Chapter 27

Community mental health

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INTRODUCTION

This chapter aims to enthuse and inform therapists and undergraduates who are engaged in, or interested in, community mental health work, which is the largest field of psychosocial occupational therapy (Finlay 2004). It hopes to shed light on some of the main features of the landscape, so practitioners can navigate their way through this very diverse area of practice. It does not presume to offer a *How to...* guide, but hopes to encourage therapists to think for themselves. Above all, it aims to demonstrate how fascinating and rapidly developing this area of practice is; how contested many of its issues still are; and how relevant and potent the core principles of occupational therapy are in relation to these.

The chapter focuses on services for working-age adults with mental health problems. It has five sections. *Working in the Community* explores the shift from institutional to community care, and the implications for occupational therapy; *Working with Service Users* highlights the importance of person-centred working; *Working in a Policy Context* presents some of the structures and policies guiding community care that influence our profession; *Working in Teams* looks at how services are configured and explores issues arising for therapists working in co-ordinated teams; and, finally, *Looking after Yourself* examines some of the resources available for addressing these issues. It ends with conclusions about the continued, or indeed renewed, relevance of occupational therapy to current national agendas and priorities in community mental health.

WORKING DEFINITIONS AND TERMINOLOGY

It may be helpful to give working definitions or background to the following key terms used in this chapter: severe and/or enduring mental health problems, service user, team, and occupation.

Severe and/or enduring mental health problems

The Department of Health (1995) outlined the elements that comprised a definition of severe mental illness: disability, diagnosis, duration, safety issues, and the need for formal or informal care, anticipating that a more precise definition would emerge from using this framework at a local level. However, as Brooker & Repper (2003) note:

> Perhaps nowhere is the potential conflict in the agendas of key stakeholders more manifest than in the question of how to define 'serious mental health problems'. (p312)

If no answer has yet been found, it may be because of a growing consensus that such an absolute right answer does not exist.

This chapter takes serious or severe and/or enduring mental health problems to refer to schizophrenia, bipolar affective disorder (or manic depression), severe depression, severe anxiety, and personality disorders which are of such intensity that they prevent a person from functioning in an adequate and satisfying way as determined on the basis of his culture and background (Sainsbury Centre for Mental Health 1998). Although serious mental health problems can last for several years, 'enduring' means lasting for at least 12 months, which is also how 'long term' is defined under the Disability Discrimination Act (DDA 2005) (www.opsi.gov.uk).

Focusing on mental health problems as lived experience, Finlay & McKay (2004) have suggested three themes that might be familiar to most mental health service users. The first is feeling out of control, in relation to the intrusiveness of overwhelming psychotic symptoms such as voices or visions, in terms of a lack of

self-determination as life events or relationships unfold or in terms of extreme emotional states of fear and loss. The second is the struggle beyond the illness, referring to the hardships beyond symptomatology that may characterise daily life and which, were it not for personal strengths and commitment, would otherwise prevent individuals from fulfilling or recovering their life roles, such as parent, worker or friend. The third is the power of the social context, referring to the huge significance of the social world as a factor in both the creation of the mental health problems and the recovery process, particularly in relation to issues such as social inclusion/exclusion, stigma, employment and occupation in general.

Service user

The conflicting agendas of stakeholders are also reflected in the terms used to refer to people who use mental health services. These include survivor, patient, client and service user. Each of these terms has a history and a context.

'Survivor' is a political term used by people who feel they have recovered in spite of the mental health system and often have a negative experience of it (Sainsbury Centre for Mental Health 2003). 'Patient' was the generic term until the 1980s but may imply a passive role and the medicalisation of care, although people may need to adopt a passive patient role at times (Morgan 2004). 'Service user' is widely used in social care, and came out of the push for consumerism in the 1980s which gave people choices and a right to have expectations of services. It has become the most widely used term and is increasingly used in legislation and policy documents. 'Client' is widely used by health professionals but has been criticised for its implicit assumption that people who use services have exercised a choice in doing so (which may not be the case) and also for its reciprocal bolstering of the professional status of practitioners and all the associated power dynamics that go with that (Whalley-Hammell 2006). Most fundamentally, community practitioners are urged to see the people they work with as citizens of their community (Stein & Test 1980). This chapter refers to a person using services as the individual or person or occasionally, where making the distinction helps clarity, as the service user.

