OF COUNSELLING AND PSYCHOTHERAPY

Psychotherapy is usually carried out in the same location weekly, and at an agreed time. Once weekly is the most usual arrangement, but frequency depends on the client's needs. If a client is in crisis, additional sessions may be required.

The type and length of the psychotherapeutic process is highly individualised, one size does not fit all. The process usually depends on the nature of the problems presented, the dynamic between therapist

and client, and other variables. Counselling and psychotherapy can be accessed in different forms. These include individual therapy, couple counselling/therapy, family therapy and group therapy. These therapies and other psychological therapies may be available through primary healthcare (local general practice or primary care team), through mental health services, voluntary agencies and private practitioners. The type of therapy a person needs is based on the particular problem that they are trying to address. For the person with marital problems, couples counselling might be recommended. If the concerns are based on childhood experiences then psychoanalysis or psychoanalytic-psychotherapy may be an appropriate intervention to seek out.

The type and level of therapeutic intervention depends on the nature of the psychological problem, including:

- how long someone has tried to deal with the issue, possibly without success
- the impact on daily functioning
- ineffective coping strategies
- the degree of distress being experienced

Counselling and psychotherapy explores these issues through listening and talking methods that consider change and personal developmental needs.

Positive progress in psychotherapy is dependent on the willingness and determination of the individual to achieve change. It can mean trying out new things and new ways of being that will be challenging. Some things that may impact on the effectiveness of psychotherapy would include:

- how ready the person is to engage in the process
- how difficult the situation is
- what other supports are available to the person
- the ability of the client to reflect

The full text of this document is available on www.shineonline.ie/publications. It includes information on understanding the process of talking therapies and how to make the right choice for you.

Life Style

There is a growing body of opinion that mental health is not solely an internal matter. It is not just an internal imbalance in the individual, but also depends upon external factors in their environment. People who experience poor mental health can adapt to stressful environments by establishing strategies for coping with events and situations in their daily lives.

IF WE ACCEPT THIS, THEN IMPROVING each individual's experience is likely to have a positive impact on their mental health and well being. Many people have developed their own strategies for coping with poor mental health, and perhaps the most important part of developing these is accepting that we are all different and need to find out exactly what suits us best as unique individuals. Engaging in this process is itself likely to bring positive benefits in terms of feelings of empowerment, of being in control of our own lives, and accepting responsibility for our own mental health.

Some people have found it useful to have a "daily checklist" to help them identify their needs, especially their emotional needs, in order to avoid becoming unwell or distressed. This may include:

- Talking to people you can trust, about the way that you feel
- Making sure you engage in at least one daily physical activity, perhaps going for a walk, or just doing something active that you enjoy, painting or writing for instance
- Eating and drinking sensibly
- Keeping in touch with your friends
- Asking for help and support if you think that you need it
- Taking a break and relaxing at regular intervals in your day
- Recognising your own limitations, and striving to improve your own patience and understanding
- In short, doing things that will help you to feel good about yourself and who you are

There will also be things that you may want to avoid. Different people find different situations stressful. Find out what causes you anxiety and unease, and try to avoid

these situations. Be aware that there will be times in your life when you are likely to be particularly vulnerable, when a close friend or relative dies, for example, or if you are in a relationship that is going through a bad patch, or if you have recently moved home or are starting a new job. If you find that you are feeling insecure and afraid, try to engage your natural resources like family and friends to help, by providing support, understanding and common sense suggestions.

Take care of your physical health. Be aware that there are often long-term physical health problems associated with certain medications. Have a regular physical check-up. Join mental health support groups in your area and ask what other people have found useful.

There is a wealth of practical knowledge that can be gained from other people's experiences of managing their own mental health issues. They may have ideas and strategies that you can use or adapt. If you do even a few of these things you will find that you are building your own inner resources that you can call on in times of stress or crisis. You will also build valuable external resources and supports, people who will be there when you need them and services that you can choose when to use. You will in fact be building towards recovery, which is a process whereby you travel towards finding your best self and becoming comfortable with the person that you are. *(Extract from Medication, Lifestyle and Recovery. Schizophrenia Ireland)*



John Nolan

Top 5 Tips To Better Health

- Reduce salt intake. Look at food labels to see how much is in them
- Cut out or reduce fizzy drinks
- Drink more water
- Try to get one more fruit or veg portion into your day
- Eat fibre

Nutrition



“Remember, cooking isn’t hard, elitist or poncey. It’s just about learning little bits of information and trying something different once in a while. Just think, if you’re lucky you’re going to live for about seventy-five years and you’re going to be eating three times a day, every single day for the rest of your life – you might as well be good at cooking!” (Jamie Oliver. *Cook with Jamie*)*

* In case you were counting that’s 1095 meals a year and 82,125 for 75!

COMMON SENSE SAYS THAT WE ARE what we eat. How we choose to eat literally shapes us! Now scientific research is backing this up, showing that our diet has a real and measurable impact on both our physical and mental wellbeing. This means that we can positively affect our mental health by what and how we eat. So take a grip on your wellbeing and get to your kitchen.

With food and diet, doing what we like can also be what is good for us. We can eat our way to health and happiness. Food is one of our earliest pleasures, and also one of the first areas of our life that we learn to control and experiment with, developing preferences and tastes.

It can also be one of the first areas in our life where we learn bad habits. It is never too late to look at your relationship with food and make it a positive one. Everyone can find room for improvement.

“The body of evidence linking diet with mental health is growing at a rapid pace. As well as its impact on feelings of mood and general wellbeing, the evidence demonstrates it’s contribution to the development, prevention and management of specific mental health problems.

The implications are far-reaching for all those with a stake in the care, treatment and prevention of mental illness. They must be embraced by stakeholders, if current and future generations are to ease the growing health, economic and social burden of mental ill-health.

There is an urgent need for policy-makers, practitioners, industry, service users and consumers to give proper credence to the role that nutrition plays in mental health.” (Extract from *Feeding Minds. The impact of food on mental health. Mental Health Foundation*)

A good diet is not one that makes you feel guilty or anxious.

Eat well, remember your 5-a-day veg or fruit, and have an occasional treat. Don’t worry if each day is not perfectly healthy, tomorrow is a new day. So look in the cupboard and shape your future health and happiness.

You can get your five a day from frozen, fresh or tinned fruit and veg, just remember to check for added salts and sugars.

LEARN TO “READ” YOUR PLATE!
Is there enough of what you need?
Is there too much of everything?
Is there room left for a nice desert?
Is there going to be a lot of exercise needed to work it off?
Is this plate going to perk you up or put you to sleep?

TOP FIVE TIPS TO BETTER HEALTH

- Reduce salt intake. Look at food labels to see how much is in them
- Cut out or reduce fizzy drinks
- Drink more water
- Try to get one more fruit or veg portion into your day
- Eat fibre

SALT FACTS
You need no more than 6g of salt per day. This would look like one teaspoon of salt. Salt can be hidden in a lot of pre-packed foods, even sweet stuff and cereals, so it is very easy to be over the limit.

If there is more than 1.5g per 100g, that is high salt content

Choose fresh foods and processed foods with no or reduced salt. Lowering your salt intake reduces your risk of high blood pressure, heart disease and strokes.

SUGAR FACTS
You should need no more than 40g of sugar a day. One can of soda can have all your sugar needs for the day. Some have the equivalent of 10 spoons of sugar!

5-A-DAY. WHAT COUNTS AS A PORTION?
1 big apple
2 plums or kiwis
90g cooked fruit or green veg
40g dried fruit (a handful)
1 cup baked beans
large bowl of salad
100ml or an average glassful of fruit juice

1 smoothie counts as 1 portion of your ‘5 a day.’ Even if you drink 3! Try some fruit for breakfast and snacks. Frozen veg are good to eat and can be easier to prepare.

Boil, steam or grill your fruit for a change and top it off with low fat yogurt for a treat

If you fry use vegetable fats, not animal fats.

FOOD DICTIONARY
The 3 fats
Saturated fats are found in meats, cheeses, cream, eggs and processed food. Too much saturated fat has been linked to obesity and cancer.

Polyunsaturated fats are essential fats, containing necessary Omega 3 and Omega 6.

Omega 3 is found in fish, fish oils, flaxseeds and walnuts.

Omega 6 is found in vegetable oils (sunflower, grapeseed).

These can help to lower cholesterol, ease arthritis, PMS and skin complaints.

Monosaturated fats lower bad cholesterol and may help to raise good HDL cholesterol. Found in olive and rapeseed oil, nuts such as almonds, pumpkin and sesame seeds and avocados.



Friank Gallagher

Proteins: Building blocks for the Body

Sugars and carbohydrates provide quick energy, known as a sugar rush. Remember they store as fat if not used. So if you do treat yourself to a cake, doughnut or chocolate bar – you need to walk it off.

Brown rice, pasta and cereals all give a slower but steadier release of energy.

Fats provide a slower release of energy, but are also prone to store as fat.

Fruit and veg provide fibre, essential vitamins and minerals.

A good breakfast with slow release of energy means a better afternoon, and less chance of binge eating and snacking.

STARTING THE DAY

Porridge with banana and honey
Dried fruits, seeds and honey
Beans on brown toast
Fruit and fruit smoothies

QUICK IDEAL SNACK

Banana, yogurt and honey
Beans on brown toast

EASY HEALTHY EATING

Boiled chicken breast and pre prepared mixed veg.
Baked potato, tuna and cheese with low fat mayo
Baked potato with beans

PICK ME UP FOODS

Bananas are said to elevate serotonin levels and so your mood.

“That we love the potato so much is partly down to its versatility and, it must be said, its ability to fill us up cheaply. Potatoes calm and comfort, satisfy and satiate us.” *Nigel Slater*

The following conversation about food took place in a support group.

“WHAT DO YOU DO TO MIND YOUR HEALTH?”

“A good diet is supposed to help. If you’re in good health you don’t notice, it’s only when

you lose it that you appreciate it. Everyone knows fruit and veg are good for you.”

“It’s to put it into practice. It’s essential. It’s not expensive.

I buy fruit and veg every week. There’s a man comes in a van. People do not get enough fruit. They need cereals and less meat. Eat lots of vegetables. A good diet can resolve side effects, Take no cream, sugar or fatty food. If you’re eating plenty of fruit and veg, especially fruit, as it’s got juice. Juice is good for the stomach. Apples are great for you. You’re supposed to take water, and there is water in fruit, fermented water.”

“Cabbage, it’s great for you, the best veg of all.”

“And take plenty of yogurt, the actimel things do lower cholesterol.”

“You can make your own yogurt, you buy yogurt in the shop, there’s bacteria in it. Heat milk slightly and add yogurt and put it in a flask.

“Yogurt is good for you, there’s bacteria running around in it. It’s associated with long life.”

WOULD YOU PAY ATTENTION TO WHAT FOODS YOU EAT, WOULD YOU FOLLOW THE FOOD TRIANGLE?

“Yes. Protein for bodybuilding, beans, meat, chicken. Carbohydrates, rice, brown bread and potatoes.”

“Beer is good for you, it’s fermented. Guinness is too dark. A little is ok for iron. The fermented barley is good for blood. Take a glass of beer; it’s good for colds. Wine is good for cholesterol.”

“One or two is ok, but with medication you get drunk a lot quicker. If I drink too much, the next morning I am down, I get the shakes, I drool.”

DO YOU COOK FOR YOURSELF?

“Yes, meat and veg. If I’m not cooking I eat cereals.”

“Porridge is good for you, I do it in the microwave.”

WHAT ABOUT SLEEP?

“The old people used to boil an onion and eat it with salt and pepper. They never had any trouble sleeping.”

“Or, milk and pepper!”

“Ugh!”

“I just take a sleeping tablet.”

“You don’t want to be taking them or you will get addicted.”

“I sleep a few hours every night, I was up at 5.30 this morning, and did my little jobs before I came in. You need to be busy.”

FOOD IN THE HOSPITAL. ONE PERSON’S COMMENTS

“You get 2 desserts a day, you only need one. They should change the food plan; there is no choice, no menu. It’s the same menu each week. They should ask the patients what they feel like eating, not have the same thing every day.

And no more chicken. They give you too much chicken.

The portions are too big. When you see it, you eat it, even if you’re not hungry, it’s comfort food. There is not enough fruit and veg, and too much meat. The food is horrible in ***** , Burn It!”

For more practical ideas and info around moods and foods take a look at the links below.

www.mentalhealth.org.uk/feedingminds

www.mind.org.uk/foodandmood



Lucy Doyle

Rehabilitation/ Training

WHAT IS REHABILITATION?

The Irish Association of Rehabilitation Professionals has defined rehabilitation as: "A facilitative process involving individuals who are disadvantaged in terms of accessing life in the main stream. The rehabilitative process aims to enable individuals to access as independent a life as possible in social, cultural and economic terms which is congruent with their aspirations."

And
"A whole system approach to recovery from mental ill health which maximises an individual's quality of life and social inclusion by encouraging their skills, promoting independence and autonomy in order to give them hope for the future and which leads to successful community living through appropriate support".
(Killaspy et al. 2005. Quoted in *A Socially Inclusive Recovery Model of Mental Health Rehabilitation*. National Learning Network)

A REHABILITATION WORKER'S PERSONAL VIEW

"Psychiatric Rehabilitation is the process of restoration of community functioning and wellbeing of an individual who has a psychiatric disability. Rehabilitation promotes recovery, full community integration and improved quality of life for people who have been diagnosed with any mental health condition that seriously impairs their ability to lead meaningful lives.

