

Promoting Recovery and Facilitating Social Inclusion: A Strategy for Practice and Implementation Plan

The Purpose of South West London and St George's Mental Health Trust

The primary purpose of the Trust is to promote recovery and facilitate inclusion: together these form the principles guiding the range of treatment and support we provide to all those using our services.

“The Trust recognises that everyone with mental health problems faces the challenge of retaining or recovering a life that is meaningful, satisfying and valued as possible.

The purpose of the Trust is to help people with mental health problems to do the things they want to do, live the lives they want to live and access those opportunities that all citizens should take for granted.¹”

The purpose of the present strategy is to articulate this vision. It provides a framework via which the trust can facilitate the recovery of those whom we serve in order to enable them to do the things they want to do, live the lives they want to lead and access those opportunities that they value.

As well as describing a strategy for translating vision into practice, this document provides an overview of what we mean by recovery and the principles underpinning it, a description of the policy context and gaps in current service and an overview of the ways in which the strategy will be implemented.

What We Mean by Recovery and Social Inclusion

“Recovery refers to the lived or real life experience of people as they accept and overcome the challenge of the disability ... they experience themselves as recovering a new sense of self and of purpose within and beyond the limits of the disability.”²

“... a deeply personal, unique process of changing one's attitudes, values, feelings goals, skills, and/or roles. It is a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.”³

¹ Trust Strategic Plan

² Deegan, P. (1988) Recovery: The lived experience of rehabilitation, *Psychosocial Rehabilitation Journal*, 11(4) 11-19.

³ Anthony, W.A. (1993) Recovery from mental illness: The guiding vision of the mental health system in the 1990s, *Innovations and Research*, 2(3), 17-24.

Everyone who experiences mental health or related problems faces the challenge of recovery: the challenge of rebuilding, or where possible retaining, a valued and satisfying life.

Too often, such problems separate a person from the communities that they inhabit – a separation made worse for those who may also experience exclusion as a consequence of their age, ethnicity, physical impairments and/or learning disabilities, gender, religion/belief and/or sexuality.

In former times - for children, those in their middle years and older people alike - this separation involved physical segregation in remote asylums. With the demise of such institutions, many, perhaps naively, hoped that such social exclusion would be a thing of the past – sadly this was not to be.

“Though a simple aspiration for most people socially isolated by mental illness, the sense of belonging to a community with all that this can imply for mutuality and participation remains stubbornly illusive in spite of community care.”⁴

In his foreword to *Valuing People*⁵ (DoH, 2001), the Prime Minister makes similar observations. Despite the closure of large institutions too many people with learning disabilities

“... find themselves pushed to the margins of our society. Almost all encounter prejudice, bullying, insensitive treatment and discrimination [that leads to] your world becoming smaller, opportunities more limited, a withdrawal from wider society ...”

The prejudice and discrimination that constructed the walls of the asylums continue to form as big a barrier to participation in community life. This social exclusion severely impedes recovery: it is not possible to rebuild a satisfying and valued life if everywhere you turn you are debarred from those opportunities that give your life meaning.

This relationship between recovery and social inclusion is reinforced in the National Director for Mental Health’s 2007 report⁶ outlining the next phase in reform of mental health services. In this report he emphasises the importance of

“... re-defining recovery to incorporate quality of life – a job, a decent place to live, friends and a social life.”

Traditionally, the primary aim of mental health services has been ‘cure’: interventions designed to change the individual so that they ‘fit in’ by reducing their symptoms and their attendant deficits and dysfunctions. The success of mental health services has been judged in terms of the extent to which they have been able to do this and so discharge people from their care.

⁴ Morris, D. (2001) Citizenship and community in mental health: A joint national programme for social inclusion and community partnership, *The Mental Health Review*, 6, 21-24.

⁵ Department of Health (2001) *Valuing people. A new strategy for learning disability services in the 21st century*, London: DoH

⁶ Department of Health (2007) *Breaking Down Barriers. Clinical Case for Change. Report by Louis Appleby, national Director for Mental Health*, London: DoH

Evidence based interventions designed to minimise distressing and disabling symptoms are critical, but symptom reduction is neither a necessary, nor a sufficient condition for recovery.

“One of the biggest lessons I have had to accept is that recovery is not the same thing as being cured. After 21 years of living with this thing it still hasn’t gone away.”⁷

For some people, symptoms may continue or recur from time to time but this does not preclude the possibility of recovering a meaningful and valued life. For those whose problems are likely to progressively worsen over time (as with, for example, dementia) this does not preclude the possibility of helping the person to live as meaningful and valued a life as possible for as long as possible and to celebrate what they have achieved in their life.

Recovery and inclusion are not contingent on the removal of symptoms, but they do require that we move beyond a sole focus on changing the individual and consider ways in which we can change the world: increase the capacity of communities to accommodate people of all ages who have mental health and related problems by providing the support and adjustments that they need to do the things they want to do in so far as is possible.

Neither does the elimination of symptoms guarantee recovery. Prejudice and discrimination extend beyond the presence of symptoms. People may be excluded because of a history of mental health and related problems. While treatments to reduce distressing and debilitating symptoms are important, they are only a part of a person’s recovery journey. Rebuilding a meaningful and valued life requires more than the treatment of symptoms. Recovery does not mean that all symptoms have been removed, or that functioning has been fully restored. Instead, it is about minimising the extent to which remaining problems interfere with the person’s ability to pursue their interests and goals.

Recovery requires that we move beyond ‘cure’ to thinking about how we can help people to make the most of their lives. If we are to do this then we must put the individual at centre stage: think not about ‘the patient in our services’ but instead about ‘the person in their life’ and the impact – for good or ill – that services have their journey through this life.

Traditionally, mental health services tend to consider a person’s needs in terms of the types of service and treatment they are deemed to require: medication, inpatient care, outreach services, cognitive behaviour therapy, sheltered accommodation, occupational therapy, medication ...

This is not the best place to start.

We cannot provide appropriate supports and interventions unless we understand the nature of the challenge that they face and those things that give meaning and value

⁷ Deegan, P. (1993) Recovering our sense of value after being labeled, *Journal of Psychosocial Nursing*, 31(4), 7-11.

to the life of each individual. Only then is it possible to consider how we might help them in their individual journey of recovery.

Having mental health problems or related problems is a devastating and life changing experience.

“When I was diagnosed I felt this is the end of my life. It was a thing to isolate me from other human beings. I felt I was not viable ... I felt flawed. Defective.”⁸

You have to cope with strange and often frightening experiences. Perhaps you find yourself unable to think properly. Perhaps those ordinary, everyday things that you always did without thinking seem impossibly difficult. Perhaps you have experiences that no one around you believes or understands.

Your confidence and self-belief hit rock bottom. You feel very, very alone and very, very frightened - not only about what is happening to you, but also about the prospect of using mental health services. Everyone knows what it is like to go to his or her GP or enter a general hospital (whether as patient or visitor). But for most people, psychiatric services remain sinister places cloaked in mystery and images of ‘Bedlam’ abound.

“All I knew were the stereotypes I had seen on television or in the movies. To me, mental illness meant Dr Jekyll and Mr Hyde, psychopathic serial killers, loony bins, morons, schizos, fruitcakes, nuts, straightjackets, and raving lunatics. They were all I knew about mental illness and what terrified me was that professionals were saying I was one of them.”⁹

You are surrounded by people who think you will never amount to very much – views that are too often reinforced by the negative attitudes and prognoses of professionals: ‘You have a chronic illness’, ‘You will not be able to work, have children, live independently ...’.

Unthinkable things may happen to you - like being picked up by the police, detained against your will, forcibly medicated – all of which reinforce the frightening stereotypes of madness. And on top of all this, you experience the prejudice and discrimination that, in our society, go hand in hand with mental health problems.

People start treating you differently: as if you are stupid, or dangerous, or both. They start talking about you, rather than to you: ‘Is she all right?’ ‘Is she taking her tablets?’. They behave towards you as if they are walking on egg-shells, fearful lest you dissolve into tears or explode into anger at the slightest provocation.

You risk losing everything that matters to you: your job, college place, friends, even your home and family.

“Out of the blue your job has gone, with it any financial security you may have had. At a stroke, you have no purpose in life, and no contact with other people. You find yourself totally isolated from the rest of the world. No one

⁸ Sayce, L. (2000) *From Psychiatric Patient to Citizen. Overcoming Discrimination and Social Exclusion*, London: MacMillan.

⁹ Deegan, P. (1993) Recovering our sense of value after being labeled, *Journal of Psychosocial Nursing*, 31(4), 7-11.

*telephones you. Much less writes. No-one seems to care if you're alive or dead.*¹⁰

To be diagnosed as having mental health problems constitutes a bereavement: loss of the life you had or expected to lead; loss of the person you thought you were or might become; and loss of the privileges of sanity – being regarded as a valued citizen. The bereavement associated with dementia involves many similar experiences and is at least, if not more, devastating.

Mental health problems have a profound impact not only on the life of the person who experiences them, but also on their family, carers and friends. The terrible strain and worry occasioned by seeing someone you love become distressed and disturbed, of feeling unsure what to do for the best, should never be underestimated. It is important to recognise that mental health problems, and other related difficulties like dementia, constitute a devastating and life-changing experience for families/carers, friends and others who are important to the person.

“What has it been like for us these past 10 years? I will begin with what has always been most painful for me – those feelings of loss, grief, mourning ... the loss of the son I once had, because in many ways he is quite different ... There is also the terrible loss of our expectations. We feel cheated of watching him mature and flower the way adults do as they grow into adults ... There is also the loss of some kind of emotional connectedness that is a consequence of some of the negative symptoms ... There is also some inner sense of shame and humiliation that I occasionally feel.”¹¹

Relatives, friends and carers grieve the loss of the person they knew, the expectations they had of that person, the relationship they shared and often find their own social life, contacts and opportunities severely restricted.

Many people with mental health problems have lost all that they value in life, but they are also at greater risk of losing their lives, both through suicide and at the hands of heart disease, respiratory disease, stroke, hypertension, diabetes, bowel cancer and breast cancer. People with serious mental health problems are not only more likely to contract such diseases but also to get them at a younger age and die of them faster resulting in a life expectancy some ten years less than that of people without such difficulties¹². Similarly, the physical health problems associated with substance misuse and learning disabilities are a matter of grave concern.

Too often people are left feeling disconnected from themselves, from friends and family, from the communities in which they live, and from meaning and purpose in life.

¹⁰ Bird, L. (2001) Poverty, social exclusion and mental health: A survey of people's personal experiences, *A Life in the Day*, 5, 3.

¹¹ Willick, M. (1992) Schizophrenia. A parent's perspective – mourning without end in N. Andreason (Ed) *Schizophrenia from Mind to Molecule*, London: American psychiatric Press

¹² Disability Rights Commission (2006) *Equal Treatment – Closing the Gap. The Disability Rights Commission Formal Investigation into Physical Health Inequalities Experienced by People with Learning Disabilities and/or Mental Health Problems*, London: DRC

For some, the identity of ‘mental patient’ eclipses all other facets of personhood and it is all too easy to lose hope and give up: abandon any belief in the possibility of a positive future – and give up.

For others the prospect of being a ‘mental patient’ may be so terrifying that the person rejects any idea that such a label could conceivably apply to them and reject any help from mental health services.

But it does not have to be this way. There is no way of going back to the way things were before the difficulties started, but they are not the end of life. Many people who have experienced mental health and related problems have shown us that there is a way forward: that it is possible to recover meaning, value and purpose in life.

As well as the many famous people who have had mental health problems¹³ - statesman like Parnell and Churchill; scientists like Einstein and Babbage who invented the first computer; scholars like Ruskin and Wittgenstein; composers like Ravel; visual artists like Van Gogh; writers and poets like Auden and Chesterton; businessmen like Ted Turner who set up Cable Network News – there are also many thousands of ordinary people who have their own homes, network of family and friends and contribute to our communities in so many ways. Despite discrimination there are millions of people with mental health problems who are husbands, mothers, friends, and colleagues.

The importance of helping people with mental health problems and their families, carers and friends to retain and recover meaning and purpose in life is not restricted to ‘adults of working age’ who have functional mental health problems.

*Every Child Matters*¹⁴ emphasises the importance of ‘enjoying and achieving’, and ‘making a positive contribution’: enabling all children, whether or not they have mental health/behavioural problems to get the most out of life, develop skills for adulthood, and be involved with the community and society.

As people get older, sources of meaning and value may increasingly lie in our past – what we have done – rather than in what we shall do in the future. But older people can and do remain part of their communities and make valued contributions to those communities unless prevented from doing so by simple prejudice, or by failure to provide the support and adjustments they need.