Team

The chapter concentrates on occupational therapy delivered through various forms of community mental health team (CMHT), all of which employ occupational therapists. For simplicity's sake, the word 'team' or CMHT will be used throughout this chapter to describe 'any team providing co-ordinated multidisciplinary input in community settings through a team process' (Onyett 2003, p7).

Consequently, the chapter will not focus on occupational therapists working with a unidisciplinary orientation, whose practice may occasionally involve interdisciplinary working or loose networking. The emphasis on co-ordinated care is put in context throughout the chapter.

Occupation

Occupation here means any goal-directed, repeatable activity which carries personal and cultural meaning, and is perceived as doing by the doer (McLaughlin Gray 1997).

WORKING IN THE COMMUNITY

A BRIEF HISTORY OF COMMUNITY CARE

Over the past quarter of a century a huge shift has taken place whereby the vast majority of mental health care is now provided by community-based mental health services, to service users living at home. Rather than being geographically or even conceptually tied to these community-based services, the psychiatric hospital is now generally viewed as one of a range of resources available in care planning.

The community is, and of course should be, a defining characteristic of community-based services and working with the community is a central theme in this chapter. The gradual evolution of services, as they have adapted to their 'new' environment, has been characterised by: the development of co-ordinated care planning; the

prioritisation of services for people with serious mental health problems; co-ordinated teamworking; and, perhaps most importantly, a widening acknowledgement of the social model of disability and an increasingly sharper focus on social inclusion and access issues. These factors will now be discussed, concluding with some implications for ourselves as occupational therapists.

Co-ordinated care planning

Whereas the old institutions at least provided a kind of seamless range of services by being all under one roof, community care initially presented a bewildering array of fragmented and geographically dispersed services that clients simply were unable to access. Additionally, the needs of clients in relation to this access issue were poorly understood because they had not been encountered before (Stein & Santos 1998).

> Where users lived might be miles away from where they collected their welfare benefit, which again would be a long way from a community mental health centre, which users might need to attend during the day - 'community care' had an inbuilt tendency to become disjointed and fragmentary. The implication of this was that the existence of a service in the community did not necessarily mean that it would be used, particularly by severely disabled clients who often found accessing such diverse and fragmented services more of a challenge than they could manage. It began to be apparent that severely institutionalised service users with long-term and severe disabilities were also substantially disadvantaged in the community. Service users often lived in poverty and severe social isolation and were subject to being stigmatised and rejected by the neighbourhood where they lived.... Also, mental health professionals were not necessarily particularly well equipped to work with severely disabled service users who had previously stayed quiet in mental hospitals year after year. (Ryan 2004, p13–14)

In short, symptom alleviation was being eclipsed by the accessibility of ordinary services as the key indicator of a client's ability to manage in the community.

The Care Programme Approach

The Care Programme Approach (CPA)(DoH 1990) was introduced to prevent vulnerable clients falling out of care in this way and now provides the structure for addressing the full range of an individual's needs. It is integrated with the care management of social care and bestows on the care co-ordinator the authority to operate across professional and agency boundaries to knit together the relevant services. It usually has two distinct of levels of care, standard and enhanced, depending on how comprehensive and complex the package of care has to be (DoH 1999b). It is, clearly, more than being a keyworker – which is a looser term normally used to describe someone who acts as the link person for a particular provider agency or resource within the broader care plan – and should not be confused with that role.