Psychiatric rehabilitation services are collaborative, person directed and individualised and should be an essential element of the healthcare and human services spectrum.

The service should focus on helping individuals develop skills and access resources required

to increase their capacity to be successful and satisfied in the living, working, learning and social environments of their choice. Ideally an effective rehabilitation service should combine pharmacological treatment, independent living and social skills training, psychological support to individuals and their families, housing, vocational rehabilitation, social support and network enhancement, and access to leisure facilities. There should also be a focus on challenging stigma and prejudice to enable social inclusion.

The rehabilitation team should be representative of a wide range of mental

health professionals acting within a team structure with the identified rehabilitation needs of the individual acting as the driving force for the programme. Ideally the rehabilitation team should consist of psychiatrists, social workers as well as a combination of allied health and social care professionals.

Rehabilitation work carried out by a team in collaboration with the individual should seek to effect changes in the individual's environment and in a person's ability to deal with the environment, so as to facilitate improvement in symptoms or personal distress."

The role of the rehabilitation services is to provide:

- Education
- Training
- Resources
- Supports

All these things foster the recovery process.

Rehabilitation services should be designed to meet the needs of the individual in a holistic manner. This means that the biological (body), psychological (mind) and social

(community) needs of service users are all taken into equal account.

A holistic approach is about taking account of the whole person.

You are not just the diagnosis you may be given. All of us are unique and need different things at different times

Rehabilitation should provide a meaningful range of occupations and lifestyle choices, so that the person can have as good a quality of life as possible. Rehabilitation builds on a person's strengths so that the person can live their life in the mainstream of society, not separate from it.

Rehabilitation services should be consultative and user friendly in their approach. The person

receiving the service should have a say in the type and style of service they use.

A number of things are important if we are to maintain our life in the community and manage our mental health.

- They include:
- Adequate income and maintenance
 - Reasonable accommodation, which should be community based and supported, at an appropriate level for the individual
 - A range of meaningful training and occupational services
 - Social integration services to ensure that issues such as social isolation, stigma and low self-esteem are addressed

"There I was lying in bed feeling really bad, not wanting or not able to get up and face the day, thoughts racing in my head, voices screaming and shouting, if only I could make out what they are saying, all I know is they were somehow insulting me. A knock came to the door, it was my Mother, she said, "John, are you awake, I have a visitor for you". Who the hell was that I thought? I could think of absolutely nobody who would visit me. I stopped talking to people a while back when I figured out they must be trying to control my thoughts.

I struggled to bring myself back to focusing on my mother and what she was saying. The doctor wants a word John. The doctor spoke to me as if I was a ten year old, "your mother has been telling me you are having problems". He then asked me if he could examine me, and for some reason I trusted him and allowed him to take my pulse, temperature and listen to my heart. When he was doing this he asked how I was sleeping, I said I wasn't. When he asked about my mood I said I was very low and felt scared. He asked me what I was scared of and I told him about how the neighbours were trying to control my thoughts and make me do things I didn't want to, I wouldn't tell him what, because I was so frightened. With what I was being asked to do, I couldn't bring myself to tell him.
When he asked me if I would be willing to go to see a specialist, a psychiatrist, I decided I can't keep living in this fear, so agreed to go with my mother to the local hospital."

One of the most traumatic experiences a person can have is being admitted into a psychiatric hospital. Relatives are also equally traumatised.

"I was 22 the first time I went to hospital. I was sure everybody was out to get me. For about four years I was hearing voices and having weird thoughts. At first I was frightened, trying to figure out where they came from and if they were spirits, ghosts or aliens. I got kind of used to them. I was maybe debating with myself, might they be some spirit guides sent by God to help me make the right choices. It was only when they began to get ugly and telling me to hurt myself that I was afraid, which soon led to pure horror about what was happening to me. Half the time I thought, I'm fine this is ok, nothing wrong here. But sometimes I knew people were looking at me and I knew I was somewhere else than with them."

Work

People who experience mental ill health want the same things as everyone else. A place to live, money in their pocket and friends to socialise with.

THE DISCRIMINATION, OR STIGMA, that people with mental health issues face, makes the achievement of these simple things very difficult indeed.

Work is not the only way to fill a day

Unemployment rates for people with disabilities remains very high and people with mental ill health are even less likely to gain employment in the open market. Many have found Community Employment Schemes to be a very valuable experience, offering as they do, part time commitment and opportunities for training.

Many people also do not feel they want the pressure and anxiety of work in the commercial world. This is not just a "lazy" response; it is a very valid lifestyle choice for some. Once you remove the money, what most people want is a life in their day. Somewhere to go where they will feel valued, meet people, talk, have a bite to eat. Many people develop a flow to their week, a morning doing this, an afternoon or two at something else, a day at home watching the television.

Society tends to frown on such a non-driven approach to life. Unemployed and retired people often struggle to develop a sense of value outside of the workforce by which they have been almost totally defined.

Living life in a personally meaningful way, at least as many days as we can, is a wholly reasonable thing to do.

The solution to improving employment opportunities for people with mental ill health is, in the end, a matter of continuing to campaign for better social inclusion overall, so that all levels of our society recognise and step up to their role in the elimination of unfounded prejudice and discrimination. For the individual, knowing what you want,

setting realistic targets and working with someone who can guide you to the best training, education or voluntary experience are still vital first steps.

The National Economic and Social Forum produced a comprehensive report on Mental Health and Social Inclusion in October 2007. Part of the learning of this report was that there was a lack of hard evidence relating to the area of work. As a result, they undertook research into the attitudes of employers and employees on their experience of mental health needs in the workforce.

They concluded, as many others have, that work is a very important element of recovery.

WORK IS THE BEST ROUTE TO RECOVERY

Employment is the best protection against social exclusion. However, only a fifth of people with severe and enduring mental ill health in Ireland are employed. Only 20% of Irish companies have a written policy on mental health, yet nearly all employers would welcome information and guidance in this area. There are negative attitudes among employers, with risks for employees in disclosing a mental health difficulty. Those with recent mental ill-health experience found the workplace more challenging and reported more negative attitudes among employers."

(Mental Health and Social Inclusion. National Economic & Social Forum. Report No 36. Summary).

When you are admitted to any hospital ward there are so many forms to fill out. One of the reasons for this is that the Mental Health Act 2001 governs your admission. There is usually the interview with a registrar, from which he/she makes a decision on the best course of action. They may believe that you need to be admitted for observation. Or, they may decide that you should be discharged and you will be given an appointment to attend a Community Mental Health Clinic to see a psychiatrist there. If you are admitted, then there is a personal information form, a medical assessment form, followed by a nursing assessment, then a property form. After this you will be shown your bed or cubicle.

"I thought to myself, if only it was a drug addiction, something could be done, we would support her and be there for her, but this... she sat there with no motivation or any idea of what she should do. If she wasn't crying she was just staring into space, I am ashamed to say it now, but I shook her until I could shake no more, all the time screaming at her, to please help herself."

"When a patient comes into the hospital, especially for the first time, they are often accompanied by their parents or family members, who are extremely upset and as bewildered as the client. We try to be as understanding as possible, but to be honest with you there is so much going on it is hard to find the time to address everybody's needs. As nurses we are the ones who have the most contact with the clients and their family. We can't always talk freely about what is happening. Sometimes because we don't know, but sometimes because we know it's going to be a long day or night and telling people the truth might not be particularly helpful at that point. Also, the patient is an adult. We can't talk about them without them knowing about it. We do try to reassure families, but they need a lot more time, often more than we have available. At that point they have often been through a lot of high octane situations and a few minutes is not going to square all that off."

Housing

Many people with severe mental illness find themselves having to remain in the family home beyond a time that is of their choosing. Through our contact with service users and relatives, housing is often cited as their most serious concern.

IN MANY OF OUR LARGE CITIES, THE ISSUE OF AVAILABLE and appropriate housing is very serious. Council housing lists are long, and single people, particularly single men are simply not considered to be a priority. Landlords in the private rental area are often unwilling to consider letting to people in receipt of benefits.

The HSE has never had sufficient high, medium and low support accommodation. For many people the best hope lies within the voluntary housing organisations.

There are no simple solutions but there is evidence that group-working can achieve positive results. Gathering a number of people together to focus on building a relationship with County Council housing staff and other agencies raises the profile and at least sheds light on the numbers of people in need of proper housing.

Making sure that you are on the housing list and on it each year is very important. Get help to make sure you have "ticked" all the necessary administrative boxes. Small mistakes or missing bits of information can delay or stop your progress.

With the backing of a wider group, some landlords can be reassured that a person in receipt of benefit payments is, in fact, a very sound and reliable tenancy option. With the support of a group, people who have not lived independently before can be assisted to learn the necessary skills to ensure a good relationship with landlords and neighbours.

"I was all alone in the world, the only friend I had was the voice who was with me all the time, although I never knew if I could trust the voice all the time, as she could be very nasty if I did not carry out what I was asked. For example, if I did not get up and check to see if there were cameras in the room the voice would repeatedly scream at me they are watching you, find the camera, find the recorder, do it, do it now. When I say repeatedly, I mean it could go on for hours and hours. At times it would be down to a whisper and this in itself was as difficult, because you would be waiting for it to increase in volume and intensity again. I'd be on edge all the time. The fear of this return to intensity and volume was one of the hardest things to cope with, because I could not rest. If I tried to relax, I would be waiting for it to start again."

"Here I am I thought, in hospital, terrified and very angry at my parents. They were supposed to protect me, make all my problems go away; I hated them. They disappointed me, who are these people? I wondered, are my parents really my parents, they could be clones who are put here to trick me into divulging the secret knowledge I have. As a result I was very guarded in talking to them, only barely speaking and not answering questions, giving as little information as possible. I look back now and laugh a little about my beliefs, but I can still remember the sheer terror and anger I felt. Sometimes now, when I am overtired or stressed, I still can experience a feeling of paranoia or a sneaking feeling of what if I was not wrong and there are aliens? But these thoughts don't take me over like they once did."

When a person is experiencing intrusive and aggressive thoughts in this way it is extremely difficult to talk or engage with other people, even close relations. Communication is impossible because the person is often unable to concentrate on anything other than what they are hearing. Equally, for people who are seriously depressed, and/or because of the side effects of medication, there can be a complete loss of energy and motivation.

Spiritual, Social, Personal

What has spirituality got to do with mental health?
Where does it fit in the greater scheme of things,
as human kind has developed through the centuries?

WE ARE OFTEN DEFINED BY OUR material and physical wealth. The first question in a social setting is frequently "What do you do?" This is a very limited way of thinking about ourselves. Looking at life in a spiritual way is about seeing a greater meaning or purpose in life above the daily routine.

For people experiencing a mental health difficulty, every contact or relationship with the world is often carried out through the filter of the mental health difficulty. People can become very blinkered in their way of thinking and seeing the world.

While insight is often seen as the holy grail of mental health, sometimes people mistake insight for a total engagement with their mental health issues. They become absorbed completely in an ongoing examination of the whys and wherefores. They become obsessed with achieving a "cure" or complete transformation. Leaving the real, true self as a lost person who needs to be overcome or at least wrestled into submission.

Life, for everyone, is not made up of absolutes. It is made up of thousands of choices, some of which are as simple as "what will I have for lunch" and then having something you want.

Spirituality is a word usually associated with religion or God or some power beyond our control. People all over the world are members of different religions and have different beliefs. Undoubtedly having and practicing religious

beliefs can be and is spiritual, but we can also be spiritual without having and practicing religion.

HOW DO WE DEFINE IT FOR OURSELVES, DOES IT MEAN ANYTHING IN OUR LIFE?

The way in which we define spirituality for ourselves, can have a big impact on how we decide to live our lives, how we justify our decisions and our relationships. A knowledge or recognition of what role spirituality plays in our lives is not about accepting or rejecting our present circumstances. It simply reminds us that any action or occurrence in our life can be neutral, neither good nor bad. It is only when we interpret them in a narrow material way that they can appear good or bad for us.

For example, if a person is cleaning their house because they feel compelled to, it can be an activity which is fraught with anger and resentment. If the person is cleaning the house because a visitor is arriving and they want the place to be nice for the visit, the activity can be fun. The activity remains the same but the emotional response changes. At a basic level, spirituality can be defined as anything that deals with matters of our spirit (or our soul), the unseen us, the very energy of life, the indescribable thing which makes us alive.

