



A PLACE TO BELONG

**BUILDING
WELCOMING
COMMUNITIES**

Lessons from The Anglicare Mental Health Project

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We are thankful to the Mental Health Branch of the then Department of Human Services and Health for the funding we received Federally through the Innovative Grants Program.

Our sincere thanks to all who have participated.

Penny Barringham and Neil Barringham

*Hiding myself
behind the self I present
to take away my shame
the shame of being unacceptable
and socially irrelevant
Letting down the guard
at the right moment is the trick
Coming out of my shell
so easily broken
exposing the timid child inside
My tears, my laughter, my pain
wait for a time
when I can sit in friendship and trust
with the gentler souls of this planet
when the fear of being judged
can be put to one side
and I can share the hope
that springs from my heart.*

– Catherine Mason

INTRODUCTION

A deeply felt yearning at the centre of everyone's heart is to belong, to feel that you have a place, where you know others and are known.

“One of the things I dream about when I think about leaving hospital and living in the community is finding a friend. A proper kind of friend, someone who does not use me ... Someone who would stick with me for a long time ... When I think of where I'd like to live in the community I think of a place just the same as everyone else. Somewhere in the suburbs, a place that I choose. Somewhere near buses and shops and a doctor ... I'd like to be able to mix in with society without being seen as unusual ... I would like to be able to muck around ...”

This was articulated by long-stay patients at a psychiatric institution in Brisbane. It is prophetic because it tells us something about belonging – that belonging is about mutual friendship, not being marked as ‘abnormal’, having one's own choice, having access to resources and just being able, when you feel like it, to ‘muck around’.

What does it mean to belong? How does one find ‘a place to belong’? This was our initial question and again and again questions such as these gripped us each step of the way. We began to see that this work is more about ‘community illness’ than about ‘mental illness’.

We have been touched and provoked again and again by the clear and unequivocal call from people who have lived with alienation, estrangement and isolation. People who have yearned to share something of their experience and quest for belonging with others.

“Where do I go to debrief?” asked one woman. Her husband would not talk with her about the anguish that led to her suicide attempt. As for her psychiatrist, *“You only see him every three or four weeks for half an hour. Apart from needing my medication it does so little ... Who mothers the mothers?”* She went on, *“Middle-aged housewives disappear back into the community after psych hospital.”* This woman yearns for a place of understanding and empathy – a place that her psychiatrist, her church colleagues and even her own husband have not ventured into. Belonging for her is about connecting her experience of brokenness with her everyday life – hence her plea, *“Where do I go to debrief?”*

Another man reported that his primary need is not for more sophisticated therapy – but for a friend with whom he can go bushwalking! Belonging for him, as for many others, seems to be about being able to do quite ordinary everyday things with others.

A social worker shared with us that “the best of treatment in our hospital will do no good if there is not strong community support.”

Thus we have reflected again on the old Hebrew sage, “There is nothing new under the sun.” We know that we do not bring marvelous new insights or significant new concepts and theories with which to enlighten others. We sense that we are saying nothing new. We sense too however that it is still the time to say things that have been heard before – to reiterate important truths that need repeating. Again we affirm the sage that “there is a time for everything, and a season for every activity.” Thus we sense that this is a season to share again, with the world, important truths that have been shared before, but which seem to have been forgotten by many of us.

We come saying, that in this season of increasingly complex, hectic and technologically advancing society, it is time to be reminded of some of the simple and basic things of life – that community is important, that community can be healing, that the little people need to be included and welcomed and cherished, and that we are all broken and need each other. We come saying that our groups and churches and organisations are missing out on the wonderful gifts that can be brought by people who cannot run from their brokenness, people who have been painfully wounded, people who bear scars and have learnt much from their experiences. We sense that belonging is about these kinds of things.

How can these issues be engaged? How can churches and other organisations become places of healing and creative and affirming responses? We agree with Pearpoint that:

“Our future depends on our capacity to learn to live together without war – creating societies that build capacity with compassion for one and for all. Inclusion is about rebuilding our hearts and giving us the tools for the human race to survive as a global family.” (Pearpoint et al, 1993).

Outline of the report

This report has been divided into seven sections dealing with different aspects of our work over the past two years. Reading each section will provide a more complete picture of our work and learning. However, if you are interested in particular aspects of our work you may want to turn to that relevant section. You will find that each section is an entity in itself.

The first three sections provide the background to the work we have done. Section one gives some background to the project, briefly outlines the project, introduces the project team and deals with definitions. Section two looks at the research methods used and suggests some strengths and weaknesses of our approach. In section three the broader context in which the project is situated is outlined. The historical, political, community and parish contexts are explored.

The next two sections are more action focused and look at the basis of our action and what we have done. Our learning from the literature as it related to our involvements is summarised in section four. This has progressively formed the foundation for our action. Belonging, empowerment, friendship and community are discussed. Section five outlines what we have done as we have worked in parishes, built a movement and liaised with institutions.

The largest part of the report is found in section six. This section deals with four aspects of our learning. We look at what we have learnt about: Building welcoming spaces in our institutions; Building welcoming communities in parishes; Building welcoming communities in our theologies; and Building welcoming communities in our hearts and homes. Our recommendations to the Church and to the Government are outlined in Section seven.

Remove the Shadows

*Last Saturday when traveling by train
I saw places that I hadn't seen for months*

*When I lived reluctantly for all that time
And what that segment of my life contained
Is briefly just about to be explained.*

*Last Saturday in those suburbs that I saw
There were people who'd been continuing
to weave,
With warp and woof, the fabric of their lives –
And this quite independently of me
Whose proper needs in life had been denied.*

*Not surprising was my growing trend of thought
Whose tenets in my mind emerged unsought
From turmoil of emotion over-wrought.*

*Once more I'd been removed from normal life –
Type-cast to play a hated alien role
In which my anger and resentment flared –*

*Most apprehensive in my quandary
Lest you relegate me in your mind
To a category of abnormality.*

*Nundah was a station on my way
To work last year. If now I come upon
You there, or anywhere, just going out
To shop, will you react as others do
Instinctively, it seems, if I reveal
That I have spent, reluctantly, two years
In aggregate in psychiatric wards –
Enduring an existence shadowy
In a dreary land I wanted to escape.*

*Whatever else I say or fail to say,
Am I a person whom you must regard
As normal – resident again outside
That dreary land to which I have referred;
Or does recognition of normality
Depend upon me taking ceaseless care
To hide those facts and grim events with which,
Exhibiting good will, we both must cope –*

*With no susceptibilities destroyed,
And no components damaged even slightly
That are vital to our self-esteem.*

*We must
Be neither of us any way aggrieved
In connection with those grim events and facts
That I, essentially, must leave behind.
I am a citizen no more no less than you.*

*So do not let me seek in vain the help
That only you can give me as a friend.*

*Who injures anyone at any time
Himself thereby an injury sustains.*

*If my lengthy and unenvied past were yours,
If you were in my shoes – my Scottish brogues
Or else some other sort, the predicament
That plagues me would be yours – but no, I do
Not ever want it to be yours – not that!*

– CJ Nommensen

SECTION 1

THE STORY OF OUR BEGINNING

The Anglicare Mental Health Project has been a journey of learning for all those involved. We have all had different starting places and reasons for connecting with the project as it has become a growing movement. In this section we will go back to our beginning and briefly look at the background to the project. The vision we began with has remained central in our journey but the objectives of the project have developed with our learning. Our vision and these objectives will be outlined.

The people involved with any work come with their own values and unique orientation. These perspectives influence and shape the work that is done. In order to understand some of our perspectives we have included a brief introduction to each of the members of the project team. Our values are also reflected in the words we use and so we have included a section where we define and explain what we mean when we use various words.

1.1 BACKGROUND TO THE PROJECT

The seeds for this work began with a simple vision. The core of this vision was about seeing if people in Anglican parishes might be prepared to walk with a person who is living with mental and emotional trauma.

This vision came out of some experiences the Reverend Owen Strong had in his parish work and his hospital chaplaincy work at a psychiatric institution.

“I think of Jim. He spent most of his life sitting at home. He was very withdrawn and had been diagnosed as having schizophrenia. I first remember Jim when he began attending morning prayers. He would rock back and forth and would sit in the meeting for only ten or so minutes. Jim came pretty regularly. Over time he was able to stay for over an hour. His mother told me how important these times were for Jim. I didn’t do anything extraordinary. I just accepted him for what he could contribute. I couldn’t think that there was anything special was going on. But his mother said there was. I was surprised that something so simple could be so important.”

Rev. Owen Strong believes that over the past one hundred years or so society has done a pretty good job of removing from our sight people who deviate from the “norm”. This has resulted in us losing our ability to relate with people who are seen to be different. Owen argues that society is very much the poorer because of this. This is highlighted when contrasted with his memories of a different experience.

“I can remember being a part of a church in Rockhampton where people who wouldn’t normally fit in church were welcomed. They changed things. They modeled the quality of “being”, of being who you are without all the filters. They made the place more human, into a nice place to be.”

Funding

Owen Strong gained the funding to initiate the Anglicare Mental Health Project in October 1994. The project was funded Federally through the Innovative Grants Program of the Mental Health Branch of the then Department of Human Services and Health.

Project Team

Three part time workers have been employed since that time and two lecturers from the School of Social Work and Social Policy at the University of Queensland acted as consultants. The project leader (Owen Strong), the three workers (Pat Strong, Neil Barringham and Penny Barringham) and the two consultants (Chris Brown and Robert Bland) formed the project team which has managed the project.

1.2 PROJECT OUTLINE

With 'A Place to Belong' our vision has been to consider afresh and in a radical way, how people who are moving out of a psychiatric hospital can come to find a sense of place or connectedness in their local area. The original vision was centred around getting to know a small number of people who were patients in a psychiatric hospital and connecting them with someone in the community who was associated with an Anglican parish. We would find out where the person in hospital was hoping to move and try to find someone from that area who would journey with them, and help them find connections in the community. There would be no expectation that the person be a church-goer or that they would become involved in the life of the church.

Objectives

The objectives of the project have been:

1. to investigate the feasibility of Anglican parishes becoming involved in supporting people who live with mental and emotional trauma and including them in their community;
2. to gain an understanding of the factors that might encourage or inhibit this development;
3. to select and work with a number of parishes and engage them in a process of investigating their willingness to become involved with a person who experiences mental and emotional trauma;
4. to develop greater awareness of mental health issues and the need for inclusion in parish communities in South-East Queensland;
5. to model inclusion of people who experience mental and emotional trauma as valued participants at all levels of project activity;
6. to develop models and principles to assist parishioners wanting to include others in their lives and community;
7. to develop strategies which could support the ongoing development of this work;
8. to develop and support links between people coming from hospital and people in parishes;
9. to work towards positive outcomes for people living with mental and emotional trauma presently situated in parishes;
10. to understand more about what a sense of belonging means to people who live with mental and emotional trauma.

1.3 WHO WE ARE AND OUR ORIENTATION

It is important for us to state clearly at the outset that, although we feel quite passionately about the things we write, we recognise in our own lives only too well the great gap that often exists between what we say and what we do. Our desire is that over time the gap will be lessened and there will be greater integrity with what we are saying and how we are living.

Owen Strong

I brought to this project a belief that the church is a largely untapped resource for healing and hope. That belief has been fed by some of the literature referred to in this paper, and by stories of the people I have met through this project. Listening to those stories has been life changing. They have caused me to ask myself many questions about my own values and priorities, and challenged me to become more inclusive in my own life.

Pat Strong

For some years I shared the struggles, the pain and the joy of everyday life of a person very close to me. I had contact almost daily, sometimes many times a day. Often I was pulled in different directions when confronted with issues concerning freedom of choice, lifestyle, belonging and medication. This was perhaps the beginning ... preparation for my involvement with the project. As I have journeyed in the last 18 months with friends associated with the project, I have valued their giftedness to me ... the sharing of self, the acceptance, the patience. I, in turn, have learned to be patient, to be more understanding and to listen. I have learned to look for the treasure, the sometimes hidden treasure.

Robert Bland

I am a senior lecturer in the School of Social Work and Social Policy at the University of Queensland. I have had a long standing interest in the welfare of people with a mental illness and their family carers. In recent years my research and teaching interests have included the more human dilemmas of mental illness, such as the importance of hope and spirituality in the recovery process. I have worked extensively with mutual support groups and with advocacy groups such as ARAFMI and the Schizophrenia Fellowship.

Chris Brown

For the last twenty three years I have been involved in social work and social policy education and research. Over the last five years I have discovered the importance of finding a location closer to people who are poor, and the value of sharing more of my life with people at the margins. The needs for places of welcome, belonging and friendship arise from deep human longings. People at the margins, in their search for these places, remind us of the limitations of our community life and expose the poverty of our attempts to form deeper human relationships. The poor have taught me much about myself. They have also shown me how limited my understanding and experience of the kingdom of God has been. To open places of welcome, friendship and belonging to the poor is an integral part of what, for me, the kingdom of God is about.