¹³ See, for example:

Chadwick, P.K. (1997) *Schizophrenia: The Positive Perspective. In Search of Dignity for Schizophrenic People*, London: Routledge.

Lawrence, P.N. (1998) *Impressive Depressives. 75 Historical Cases of manic Depression from Seven Centuries*, London: The Manic Depression Fellowship.

Post, F. (1994) Creativity and psychopathology: A study of 291 world-famous men, *British Journal of Psychiatry*, 165, 22-34.

Post, F. (1996) Verbal creativity, depression and alcoholism: An investigation of one hundred American and British writers, *British Journal of Psychiatry*, 168, 545-555.

Jamison, K.R. (1989) Mood disorder and patterns of creativity in British writers and artists, *Psychiatry*, 32, 125-134.

Jamison, K.R. (1993) *Touched with Fire: Manic-depressive Illness and the Artistic Temperament*, New York: The Free Press.

¹⁴ Department for Education and Skills (2003) *Every Child Matters. The National Service Framework for Children and Young People*, London DfES

Dementia may signal the end of life, but it is not immediately fatal. If people are to make the most of the lives that are left to them, then it is living with, rather than dying from dementia that is critical. As with people of all ages who develop other terminal physical illnesses, the challenge becomes one of living as valued and meaningful a life as possible for as long as possible.

*Everybody's Business*¹⁵ makes this point when it talks about promoting respect and dignity, encouraging people to be as independent as possible, providing people with the integrated support and assistive technologies they need to live independently at home in so far as is possible, and the need for care in residential settings to promote social inclusion. Maybe people can preserve their value and identity by, for example, constructing story-books of their lives while they are still able to do so.

For those with learning disabilities the essence of *Valuing People*¹⁶ lies in promoting citizenship, inclusion and independence and ensuring that everyone is valued no matter what, or how severe, their impairments and the National Treatment Agency for Substance Misuse(2006)¹⁷ emphasises the importance of community integration for drug users.

“Whether service users are in treatment (e.g. maintained on substitute opiate medication) or leaving treatment they should have access to social support (e.g. housing support, educational support, employment opportunities) to maximise positive gains made in treatment.”

The draft NICE guideline on drug misuse¹⁸ places “a full assessment of medical, psychological, social and occupational needs” first in a list of five areas that healthcare professionals must consider when developing care plans for drug misusers.

Principles of Recovery and Inclusion

People with mental health and related problems may benefit from a wide range of support and treatment – and it is critical that these are available to people of all ages and to those who may experience additional discrimination and disadvantage as a consequence of physical impairments, progressive organic conditions or learning disabilities, or because of their ethnicity, sexuality or religion. The critical question is whether these help the person to pursue their ambitions and make the most of their life. Therefore the philosophy and principles guiding our work are particularly important¹⁹.

Recovery is about people's whole lives – not just their symptoms

There are a variety of different ways in which people may gain relief from distressing symptoms: these may include medication, psychological therapy, self-help and self-

¹⁵ Care Services Improvement Partnership (2005) *Everybody's Business. Securing Mental Health for Older Adults*, London: CSIP

¹⁶ Department of Health (2001) *Valuing people. A new strategy for learning disability services in the 21st century*, London: DoH

¹⁷ National treatment Agency for Substance Misuse (2006) *Models of care for the treatment of adult drug misusers: Update 2006*, London: national Treatment agency for Substance Misuse

¹⁸ NICE (2007) *Drug misuse: psychosocial management of drug misuse. Draft for consultation*. London: NICE

¹⁹ Perkins, R. & Repper (2007) Recovery and Social inclusion, chapter 5 in I. Norman & I. Ryrie (Ed) *The Art and Science of Metal Health Nursing* (second edition), Berkshire, UK: Open University Press

management to enable the person to manage their difficulties themselves, and a range of complementary therapies. But it is rarely a person's ambition in life merely to get rid of distressing and disabling symptoms. Usually they want to do this in order to do the things they want to do and live the lives they wish to lead. This is what recovery is about: enabling people to live well - have the homes, friends, jobs, educational and other opportunities that lend everyone's life meaning and via which we gain our sense of value and social standing.

As The National Director for Mental Health's 2007 report²⁰ says: enabling people to access accommodation, material resources, employment, education, relationships, social and leisure activities, as well as ensuring their safety from exploitation and abuse, are at least, if not more, important in the recovery process as reducing the mental health problems themselves. Enabling people to be valued for the contribution that they make, and have made, to their communities, rather than always being on the receiving end of care from others.

Recovery is about growth

*"Schizophrenia is an 'I am' illness, one which may take over and redefine the identity of a person."*²¹

It is very easy for people with mental health problems to become nothing other than their illness, ceasing to be a person and becoming 'a schizophrenic', 'a manic depressive' or 'a geriatric', 'a retard', a 'drug addict', 'an antisocial hoody' .

If mental health practitioners focus only on deficits and dysfunctions then the identity of 'mental patient' (or geriatric, or hoodlum, or addict) is reinforced at the expense of all other facets of personhood. People are always more than their problems or illness. Recovery involves redefining identity in a way which includes these difficulties, but enables the person to develop and move beyond them.

However, growth is often limited not by characteristics of the person, but by the barriers imposed by discrimination and exclusion.

*"My recovery was about how to gain other people's confidence in my abilities and potential ... in my own experience the toughest part was changing other people's expectations of what I could do. Combating a disempowering sense of being undervalued ..."*²²

The traditional focus of services is helping the individual to change: reducing their symptoms, helping them to develop new skills, helping them to adjust to what has happened. These may all be important in facilitating recovery, but it is equally, if not more important that we attend to reducing the external barriers that they face – increasing the capacity of communities, services and institutions outside the mental health system to accommodate people with mental health and related problems and the associated impairments and disadvantages they face. Growth is not possible if

²⁰ Department of Health (2007) *Breaking Down Barriers. Clinical Case for Change. Report by Louis Appleby, national Director for Mental Health*, London: DoH

²¹ Estroff, S.E. (1989) Self, identity, and subjective experiences of schizophrenia: In search of the subject, *Schizophrenia Bulletin*, 15(2), 189-196.

²² May, R. (1999) *Routes to Recovery – the roots of a clinical psychologist*, paper presented at Strangefish Conference 'Recovery: An Alien concept' at Chamberlin Hotel, Birmingham.

you are prevented from doing the things you want to do and excluded within the community in which you live.

The mental health world has a lot to learn from the physical disability movement. When we think about a person with a broken spine or limited hearing, treatment may be important but it is not the primary consideration. Instead we think about the things that the person may need in order to participate as equal citizens:

- supports like wheelchairs and personal assistants,
- adjustments in the environment that facilitate access – like ramps and induction loops, and
- changing the attitudes and skills of others in the community in order to remove ‘them and us’ barriers.

The challenge for both the individuals, and the mental health workers and informal carers who assist them, is to find the psychiatric equivalents of the wheelchair, the induction loop and the disability awareness training. To identify the supports and adjustments that the individual and others in the community might require, if people with mental health and related problems are to participate fully in community life.

Recovery is not an end product or result but an ongoing journey

“Recovery is a process, not an end point or destination. Recovery is an attitude, a way of approaching the day and the challenges I face. ... I know I have certain limitations and things I can’t do. But rather than letting these limitations be occasions for despair and giving up, I have learned that in knowing what I can’t do, I also open up the possibilities of all I can do.”²³

People cannot be ‘fixed’ as one might mend a television or refurbish a building. If recovery is a continuing journey, then help and adjustments often may need to be seen as a continuing process of supporting people in that journey. And must involve not only helping the person to move forward, but also helping them to maintain and celebrate what they have already achieved.

The critical yardstick of success is not whether the person can be discharged and function unaided – this may or may not be possible or desirable - but what they are able to achieve in their life in the presence or absence of support. To again take a parallel with physical impairment the efficacy of a wheelchair would never be judged in terms of the extent to which it enabled a person to walk unaided, but in terms of what it enables the person using it to do.

Recovery is rarely linear– there will be problems and set-backs along the way.

“The recovery process is ... a series of small beginnings and very small steps. At times our course is erratic and we falter, slide back, re-group and start again ...”²⁴

It is important to minimise the likelihood of relapse and exacerbation of symptoms, but there will be times when this is not possible. It is destructive if people feel that if they relapse they have in some way ‘failed’. Relapse may be part of the recovery process – a learning opportunity that can enable a person to move beyond their

²³ Deegan, P. (1993) Recovering our sense of value after being labeled, *Journal of Psychosocial Nursing*, 31(4), 7-11.

limitations and identify additional support and adjustments that they, or the people around them, may need to successfully pursue their ambitions.

The importance of seeing relapse as part of the recovery process is implicit in the guidance offered by the National Treatment Agency for Substance Misuse:

“It is vital that service users have explicit accessible pathways back into specialised structured drug treatment services if needed (e.g. in case of relapse).”

If a person is not to become dispirited and give up, they need people around them who can ‘hold on to hope’: believe in them and their possibilities during those times when they are not able to believe in their own worth and future.

Recovery is not a professional intervention

Recovery is an individual journey in which the person’s own resources and those available to them outside the mental health system are central. The sources of meaning and satisfaction in most people’s lives do not lie within mental health services but in our relationships, work, homes, families and friends, leisure pursuits, religion or spiritual beliefs, and the contribution that we make to our communities. If people are unable to access the range of ordinary opportunities that other citizens usually take for granted then they are unlikely to be able to rebuild lives that they find satisfying and meaningful.

The expertise of experience is also important. Many people have described the enormous support they have received from others who have faced a similar challenge²⁵.

“... the gift that people with disabilities can give each other ... hope, strength and experience as lived through the recovery process ... a person does not have to be ‘fully recovered’ to serve as a role model. Very often a person who is only a few ‘steps’ ahead of another person can be more effective than one whose achievements seem overly impressive and distanced.”²⁶

This may be achieved via self-help groups, user/survivor organisations and more informal friendships and networks within which people can share experiences and support each other’s journeys. It can also be achieved by enabling people to share the writing of others via the many ‘first person’ stories that have now been published and by including the expertise of personal experience of mental health problems in the ‘skill mix’ available within mental health teams. The Trust’s ‘*Charter for the Employment of People who have had Personal Experience of Mental Health Problems*’ contributes towards achieving this: since 1999 at least 15% of recruits to all levels of the Trust have personal experience of mental health problems in addition to their other skills and attributes.

The importance of self-help is also emphasised in the draft NICE guidance on the psychosocial management of drug misuse²⁷:

²⁵ Chamberlin, J. (1995) Rehabilitating ourselves: The psychiatric survivor movement, *International Journal of Mental Health*, 24(1) 39-46.

²⁶ Deegan, P. (1993) Recovering our sense of value after being labeled, *Journal of Psychosocial Nursing*, 31(4), 7-11.

²⁷ NICE (2007) *Drug misuse: psychosocial management of drug misuse. Draft for consultation*. London: NICE

“Healthcare professionals should routinely provide information about self-help groups for people who misuse drugs. The most established of such groups are those based on 12-step principles, for example, Narcotics Anonymous and Cocaine Anonymous.”

Indeed, it might be argued that the alcohol misuse field has led the way in relation to self-help and the Alcoholics Anonymous 12-step approach has informed subsequent recovery models (e.g. Wellness and Recovery Action Planning²⁸).

A recovery vision is not limited to a particular theory about the nature and origins of mental health problems

Just as professionals have developed a range of different organic, psychological, and interpersonal models for understanding mental distress, so people who have had these difficulties need to find ways of making sense of their experiences. Based on the narratives of 30 people with serious mental health problems, Jacobson²⁹ identified six frameworks that people have used to understand their difficulties: biological; and interaction of biology and environment; abuse or trauma; spiritual or philosophical; political; and the dehumanising impact of long-term contact with mental health services.

A recovery vision does not commit one to a particular understanding of distress and disability³⁰. People need ways of understanding what has happened to them (‘Why me?’ ‘What is the point in my life now?’) but whether they choose genes, inter or intra personal problems or the action of various deities, recovery – the rebuilding a meaningful and satisfying life - is equally important. The critical issue is not veracity of a model or explanation but the extent to which it:

- makes sense to the person: any number of randomised controlled trials are unlikely to persuade a deeply religious person that their lives are wholly determined by their biology.
- enables them to move forward in their life: genetic explanations, for example, may impede growth if characteristics are seen as fixed and immutable; explanations revolving around abuse and trauma preclude the possibility of growth if these are considered to have done irreparable damage. However, both genetic and traumatic explanations can facilitate growth if they are seen as something over which the person can exercise control or influence, or something that may be modified by social and environmental circumstances.

