

NEWSLETTER

APRIL 2002

THE FRONT PAGE CONTRIBUTION

WHY DO MILLIONS OF US WATCH "FRASIER"? (Dr Frasier Crane, Channel 4 and The Paramount Channel)

Because he is a psychiatrist who not only counsels patients in his office but also gives others all kinds of personal advice over the radio with thousands listening in. Sometimes his advice seems reasonable. Other times it is ludicrous. But he always gives of himself! And what a 'self'! More than all the patients who consult him with their problems, his own personality is most in need of therapy as is demonstrated in his need always to be right, his failed relationships with ex-wives and girlfriends, his life long childish rivalry and envy of his younger brother Niles. Even so, we are not **laughing at him**, in some subtle way we are **laughing with him**! All his pomposity is always reduced to humility. Martin his patient father teases him with a benevolence which demonstrates deep parental love. Even Eddie the dog sits and stares disconcertingly at Frasier as if trying to fathom out this huge little boy. I personally always wait for the final benediction with which Frasier closes each show from his radio counselling desk, wishing us all **"GOOD MENTAL HEALTH."**

This was also the theme for our Annual National Study Day on 3 November 2001. I felt rather proud at being able to persuade Chris Gilleard to be our main Speaker/Enabler because he is the Director of Psychology for South West London & St George's Mental Health Trust which sounds very impressive (and is!) but Chris himself, an open, friendly, involved person was pleased to give us the Saturday morning. With him came Ros Lobo who is the leading person and Chair of Merton, Sutton and Wandsworth Mental Health Promotion Alliance. Both have impressive titles, both work together and both value their work – and ours – very highly. What work? The great work of **PROMOTING GOOD MENTAL HEALTH.**

At the study day, the roving microphone became the means of bringing most of us together. Everyone and anyone seemed to want to use it, at first to ask questions for our guests to answer and then to make their own contributions - more a lively workshop than a lecture. I particularly valued the way Chris included "a user" (an ugly word but you know what I mean) whose problems seemed to be taking over the session. I tried to suggest he could get help after the meeting but Chris quietly answered his every interruption and in a masterly way used each of his problems as an opportunity to give us even more insight. Perhaps the fullest evidence of the effect APCMH must have had on "the Director" was to see him still in conversation with members at 2pm, after he had told me he would have to leave by 12.30!!

Ros Lobo is supremo for Mental Health Promotion for three boroughs and keeps letting me know of opportunities for APCMH and contributes to our volunteers training course each year. It was she who suggested that the title for the morning's session could be **IN SEARCH OF A TEFLON SOUL** thinking positively about mental health. **TEFLON** coating, originally developed for the international space programme, is now widely used on kitchen utensils. It is easily cleaned and makes pots and pans gleam like new, it might do the same for a **TEFLON 'SOUL'**! On the programme itself the word **TEFLON** had in a (Freudian) way been printed as **TELEFON**. At first I felt disappointed but then I realised that the conflict between the two words was teaching a valuable lesson.

Planning for our day on Mental Health Promotion we were also thinking of those of us engaged in **CARING FOR OTHERS**. **TEFLON** is so close to **TELEPHONE**. Everywhere we go today people are using Mobile Telephones to keep in contact – on the bus, in shops, on the pavement...talk, talk, talk, we can't help but listen because the people using them shout into them. Add to that the permanent news bulletins on our TV screens with all its pain and the 'nonsense' programmes (like Frasier). The **TELEPHONE SOUL** has already arrived ... or taken us over. Our souls are flooded with information, with other's demands on our time and attention...and too much noise. Too often the carer too becomes depressed, exhausted, over anxious. If we can protect our own soul with **TEFLON MATERIAL** we may be able to let some of the anxiety, depression, even tiredness wash off us. Putting this in "theological terms" our prayer life, our spiritual life, our relationship with our Lord can be as effective as **TEFLON** on a saucepan.