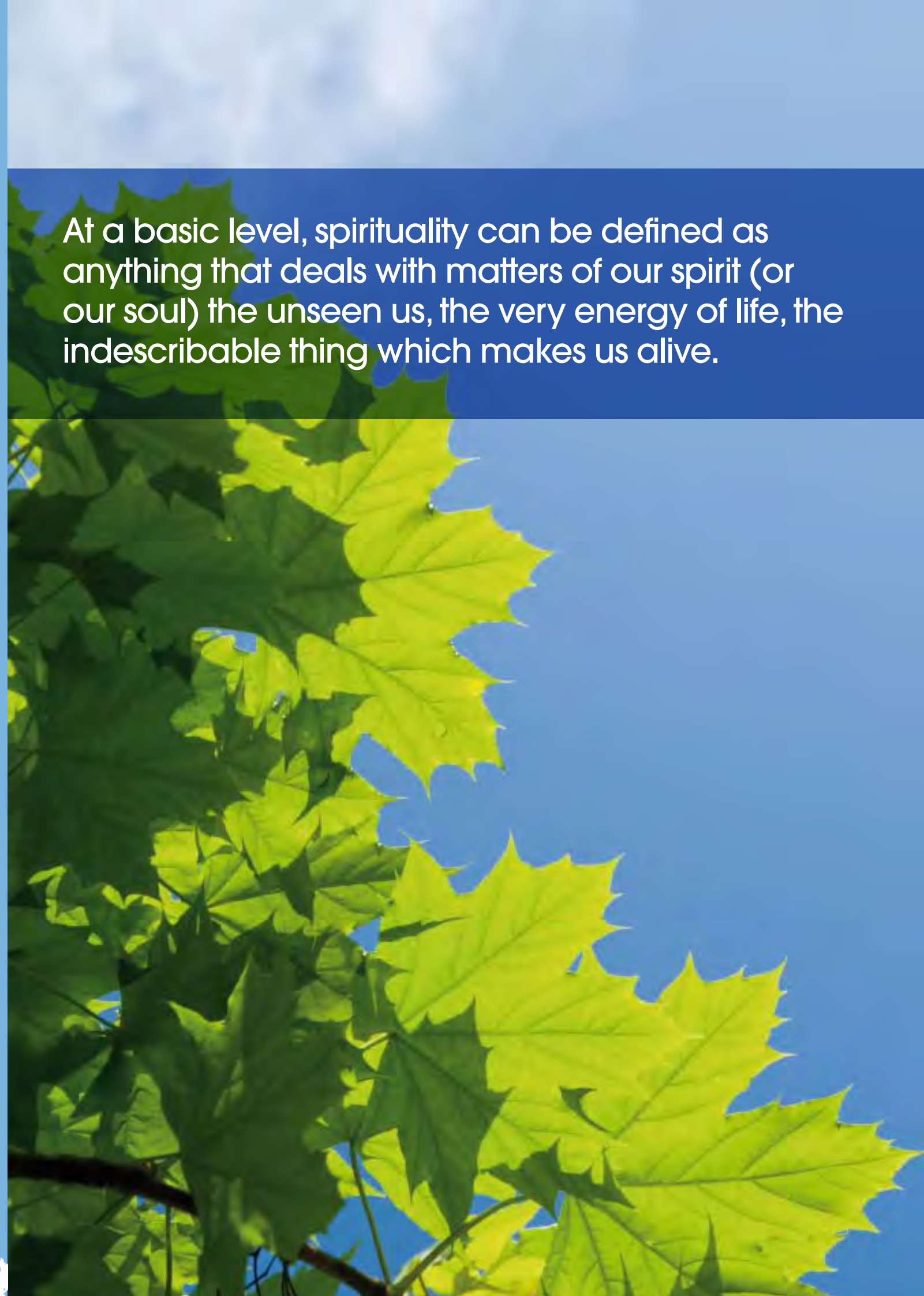
We all have an aspect to us, which is unseen but very real. The Kilkenny Basement Discussion Group described it as: "our central being, our core, our wise voice, inner child, self identity, or I. It is everything yet we cannot touch it, see it, or smell it, although sometimes we experience it. In our everyday lives it is the

feeling of goodness, joy, coping." Regardless of your definition of spirituality, each and every one of us has an aspect of ourselves that is invisible to the world but still very real. Spirituality, is about being able to connect our inner self to the physical material world around us; helping us to experience and interpret the world in our own terms, not as we are told to; living life according to our inner self, allows us to see the ups and downs of life for what they are and not allow the molehill to become a mountain.

We can experience this essence of life by walking in a field or park, feeling the wind, looking at a blade of grass, meditating, listening to music, driving. Anything can be spiritual as long as we take time out for ourselves and allow our inner wise selves time and space to see and feel these things. Having a good sense of your inner spiritual self will increase awareness that it is us who have ultimate control over our own lives. We do have choices. We may not exercise this control or we may find that we need support to do so, but it is ours to decide.

Spirituality is about actively seeking opportunities to experience a feeling of wholeness and allowing us a different appreciation of life. It involves nurturing and cultivating the inner essence of our existence, paying more attention to ourselves, existing for ourselves first and foremost in an open, unselfish and non-judgemental way. It is possible to have more control over our physical world and more control over our mental health if we can learn to like and love ourselves because we are worthy of it.

At a basic level, spirituality can be defined as anything that deals with matters of our spirit (or our soul) the unseen us, the very energy of life, the indescribable thing which makes us alive.



the most important ingredient to keep a relationship going is talking, communicating.

Relationships

One of the first things that begin to disintegrate when people experience mental ill health are relationships. When people feel ill or are having an off day (depending on how severe it is) they frequently withdraw into themselves.

THIS MEANS A LOT OF DIFFERENT things: a ring in sick to work, cancelling an evening out. If the feeling continues or deepens, people don't go out unless they have to, and if they see someone they know across the road, they might avoid them. As the feelings of being down, or miserable develop, the phone will not be answered or if it is, the response will be unfriendly and short, even with close family and friends. Sometimes people will spend the day watching television, grunting at the world, and finally, we go to bed, cover our head and won't talk until we are ready. We have all done the above at some stage in our lives and made excuses for ourselves. We were sick or we were not feeling great. We get a little sympathy, we recover and everyone is happy again. No harm done, that's life.

When a person withdraws for long periods of time and there appears to be no good reason for it, the sympathy, understanding and acceptance can wear thin.

"We didn't know what to do when we went in to visit him in the hospital. He was just staring into space. He went from being talkative and energetic, always rushing around the place to just sitting on the chair in the hospital looking at the TV and not watching it. He was smoking 60 cigarettes a day, eating massive amounts of junk food; crisps, chocolate, washed down with litres of coke. He looked as if he swelled up and put on three stone. Christ we thought, what have we done to him, the supposed cure seemed worse than the mental illness."

Relationships are based on a lot of things. We all make judgements about people consciously and unconsciously, good and bad for all sorts of reasons. It has been said that 95% of what we think about a person is decided within the first five minutes of meeting them. Communication happens in different ways, body language, the expression on our faces, eye contact, clothes and of course talking. Understanding how we are seen by other people can be very important in building and maintaining relationships. If a person is not happy with themselves, or is only interested in themselves, other people will instinctively see this. So, having a good self-image is half the battle in being able to relate to others.

Like everything else, we have to take a bit of responsibility and perhaps step outside our comfort zone. Feeling isolated and friendless is a very common experience for people with mental ill health and it is a very difficult place to live your life. What some people forget though is that not every person you meet is

going to be "best friend for life" material. A daily trip to the local shop to buy a paper, a few words with the person behind the counter, can be the start of a small but precious strand of inclusion.

Being involved with groups, support groups, for example can connect you in a general way to other people, a casual place where you can be yourself and share, talk, or be silent without feeling out of place.

Medication is a very thorny subject. Compliance is a word heard often in this context. Most people who are diagnosed with a significant mental illness are prescribed medication. All the medications have side effects. Some people are particularly sensitive to the side effects and have to cope with very real discomfort and disturbance to their bodies, while at the same time experiencing a lot, some, or no relief from the symptoms of their mental illness. Getting the balance right can be a long process for some people. Many speak of the medication as if it were worse than the mental health problem it is prescribed to treat. Does the benefit of taking the medication outweigh the consequences of not taking it? As we know, medication works fully for some people, works fairly well for some people and appears to work hardly at all for another group. Research suggests that people want and need a lot of explanation and information about the purpose, side effects and results of the medication they are prescribed.

Family relationships are much the same. We will get on better with some of our family than we do with others. That is normal. We do, however, need to make the extra effort to take part in things, in our own way. Be willing to step out of your comfort zone to help a family member or friend or just to meet up with them.

We need to appreciate and understand who we are before we can have good relationships with others. Casual friends will come and go, but long-term ones need work.

The three biggest barriers to forming or maintaining a relationship are isolation, isolation, isolation.

When we are in a situation of pain, suffering or hurt, there is a tendency to withdraw into our worst self. That is, the quiet, lonely, scared, angry or withdrawn self. All ties are cut with the outer world and we become small, seeking ways to feel safe.

Other people do not know what is going on and react accordingly. They become fed up with the behaviour and drift away or become angry. People can become totally isolated, and in a very short period of time lose the confidence to form or maintain relationships.

The most important ingredient to keep a relationship going is talking, communicating. Whether it is with a friend, a family member or just someone you meet occasionally. Tell people what is going on for you. Ask them about themselves. Keep in touch, text, telephone, write.

Display understanding, and show interest. Let people know that you want what is best for them. Celebrate their successes and listen during their hard times.

"Our job a lot of the time involves making sure the patient takes the prescribed medication and follows all aspects of the care plan, so they are stabilised and able to be sent home. There is always somebody else waiting to come in. We sometimes enlist the relatives to try to ensure the patient is compliant with their medication when they go home. We know how difficult it is to make sure someone takes the meds when they do not see the benefit of it."

"Don't be talking to me about the medication, it was a constant battle. We tried cajoling, threatening, bribing and sweet talking, cursing and one time I stood on my head; all to no avail, or maybe it might work for a while. Eventually we said please yourself take it if you want. She didn't, and we spent another 8 hours of our life in the A&E.

We got little support from the so-called professionals. We didn't know what the medications were for; we didn't know the side effects. Looking back now we wondered why we didn't ask someone, but in reality we know we gave all power over to the consultant. We believed medication alone would solve all difficulties. One of the things we have learned is that when a person within the family becomes unwell the whole family becomes unwell as a result, and we all needed to recover together."

"As a doctor, I am very well aware of the complex reactions a patient can experience as a result of taking medication. The medication prescribed for mental illness is strong. It is also working on the brain in a general way. It can and does affect many functions of the brain, not just the ones we may want it to. Psychiatrists are nearly always dealing with symptoms only. By that I mean we cannot be sure what the cause is. Most medical conditions can be accurately diagnosed by tests or biopsies, or other tools. We are listening to the patient, using our judgement and experience to assess and decide what we believe the main problem is, and how best to manage the presenting set of symptoms. Anti psychotic medication is the main treatment available at the moment. People react to it in very different ways. They are also trying to live with sometimes very challenging symptoms. Medication should be only one part of the treatment. A multi disciplinary team provides a wide range of professional skills and interventions, which are all part of the treatment package, so to speak. Colleagues work with patients in different ways, providing different perspectives. The expertise of the whole team is utilised to develop a plan."

"Medication is the bane of my life. Everywhere I go or anything I do is somehow clouded by the obligation I have to prescribed medication. For example, I open my eyes in the morning (well 11.30am, my morning) and the first thing I see on my bedside is medication. My first action is to try and swallow, but my mouth is too dry. Although better than when I was on different medication and I awoke with my face stuck to the pillow as a result of the "overproduction of saliva" I think they said, a side effect. Anyway, I make my way to the bathroom shuffling, barely registering what the outside temperature is; I take a fist of meds with a glass of water swallowing each one with difficulty as a result of my dry mouth. Every time I take the meds I am reminded of my mental state. I used to fantasise that if I did not take my meds I wouldn't have this problem, as I would just forget about it. I go down to breakfast, my mother, is there I answer before she asks, "yes I have taken my meds". I meet my father, he looks at me, and I know the look, I say, "yes I have"."

Feeling less sluggish I make my way to the clinic looking at all the happy well-washed faces going about their business. Well I like to think they are happy because if they are not, where does that leave me and what hope have I got. My community mental health nurse is there, although I have never met her in the community, only in the day hospital. She asks, as I knew she would, "yes" I answer.

"Ok wait there; he will see you in a minute". I always think; if Beckett was in a psychiatric hospital he would call his play "Waiting for Doctor". I am called in. A big head of hair motions me to sit down with a wave of the hand. Another doctor I do not know. He never looks up, reading my file he asks me the same questions all over again, why the hell can't he look at the file he looks so busy reading. He asks, "how are you"? Fine I say. He asks, "are you taking your medication"? "Yes" I answer for the umpteenth time, "ok then see you in six months"."

Advocacy

Sometimes people need support that is very objective. It could be to do with social welfare payments, or benefits of any kind. You may need support negotiating with an employer, doctor or service. You may want to complain about a service.

ADVOCACY IS ABOUT PROVIDING information and support so that the person can decide which route to take. It's about travelling with a person so that they can try and get to where they want to go. An advocate will help with the route or map, 'ride tandem', sitting on the back seat, leaving the person in control at the front. An advocate will also sit in the front seat when asked to.

Advocacy is intended to help a person along the road to recovery.

Being in control of your own bicycle is the aim, but making sure that if you need to ride tandem, it will be there when you need it.

WHAT IS ADVOCACY?