Everyone’s recovery journey is different and deeply personal

There are no rules of recovery, no formula for success.

“Everyone’s journey of recovery is unique. Each of us must find our own way and no-one can do it for us.”³¹

“Once recovery becomes systematised, you’ve got it wrong. Once it is reduced to a set of principles it is wrong. It is a unique and individualised process.”³²

²⁸ Copeland, M. E. (2002) *Wellness Recovery Action Plan*, Vermont: Peach Press

²⁹ Jacobson, N. (1993) Experiencing recovery: A dimensional analysis of recovery narratives, *Psychiatric Rehabilitation Journal*, 24,3,248-255.

³⁰ Anthony, W.A. (1993) Recovery from mental illness: The guiding vision of the mental health system in the 1990s, *Innovations and Research*, 2(3), 17-24.

³¹ Deegan, P. (1993) Recovering our sense of value after being labeled, *Journal of Psychosocial Nursing*, 31(4), 7-11.

It is easy for the destructive rigid routines and block treatment of old asylums to spill over into community services³³.

- There remain community services where a set of rules dictate how people must use them, like 'you cannot have lunch at the day centre unless you attend a group'. If all a person needs is a hot meal it is a waste of their time and scarce resources to insist that they attend a group as well.
- The 'ladder' models adopted by some services insist that people start at point A and then move in an orderly fashion to point Z: you must start in the rehabilitation ward, and then show that you can manage in a staffed hostel before you can have a flat of your own. It is entirely possible for someone to move directly from hospital to independent accommodation, or be sustained in their own place during a crisis – is this not what Home Treatment and Assertive Outreach Services are designed to achieve?
- The often implicit assumption that there exists a hierarchy of skills in which you can only move on to more 'advanced' endeavours when you have mastered 'basic' ones: you must be able to wash your socks before you can live independently or go to work. Yet it is entirely possible for a person to need help in many aspects of daily life and still hold down a responsible job: how many high flying executives do their own cleaning and cooking?

Prescribed rules of engagement inevitably mean that services cannot be tailored to the individual wishes and aspirations of the people who use them. Not only is this likely to impede recovery, it is also likely either to de-skill people – prevent them from using their skills/abilities to the full - or alienate them by offering support in a manner that they find unacceptable and infantilising.

Recovery is possible for everyone

Recovery is not just for those who are more able. It is not contingent on the removal of symptoms or the development of skills. Some people will remain profoundly disabled but with the right kind of support they can find sources of value and meaning in order to move forward in their lives. Some people deny their need for services and reject professional help but they can still achieve the support and encouragement they need to pursue their ambitions outside specialist services: among those friends, family members, and agencies that exist to help all citizens. The critical issue then becomes not whether the individual has appropriate support from mental health practitioners but whether friends family and community agencies receive the help they need to accommodate and assist the person.

Recovery is not just for adults of working age. People need sources of meaning and value at the start and end of their lives as well. Neither is it just for people with functional mental health problems. For example, our aim must be to promote the

³² Deegan, P.E. (1999) *Recovery: An Alien Concept*, paper presented at Strangefish Conference 'Recovery: An Alien concept' at Chamberlin Hotel, Birmingham.

³³ See, for example, Goffman, E. (1961) *Asylums: essays on the social situation of mental patients and other inmates*, New York: Anchor Books

Brown, G.W., Bone, M., Dalison, M. & Wing, J.K. (1966) *Schizophrenia and Social Care*, Oxford: Oxford University Press;

King, R., Raynes, N. & Tizard, J. (1971) *Patterns of Residential Care*, London: Routledge

Wing & R. Olsen (Eds) *Community Care for the Mentally Disabled*, Oxford: Oxford University Press

independence, choice, inclusion and citizenship of people with learning disabilities and/or addiction problems and enable those with dementia to participate in those roles, relationships and activities that they value as much as possible and for as long as is possible³⁴. For younger people, enjoying, achieving, making a positive contribution are as important as ensuring their safety and well-being³⁵.

Carers, relatives and friends also face the challenge of recovery

It is not only the person who experiences mental health problems who faces the challenge of recovery. Those who are close to them – their relatives, carers, friends – face a similar challenge.

It is important to remember that it is not mental health services, but informal carers – relatives and friends - who provide most of the support that people with mental health and related problems receive. They therefore have a critical role to play in promoting recovery and facilitating inclusion. If they are to do this it is important that they understand the person's situation and the challenges they face and receive the support they need to help the person to make the most of their life. Sadly, it is too often the case that relatives, carers and friends feel ill-informed and unsupported and feel that mental health workers do not recognise the contribution that they make and the difficulties they face. Some continue to feel that services blame them for their relative's problems³⁶.

However, they also face the challenge of recovery in their own right. Relatives, carers and friends must discover new sources of value and meaning for themselves, in their loved one and in their relationship with them.

Research suggests that there may be a number of stages in the recovery³⁷

- *Discovery/denial* when family members look for alternative explanations for the behaviour of the person.
- *Recognition/acceptance* when, as problems persist, the family begins to accept that one of their kin has mental health problems (or related difficulties like dementia) and begin to grieve lost hopes, expectations and relationships. Sometimes parents and partners/spouses own sense of value is contingent on the 'success' of their offspring or partner – at school, at work, in relationships. They too must find new sources of hope and possibility.
- *Coping* when grief is overtaken by the reality of the difficulties that the family face and they begin the struggle of managing and may feel angry, despairing, inadequate.
- *Personal and political advocacy*. As families recover they blame themselves less, let go of the things they cannot change, find new possibilities, and become more confident and assertive about their role. Some may become involved in political

³⁴ Care Services Improvement Partnership (2005) *Everybody's Business. Securing Mental Health for Older Adults*, London: CSIP

Department of Health (2005) *Independence, Well-being and Choice*, London: DoH

³⁵ Department for Education and Skills (2003) *Every Child Matters. The National Service Framework for Children and Young People*, London DfES

³⁶ See, for example, Winefield, H. & Burnett, P. (1996) Barriers to an alliance between family and professional care givers in chronic schizophrenia, *Journal of Mental Health*, 5, 223-232

³⁷ Spaniol, L. & Zippel, A. (1994) Coping strategies for families of people who have a mental illness in H. Lefley & M/. Wasow (ed) *Helping Families Cope with mental Illness*, New York: The Guildford Press

action to improve systems of support. Through such action they may experience, for the first time, their own collective power and influence.

Too often informal carers find their own social networks, contacts and opportunities diminished. It is therefore important that mental health services facilitate the recovery of carers and people who are close to the person: help them to accommodate and make sense of what has happened, rebuild their own lives and access those opportunities that they value.

The Policy Context

Published in 2000, the *NHS Plan* heralded many major changes that have been elaborated in subsequent policy initiatives³⁸.

The primary imperative is to organise services around the convenience, concerns and preferences of those who use them.

*“Patients are the most important people in the health service. It doesn’t always appear that way. Too many patients feel talked at, rather than listened to. This has to change. NHS care has to be shaped around the convenience and concerns of patients. To bring this about, patients must have more say in their own treatment and more influence over the way the NHS works.”*³⁹

However, it is also emphasised that high quality clinical care is not enough.

*“Quality is not restricted to clinical aspects of care, but include quality of life and the whole patient experience.”*⁴

We must ensure that people’s experience of using services is a positive one and move beyond a focus of treating illness to positively promoting health and well-being: an agenda that has been reinforced by cross government initiatives to promote social inclusion⁴⁰, improve the life chances of people with mental health problems⁴¹ and the National Director for Mental Health’s report on the next phase of mental health service reform⁴².

The changes heralded in these policy documents are both structural and cultural.

A great deal of work has already been done to develop new teams, services commissioning and performance management arrangements, and further structural

³⁸See, for example,

NHS Improvement Plan: Putting people at the heart of services (2004)

National Standards, Local Action: Health and social care standards and planning framework 2005/2006 – 2007/08 (2004)

Creating a Patient-led NHS: Delivering the NHS improvement Plan (2005)

Independence, Well-being and Choice: Our vision of the future of social care for adults in England (2005)

Our Health, Our care, Our Say: A new direction for community services (2006)

Breaking Down Barriers. Clinical Case for Change. Report by Louis Appleby, National Director for Mental Health (2007)

³⁹ *The NHS Plan*, Department of Health (2000)

⁴⁰ See, for example,

Reaching Out: An Action Plan for Social Exclusion (2006) Prime Minister’s Strategy Unit

⁴¹ *Improving the Life Chances of Disabled People* (2005) Prime Minister’s Strategy Unit

⁴² Department of Health (2007) *Breaking Down Barriers. Clinical Case for Change. Report by Louis Appleby, National Director for Mental Health*, London: DoH

changes are planned. However, if these are to improve the experience of people who use services they must be accompanied by changes in culture and practice: a change in the vision and values guiding our work.

Recovery and social inclusion as the guiding vision and purpose of mental health services was first outlined in the 2001 Department of Health vision for mental health services *Journey to Recovery*, the Social Inclusion Unit's 2004 *Mental Health and Social Inclusion* and subsequent National Social Inclusion Programme led by the National Institute for Mental Health in England.

“Our vision is of a future where people with mental health problems have the same opportunities to work and participate in their communities as any other citizen. This will mean communities accepting that people with mental health problems are equals ... people having genuine choices and a real say about what they do and the support they receive ... people keeping jobs, returning to employment faster and with real opportunities for career progression ... recognition of the fundamental importance of people’s relationships, family ... a decent home and participation in social and leisure activities.”⁴³

The centrality of recovery as the guiding framework for services was reiterated in the Chief Nursing Officer's 2006 review of mental health nursing stated that:

“Mental health nursing should incorporate the broad principles of the Recovery Approach into every aspect of their practice.”

Most recently, in his report published in May 2007⁴⁴, the National Director for Mental Health, Louise Appleby, has identified promoting social inclusion and facilitating recovery as the key challenge for the next phase of reform in mental health services. In this report, Professor Appleby emphasises that

“Employment, housing and a strong social network are as important to a person’s mental health as the treatment they receive ... we have to continue to improve community care and break down the barriers that can prevent people from rebuilding their lives ... go beyond traditional clinical care and help patients back into mainstream society.”

Similar principles relating to citizenship, rights, inclusion in communities, choice in daily life - underpin the ‘Valuing People’ strategy for adults and young people with learning disability in the 21st century.

“Our objective is to enable people with learning disabilities to lead full and purposeful lives in their communities.”⁴⁵

Issues relating to access to educational opportunities for disabled children, equality of opportunity and access to ongoing education, training and employment in the transition from childhood to adult hood, choice and control for adults with learning disabilities are also emphasised.

⁴³ Social Exclusion Unit (2004) *Mental Health and Social Exclusion* (2004) Social Exclusion Unit, Office of the Deputy Prime-Minister

⁴⁴ Department of Health (2007) *Breaking Down Barriers. Clinical Case for Change. Report by Louis Appleby, national Director for Mental Health*, London: DoH

⁴⁵ Department of Health (2001) *Valuing people. A new strategy for learning disability services in the 21st century*, London: DoH

The starting point of the government’s vision for the future of social care for adults of all ages⁴⁶

“... is the principle that everyone in society has a positive contribution to make to that society and that they should have a right to control their own lives. Our vision is to ensure that these values will drive the way we provide social care.”

Self-help and social inclusion form part of the draft NICE guidance on drug misuse⁴⁷ and community integration is one of the core components of the National Treatment Agency for Substance Misuse effectiveness strategy. This emphasises the need to focus on the individual’s holistic needs – including housing, education and employment – to maximise the benefits of treatment⁴⁸:

“Whether clients wish to be maintained in the community on substitute opioid medication or wish to be drug-free, drug treatments systems should be well integrated with other systems of care and support to provide opportunities for drug users to receive appropriate housing, social support, education and employment to maximise treatment gains and enable reintegration into local communities.”

It also indicates that

“DAT partnerships should consider linking their drug treatment targets to wider mainstream targets that relate to housing, education and employment for drug users.”

Indeed housing and employment status are two of the five performance indicators that the National Treatment Agency indicated that it would pilot in its 2006/7 business plan⁴⁹.

‘Everybody’s Business’⁵⁰ - the guide to the development of integrated mental health services for older people - stresses the importance of respect and dignity and the principles that must underlie services: a person-centred approach, improving quality of life, meeting complex needs in a co-ordinated way and promoting age equality. It emphasises, for example, the importance of social networks and combating social isolation, ensuring financial security and access to adequate housing and support to maintain independence and the importance of purpose and meaning in life.

