BRIEFING

Implementing Recovery through Organisational Change

Centre for Mental Health

Mental Health Network NHS CONFEDERATION

3. Recovery, Public Mental Health and Wellbeing

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Introduction

Recovery is concerned with living a life beyond illness (Shepherd *et al*., 2008). While the ideas of recovery and recovery-oriented practice have the potential to transform mental health services, we need to look beyond what is provided by these services and examine the whole range of resources and opportunities that can support quality of life, full citizenship and human rights for people with mental health problems.

Recent developments in public health, notably the emphasis on mental health and wellbeing, can contribute to a greater orientation towards recovery – in local systems and in services, as well as in communities. The public health responsibilities of local councils, as well as the development of Health and Wellbeing Boards, are prompting creative thinking about what supports recovery where people live, as well as the benefits of greater integration between mental health services and public mental health and a more holistic approach to mental and physical health.

This paper outlines how public mental health and the growing 'wellbeing' movement can contribute to one of the key challenges for recovery: increasing opportunities for building a life beyond illness (Sainsbury Centre for Mental Health, 2009a), keeping in mind the principles of respect for people's self determination, choice, control and potential, as well as for support that does not undermine citizenship.

It sets out the ways that health care providers, those using or working in mental health services, voluntary groups, commissioners of services, colleagues in public health and those with a role, or potential role, on Health and Wellbeing Boards, can support recovery through the development of public health and community based approaches. Health and Wellbeing boards have the potential to influence commissioning that promotes and protects mental wellbeing and supports recovery. We conclude by outlining 12 opportunities for these boards to support recovery-oriented commissioning.

Public health and local systems

Developments in public health

The context for commissioning, delivering and using mental health services is changing radically (Joint Commissioning Panel for Mental Health, 2012). As well as a continuing focus on personalised approaches to supporting people with mental health problems, this includes changes in local health and social care systems, giving a much stronger role to primary care and local authorities.

These changes have the potential to support a stronger recovery focus, both within services and within local communities. They also provide opportunities for wider public debate about meeting mental health needs. For mental health services, this should result in a richer awareness of different local resources and opportunities, how these can be drawn on by people involved in the design of their own care and support and how to protect valued community resources, especially in the context of sharp cuts in public spending.

Local government

Responsibility for public health is moving to local government and there is a growing emphasis on 'public mental health' or promoting the mental wellbeing of the whole population, as well as an ongoing commitment to reducing inequalities in health.

Equal recognition for both mental and physical health and the importance of mental health to overall health and quality of life is a core theme in a range of Government policy, including:

- *Healthy Lives, Healthy People* (Public Health White Paper: Department of Health, 2010a)
- *No health without mental health* (Cross Government Mental Health Outcomes Strategy: HM Government, 2011)
- *Mental Health Implementation Framework* (HM Government, 2012a).

Health and Wellbeing Boards

Health and Wellbeing Boards (HWBs) are statutory bodies, to be established by local authorities, with a formal wellbeing remit and strategic responsibility for coordinating commissioning across the NHS, social care, children's and public health. HWBs must include at least one local councillor (elected member), directors of social services, children's services and public health, representatives of clinical commissioning groups and the local Health Watch. They may also include any other partners considered to have an important influence on health and wellbeing locally.

Some localities have plans for both a formal Health and Wellbeing Board and a wider 'partnership for wellbeing' which could include a range of local providers, community and voluntary agencies and representatives of local communities e.g. faith communities. North Yorkshire County Council describes their new arrangements as follows:

"The [health and wellbeing] board will give communities a greater say in the services needed to provide care for local people and to tackle the wider influences on health, such as education, transport, housing, employment and leisure services. The board will have two "doing arms" to drive forward its day to day work. These will be North Yorkshire's Children's Trust and North Yorkshire's Adult Partnership Trust (involving representation from acute hospital trusts, mental health trusts, the voluntary sector and care sector etc)."

North Yorkshire Partnerships, 2011

Assessing needs

HWBs are responsible for identifying and addressing local health and wellbeing needs, including undertaking Joint Strategic Needs Assessment (JSNA) and producing a Joint Health and Wellbeing Strategy (JHWS) based

on local priorities (Department of Health/Local Government Association, 2011). JSNA's should ensure that changing needs (e.g. housing, transport, demographics) are captured in local planning and that commissioning responds to the wider, societal determinants of health and health inequalities. In some areas, the JSNA will include a JSAA or Joint Strategic Assets Assessment, reflecting a growing interest in strengths-based approaches that capture health assets, as well as deficits, in local communities (Department of Health / Local Government Association, 2011; Foot & Hopkins, 2010).