My acute memory from among the contributions from the floor is someone's anxious plea that he was being so loaded by other members who keep giving him more and more to do when really he couldn't do or give anymore. You may find it hard to believe from someone who was a vicar for more than thirty years, my advice was that he had to say and mean, **"NO"**! for good, positive reasons..... **HIS OWN GOOD MENTAL HEALTH.**

ALAN WHITTLE
CHAIR, MERTON APCMH

The MANAGEMENT of FINANCE for MENTAL HEALTH PATIENTS

The first in an occasional series of legal assistance articles written by a solicitor

Mental Health Incapacity

In the management of personal finances, mental incapacity can have far reaching implications for an individual as well as for their family and other dependants.

In order to minimise the disruption it is important to have in place a system whereby an individual's assets are safeguarded once incapacity occurs. Such protection can be achieved through the use of an Enduring Power of Attorney (EPA as they are commonly referred to) or through the intervention of the Court in the appointment of a Receiver.

Enduring Power of Attorney

An Enduring Power of Attorney is a legal document that allows an individual (the 'donor') to appoint one or more 'donees' to act in the management of his or her financial affairs in the event that mental capacity is lost.

All the parties must sign this document whilst the donor has the capacity, but once capacity is lost, even if temporarily, it must be registered at the Court of Protection to enable the donees to take control of the donor's financial affairs. Until registered the donees can only deal with the financial affairs of the donor with his or her consent. Further, until registered the EPA is revocable by the donor at any time prior to the loss of capacity.

It is important to note that the EPA must be executed whilst the donor has capacity and it is therefore important that if you have reason to believe that you may shortly lose capacity and want to appoint an individual or individuals to manage your financial affairs or are looking after someone whom you believe will lose capacity in the future and will need to have their affairs administered, that an EPA is executed without delay.

There are situations in which a donor's capacity may be challenged and in order to ensure that the EPA is not declared invalid due to incapacity on the part of the donor it is advisable in borderline cases to have a doctor confirm that the donor's capacity is sufficient and provide a brief written statement as to the mental ability of the donor at the time of execution. A doctor may also be requested to witness the signature of the donor that is further proof of capacity at the time of execution.

This is particularly important as if it is subsequently found that a donor did not have capacity at the time the EPA was executed the donees may find themselves liable for transactions which they have entered into on behalf of the donor.

The Court of Protection

The Court of Protection is the alternative route to the management of the finances of an individual who has lost capacity without having executed an EPA.

The Court will appoint a 'Receiver' who is accountable to the Court and who must produce annual accounts and seek the Courts prior approval of any changes in the capital structure of the 'patient's' affairs. Annual accounts must be prepared and copies of bank statements produced for the Court to audit.

An application to the Court may arise despite the existence of an EPA if, for example, persistent family conflicts make an EPA unworkable, where the patient's assets are substantial and more complex than family members are accustomed to handling or where an individual does not have any immediate family and is in residential care or has been brought to the attention of the Court of Protection through Social Services.

Comparison of Attorneys and Receivers

A major disadvantage is that the Receiver is chosen by the Court and therefore may not be connected to the family or the patient at all, and so any sort of personal touch is lost. A Receivership also tends to be more expensive, particularly in the case of a professional receiver as there will be professional costs and also Court costs incurred in approving the annual accounts and dealing with any unusual requests. The major advantage is that the Receiver is closely monitored by the Court and must have professional insurance against any loss they cause to the patient's property.

The main benefit of having an attorney is the power you have to choose who acts on your behalf and the minimal level of administration or Court intervention involved. However, it is estimated that financial abuse occurs in approximately 10.15% of cases in which an EPA is used, so if you are a donor thinking of using an EPA to safeguard your assets it is important to choose your donee wisely.

Finally, where a donor is already a patient under the Mental Health Act 1983 and therefore their affairs are under the care of the Court of Protection or some other nominated authority, there is power for the Court to authorise the execution of an EPA by a patient. If the Court approves an application the Receiver would then transfer the management of the finances to the attorney chosen by the patient.

Christine Brown

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Let the presence of another warm you
that the waters of healing may flow.
The ice has formed for your protection.
But there comes a time when it is not needed.
And though it will always feel risky
to be open and vulnerable again,
to say what you feel and what you need,
only so can the ice melt,
only so can you learn to receive.