- First and foremost, enabling and supporting a person to speak up for themselves (self advocacy)
- A means of empowering people by supporting them to assert their views and claim their rights and entitlements
- A means of enabling people who may have difficulty speaking up for themselves to do so
- Representing and negotiating on a person's behalf
- Information and support in accessing community services e.g. housing, social

welfare, employment, education, community mental health services

- Support and representation when dealing with services and 'officials'

WHY IS ADVOCACY NEEDED?

People with experience of mental ill health are often disadvantaged and excluded from the communities in which they live, and they may want the support of a person who is not there to judge their situation or problem, but who will travel beside them so that they can regain control of their life and its direction.

Shine has a community advocacy service called Ár nGlór. There are advocates in Dublin, Cork, Galway and Kilkenny.

The Irish Advocacy Network is a peer advocacy service. They provide advocacy services, mainly but not exclusively, in in-patient settings. All of their advocates have personal experience of mental ill health.

Citizen Information Centres provide a wide range of information and support. There are 53 centres throughout the country.

Contact details for these services are at the back of this guide.

being in control of your own bicycle is the aim. But making sure that if you need to ride tandem, it will be there when you need it

Stigma and The Media

Mental Ill Health and the Media

PEOPLE EXPERIENCING MENTAL ILL health are often reluctant to discuss their illness with those outside their inner circle. A recent study into mental health attitudes in Ireland found that while 85% of people in Ireland feel that mental health problems can affect anyone, 62% would not want anyone to know if they had a mental health problem. This suggests that while most people accept that anyone can be affected by mental ill health, they would still be reluctant to let people know if they were experiencing mental ill health.

The stigma surrounding mental illness prevents people from coming forward and seeking the help and support they need. It also means we are prevented from understanding the voices of those experiencing mental ill health and recovery. As a result, much of what we learn about

people with mental illness comes to us through the filter of the media. Many of our attitudes will have been shaped by articles we have read or TV and movie portrayals of mental illness. Chances are that until someone accesses the mental health services or a support service, their main source of information about mental health and mental ill health has been the media. This is a cause of concern, as media portrayals of mental illness often do not reflect the reality of mental illness.

The most frequently cited source of information about mental health in Ireland is newspapers. This shows just how important a role the media play in informing our attitudes and awareness of mental health. Unfortunately, the media does not always reflect the true experiences of those with mental ill health, and media reports often reinforce negative perceptions and attitudes towards mental illness.

Media reports often sensationalise mental illness by linking mental illness with violence, despite the fact that mental illness alone does not make someone more dangerous. Recent research conducted by the University of North Carolina found that a person with severe mental illness without substance abuse

and a history of violence has the same chances of being violent during the next 3 years as any other person in the general population. Even where substance abuse is present the risk of violence is still lower than the risk associated with various other factors. Media pieces can also contribute to the misinformation surrounding various mental illnesses. For example schizophrenia is often confused with multiple personality disorder and spilt personality in media portrayals.

Media portrayals often fail to get the message that recovery from mental ill health is possible and that there are supports available. There is a need for the true experiences of people with mental ill health to be told.

Support groups can be a good way to build up your knowledge and develop ways to manage your mental ill health. People who attend support groups hear about them from a number of sources; by word of mouth, from members of their multi-disciplinary team, family members, talks within the hospital and newspaper advertisements. It is becoming increasingly common for people to research on the Internet and find support contact details there, or log into blog sites.

"We didn't know what to think when Brian started attending the support group. We went to speak to a regional development officer with Shine, and he told us what a peer support group was and how they work. More importantly, he gave us information about bipolar disorder that was easy to understand, filling us in on what the possibilities were. We were also given a bit of information about how to manage things, which other relatives found helpful. I think we were lucky to run across them so early on, because I met another woman who said she had only found out about things for families after years of struggling on their own. It was a never-ending source of amazement to her that her child could access a community mental health nurse, nobody told them. She is now a firm believer in "she who shouts loudest gets heard first".

One of the main difficulties encountered by people who are in a psychiatric hospital for any length of time above a few weeks, is the danger of being institutionalised. People in hospital are often denied the ability to choose, due to the routine of the ward. This can of course be comforting, but it is surprising how quickly an unchanging daily schedule can become disabling. How you spent your day and life outside the hospital becomes more and more a memory, and because your own skills are used less, people become unsure of their own ability to make the right choices.

"I was worried about going home. Don't get me wrong, I love my children, but I feel so guilty, ashamed and weak for having a mental illness, that I can't look my children in the eye."
"When I am at home my wife keeps looking at me as if waiting for me to burst into flames or something. It was not until I asked her to give me a bit of space and told her that I will let her know if I am feeling bad or unwell that she kind of understood. I know she's just worried. She agreed, and we started talking about how I was feeling. It was great to be able to talk in an honest open way; it actually took an awful lot of pressure off me. We decided to form a plan of action in case, well in case things got a bit dodgy, like I began to find it difficult to cope."

"I statements" are one of the most important things I have learned from Shine meetings. I use them all the time now. Rather than me screaming back accusing her of being a brat or saying things like you make me so angry, or you have upset me, I now say, "I feel sad when I cannot support you", or "I feel cross when the food I cook is just left there". This way of talking helps me to know what I am feeling and it personalises it. Whereas "you make me feel" statements are a confrontational way of talking and will invariably lead to a row. It sounds a bit silly maybe but it works, most of the time!"

If you see, read or hear something in the media, which you feel is stigmatising to people with experience of mental ill health, there are a variety of actions you can take and organisations, which you can make a complaint to.

HEADLINE - the national media monitoring programme for mental health and suicide works to promote accurate and responsible media coverage of mental health and suicide related issues. You can contact Headline about media pieces, which you feel deserve attention, and Headline will either support you in making a complaint or take action directly.

01 8279022

www.headline.ie info@headline.ie.

Other relevant organisations are listed at the back of this guide.

Knowing Your Rights

"Where, after all, do universal human rights begin? In small places, close to home, so close and so small that they cannot be seen on any map of the world. Yet they are the world of the individual person: the neighborhood he lives in; the school or college he attends; the factory, farm or office where he works. Such are the places where every man, woman and child seeks equal justice, equal opportunity, equal dignity without discrimination. Unless these rights have meaning there, they have little meaning anywhere. Without concerted citizen action to uphold them close to home, we shall look in vain for progress in the larger world."

(Eleanor Roosevelt)

This statement was written in 1948, shortly after the Universal Declaration on Human Rights, adopted by the General Assembly of the United Nations. The continuing authority of this declaration means that it is universally accepted and makes it a common reference point in the human right's field, for all peoples.

THE RIGHTS OF PEOPLE WITH MENTAL health difficulties are further enshrined in many international legal instruments as well as in domestic Irish law.

All people with mental health difficulties have rights. Some rights are absolute, such as the right to life, with the State having an absolute duty to protect the right to life of the person. Other rights such as the right to health are qualified and may be subject to available resources to the State.

Your Human Rights

- The right to life
- The right to liberty
- The right to bodily integrity
- The right to privacy
- The right to home and family
- The right to an education
- The right to be heard
- The right to health
- The right to work
- The right to non discrimination
- The right to express your opinions
- The right of access to justice
- The right to vote

It should be noted that the above list of rights is not exhaustive, and most rights can be and are subjected to limitations by the State.

KEY RIGHTS IN IRISH LAW FOR PEOPLE WITH MENTAL HEALTH DIFFICULTIES. WHERE DO THEY COME FROM?

The Irish Constitution

Written in 1937, it is the highest law in the land. The Constitution contains individual rights and sets up the organs of State that will protect and vindicate the rights of the person.

The key constitutional rights are as follows:

- The right to life
- The right to earn a livelihood
- The right to privacy
- The right to bodily integrity
- The right to free expression
- The right to health
- The right to home and family
- The right to liberty
- The right of access to justice

The Employment Equality Act 1998

This Act was enacted to prohibit discrimination in relation to employment for people with disabilities. Discrimination is defined as "the treatment of a person in a less favourable way than another person, in relation to any aspect of their employment". An employer is under a legal duty to take appropriate measures to enable a person with a mental health disability to have access to employment, participate or advance in employment or undertake training, unless the measures would impose a disproportionate burden on the employer. People with disabilities cannot be discriminated against in relation to the following aspects of employment.

- Advertising
- Equal pay
- Access to employment
- Terms and conditions of employment
- Promotion or regrading
- Classification of posts
- Dismissal
- Collective agreements

Making A Claim Under The Act

- The Equality Tribunal is the body established to investigate, hear and decide on claims for discrimination
- A complaint of discrimination or harassment must be made within a six-month time limit

from the last act of discrimination, in writing, to the Director of the Equality Tribunal

- There are a number of ways in which the complaint may be handled

The Mental Health Act 2001

This Act was enacted to protect the rights of persons who are involuntarily detained in psychiatric hospitals. The Act sets out the formal procedures that must be followed when a person with a mental disorder is involuntarily detained.

A mental disorder is defined as follows:

- You have a mental illness, severe dementia, or significant intellectual disability and there is a serious risk that you may cause immediate and serious harm to yourself or others.
- or
- You have a mental illness, severe dementia or significant intellectual disability and your judgement is so impaired that your condition

"It is brilliant when I start to feel better. My mood improves; I can feel a bit of hope and slowly try to come to terms with my life. However, when this first high of leaving hospital dies out, I am left with an overwhelming feeling of inadequacy. I feel my symptoms building up, but feel I cannot talk about them, because my partner is so happy and delighted that I feel so well, that I do not want to burst his bubble. Although I do try to give hints about how I feel, when he asks how I am? I reply I am grand. He just leaves it at that and doesn't pursue it anymore, when I know he knows that I know he knows I am not good.

could get worse if you were not admitted to hospital for treatment that could only be given to you in hospital and going into hospital would be likely to improve your mental health significantly.

Who Can Make The Application?

- Your spouse
- An Authorised Officer
- A member of the Gardai
- Any other person aged 18 or over

How Is The Recommendation Made?

- The doctor must meet and examine you within 24 hours of receiving the application
- He/she may visit you at home
- The doctor will examine your behaviour, mood and assess your thought processes
- If the doctor feels that you meet the conditions for involuntary admission, he/she will make a recommendation to admit you to hospital for mental health care and treatment
- The doctor will fill out a recommendation form
- You will then be admitted to an approved centre
- At arrival at the centre you will be under the care of a nurse or a doctor
- Within 24 hours a consultant psychiatrist will examine you to decide if you have a mental disorder
- If the doctor believes you have a mental disorder an admission order will be signed
- An admission order lasts for 21 days
- Your consultant will examine you 7 days before the admission order ends
- If the doctor thinks that you have a mental disorder, he/she will sign a renewal order
- A renewal order means that it is in your best interests to stay in hospital for another period of time

When this happens I get so angry and frustrated with him that I cut him off completely and then we get back into the spiral of communicating with each other in a polite way rather than a real live way. The voices kick in "there you are now you are no good, a selfish bitch, not able to say anything interesting, no wonder nobody loves you, why don't you just kill yourself". I resist and resist until eventually I get so distressed, I cut myself to release the pressure. Usually I wind up back in hospital, thinking, if only I could let my feelings be known to my partner this pattern might not occur as often, I will do it next time. Talk to my partner that is, not kill myself. It's tough though."

- A renewal order can be extended for a further 6 and 12 months

The Rights Of Patients

- The right to information
- The right to a review by a mental health tribunal
- The right of access to a lawyer
- The right to appeal to the Circuit Court
- The right to contact the Inspector of Mental Health Services

Amnesty International has produced a guide that details the specific issues relating to mental health and human rights. Its development was directed by a steering group of people with self-experience of mental ill health. Experts by experience in other words.

"We are not asking for anything more than for the human rights of people experiencing mental health problems to be respected. We want them to be treated with dignity and respect. To be truly given a choice in relation to treatment and support to challenge, in a positive manner, the predominant medical model of mental health problems. We want a system which supports everyone's right to housing, employment and education — all essential to recovery and wellbeing. We are not powerless, we have a voice." (*Mental Health and Your Human Rights. A Brief Guide*)

Amnesty International published "Let's Make It Happen" an action briefing document on mental health policy in 2006. This campaign

"What can you say? Things are going well, but it is like a ticking time bomb. When she says she is grand, I am so afraid; sometimes I just want to bury my head in the sand. Do you know the most difficult thing in all this, is knowing what to do? When she is sitting there looking into space I have not got a clue what is going on in her head, if she could only tell me we could face it together, deal with it, instead of the self-harm and hospitalisation. She has to know how much I love her, I would walk across red hot coals for her, I wish she would just tell me what is going on for her, the waiting is agony."

The first six weeks after a person with mental illness leaves hospital is the most difficult and dangerous time for them. One explanation for this is the fear of re-experiencing symptoms, which can be very clear to a person as they are now feeling a bit better. The anxiety of going back to the cycle of illness becomes unacceptable.

"We should have known. He was very well for at least five weeks. John came in from the fields after shooting crows, he left the loaded gun against the wall by the back door, poor Jimmy went out for a smoke, next thing we heard a loud bang, and we knew exactly what it was. We ran out but were too late, he was dead. John found it very hard, he got really depressed after it, especially after he had just finished a suicide awareness course and one of the don'ts was: do not leave a loaded gun, large amount of medications or poisons easily accessible."

followed their work in 2003 on Mental Illness: The Neglected Quarter. They document how and why government policy must be challenged in the area of mental illness.