A number of Health and Wellbeing Boards are using policy objectives from the Marmot Review to drive their health and wellbeing strategies and to ensure a focus on the wider determinants of health (Marmot, 2010; Commission on the Social Determinants of Health, 2008).

Place based approaches

HWBs have considerable potential to generate creative thinking and to encourage collaboration between councils, the NHS, the voluntary sector, communities and the public and to influence major shifts in local public sector spending. They reflect the importance of the 'place shaping' role of local government and will contribute centrally to how local people, especially those who are most vulnerable, experience their neighbourhoods. Joint Health and Wellbeing Strategies can be used to reflect growing evidence on the importance of mental health and wellbeing, the social, economic and human costs of mental health problems (Department of Health, 2010b) and to influence commissioning that promotes and protects mental wellbeing and supports recovery.

Recovery

Recovery oriented commissioning, that is working beyond the boundaries of conventional mental health systems, involves ensuring that people with mental health problems have a wide range of options for meeting their needs and aspirations, and that these are consistent with enjoying full citizenship and a life beyond services. This involves addressing how much people have to live on, housing, transport and getting out and about, opportunities for employment, training and education, safety, access to the natural world, leisure, sports and culture. In other words, the rich fabric of opportunities, activities, resources and relationships available where people live, which are central both to recovery and to public health. The responsibilities of HWBs include factors that have a strong influence on recovery and on opportunities for people with mental health problems (and other people with long term conditions) to determine how their support needs are met (Box 1). A recurring theme in the recovery literature is the importance of acknowledging and responding to the wider circumstances of people's lives and experiences (Kalathil, 2011).

Much of the thinking about new approaches to providing care and support has come from mental health and disability rights and from people involved in the user, survivor and recovery movements (www.recoveryin-sight.com). There is still a considerable way to go before the full realisation of approaches which enable people with mental health problems to exercise real choice and control (Duffy, 2010a). It's crucial that these issues are on the HWB agenda.

Box 1: HWB remit – factors influencing recovery

- Housing
- Education
- Transport
- Training and skills
- Employment
- Built and natural environment
- Income
- Social networks and neighbourhood life
- Arts and culture
- Sports and leisure
- Safety
- Primary care

Public mental health and wellbeing

Public mental health aims to improve mental health and wellbeing for the whole population and includes promotion and prevention, as well as achieving greater equity, quality of life and better outcomes for people experiencing mental ill health (Box 2).

Social determinants

Public mental health is concerned with the social determinants and understanding how factors like social position, occupation, income, housing, education and employment influence people's mental health, including their chances of recovery (Campbell, 2010; Fair Deal for Wellbeing Discussion Kit). Public mental health is also centrally concerned with mental health inequalities, the impact of adverse events (violence, abuse, racism and other forms of discrimination) and the relationship between mental health and physical health (Fernando, 2010; Royal College of Psychiatrists, 2010). Poor mental health and wellbeing contribute to poorer outcomes in many areas of life, often reinforcing inequalities, because those who are most disadvantaged are most likely to experience both mental illness and poorer mental wellbeing. So, mental health is both a consequence and a cause of inequalities (Friedli, 2009).

Public Health England

Nationally, responsibility for public health, including public mental health, is transferring to a new public health service, Public Health England, sitting within the Department of Health. Public Health England will drive the new public health system, with greater alignment across the NHS, public health and social care, the integration of mental and physical health and a stronger focus on the prevention of ill-health. As part of this, it will support local public health services in ensuring that local commissioning takes full account of local mental health and wellbeing needs, and that local allocation of resources reflects these needs. In line with the leadership role of local government, Directors of Public Health (DPH) will be located within local authorities, with overall responsibility for health improvement in their areas.

Box 2: Cross government mental health strategy

No Health Without Mental Health is the key policy framework for promoting mental health and wellbeing, preventing mental health problems and improving treatment outcomes:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination

(From: HM Government, 2011)

Whole community approaches to recovery

Public mental health and the wider wellbeing movement are concerned with addressing the factors that influence mental wellbeing for everyone, whether or not they have a diagnosis, and with creating environments and cultures that support wellbeing: in schools, colleges,

workplaces and on the streets. Public mental health can support recovery goals by asking what kind of communities support recovery and by investing in community based support that:

- builds community capacity
- reduces need and demand for specialist secondary mental health services
- alleviates the risk of crises.