Jim Cotter

If children live with criticism, they learn to condemn.
If they live with hostility, they learn to fight.
If they live with ridicule, they learn to be shy.
If they live with shame, they learn to feel guilty.
If they live with tolerance, they learn to be patient.
If they live with encouragement, they learn to have confidence.
If they live with praise, they learn to appreciate.
If they live with fairness, they learn what justice is.
If they live with security, they learn to trust.
If they live with approval, they learn to like themselves.
If they live with acceptance and friendship,

They learn to find Love and God in the world

Lorna Brockett

My Own Experience *by Michael Devalda a member of HVN*

I think that if our doctor told us reassuringly that our minds are able to do things like create voices, though we are not fully able to understand it, then people would go home feeling better than if they were diagnosed schizophrenic.

WHERE DO VOICES COME FROM?

Hearing voices when nobody is around or at least when nobody seems to be saying the words you hear is quite a common thing to happen. Sometimes the things you hear seem to come from neighbours or people you pass in the street. Other times they can just seem to come out of the air. They seem to be very real; they can be very loud. They may shout at you or just whisper. They can say all sorts of things. Sometimes the things said are not particularly upsetting, but for many people they are worrying, threatening or abusive.

They may seem to be talking about you, even telling you what you are doing or thinking. This can be very puzzling as it is difficult to understand how they can know such personal things. They can be particularly distressing when they are rude or abusive towards you. Sometimes they can swear or tell you to do awful things. They can sound very convincing as if they have the power to make you do things, even when you don't want to do them. It can be very difficult to work out where they are coming from. So it may be worth checking whether other people can hear the voices. If they can, they may be able to help you do something about them. Sometimes they can work out what or who is saying these things to you. If they can't hear them, you need to work out why that might be the case. It may be that they aren't with you when the voices happen; trying to tape-record them might be worth trying. Maybe the voices seem to be directed at you alone, only you can hear them. It's worth trying to work out why that might be and talk about it with someone, like a nurse, psychologist or doctor, who might be able to help. The voice can sometimes seem like it comes from God, or Satan, or some supernatural source or even aliens of some sort. Would God say such unpleasant things? Satan (if you believe he exists) might, but are you maybe jumping to conclusions that because the things said are so evil that it must be from an evil source – like the devil? Such evil voices can occur as the result of being depressed or the effects of drugs, like speed or cocaine. Maybe you or your family have got involved with Spiritualists churches – these unpleasant thoughts can sometimes follow. If you do have religious belief, you may find help through discussion with your spiritual adviser, but in our experience churches of any denomination are not always able to understand or be tolerant of non-ordinary experiences.

HVN is a network of people who hear voices and their relatives, carers and workers who work towards gaining a better understanding of the experience of hearing voices and seeing visions and reducing ignorance and anxiety about these issues. The network aims to de-stigmatise voice hearing experiences, believing that this will lead to greater tolerance and understanding of this phenomena.

Philip Dixon, a member of APCMH, would like to know of any APCMH members' who have had any experience with people who hear voices and have discussed those experiences with a professional doctor, counsellor and particularly clergy of all denominations. He would be grateful for readers views and these will be published in the newsletter.

Wise Words

Until one is committed, there is hesitancy, the chance to draw back, always ineffectiveness, concerning all acts of initiative (and creation). There is one elementary truth the ignorance of which kills countless ideas and splendid plans: that the moment when one definitely commits oneself, then providence moves too. All sorts of things occur to help one that would never have otherwise occurred. A whole stream of events issues from the decision, raising in one's favour all manner of unforeseen incidents and meetings and material assistance which no man could have dreamt would have come his way. Whatever you can do or dream, you can begin it now

Goethe. *Submitted by Peter Sommers*

Did schizophrenia start the Jazz Age ?

Doctors claim that the birth of Jazz may have been triggered by a master musician's struggle with mental illness.

One hundred years ago Charles Buddy Bolden is credited with creating the improvisational style that led to a century of distinctive American jazz. At the time, he was denigrated by other musicians for being unable to read music – although the paying public applauded his innovation and his ability to sustain long passages of improvised playing.