Penny and Neil Barringham

For the last five years we have lived in Highgate Hill and been involved in living with and journeying with people who are quite vulnerable and who experience mental and emotional trauma. Our journey with people has led to us traveling some painful paths. We have journeyed with people whilst they have been homeless, in John Oxley maximum security hospital, in prison, in intensive care due to suicide attempts and many other places. Our journey is a faltering struggle towards the inclusion and welcome of all people, especially those who are considered less than others, into all facets of life. For us this is an attempt to enfold the gospel of Jesus of Nazareth. This incorporates a recognition and acceptance of our own brokenness and yearning for welcome and a place to belong. Our brokenness and inner yearnings are manifested frequently when we perceive our struggle to maintain community between even each other – let alone with others in our community. We struggle to deeply hear each other, to be compassionate to each other, to recognise each others' need and wants as more important than our own. Our humanity is evident often!

1.4 DEFINITIONS AND UNDERSTANDINGS

There are a number of phrases and words that we have used that may need clarification and defining. We will define and explain what we mean when we use: mental and emotional trauma; inclusion; project; and parish.

1.4.1 Mental and Emotional Trauma

The problem of being labelled

It has been a very real struggle for us to work out what words to use to describe the experience that is usually labeled as a 'mental illness'. We know of the damage that people have experienced as a result of being labeled as having a 'mental illness'.

"You're given all these labels – 'sick', 'manic-depressive', 'schizophrenic'. You carry the labels and tend to absorb them. The injury that the label has done stays with you." (Mary)

There is also the recognition that the "mental illness label in our society carries enormous stigma" (Wolfensberger, 1972:13). To label a person as mentally 'sick' means to be able to exert great power over that person. This power and subsequent label carry implications for a person's legal status, social status, employment and medical provision. When a person has been diagnosed with a label such as

schizophrenia, a new chain of processes is set off (Throssell 1971:106-107). The person is less likely than before to be seen as human and more likely to be seen as an object of interest for scientific study. The person is less likely to be seen as an individual but seen more as a category, because the person is less likely to be responded to in authentic ways. This depersonalizing use of labels is evident in comments made by people involved in the project. One woman said that professional mental health workers and services have often left her feeling as if she is of no value, she says it is “as if I don’t really count.” Another man said “my case worker doesn’t treat me like a human being. I’m treated like a file number or a statistic.”

An inadequate alternative

Giving something a different name is not going to redress the pervading stigma of this complex experience. It would be very, very easy for us to follow the dominant thinking and use the term ‘mental illness’ to label people’s experiences. However we believe that “nobody makes a greater mistake than he who did nothing because he could only do a little.” (Shields, 1991:12). In our attempt to at least do something, even though we recognise the inadequacies of our attempt, we have chosen to use the phrase ‘a person living with mental and emotional trauma’. In using this phrase we are attempting to describe something of what people experience. We deliberately do not say that a person is ‘sick’ as some people do not believe that their experience is an illness, or that it fits within the medical model. It is important for us to recognise that it is always the person first, and a description or experience last.

Our understanding is that the line which separates those who struggle with mental and emotional trauma from those who don’t does not separate one group permanently from another. Rather, the line goes through all our hearts. We all move at different points in our lives through different points in the continuum – some times of strength and stability and other times of fragility and brokenness. (Grow 1982:42).

We believe that the root of the problem lies in our inability to accept and value difference and disability, our own and others. Our society is one in which behaviour that is seen to be different from ‘the normal’ is negatively evaluated. In our work we have attempted to acknowledge our common brokenness, to welcome all people and to recognise that all have valuable contributions to make. One parishioner described her involvement by saying:

“I have come away feeling privileged and thankful to have been with people as they are, made in the image of God and with such potential to love and endure and laugh and cry and overcome and support each other. Ted’s face with its pure joy as he presented his item! John’s wisdom through suffering ... and Joanne’s pride in sharing her gift of washing up – all so truly human.”

1.4.2 Inclusion

Two roads: Inclusion or Exclusion?

It is easy to understand what inclusion means when we compare our feelings of a time when we felt welcomed and included with a time when we felt left out and excluded. When describing our feelings of being excluded we would probably use words such as awful, lonely, sad, mad, depressed or unhappy. When people are excluded they usually feel ‘bad’. When a person feels really welcomed and included they feel happy, great, loved, important, wonderful, etc. (Pearpoint & Forest 1996:2).

When we compare exclusion with inclusion the difference highlights our understanding.

- Instead of isolation we see community.
- Instead of rejection we see acceptance.
- Instead of labels and stigma we see first names and being known.
- Instead of loneliness we see friendship.
- Instead of fear and anxiety and being unwelcome we see confidence, peace and being welcomed.
- Instead of competitiveness and individualism we see cooperation and collaboration.
- Instead of blaming the ‘victim’ we see acknowledging of systems failure.

Exclusion comes from devaluing people because of a disability whereas inclusion considers the giftedness of each person and recognises that we all have disabilities. (Pearpoint et al 1993:5).

Inclusion means living ‘with’

The road to inclusion thrives on diversity and celebrates difference. It means learning to live ‘with’ one another and welcoming back the stranger or the one who has been left out in any way.

1.4.3 Project

Early on in our work we began to feel uncomfortable calling our work a project. Project conjures up in our minds the idea that we have a clearly outlined plan and predetermined course of action. Project communicates a beginning and an end, an entry and exit. We were concerned that as people became involved with us they would feel “slotted into our plan”. These notions conflicted with our vision and the ethos we wanted to develop. Our vision is about people finding a sense of belonging in the community. This is not something that one person can do for another. It involves more of a developmental approach where relationships are built and planning revolves around what the other person wants. Our vision was more about lifestyle, involvement, ongoing relationships and community building. These things are all dynamic, organic, involving ebb and flow.

Means consistent with end goal

It was important to us to look carefully at the processes we were using to determine if they complimented rather than contradicted our desired goal, or violated other values. For some it is not important whether the means are consistent with the ends. (Moa in Kelly, 1987:65). The primary concern of others is whether the ends are achievable and worth the cost, and whether the means will work (Alinsky, 1972:24). We agreed with Gandhi that “our progress towards the goal will be in exact proportion to the purity of our means.” (Gandhi, 1954:6). This route may appear to be long but in the end it is the shortest because “the means are to the end as the seed is to the tree.” (Gandhi in Shields, 1991:79).

Developing a project or building a movement?

Describing our work as a project did not adequately communicate the dynamic, process oriented nature of our work. We were never comfortable with describing our work as a project but we could not find a suitable alternative. We continued to use it with a sense of tension. Only recently have we decided that in the future we would call our work a movement. Using processes that are consistent with our end goal seemed to fit best with the notion of our work being described as building a movement rather than doing a project.

In this document we use the word project to describe our work. We have done this because that is what we have used over the past two years and it is how we have become known. However it is important to bear in mind that when we use that term, the ethos of our work and our understanding is as we have outlined them above.

1.4.4 Parish

Parish originally denoted a geographical area services by a clergy. Now it refers to a group of people who identify with a particular church or place of worship, regardless of where they may live.

1.4.5 Names

When using a quote from someone’s story we have changed their name in order to protect confidentiality.

1.5 CONCLUSION

From this review of our beginning some of the background of this project has been explained. This next section provides more of the background by discussing the research component of our work.

*There is a hunger in me
a deep longing, felt to the bone
something other people cannot fill
It is a yawning chasm of loneliness
that has been there
through all the years of suffering
How am I not to believe
that the natural state is to suffer?
and that God
is the only one I can love
and trust with the innocence
I keep in my heart
I falter beneath the burden
of stigma and rejection
and hide the most broken part of me
the part of me that says – Where is love?
The tears that come are a release
the pain is recognised as an old friend
solid, familiar
I wrap my cloak of loneliness around me
and wait, and wait
for the time when hope will come
and I will know the love of Christ again.*

– Catherine Mason

SECTION 2

THE RESEARCH COMPONENT

The project embraced both a research component and a community development component. Both components were intertwined. In this section we will describe more fully what the research process was about. Elsewhere in the report (Section 5) we describe the community development aspect of the work.

The importance of adopting appropriate methods

When considering what research methods to use it is important to understand how the chosen methods will impact on those who participate in the research. Learning from people who experience mental and emotional trauma was pivotal to our research. However it is well recognised that many people who have been long term stay patients in psychiatric hospitals have become institutionalised, been labeled, devalued, marginalised and as a result a low self concept pervades their lives (Deegan, 1992:12. Holloway, 1994). Therefore it was important for us to incorporate research approaches that would address the debilitating cycle that gives rise to these oppressive conditions.

The project team was committed to working in ways that facilitated mutual and respectful relationships. It was important that each person be treated as an unique individual. We needed to use methods with processes that did not conflict with these values.

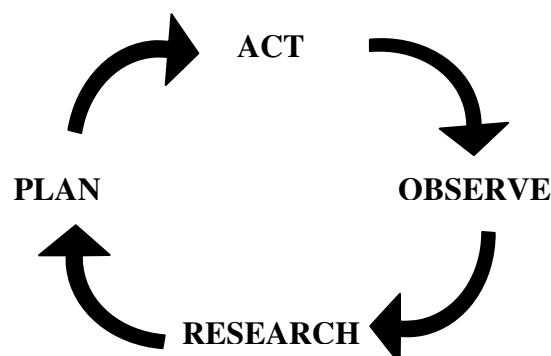
This section will outline the methods and approaches used in our research and evaluate the strengths and weaknesses of our implementation of these methods.

2.1 A PARTICIPATORY ACTION RESEARCH PROCESS

Action Research is a form of self-reflective enquiry undertaken by participants in order to improve their own social practices, their understanding of these practices and the situations in which these practices were carried out. It has an individual aspect-action researchers changing themselves, and a collective aspect-action researchers work with others to achieve change and to understand what it means to change (McTaggart, 1990:13).

The Action Research model is concerned with how things are done, with issues of control and power and has a focus on the relationships between all involved (Carter and Wharf, 1973:31. Glesne & Peshkin, 1992:11-12). For these reasons it was considered the best model for the purposes of the research.

Action Research contains the idea that change inevitably results from the research process and is actually built in to the approach. So we have:



Rather than being a linear process it is ongoing (Wodsworth, 1984:28).

To do Action Research a group and its members undertake:

- to develop a plan of critically informed action to improve what is already happening;
- to act to implement the plan;
- to observe the effects of the critically informed action in the context in which it occurs; and,
- to reflect on these effects as a basis for further planning, subsequent critically informed action and so on, through a succession of cycles (Kemmis, 1988:10).

Throughout this Action Research project we have sought to have our observations and research inform our plans and action. Likewise reflecting on our action has influenced further research and action. This process has helped us to act and to critically reflect on and evaluate what we have done or were about to do. This report is part of the ongoing critical reflection phase of this approach.

The participatory nature of the action research process means that we have constantly sought to involve others in the process. We have done this by consulting, holding workshops, writing papers, developing a reference group and more recently a guiding group. Section five will explain this process and these groups in more depth.

Strengths and weaknesses of this process

We have come to see some strengths and limitations in our implementation of this process.

Strengths include:

- a growing degree of participation and ownership of the movement from people;
- most activities have been open to whoever wanted to participate;
- there has been regular critical evaluation of the fit between theory and practice;
- what was done was responsive to the issues that people face;
- the production of a number of discussion papers and handouts.

Weaknesses include:

- not using people in the reference group more at the project team level;
- some of the literature was unavailable to many until late in the work, and some was written in a complex form.

2.2 AN EMPOWERMENT PROCESS

Empowerment refers to the ongoing capacity of people to act on their own behalf in order to achieve a greater measure of control over their lives. (Section 4.2 provides a more details explanation of empowerment.) A central strategy in empowerment action research is to give people the opportunity to tell their own story with a hope that it may provide a greater understanding of issues in their lives. It is hoped that the telling of a story will contribute to empowerment as the listeners, as well as the storytellers, recognise the importance of connecting different ideas and activities which normally remain separate. The researchers' task is to unravel these stories by not only making observations but also by seeking to make connections between these observations. This could lead to a better appreciation of obstacles to empowerment (Rees, 1991:21-44).

We sought to implement empowering processes by:

- Seeking affirming and mutual human relationships with all people with whom we worked;
- Honouring a person's lived experience and their understanding of the experience as a valued resource. We sought to do this by inviting people to share experiences, understandings, stories, and perspectives. We encouraged participants to share their stories and experiences, which were seen as a valuable resource, with other participants in this project;
- Bringing people together around shared or similar experiences, hopes and dreams. We invited people to reflect further on themes and learning and to be involved in learning exchanges;

- Extending people's influence in the project. We encouraged people to be active participants in project planning and decision making;
- Bringing all people together in ways that model the project's vision of people finding a place to belong by building welcoming and inclusive communities.

Strengths and weaknesses of the process

Some of the strengths and weaknesses in the implementation of this process are mentioned below.

Strengths include:

- The development of leadership from among people who are on the edges of parishes and people who experience mental and emotional trauma;
- People re-evaluating their self concept. Once person said: "I've re-evaluated myself from being a sick person to being a capable person";
- The inclusive nature of the activities of the project meant that it was difficult to tell who were 'parishioners', 'patients', 'priests', 'family members' or 'people who live with mental and emotional trauma'. People were not labeled;
- A number of people are taking responsibility for the ongoing movement;
- People gained some sense of hope.

