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Abstract

As community-based mental health services evolve there is increasing awareness of the restorative potential of community participation and of its importance in promoting social inclusion. Many mental health service users are stigmatised by the segregated services they use as well as by the negative attitudes commonly held in our wider society. This article reports on a participatory action research inquiry in Bristol UK which examined the positive impact of mainstream community participation on mental health service users' recovery and social inclusion and how service users' experiences informed joint-planning between mental health services and the learning community to promote social inclusion. Focusing on the significance of inter-agency work and highlighting the value of micro-level knowledge of the daily challenges faced by service users, it identifies ways of improving access to mainstream services.

Introduction

Different UK governments have acknowledged the need for a single mental health strategy that encompasses mental health service delivery, and the mental health of the population as a whole (DH, 2009; DH, 2011). One issue that unites these spheres is social exclusion. This has been defined as non-participation in the key activities of the community in which one lives and is recognised as both a cause and a consequence of poor mental health (Burchardt et al, 2002). Approaches to promoting social inclusion therefore range from mental health sector initiatives aiming for greater community-embeddedness of mental health services, to community development work aiming to tackle societal stigma and social exclusion.

This article seeks to develop an approach to mental health practice that spans both mental health services and a whole population approach. It draws on evidence from a participatory action research (PAR) project in Bristol UK which examined how community mental health work orientated to service users' community participation had produced positive outcomes,

and how the cross-cutting inter-agency work necessary to support this kind of work was facilitated. A comprehensive research report is provided elsewhere by Fieldhouse (2012) and this article is therefore a reflection on the implications of its findings for community mental health practice. These are characterised as a community development work approach (Seebohm and Gilchrist, 2008), which builds on traditional micro-level mental health practice operating within the bounds of one-to-one client-practitioner relationships, and extends outwards to more collective community activity.

Mental health and social inclusion

Most mental health services are now delivered to people living in the community. The social inclusion agenda challenges the historical practice of segregating service users from society and focuses on the need to support people's access to a full range of mainstream life opportunities not just within community based mental health *services* (SCMH 2010). Such opportunities are essential to service users' *recovery.* This term refers to the subjective experience of hope and empowerment through re-connection with a satisfying and purposeful life (Slade, 2009). However, complex barriers to such participation exist.

The social model of disability draws a distinction between the 'impairment' of the person through a diagnosed condition, and the disabling impact of the negative societal reaction to the condition (Beresford et al, 2010). Members of the wider society appear to wish to distance themselves from mental health service users, through reluctance to work with them, marry them, live close to them, or have them as friends (Leff and Warner 2006). Indeed, nearly nine out of ten people (87%) with mental health problems state that they have been affected by stigma and discrimination (NMHDU, 2011). Reducing this figure is among the UK government's top six mental health objectives (DH, 2011); the others being to improve wellbeing, recovery, physical health, experiences of care and support, and to reduce avoidable harm.

There is now wide social acceptance of the principle that buildings and services should be designed to be accessible and usable by everyone, including people with physical disabilities. However, there is arguably much less awareness or acceptance of the need to

avoid a 'disabling' *psychosocial* environment and to uphold similar access rights for people with mental health problems:

> For wheelchair users, it is having a wheelchair and ramps to be able to get into buildings so they can use those facilities. It's a bit complicated for mental health service users (Beresford et al, 2010: 20).

Governmental guidance has for some time emphasized that social inclusion is the responsibility of all sectors, not just health – including employment, housing, criminal justice and education (ODPM, 2004). However, the broader societal issue of enabling citizenship through fuller community participation was not taken up specifically. It has since become a pressing issue, regarded as a matter of *occupational justice* by Stadnyck et al (2004) who advocate lobbying for the occupational needs of individuals and communities as part of a fair, inclusive, and empowering society; as a community regeneration issue by Fawcett and Karban (2005) who highlight the need to address wider 'upstream' social factors that may be precursors to distress and subsequent intervention by mental health services; and as an integral part of recovery because social participation and social relationships are essential ways in which people rebuild their own lives (Slade 2009).

'Community mental health'

Commentators on the era of de-institutionalisation have suggested that mental health services are 'at the crossroads' (Ramon and Williams, 2005) or in the midst of an 'unfinished revolution' (SCMH, 2005). Although most mental health services have moved from institutions into the community the very resource that is most richly and uniquely restorative – the *social capital* of the community itself – remains inaccessible to many service users (NSIP, 2006). Social capital is a resource within and for whole communities incorporating issues such as sociability, social networks, trust, reciprocity, and community and civic engagement (HDA, 2004). It is of interest to mental health practitioners because social connectedness is a fairly good predictor of mental health status (Pilgrim 2009).