He led a band in New Orleans at the beginning of the 20th century before disappearing in 1906 from public view – a victim of worsening schizophrenia which kept him in an institution until his death 25 years later. Dr Sean Spence, a jazz fan and senior lecturer in psychiatry at Sheffield University, says "there is now evidence that the improvisation was triggered by Bolden's illness". He was given the diagnosis of dementia praecox before the term schizophrenia was agreed upon by the medical community in 1911. The word jazz was not applied to music until 1917, but Bolden is regarded as the musician who introduced improvisation, and he was the first to be dubbed King of Jazz, to be followed by King Oliver and Count Basie.

He couldn't read music or deal with some of the complexities of some pieces, so he resorted to improvisation to help himself through Dr Spence told the Annual Meeting of the The Royal College of Psychiatrists in London. It was not a falling off of technique, but as we now know he had schizophrenia and this affects the frontal lobe of the brain. It seems likely the area affected is the area that led directly to the novel musical style he developed. Lack of modern treatments meant he could not continue to lead his successful life, but, said Dr Spence, ironically the mental illness has led to a style of playing that has stood the test of time and is much loved.

Even today music therapy revolves around the art of improvisation. It exercises the frontal lobe area of the brain which helps therapeutically to allow more effective functioning of the brain.

***From the Dover and Deal September newsletter. "JAZZ"
Taken from the November issue of The Kensington and Chelsea NSF. magazine***

A MEDITATION

"And what is truth?" asked Pilate.
well, I would say
that except when stating "Yea" or "Nay"
that man communicates in shades of grey;
but truth, Truth is the Sun, the Word, the Way,
The Holy One.

O Brother Pilate, facing truth that day
you washed your hands and turned away
Like us – preferring shades of grey.

ON THE LEVEL: THE SOMERSET SPIRITUALITY PROJECT

Vicky Nicholls of The Mental Health Foundation writes:

"To invalidate a person's spirituality, no matter how distorted that is, is to invalidate that real core sense of self."

Many people in mental or emotional distress thirst for the chance to be able to discuss and explore their spiritual and religious beliefs and experiences when in mental health services, or when in touch with a local religious or spiritual community. Recently a group of people who use or have used the mental health services in Somerset designed and carried out research to find out more about the religious and spiritual needs and resources of mental health service users/survivors in the county, mostly through interviews. Twenty-seven interviews in total were carried out, with twenty-five of these forming the basis of the report that is shortly to be published. Interviewees described their experiences in ways that could be thought of as a journey: a journey through life and a spiritual journey. They highlighted what and who had helped and hindered them on their journeys, including at times of crisis, periods of confusion and anguish: what sort of attitudes and approaches had served as beacons along the way; and what had been decidedly unhelpful, made them feel rejected, misunderstood or left out.

People described times of severe mental health distress or breakdown as, for example:

"You experience both heaven and hell – in a sense the very worst depths of despair, but also moments of joy".

Many said that spirituality is taboo in mental health services and that if they speak about such things it is either ignored or seen as a sign of illness:

Many interviewees spoke of the support they had received from fellow service users. Some had also encountered very helpful professionals:

"The community psychiatric nurse was terrific. Although he was not religious, he asked me very pertinent questions about how I could reconcile my faith with what was happening to me and what God meant to me."

The chaplaincy service came in for particular praise:

"It was like talking to an old friend (chaplain), who would give me an arm around the shoulder and say you're doing well, glad that you've come to see me."

Some people recognised how difficult it could be for mental health services to cope with the spiritual aspect of care:

"I think they need to believe in their particular profession and perhaps it is scary to admit that there are vast areas beyond what we feel comfortable with."

What helped most in faith communities was being available and non judgemental, and for people of faith, finding acceptance from other religious and spiritual people could be especially helpful when the person's own faith was shaken.

A practical leaflet aimed at service users will be published as well as the report of the research. This includes more information on people's experiences and reminds people of their rights under the National Service Framework to have their spirituality, values and beliefs respected and taken very seriously by those responsible for their treatment and care:

"I think it was a combination of my GP, the medicine and my spiritual life. In some incredible way they all came together and I think it was the spiritual element that was the glue that held it together."