This means support that is informed by needs assessment and consultation, building on knowledge of what people find helpful in their neighbourhoods (Box 3). This might include peer support groups, advocacy, tenancy support, adult education and training opportunities, sources of information and advice, e.g. on welfare rights or employment, as well as resources that support overall wellbeing and quality of life: culture and leisure services, public toilets, park benches and accessible footpaths.

From walking groups to literacy and numeracy classes, from learning English to managing debt, finding out about sources of low cost credit, tenancy maintenance, cookery classes and gardening projects, access to natural spaces and places to 'stop and chat', all neighbourhoods will have assets that support recovery and many are rich in community and voluntary organisations. Commissioning that supports and protects these sources of support, as well as identifying gaps and barriers to access, makes good economic sense (Department of Health, 2010b; Knapp *et al.*, 2010) but may be vulnerable to short-term thinking in the current financial climate.

Box 3: Mental Wellbeing Impact Assessment

Mental Wellbeing Impact Assessment is a tool to assess and measure the impact of policy, planning and interventions on mental health and wellbeing. It has been widely used to inform planning and commissioning decisions and to ensure, for example, that the likely mental health impact of how a service or policy is delivered is taken into account.

It is built around four key factors that promote and protect mental wellbeing:

1. enhancing control ,
2. increasing resilience and community assets,
3. facilitating participation and inclusion,
4. the wider social determinants of mental wellbeing: equity and social justice.

Mental Wellbeing Impact Assessment is also being used by local authorities to increase understanding of mental health and wellbeing and as a strategic tool for health and wellbeing boards.

(Cooke *et al*. 2011; Local Government Association, 2012)

Wellbeing debates

During 2011, The Office for National Statistics ran a public consultation on 'what matters to people's wellbeing' , which will inform the development of new measures of national wellbeing (ONS, 2011).

A wide range of campaigns and agencies are involved in ongoing debates about what wellbeing means and what influences it (www.actionforhappiness.org/). Some are focussed primarily on individual wellbeing; others are concerned with wider economic and environmental factors (www.wellbeingproject.co.uk). Some councils are using 'wellbeing' to bring together different stakeholders, for example the Wellbeing and Happiness in Lambeth Programme (www.lambethfirst.org.uk/mentalwellbeing/). Wellbeing can provide an umbrella for exploring different cultural perspectives on health and mental health, for addressing issues of race and class (Fernando, 2010) and for reducing stigma and taboos around mental health problems.

Since publication of the Government Foresight Report (Government Office for Science, 2009), there has been growing interest in how mental health and wellbeing contribute to a wide range of outcomes - in education, employment, health, relationships, criminal justice and quality of life (Stoll *et al*., 2012). Increasingly, mental wellbeing or 'mental capital' is seen as an asset and a core element of resilience for individuals, families, organisations and communities.

Wellbeing and Recovery

Wellbeing is not only, or necessarily, about the absence of mental illness and there are many parallels between the literature on wellbeing and the principles of recovery, for example a common emphasis on what supports mental wellbeing, notwithstanding diagnosis or symptoms of illness. In this sense, a focus on wellbeing can be helpful in moving beyond narrow and contested definitions of mental illness, to address factors that underpin positive mental health for everyone, and to reduce inequalities in exposure to factors that are known to increase risk for mental health problems.

A valued life

Wellbeing is relevant to many different agendas that are also important to recovery, including health inequalities, social justice and the rights enshrined in the UN Convention on the Rights of Persons with Disabilities. The wellbeing literature also draws on a deeper understanding of the factors that make up a valued life for individuals, families and communities. These include a sense of meaning and purpose, opportunities to contribute, respect and dignity, freedom from racism and other forms of discrimination, feeling valued, family life and relationships, security, political voice, sense of belonging and affiliation (Nussbaum, 2011). People living in poverty, as well as other vulnerable or excluded groups, including people with mental health problems, consistently describe the pain of being made to feel of 'no account', which is often experienced as more damaging to wellbeing than material hardship.

This focus on the importance of values and social relationships is also central to assets-based approaches and has influenced a greater emphasis on social outcomes or commissioning for social value i.e. how each pound spent also produces wider community wellbeing. Examples might include commissioning that supports family life, creates local jobs, empowers communities, strengthens control, uses local resources or skills and builds connections (O'Leary *et al*., 2011).