There is, therefore, a clear case for addressing the barriers to community participation and for regarding this as a task facing both community agencies and mental health services

(Seebohm and Gilchrist, 2008). This widens the scope of stakeholders involved in 'mental health work', implicitly challenging the dominance of a medicalised perspective. There is a growing view among mental health service users that mental health issues are poorly understood in society and shaped by a medicalised model which is largely negative in effect due to the stigma associated with diagnoses and an *individualisation* of problems that fails to acknowledge society's role in the creation and maintenance of them (Beresford et al, 2010). There is also a concern that the increasing integration of health and social care might – given the imbalance between the two sectors in terms of resources committed to mental health services – lead to an erosion of the influence of the social model of disability and a corresponding increase in the influence of a medicalised model (SPN, 2007). The social model of disability highlights the disabling impact of societal responses to a person's condition rather than the impairment itself (Tew, 2008). Without this perspective, the tendency of mental health services to pathologise people's difficulties may result in 'social inclusion' degenerating into something *done by* mental health services to service users – a kind of 'inclusion therapy' (Bates and Seddon, 2008).

Significantly, the Social Perspectives Network (SPN), originally an associate body of the UK National Social Inclusion Programme, urged services to respond to service user calls for 'social' interventions such as support in accessing leisure and education in the mainstream community, working at both individual and community levels to do this (SPN, 2007). The national programme emerged from the UK Government's Mental Health and Social Exclusion report (ODPM, 2004) which aimed to promote social inclusion for people with mental health problems. Supporting mental health service users' access to local educational opportunities was the focus of the participatory action research (PAR) which forms the basis for this article.

Generating actionable learning

The PAR – initiated from within the mental health sector – involved stakeholders from Bristol's multi-agency Social Inclusion Forum in concerted action and systematic reflection on their work together (Kemmis and Mc Taggart, 2008). The PAR focused on this forum's

Community Involvement Subgroup (CIS) which had a remit to tackle the barriers to community participation encountered by local service users. It was funded by the National Institute of Mental Health (NIMH) in England and approved by the local NHS Research Ethics Committee.

The PAR explored how the CIS's work could be informed by new learning drawn from thematic analysis of qualitative interviews with eight individuals who used an assertive outreach (AO) service. The AO model was created to address the depth and complexity of needs of individuals who, whilst having severe and/or enduring mental health problems, were unwilling or unable to engage with existing services (Onyett, 2003).

This is significant because, at the point of referral to AO, the interviewees were unengaged with services and extremely socially isolated and excluded. With AO support, however, they had become engaged with local mainstream community activities, generating a sense of social connectedness and belonging which propelled their own recovery journeys. The PAR purposefully sampled from this group of service users, aiming to discover *how* these individuals had overcome barriers and become engaged in the community and to use that learning to inform the CIS's work. All eight interviewees were male and six were from black and minority ethnic backgrounds or dual heritage. Their ages ranged from 24 to 57 years.

The PAR design comprised two focus groups drawing on participatory models: *co-operative inquiry*, which facilitates combined reflection on an issue of concern for a group of people in order to explore it fully and effect change (Reason, 2001); and *appreciative inquiry*, which focuses on positive action and promotes change by instilling in people a sense of being engaged in organisational innovation (Cooperrider and Whitney, 2005). The application of these inquiry models to community mental health practice is examined further by Fieldhouse and Onyett (2012).

CIS membership cut across mental health professions, health and social care, voluntary and statutory sectors, and the service provider/service user divide, as shown in Box 1. Apart from the lead researcher (the author of this article) the names are pseudonyms.

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Colin – Community Mental Health Nurse from the AO team
Emily – Service User Researcher from Bristol MIND
Dave – Manager for a Continuing Needs Mental Health Rehabilitation Service
Kate – Manager for Disability and Mental Health Support Services at City of Bristol College
Jon – Community Occupational Therapist with the AO team, lead researcher
Jenny – service user

Box 1: Community Involvement Subgroup Membership

Understanding service users' experiences

A recent UK survey showed that 71% of people with mental health problems say they stopped doing things they wanted to do because of stigma and 73% say they stopped because of the *fear* of stigma and discrimination (NMHDU, 2011). There thus appears to be a process of pre-emptive *self-exclusion*. Significantly, at the point of referral to AO, the interviewees in this PAR felt they were living in an excluding society where they were not 'entitled' to do the same things as the other people they lived amongst. For each interview participant, this reinforced an internalised stigma and a diminished sense of being 'access-worthy';

> A lot of the time, I misses out on being with just the people in the area, y' know, in the locality, and it makes me think: 'Well that's not right, that I should sort of stay away from them, because they are part of where I am. (Matthew, Service User)

This was experienced in terms of complex and subtle active 'differencing' by others in various ways identified by Parr (2008) such as by physical avoidance, curtailing conversation, or body positioning and gesture.