Weaknesses include:

- Unanswered questions about how to make spaces in institutions to hear people's voices in a way that will be empowering;
- Not resolving the dilemma of how to determine the monetary value of different people's contributions and what implications can be made by those who receive less than others. This is particularly pertinent when the people who are often paid the least are people who have already been devalued by society.

2.3 CONCLUSION

Clearly the research approach used in this work was not the type of research where a clinician sits back in a detached way and makes measurements and counts statistics. This research approach is about active engagement rather than detached observation. In fact all participants were researchers! We, as a project team, sought to make ourselves subjects of the research as well. Space was given in as many ways as possible for people to raise questions and to give insights.

This section has described the action research and empowerment approaches to research which were utilised in this work. Now it is time to briefly describe the contexts in which we operated. This will conclude the background information of the project.

City Ways

*You were strolling in the city
when I was also waling there –
together with the many others all
around us in the City Mall.*

*I saw but did not know you
or any of the others.*

*Despite our shared
humanity, there were no words between us –*

*no words of any care for one another
when most likely you and I, and the others too,
will never see each other any more.*

*In all the days that yet for us remain,
We'll have no such opportunity again.*

– CJ Nommensen

SECTION 3

CONTEXT IN WHICH THE PROJECT IS SITUATED

We do not work in a vacuum. On the contrary we live and work in a world that is becoming increasingly complex. There are numerous things that impact on us and affect what we do and how we go about doing them. It is important to understand the context in which the project is situated as this provides the framework for our work. This section will briefly overview the historical, political, community and parish contexts.

3.1 HISTORICAL CONTEXT

It is well known that people who experience severe mental and emotional trauma have historically been separated from mainstream community life and segregated into asylums. With deinstitutionalisation and institutional reform policies and practices many people have found themselves back in the community, but still leading isolated lives away from family, friend and neighbours. It is important to remember that there are still many others who continue to live in institutional settings with very little hope of ever returning to the community.

3.2 POLITICAL CONTEXT

There are many policies and strategies that state and argue that people with a “mental illness” are entitled to be included in the community and enjoy the same rights as other Queenslanders (Macklin, 1993:14). Unfortunately there is often a great chasm between policy intentions and people’s lived experiences. Political decisions are increasingly being made according to a narrow economic agenda with a seeming disregard for the impact of their decisions on those in most need. We are becoming economically rational rather than economically compassionate (McCleod, 1996).

3.3 COMMUNITY CONTEXT

Living in a society that promotes radical individualism, competitiveness and materialism can mean that people who have a disability are devalued and marginalised rather than welcomed. Our great challenge is to determine how a person who comes from a long term institutional context will find a meaningful place in the community where there is participation and genuine inclusion and not just presence. We need to find out how this can occur in a context where the predominant values, lifestyles and resource allocations place barriers against this occurring. It is important to ask what it will take for you and me to include in our lives someone who is seen to have a disability and is viewed negatively by our society.

3.4 PARISH CONTEXT

We are interested in the parish context because people are exhorted to love their neighbour as themselves, and are taught that the first will last and the last will be first. It would be assumed that this would be a place where all people, no matter who they are or how different they appear, would find a welcome and a place of significance. However we are finding that some parish communities are really struggling to know how to welcome and include people (Anglicare Mental Health Project, 1995).

3.5 CONCLUSION

So far we have shared the story, discussed the research component and considered the context. The next two sections look more closely at what we have done. Section 4 will review the literature which has provided a foundation for action. Section 5 will look at what we have done.

*I want to take action
to move forward
out of my inertia
But then the layers of depression
fold over my mind
and the sinking starts
Deeper and deeper
further and further
from the sharpness of reality
I am immobile again
the mind struggling and gasping
like a fish out of water
There is no rest
I will die in my agony
and bury myself
in the hopelessness of the now*

– Catherine Mason

SECTION 4

FOUNDATION FOR ACTION

At the outset of our work we recognised that we had much to learn from other people. Learning has come from consulting with key people in this field of work, and from what others have written. In seeking to tread new ground it was important to learn from the journeys other had taken. The learning of others needed to inform the project.

The development of our work has been significantly influenced by a review of the literature. Learning has come from an interaction of the literature with our experience, and our learning from our work has grounded our ongoing involvements.

In this section we will summarise our learning in four areas: Belonging, Empowerment, Friendship and Community. This section is different from previous ones and some may find it harder to read. It is very compact and deals with some complex issues. You may prefer to take your time in reading this section, or come back to it at some other time.

4.1 BELONGING

We have already mentioned how our vision is about people finding a sense of belonging or connectedness in the community. The Webster's dictionary (1990) defines belonging as "being connected with" and the Oxford dictionary (1989) defines it as "being attached to in some capacity". A sense of belonging comes from having connections in the community and comes from different people and places at different times in our lives (Amado et al, 1990:28). A sense of belonging is not something that is unimportant or incidental, rather it is primary to our existence (Pearpoint, 1996:2).

Many people who experience mental and emotional trauma feel that they don't belong. Little or no contact with their family remains, they have few friends, no place to call home and they lack a feeling of being welcomed and accepted by other community members (Holloway, 1994:4). Other people have been enmeshed in service systems and often feel "they don't belong" (Holloway, 1994; Sherwin, 1994:3). Those who are not seen to have a disability can also find it difficult to experience a sense of belonging.

A sense of belonging is priceless. We need to recognise the enormous importance of having a sense of place (Hamilton, 1994:12). We all need a sense of belonging and to be recognised as having a respected place in society where our gifts are recognised and received. "There is no worse fate than to be excluded from society" (Hamilton, 1994:12). Some people are excluded by the responses of society around them, as well as experiencing a sense of complete isolation and estrangement as a component of their "illness". For such people a feeling of belonging is priceless (Stein, 1994:58).

People who experience mental and emotional trauma suggest that finding a sense of belonging involves having friends, a place to call home and things to do in the community. (Sherwin, 1994:23).

4.2 EMPOWERMENT

We are confronted with the reality that the people that we know have been institutionalised many times over in hospitals and hostels. People have been told that they are ill and therefore incapable. People are dosed with major tranquillisers which suppress feelings, emotions and energy as well as symptoms. What does empowerment mean for people in these circumstances? It means that these people who have experienced more oppression have more layers of resistance to get through before they have a sense of their personal power. These layers of resistance are both external and internal, because oppressive beliefs such as being told (word or action) that you are incapable can easily become internalised and accepted as being true (Shields, 1991:13).

Empowerment refers to the ongoing capacity of individuals or groups to act on their own behalf to achieve a greater measure of control over their lives and destinies. It is important to recognise in this process that one person cannot empower another person. Rather, information and assistance can be provided but only each person can decide to empower themselves (Tenth Anniversary Report, 1994:21).

The process of empowerment occurs in a movement from a passive to a problem solving orientation (Rees, 1991:80). In this move at least three stages are traversed – education, solidarity and confidence in taking action. The steps for achieving power according to Rees are similar to Freire’s “conscientisation” process. This process is not carried on by one person “for” another, or by one person “about” another, but by one person “with” another in a relationship of mutuality (Freire, 1972:66). It is understood that power differentials will still be inevitable, however the process attempts to extend friendship with an attitude of mutuality where it is acknowledged that we are all broken and vulnerable and is aimed to minimise such differentials. Vanier recognises that this process of liberation, or empowerment, is a long one and that it is never fully completed (1982:273).

For people who have been institutionalised and oppressed for much of their lives, the development of a sense of empowerment will be an extremely slow process. However, it is a process that we need to be party to. This process will involve taking one step at a time, and within the limitations of this work, it may mean that only one or two steps are taken, and in many cases maybe none at all. A limiting factor of these approaches is that they are often slow, tedious and unpredictable.

4.2.1 Impediments to people being empowered

There are many impediments to the process of empowerment. Some of these are outlined below.

Seeing the disability as the problem

The disability a person has needs to be seen as a given, not a problem. People with a psychiatric disability are often taught that the problem exists inside their head, or within their own person. Therefore the focus becomes to change the person. However, for many people, having a psychiatric disability is simply a given. The problems come when people engage with their environments. Howie the Harp (1991:1) says “I have a condition that is neither positive nor negative – not an illness to be ‘cured’, but a condition that can be accommodated in order to enable me to live the way I choose.”

Those with more power not allowing others the space to exercise their power

Deegan (1992:8) says that those of us with disabilities live in environments which are oppressive, which rob us of our right to self determination, and which create and nourish dependency on people who have great power to determine the course of our lives.

Lack of options inhibits empowerment

It will be difficult for people who have been institutionalised to learn skills of empowerment because “they find it difficult to understand the concept of choice” (Renshaw, 1987:10). Part of the reason for this is that “choices are a function of options” (QPPD 1995). If, for example, people have only had the experience of segregated or congregated options they may not consider inclusive choices in community living.

Mental Health ideology and diagnostic labels reinforce power differentials

Influential mental health ideology and language can dominate encounters between service providers and service users and reinforce power differentials between them (Brown & Reeves, 1993:7). In speaking to mental health professionals, people who are their clients clarify that “You need to know that I speak to you with a voice that is quite powerless and that you listen with an ear of authority and great power. I need to call you beyond that space where you rule by means of your ideological and methodological superiority into the real world that we both share where your personhood encounters

my personhood” (Brown & Reeves, 1993:7). Many mental health professionals view the issues faced by their clients from their own framework (for example from a medical model), rather than from the perspective of the person who is their client. The use of the medical model may lead to viewing the person who is a patient as a diagnostic label rather than as a unique individual (Ridgeway, 1988:3).

4.2.2 Encouragement for empowerment

Processes that have encouraged a context where people have been able to empower themselves have included the following.

Affirming and mutual human relationships

The development of affirming and mutual human relationships where a sense of relatedness, meaning and power through re-affirming people as people of worth is encouraged (Brown & Reeves, 1993:5). Leavey (1994:4) argues that it needs to be recognised that all people are interdependent and experience fluctuating levels of dependency, and require a variety of formal and informal supports and services in their lives (i.e. ranging from family and friends, to self-help and asylum, to formal treatment).

Validating peoples lived experiences / Attentive listening

Empowerment will only come when we recognise and validate the significance of people’s lived experiences and understandings. Honouring and valuing people’s experiences and understandings begins by trusting their capacity to assess their immediate world. It means attentive listening. It is extended through mutual, critical and liberating dialogue and through encouraging them to reflect on their world. (Brown & Reeves, 1993:5).

Acknowledging our own power, values and agendas

It is important to identify our own values, agendas, interests and goals and those of the people with whom we are working and to distinguish between the two (Croft & Beresford, 1988:278-279). This is important because it will be difficult to respond to issues of power and devaluation in others lives if we are not able to identify our own agendas and values and understand how these may impact on the lives of others.

Being sensitive to others lack of assurance

There is a need to be sensitive to the fears and uncertainties that people may have, and to appreciate people’s need for encouragement in order to feel confident to work with you (Croft & Beresford, 1988:278-279).

Sharing Knowledge

Knowledge can be a source of power, and so education is a crucial step in the empowerment of a person (Tenth Anniversary Report, 1994:20).

Joining with others

“By daring to express our angry indignation and joining with other people with psychiatric disabilities who can validate and affirm our anger (about oppressive conditions), we discover that we have power in our numbers and can begin to work toward social justice and our own liberation.” (Deegan, 1992:9).

Increasing options

To increase choice there needs to be increased options, and a recognition, valuing, and trusting of the choices that people are already making (Srebnik et al, 1995:148; Tenth Anniversary Report, 1994:21). Some people may not have developed skills in generating and evaluating options, and some may have learned self-defeating decision-making skills. In these situations it is important to provide adequate information about options and to help people through a process of predicting possible outcomes of their choices (Srebnik et al, 1995:148).

Understanding the difficulty of the process

We are talking about very vulnerable people, some of the most vulnerable and disempowered. The pathway that lies ahead is very hard. As previously mentioned it may be difficult for people who have been institutionalised to learn skills of empowerment. We may not find a perfect process and so will need to work with an approach that we feel is the best we can do in the circumstances. This will mean understanding the ideal and the reality and finding an alternative way forward. In working with people who are so incredibly disempowered and vulnerable and who have been institutionalised for many years one person suggested that it may mean the empowerment may need to be kicked off with an unempowering process.

4.3 FRIENDSHIP

A real friend is an essential resource (Vanier, 1989:183). We survive in life by having a little help from our friends (Veninga, 1985). Life must be very difficult for those who have no friends and where the main people in their lives are paid professionals. One thing that many people talk about, when they think about leaving hospital and living in the community, is their desire to find a friend. They say they want “a proper kind of friend” and they define this as someone who will accept them, stick with them for a long time and believe in them. They have also clarified that a friend is not a person who tries to “fix you up”.

The following discussion looks at some of the issues related to people who are coming out of hospital finding a friend.

Deinstitutional movements have been focused on integrating people into community settings so that they live alongside other valued citizens. It has been thought that this would facilitate their involvement with others. It has been recognised that people often participated in more community based activities but still had very few opportunities to meet people without disabilities. Their segregation and lack of friendships continued to be a main source of dissatisfaction (Jahoda et al, 1990; Gaventa, 1993; Lutfiyya, 1988).