What a stronger focus on public mental health and wellbeing should mean for recovery

Recovery focuses on the individual: their unique experiences, values and preferences and emphasises the development of a personalised approach. This fits comfortably within clinical and social services where the development of a relationship between, say a professional and a service user, is crucial. In a recovery-oriented service the emphasis would be on co-production, where attention to the perspective of the person is balanced by a supportive external perspective. In addition, there is a greater emphasis on moving the impact of services into the background, while supporting the relationship between people, their families and the communities in which they live. Professionals and others thus become available for help or intervention when needed, being "on tap, rather than on top". These general principles are consistent with public health and wellbeing strategies which promote a greater sense of autonomy, agency and respect for people's capacities.

Social justice

As well as emphasising recovery principles, personally valued goals and the need for mental health services to change, the recovery movement has also argued for social transformation to address the stigma and exclusion that are the common experience of people with mental health problems (Frese *et al.*, 2009). In this way, recovery connects the personal with the political and is concerned with social justice, individual rights, citizenship, equality and freedom from prejudice and discrimination. A public health approach offers a strong focus on social determinants of health and on the reduction of health inequalities, which support the recovery movement's concerns with social justice. Progress in these areas depends on changes that extend beyond the scope of health and health services, to economic, legal, political and social changes that support equity and the rights of all citizens, confronting for example poverty, the welfare system, discrimination, isolation and powerlessness (Duffy, 2011).

The principal ideas of recovery – hope, agency and opportunity – are also integral to practical considerations for citizenship: control over one's life and decisions, setting one's own direction, the means to shape one's life, a place to belong, help from others and the opportunity to help others. This means an emphasis not only on personal development, but also on the need for collective support and reciprocity to allow people to build decent lives and for their communities to flourish (Duffy, 2012).

Social inclusion

"A focus on improving social inclusion, becoming social activists who challenge stigma and discrimination, and promoting societal well-being may need to become the norm rather than the exception for mental health professionals in the 21st Century."

(Slade, 2010)

It is well documented that people with mental health problems, particularly those with long-term problems, are likely to be excluded from participating in many areas of society (Boardman *et al.,* 2010). They are likely to have limited incomes, to be unemployed, have limited education or training, to have restricted social networks, to experience discrimination, to have few opportunities to engage in their local communities and to have poor physical health.

Being part of civil society has important implications for people with mental health problems to live a better life and one that they choose. They feel that it is important for themselves and their families to be part of their communities; to be valued members

of those communities; to have access to the opportunities that exist in their communities and the prospect of contributing to them.

Community is both a means and an end (Duffy, 2010a). Rich and diverse communities provide opportunities for contribution, support and self-expression: the conditions for full citizenship and for strengthening families and civil society. They also have potential to challenge stigma by providing a means of breaking down ignorance, prejudice and discrimination. The rights to a reasonable level of support, income and freedom from discrimination are essential components of this citizenship (Duffy, 2011).

Housing

Good housing is crucial for mental health and underpins recovery, social inclusion and citizenship. Settled housing provides the basis for individuals to build a more independent life and the opportunity to access employment, education, and the help and support they might need. Support with housing can improve mental health and help reduce the demand for health and social care (NHS Confederation, 2011).

Action to address housing is fundamental and, to be effective in improving recovery and reducing the unnecessary costs associated with poor access to housing and housing support, this means integration and collaboration across acute and secondary health care and housing (National Housing Federation, 2010; NHS Confederation, 2011; National Mental Health Development Unit, 2010). The creation of Health and Wellbeing Boards provides an opportunity for improving such collaboration and recognising the housing needs of people with mental health problems (NHS Confederation, 2011).

Employment

Like housing, employment is both a means of supporting wellbeing and an important indicator of recovery. Generally speaking, work is good for you (Waddell & Burton, 2006). People with long-term mental health problems have high rates of unemployment and worklessness is a key factor in contributing to their exclusion from mainstream society (Boardman *et al.,* 2010). Lack of work is detrimental to mental health and wellbeing and it has been shown that, for people with mental health problems, having a job can lead to reduced symptoms, fewer admissions and reduced use of services.