Reflecting on their recovery journeys, service users described the benefits of care-planning which focused on community participation. AO practitioners accompanied individuals as they explored volunteering opportunities (often working alongside them initially), leisure pursuits, and adult education until the individual's skills and confidence were such that the practitioner could step back. Crucially, these supportive one-to-one relationships were combined with advocacy and close partnership working with the relevant community

agencies. Once engaged, participants described feelings of belonging to, and contributing to, their community; and they felt this was qualitatively different to engagement with mental health *services*;

> Okay, I go to a couple of drop-ins, but this is beyond the drop-ins. This is working in the community; whereas a lot of my friends at the drop-ins – they're nowhere near that stage (Matthew, Service User)

The CIS experience

The CIS reviewed eighteen month's work in the PAR focus groups. A brief overview of the CIS's experiences will now be given highlighting the key factors that facilitated effective inter-agency working (presented in Table 1) followed by consideration of the implications that this joint work had for CIS action-planning.

Theme	Sub-theme
1. Identifying a Consistent Membership	1.1 Clear task definition
	1.2 Agreeing goals collectively
2. Valuing Open Discussion	2.1 Combining action and reflection
	2.2 Developing a common language across agencies
3. Developing a Common Agenda	3.1 Being prepared to challenge and be challenged
	3.2 Agreeing a collective, inter-agency action plan
4. Adopting a Long-term Perspective	4.1 'Planning lite'
	4.2 Securing senior sponsorship

Table 1: PAR findings: critical ingredients in effective inter-agency working

Although efforts were made by the CIS subgroup to identity specific aspects of the multi-faceted social inclusion agenda, this still did not initially translate into easily defined tasks. 'Community involvement' was open to a range of interpretations. These included the accessibility of community agencies, the community-embeddedness of statutory mental health services, and schemes for supporting service users to become more 'access-ready'.

Each agency represented in the CIS had its own particular work culture, language, and set of assumptions about what was needed. Where different work-cultural nuances of meaning went unexplored discussion could lead to the adoption of polarised positions and be rendered fruitless. The potential existed for language to remain a barrier that limited understanding and hampered discussion, instead of advancing it.

Ultimately, understanding the solutions that had worked for service users, described in the service user interviews, allowed a CIS task to become defined (1.1) in terms of practical goals (1.2). Once regular membership had crystallised around practical tasks CIS members quickly learned that, whilst collective goal-setting might initially be time-consuming, reflecting (2.1) on the process paid huge dividends. It allowed members to consciously develop ways of bringing differing knowledge, skills, perspectives, and networks to bear on of the *same* task by pooling resources and breaking down barriers. This process created its own momentum. Closer working fostered a more urgent need to create a common, unambiguous, collectively derived language (2.2). For example, CIS members came to a fuller appreciation of the term 'community', understanding that it was subjectively experienced as a network of discrete and diverse 'communities'. Consequently, the decision was made to develop an action plan (3.2) focused on the 'learning community' initially, and Further Education (FE) in particular. The round table ethos, whereby CIS members were prepared to challenge each other and be challenged (3.1), proved constructive;

> It's very difficult to create that sort of environment isn't it, because we all say stupid things. And we all can be challenged for the stupid things we say. But there's probably more value in saying them than not saying them – the stupid things. And, you know, you can scout all round the edges trying to say the stupid thing in the most un-stupid way; waste of time to be honest … You're challenging the comment, not challenging the individual. That's the thing, isn't it. (Dave, Mental Health Team Manager)

The CIS was committed to the 'long haul' yet there was no clear structure within which to operate. *'Planning lite' (4.1)* was how the group described its practice of creating enough

workable structure to enable progress one step at a time. This challenging work highlighted the need for *senior sponsorship (4.2);*

> Investment in the group so far has been an idea off the back of a fag packet, drawing in the willingness of a certain number of volunteers to do it, but if it's going to develop any further … it needs wider investment from the stakeholders. (Dave, Mental Health Team Manager)

Significantly, strong and visible leadership at national and local levels is identified as a critical factor in connecting policies for community cohesion and social inclusion (Seebohm and Gilchrist, 2008).