“Staying mentally and physically active gives a sense of purpose and personal worth, as well as enabling people to make an effective contribution to their communities. Participating in valued activities can also provide opportunity for social contact. Hobbies and leisure activities, lifelong learning, as well as volunteering, employment, and engagement in the development or delivery of local services should all be supported.”

⁴⁶ Department of Health (2005) *Independence, Well-being and Choice: Our vision of the future of social care for adults in England*, London : DoH

⁴⁷ NICE (2007) *Drug misuse: psychosocial management of drug misuse. Draft for consultation*. London: NICE

⁴⁸ National treatment Agency for Substance Misuse (2006) *Models of care for the treatment of adult drug misusers: Update 2006*, London: national Treatment agency for Substance Misuse

⁴⁹ National Treatment Agency for Substance Misuse (2006) *Towards treatment effectiveness. Business Plan 2006/7*, London: NTA

⁵⁰ Care Services Improvement Partnership (2005) *Everybody’s Business. Securing Mental Health for Older Adults*, London: CSIP

Promoting Recovery, Facilitating Inclusion: A Strategy for Pursuing the Trust's Primary Purpose

Promoting recovery and facilitating inclusion requires a major change in the guiding philosophy of services: moving away from a primary focus on minimising symptoms and reducing dysfunctions towards one of enabling people to do the things they want to do and live the lives they want to lead. But it also requires a review of the sort of help and support that people need if they are to retain, build or rebuild a life that they find meaningful and satisfying and the skills that are needed to provide this support.

In order to do this it is necessary to look to the expertise of personal experience for guidance: what people who are recovering from mental health and related problems have found helpful in their journey.

While everyone's journey is unique, the accounts of people who have faced the challenge of recovery identify a number of common features that seem to be critically important: hope, relationships, coping with loss, spirituality, philosophy and understanding, taking back control, finding meaning and purpose in life and having the opportunity to do the things that they value. It is also clear that these do not constitute a recipe for recovery. They are intimately interlinked and follow no set sequence. For example, some people cannot regain hope, or address what has happened to them, until they have the opportunity to do things they value. Others need regain a sense of possibility before they are able to think about embarking on the re-building process.

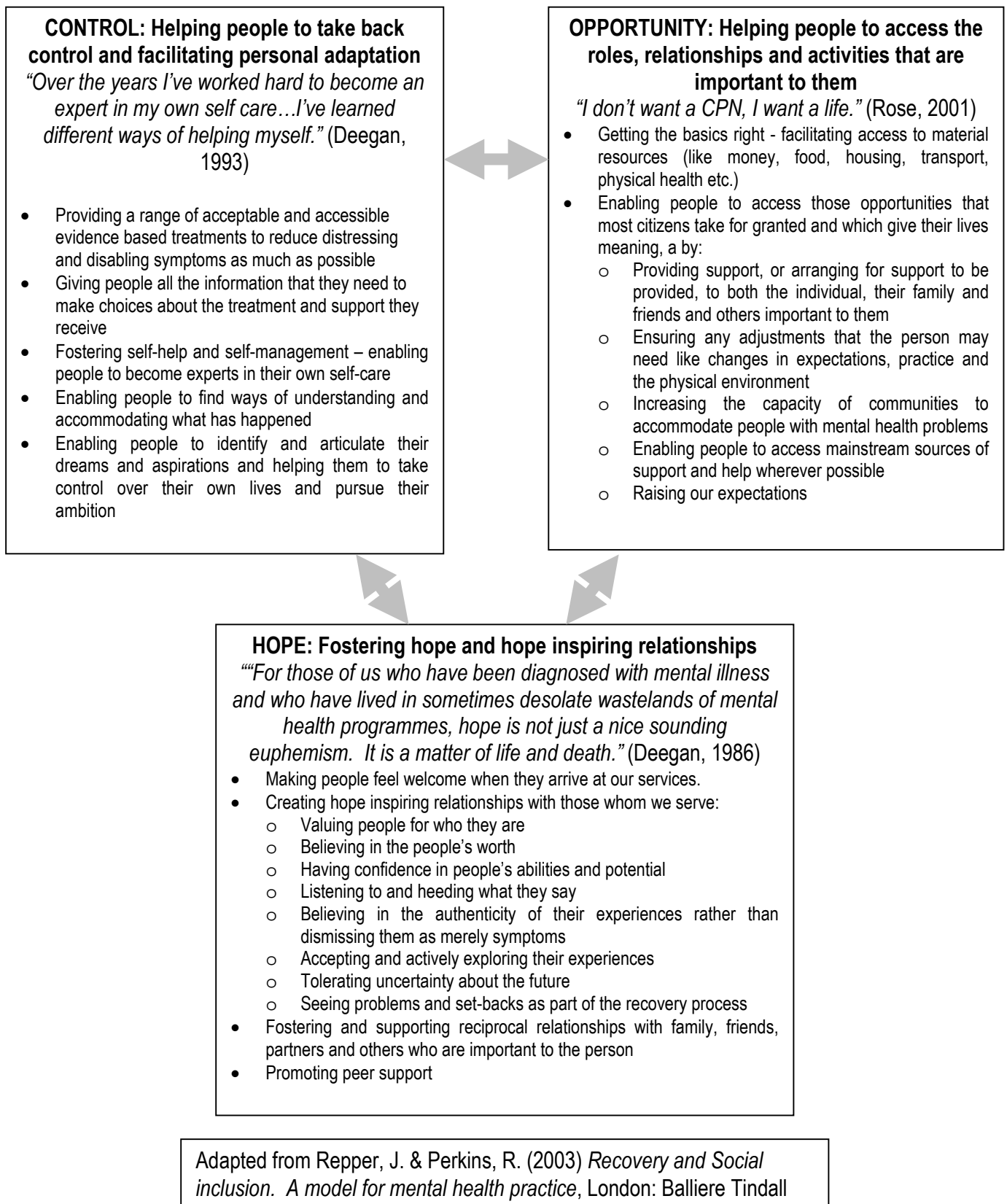
If mental health practitioners are to really support people in their recovery journey then three inter-related components are central - **hope, control and opportunity**: fostering hope and hope inspiring relationships, helping people to take back control - facilitating personal adaptation and enabling people to access opportunities – homes, friends, jobs, education - that are important to them and facilitating social inclusion. (see Figure 1).

It is these three components on which the Trust's strategy for promoting recovery and facilitating social inclusion is founded.

1. HOPE: Fostering hope and hope inspiring relationships

Hope is essential for recovery: unless a person can see the possibility of a valued meaningful and satisfying life then recovery is impossible. Research has demonstrated that hope is important in many domains, like the outcome of psychotherapy, coping with long-term illness, the outcome of first episode psychosis or rehabilitation for people with serious long-term mental health problems and there is a link between suicide and hopelessness.

Figure 1: Promoting Recovery, Facilitating Inclusion



*“For those of us who have been diagnosed with mental illness and who have lived in the sometimes desolate wastelands of mental health programs and institutions, hope is not just a nice sounding euphemism. It is a matter of life and death”*⁵¹

*“In the context of life threatening situations, hope functions as a life saving force for individuals who have been overwhelmed by despair.”*⁵²

However, hope does not occur in a vacuum – the extent to which a person feels hopeful about their possibilities is heavily dependent on the views of those around them. If everyone around is pessimistic about a person’s possibilities then it is almost impossible for them to remain hopeful about their own possibilities.

Hope is equally important for carers, relatives and friends, as one mother of a young man with a diagnosis of schizophrenia describes:

“the one thing we find most soul destroying about the whole issue, is that nobody gives you any hope. We are intelligent people, we can understand that nobody can say ‘your son will get well, he will get a job or whatever’ but nobody ever gives you hope. For example when [our son] wasn’t well, he said, ‘I want to go back to the hospital’. To me, this is a good thing because it shows me he realises that he’s not very well, but you say that to the staff and they say ‘well no, he’s pretty ill, he’s not responding a lot’ and you think to yourself ‘Jesus Christ, just somebody give me hope”

Fostering hope inspiring relationships with those whom we serve is therefore central to the work of the organisation. We will therefore strive to:

a) Ensure that people are made to feel welcome when they arrive at our services. First impressions are important and have an enormous impact on the subsequent relationship that we have with those who use our services and their friends and relatives.

b) Develop hope-inspiring relationships between Trust staff, those who use services whatever their age or the nature of their problems – people with mental health and related problems as well as their relatives, friends, and people important to them. On the basis of existing research⁵³, this will involve:

- Treating everyone who uses services with dignity and respect.
- Valuing people for who they are.

⁵¹ Deegan, P. (1989) *A letter to my friend who is giving up*. Paper presented at the Connecticut Conference on Supported Employment, Connecticut Association of Rehabilitation facilities, Cromwell, CT.

⁵² Russinova, Z. (1999) Providers’ hope-inspiring competence as a factor optimizing psychiatric rehabilitation outcomes, *Journal of Rehabilitation*, 16, 4, 50-57.

⁵³ See, for example,

Woodside, H., Landeen, J., Kirkpatrick, H., Byrne, C. Bernardo, A. & Pawlick, J. (1994) Hope and schizophrenia: Exploring attitudes of clinicians, *Psychosocial Rehabilitation Journal*, 8, 140-144.

Repper, J. & Perkins, R. (2003) *Recovery and Social Inclusion. A model for mental health practice*, London: Balliere Tindall

Russinova, Z. (1999) Providers’ hope-inspiring competence as a factor optimizing psychiatric rehabilitation outcomes, *Journal of Rehabilitation*, 16, 4, 50-57.

- Believing in the person's worth.
- Seeing and having confidence in the person's skills, abilities and potential.
- Listening to and heeding what they say.
- Believing in the authenticity of the person's experience.
- Accepting and actively exploring the person's experiences.
- Tolerating uncertainty about the future.
- Seeing problems and set-backs as part of the recovery process: helping the person to learn from, and build on these.

c) Enable people to develop hope inspiring relationships with others outside mental health services. Relationships with people outside the mental health system – with relatives, friends, partners, neighbours, colleagues, classmates, fellow students etc. – are a crucial determinant of well-being and a person's sense of belonging. Everyone needs ordinary reciprocal relationships in which they can give, as well as receive, support and succour. Helping people to retain and/or regain the social relationships that are valuable to them will involve:

- Ensuring that maintaining relationships with people who are important to them, and addressing any relationship difficulties, form part of the assessment and care planning process.
- Providing the support that people need to maintain relationships that are important to them.
- Providing the help and support that relatives, friends, carers need.
- Helping people to access new relationships that may be of value to them.

d) Promote peer support. Others who have experienced similar difficulties are often in the best position to understand what an individual is experiencing and are an important source of hope, inspiration and support. This will involve:

- Actively facilitating contact between service users.
- Fostering and supporting self-help initiatives.
- Maximising the involvement of service users in the provision of mental health services as service providers, volunteers and co-therapists.
- Promoting user-run and user-led services.
- Actively facilitating contact between carers, relatives, friends so that they can support each other

2. CONTROL: Helping people to take back control and facilitating personal adaptation

Traditionally, professionals have been viewed as the experts who prescribe what is good for people – a situation that can result in a disempowering passivity that is incompatible with retaining or rebuilding a meaningful and satisfying life.

Self-determination is central to recovery. Professional skills remain important, but they must be employed in the service of enabling people to take back control and extended beyond symptom reduction alone.

“To me, recovery means I try to stay in the driver's seat of my life. I don't let my illness run me. Over the years I have worked hard to become an expert in my own self-care ... Over the years I have learned different ways of helping

*myself. Sometimes I use medications, therapy, self-help and mutual support groups, friends, my relationship with God, work, exercise, spending time in nature – all of these measures help me remain whole and healthy, even though I have a disability.*⁵⁴

Enabling people to take control of their problems and their lives involves a number of elements. We will therefore strive to:

a) Enable people to take control over their problems. This will include:

- Providing access to the full range of evidence based treatments and interventions as outlined in NICE guidance.
- Providing all the information that a person needs to make choices about what treatment and support they want.
- Providing people with real choices about the type of treatment and help they receive, offering the support and help they need to make those choices, fully involving them in decisions about all aspects of treatment and support, and heeding and acting upon their feedback.
- Helping people to access Direct Payments and similar resources that enable them to take control over the support they receive.
- Promoting self-management⁵⁵ and helping people to work out plans for themselves: what helps them to stay well, how to manage ups and downs, what they can do when problems begin to occur, how they want crises to be managed, what helps them to regain their equilibrium after a crisis.

b) Enable the individual and their relatives, friends and carers to find ways of understanding and accommodating what has happened. Mental health problems and related difficulties constitute a life changing event – a kind of bereavement that the person needs to understand and accommodate. Helping people to make sense of what has happened to them will involve:

- Providing people with time and space to talk about what has happened, what it means to them.
- Understanding and accommodating the range of emotions that anyone trying to accommodate a traumatic event may experience like anger, despair, hopelessness, and guilt.
- Helping to dispel the myths popularly associated with mental health problems and providing people with information about what is possible and what other people with mental health problems have achieved.
- Helping people to come to their own understanding of what has happened in a way that both makes sense to them and allows them the possibility of moving forward, even when this does not accord with the professionals understanding.

c) Enable people to take control over their lives and pursue their ambitions.