4.3.1 Obstacles to friendships developing

Friendships generally develop very naturally and spontaneously for most people. However for people who have been devalued by our society there are barriers to this occurring. The obstacles to friendships fall into three categories. There are: a low expectation for friendships to develop; few opportunities for friendships to be initiated; and, inadequate supports for friendships to be fostered (The G. Allan Roeher Institute, 1990:12).

There are at least six characteristics experienced by most people in their efforts to meet others and develop relationships that may not be available for people with disabilities. These characteristics include “opportunity to meet people, diversity, continuity, relationships that are freely chosen and given, and intimacy.” (Lutfiyya, 1988:3).

4.3.2 Facilitating friendships

Once a person is living in the community and others want to be involved in facilitating opportunities for friendships, this encouragement of friendship needs to be seen as more than another program. It must be part of a broader movement that “calls for an inclusive community, even when currently unachievable or extremely difficult.” (Uditsky, 1993:87).

Friendships can easily be viewed narrowly and romantically, with the complexity of friendship being ignored. It needs to be recognised that “for some people, friendship is not cemented until some mutual rite of passage is accomplished. Processes that overly control possible development of friendship may inhibit necessary and cathartic experiences that happen by chance. The real depths of some friendships are never known until they are tested; yet some programmatic friendship efforts do everything to maintain friendships on a controlled artificial plane.” (Uditsky, 1993:89). With relationships there is a tremendous dichotomy. Part of the reality is that while friendship will hopefully bring joy and belonging into lives, it will also expose people to sorrow, pain and rejection. (Uditsky, 1991).

Friendship is often viewed as something that occurs very naturally and therefore should not be facilitated or encouraged. It is thought that once you begin tampering with a relationship you could run the risk of creating something artificial. The belief that friendships should not be facilitated and encouraged can have unfortunate consequences for people who lack the skills to make friends and the conditions to meet people. “The simple reality is that many individuals are unable to have friends without some kind of support.” (The Roeher Institute, 1990:22).

The facilitation of friendship may be necessary, as it probably is for all of us, but we need to be aware that there are healthy and unhealthy ways of going about it. Facilitating possibilities for friendships and relationships is about understanding relationships. There needs to be a change in our thinking from the idea of “simple or technological solutions to complex human problems, and into disorganisation, disarray, and incoherence of ordinary life.” (Uditsky, 1993:93). This means moving away from some specific formal strategies and moving to more “unpredictable meandering pathways” that are closer to what most of us experience. According to Uditsky (1993:93), this will more likely result in the possibility of friendship.

In recognising the need for the facilitation of friendship it is easy for us to dominate the relationship and to want to manage it. We need to acknowledge that the process of becoming friends is as much a part of friendship as the outcome itself (Uditsky, 1993:93). Support “should occur as naturally as possible so as to preserve the voluntary and self chosen nature of friendship.” (The Roeher Institute, 1990:23).

In light of the obstacles that hinder a person finding a friend it is clear to see how vital it is for people to be found who will help the facilitation of friendship.

4.4 COMMUNITY

Early on in this project we realised that we were dealing with much more than the topic of “mental illness” – we were dealing with the broader area which we called “community illness.” One of the first signposts to this was a comment by a man at Wolston Park Hospital who said: “*When we look at the community through our eyes and experience, we see people who don’t seem to have much time of energy for us ... Our picture of people in the community sees every one as being very busy with their own lives and family ... We wonder if enough people could be found who would be interested in helping us.*”

These comments are underscored by Uditsky’s comments that, “of all the key challenges of the 1990s, it is *life and relationships* that have a fundamentality and importance that are more basic than many of the issues that we struggle with in our reform of systems and services for people with disabilities and their families.” He challenges us to look at ourselves and our own relationships in community life. “Relationships that deeply evidence the valuing of vulnerable people and of each other are the essence of community living and are crucial to the opportunity to ‘live’.” (CRU, 1995:2).

Thus, life in community is at the essence of what this project is about. Questions arise such as: What is community? What is needed to build stronger and more inclusive communities? and, Are churches and social services communities?

4.4.1 What is community?

There is a certain vagueness about what we mean by the concept of 'community' and people have differing ideas of what community is. There are many myths about community that we carry with us from our childhood and from stories from the past. Lee asks whether 'community' in practice is still a geographic notion of whether it has actually changed as our population has become increasingly mobile. He thinks it may be more "communities of interest" and "communities of shared purpose" that for many people have become significant in terms of providing a sense of identity and belonging (CRU Feb. 1995:11).

We are living in a period of the romanticising of 'community' life (when compared with institutional life). (Kendrick, 1982:22). Kendrick quotes Jean Vanier's definition of living in community as "a continuous act of sacrifice and forgiveness." (1989:22). He continues, "Community means being with people who are not at their best. If we have an idea of community like that, we can probably stand it. But if it is a 'community' where nothing goes wrong, where there are no mistakes made, where there is no pain and suffering and tragedy, and broken promises, then we do not have a realistic community life. We will have a sanitised wasteland of denial of our humanity." (Kendrick, 1989:22-23).

O'Brien works from Sarason's definition of the sense of community being "the sense that one is part of a readily available, mutually supportive network of relationship ..." Community cannot be manufactured, he says; it is not a commodity or the reliable outcome of any professional activity. It arises when valued personal involvements with a network of others give rise to purposeful action and celebration. (O'Brien, 5-25).

Thus it is clear that as part of this work we affirm Carling's observation that community is not a geographical area, about getting out of hospital or about new services. Community is about a sense of belonging and this takes time to develop.

4.4.2 What is needed to build stronger and more inclusive communities?

It seems that the following areas are important.

Cornerstones

The four cornerstones to community inclusion are family, home, friends and community membership. (Uditsky, 2-3). It is helpful, he says, that there has been a shift from talking about "community living" to "community inclusion", as the former can simply mean anything other than an institution. O'Brien and Lyle explain that there are five conditions needed to significantly improve the quality of life for people with disabilities in the community: the opportunity to access the same places that ordinary citizens go to, the opportunity to make choices, the opportunity to have dignity and a positive reputation, the opportunity to grow in relationships, and the opportunity to develop. (O'Brien & Lyle, 1986, quoted in Roehrer 1990). It is evident then, that the simple process of providing 'community-based services' is insufficient to ensure the community integration of people who live with mental and emotional trauma. Community integration signifies more than a person simply remaining out of the psychiatric hospital. True involvement in community processes is reflected in having meaningful work, families and friends, recreational activities and opportunities to make choices about one's life. (Sullivan, 1992:204).

Attitude

“A belief that friendships are possible between people, particularly someone who has a mental disability and someone who doesn’t, needs to be grounded in ‘sociology of acceptance’” says the Roeher Institute. “The ‘sociology of acceptance’ is important to overcoming our low expectations, so that we can encourage rather than prevent badly needed friendships, and therefore a good quality of life, for people with disabilities.” These friendships involve not a denial of disability but an acceptance and accommodation of it. (Roeher, 1990). Similarly, Sullivan comments, “Simply put, mentally ill individuals have been viewed as too impaired to deal with the rigours of community life, which is viewed as toxic.” (Sullivan, 1992:204). An alternative framework, he suggests, is embodied in the strengths perspective. Many models of helping proceed by emphasising the identification and eradication of deficits and disease, but the strengths perspective assumes that helping can proceed fruitfully from the identification and enhancement of the individual.

Policy considerations

There is some cynicism and suspicion that ‘community care’ in the minds of policy makers can simply be a euphemism for ‘throwing volunteers’ at social problems rather than ‘throwing money’ at them. (Walker, 1987:378). The informal sector can be idealised, he says, and too much asked of it. “It is unlikely that an increasing amount of care will be provided by the community without economic and social policies to care for the community” he adds. (Walker, 1987:381). Thus we suggest that there is need for greater commitment both on the policy level and at the community level – not either or!

Membership

O’Brien and O’Brien argue strongly that the notion of membership is critical when considering community inclusion. “Good lives for people with disabilities depends on whether they are recognised as members of the social networks and associations that constitute community.” (O’Brien & O’Brien, 1991:1). “Unless people with severe disabilities, their allies, and those who serve them continuously widen their common recognition as members, the negative effects of moral exclusion will continue to undermine the quality of communal life.” (O’Brien & O’Brien, 1991:8). People weave their membership with four different threads. These include: feeling attached to emotionally important other people; having the opportunity to engage in shared activities; being part of a network of people who can approach one another for information and assistance; and, having a place and playing a variety of roles in economic and civil life. Problems are often encountered for people with severe disabilities because: moving from isolation to membership typically takes hard work; people with severe disability often violate the common expectation of recovery; and, because the needs of those with severe disabilities lie outside the typical ways that people help each other and this creates a barrier. “Everyone benefits when all who are part of the human collective are allowed to participate in human expression.” (Sullivan, 1992:208).

The essentials for community are:

- that we each need to cultivate the desire to love one another;
- that we each need to develop positive ideals and work towards them;
- we need to encourage specific examples of mutual sacrifice and sharing;
- we each need to work at changing ourselves and not just criticise others;
- we each need to forgive others; and,
- we each need to pay a lot of attention to those who are at risk in the community (Kendrick, 1988:23-27).

4.4.3 Are churches and social services communities?

According to Christ, His followers were to be characterised by love and commitment to one another. Whether a particular church is really a community seems to be answered by which approach it takes. McKnight (1980:6-12) suggests two contrasting approaches to working with people.

professional/bureaucratic view

managed and hierarchical
efficient and technical and ordered
focus on technique and professional knowledge
works towards providing 'services'
often about control
formal
good for making products and things
people learn through studies and reports
commodifies people's deficiencies and deficits

associational view

unmanaged
created naturally and from the heart
happens between people
sees importance of 'home' over 'residence'
often about consent
informal
good for creating a sense of belonging
people learn through stories
draws on people's capacities

Both views have a valid place in the world. Interdependence is important. However organisations often do not incorporate the second view.

This model has significance for our work and projects like it because our aim is to work towards a sense of belonging (or 'psychological sense of community'). Schwartz (1992:6) argues that belonging tends not to be found in managed/professional systems. This being true, we should not use the tools for pursuing this form of work in encouraging people to care. Rather, the correct tool for caring, arises from an understanding of the contrasting associational world view. This recognises that caring always arises in a cultural setting and that it is always something that happens between people. You cannot produce love. Yet love can always be found, growing naturally in the world, in the hearts of human beings.

A further concept of 'mediating structures' is helpful. These are the institutions that stand between the individual and their private life and the large institutions of public life, for example family, church, voluntary association. When people are in distress they will often go to friends first or to people from mediating structures. It is only after all these have been tried that they will go for professional assistance. Here clearly is a significant role for the church. (Schwartz, 1992:6).

Schwartz argues that, for development workers in the disability field, there needs to be a conceptual revolution. As we utilise an associational world view rather than a professional/bureaucratic world view and begin to see the role of mediating structures, then we can find many live and vital areas in which to look for associational life. We can look for "clans of voluntary affiliation". These need to be discovered and nurtured in their capacity to support and include people with disabilities. (Schwartz, 1992:9).

4.5 CONCLUSION

The learning gained from interacting with the literature in light of what we were doing gave significant direction throughout the project. In this next section we will outline in more detail what we have done.

Paradoxical

*Clad in readily
accepted unassuming
anonymity
in a busy city centre
where I had need to be,
my expectation was
that no one who was known
to me would come along.*

*And now it seems to me,
if contact had occurred
with anyone I knew,
my anonymity
would soon have been replaced
by my identity.*

*But no one that I knew
appeared among the crowds.*

*So all the morning passed
and my anonymity
remained a garment that I wore
with no opportunity
to remove it in exchange
for the personal attire
and individual
accoutrements that are
my own identity.*

*But shops both small and large
for mere financial gain
were flaunting blatantly
such brash identities.*

– CJ Nommensen

SECTION 5

WHAT WE HAVE DONE

Our work has focused on parishes, at building a movement and liaising with institutions. We will look in more depth at what we have done in these three areas.

5.1 WORKING WITH PARISHES

The Project began with a series of exploratory workshops and think tanks with parishioners, mental health professionals and patients and staff at Wolston Park Hospital in Brisbane. Interviews were also held with highly qualified people in the mental health field. These workshops and interviews helped to lay important groundwork for how the project was to develop. Because the vision is about belonging and connectedness the logo of “A Place to Belong” was chosen.

A questionnaire was sent to one hundred and forty-six parishes and clergy in the Brisbane Diocese. This provided contact with people who wanted to explain how they were involved in the mental health area. A report was written about what was learnt from the fifty parishes which responded. (Anglicare Mental Health Project, 1995). Project staff visited parishioners who indicated they were already involved in mental health related activities or interested in learning about how they could be allies for someone experiencing mental and emotional trauma. The use of relevant media also helped to arouse interest. Deputations and discussions were held with the Archbishop and other senior leaders in the Diocese to gain support and to create awareness about the work.

Project staff then began to articulate the vision at workshops and meetings in parishes. A newsletter (Belonging) became a useful vehicle for keeping in touch with interested people. Bimonthly Sunday afternoon workshops became a contact point for people to become more informed and to meet others. A retreat was held over one weekend eighteen months into the work. This served as an indicator that a growing movement of people was forming and consolidating from across parishes in the Diocese.