The implications of effective inter-agency working

The CIS's positive experience of partnership working offered a vantage point from which a number of innovative practice development ideas emerged. It was envisaged that these would promote cooperation and counteract silo-working, create bridges from segregated services into the mainstream of the community, generate new skills among practitioners, and widen the range of stakeholders involved in such work. What follows is a discussion of each of these ideas. The PAR time-scale did not extend to testing them in practice, however, so outcomes cannot be reported on here.

1. *Counteracting silo-working*

'Silo-working' occurs when an organisation is interested primarily in pursuing its own agenda and prioritises its own organisational concerns, allowing an easy internal or vertical flow of communication but offering only limited exchange across its own departments or with outside organisations (Douglas, 2009). The CIS's partnership working challenged this by underlining that community participation could not be promoted by mental health services working unilaterally. It must necessarily involve a re-drawing of plans in partnership with community agencies. A community-orientated mental health *service* was only viable in conjunction with a community accessible to mental health service users. In the CIS, it became clear that mental health services' social inclusion agenda was complimented by the

learning community's widening participation agenda. This agenda highlighted access to FE as a social inclusion and disability discrimination issue, and advocated partnerships between learning providers and mental health service providers (LSC, 2006). One CIS member described feeling 'as if a wall was being dismantled from both sides'. For example, Kate's working relationship with mental health service colleagues in the CIS directly benefited her job at City of Bristol College:

> For me I think it's made a big difference because I go away feeling really energised and actually go and look at my priorities. And one thing I've managed to do is get some money … to do some case studies about how people have come in to college, y'know, get funding to do that. So that's made a difference. (Kate, FE Provider)

In the CIS new learning from local hands-on work was seen as able to potentially inform national policy;

> Kate: And I think those agencies like the LSC are looking for the solutions, they know they've got to do something around mental health, and they would love it if we gave them a document saying 'right, we need to do this', they'd be handing over the dosh like anything … I'm absolutely sure of that.

The CIS discussed three options for improving access to mainstream educational opportunities, all of which focused on creating a psychosocial environment capable of supporting mental health service users' participation. These were:

(i) providing mental health support worker assistance to support FE learners with mental health problems;
(ii) providing additional training for staff in mainstream FE services around mental health difficulties and related access issues;
(iii) re-locating existing mental health day service staff as co-workers in FE colleges to offer 'transitional' or 'bridge-building' groups to support existing mental health service users

This last proposal above [(iii)] related to the *day service modernisation* agenda (SCMH, 2010) which aims to counteract the segregation and stigmatising of individuals in 'bricks and mortar' day *hospitals* by promoting more flexible, community-embedded day *services* capable of accessing mainstream opportunities. It attempted to create affirming micro-environments where empathic attitudes and peer support could flourish and a de-stigmatising process could begin. These 'affirming environments' have been shown to promote experimentation with new roles and the acquisition of new skills by mental health service users (Rebeiro, 2001).

2. *Community bridge-building*

Taken together, the CIS's three options involve the promotion of a *social disability and access model* (Perkins and Repper, 2003) which urges practitioners to widen their horizons. Instead of focusing over-exclusively on 'changing the disabled individual' it is more about 'changing the community' in which the individual lives and to which they want to access. It is based on the premise that the skills needed to live in the community are best acquired *by living in the community*, rather than by receiving 'care' exclusively in segregated, synthetic, clinical environments.

CIS discussion highlighted FE's long-standing appreciation of the transforming nature of education on people's lives and its commitment to the principles of social justice (Atkins, 2010). Informal adult education has usually been open to anyone, catered for a wide range of interests and abilities, allowed for flexibility in attendance (such as a single term or a full year), offered concessions to unwaged people, provided a structure to the week, created an informal social milieu focused on meaningful occupation, and involved little or no pressure or competition associated with examinations (Leff and Warner, 2006).

The CIS's proposals presented rehabilitation as a process of *skill acquisition* in the real life settings where the new skills are most applicable and therefore most valued. It also marked a progression from inclusion being about gaining wider community acceptance of community-based *services*, to being about supporting service users to participate and express themselves in the wider community (Gale and Grove, 2005) through engagement in new roles which are socially valued. For example, the 'patient' identity would gradually be

re-shaped into an emerging 'student' identity. It resonates with the *social contact hypothesis* (Allport 1954, cited Bates 2011) that direct social contact with people with mental health problems is the most effective way to change stigmatising and discriminatory attitudes.