Being in employment gives people the benefits of an income, social contact and a sense of purpose. There is a wealth of evidence for the effectiveness of supported employment schemes, in particular Individual Placement and Support (IPS), which aim to get people with severe mental health problems into paid competitive work (Sainsbury Centre for Mental Health, 2009b; 2009c). However, IPS is only patchily implemented in the United Kingdom and this deficit needs to be addressed by commissioners. Effective partnerships between health services, employers and employment agencies are essential to the process of getting people with mental health problems into work and supporting them while in work (Seymour, 2010).

Mental health problems contribute significantly to absenteeism and presenteeism and stigma and discrimination towards people with mental health problems in the workplace is high (Sainsbury Centre for Mental Health, 2007). The workplace offers important opportunities for improving wellbeing and combating stigma.

Recovery – from services to community development

The challenge for public mental health is to translate the principles of recovery, and what is known about recovery-oriented practices, into action at the community level. This may be easier where local authorities, for example Manchester City Council, are already commissioning mental health services in line with IMRoC principles.

Some suggestions are shown in Box 4. This involves change at two levels:

- First level change that benefits individuals through accessible services and opportunities which facilitate recovery.
- Second level change aimed at creating the conditions within communities that maintain recovery, including improving public attitudes, increasing access, reducing barriers and supporting connections.

(Onken, *et al.,* 2007; Lanarkshire Recovery Network: Reflections and Future Focus http://www.elament.org.uk/lanarkshire-recovery-network.aspx)

It is important that the principles of recovery are taken into community organisations and form the basis for staff training and the development of their organisational cultures.

The development of a strength-based approach, important for recovery-orientated practice (Slade, 2010) has its parallel in an asset-based approach to improve community health and wellbeing (Foot & Hopkins, 2010). These assets include the practical skills, capacity and knowledge of local residents, social capital, the effectiveness of local community and voluntary associations, and the resources of public private and third sector organisations. Assets-based approaches also place a strong emphasis on new models of partnership, where health and wellbeing are co-produced through more equitable and reciprocal relationships between health or social organisations and local communities (Foot & Hopkins, 2010; Solutions for Public Health, 2011).

Personalisation

The development of personal budgets and self-directed care is a key element of a recovery-oriented service (Alakeson & Perkins, 2012). Duffy (2010a; 2010b) has extended this into a personalisation model, the purpose of which is to allow people to take control of their own lives. This model contains four features: self-directed support, co-production, community-based support and total place commissioning. To operate this model requires support through the strengthening of informal networks, the extension of peer support, the use of community organisations, the engagement of support services and means of ensuring professional advice (Duffy & Fulton, 2010).

The use of peers is key to developing recovery-orientated services and this is reflected in public health developments. The challenge is developing not only a cadre of trained or formal peers, but also informal networks of peers and significant others. This would apply not only to people with mental health problems, but also their families and carers. The extension of the educational approach also requires co-produced solutions using peer trainers.

The development of community and public health approaches that support recovery through strengthening community and citizenship can complement, but not replace, good mental health services. It is important that the necessary support services and professional advice can be ensured when needed and that recovery-orientated mental health service are outward looking and are complemented and enhanced by parallel developments in local communities.

Box 4: Translating recovery principles and recovery-oriented activities into community developments

Recovery principles and approaches	Supporting recovery through public health and wellbeing developments
Maintenance of Hope	Developing a recovery-oriented culture in community organisations and in the community
Agency (control)	Development of personal meaning, responsibility, positive identity. Giving people greater opportunities to influence decisions.
Opportunity	Community support and developments.
Strengths-based approach	Using an asset-based approach; reducing health inequalities, stigma and discrimination; valuing resilience; improving wellbeing; strengthening community networks; supporting local expertise; complementing, not replacing, good service delivery; people-centered partnerships and scrutiny; strategic commissioning; co-production.
Importance of peers	Peer workers, mutual self-help groups, peer run programmes. Mobilise informal peer support.
Importance of family, carers, significant others, informal supports	Valuing resilience. Improving well-being. Strengthening community networks. Supporting local expertise.
Co-production	Co-production for health (Solutions for Public Health, 2011): develop co-productive model for health and wellbeing; promote an asset-based approach; create partnership and leadership.
Emphasising an educational approach	Promotion of well-being, anti-stigma programmes.
Needs and outcomes defined and valued by service users	Strategic commissioning (co-production, measuring assets), developing wellbeing action plans. Defining needs and outcomes for local communities (Duffy, 2010a).
Personalisation	Personalisation model – self-directed support, co-production, community-based support, total place commissioning (Duffy, 2010a; 2010b; Duffy & Fulton, 2010).
Supporting personalisation	Strengthening existing networks, extending peer support, using community organisations, engaging support services, ensuring professional advice (Duffy & Fulton, 2010)
Professionals 'on-tap'	Community developments complementing, not replacing, good service delivery, engaging support services, ensuring professional advice.
Developing community opportunities	Ensuring that what already exists in communities for everyone – from libraries to welfare rights to leisure services to walking groups – is accessible.