Project staff have seen their role as catalysts or community development workers rather than service-providers. Some of what this has meant is described by Heal when talking about the community development approach. “We must switch from models of pity, resistance, and of ‘helping’ to ones of respect and dignity. We must tear down the curtain between ‘client’ and ‘professional’, between ‘handicapped’ and ‘non handicapped’, between ‘special’ and ‘normal’. “We and they’ must give way to a celebration – and quiet acceptance – of the multitudinous, varied ‘we’.” (Heal, 1989:305).

The research component of the project worked hand in hand with the above activities. A literature review helped to inform the work at many points. Several user-friendly handouts were developed and disseminated at workshops and events (see Appendix 1 for list). The material for most of these arose from relevant literature. Individuals shared their stories and experiences and these became a fundamental source of knowledge for the project. People articulated their experiences of trauma, of recovery, of hospital, of services, of family, of community supports. Frequently these stories became the centre-point of workshops and talks that were delivered. People who are patients at Wolston Park Hospital were interviewed as part of the research process to hear something of their aspirations and hopes and dreams. A consultancy group of people who have experienced mental and emotional trauma has also helped to inform the project. This group consisted of five people who shared their stories individually with a project worker. Then they gathered together to share insights on an occasional basis. Most of this group attended workshops or parish meetings and shared some of their journeys. Audiences frequently responded with great gratitude for their courage and openness. These experiences appeared to be highly empowering for group members.

5.2 LINKING WITH PEOPLE

One of the primary goals of this work has been to investigate the feasibility of people from parishes becoming involved with people moving from hospital. This has proved to be a much slower process than we envisaged. Originally we hoped to see around six connections being successfully made. As mentioned elsewhere we found we became involved with people already needing inclusion in parishes. Generally parishioners were concerned about the hard work and commitment required and felt their hands were full already. Notwithstanding these factors five connections have begun to be made. One group in a parish met for over a year before they felt ready to make contact with someone. Another woman has been regularly visiting a woman who moved to her area. Three other connections are still in the formative stages. A number of other people are available to meet someone coming to their area but we do not yet know of anyone coming to their location.

5.3 BUILDING A MOVEMENT

A significant piece of learning from this project is that it is possible to nurture and generate a movement of people who want to learn how they can be allies. As remarked in the discussion about “Community” earlier, community needs to be thought about more in terms of shared purpose than geographical location.

Because the geographical grounding for community has weakened, the notion of “community of interest” is perhaps more appropriate now. This is very much what has happened with this project.

Since the initiation of this project there has developed a collection of previously fragmented people who have begun drawing support and encouragement from each other in various ways. Thus, given the inhibitions and fears which many feel, we have found that connecting people in a growing movement can instil encouragement to motivate a person to be involved. Lesley Chenoweth (1996) has evaluated this project and remarked that, “While there has been some useful work with parish communities, the main outcome has been a core group of people scattered throughout the church communities – some clergy, some parishioners, some people with mental illness and family members ... the community of interest created through the project’s work has guided and sustained them.”

The development of this movement has included four phases: gaining broad exposure; responding to the warm spots; connecting and gathering people; and, the emerging of leadership.

5.3.1 Broad exposure

The first phase of movement development involved projecting our vision and finding interested people. As mentioned above, this occurred within the context of support from leadership in the Anglican denomination. The use of the Anglican Diocesan paper “Focus” gave broad media exposure. The questionnaire already mentioned sent to the 146 parishes and clergy in the diocese gave opportunity for interested clergy and laity to identify themselves to us. As documented in “Finding a Place Together” (Anglicare Mental Health Project, 1995) many people in parishes were already trying to respond to others who experienced mental and emotional trauma – albeit often struggling and unsure of the best ways ahead. Thus mental and emotional trauma was already on the agenda for people in many parishes but they also often felt out of their depth and unsupported.

Exposure was also provided through talks and presentations at various parish groups and gatherings. Sometimes we spoke at worship on Sundays, sometimes to midweek groups; sometimes to groups of clergy, other times to laity. Interest was often very high at these meetings. We arrived to speak at an evening gathering at one church expecting a dozen people and found over sixty had come to ask questions. A similar meeting occurred in another place at which some people “came out” for the first time about their psychiatric experience.

5.3.2 Responding to the 'warm' spots

The questionnaire provided many people to contact and follow up. Consultations were held with such people. Questions were asked about what people were thinking, doing and learning, what they thought belonging meant, and ways forward they would recommend for this project.

In some places we were presented with questions or problems that people were facing. These gave us raw material to work with and issues to respond to in workshops. Many of the people we met on these consultations became key players in the movement as it began developing. This process also involved hearing people's stories. Some of these people were willing to share their stories at subsequent workshops and meetings.

As with broad exposure the process of 'responding to the warm spots' continued throughout the project.

5.3.3 Connecting and gathering people together

A newsletter began to be produced to help provide information and a sense of connection between people we had met.

As we contacted interested people and workshopped around various parishes it was felt that benefit could be gained from gathering people from different parishes together. A format developed of bimonthly Sunday afternoon workshops held at a central location to which people from wide ranging parishes came. The format was aimed at encouragement and nurture for people along with some brief input. Usually someone would share some of their story or be interviewed. These workshops later became once every six weeks. As well as connecting people from different parishes these workshops also became a public "window" through which people could look to see what was happening in the work. For some they also became a "door" which gave them access to the movement. Usually about twenty-five to thirty-five people, coming from about fifteen different parishes, would attend workshops.

Originally our vision was to germinate and nurture small groups of people from parishes. Only two groups got going in the way we expected and one of these only lasted for four months. We found ourselves working more and more with individuals from parishes and gathering groups of people from parishes at project events.

Another form of workshop was also attempted with great success. Focussed discussions were held on particular topics of broad interest. For example, a workshop was held about "How to work for change in your parish", and another on housing issues. This latter discussion led to the formation of an ongoing action group which researched how to respond to a hostel manager's concerns to create a more caring environment in his hostel. We were always most encouraged and even surprised at the interest aroused by these topical discussions.

As these different forms of workshops gathered momentum we began to sense that further development could occur. A weekend retreat was organised to gather new people and to add to the dynamic which was being created by the workshops. Forty-five people attended this significant event in September 1996. This included some 'new' people whom we had not met to that point. We observed from this that a range of strategies are useful to gain contact – some people will come to workshops while others will prefer to make contact through coming to a retreat.

The retreat was an excellent opportunity to model the values which were important to us. Sessions were experiential rather than didactic. Story-sharing and dialogue were central. Long stay hospital residents, carers, people who experienced mental and emotional trauma, hostel residents and others all mixed together. Comments were heard about the power of this "blurring of the boundaries" which conventionally are so strong.

So pivotal was this retreat in people's perceptions of the progress of this "community of interest" that Lesley Chenoweth (1997), in evaluating the project, recommended that further one day and half day retreats be held to continue the growth spurts.

5.3.4 The emerging of leadership

Through our consultations around parishes we made contact with people who were taking leadership in their own localities. In the second year of our work we began to sense that some particular individuals were interested in taking some leadership of the "community of interest" what was forming around the project.

We decided to initiate a 'guiding group' of those who wanted to think and brainstorm and plan the way ahead for the project. About a dozen people expressed commitment to such a venture and this group began to meet on a monthly basis to provide the impetus and leadership for the future of the project. At the same time an occasional 'companions group' began to meet. This was for those who were beginning the work of welcoming someone to their locality and who wanted support or a place to raise issues.

By the end of the second year of working through this process project staff had spoken in meetings and workshops in over twenty-five parishes. Over 100 people from over thirty parishes had expressed some form of identification with the work of the project. Some 50-60 people had shared something of their experience of mental and emotional trauma. Two hundred people were on the mailing list.

5.4 LIAISING WITH INSTITUTIONS

This project necessitated working with institutions in two primary contexts – the church and the hospital.

Support had been ascertained from senior church leadership from the time of the original application for funds. At the initiation of the work contact was again made with the Archbishop who publicly notified clergy and offered support. The project workers visited a meeting of bishops and other senior diocesan leaders. These processes gave helpful legitimacy and also access to diocesan media outlets.

On a local church level it was found that clergy were the primary gatekeepers. Even tacit support was helpful for gaining contact with people who were returning to life in the community. We attempted to maintain cooperative relationships, but with some distance at the same time, so we would not be identified with the hospital staff culture. We saw our work as being about friendships and informal relationships rather than having a clinical and professional orientation. The worker's role here was to negotiate with the hospital structure where necessary and then to spend time with, and create spaces for getting to know, patients. Clarification of our purpose needs to be regularly made with hospital staff.

Over the course of our dealing with hospital staff we found some individuals very supportive of the vision and helpful with information and introductions to other people. A difficulty encountered was the constant turnover of staff at both senior management and ward levels. The slow process of connecting people with someone in hospital was also further decelerated by very slow hospital discharge processes.

5.5 CONCLUSION

The basis for our work and what we have actually done has been outlined in these previous two sections. The learning from our work is dealt with in the following section.

*“I listen to my friend
talk of things that confuse me
I return to my own silence
and find that I have been robbed
of the peace in my heart
Lord, banish the cackling gargoyles
to the outer regions of darkness
and return my mind intact
as it has been shaken by a cruel tongue”*

– Catherine Mason

SECTION 6

WHAT WE HAVE LEARNT

Over the past couple of years we have spent a lot of time listening to the stories of people. We have been hearing from people in discussion, at workshops and meetings, at worship services, in people's homes and during the retreat. People have also shared with us in conversations, letters and phone calls. We have a wealth of rich material. Stories of people's experiences, of insights and confusions, of joy and pain, of dreams and shattered dreams, of the process of recovery, of sources of hope and despair. We too have shared some of our story.

We have sat with our notes and done our analysis in such a way that best represents what people have said to us. This has not been done in a detached manner. Themes have arisen and form the basis of our learning in this section. Over two years of learning cannot be captured in a report such as this. We have selected the material we think would be most important to those who have been journeying with us. The frameworks incorporating our learning have been reviewed at meetings and with a number of individuals to check our analysis.

This is the critical reflection phase of the action research process. Our learning indicates that issues of friendship, connectedness, belonging and community are complex and subtle, and cannot be contained in a simple linear model.

The core of our learning argues, that in order for people who live with mental and emotional trauma to find a place to belong, we need to be building more welcoming communities. We need to be building more welcoming communities in our institutions, in our parishes, in our spirituality and in our hearts and homes. This section is divided into four parts and addresses each of these issues.

6.1 BUILDING WELCOMING SPACES IN OUR INSTITUTIONS AND SERVICES

"Hospitals should be places of care and not add to people's suffering." (Sally)

Many people who experience mental and emotional trauma frequently use psychiatric hospitals and mental health services. These services and institutions usually have vision to be places that promote growth, places of safety and security where treatment is given in a nurturing environment to promote healing. We affirm this vision and all those who labour to make it a reality. Unfortunately for many people their encounters with mental health services and institutions have left them feeling far from safe and secure, and they have not found these places to be nurturing and healing environments.

"Hospital life can sometimes restrict my growth. Sometimes it seems like I have not gained anything from being in here. It seems like my life has gone down hill. I feel like I am in prison. It can result in me feeling like my wings have been clipped, that I need controlling and confining, that I need to be different." (Issues Paper 1995:5).

One person said that the process of hospitalisation "is totally destructive" and another person described it as a "nightmare".

For Sally, "To go into a mental hospital is culture shock." Sally finds it overwhelming because there are so many different types of patients. In order to survive Sally believes that you need to be protective of yourself.

These types of experiences reinforce a person's sense of alienation rather than building a sense of connectedness and being valued. It seems that some very simple things could make a significant difference in the experience of people who use these services. A place to start may be the building of some welcoming spaces in our institutions and services.

We recognise the paradox that exists when we try to talk about community in the context of institutions. Institutions can deliver a service but cannot deliver care due to habits such as segregation, professionalisation and bureaucratisation (Andrews, 3-4). People who are patients in hospital sometimes talk about the sense of community that they have built with one another but it does not incorporate the staff. We have chosen not to talk about building welcoming 'communities' in our institutions and services but rather to talk about building welcoming 'spaces' in our institutions and services.

Some of our friends have mentioned that it is important to ensure that the experience of hospitalisation is not too welcoming because they may never want to leave. They have mentioned that sometimes while they are in hospital they do not want to leave because the thought of returning to their responsibilities and life back in the community seems too difficult.

It is important to recognise that our research has not included hearing the perspectives of staff. We acknowledge that we do not know what it is like for them to keep in touch with, and empower people who are patients.

How can we start to build welcoming spaces in our institutions and services? From our research and work some common themes emerged. These themes represent some very simple suggestions but we believe they could make a profound difference in peoples lives.

6.1.1 Institutionalisation and service often lead to isolation and losing contact with friends.

Can you help me keep in contact with people outside this service?

"I lost contact with all my friends. (Why?) Lack of motivation to keep in contact. Friends have own life to live." (Len has been in hospital for seven years.)

There are a number of barriers set up, between people who are part of a service or institution and people in the community, which inhibit the maintaining or developing of friendships. This is the case because people are surrounded by paid staff and others receiving the same services and are consequently "made into 'clients', 'service users', or 'program participants' " (Lutfiyya, 1988:3). Section 4.3 detailed more about these barriers.