The full report and leaflet will be available from The Mental Health Foundation from April 2002. For further details or to register your interest in a copy of either publication, please contact MHF on 202 7802 0300 or email vnicholls@mhf.org.uk. (From the South & West NSF)

CARING FOR THE CARERS

When the NSF chief executive Cliff Prior speaks about carers' assessments, he often quotes the story of the 85-year-old mother who drives to visit her son once a week, to stock his fridge and do some domestic chores. She, like me, and many other ageing parents with middle-aged offspring, wish that the sort of domestic support we provide, could be provided through statutory or voluntary services. Many of these service users are in receipt of DLA and other allowances and could pay for a service. However, this is not my main concern.

At a recent meeting of people responsible for implementing standard 6 of the National Service Framework in the Midlands it was said that, by pushing for users' services to relieve us, we were not pushing for the needs of carers but of users. But the type and quality of services received by the service user affects how much a carer does and what we feel compelled to do. I would like to have a paper to accompany the NSF's Carers Assessment Pack identifying the many and varied needs of carers.

I believe that this would help carers to fight for what they really want for themselves and to insist on getting it, should the response be "but you are asking for a service for the service user, not a service for yourself".

My needs in the beginning were quite different to now, 20 years on. It started with staff that helped me to deal with understanding what was happening, crisis help, a telephone help line, meeting other carers and much more. All the time, quality of services underpinned how much, as a family, we were involved.

Twenty years on, we have learned how to cope and to get many of the services we need, and friendships have been formed. Sometimes, a plateau of recovery in the user means that our role is one of very basic support with domestic chores and befriending and I am not alone. But it is sad that this is not seen as part of a carers' assessment of needs. When service users don't cook or do any rudimentary cleaning, many professionals say that this is their choice. But the reason that service users can't cope with domestic living is as much to do with lacking motivation and being physically tired, the effects of severe illness and medication.

I believe the fellowship needs to discuss it's own philosophy and produce a policy paper on how much we (carers) "help" and how these services could be delivered imaginatively by others to enhance the lives of service users, not to stigmatise them further. This is a contentious issue. No one wishes service users to lose independence or to have their lives dictated. But few people turn down warmth, comfort, a hot meal and the right company. And a cheerful, well maintained environment can lift depression.

There is a need for open discussion to assist the carers' assessment and to enable the NSF to campaign for support services. The homes managed by the Fellowship and other bodies also require a consistent policy of support to people living by themselves or in group homes. This is an issue which, so far, carers have often tackled alone with little support. The philosophy that the right of the individual is paramount has failed to get people care when needed, leaving many to be discharged to live in substandard conditions without comfort, cleanliness and hot food when the crisis is over.

I believe that the discussion needs to be high on NSF's list of policies and campaigns. For 20 years I have heard of families' distress about the degrading conditions in which their people live, adding to the agony of "What happens after I am gone?" In view of the National Service Framework, it is time for the Fellowship to help carers by adopting a firm stance on the need for domestic help and support for those who live alone. Many carers are too shy to ask because of their fear of being told that they are over-involved and interfering with the independence of the individual. Carers need to feel that our Fellowship is behind them in asking for these very practical things which enhance the quality of life for service users and consequently that of the carer.

Pauline Arksey
from The Kensington & Chelsea NSF Newsletter

***You are warmly invited to this year's
APCMH STUDY DAY AND A.G.M.***

“Growing into Wholeness”

***Exploring personal experiences with
a Carer : a Survivor : a Professional***

Following the Speakers there will be a
GROUP DISCUSSION SESSION

which will be followed by a

**GROUP OF SURVIVORS SHARING WITH US
POEMS THEY HAVE WRITTEN**

Saturday 13th July 2002

10.00 am to 4.00 pm

at St Paul's Church, Rossmore Road, London NW1

(5 minutes from St Marylebone Station)

Admission : £10.00 . Unwaged: £5.00 including a buffet lunch



Please use this Booking Form

To: Mrs Pam Freeman, 16 Beechwood Court, West Street Lane, Carshalton, Surrey CR5 4PZ

Please send me :

..... tickets for the StudyDay & A.G.M. I enclose £ to help cover the cost

Name : **Address**

..... **Post Code :**

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The views expressed in the Newsletter are not necessarily those of the Association

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