Commissioning for recovery: messages for Health and Wellbeing Boards

"Those most at risk are those without committed, unpaid relationships in their life. However good the service provider, people who have no one in their life who is not paid to be with them are vulnerable not only to abuse, but to gentle neglect and complacency."

(Fitzpatrick, 2010)

1. Recovery is made possible through access to everyday resources, relationships and opportunities, with professional support and services planned and organised around the needs and capacities of individuals, their friends and families. A core task for HWBs will be to ensure that Health and Wellbeing Strategies support the inclusion of people with mental health problems as full citizens.

2. Commissioning for Recovery involves two key principles:

   - an overall commissioning strategy that reflects the importance of mental health and wellbeing and addresses the determinants of mental health;

   - ensuring that people with mental health problems (and those who are vulnerable to poor mental health) have access to resources, opportunities and support from services that promote recovery.

3. The strength of the evidence on the importance of social contact, social relationships and social networks for public health, mental health and recovery (and the impact of isolation and loneliness, notably on those who are vulnerable or elderly), means that commissioning for social value should be central to Joint Health and Wellbeing Strategies. This includes addressing financial, environmental and service barriers that inhibit or undermine social relationships.

4. HWBs will need to provide leadership on the wider public mental health agenda, which creates a framework for commissioning that is 'mental health aware' and reaches out to those whose mental health needs are not being met, who face barriers in accessing support, have complex needs or experience multiple disadvantage (HM Government, 2012b). Improving mental health will contribute centrally to improving outcomes across a very wide range of domains (Department of Health, 2011a; 2011b; 2012a; 2012b).

5. The features of local communities that support recovery cut across all sectors, organisations and agencies: 'good support can come from many places' (Alakeson & Duffy 2011). HWBs will therefore have a crucial co-ordinating and partnership building role, notably with those outside health and social care e.g. local employers, schools and colleges, police and criminal justice, sports, leisure, culture and environmental services.

6. Knowing what mental health support is available, helpful and trusted and protecting valued assets for mental health will depend on:

   - Finding ways to involve people with mental health problems and their networks, especially those whose voices are rarely heard, for example those who are homeless, gypsy travelers and other BME groups and young people;

   - Building, maintaining and disseminating information about sources of support, particularly small scale community or business services, faith groups and informal networks that are not part of mainstream statutory or voluntary sector networks;

- Increasing accountability to those who use (and those who are reluctant to use) services (NICE, 2012);

- Using the evidence to demonstrate the value of prioritising mental health spending and thinking creatively about spend, e.g. linking up the ring-fenced public health budget with other budgets to join up services across the NHS and local government.

7. Draw on the learning from approaches that have been successfully used in promoting recovery-oriented services. These include personalisation, co-production and peer support.

8. Good housing is crucial for mental health and underpins both recovery and citizenship. Addressing housing is associated with a very wide range of improved outcomes and is also cost-effective. Collaboration between mental health services and housing agencies is essential.

9. Employment is a key recovery outcome and important for wellbeing and inclusion. People with mental health problems should be supported to remain in work. There is a strong evidence base for schemes to support people with mental health problems into open employment. The joint strategic needs assessment should provide a view of the local mental health and employment situation (London Mental Health and Employment Partnership, 2012).

10. The principles of recovery oriented commissioning for people with mental health problems, with their focus on shifting power and control to those who use services, are also relevant to people with physical and intellectual disabilities, people with long term physical conditions and to addressing wider issues of equity, justice and empowerment raised by the user/survivor movement and advocates within the Black and minority ethnic mental health voluntary sector.

11. Poverty, deprivation, exclusion and disadvantage are major barriers to recovery. Total place or 'whole place' approaches, which may include community budgets, are based on growing evidence that neighbourhood life is a key factor in health and other outcomes and that poor outcomes cluster at a very local level.

12. Concerted efforts to ensure that employment services meet the needs of people with mental health problems and addressing barriers to good quality employment, should be matched by ensuring that people are aware of their entitlements and dignity in entitlement.

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