Other than her family and other hospital patients Karen does not have many friends. She lost contact with her friends when she was sixteen. She began to get sick at that age and her family moved from the town that they were living in so as to be closer to treatment facilities. Karen says that it doesn't feel very good when you don't have many friends. What she would really like is to have some nice friends so that she could be free to drop around to their place for a chat or to go shopping with them.

Helping a person keep in contact with friends usually means doing simple little things like calling a person to the phone when someone rings to talk with them, rather than taking a message. People in hospital mentioned how taking messages tended to cut them off from people.

One woman expressed disappointment about not being invited to her sister's wedding or even being told about it until after the event. This isolation tends to have an accumulative effect. Once you have been left out of some experience, then the common experiences you share with others is decreased and so are the topics of conversations you can participate in. People are left with bigger and bigger gaps in their lives and experience.

Will you hear the plea from people? Can you help me keep in contact with people?

6.1.2 Institutionalisation and providing services can often lead to doing things on an impersonal and large scale.

Can you do things on a smaller more personal scale?

Going to hospital can be a scary experience for anyone. However for people whose vulnerabilities are heightened and who need to spend some time in a psychiatric hospital the experience can increase their trauma.

Can you imagine struggling with some unusual and frightening thoughts that keep bombarding your mind? The things in your head seem to be getting out of control. You feel you may be at risk of hurting yourself because what is going on in your head is pretty hard to live with. You seek a place you hope will be safe and healing. You admit yourself to hospital. As soon as you get in you want to get out because there are all these other people behaving in unusual ways and saying bizarre things. Tim went to hospital for two weeks. He says:

“it was terrible, it was like a nightmare. There were all these people letting their heads go ... The Doctors were cruising around giving you the third degree ... The doctors would cruise in like King Farouk and make their pronouncements from on high and then disappear for two to three days. Hospital was terrible. As soon as I got in I wanted to get out.”

Fortunately for Tim a second stay in hospital was better than his first. The ward rounds however were still daunting and frightening. This wasn't a friendly space and the style was authoritarian. “It was hardly the place to talk about much at all.”

6.1.3 Institutionalisation and providing services can mean not having time for people.

Can you make time for us?

In talking about a visit to a clinic one person said:

“Each time you go in they ask you the same set of questions. It's very regimental. The doctor does not look you in the eye. You can tell that he is busy. You feel like you are taking up his time and that he can't wait to get you out. There is no support there.”

Have you ever gone to use a service and had the distinct feeling that your presence was distracting the staff from something much more important, although you thought that the staff were actually there to serve people like you? You thought that this was actually their 'raison d'être'. We have heard of staff that spend more time in meetings than with the people the service was set up to serve.

Tim mentioned that when he was in hospital for the second time he had a nurse who seemed to be looking out for him each day. This person gave him space, was available, listened and helped him with practical suggestions. He also said:

“There was one doctor that was nice, and if he had time he could have been helpful.”

6.1.4 Institutionalisation and providing services can lead to disrespecting people.

Can you respect me and help develop my sense of dignity?

“I can talk but I may not be heard. I can make suggestions, but they may not be taken seriously. I can voice my thoughts, but they may be seen as delusions. I can recite experiences, but they may be interpreted as fantasies. To be a patient or even an ex-client is to be dismissed.” (Leete, 1988).

Some people have said that the attitudes of staff are some of the biggest barriers to healing they have to deal with in hospital.

“individual staff make or break a person. I have taken extra overdoses because of staff.”
(Rene)

We have heard about the incredible wounding that has occurred as a result of hospitalisation and stigmatisation. We have already heard how people in hospital have said that the process of hospitalisation is totally destructive.

Here are some of the reasons:

“They annihilated your sense of being you, a person. You just become a thing, a number or a set of symptoms. You’re given all these labels – ‘sick’, ‘manic-depressive’, ‘schizophrenic’. You carry the labels and tend to absorb them. The injury that the label has done stays with you, but you can grow through it.” (Mary)

People from the parishes also said that Professional mental health workers and services have often left them feeling as if they are of no value. One man said:

“My case worker doesn’t treat me like a human being. I’m treated like a file number or a statistic.” (Scott)

All that people are asking for is to be treated as a valuable human being. People have asked for little things like:

“Don’t yell at me across a room, come and speak to me as you would anyone you respected.”

6.1.5 Institutionalisation and providing services can keep you in a rut.

Can you make the time to learn from others?

Tim has found that places have different cultures and that some are more healing than others. It is important that staff in services and institutions take the time to learn how they can be doing a better job.

6.2 BUILDING WELCOMING COMMUNITIES IN OUR PARISHES

Moving from hospital into the community

The move from hospital into the community, so that people can establish themselves more independently and pursue a life-style of their choosing, is a significant but often taxing transition. For a number of people, part of the experience of mental and emotional trauma, including moving in and out of hospital, is a significant loss of contact with family and friends. For a person with almost no social contacts, the move from hospital can be a move to extreme social separateness, or what Uditsky has called “individual independent isolation” (Sherwin, 1995:11). Public policy that encourages the movement of people from hospital to community can significantly underestimate, or even remain naïve “about the capacity of the community to respond in the most helpful ways to people with disability, and about how best to enable community membership” (Sherwin, 1995:11).

One beginning point in considering how we might welcome people coming out of hospital into our parish communities is to consider for a moment what it might be like to be feeling personally vulnerable and to live isolated from contact with family and friends.

It is not enough for a person to be living in a house in a suburb. People need meaningful relationships with others in order to feel a part of the community. Community means social relationships, not social location.

“A year ago I moved into a housing commission unit ... I am not happy living on my own.” (Don)

We know of many people who are living in the community and who are connected to various services. They however, remain lonely, deprived of meaningful work and are forced to struggle with their mental and emotional trauma in the midst of unsupported environments. They are longing for ordinary relationships. Most people don't need more referrals to mental health services, they need referrals to life and community.

Our hope has been to find people in the parishes who would journey with a person who is moving out of hospital and help them find a sense of connectedness and belonging in the community.

Potential of the parish as one part of community

We are interested in the parish context because people do find meeting points in churches and friendships can develop. In addition, through churches people are exhorted to love their neighbour as themselves, and are taught that the first will be last and the last will be first (Mark 9:35).

It could be assumed that this would be a place where all people, no matter who they are or how different they appear, would find a welcome and a place of significance. However we are finding that some parish communities are really struggling to know how to welcome and include people (Anglicare Mental Health Project, 1995). We have learned that many people are not responding in helpful ways or with acceptance towards those who experience mental and emotional trauma. If parishes are to be considered as potential ports of call in finding a sense of welcome and friendship, it is important that we do not make the assumptions that these elements of community already exists. There is community building to be undertaken if the teachings and example of the Gospels are to become manifest.

Building parish as community

In order to build parishes where people who live with mental and emotional trauma can find welcome and a place to belong we are learning that we need to work in a number of different ways. The different dimensions of the framework outlined below are not meant to be seen as a linear movement where each section is progressed through one after the other. Rather one can enter at any point, and the sections interact on each other to varying degrees. Each parish is unique and has its own strengths and weaknesses. The dimensions of this framework will be relevant to each parish in a different way and can be applied at an individual, small group or parish level.

This framework outlines what we have been learning about how we can be building welcoming communities in our parishes. The dimensions explored are:

1. Reflecting
2. Welcoming
3. Making Commitments
4. Sharing Knowledge
5. Gathering
6. Challenging

6.2.1 Reflecting

Most of us lead very, very busy lives where we are continually reacting to the issues and demands that continually come across our paths. Not many of us are living in a way where we can respond from our centre to those things that are most important to us. (Nouwen, 1982:50). “We all must take the time to be silent and to contemplate, especially those who live in big cities ... where everything moves so fast.” (Mother Teresa, 1995:43).

If we are going to reach out to people who are seen to be different, and who have been devalued by society, we need to be acting in different ways. In order to act in different ways it is imperative that we take time to reflect. If we do not make time to reflect we will never have space in our lives for those who have been devalued. Taking time to reflect is important because often it is only in those silent places that insight and direction come. Reflecting needs to involve at least three processes: dreaming, examining our motivation and clarifying our values.

Dreaming

We need to have a dream. A dream of what we want our world to be like. If we don't have a dream we don't know what to do (Andrews, 1996:35). This dream is what guides how we live our lives.

“A sense of community such as I dream about – gentleness and respect for one another, stories of courage and respect and humour, hope for change in our society, opportunity to get to know people better.” (Pam).

The dream of Jean Vanier's, who engaged deeply with the life and teachings of Christ and with people who experience disabilities, helps us. He says:

*“The basis of true human life
is a rooting in the earth,
faithful relationships,
fidelity to those whom we are bonded to in love,
carrying one another's burdens,
sharing with them their joy and their pain.
It is compassion and forgiveness.
Small is truly beautiful*

*And it will be from there,
from fidelity and love
for those with whom we are called to love,
that we might be called to stand firm
against insolent might and power structures;
called also to the struggle
to help each person find
their rightful place in society
and the space in which to grow.
It will be from there that each of us,
according to our call and our gift,
will become an agent of change and of love
for the whole of society ...
We must create situations and communities
where each person
- especially the poorest and the weakest -
can attain human dignity,
find fulfilling work and the warmth of family life.
This is the vocation of us all:
to live real and loving relationships,
to be peace-makers,
creating and recreating the body of community.” (Vanier, 1988:138-139)*

We need to make time to dream and reflect on what it is that is really important to us. This inspires us and gives us energy for our involvements.

Examining our motivation

From the outset of our work concern was expressed about what would be people's motivation for involvement with someone living with mental and emotional trauma. Concern was expressed that parishioners' motivation for involvement may be negative.

"It is important to find the right kind of people from the parishes. They need to be natural and not try to rescue or judge people." (Harry)

It was suggested that people may do things to gain points for their faith and goodness, or to reinforce some sort of Messiah complex to be a saint or saviour.

"Parishioners need to understand that their role is not to solve problems, or to try and fix things." (Mac)

Concern was regularly expressed that parishioners may come with patronising attitudes of thinking they knew what was best for others. This attitude was affirmed by people living with mental and emotional trauma who, when indicating those things that were not helpful, mentioned people who were patronising, people who took control, and told them to pull up their socks. Our motivation for involvement needs to be examined.

Clarifying our values

It is from our values that our actions spring. Consequently it is important to clarify our guiding values and to ensure that we choose strategies which foster rather than offend our principles.

Some of the values that have been important for our work include:

- Processes being empowering for the person who was a mental illness;
- Mutuality, reciprocity and respect as a part of all relationships. All of humanity are people first, of equal value, each having a disability to some degree. (Hely 1996).

"Parishioners need to be encouraged to consider how they will benefit and what they will learn from their involvement with a person who has a mental illness." (Mac)

- There should be give and take in relationships and the diverse gifts of people recognised;
- All decisions are to result in positively enhancing the social value and wellbeing of the person who has a mental illness;
- Each person is to be treated as a unique individual;
- Decisions and opportunities affecting people's lives will be made with them;
- Communities grow healthier when new and different people are included.

"Do-gooders can do much harm. People who are vulnerable will withdraw."
(Parishioner)

Our reflection will lead to insight, humility and wisdom.

6.2.2 Welcoming

Picture for yourself a Sunday morning gathering at an Anglican parish. Kids are there, as are elderly people, families, and babies. Some come alone, some with others. Some are there for the quietness, reverence and solitude; some are there for the instruction and exhortation; some are there for an opportunity for confession and closeness to God. Who knows what there are all there for.

The one unifying factor amongst most of the people at worship is the liturgy – the form of the service. Everyone knows there is a form, a certain order to follow and the priest will call the congregation to follow through that progression. Everyone knows – that is, except one man.

During the service a man walked in and sat down. This man was not very well dressed and it was obvious that he did not regularly attend church. When the priest began giving the sermon the man began asking questions and talking. Fortunately the priest was quite comfortable with the interjections. Sometime during all of this one of the members of the congregation used his mobile phone to ring the police to have the man removed. The police arrived and escorted the man from the service. Another priest who was in the pews went outside and told the police that the man had not done anything that required his exclusion. The police indicated that if they did not take the man with them they would not return if phoned another time. The priest thought that there was no need for police involvement and invited the man to rejoin the worship service. The man said that he did not want to. The priest drove him home and stayed for a cup of tea.

The incredible sadness of this story comes from the fact that it illustrates how most of us want to respond when in similar situations. We want to remove the disturbance to the routine with which we are familiar and feel safe.

“One of our problems is that we tend to be homogenous. We tend not to attract people who are different. Our preoccupation with good order makes it uncomfortable for others who are different, and embarrassing for us, when someone comes in who is different.”

(Priest)

Jesus can come in the guise of a stranger: ‘I was a stranger and you welcomed me’. ‘The stranger is the person who is different ... To welcome is to make the stranger feel at home, at ease, and that means not exercising any judgement or preconceived ideas, but rather giving space to be. ... It is always a risk to welcome anyone and particularly the stranger. It is always disturbing.’ (Vanier 1989:266).

Unfortunately this story is highlighting a more widely spread problem. We have heard clergy mention how difficult they find it to enter a new parish. In our parish communities we regularly hear people talk about how difficult they find it to enter a new church. This gives us a bit of insight into how difficult it might be for those who are more vulnerable and seen as less valuable.