"The right to mental health services General Comment 14 of the UN Committee on Economic, Social and Cultural Rights instructs that a mental health system must meet the following "interrelated and essential" standards:

1. Availability, i.e. health facilities and services have to be available in sufficient quantity.
2. Accessibility, health facilities, goods and services have to be accessible to everyone without discrimination based on:
 - policy of non-discrimination in law and in practice
 - physical accessibility (including for marginalized peoples including people with disabilities)
 - economic accessibility (affordability) whether privately or publicly provided
 - accessibility of information, including the right to seek, receive and impart information, consistent with confidentiality of personal data
3. Acceptability, i.e. all health facilities, goods and services must be respectful of medical ethics and culturally appropriate.
4. Quality, i.e. health facilities, goods and services must also be scientifically and medically appropriate and of good quality.

General Comment 14 further instructs that the state's obligations to realize the right to mental health are of three types:

To respect: not to interfere, directly or indirectly, with a person's enjoyment of the right to mental health. This is an immediate obligation.

To protect: to ensure others do not interfere, with a person's enjoyment of the right to mental health, primarily through effective regulation. States must prevent, investigate, punish and ensure redress for the harm caused by abuses of human rights by third parties – private individuals, commercial enterprises or other non-state actors. This is an immediate obligation

To fulfill: including to promote rights, facilitate access to rights, and provide for those unable to provide for themselves States have an obligation to fulfil the right to mental health by taking promotional, legislative, administrative, budgetary, judicial and other steps towards the full realization of that right (and related rights). As many aspects are resource-dependent, international standards recognize that this obligation may be realized progressively. Governments must give immediate priority to meeting the minimum essential levels of each right, especially for the most vulnerable.

International human rights standards take the form of declarations, resolutions or recommendations issued by international bodies like the UN. They are not binding, but are guidelines as to what states should do to comply with human rights conventions. Some apply specifically to mental health, such as the 1991 UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (called the MI Principles). There is no human rights convention specific to mental health, but mental health human rights standards, while not legally binding on States, can and should influence national mental health policy, practice and law, since they represent the consensus of nations."
(*Let's Make It Happen. Action Briefing. Amnesty International 2006*)

Supporting Life

Suicide Prevention and Mental Health

THE EXPERIENCE OF MENTAL DISTRESS, COUPLED WITH THE demands of 21st century life is a potent combination. Over the past twenty years, increasing efforts to reduce the number of suicides have mostly met with a stubborn refusal of the numbers to change in Ireland.

Suicide is about ending the pain. The many and complex theories that surround the act of suicide can sometimes distance us from the simple idea that no one takes their own life unless there is something very wrong with it.

It is often said that suicide is a permanent solution to a temporary situation. Many survivors of suicide speak of their desire to end the deep and desperate pain they felt, not necessarily to end their lives. At the time though, they could simply see no other way out.

"We know from clinical experience and from research that people with schizophrenia are more vulnerable to suicide than any other group in the general population. In fact, they are 40 times more vulnerable to taking their own lives than people who do not have this particular form of human experience. These are disturbing statistics and understandably cause concern among service users and their families. Why does schizophrenia make a person more vulnerable to suicide? And what do these statistics say to those of us in mental health services whose role it is to care for them?

Let us consider what we know about suicidal behaviour in general. We know that people reach a point of taking their lives when they feel trapped by their particular circumstances, with no possibility of being able to escape their predicament and no likelihood of rescue. Could it be that schizophrenia leaves a person more vulnerable to feeling this way? Research suggests that some 10% of those with self-experience of mental illness may well feel very

How do you live with a person who is home and argumentative?

trapped and overwhelmed by this disorder. Furthermore research has narrowed down the factors that suggest those who may be particularly at risk for suicidal behaviour. Being familiar with these factors should alert us to people who particularly deserve our attention. Knowing who may be vulnerable should encourage us to talk with them about the real difficulties they experience and prevent problems escalating to a point where they view self-harm as their only means of ending their pain.

For example, we know that among key risk factors are: being young, being male, having a course of illness characterised by repeated lapses, short hospitalisations and also having a high IQ or higher education. In addition, we know there are times when these individuals are more at risk than other times, notably during their hospital admissions or in the weeks directly following discharge. What can we "read" from these cold "risk factors" that might inform us as to the state of mind of the service user, a state of mind that may lead them to feel despair and consider suicide?

For some of these individuals their experience of mistrust of others become so intense that their paranoia and suspiciousness leads them to feel increasingly isolated and alone. It may be difficult to engage these individuals in counselling, and medication may be the critical intervention they require. For others, their repeated hospitalisations may suggest they are non-compliant with medication, perhaps because they refuse to accept that they need this kind of help. For this group it may be important to hear how they understand and make sense of their own experience and work with them to see how a variety of interventions, including medication, make sense. And finally, for those with high IQ and insight, it may be that they understand all too well what's happening and see a future unfolding before them where their lives will be limited in painful ways by the experience of schizophrenia. This group particularly deserves an opportunity to grieve the life they may have wanted for themselves, and their crushed dreams.

"He just stands there glaring at everybody, ready to fly off the handle. When my other brother Tony acts like that I give him a clatter, but no we can't treat Greg like that, I know violence is never the answer, but he is ruling the roost. The worst part is when his brothers and sisters complain about Greg getting special treatment. He is not getting special treatment, just different treatment. Another mother in my support group found that when she gave her son a bit of time and allowed time for him to digest what is being said, and allowed time for the answer to come, everybody in the family started to get a grip on the thing. Trying to understand what was really being said, and not only hearing what each person wanted to hear, you have to learn a new way. I do find if I give it a bit of time, Greg does come along with his answer. Sometimes."

This is not to imply that all is lost and it is critical to maintain an attitude of optimism in these discussions. Adopting a "recovery" approach means being realistic about what has been lost, but also conveying a strong message that the experience of schizophrenia is never the whole story for any person. There is still a life to be lived. There are resources available both within and around this persona and these can help them achieve valued and meaningful goals in their lives.

Finally, working from what research so clearly reports over and over again, the time of great risk is during and immediately after hospital admission. This highlights the need to engage people in hospital in some form of realistic care planning as soon as possible following their admission. Having a plan, particularly one that you personally have been part of constructing, gives a person a feeling of hope that something good can happen, even when things feel chaotic. This plan needs to take into account what the service users themselves want to achieve and to address the real and practical problems that are making it hard for them to find their place in the world.

Even when a person achieves stabilisation in hospital and may feel very optimistic about their lives at the point of discharge, it is crucial we pay attention to ensuring continuity of care for them when they return to the community. The risk of suicide is not merely to do with how hard the experience of distress is for someone; it is also affected by those "protective factors" in their life, which support them in facing the challenges ahead of them when they leave hospital. Where these protective factors are not readily available, we should be alert to the risk of relapse and consider ongoing support after discharge for as long as it may be required."

(Dr. Tony Bates Supporting Life. Suicide Prevention for Mental Health Service Users. The full text of this document can be viewed on www.shineonline.ie. Occasional Papers.)

Protective factors against suicide include:

- High self-esteem
- Social "connectedness" especially with family and friends
- Having social support
- Being in a stable relationship
- Religious or spiritual commitment
- Early identification and appropriate treatment
- Interventions based on the principle of connectedness
- Easy access to supports such as helplines, psychosocial interventions and suicide prevention centres

"We have not got a clue what happens in the home. It is only if they, the family speak about it. We are very limited in what we can do about a sticky situation at home. What we need is a home liaison worker available. Someone who can go out and work with the whole family, in their own home."

People with self-experience of mental ill health have an increased risk of suicide if they are:

- Young, single, unemployed males
- In the early stage of illness
- Depressed
- Prone to frequent relapse
- Highly educated
- Paranoid (suspicious)

People with mental ill health are more likely to be suicidal at the following times:

- In the early stages of their illness
- Early in their recovery, when outwardly their symptoms are better but internally they feel vulnerable
- Early in a relapse, when they feel they have overcome the problem, but the symptoms recur
- Soon after discharge from hospital

(World Health Organisation)

Remember you are not bound by any confidentiality agreement when there is a risk of suicide. If a person divulges to you that they are thinking about suicide always contact someone who is qualified to deal with it. Do not attempt to deal with it your self.

"When I came home from hospital I did what I liked, went to bed, got up to eat my meals whenever I decided. Even if it was two o'clock in the morning I would turn on the telly loud enough to wake the neighbours, let alone anybody in my own house. If I am honest I did not realise how disruptive I was being. I was just trying to blot out my thoughts, keep my mind occupied. Depression is like a big hole, which has unknown depths. I would think I was at the bottom of it, only to find there was further to go. If there was light at the top of the hole, it was so far I couldn't see it; a bit like viewing stars at night, you know there is light but it is not much use to you."

The more warning signs/risk factors, the higher the risk. Always stress to your relative or friend that their life is important to you and to others and that his or her death by suicide would be a tremendous and upsetting loss to you, not a relief. If death by suicide is attempted, contact the emergency services and phone someone to come and be with you.

Asking someone if they have thought about suicide will not put the idea in their head if it has not been there previously, in fact they may be so shocked by you being so upfront they will give an honest answer.

If you experience thoughts of suicide there are a number of things you can do.

- The most important action is to be open and confide in other people you trust or talk to a trusted health professional
- If the thoughts are associated with depression, delusions or other symptoms, then a change in medication may help to reduce or eliminate them
- Keep a list of people who you know you can telephone when you are feeling really down
- Also keep the numbers of 24 hour services that can help at these times
- Make an agreement with one or more people that you will call them if you actually plan to attempt suicide
- Remember that you do not have to act on that thought. With time many of the things that are making you feel that your life is too difficult to continue will pass
- Distance yourself from any means of dying by suicide
- Avoid alcohol and other drugs of abuse
- Avoid doing things you are likely to fail at or find difficult until you're feeling better
- Make a written schedule for yourself every day and stick to it no matter what
- In your daily schedule don't forget to schedule at least two 30-minute periods for activities, which in the past have given you some pleasure
- Take care of your physical health
- Make sure you spend at least 30-minutes a day outside
- You may not feel very social but make yourself talk to other people

Some of the warning signs a person wanting to die by suicide may display:

- After a period of depression and sadness, a sudden change of mood to one of smiling and laughing
- Making statements like, "I won't be here to see it"
- Giving away treasured possessions
- Having been recently discharged from hospital

- Being withdrawn or unable to relate to people around them
- Having definite ideas of how to kill themselves, and/or speaking of tidying up affairs or giving other indications of planning suicide
- Talking about feeling isolated and lonely
- Expressing feelings of failure, uselessness, hopelessness or loss of self-esteem
- Constantly dwelling on problems for which there seem to be no solutions
- Hearing voices, which may be instructing them to die by suicide
- Early morning waking and loss of appetite

WHAT DO YOU DO IF A PERSON IS IN CRISIS?

It is important to emphasise that people experiencing mental health problems are very rarely violent towards others. However, the degree of their emotional distress can look and sound more threatening than it may be.

- First and foremost, remain calm. If you remain calm others will also
- Make sure you are safe and have an exit route planned in the unlikely event that you need it
- Adopt a non-threatening approach. When a person is in distress they will need quiet, gentle reassuring words and body movements
- Do not approach the person from behind without warning
- Don't stare as this could be interpreted as threatening. But do make eye contact as often as you can
- If there are other people around calmly ask them to leave the room or area
- Some situations can be very frightening and distressing. If you do not feel confident approaching the person, don't. Go and get help
- If you stay in the room give the person breathing space, and do not touch them unless you are sure that they do not feel threatened by you. If you are unsure, ask
- Explain your actions before you act and continue to reassure the person without being patronising
- Tell the person you are listening to them and trying to understand what they are saying and feeling
- Ask the person what would help in the situation. Allow them as much control as possible
- If a person becomes severely distressed or unwell it may be necessary to call a GP and/or the Emergency Services (999). Do not hesitate if you believe the person's life is seriously at risk
- Calling the Emergency Services may be the first thing you have to do

(Adapted from Garda Mental Health Awareness Training. Shine 2008.)

When a person with mental ill health is at home, either living on their own or with others, it is very difficult to appreciate how hard it can be for them to look after the basic daily things that we take for granted.

"Then miraculously you wake up one morning and life seems ok. By no means good, but less difficult. This feeling of regaining energy, recovering control of my own destiny, moving forward, being part of the world or like a fog gently lifting, over a period of time, moving out of the tunnel, coming into the light, beginning to feel good, excited that there is such a thing as recovery, enjoying my family, food, washing, socialising. Now don't get me wrong, life is still tough, when I am well I still have the problems everybody else has. Having a routine helps so much. The whole 8 years of my illness and how I am now, brings to mind the Winston Churchill quote "when you are in hell keep going."

"I don't know what he is doing in the room all night. Whenever I do manage to get in, all I find are weeks and weeks of dirty cups, food plates; ashtrays that are so full you would not know they were ashtrays. The bed linen was like the Turin shroud, just an imprint of where James slept on the sheet. I mean why doesn't he bother? I didn't bring up a dirty child; I taught him better than that. He wears the same shoes day in and day out. They are falling apart. I wish he was normal. He is 43, what is he going to do after I die, his sister won't look after him?"