This will involve:

- Ensuring that all assessments:

⁵⁴ Deegan, P. (1993) Recovering our sense of value after being labeled, *Journal of Psychosocial Nursing*, 31(4), 7-11.

⁵⁵ See MDF The Bipolar Organisation – www.mdf.org.uk – and Rethink – formerly the National Schizophrenia Fellowship – www.rethink.org.uk Mary Ellen Copeland (1997) Wellness and recovery Action Plans www.mentalhealthrecovery.com

- focus on a person's skills, resources and possibilities, not simply their deficits and dysfunctions,
- tap all aspects of a person's life, identify the things they value, and,
- identify a person's existing vocational, social and personal ambitions.
- Tailoring the care planning process to
 - helping the person to move towards their aspirations and ambitions even if these seem 'unrealistic', and/or
 - helping the person to re-evaluate their aspirations/ambitions and develop new ones.
- Providing people with the support and help they need to move towards achieving their ambitions.
- Providing the support and help that carers, relatives and friends need to accommodate and make sense of what has happened, rebuild their own lives and access those opportunities that they value.

3. OPPORTUNITY: Helping people to access the roles, relationships and activities that are important to them

If people are to rebuild their lives they need to be able to access those opportunities that most citizens take for granted (including home, school, friends, jobs, education, social pursuits, leisure activities, spiritual possibilities and physical health services) and have the opportunity to be a part of, and contribute to, community life.

Facilitating social inclusion and enabling people to access those social, economic, educational, recreational, spiritual opportunities that they value, and the physical health services that they need, is a key component of the health and social care services that we provide. We will therefore strive to:

a) Get the basics right. Help people to access the day to day resources that they need including:

- Ensuring that people have access to the support they need to maintain adequate nutrition, personal hygiene and completion of domestic chores.
- Promoting and maintaining physical health by ensuring that people have access to those mainstream health services that provide:
 - the regular health screening and check-ups that they need,
 - timely and appropriate treatment when they are physically unwell, and
 - help and advice about maintaining and promoting health including diet, exercise, smoking cessation.
- Helping people to access the money/benefits and other material resources to which they are entitled.
- Supporting people to get and keep appropriate housing. Where possible priority will be given to providing the help and support they need to gain/maintain ordinary, independent accommodation alone, or with families and friends if this is their choice. However, we also need to ensure that there is sufficient supported/sheltered accommodation for those who need it.
- Providing the information and support that carers, relatives and friends need if they are to support the person in rebuilding their life.
- Providing assistance to access the transport and concessionary travel/'bus passes' that they need to do the things they want to do.

- Ensuring that people are aware of their rights – for example those afforded by the 2005 Disability Discrimination Act – and helping them to exercise these.
- Ensuring that people are safe from harm and neglect.

b) Providing the support that people need to access opportunities that they value. If this is to be effective, it will require:

- Providing a range of evidence-based support and assistance.
- Ensuring that the support provided is acceptable and accessible to the individual.
- Maximising the choice and control that the recipient has over the type of support that they receive, and how, when and from whom they receive it.
- Minimising the extent to which the support provided draws negative attention
- Offering support for as long as the person needs it: some people may be able to manage unaided after a period of support, but for those who have ongoing or recurring problems access to time-unlimited support may be essential.

c) Maximising the extent to which people can access mainstream sources of help, support and expertise available within their communities. Assistance may be provided directly by mental health services and practitioners but wherever possible, priority should be given to helping the person to access support outside specialist mental health services: within their family, social networks and community.

The range of possibilities supports and services outside mental health services will always be far greater than that which exists within them – the rich variety of mainstream statutory, voluntary and community organisations/agencies like Connexions, Job Centre Plus, Citizens Advice Bureaux, General Practitioners, Expert Patient Programmes, faith groups and organisations, support and self-help groups. Too often people with mental health problems and related difficulties have difficulty in accessing this expertise either because of the cognitive and emotional problems associated with their mental health difficulties or because they are excluded as a consequence of the prejudice, discrimination associated with mental health problems – breaking down these barriers is essential if people are to have the opportunities that other citizens enjoy. This requires ‘bridge building’:

- The formation of effective joint working relationships with agencies and individuals providing mainstream health, social, educational, economic, vocational, recreational and religious/spiritual support within local communities.
- Providing information and support not only to the individual but also to the individuals and agencies outside the mental health arena who are providing support.

d) Ensuring the adjustments that people need to facilitate access. The problems that some people experience may necessitate changes in roles, expectations and facilities if the person is to be able to do the things they want to do: the ‘reasonable adjustments’ required of employers, educators, and the providers of goods and services by the Disability Discrimination Act. These may involve changes in the physical environment, but they are more likely to involve helping the person to negotiate:

- Changes in practice like the provision of written instructions if someone has difficulties in concentration or memory, the provision of extra supervision at work or school, ensuring that the person can sit on the end of the row in the cinema so that they can leave easily if they need to.
- Changes in the expectations of different roles like the possibility of part time working or studying, relieving people of some of non-central duties at work (or non-central requirements of an education course) that they are unable to meet, and the many changes in expectations that occur within families and other relationships that are required by someone with recurring or ongoing problems.

e) Increasing the capacity of communities to accommodate people with mental health problems. If people with mental health problems are to be a part of their communities of choice, then the individuals and groups within those communities must be able to accommodate their needs and problems. This includes working with individuals, groups and agencies outside the mental health arena to:

- Break down the prejudice, ignorance and fear that form the basis of exclusion.
- Increase people's confidence in relating to people with mental health problems.
- Provide the support that other individuals and agencies need if they are to include people with mental health problems.
- Promote positive images of people with mental health problems.

All of these endeavours must centrally involve people who have themselves experienced mental health problems.

e) Inclusion within mental health services. The prejudice and discrimination that exist in the broader community are frequently reflected in the 'them and us' barriers that exist within mental health services. If services for people with mental health problems are to enable those whom they serve to access for people with mental health problems outside mental health problems then we must do likewise within our own services. Such inclusion requires that we value the 'expertise of experience' in all that we do and ensure that we:

- Fully involve those who use services at all levels of the organisation: individual, operational and strategic.
- Continue to recognise the expertise of experience as desirable among those who provide services and actively encourage people who have experienced mental health problems to apply for jobs at all levels of the organisation in line with our 'Charter for the Employment of People who have Experienced Mental health Problems'.

f) Raising expectations

One of the biggest barriers to inclusion is low expectations⁵⁶: if everyone around a person believes them to be incapable of doing the things they want to do then it is highly unlikely that they will be able to do so. In this context the expectations of specialist mental health professionals are critical.

⁵⁶ See Social Exclusion Unit (2004) *Mental Health and Social Exclusion*, London: Office of the deputy Prime minister

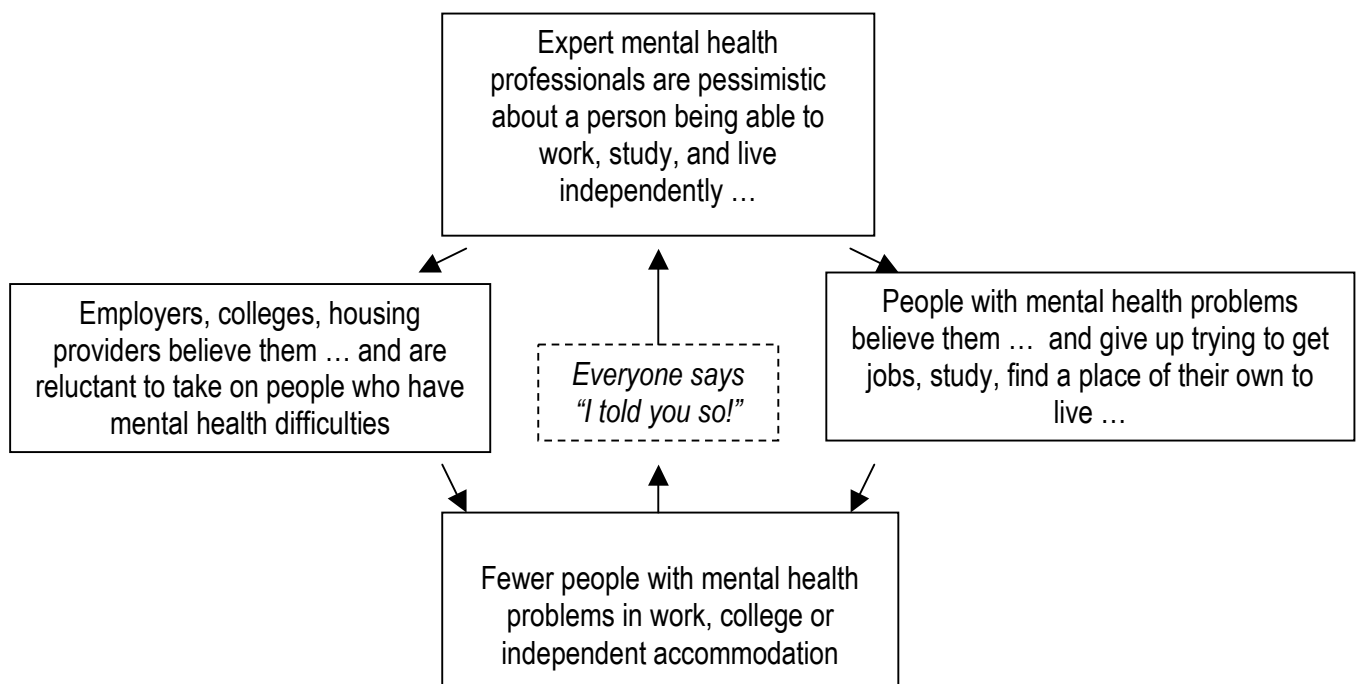
If professional expectations are low then this drives a destructive vicious cycle of despondency (see Figure 2).

If mental health experts say that many people with mental health problems are unlikely to be able to hold down a job, do a college course, manage the demands of living in their own place then many people with mental health problems believe them – and stop applying for jobs, college places, trying to get a home of their own.

But employers, colleges, housing authorities are also likely to believe them – and be reluctant to take on people with mental health problems.

These two combine to ensure that fewer people with mental health problems are in employment, education or independent accommodation and everyone can say ‘I told you so!’ and a vicious cycle is established. Take employment for example. Mental health professionals see the small number of people with mental health problems in work and this ‘evidence’ reinforces their belief that they are unlikely to be able to work. Employers see the small number of people with mental health problems in work and conclude that they were correct in not taking them on. And people with mental health problems see the small number of people in work and think ‘what is the point?’.