If we want to include in our parishes and communities people who live with mental and emotional trauma we need to be openly welcoming. Inclusion is about learning to live with one another and it means “inviting those who have been left out, in any way, to come in.” (Pearpoint et al 1993:1). We are learning that welcoming involves respecting, listening, creating safe spaces and empowering.

Respecting

Respecting means that we see people as human beings who are created in the image of God. This means that our response to people is not dependant on how they dress or behave. To really recognise individuals is to fully understand a person’s strengths. It is in this understanding of the fullness of our strengths that our uniqueness as humans comes out. We are suggesting that people are people first. They may also be people who have been labeled with a mental illness, but they are still people first with very similar needs, interests and desires as many of us. Therefore we need to embrace the person and journey with them. Issues to do with mental and emotional trauma are one aspect of their life and so need to be treated as such.

Listening

“People don’t want to listen, don’t want to hear. Why is that?” (Pam)

One recurring comment we heard from people from the parishes who experience mental and emotional trauma was about how other people do not want to know about the anguish and pain that they are living with. This included friends, family members and fellow parishioners. One woman said,

“If you have a mental problem people run in the opposite direction.” After attempting to suicide another woman said, *“My friends did not talk with me about what had happened ... and now a year later still nobody has talked with me about what happened and why I did it.”*

“Once I learned to listen I was able to heal myself better.” (Steven)

Creating Safe Spaces

“There was a closeness and trust for people to express themselves and their problems.”
(Parishioner)

Scott Peck talks about safe places being places where we are free to be ourselves, to be open and vulnerable and accepted. Where people won't be trying to 'heal and convert' one another, and yet because we are safe we will tend to heal and convert ourselves.

“I didn't have support because I didn't tell anyone ... Three years ago I did Cursillo and blurted out what was going on because I felt like it was a caring place. From this time on people always inquired after me. I had a network. I felt free to say things ... and I would know that I would be listened to and believed.” (Parishioner)

Empowering

People who use mental health services are taught and encouraged by the mental health system as well as the other people around them, to feel incapable of making basic decisions about their own lives. This creates a kind of learned helplessness (Deegan, 1992;12. Ridgeway, 1986). Deegan (1992:13) argues that the effects of learned helplessness can be more damaging than the original illness.

The “antidote” to learned helplessness is choice. This means taking back power and learning to take control over our own lives. What people say they want has been proven to be effective in programs designed to help them.

“Everyone is an individual. It is important to find out what people want to do, and to help them go along the path they choose.” (Issues paper, 1995:12, Jan.)

We are not suggesting that a program be set up to respond to people – for none of us wants to be welcomed by a program – the welcome needs to come from people's hearts (see section 6.4 – Building Welcoming Communities in our Hearts and Homes). We don't need a program response we need a personal response. A program response can hinder a personal response because people think 'it's not my job, someone else has that job'. We don't want to just be the recipients of 'charity'. Some people have suggested that we need to develop a mental health support group into which people can be channeled. As will be mentioned in the next section many people do find support groups essential for their wellbeing. However for people to be welcomed into the life of the community they need to be invited into whatever activities there are that they are interested in. This involves embracing people, walking with people and learning from them. It assumes a mutual and respectful relationship.

6.2.3 Making Commitments

In our attempts to walk with people there have been a few things that we have found helpful, and have found that other people have wanted. They include loving unconditionally, clarifying expectations, joining with others and building bridges.

Loving unconditionally

What people seemed to find helpful and wanted most was people who would just be there for them in the midst of their struggles, people who would listen to them and accept them as they are.

A PLACE TO BELONG

“What was helpful for me was a group of ordinary women – people who understood the shit you felt when you didn’t get out of bed. They don’t say ‘you should get better’. They let you say the same thing over and over again – one hundred times if you have to.” (Karen)

Another said,

“The best way to help people is to forget the labels, to take an approach like Jesus would take. Just be there for people, being good Christian people and doing ordinary, everyday things.” (Mary)

A deep commitment to the person is needed.

“Sometimes it is in the middle of the night or during holiday times when the ‘demons’ come out.” (Louise)

When Mother Teresa talks about her ministry of loving and serving the poor in Calcutta, she says that “it is simple but not easy.” It is not easy because it involves a sharing of the suffering the other lives with. (Vardey, 1995:32)

“I don’t have the resources within myself – you have to have God’s love.” (Tom)

Clarifying expectations

“...there needs to be disclosure from both sides. For example, the person with a mental illness needs to be able to say, here is a range of things that are possible, how flexible are you and what are you prepared to give? ...need to clearly set boundaries and limits.” (Harry)

“There needs to be a statement of the rights and the responsibilities in relationships.” (Parishioner)

Joining with others

“Can’t do anything unless there is a team ... You have to have a committed group of people.” (Tom)

People from the parishes have raised some concerns about whether it is really feasible to journey with someone who lives with mental and emotional trauma. Questions were raised about whether parishioners could cope with welcoming someone because they believed that it could be difficult and exhausting. People were concerned about burnout and becoming overwhelmed. Because it may not be easy we have come to believe that it is important to join with others who are willing to journey with this person. The person involved can be supported knowing there are others involved. The person who is living with mental and emotional trauma is supported by having others who are willing to work with them on the things that they want.

“I see that I need the support of this group in the short term. But it is like we are grappling in the mist.” (Don)

Building bridges

“One of the things I dream about when I think about leaving hospital and living in the community is find a friend, a proper kind of friend, someone who does not use me. Someone who just wants to be with me and wants me to be their friend.” (Sarah)

Most people are aware of how difficult it is to maintain friendships, and how even more difficult it is to make new friends. For people with disabilities who are segregated in institutions or isolated in the community, it is even more difficult. When people have been consistently kept out of their communities, what they need are people who can build bridges to help make connections in the community. Building bridges is about linking individuals with people and places in their community so that they may find “*a proper kind of friend*”. A Bridge Builder provides entry into a wide array of ordinary, every day contacts who know you and know your name. (Mount et al, 1988).

6.2.4 Sharing Knowledge

Welcoming and making commitments will not occur unless people’s attitudes are changed. One way of changing attitudes is by sharing knowledge. This needs to occur on a number of different levels and needs to deal with many different issues. We will look at story telling, de-stigmatising ‘mental illness’, acknowledging fears, and modelling.

Story telling

Telling stories can serve as a “basis for understanding, building community, personal transformation and political action.” (Shields, 1991:45). As we told our stories and listened to others a transformation began to occur. Barriers of ignorance, fear and prejudice began to be replaced with a recognition of our common brokenness and the development of more mutual relationships. One woman initially made contact with this work in her role as a mental health worker. Later she decided to change roles and spoke in a session on “recovery” about her journey through anguish. She was not only valued for her contribution but she herself felt liberated to become much more wholeheartedly involved in this work.

De-stigmatising mental illness

“It’s hard to know what to say when people are chatting with you and they ask the normal conversational questions like: Where do you live? How long have you lived there? What do you do? These questions are hard to answer when you have been in hospital for a long time. Being in a psychiatric hospital has a bad stigma to it and when you tell people that you have come out of hospital they tend to shy off from you.”

“We have been subject to the messages which socialise us into believing the false assumptions about people with disabilities and the stereotypes.” (Jane Sherwin, CRUcial Times, 1995:9). Stigma penetrates every aspect of a person’s life and can be worse than the experience of mental and emotional trauma. “There is not only a personal distress to overcome when recovering from social disease, there is the stigma which one can never truly overcome.” (Meagher, 1990:47). Sally talked about a time when she was in a psychiatric hospital and she was given a card signed by people from her church. She was touched by their concern until her friend who gave her the card told her that people from church had only been told she was in hospital, not that she was in a psychiatric hospital. Sally gets angry that people feel that this needs to be hidden. She feels that she needs to live two separate lives.

Stigma is a powerful blockage to inclusion.

“The biggest hurdle is to de-stigmatise mental illness within the parish. Once you have done this you will not need a friendship program.” (Issues paper, 1995:11).

Acknowledging fears

Owen Strong the project leader said: “When we as a society are frightened by something we shrink away, we are diminished as persons. Some people are frightened by people with a mental illness, some are not sure how to respond or how to talk with someone, some simply avoid them. When this happens, people fail to grow and individually and collectively we are the poorer for doing so. We are inviting people to establish meaningful relationships – and not to avoid each other. We are inviting people to take considerable risks. We are asking people to diversify their groups of friends and associates and hence to enrich their life and faith experience.” (Belonging Newsletter No. 2).

Fear of mental and emotional trauma and the fear that people coming from hospital might disrupt “good” church order and behave “inappropriately” has inhibited people’s involvement. Forest and Pearpoint (1993:11) argue that there are three fears that inhibit inclusion: fear of the unknown, fear of losing control and sharing power with others, and fear of change – wanting to maintain the status quo. These fears need to be brought out into the open in order to be dealt with.

Modelling

We need the example of others to help spur us on and show us what it is possible to do. We also need to provide this model for others. “The hard task of building a better world doesn’t begin with changing others, but with changing ourselves. If we can make some changes in our own lives, it not only makes it easier for us to believe that we can change, it also makes it easier for others to believe they can change too.” (Andrews, 1996:44).

This project saw one of its aims as to model inclusion at all levels of project activity. As we ran activities where “... I couldn’t tell who was a consumer, who was a carer, who was a hospital patient, who was a priest ...” (Chenoweth, 1997), we sensed that important changes were occurring in mind-set. At a retreat we organised, some of the most sensitive and inciteful comments were made by a man who is a long stay hospital patient. At this retreat the line between the person “with mental illness” and the person “without”; the line between the person in hospital and the person outside of hospital; the line between the “struggling” and the “secure” – all these lines became a little more blurry ... and this is something of what modeling inclusion is about. It is important, we believe, for individuals, groups, parishes and movements such as ours to begin to make the subtle but significant changes that are necessary to begin raising hopes that, indeed, inclusion can work.

6.2.5 Gathering

It is difficult to bring about change in an organisation that is used to operating in particular ways. Therefore it is important to find other like minded people because together we can do more than if alone. Gathering involves networking and leading.

Networking

We need to find others who share a common vision with whom we can work. Joining with others helps to sustain and encourage us. We also need to be apart of a broader social movement to help find encouragement and training. The most effective and ongoing work that we have observes in parishes occurs where a number of people meet or support each other in initiatives taken – even if their meeting is simple to pool their ignorance! The places where initiatives are hardest to get off the ground is where individuals have been unable to find allies in their vision.

Leading

Since providing a welcome space for the stranger and for those who are seen to be different is not something that happens naturally we need leadership to help facilitate it occurring.

“To make sure it happens you need people who have ‘energy’ or ‘oomph’.” (Sally).

This means someone needs to put in energy to locate others, maybe to be a bit ‘public’ in the parish or ‘known’ for their vision, and willing to lead by working hard.

6.2.6 Challenging

In working at building more welcoming communities in our parishes it is likely that at some stage we will need to challenge the way things are, or the way things are done. This may need to involve analysing and working on the edge.

Analysing

It may be helpful to make a critique of what is happening in one's parish in order to gain some understanding of the structures, forms or processes that may inhibit people feeling welcomed and included. A simple model such as the one described in "Community" in section 4.4, gives a starting point for analysis. A church may identify more with a "professional/bureaucratic" mindset than with an "associational" mindset. That is, there may be a primary concern for order, for clerical control, for hierarchy and for offering programs. Someone may be wanting to generate natural, informal supports in this context. It will be to their advantage to carry out a simple analysis such as this to work out strategies that may be more appropriate or have more of a chance to work effectively, for example working more 'on the edge' so the initiative will have less likelihood of being controlled and questioned.

Working on the edge

Many of the people who are welcoming or wanting to learn to welcome others are people who have come from the fringes of the parishes. They are people who are wounded and on the margins. They are also people who feel isolated and unsupported as they seek to care for loved ones. They are people who have felt some sense of rejection or isolation because of this lack of support. This has developed into something quite dynamic and has been showing us a way forward. Andrews (1996:151) believes that more free space can be found on the sidelines of an organisation than virtually anywhere else. So when he is thinking about trying to bring about change he looks for those places that are on the edge, but in the middle, just inside or outside of an organisation where he can be involved – rather than in the centre or at the top.

6.3 BUILDING WELCOMING COMMUNITIES IN OUR SPIRITUALITY

"I had to leave church to find healing. They told me I was bad." (Nancy)

Rene mentioned how when she was in hospital she and her family received hardly any support from people in her church. When she went back to church they were singing 'brother let me be your servant'. The hypocrisy drove Rene from the church.

In hearing these stories we recognised that something was not right. This is not how things ought to be. We were hearing from people, some of whom were leaders in their churches, that when they were at their most vulnerable place they felt they needed to leave the church to find healing. Church was not a welcoming, safe or healing place.

"To work with people who are very vulnerable churches need to have a great understanding of spirituality." (Sue).

Jesus said, "Come to me all you who are weary and burdened and I will give you rest ... My yoke is easy and my burden is light." People who are living with mental and emotional trauma have an experience of church that has often increased the weight of their burden and caused painful unrest.