My Role, Recognising My Best Me

“When it is dark enough, you can see the stars.”
(Ralph Waldo Emerson)

THE EXPERIENCE OF BEING MENTALLY unwell is a complicated and very personal thing. It involves losing a sense of self, losing confidence, losing trust. Almost always it means that we have to engage with professionals who are there to diagnose and develop a plan of treatment. This often takes place in hospital.

In other words, as well as “walking out of our minds” we walk out of our lives too. It is very human to want to have the doctor tell us what is wrong, give us a prescription and feel the cure coming on.

The word cure is very interesting – “Restore to health”. Most of us have come to expect when we are sick that a treatment or medication or both, will restore us back to where we were. The science of medicine has indeed produced medicines that do just that for many human conditions. In spite of all the expensive (and necessary) research though, some human conditions continue to elude the will of the scientists. Thankfully, they don’t give up. Thankfully they keep looking.

What we sometimes forget is that we too have a big role to play in our own health, mental and physical. All too often we depend totally on the doctor or the services to deliver the return to health. Sometimes it feels as if our own ideas and feelings are not relevant or important. When you hear stories of recovery, the sense of being out of control of things is often there. When we can begin to take back some control there is a sense of more wellbeing. Messy it might be, but it is the start for many people to really explore what is happening and what they want to do about it. Everyone has to find their own way to take hold of a situation.

Everyone does it better if there are a few people around them who believe in them and are willing to listen and really hear what is going on. It is also important to have some trust in the system or in some people within it.

Taking responsibility for who we are and what we do is very hard. It is one of the things that make us human. Blaming others, raging about unfairness or resentfully taking everything on the chin are all stages we have to go through, sometimes daily. Living a life this way, however, will constantly dilute our ability to find and nurture a sense of personal worth. It will mean the best me is always fighting someone or something and leaves little energy to think about or even notice the small but life giving pleasures of everyday life.

The tools, methods and supports you employ to build a kindly and accepting sense of self are personal.

Recognising and meeting your best self halfway is an essential and endlessly worthwhile activity.

“It is the most boring place on earth. If I have to do paint by numbers once more I will lose the will to live. I know people tell me routine is one of the best ways to get on with life, but there has to be a point where routine becomes so boring that it will affect me in a negative way. I hear a lot of talk about the gym, art exhibitions, self-development courses, job shadowing, computer skills, and cooking lessons even. But not much happens on that front. I would love to do something intelligent, but I don’t know, I think I need a bit of a push or maybe to try a few things. I tried the computers but I was, am, very doped up so it was slow going, so I left it. Also, I could paper my room with the amount of meaningless certificates I have.”

“We have about twenty clients and two staff. If one of us assists somebody in bathing, the other person will be supervising the 19, as well as doing all the other tasks, such as medication, setting up activities and paperwork. Sometimes I feel that all I am doing is opening and closing the door, when I should and need to be offering therapeutic support. We do organise activities and some training, but we just don’t have the resources to give the individual the time they need to get motivated. Some clients are pretty active themselves but others really need a lot more involvement.”

When a person leaves hospital or is deemed to be fit enough to leave supervised care, where do they live?

“Last time I was in hospital I was terrified of leaving, where would I live? I lost my flat when I was unwell. Sometimes when I experience my manic phase I spend money and get myself into debt very quickly and I don’t pay my rent. Luckily this time I was assigned a social worker, and accommodation was arranged in a local hostel, and from there I moved into sheltered accommodation, stayed away from the drink and eventually I got a council flat. Only twenty years of being on the list, I did well. Life is good now though.”

“What people don’t understand is that I am ashamed to be naked, ashamed to see myself nude, it rules my life; it stops me from undressing to wash, to change my underclothes. I do not enjoy being dirty. All anybody seems to be interested in is that I am clean and tidy, that the house is tidy. I am tormented by being told “look at you, you are ugly, how can you look at yourself in the mirror, the dirty girl, the dirty, dirty girl”. It’s in my head all the time. When I begin to feel better within myself I may not be any cleaner, however, the choice to be or not to be is mine, whereas when I am not good I have no, or little choice.”

“I am thrilled he is going to a day centre. At least he gets fed and they can keep an eye on him. It gives him a routine, in which he can plan his week and I can plan mine.”

At a Glance

THE REDUCED GUIDE

This guide gives you basic information about mental ill health, the services and supports available and an introduction to your options.

Shine is the national organisation supporting people affected by mental ill health.

Shine supports people in a number of different ways by providing information, education, support groups, rehabilitation, advocacy and counselling.

The Mental Health Act 2001 is the law that relates to people with a mental disorder.

A Vision For Change is a document that details a comprehensive model of mental health service provision for Ireland.

At the centre of these is a clear focus on the “best interests” of the person (Mental Health Act 2001) and the principle of recovery to guide and deliver those best interests for each individual.

WHAT IS MENTAL ILL HEALTH?

“... a state of mind of a person which affects the person’s thinking, perceiving, emotion or judgement and which seriously impairs the mental function of the person to the extent that he or she requires care or medical treatment in his or her own interest or in the interest of other persons.” (Mental Health Act 2001)

All of us experience varying degrees of mental health. These are the normal ups and downs of life. Mental ill health is complicated and, like many physical conditions, the experience of it is unique to the individual.

One central principle of the concept of recovery is that the person’s own unique experience is the starting point for all actions. It is, therefore, very important, as you look for information and educate yourself, that you acknowledge your own feelings and experiences, identify your own needs, and try to match your exploration of the information to those.

“We spoke to every politician, housing officer, social welfare officer, priest, doctor, housing agency in the phone book. Eventually we found a place for Andrew, however he was plagued by every stray and waif in the town. He felt because he knew what it was like to be homeless; it was his duty to help others. He became what’s known as a soft touch, the house became a drinking den, and he was kicked out, became homeless again and now is back living with us at home, which in all honesty suits nobody only the services I think.”

“I really appreciate the support my family offered me. Being able to live with my parents is a God send, although I do get lonely, it is something everybody in the group talks about, the loneliness. How difficult it is to make new friends. So, the group as well as being supportive is a bit of a social as well. It connects me with other people in the world, which is important when I am remaining well and proceeding along the route of recovery. For me, recovery is all about my choices being mine.”

What does recovery look like? How different will the person be? Is there an end point to all of this?

DIAGNOSIS

In order to receive a diagnosis, we must experience a number of symptoms over a period of weeks. The important bit to remember is the diagnosis we receive is a general classification only, and a person will not experience all the symptoms. However, they will have to deal with the ones that are limiting how they live their life at this present moment in time.

WHY ME?

No one single thing causes mental ill health. Many things may play a role. Like other illnesses, a combination of hereditary and life experience can come together and make it very hard to get on with day-to-day living.

WHAT IS RECOVERY?

Recovery is not a panacea – rather it is a philosophy that respects the individual’s right to achieve wellness on his or her own terms, in his or her own time.

In practical terms, recovery can be described as two processes:
1 Spiritual recovery – involving acceptance of who we are
2 Practical recovery – the supports and actions we need to stay well

INFORMATION

Gathering the main things you need or want to know.

MEDICATION

Is prescribed by your doctor. Medication helps a lot of people. It works best when combined with other things, such as counselling, good lifestyle, healthy eating, hobbies and staying in touch with family, friends and groups.

TALKING THERAPIES

Counselling of different sorts. Ask for more info from your doctor, Shine helpline 1890 621 631 or your Shine Regional Development Officer.

LIFE STYLE

Accepting that we are all different and need to find out exactly what suits us best as unique individuals is important to our mental health. A “daily checklist” listing your own needs could be helpful, for example, talking to people you can trust, perhaps going for a walk, or just doing something active that you enjoy. Eating and drinking sensibly, doing things that will help you to feel good about yourself and who you are, will all contribute to a healthy lifestyle.

NUTRITION

Eat well. Cut down on sugar and fat. If you treat yourself and have chocolate, go for a walk to burn it up.

REHABILITATION

The role of the rehabilitation services is to provide education, training, resources and supports that foster the recovery process. Rehabilitation should serve to provide a meaningful range of occupations and lifestyles so that the person can have an acceptable quality of life.

WORK

People who experience mental ill health want the same things as everyone else. A place to live, money in their pocket and friends to socialise with.

Knowing what you want, setting realistic targets and working with someone who can guide you to the best training, education or voluntary experience are still vital first steps. Remember too, work is not the only way to fill a day.

Living life in a personally meaningful way, for at least as many days as we can, is a wholly reasonable thing to do.

HOUSING

Making sure that you are on the list and have “ticked” all the necessary administrative boxes is very important. Seek assistance, don’t try to do it alone.

SPIRITUAL, SOCIAL, PERSONAL

We are often defined by our material and physical wealth. The first question in a social setting is frequently “What do you do?” This is a very limited way of thinking about ourselves. Looking at life in a spiritual way is about seeing a greater meaning or purpose in life above the daily routine.

RELATIONSHIPS

Relationships are based on a lot of things. We all make judgements about people consciously and unconsciously, good and bad for all sorts of reasons. It has been said that 95% of what we think about a person is decided within the first five minutes of meeting them. Communication happens in different ways; body language, the expression on our faces, eye contact, clothes and of course talking. Understanding how we are seen by other people can be very important in building and maintaining relationships. If a person is not happy with themselves, or is only interested in themselves, other people will instinctively see this. So, having a good self-image is half the battle in being able to relate to others.

ADVOCACY

Advocacy is about providing information and support so that the person can decide which route to take. Helping with the route or map, an advocate can ‘ride tandem’, and will sit on the back seat, leaving the person in control at the front and will sit in the front seat when asked to.

“When I look back on my life, I am now conscious that if I did not have a mental health difficulty, I would not be the person I am today. Life could have been easier, but I feel I really understand myself. I now can see clearly who I am. Recovery for me is being able to have a better input into the decisions which affect me and my life.”

STIGMA AND THE MEDIA

Media pieces can also contribute to the misinformation surrounding various mental illnesses. For example, schizophrenia is often confused with multiple personality disorder and split personality in media portrayals.

Media portrayals often fail to get the message that recovery from mental ill health is possible and that there are supports available. There is a need for the true experiences of people with mental ill health to be told.

If you see, read or hear something in the media, which you feel is stigmatising to people with experience of mental ill health, there are a variety of actions you can take and organisations to which you can make a complaint.

KNOWING YOUR RIGHTS

All people with mental health difficulties have rights. Some rights are absolute such as the right to life, with the State having an absolute duty to protect the right to life of the person. Other rights such as the right to health are qualified, and may be subject to available resources to the State.

Your Human Rights

- The right to life
- The right to liberty
- The right to bodily integrity
- The right to privacy
- The right to home and family
- The right to an education
- The right to be heard
- The right to health
- The right to work
- The right to non discrimination
- The right to express your opinions
- The right of access to justice
- The right to vote

“We used to look at recovery as cure or when Mary would be able to go back to college, now we are happy that Mary is happy with being able to get up in the morning. We understand that other aspects of Mary’s life will fall into place as she makes her own choices. Of course she may well re-experience symptoms, but she will have learned which skills she needs to use, to deal with things as they occur. We have learned from other relatives that recovery is an important belief for the family to hold as well. Mary’s life may or may not change, but as family members our role is to support Mary to achieve what she wants to achieve, and not try to push her towards what we want.”

SUPPORTING LIFE

Suicide is about ending the pain. The many and complex theories that surround the act of suicide can sometimes distance us from the simple idea that no one takes their own life unless there is something very wrong with it.

It is often said that suicide is a permanent solution to a temporary situation. Many survivors of suicide speak of their desire to end the deep and desperate pain they felt not necessarily to end their lives. At the time though, they could simply see no other way out.

MY ROLE: RECOGNISING MY BEST ME

The tools, methods, supports you employ to build a kindly and accepting sense of self are personal.

Recognising and meeting your best self half way is an essential and endlessly worthwhile activity.

It would be very nice if we had a happy ending but in real life happy endings are relative to the individual’s expectations. That is not to say it has an unhappy ending, it is about how you see it.

Recovery will happen, sometimes in spite of ourselves. Knowing what it looks and feels like and deciding to work at it, is all part of the journey.