This approach emphasises that stigma is not the stigmatised individual's problem to solve, but the wider society's. It has been argued that dominant social ideologies involve denial of society's role in creating disability, projecting responsibility on to the 'disabled' person (Sinason, 2002). Indeed, Szasz (1972) suggested that 'mental illness' is maintained to serve a range of social functions including the exclusion of devalued subgroups. Perkins (cited O'Hara, 2010, p3) highlights how unhelpful it is to allow stigma to become an individual rather than a societal issue;

> I prefer not to use the term stigma, because it attaches to the person. We don't talk about the stigma of race. We talk about racism. The problem with anti-stigma campaigns is that they identify the class of people by their impairment.

The CIS's interactive approach combined individual support for service users with community development activity to create a bridge between mental health services and the wider community. Significantly, interviewees' experience of crossing this 'bridge' was that the connection was seamless, natural, and allowed access to mainstream supports that were beneficial;

> Staff at the college is absolutely – well, she's amazing, she's so relaxed, she's brilliant, brilliant. (Stanley, Service User)

3. *Generating new skills, knowledge and attitudes among practitioners*

Instead of regarding access to FE as a way to facilitate discharge pathways *out of* mental health services, the CIS proposals located the transitional groups *within* a mental health care-planning framework. They cast ordinary mainstream services in a broadly rehabilitative or restorative role. This did not replace existing mental health services but complimented them, looking for a blend, in which the precise composition could be varied depending on

the individual's needs. It attempted to transcend the distinction between treatment agencies and the wider world, which has been highlighted as a necessary feature of 'enabling environments' for people with mental health problems (Johnson and Haigh, 2011). One CIS member noted;

> So I can see how it might mean – instead of trying to get people to go to groups about anger management at [a local day hospital] – they go to an anger management group in Bristol City College somewhere. And that's the beginning of a shift that needs to take place (Emily, Service User Researcher).

It was anticipated that serving a needier and more vulnerable population in 'new' community locations would oblige mental health staff to re-appraise their professional role. The CIS was aware of the pitfalls of merely *re-locating* services into the mainstream if 'old habits' also got relocated too. It acknowledged that if mental health services tried to 'colonise' or co-opt community activities into being a *pseudo-mental health service* this would undermine the restorative power of community participation. Instead, an acceptance of the need to re-negotiate the power dynamics of practitioner/service user relations was implicit, as was a gradual shift in mental health services' relationship with the community they served. This relationship is something which the UK mental health system has only recently been exploring in a conscious way (Bates 2011).

The participatory action research (PAR) found that this shift raised issues for some practitioners who felt that using mainstream community FE venues would cross a 'conceptual dotted line' between therapy and training and the *therapeutic* aspect of their work might be lost. Another major professional barrier was a widespread risk-averse view that community settings would not be supportive enough. This risk-averse culture was noted in early practice guidance as a contributory factor in service users' exclusion (ODPM, 2004). However, it was felt that community development work *should* challenge practitioners on such issues, and that this would trigger a reflective process – helping to deconstruct medicalised thinking and develop more recovery-orientated services:

> If recovery from mental ill-health is about growth, taking control back over one's life, having people around who believe in you, and gaining a sense of worth by contributing to society, then CD (community development) clearly promotes recovery (Seebohm and Gilchrist 2008, p.54).

The expectation that mental health practitioners would be open to this deconstruction process is underlined in the first of the UK's *The Ten Essential Shared Capabilities for Mental Health Practice* (DH 2004): *working in partnership.* This framework subsequently sharpened its focus on social inclusion in the *Capabilities for Inclusive Practice* (DH 2007a, p. 13), which urged practitioners to:

> Support community organisations to develop new responses as needed (partly through working with Community Development Workers) so that citizens with mental health problems have fair access and effective support.

The need to adopt more community-orientated professional roles is already widely recognised by the *New Ways of Working* projects undertaken by the various mental health professions in recent years (DH, 2007b). As Rachel Perkins, Champion of the Year for 2010 for MIND, an influential UK mental health charity, argues:

> *We've got to totally rethink mental health services …We need to be building up communities to accommodate mental distress and put professionals back in their boxes. I think what we've done is over-professionalise mental health* (Perkins, cited O'Hara 2010 p.4).