What does this mean for our churches? We believe that it means that our spirituality, and the actions that come out of these, continually need to be re-examined in light of our growing understanding of the teachings of Christ. We have often been reminded that our spirituality can be rejecting rather than welcoming.

How then can we develop more welcoming communities with our spirituality? Here are some examples of elements of our theological thinking that has be reframed in ways that will be more welcoming and fit better with our understanding of the life and teaching of Jesus. How we think about God (or 'do theology') shapes our spiritual life or spirituality.

6.3.1 Good news

Christ came to give life and life in all its fullness – this is meant to be good news for people who experience lack of life and especially for those excluded form life in the community (Luke 4:18). After visiting a church one man thanked God that he wasn't associated with people from that church because he said that a person coming out of hospital to this church would be very damaged. This is not 'good news'.

6.3.2 What it means to be human

From Genesis one and two, we see that all people share a common humanity. God declared all creation as good. All people with their frailties, brokenness and limitations are God's image bearers. With the fall this image has been tarnished. None of us can claim to be without faults and frailties.

6.3.3 Hope

We live in a tainted world where it is easy for evil to rule and for us to feel hopeless. A theology of hope is related to two things. First is the notion that there is goodness in people's hearts. Second is the recognition that God is present and can make a difference in a situation.

6.3.4 Community

God is God in community of Creator, Redeemer and Sanctifier. To reflect the God of community it is important for people to be together. Acceptance of diversity is needed for there to be real community.

6.3.5 The upside down kingdom

Kingdom thinking considers those who are seen to be last, to be first. This means including and honouring those that society dishonours and devalues. Jesus teaches us that what we do to the least, we do to him (Matthew 25:40). Jesus showed love and extended hospitality to the most broken, suffering and rejected people.

We need to see the gift of those who are seen to be the least. We need to see the gift of the stone the builders rejected and see how this can become the cornerstone of what we do. We need to reflect on how those who are rejected by society can show us the way forward, rather than joining in with the crowd and rejecting them as well.

6.3.6 Leadership

“The laity do not cope with the intensity of people’s problems ...” (Priest).

Clergy are powerful gate keepers and need to use this power to empower the parishioners rather than to control them. There needs to be a theology of leadership that enables people to move towards their dreams rather than telling people what their dreams should be.

“I told the minister that support was needed, but he didn’t do anything about it.”
(Parishioner).

6.3.7 Servanthood

We live in a society that values upward mobility. Servanthood involves giving up the drive for security, status and privilege of position. It involves emptying ourselves of our own concerns and allowing others concerns to fill our lives. (Philippians 2:6-7).

“We need to be challenged to be less self centred and more others centred.”
(Parishioner).

6.3.8 Love

We are called to love our neighbour as ourselves. A theology of love calls us to move from our comfort zones and to consider others we would otherwise ignore. A theology of love means laying down one’s life for one’s friend. (John 15:13). Rarely do we find encouragement to love in a way that involves sacrificially giving of ourselves to others.

“For myself in the parish I find comments such as ‘you do too much for him’ – or ‘you need to withdraw’ very lacking in any understanding.” (Pam, a carer).

6.3.9 Ordinairiness

“We need churches that will accept you, knowing that you are struggling and not happy all the time.” (Rene, church leader).

Christ was acquainted with the ordinariness of life – with the pain and tragedy of life. He was not always happy as he walked the treacherous road to Jerusalem.

6.3.10 Little Things

A theology of the little things, like mustard seeds, recognises that the seemingly little things may be very significant. People saying hello at church helped one man feel like he had friends.

When we have reframed some of our theologies maybe this priest’s vision will become reality.

“I would like to see if our churches could become places where people could come for holistic healing.”

6.4 DEVELOPING WELCOMING COMMUNITIES IN OUR HEARTS AND HOMES

“To welcome is one of the signs of true human and Christian maturity. It is not only to open one’s door and one’s home to someone. It is to give space to someone in one’s heart.” (Vanier, 1989:265).

What will it take for people who have been excluded from our communities to find a sense of belonging and a welcoming space. History has shown us that it will not happen through legislation, deinstitutionalisation or education. People who have been long stage patients in hospital have questioned the community’s capacity to welcome them. One person in hospital said:

It seems that there are less and less people who have time and energy to help people like us. (Issues paper No. 1, 1995:6).

We have also learnt as a result of our work over the past two years that it is not something that will easily happen even with a lot of hard work.

Burton Blatt (Gardner, 1977:91) argued twenty years ago that nothing will change unless we each change.

“My thesis is that society will not eradicate institutional back wards, will not guarantee human rights...or reduce inhumanity...by tearing down back wards. If humanity is to survive...what must we change? Where shall we do battle? Who are the people responsible? You are the only person and I am the only person responsible and accountable. If you do not change, all is lost. And if I do not change, nothing will change. If I blame an evil world, a stupid system, blind leaders, or peoples’ obvious imperfections, I may be right. But if it means I do not have to change, I contribute to this evil.”

To develop welcoming communities in our hearts and homes we need a continual conversion. “The Christian gospel calls people to a renewed, holistic spirituality in the face of today’s life-threatening forces, particularly towards the marginalised in society...” (Hely, 1996:3). Our hearts need to be rebuilt in a fashion that reflects healthy values rather than society’s values. We each need a radical turning about in our attitudes, values and lifestyles.

6.4.1 Attitudes

To welcome is not something that just happens when people come to visit. It is an attitude. It is an attitude that is expressed in a constant openness of the heart. It is saying to people every day and at every moment of the day, ‘come in’. It is giving people space. It is listening to them attentively (Vanier, 1989:267). People who experience mental and emotional trauma often do not find this attitude of welcome.

“If I had a broken leg or cancer I’d be on the receiving end of compassion. When I had my breakdown and the need was greatest, others weren’t there. The sympathy for people with cancer is assumed – but the sympathy for people with a mental illness is not there – and they should be the same.” (Liz).

When we open our hearts and welcome people transformation may occur as it has for this woman.

“Mental illness has meant a loss of dignity, the loss of friends and family, the loss of self, the loss of identity, and I have been fragmented by the way that people treat me and the times I had in hospital. This is the first time I had the chance to join with other women having lost my identity. This group of women helped redefine who I am as a woman in society. This is the first time in years and years that I have felt more positive – not as bad as I thought I was – I am a real person.” (Mary).

6.4.2 Values

When we live with a radically different vision of people who have been devalued, this often means coming into contradiction with the values and dynamics of the prevailing culture. We discover the work involves a deep and continuous letting go. It involves a letting go of the security of approval, of life in the fast lane. This kind of work requires a descending focus, which is difficult, indeed, in a culture obsessed with ascendancy and power. Some speak about how this will require “unreasonable commitments”, others talk about “the broken body”, and others of the requirement to overcome deeply rooted fears (Wetherow, 1992:55).

Our values cause us to question what are the most important things in life. We suggest that our lives need a reorientation so that we can wholeheartedly agree with the Maori proverb:

Ask me what is most important in the world
Let me tell you
It is people! It is people! It is people!

6.4.3 Lifestyles

“Community living and community inclusion cannot work unless people commit to living their lives in relationship with vulnerable people.” (Cross in Crucial Times, 1995). Not having time and being fearful inhibit this occurring.

It is difficult to share your life with others when we seem obsessed with living life at a frantic pace. One parishioner admitted that a “big stumbling block was having the time to do it”, and another said “everybody is so busy – you can’t find anyone.”

One parishioner said that his “biggest worry is the safety of the children because you hear that people are violent.” When we are daily bombarded with explicit details of murders, break-ins, rapes and all sorts of violent acts it is easy to understand why people withdraw and build protective walls around themselves. We need to work at not allowing these fears to dominate how we live our lives. We need to become more open if we are to welcome people into our hearts and lives.

6.5 CONCLUSION

In Section 6 we have brought out the major themes that have come from our research. This section looked at what we have learnt about how people might find a place to belong. We have argued that for people to find a place to belong we need to be building welcoming communities in our institutions, in our parishes, in our spirituality and in our hearts and homes. In Section 7 we will make recommendation to the Government and to the Church about what we believe they need to do in order to assist people finding connections and a sense of belonging in the community.

*I am a child of God
He will cherish me
He will hold me to his bosom
in the bad times
and rejoice with me
when my cup is full*

– Catherine Mason

SECTION 7

RECOMMENDATIONS FOR THE FUTURE

7.1 RECOMMENDATIONS FOR THE CHURCH

It is recommended that parishes:

- a) Examine themselves by making a critique of their structures, forms and processes that may inhibit people feeling welcomed and included.
- b) Consider making a study of Jesus' ministry among people who were marginalised and opposed and explore the giftedness of these people.
- c) Make time within and outside of worship to listen to the stories of people who have experienced mental and emotional trauma.
- d) Encourage people to welcome strangers and those who appear different as if they were welcoming Jesus.
- e) Seek to welcome people who live with mental and emotional trauma into their fellowship and explore the establishment of a small group of people willing to do that.
- f) Explore ways in which they could be bridge builders, helping to link individuals with people and places in their community so that they may find friends.

7.2 RECOMMENDATIONS FOR GOVERNMENT

People who have been institutionalised, marginalised or devalued by our community find it extremely difficult to find a sense of belonging and inclusion. It is therefore recommended that:

- a) Government funding is made available to fund organisations undertaking community inclusion work.
- b) Such funding decisions are made on the basis of compassion and justice as well as on the basis of economics.
- c) Greater resources be provided to community-based organisations which are strategically placed to facilitate inclusive community for marginalised people
- d) Innovative grants are made available for the development of accommodation and treatment options to augment current hospital based clinical settings.

CONCLUSION

We have found ourselves confronted by the work of this project. The messages that have emerged from people's stories are confronting to us, confronting to the church, confronting to our systems and services and confronting to our community. Our focus has often been just as much on "community illness" as on "mental illness". As one man said to us, "People think that I am mad but when I see how people drive on the roads I wonder if they are mad too!"

We hope that one day there will be as much research done into developing healing communities as there will be done into developing healing medications. We have heard that acceptance and personal, ordinary, informal responses are critical to people's healing and recovery. As we have listened to people's stories we have heard that a dominant role is often played by those who refuse to treat the person as a patient, a label, or a psychiatric case.

We have also heard that we need a reawakening in our vision for community. Our communities are often not responding in helpful ways to people who live with mental and emotional trauma. Many are stressed, to busy, intolerant, uninvolved and too frightened. Our communities are often very disabled in their responses. The same is often true of churches.

We have been encouraged to see that it is possible to gather people who want to nurture a vision for something better. Inclusive community can be modeled by groups and churches. With encouragement, support and modeling, people who genuinely do want something better can learn and begin to make more effective responses. It seems evident to us that the church is poised at a strategic and critical point. The church can become a model, a trendsetter. It can begin providing a glimpse of something better to a community which places mental health in the 'too-hard basket' and which often leaves mental health work to the service providers.

We sense that subtle but significant changes need to occur. There needs to be movement: from seeing others as patients to seeing them as people; from labeling people to loving them; from seeing others as *problems* to seeing them as *prophets*; from seeing others as broken to recognizing our common brokenness; from giving *things* to people to giving *ourselves* and from doing things *for* people to doing them *with* people. The attitudes we hold towards others and the ways we treat others mean we can be agents of healing or of continued oppression. Better policies will help, better mental health services are essential too ... but a critical foundation will be building welcoming communities.

Let's hold the vision!

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APPENDIX 1. RESOURCES

A number of papers and user-friendly handouts have been developed and disseminated during the period of this project. Some of these along with other helpful articles are listed below and are available on request.

Handouts

How do we know when we are ready? – questions for a person or group who are considering involvement with a person coming from hospital

Recovery – notes from a talk and discussion by Irene Oliver at the Anglican Mental Health Project retreat in September 1996

Being catalysts for change – notes about theology and practice for introducing change in parishes and organisations

Guidelines for providing natural support – eight points summarizing some central values of this project

The impact of language and labeling – notes about the significance of language and how we can choose appropriate terms

How to help people when they are struggling – notes from a morning tea discussion by some women about what they find helpful

Processes are very important – adaptation of an article by Hawken

Housing models – a shift in thinking – compares two models of housing for people with disabilities

The Strengths Perspective – notes from a talk by Charles Rapp

Recovery – what does it mean? – adaptation of an article by P Deegan

Belonging in the community – notes about inclusion

Papers

Connecting – a literature review about the importance of bridge building and significant ways of building community through connecting people in.

The role of parishioners – a literature review and discussion about the kinds of roles people can adopt in welcoming others to their area

Empowerment – a discussion and literature review

Finding a place to belong – Paper presented at the Mental Health Services Conference in Brisbane, 1996.

Reports

Anglicare Mental Health Project. 1995. *Finding A Place Together: A Review of How Anglican Parishes in the Diocese of Brisbane are Responding to People with Mental Illness*. August. Unpublished.

Chenoweth, L. 1997. *Anglicare Community Mental Health Project Evaluation: Final Report*. January. Unpublished.

Newsletter

Belonging – a bimonthly newsletter to connect people interested in this work. (Contact project workers if you want to be on the mailing list.)

Kits

Some user-friendly discussion guides for groups or individuals have been developed. These are useful for helping people reflect on and apply some of the primary learnings from this project. The kits are available from the project team.