References

literature

- ***A Beautiful Mind* by Sylvia Nasar.** The true story of John Nash, the mathematical genius who was a legend by age thirty when he slipped into madness and who, thanks to the selflessness of a beautiful woman and the loyalty of the mathematics community, emerged after decades of ghostlike existence to win a Nobel Prize and world acclaim. The inspiration for a major motion picture, Sylvia Nasar's award-winning biography is a drama about the mystery of the human mind, triumph over incredible adversity, and the healing power of love.
- ***An Unquiet Mind* by Kay Redfield Jamison.** An Unquiet Mind is a powerful, uncompromising and illuminating story of severe manic-depressive illness from the informed perspective of a psychologist, psychotherapist and researcher who has lived with the illness for more than 30 years.
- ***Darkness Visible: A Memoir of Madness* by William Styron.** U.S. writer William Styron's memoir about his descent into depression, and the triumph of recovery.
- ***Divided Minds: Twin Sisters and Their Journey Through Schizophrenia* by Pamela Spiro Wagner and Carolyn Spiro.** This harrowing but arresting memoir - written in alternating voices by identical twins, now in their 50s - reveals how devastating schizophrenia is to both the victim and those who love her.
- ***Girl Interrupted:*** Girl Interrupted is a best-selling memoir by American author Susanna Kaysen. In the book, Kaysen relates her experiences as a patient in a psychiatric hospital in the 1960s after being diagnosed with borderline personality disorder. The memoir's title is a reference to the Vermeer painting *Girl Interrupted at her Music*.
- ***I Never Promised You a Rose Garden* by Joanne Greenberg.** It is a story about 16-year-old Deborah Blau and her quest for mental health. She had schizophrenia since her early childhood, but it was only when she slit her wrists that her parents decided to admit her to a mental hospital for treatment.
- ***Out of It: An Autobiography on the Experience of Schizophrenia* by anonymous.** Publisher: iUniverse. Available in paperback or electronic format. Published May 2005. This book provides a very good introduction to schizophrenia from a first-person's perspective.
- ***The Bell Jar* by Sylvia Plath.** The novel is semi-autobiographical with the names of places and people changed. The book is often regarded as a roman à clef, with the protagonist's descent into mental illness paralleling Plath's own experiences with what may have been either bipolar disorder or clinical depression. Plath died by suicide a month after its publication.

- ***The Centre Cannot Hold* by Elyn R. Saks.** Professor of Law, Psychology, and Psychiatry at the University of Southern California Saks tells the story of her ongoing battle with schizophrenia. Considering the psychotic breaks she endures, it is incredible she's managed to build a successful academic career. And yet she has, and this book is the story of her battle through madness, searching for some understanding of the illness she is both fighting and trying to accept as part of herself.
- ***This Much I know Is True* by Wally Lamb** The topics Lamb unflinchingly explores include mental illness, dysfunctional families, domestic abuse. They are rendered with unsparing candor but thanks to well-sustained dramatic tension, funky gallows humour and some shocking surprises, this sinuous story of one family's dark secrets and recurring patterns of behaviour largely succeeds in its ambitious reach.
- ***The Day the Voices Stopped: A Schizophrenic's Journey from Madness to Hope* by Ken Steele.** For thirty-two years Ken Steele lived with the devastating symptoms of schizophrenia, tortured by inner voices commanding him to kill himself, ravaged by the delusions of paranoia, barely surviving on the ragged edges of society. In this inspiring story, Steele tells the story of his hard-won recovery from schizophrenia and how activism and advocacy helped him regain his sanity and go on to give hope and support to so many others like him.
- ***The Quiet Room: A Journey Out of the Torment of Madness* by Lori Schiller.** Lori Schiller guides us through her life with schizophrenia.
- ***Touched with Fire* by Kay Redfield Jamison** examines the relationship between bipolar disorder and artistic creativity.
- ***Ward No. 6* by Anton Chekhov.** A moving portrayal of Ivan Dmitritch, who has a diagnosis of paranoid schizophrenia.
- ***Welcome Silence: My Triumph Over Schizophrenia* by Carol S. North.** This book is the very personal story of one woman's struggle against a debilitating mental illness, which fortunately she helped to overcome in time to allow her to complete her medical education and become a practicing physician. She says that the material was recalled partly from a diary kept during the time of original events, from memories of others, and from medical records.

Introductory Books for Information on Mental illness / Books for families

- ***Carer's Handbook* by Sane Australia.** A guide to caring day by day for someone disabled by schizophrenia or an allied disorder.

- ***Consumer's Guide to Psychiatric Drugs*, by John D. Preston, John H. O'Neal, Mary C. Talaga,** This guide outlines treatment options and tells patients what to expect.
- ***Diagnosis: Schizophrenia* by Rachel Miller (Editor), Susan Elizabeth Mason (Editor)** Diagnosis: Schizophrenia recounts the journeys of thirty-five young people who have been diagnosed with schizophrenia. The book is designed for those who wish to understand how it feels to have the disease, including the patients themselves, family members, students and anyone with an interest in how people sustain hope through a debilitating illness.
- ***Drugs used in the Treatment of Mental Health Disorders: Frequently Asked Questions. Edited by Stephen Bazire.*** Clear and accessible guide that explains the benefits, adverse effects and hazards of the complete range of psychiatric drugs.
- ***How to Cope with Mental Illness in Your Family: A Self-Care for Siblings, Offspring, and Parents* by Diane T. Marsh and Rex Dickens.** A book on how severe psychiatric disorders affect other members of the family and what to do about it.
- ***How to Live With a Mentally Ill Person: A Handbook of Day-To-Day Strategies* by Christine Adamec, D. J. Jaffe.** This book instead advises the caregiver on how to balance the needs of the family as a whole and suggests strategies for dealing effectively with common and serious symptoms (e.g., hallucinations, poor hygiene) and situations (e.g., refusals to take medication, disagreements between the caregiver and doctors or therapists).
- ***I am Not Sick, I Don't Need Help! - Helping the Seriously Mentally Ill Accept Treatment* by Xavier Amador, Anna-Lica Johanson (Contributor).** This is the first book that attempts to address the question: Why won't the sick person take his/her medicine? Amador provides families and mental illness professionals with a concrete, step-by-step plan to improve awareness of illness in the person who has schizophrenia.
- ***Living with Mental Illness: A Book for Relatives and Friends* by E Kuipers and P Bebbington.** A practical book that has established itself as an essential guide for relatives and friends of people with a mental health problem. Written by a psychiatrist and a clinical psychologist, it provides helpful advice on how to cope from day to day, what to do in a crisis, and how to handle financial and legal problems that may arise.
- ***Mental Health and Your Human Rights: A Brief Guide by Amnesty International Ireland.*** This guide is for people who have direct experience of mental health problems.

- ***Movies and Mental Illness, Using Films to Understand Psychopathology* by D Wedding, M. A Boyd and R.M. Niemiec.** There are 15 core clinical chapters of Movies and Mental Illness, each using a case history along with synopses and scenes from one or two specific, often well known films to explain and teach students about the most important disorders encountered in clinical practice. Helpful teaching tools such as suggestions for class discussions and key issues to consider while viewing films are provided throughout.
- ***Overcoming Depression, 3rd edition* by Demitri Papolos.** The author describes an ideal treatment approach, contrasting it with the actual treatment most patients receive.
- ***Psychosis – what is it? By the Schizophrenia Fellowship of Victoria.*** An introduction to psychiatric illness in everyday language for carers, family and friends.
- ***Schizophrenia and Mood Disorders: The New Drug Therapies in Clinical Practice* by Peter F. Buckley and John L. Waddington.** Information on antipsychotics and mood stabilisers, along with summaries of the older medications.
- ***Suicide: Ireland's Story* by Emily Cox.** Reveals the human face of suicide, while also examining the major issues that surround it. An insightful and informative read.
- ***Suicide: The Irish Experience* by Sean Spellissy.** Trying to understand the pressures on victims and their circumstances may help those who need to put the suicide of a friend or loved one in perspective.
- ***Surviving Mental Illness: Stress, Coping, and Adaptation* by Agnes B. Hatfield, Harriet P. Lefley, John S. Strauss.** A comprehensive, realistic and compassionate approach to surviving mental illness.
- ***Surviving Schizophrenia: A Manual for Families, Patients, and Providers (5th Edition)* by E. Fuller Torrey.** Surviving Schizophrenia, in understandable terms with practical suggestions for families, written by a psychiatrist whose sister has schizophrenia.
- ***Tell Me I'm Here* by Anne Deveson.** This book is a powerfully written account of a son's schizophrenia as seen through his mother's eyes.
- ***The Complete Family Guide to Schizophrenia: Helping Your Loved One Get the Most Out of Life* by Kim T. Mueser and Susan Gingerich.**
- ***The Dinosaur Man: Tales of Madness and Enchantment from the Back Ward* by Susan Baur.** Written by a clinical psychologist describing the years she spent working with hospitalised, "chronic" psychiatric patients.

- *The Essential Guide to Psychiatric Drugs by Jack M. Gorman (New York, 1997).* A general guide to psychiatric drugs.
- *The Lucia Anthology: A New Song to Sing. Published by SI.* A collection of poems and prose by people with schizophrenia and carers.
- *Understanding and Helping the Schizophrenic by Silvano Arieti.* Provides a simple and clear description of the inner world and experiences of people who have a diagnosis of schizophrenia. The difficult emotional conflicts, which often precede the onset of psychosis are emphasised and how they can contribute to the development of symptoms, both "positive" and "negative".
- *When Someone You Love Has a Mental Illness: A Handbook for Family, Friends, and Caregivers, by Rebecca Woolis, Agnes Hatfield, Publisher: J. P. Tarcher.* An essential resource featuring 50 proven Quick Reference guides for the millions of parents, siblings and friends of people with mental illness, as well as professionals in the field.
- *50 Signs of Mental Illness: A Guide to Understanding Mental Health by James Whitney Hicks.* An easy-to-read reference book which de-mystifies mental illness. Each chapter begins with a short, first-person description of a "sign" or symptom of mental illness, in alphabetical order. Examples range from deceitfulness to delusions, panic to paranoia, self-mutilation to psychosis, memory loss to mania.
- *Accepting Voices By Prof. Marius Romme and Sandra Escher.* A new analysis of the experience of hearing voices outside the illness model. This original research is a powerful challenge to popular stereotypes and the psychiatric orthodoxy, which inhibits rather than stimulates personal growth.
- *Hearing Voices by John Watkins.* A self-help guide and reference book with practical advice for those living with the experience of hearing voices. A wide range of practical coping strategies are described which people might find helpful.
- *Living Well with Schizophrenia by Sandra Miller, Walter Culture, Mark Cruikshank and Maxie Ashton.* This book is a collection of very useful, practical tips for people with schizophrenia and their carers. Written by people with Schizophrenia.
- *Living with Schizophrenia by John Watkins.* A holistic approach to understanding, preventing and recovering from negative symptoms.
- *The SANE Guide to Schizophrenia.* This guide defines exactly what a schizophrenic illness is, and different treatments available.

- *The SANE Guide to Bi - Polar Disorder.* This guide defines bi-polar disorder and describes treatments available.
- *The SANE Guide to Staying Alive.* This Guide offers advice to family, friends, health workers and service users. It covers the warning signs of suicide and supports available, life after a suicide attempt, and how to cope with the suicide of a loved one.
- *Recovered Not Cured - A Journey Through Schizophrenia by Richard McLean.* A very personal exploration of schizophrenia, from the early signs and reactions from friends and family to seeking help and the challenges of recovery. McLean shares his paranoid delusions and offers both a verbal and a visual experience by including digital artwork he created to help objectify and control his impulses and fears.

movies

- *A Beautiful Mind (2001):* This film was inspired by the true story of mathematician John Forbes Nash, Jr., who was one of three Nobelists celebrated in 1994 for their work in game theory. The film is driven by the agonising conflict between Nash's mathematical brilliance and the paranoid schizophrenia, which almost destroys both his career and his marriage.
- *An Angel at My Table (1990):* Jean Campion's film based on the biography of New Zealand novelist Janet Frame, who was misdiagnosed with schizophrenia and mistreated with electroconvulsive therapy.
- *Angel Baby (1995):* This film won seven Australian Film Institute awards in 1995. It is a sensitive, realistic portrayal of love between two people with schizophrenia. It deals frankly with many important issues affecting those with experience of serious mental illness: sexual relations, independent living arrangements, relationships with family members, noncompliance with medication, pregnancy, stigma and suicide.
- *Awakenings (1990):* Film based on Oliver Sacks' memoir of the same name. It tells the true story of a doctor (Sacks, who is fictionalised as Malcolm Sayer, played by Robin Williams) who, in 1969, discovers beneficial effects of the then-new drug L-Dopa. He administered it to catatonic patients who survived the 1917-1928 epidemic of encephalitis lethargica. Leonard Lowe (played by Robert De Niro) and the rest of the patients were awakened after decades of catatonic state and have to deal with a new life in a new time.
- *Benny & Joon (1993):* A generally sympathetic portrayal of schizophrenia. It does however trivialise schizophrenia by suggesting that love alone is enough to conquer the illness.