Figure 2: The vicious cycle of despond⁵⁷



⁵⁷ Adapted from Rinaldi, M. & Perkins, R. (2005) Early intervention: A hand up the slippery slope, Chapter 15 in B. Grove; J. Secker & P. Seebohm (Eds) *New Thinking about Mental Health and Employment*, Oxford: Radcliffe, and Perkins, R. (2005) Is what we offer to patients half acceptable? Chapter 23, in C. McDonald, K. Schulze, R.M. Murray & M. Tohen (Eds) *Bipolar Disorder: Upswing in Research and Treatment*, Oxford: Taylor & Francis

Current Gaps in Service

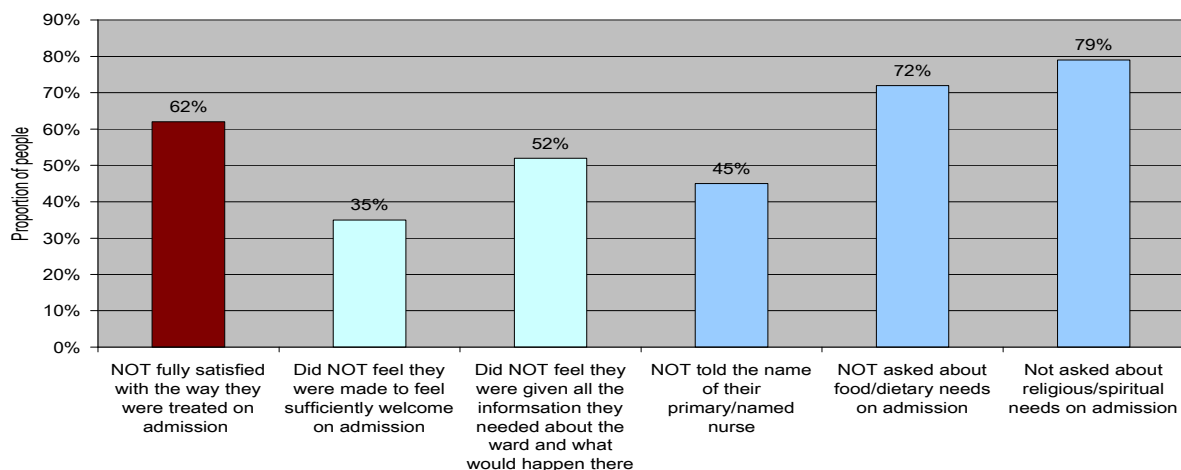
The Trust has already defined primary purpose as helping those whom we serve to do the things they want to do, live the lives they want to live and access those opportunities that all citizens enjoy. A number of initiatives have already been instigated that might promote recovery and social inclusion like our vocational services to help people to access work and educational opportunities; assertive outreach and home treatment teams to enable people to maintain their community tenure; and the modernisation of day services to better help people to access community social and leisure opportunities. Others are in progress like the development of Recovery Support Workers⁵⁸ and the Quality Improvement Programme. Some individual clinicians and teams have always helped people to access those activities and opportunities that they seek and there is an increasing emphasis on helping people to access Direct Payments.

However, these endeavours have often taken the form of ‘add-ons’ to the core business of the organisation that can too readily be cut if time and resources are scarce. It remains the case that many of the strategic aims outlined above have yet to be addressed. Although comprehensive means of monitoring the extent to which our services promote recovery and inclusion have not yet been established, data collected from surveys of people’s experience of using both inpatient and community services indicates that there are a number of gaps in our service.⁵⁹

HOPE: Fostering hope and hope inspiring relationships

Figure 3 shows that inpatients did not always feel welcome when they were admitted and were not always given the information they needed or asked about their needs on admission.

Figure 3: Inpatient’s ratings of the way they were treated on admission

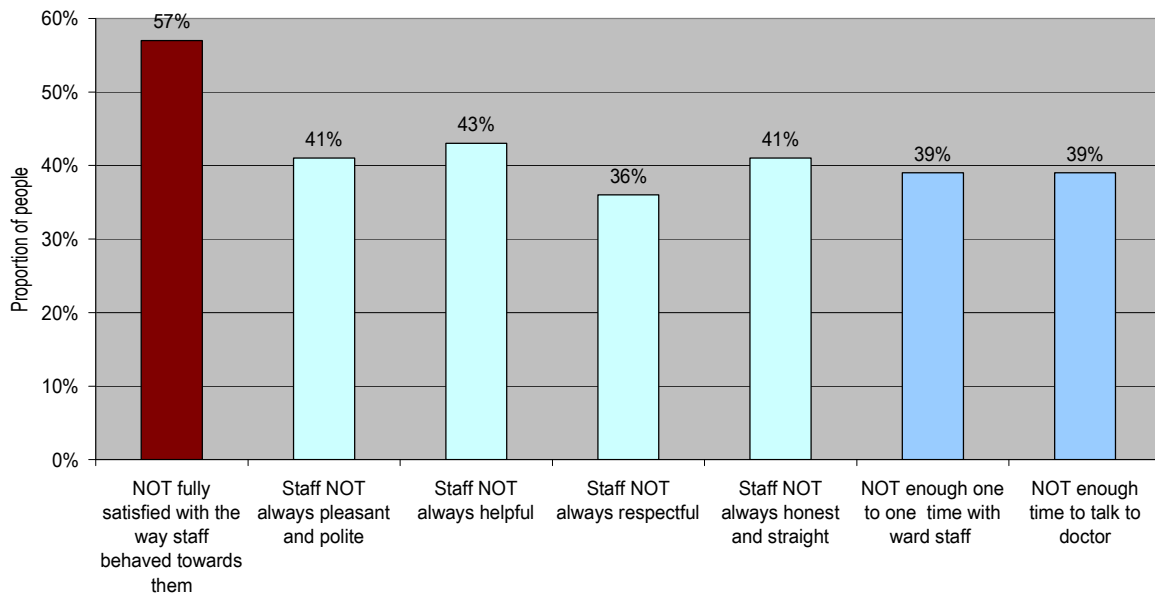


⁵⁸ The Trust has decided that the term ‘Recovery Support Workers’ is preferable to ‘Support Time and Recovery (StaR) Workers’

⁵⁹ The data presented here is taken from the evaluations of the experience of inpatient care conducted in 2006 and involving interviews with 202 people in adult acute, addictions, forensic, rehabilitation and intensive care facilities and evaluations of the experience of using community services for adults (including CMHTs, older people’s services, drug and alcohol services, assertive outreach teams and psychotherapy services) in which questionnaires were returned by 1372 people.

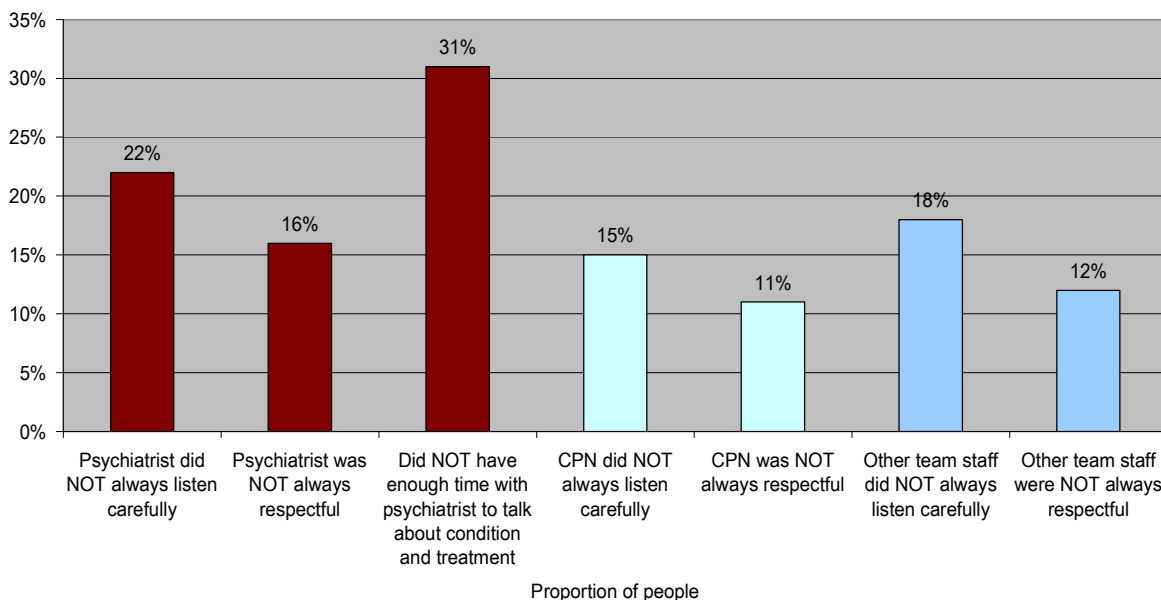
Similarly, they were not always satisfied with the way they were treated by some staff during their stay. Neither did they feel that they had sufficient opportunity to talk to ward staff or doctors about their problems and concerns.

Figure 4: Inpatient’s ratings of the way staff behaved



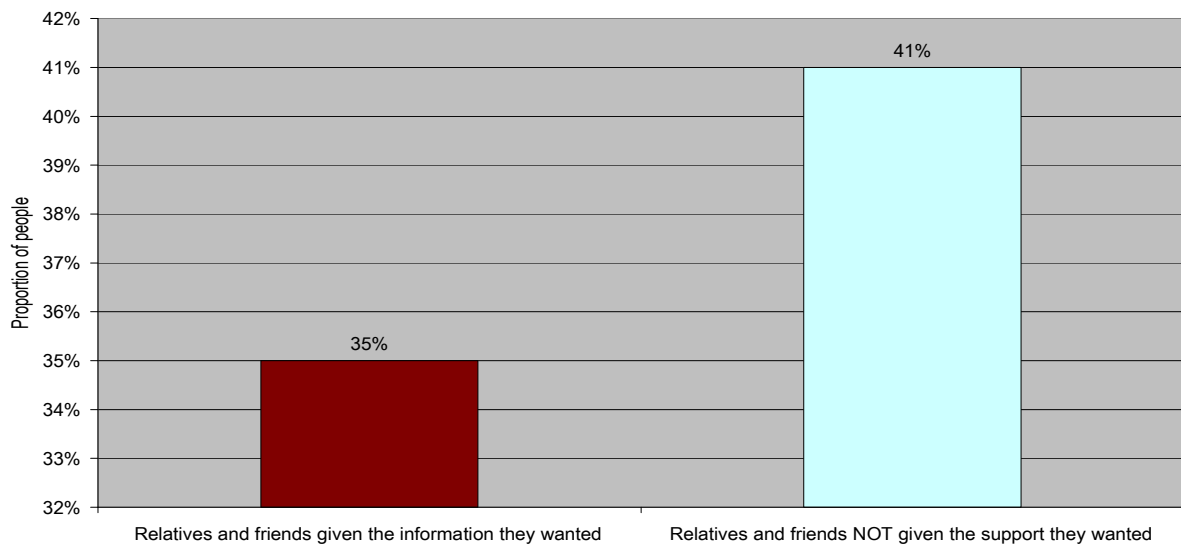
Although people’s ratings of the way in which they were treated by community staff were generally better, it remained the case that not everyone was wholly satisfied.

Figure 5: Community client’s ratings of the way staff behaved



Community clients did not always think that their relatives received the information and support they wanted. In addition, 2006 Key Performance Indicator data indicates that less than 20% of identified carers had an assessment of their needs as carers.

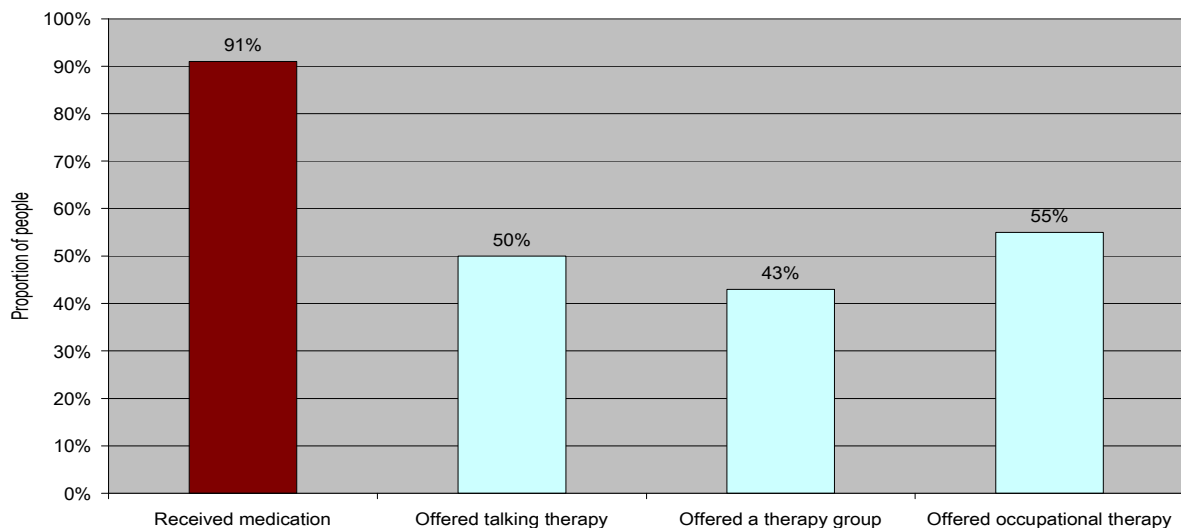
Figure 6: Community client's views about the information and support given to their relatives and friends



CONTROL: Helping people to take back control and facilitating personal adaptation

While the vast majority of inpatients received medication, only much smaller proportions said they had been offered talking therapy, occupational therapy and the opportunity to attend a therapy group.

Figure 7: Inpatients: Different treatments offered



A substantial proportion of both inpatients and community clients felt they were not given enough information. In the absence of sufficient information it is not possible for people to make informed choices.