It was hoped that re-appraising power dynamics would also challenge the habitual service-culture 'deficit mindset' (Bates and Seddon, 2008) whereby mental health practitioners see service users as needing to always be *cared for*, focusing over-exclusively on special places where help can be found in the community without also recognising the ordinary places where positive roles and relationships can be built and personal skills and strengths can find expression.

4. Accommodating a widened range of stakeholders

Seeing inclusion as a social issue necessarily widens the scope of stakeholders who have views about what constitutes 'good practice'. Bates (2010) argues that the parameters of mental health work need to be expanded beyond the idea of individual care and personal recovery, which is still about 'the individual', to a conceptual framework encompassing *citizenship.* In this way the political, civil, and social rights of *all* members of society would come to determine the social role and identity of people with mental health problems, eclipsing the social role of 'mental patient' (Tew, 2008; Bates 2011).

Bates's (2010) metaphor of the community as a triangular island offering three competing viewpoints – one service-centred, one person-centred, and one derived from a community development perspective – not only highlights why differences between agencies may exist (as was *felt* in the Community Involvement Subgroup (CIS) initially) but points to potential common ground between health service providers and mainstream community services. This may explain why the development of a common language and reflective culture within the CIS was felt to be so unifying and energising.

Bates (2011) observes how deep-rooted and organisationally-driven mindsets and behaviours, when juxtaposed with those of potential partner organisations during joint-working, can elicit strong, hidden emotions. Tension points noted in practice include differing perspectives on mental health problems and the role of social inequalities in their onset, and the perceived higher status of professional expertise compared with community development worker know-how (Seebohm and Gilchrist 2008).

To address these tension points the CIS advocated an extended and 'de-medicalised' use of the Care Programme Approach (CPA)(DH, 1990). This approach ensures a single care plan exists which addresses the whole range of a person's needs related to health and wellbeing, not just their *psychiatric* problems. Through an extended CPA practitioners saw themselves as part of a wider network of facilitative relationships that collectively supported service users' recovery. It extended the notion of a 'team' beyond the mental health service by crossing the gulf between 'care' and mainstream resources. CIS members' commitment to community-orientated work developed their appreciation of the richness, complexity, and

restorative potential of the community as a web of opportunities for participation. Prior to facilitated community participation, 'the community' was seen by interviewees in this PAR as an 'excluding community'.

We have yet to see how the current economically straightened times impact on this kind of work and on societal attitudes towards community participation by people with major mental health problems. This is of considerable concern given that many routes towards inclusion focus on enhancing life chances through education, voluntary work, training, and employment. These pathways are threatened in the UK. As NHS and local authority cuts bite, unemployment rises, and access to further education is constrained (Linford, 2011) how will mental health services, and society adapt? There is an increasing emphasis on 'accredited learning' in FE, for example, and informal learning for learning's sake is disappearing. Furthermore, in 2011 57% of the public believed people with mental health problems should be kept in psychiatric hospitals, up from 52% in 2009 (NMHDU, 2011). The threat to mental health services' facilitation of community participation for mental health service users and a potential hardening of societal attitudes is thus a serious concern.

Conclusions and Implications

This article has shown how knowledge and understanding of the micro-level day-to-day challenges faced by service users gained through intensive qualitative interviews informed the macro-level community development work undertaken collectively by the CIS. This awareness helped to turn the vague ideal of 'social inclusion' into a realisable practical project.

This participatory action research supports the claim that for mental health services that the *intentional* utilisation of a community resource – social capital – can foster a sense of belonging which supports recovery and social inclusion for people with major mental health problems. Moreover, this work can proceed through inclusive strategies that do not involve segregating service users, and in ways that tackle institutionalisation and stigmatisation. The success of this approach is due to the person-centred support and facilitation provided by mental health services, the restorative potential of the community, and the effectiveness of

joint working between mental health and non-mental health agencies. It is not enough for mental health services to know what is 'out there' in the community, it is necessary to actively engage with community partners and jointly develop routes into it.

Harnessing the efficacy of 'real life' opportunities (as opposed to synthetically-produced activities used within mental health services) created a robust bridge capable of spanning the gulf between clinical settings where 'care' is provided for *service users* and ordinary mainstream settings characterised by *citizenship* and participation in the wider society. The CIS learned that this bridge-building was most effective if construction commenced on both sides of the divide. Shared agendas around inclusion and participation meant mental health services' traditional role in supporting individuals could be enhanced further by community agencies addressing the barriers, stigma, and exclusion experienced by mental health service users as a population. There is much cross-cutting work to be done.

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