- *Birdy (1984):* Nicolas Cage tries to help his friend, Matthew Modine, who is a catatonic inpatient in a military hospital. Both men are Vietnam veterans, but Modine's problems seem to predate the war.
- *Clean, Shaven (1995):* Film about a man with schizophrenia who is desperately trying to get his daughter back from her adoptive family. He attempts to function in a world that, for him, is filled with strange voices, electrical noise, disconcerting images, and jarringly sudden emotional shifts
- *Dialogues with Madwomen (1993):* This documentary presents a pastiche of illness narratives. The stories of seven women who have struggles with mental illness, including depression, bipolar disorder, and multiple personality disorder.
- *Donnie Darko (2001):* A Delusional college student frequently hallucinates a "demon bunny" who instructs him that the end of the world is near. It is a fairly complex film with important comments on fear, the pain of mental illness and the nature of reality.
- *Final (2001):* Bill wakes from a coma in a psychiatric hospital. He has frequent paranoid delusions, hallucinations and anger outbursts as his therapist helps him to remember flashbacks of his car accidents and the death of his father. The portrayal of the "doctor-patient" relationship presents many questions about boundaries, ethics and relational dynamics.
- *Frances (1982):* This film is biographical, based on the life of the actress Frances Farmer (1914-1970), who was briefly successful in Hollywood in the early 1940's and was then institutionalised for mental illness. She was "cured" by a transorbital prefrontal lobotomy.
- *Frailty (2001):* Bill Paxton plays a serial killing, religious zealot with a delusional disorder who believes he is on a mission from God to fight off demons.
- *Girl Interrupted (1993):* Girl Interrupted is a best-selling memoir by American author Susanna Kaysen. In the book, Kaysen relates her experiences as a patient in a psychiatric hospital in the 1960s after being diagnosed with borderline personality disorder. The memoir's title is a reference to the Vermeer painting Girl Interrupted at her Music. In 1999, the memoir was adapted into a film of the same name starring Winona Ryder and Angelina Jolie. It was directed by James Mangold.
- *House of Fools (2002):* Based on a true story. The staff in a mental institution flee due to conflicts in Chechnya, leaving the patients to fend for themselves. Soldiers occupy the institution. Full of psychopathology examples, including a woman who believes she is the fiancé of singer, Bryan Adams (who appears in the film).
- *Images (1972):* An examination of the confused life of a woman with schizophrenia by Robert Altman. It is a difficult

but interesting film, which offers a heuristic presentation of hallucinations.

- *I Never Promised You a Rose Garden (1977):* Accurate rendition of the popular book by the same name. The patient has command hallucinations that tell her to kill herself. The film offers a sympathetic portrayal of psychiatry and treatment.
- *Julien Donkey-Boy (1999):* A portrait of the effects of schizophrenia on family life is the central focus.
- *Keane (2004):* A man in his early 30s (Keane) struggles with the supposed loss of his daughter from a port authority bus terminal in New York, while fighting serious battles with schizophrenia. We can never be sure if the loss is real or imaginary; or whether his overt interest in helping young girls is innocent and of a fatherly nature, or is of a darker, scarier motive. The film is about a search for family, belonging, and the overwhelming need for human connection. It is a disturbing and thought-provoking story about real characters dealing with everyday life. Keane's quest for his daughter and Kira's (Kira is a young girl he befriends) longing for a nuclear family is what connects them and the audience to a heartbreaking story.
- *Out of the Shadow (2004):* The documentary film opens with the filmmaker, Susan Smiley, in search of her mother, Millie, who suffers from paranoid schizophrenia and who, once again, has disappeared into the woefully inadequate public health care system of Middle America. Through old photographs and home movies, interviews with family members and health care professionals, and voice-over and direct narration by Smiley herself, the film chronicles the descent of a young, beautiful woman in her twenties into severe and chronic mental illness.
- *Possessed (1947):* Drama. Joan Crawford stars in a suspense film depicting catatonic schizophrenia.
- *Shine (1996):* True story of David Helfgott, an Australian prodigy whose brilliant career is interrupted by the development of an unspecified mental illness that is probably schizophrenia. The film suggests that his father was directly responsible for his mental illness and conveys the misleading but endearing message that hope and love can conquer mental illness. This film won seven academy awards.
- *Sophie's Choice (1982):* Based on a novel by William Styron. Meryl Streep won an Academy Award for her portrayal of a concentration camp survivor infatuated with Nathan, who is described as having paranoid schizophrenia but who may suffer from bipolar disorder.
- *Spider (2002):* Directed by David Cronenberg. Ralph Fiennes plays a patient, Dennis Clegg, with schizophrenia who is released from hospital to a home group. The film is a dark, bleak, psychologically complex film and a brilliant portrayal of the isolation and inner world of schizophrenia.

- **Sweetie (1989):** Director Jane Campion paints a memorable and realistic picture of a woman with schizophrenia and the difficulties her illness presents for herself and for her family.
- **Tarnation (2003):** Describes the life of a family with mental illness. The film illustrates schizophrenia and depersonalisation disorder as well as the effects of brain damage and traumatic abuse.
- **The Devil and Daniel Johnston (2005):** Tells the story of Daniel Johnston, a mentally ill artist whose drawings have been exhibited and sold worldwide; whose music has been recorded by Beck, Wilco, Nirvana, Sonic Youth, and Pearl Jam. Diagnosed with manic depression complicated by delusions of grandeur, Daniel has spent the last three decades of his life in and out of mental hospitals. His wild fluctuations, downward spirals, and periodic respites are chronicled in the film through compelling interviews, home movies, recorded tapes and performance footage.
- **The Fisher King (1991):** Robin Williams plays a homeless, mentally ill man who is befriended by a disillusioned former disc jockey. Although it is a humorous film, it is misleading as it suggests a traumatic etiology of schizophrenia.
- **The Ruling Class (1972):** British black comedy in which a member of the House of Lords inadvertently dies by suicide and leaves his fortune to his son who is delusional and has schizophrenia.
- **The Saint of Fort Washington (1993):** A man with schizophrenia is evicted from his home and ends up in a shelter. The film is a good portrayal of the life of people who are both mentally ill and homeless.
- **Through a Glass Darkly (1961):** Tells the story of Karin who has returned from the hospital on a remission from her illness after having being treated with ECT. Gradually her schizophrenia returns including symptoms of acuteness of hearing and auditory hallucinations. A very moving depiction of her symptoms. This film won an Academy Award for Best Foreign Language Film in 1961.

websites

- **www.actiononsuicide.ie** The mission of the Action on Suicide Alliance is to reduce the incidence of suicide and self-harm in Ireland by advocating for Government provision of suicide prevention measures and mental health services.
- **www.amnesty.ie** In Ireland and across the World, Amnesty International exposes the truth, speaks out and creates change.
- **www.aware.ie** Helping to defeat depression
- **www.barnardos.ie** Helps vulnerable children across Ireland
- **www.bcc.ie** The Broadcasting Complaints Commission (BCC). The BCC is an independent statutory body. It investigates complaints about advertisements that are

- broadcast in Ireland. Details about the complaint procedure and an online complaint form can be found on the BCC website or by phone.
- **www.bodywhys.ie** The Eating Disorders Association of Ireland. Support, information and understanding for people with eating disorders, their families and friends.
 - **www.chovil.com** Useful for people with schizophrenia as the author enhances the information provided with insight and personal perspective.
 - **www.citizensinformaton.ie** Provides public service information.
 - **www.connectcounselling.ie** Connect is a free phone counselling service for any adult who has experienced abuse, trauma or neglect in childhood. The service is also available to partners or relatives of people with these experiences.
 - **www.console.ie** Supporting and helping people bereaved through suicide.
 - **www.dohc.ie** The Department of Health and Children's statutory role is to support the Minister in the formulation and evaluation of policies for the health services. It also has a role in the strategic planning of health services.
 - **www.fas.ie** Ireland's National Training and Employment Authority.
 - **www.femalehealthissues.co.uk** Information and advice on women's health issues.
 - **www.grow.ie** Helps people who have had, or currently have mental health problems.
 - **www.headline.ie** Headline is Ireland's national media monitoring programme, working to promote responsible and accurate coverage of mental health and suicide related issues within the Irish media.
 - **www.headstrong.ie** Headstrong is a new initiative working with communities in Ireland to ensure that young people aged twelve to twenty five are better supported to achieve mental health and wellbeing.
 - **www.hrb.ie** Health Research Board. Supports and funds health research.
 - **www.ias.ie** Irish Association of Suicidology. Highlights various aspects of suicide and endeavours to influence public policy and insure that positive action is taken to provide adequate strategies to combat this tragic problem in our society.
 - **www.irishadvocacynetwork.com** Support and information to people with mental health difficulties by befriending them and offering a confidential listening ear or peer advocacy.
 - **www.iris-initiative.org.uk** Early intervention in Psychosis.
 - **www.irishpsychiatry.ie** The professional body for psychiatrists in Ireland.
 - **www.imhc.ie** The Irish Mental Health Coalition campaigns for improved and prioritised mental health services in Ireland.
 - **www.livinglinks.ie** Provides assertive outreach support to the suicide bereaved.
 - **www.livingworks.net** Provides ASIST training (suicide intervention) and other programmes.
 - **www.menshealthforum.org.uk** Provides news, information, events and discussion on all aspects of men's health policy.

- **www.mentalhealth.com** Allows users to search their diagnosis or medication to get specific and detailed information.
- **www.mentalhealthireland.ie** Aims to promote positive mental health and to actively support persons with a mental illness, their families and carers by identifying their needs and advocating for their rights.
- **www.mhcirl.ie** Mental Health Services. Promotes high standards in the delivery of mental services and ensures the interests of those involuntarily admitted to approved centres are protected.
- **www.mindwise.org** Mind Wise New Vision was registered as a company limited by guarantee in Northern Ireland on 10th March 2009. The new company was established in order to facilitate a demerger of the Northern Ireland region of Rethink from the national charity (also known as the National Schizophrenia Fellowship) on 1st April 2009.
- **www.mymoodmonitor.com** Mental Health Checklist
- **www.nda.ie** The National Disability Authority provides independent expert advice to Government on policy and practice.
- **www.nmhdn.org.uk** The National Mental Health Development Unit (UK) provides national support for implementing mental health policy by advising on national and international best practice to improve mental health and mental health services.
- **www.nosp.ie** The National Office for Suicide Prevention.
- **www.nsrif.ie** The National Suicide Research Foundation has been recognised as the centre of excellence and the Irish focal point for information regarding suicide and its prevention by the World Health Organisation.
- **www.pieta.ie** Pieta House – Centre for the Prevention of Self-Harm or Suicide.
- **www.power2u.org/articles/fisher/consumers-step-up.html** How consumers step up to design a truly recovery-based mental health system.
- **www.presscouncil.ie** The Office of the Press Council and the Office of the Press Ombudsman provide an independent press complaints mechanism that is quick, fair and free. Information about making a complaint can be obtained from the Press Council's website or by phone.
- **www.recover.ie** Shine Information Resource. Recover.ie is a user-friendly database of comprehensive information for persons with self-experience of schizophrenia and related illnesses, their caring relatives, the general public and healthcare professionals. Recover.ie provides information about Schizophrenia and related illnesses and offers a platform to centralise the relaying of information in Ireland.
- **www.rehab.ie** National Training and Development Institute.
- **www.rethink.org** Rethink works to help everyone affected by severe mental illness recover a better quality of life.
- **www.rethink.org/siblings** New on-line UK national network for siblings to share experiences and get support set up by Rethink mental health charity.
- **www.samaritans.org** Provides confidential, non-judgemental emotional support, 24 hours a day for people who are experiencing feelings of distress or despair.

- **www.sane.org.uk** Helping people affected by mental illness.
- **www.schizophrenia.ca** The Schizophrenia society of Canada.
- **www.schizophrenia.com** Provides in-depth information, support and education related to schizophrenia.
- **www.seemescotland.org.uk** 'See me' is Scotland's national campaign to end the stigma and discrimination of mental ill health.
- **www.sibs.org.uk** Sibs is the UK charity for people who grow up with a disabled brother or sister.
- **www.studentmentalhealth.org.uk** Student Mental Health Planning, Guidance and Training Manual.
- **www.spunout.ie/healthy-mind** Supportive information on a range of mental health issues, as well as signposting to relevant support services.
- **www.teenline.ie** Helpline for young adults.
- **www.yourmentalhealth.ie** Aims to improve awareness and understanding of mental health and well-being in Ireland.
- **www.who.int** The World Health Organisation is the directing and coordinating authority for health within the United Nations system.
- **www.3Ts.ie** Turning the Tide of Suicide. Helping to prevent suicide through research, intervention and support.

email

- **voicesireland@gmail.com** An organisation that promotes and fosters acceptance of voice hearing as a valid human experience.

Shine Regional Offices

Eastern Area	Regional Development Officer m: 086 852 5221
Basin Club Resource Centre	39 Blessington Street, Dublin 7. tel: 01 860 1610
Counselling Service	38 Blessington Street, Dublin 7. tel: 01 860 1620
Southern Area	Regional Development Officer m: 086 852 5755
The Basement Resource Centre	Cork. m. 086 8525147
Counselling Service	Cork. m: 086 040 1657
Mid-Western Area	Regional Development Officer m: 087 7878222
Western Area	Regional Development Officer m: 086 8525157
Midland Area	Regional Development Officer m: 086 8525281
South-Eastern Area	Regional Development Officer m: 086 8525562
North-Eastern Area	Regional Development Officer m: 086 8525422

For further information on our services and how to contact us go to www.shineonline.ie or ring our information helpline 1890 621 631.



Donations

There are many activities that we believe would support the recovery of people with self-experience and their families.

Our ambition is limited only by our budgets.

You can help extend the services of Shine by donating either on a once off basis or by taking out a standing order.

For further information please go to www.shineonline.ie or contact Elaine on 01 8601620

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Taking Control of your Mental Health

Shine,
38 Blessington Street,
Dublin 7

Information Helpline 1890 621 631
www.shineonline.ie