Figure 8: Inpatient’s views about the information they were given

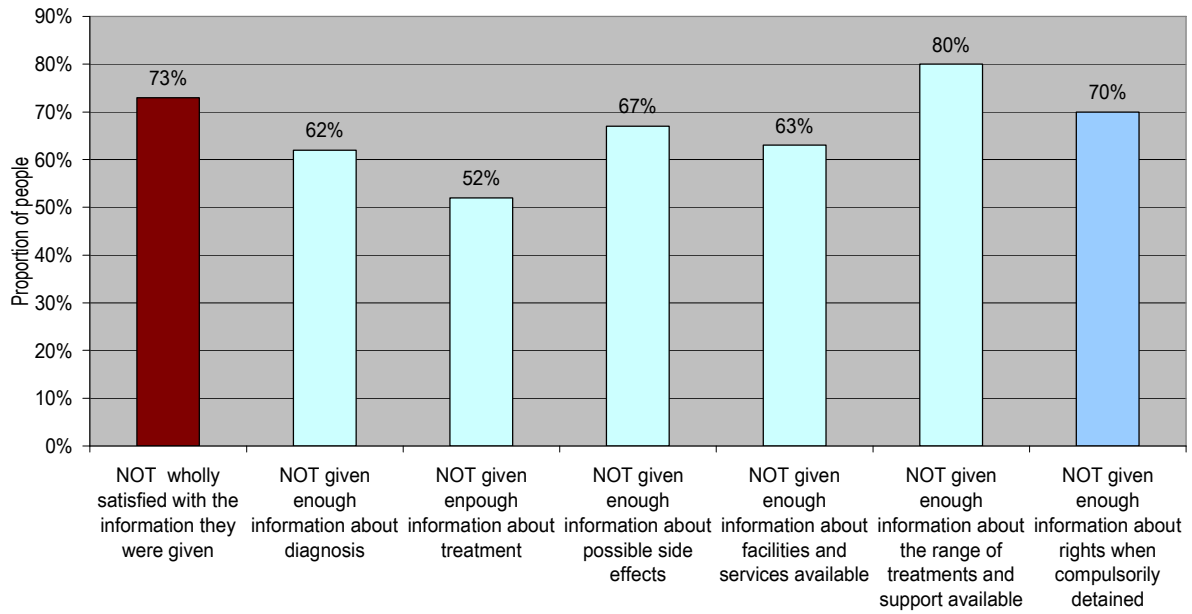
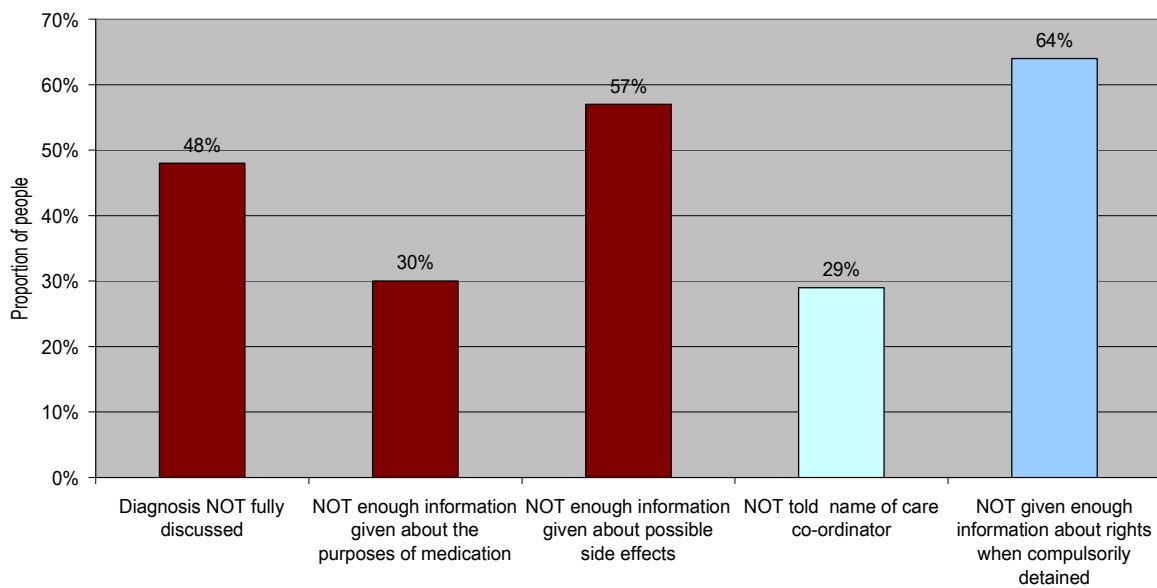
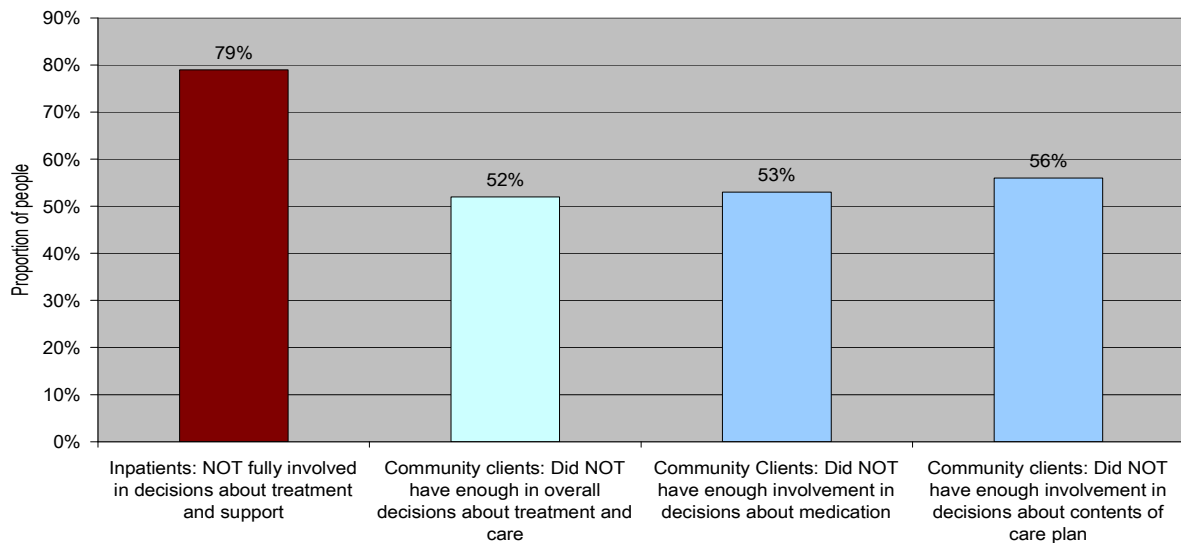


Figure 8: Community client’s views about the information they were given



The majority of both inpatients and community clients felt they had not been fully involved in decisions about their treatment and care.

Figure 9: Inpatient’s and community client’s views about their involvement in decisions about treatment and care

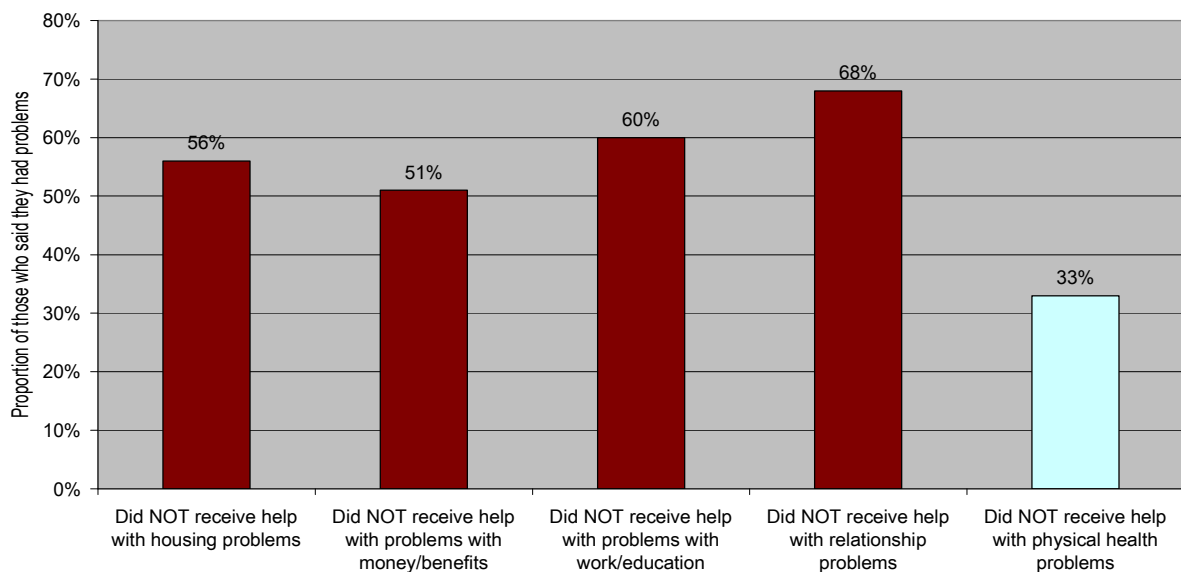


OPPORTUNITY: Helping people to access the roles, relationships and activities that are important to them

There was a considerable amount of unmet need in relation to social and physical health problems.

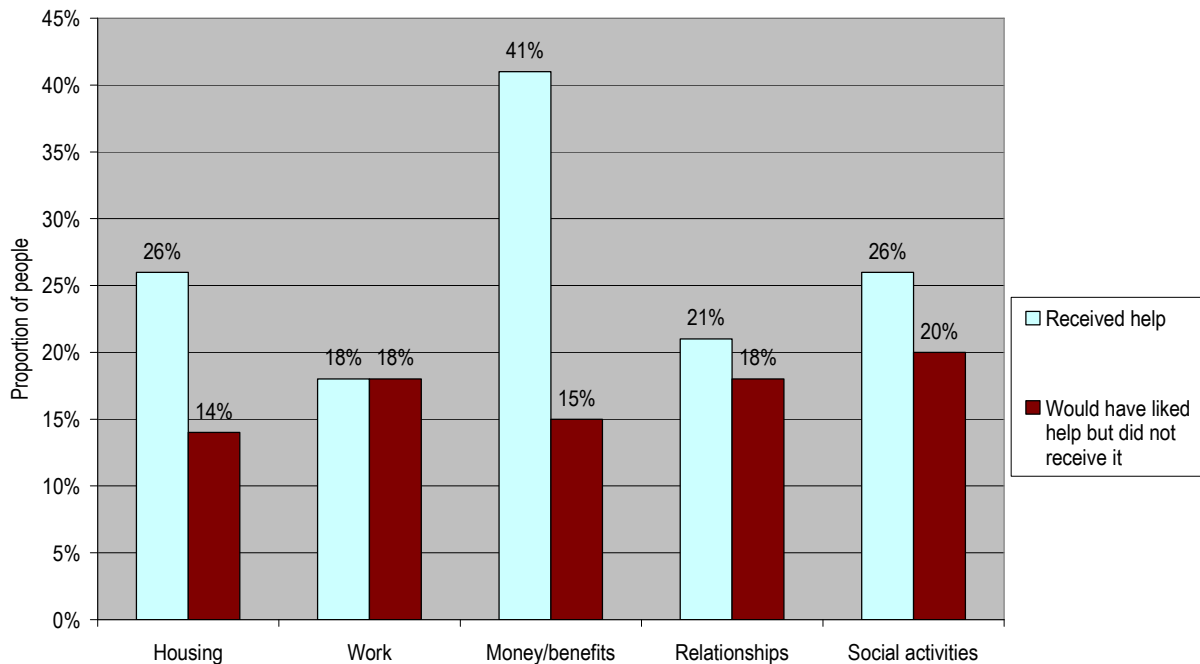
A large proportion of inpatients that said they had social problems – difficulties with housing, work/education, money/benefits, and relationships – said they had not received help with these.

Figure 10: Inpatients unmet need for assistance with social and physical health problems



Similarly, a substantial proportion of community clients said they would have liked help with getting/keeping open employment or with housing, money/benefits, relationship problems or social activities.

Figure 11: Community client’s unmet need for assistance with social and physical health problems



Implementing the Strategy

In order for the promotion of recovery and social inclusion to become the principles guiding the work of the organisation then two fundamental changes of focus are required.

- 1. The principle guiding our work at all levels of the organisation must move away from a primary focus on the reduction of symptoms towards one of enabling people to do the things they want to do and lead the lives they wish to lead.** The yardstick of success must be the extent to which the treatment and support we provide enables them to rebuild valued and satisfying lives and to gain/maintain the homes, friends, families, relationships, jobs, social and spiritual opportunities, leisure and cultural activities that give their lives meaning.
- 2. We must move away from a culture of ‘altruism’ towards a ‘customer service’ culture where the needs, wishes, concerns and convenience of those who use services are paramount.** No longer can we operate on the implicit assumption that people should ‘take what you are given and be grateful for it’ approach in which “*the convenience of the patient comes a poor second to the convenience of the system.*”⁶⁰ With an increasing emphasis on choice in health and social care, if people do not have a positive experience of using our services they will have the opportunity to go elsewhere.

⁶⁰ Department of Health (2000) *NHS Plan*, London: Department of Health

However, a number of other key changes at all levels of the organisation will also be needed:

- a. ***A move away from a primary emphasis on the identification of problems, deficits and dysfunctions towards an emphasis on the identification of a person's strengths and possibilities*** – it is these that form the basis for recovery.
- b. ***A move away from a primary emphasis on providing care towards an emphasis on fostering and promoting opportunity.*** Physical safety is critical – if a person harms themselves or other people, or is vulnerable to abuse from others, then this severely restricts their possibilities for rebuilding a meaningful and valued life. However, pursuing opportunities necessarily involves taking the risk of being unsuccessful: entering any relationship carries with it the risk of being rejected; applying for a job carries with it the risk of being turned down; obtaining qualifications carries with it the risk of failing examinations. Our task is to support people in taking such risks and help them to build on failures that do occur rather than protecting them from the possibility of failure.
- c. ***A move away from a sole focus on changing the individual so that they can 'fit in' towards one which includes increasing the capacity of communities to accommodate people with mental health problems*** and providing the support and adjustments that people need to access the things that give their lives meaning.
- d. ***A move away from an emphasis on prescribing what is good for people towards an emphasis on enabling people to take control over their own problems, lives and the support they receive.*** Mental health professionals need to be 'on tap' rather than 'on top'.
- e. ***A review of the skills and personnel we require to implement the recovery and social inclusion agenda.*** This must include a review of the core skills required by all staff, the ways in which the specialist skills of different professions can best be employed in the service of promoting recovery and facilitating inclusion and an exploration of additional skills and expertise required beyond the traditional mental health professions.

If the Trust is to fulfil its primary purpose of enabling those whom we serve to do the things they want to do, live the lives they want to lead and access those opportunities that all citizens should take for granted then recovery and social inclusion must be the principles guiding all that we do. In order to achieve this, a combination of clear corporate leadership will be required together with effective local implementation tailored to the needs and circumstances of individual boroughs, departments and specialist areas.

Provide expert leadership in implementing the Recovery and Social Inclusion Model and ensure that it is publicised and debated throughout the organisation. It is important that all staff are aware of what is expected of them and actively address ways in which they can tailor their interventions and support to facilitating the recovery and inclusion of those with whom they work.

Create of a Trust Head of Recovery, Social Inclusion and Vocational Services.

The primary aim of this post is to provide a resource to assist boroughs, departments and professions in taking forward the social inclusion agenda. This will include: ensuring the effective integration of different initiatives and facilitating the sharing of learning and good practice; identifying gaps in provision and assisting in developments to remedy these; developing a network of recovery and social inclusion leads who can deliver training/support other staff in the boroughs; contributing to the development of effective monitoring systems and performance indicators for evaluating progress in delivering the strategy; stimulating effective joint working with external agencies especially those outside the mental health arena; and exploring non-mental health funding/resources..

Establish a Recovery and Social Inclusion Steering Group. This group will comprise the Operational Management Group and Professional Heads and be responsible for co-ordinate initiatives and ensure the implementation of the Recovery and Social Inclusion Model across the organisation.

Obtain sign up to the agenda by commissioners and key partner agencies.

Promoting recovery and facilitating inclusion is a multi-agency endeavour. It is critical that at both corporate and local levels health and social care commissioners and partner organisations sign up to the recovery and social inclusion agenda and work with the Trust to develop this.

Develop a 'Recovery and Social Inclusion Action Plan' in each borough. These plans will describe how the broad strategic objectives will be taken forward in each area in a manner that is sensitive to local needs and circumstances. They will be developed in conjunction with local partner agencies and organisations including user and carer groups.

Develop appropriate monitoring, evaluation and performance indicators to measure progress in implementing the strategy and identify areas where further work is needed.

- *Core indices to evaluate progress in facilitating social inclusion* (e.g. accommodation, vocational status, physical health screening/promotion, the inclusion of targets relating to the provision of support with housing, work/education, money/benefits, relationships/social activities need to be included within electronic information systems (RiO).
- *Key performance indicators* developed in conjunction with commissioners to ensure that they include recovery and social inclusion outcomes.
- *An audit programme* needs to be developed to explore progress in specific components like self-management action plans and self-help initiatives, the implementation of plans for promoting physical health and well-being and engagement in mainstream leisure/social activities.

Require that all policies, service and practice developments be assessed for their impact on promoting recovery and facilitating inclusion. A methodology for evaluating the impact of policies, service developments and quality improvement initiatives on the promotion of recovery and inclusion will be developed. These

impact assessments will form part of all business cases, project plans and policy reviews and will be scrutinised by the relevant body (Trust Board, Trust Management Team, Borough Management Team, Project Board etc.) prior to approval of the development or policy.

Develop the recovery and social inclusion agenda within different specialist areas. In order to inform borough Recovery and Social Inclusion Action Plans individual clinical specialties (addictions, older people's services, child and adolescent mental health services, learning disability services etc.) will identify ways in which recovery and social inclusion will be promoted among different client groups. It will also be necessary to consider the implications of a Recovery and Social Inclusion model for different parts of the service e.g. inpatient wards⁶¹ and community teams.

Staff training and development.

- *Develop the general recovery and social inclusion competencies of all clinical staff⁶².* This will form part of the Trust induction for all new staff together with seminars and training opportunities for existing staff. The training being developed for the Recovery Support (STaR) Workers might be adapted for use in these endeavours.
- *Develop a group of staff (drawn from interested parties across professions/staff groups) to deliver the training and act as a source of expertise within different boroughs.* Embedding the recovery and social inclusion agenda at the level of individual care will require a group of people who can act as trainers, mentors and advisors. This cannot be the domain of a particular profession but must include people with the appropriate interests and skills from different professions and grades as well as the new Recovery Support Workers and existing Employment Specialists and Welfare Benefits Experts.
- *Include recovery and social inclusion competencies in the Knowledge and Skills Framework for all clinical staff and those who have contact with clients.*
- *Ensure that recovery and social inclusion competencies form part of staff supervision and appraisal.*
- *Negotiate with local universities and colleges to embed a recovery and social inclusion perspective, and the skills required to deliver this, in pre-qualification training.* If the Trust's primary purpose is to promote recovery and inclusion then the skills necessary to do this cannot be seen as a post-qualification add-on. They need to be embedded in pre-qualification training and we need to work with partner education/training providers to ensure that this is the case.

Review staff skills and skill mix. This would involve:

- *Review the specialist skills of existing professionals and how these might be tailored to the goal of promoting recovery and inclusion.* This should be informed

⁶¹ See, for example, Repper, J. & Perkins, R. (2002) Working for Inclusion: Acute Care in P. Bates (Ed) *Working for Inclusion*, London: Sainsbury Centre for Mental Health in conjunction with the Community development foundation, mentality, the National development Team, Mind and the Disability Rights Commission

⁶² O'Hagan (2001) *Recovery Competencies for New Zealand Mental Health Workers*. (2001) Wellington, NZ: Mental Health Commission

CSIP / DH (*in press*) Social Inclusion Capabilities. CSIP: London

by work already being conducted at a national level within different professions and in the context of the CSIP 'New Ways of Working' programmes.

- *Explore the new skills and expertise that we need.* This must involve looking beyond the traditional professions and consider the need for expertise in other areas. We already have some Employment Specialists, Welfare Rights Experts, Exercise Therapists and an Artist in Residence, and are in the process of developing Recovery Support Workers (STaR workers), but we may also need to think about other areas of expertise like housing, anthropology to help with the many clashes of culture that exist within our services, teachers, musicians, writers, handymen(and women) to help people to set up home and maintain their accommodation, and increasing the availability of expertise through personal experience of recovery from mental health problems.
- *Establish proper career structures* that enable people with skills outside the traditional mental health professions to gain promotion to the higher grades within the organisation.

Rachel Perkins,
Director of Quality Assurance and User/Carer Involvement

Miles Rinaldi
Vocational Services Manager and
Head of Delivery National Social Inclusion Programme, CSIP/DH

23rd May 2007

Recovery and Social Inclusion Strategy Implementation Plan

Objective		People responsible	Date to be completed
1. Provide expert leadership in implementing the recovery and Social Inclusion Model and ensure that it is publicized and debated throughout the organisation	Launch the strategy at the 'Focus on the Future' event on 22 nd June 2007	<ul style="list-style-type: none"> • John Rafferty, Chair • Peter Houghton, Chief Executive • Maresa Ness, Chief Operating Officer • Rachel Perkins, Director of Quality Assurance and User/Carer Experience 	June 2007
	Organise seminars for individual teams in the trust. Collect and distribute information and materials that may be of use to teams/services	<ul style="list-style-type: none"> • Rachel Perkins, Director of Quality Assurance and User/Carer Experience 	Ongoing, from July 2007
2. Create a Trust Head of Recovery, Social Inclusion and Vocational Services		<ul style="list-style-type: none"> • Peter Houghton, Chief Executive • Maresa Ness, Chief Operating Officer 	June 2007
3. Establish a Recovery and Social Inclusion Steering Group		<ul style="list-style-type: none"> • Maresa Ness, Chief Operating Officer 	June 2007
4. Obtain sign up to the agenda from commissioners and key partner agencies		<ul style="list-style-type: none"> • Service Directors • Peter Houghton, Chief Executive 	October 2007
5. Borough Recovery and Social Inclusion 'Action Plans'	Each borough to develop an implementation plan in conjunction with partner agencies, service users and carers	<ul style="list-style-type: none"> • Service Directors 	December 2007
	Implement borough plans		January 2008 ongoing
6. Develop appropriate monitoring, evaluation and performance indicators to measure progress in implementing the strategy and identify areas where further work is needed	Methods for collecting core indices to evaluate progress from existing electronic information systems	<ul style="list-style-type: none"> • Glynn Dodd • Director of Planning and Performance • David Green, Manager of IMT and IT • Head of Recovery, Social Inclusion and Vocational Services 	March 2008
	Develop key performance indicators in conjunction with commissioners	<ul style="list-style-type: none"> • Glynn Dodd • Director of Planning and Performance • Service Directors • Head of Recovery, Social Inclusion and Vocational Services 	March 2008

Recovery and Social Inclusion Strategy
Final – approved by Trust Board on 31st May 2007

Objective		People responsible	Date to be completed
6. (continued)	Ensure audit programme includes issues relevant to recovery and social inclusion agenda	<ul style="list-style-type: none"> • Director of Nursing and Governance • Service Directors 	March 2008
7. Require that all policies, service and practice developments be assessed for their impact on promoting recovery and facilitating inclusion		<ul style="list-style-type: none"> • Director of Nursing and Governance 	Ongoing from October 2007
8. Develop and implement the recovery and social inclusion model within different specialist areas.		<ul style="list-style-type: none"> • Clinical Leads • Rachel Perkins, Director of Quality Assurance and User/Carer Experience • Head of Recovery, Social Inclusion and Vocational Services 	March 2008 ongoing
9. Introduce appropriate staff training and development	Include description of recovery and social inclusion approach in staff induction	<ul style="list-style-type: none"> • Sandy Gillett, Director of Human Resources • Rachel Perkins, Director of Quality Assurance and User/Carer Experience • Head of Recovery, Social Inclusion and Vocational Services 	Ongoing from July 2007
	Develop training for staff (including Recovery Support Workers)		Ongoing from July 2007
	Negotiate inclusion of a recovery and social inclusion approach in pre-qualification training	<ul style="list-style-type: none"> • Director of Nursing and Governance • Professional heads of Occupational therapy, Psychiatry, psychology, Social Work 	December 2008
	Include recovery and social inclusion competences in the Knowledge and Skills Framework for posts and the supervision/appraisal of staff	<ul style="list-style-type: none"> • Sandy Gillett, Director of Human Resources 	March 2009
10. Review staff skills and skill mix needed to deliver the social inclusion agenda		<ul style="list-style-type: none"> • Sandy Gillett, Director of Human Resources • Professional Heads • Rachel Perkins, Director of Quality Assurance and User/Carer Experience • Head of Recovery, Social Inclusion and Vocational Services 	March 2008

Rachel Perkins, Director of Quality Assurance and User/Carer Experience
23rd May 2007