Prioritising severity

Throughout the 1990s services were expected to prioritise people with severe and enduring mental health problems because it was recognised that their needs were not being met. In the 1980s practitioners were largely able to choose who they worked with but with the advent of the CPA this had to stop (Ryan & Morgan 2004a). Community mental health services now focus on people with serious mental health problems and on delivering a co-ordinated, individualised package of care to each person.

Co-ordinated teamworking

Teamwork is not, itself, a clinical intervention but it does provide a platform for the effective delivery of care. In community mental health work the focus on severity and the complexity of challenges faced by service users mean that professional skills are pooled and services are generally provided through a process of co-ordinated multidisciplinary teamworking, in which the team becomes the conduit for all multiprofessional (and, for that matter, uniprofessional) interventions. The team, therefore, is the resource and effective teamworking between its members is the key to positive outcomes for clients; or, as Onyett (2003) puts

it: 'Teams should be used when teamworking is required' (p.2).

In other words, teamworking is not the be-all and end-all of clinical intervention but when required, it must be effective and that requires both clarity of role and commitment to that role.

Onyett (2003) summarises the functions that any community mental health service must fulfil, as follows.

> We do need to be clear about the range of functions that need to be delivered locally. These include early intervention, assertive outreach for people who are difficult to engage, home treatment for people in crisis, services addressing the needs of people with dual diagnosis, culturally appropriate services for black and minority ethnic communities, and services for homeless people and mentally disordered offenders. All these services need to be able to address people's housing, income, occupational and social needs. (p.7)

These functions are usually performed by specific teams and are explored in detail later in *Working in Teams*.

The concept of a family of interconnected but autonomous teams, each with a specific function, is one way in which a traditional service-centred model of care has evolved into a more modern service user-centred model. Instead of the old-style hospital-based services serving a local population of generic mental health service users (that is, people with all types of mental health problem) with separate referral routes to different professional specialisms within that service, there is now a range of specialised community-based teams. Each has its own in-house range of professionals, and each addresses the particular needs of a more specialised service user population who access the relevant team via clear, unique acceptance criteria.

This represents an important evolutionary stage in community mental health practice. The problems of the former model are well documented and included multiple (often duplicated) assessments and care plans, confusion for service users and services, poor communication between the different specialties, and no single evaluation framework. The modern model means teams can be more responsive and hence more adaptive, developing new kinds of knowledge and skills by focusing their collaborative problem solving on the specific presenting problems associated with particular service user groups.

The social model of disability

If the history of community service provision is the story of a move from fragmented to co-ordinated services, then a similarly overarching theme is an awakening sense of the restorative potential of community participation.

Many people have ongoing symptoms that cannot be removed by traditional treatment and the social inclusion agenda has highlighted that community living cannot be contingent on people ceasing to have problems. There is now far more of a consensus on the need for a broad interpretation of health and what sustains or restores it.

The social model of disability makes a distinction between impairment and disability. It sees disability as being imposed by society on top of any impairment (Oliver 1996). This shifts the emphasis from facilitating change in the disabled individual to changing the community in which they function. Perkins & Repper (2003) describe the importance of facilitating access to ordinary resources and relationships, noting that people with disabilities arising from mental health problems differ from others not in terms of their needs, but in terms of their ability to meet these needs with the ordinary resources available to them. It puts the onus on practitioners to facilitate access to the ordinary means by which people meet their needs, such as work, a home, a reasonable income, a social network and social activities, rather than treating an illness as such. Intervention must focus on a person's life as it is being lived and be compatible with it.

Implications for occupational therapy

From this brief history it is clear that a specifically occupational perspective of health is now highly relevant to the needs of people with serious mental health problems. Confidence in articulating the relevance of this to team goals is likely to be a crucial factor in the evolution of our practice.

The development of skills through an ongoing dynamic relationship with one's environment is fundamental to occupational therapy. We know occupation is contextual and does not happen in a vacuum; neither does occupational therapy. Nothing is context free. If we apply open dynamic systems thinking to ourselves as practitioners and develop our understanding of how our unique occupational perspective of health and our professional skills can harmonise with our environment (referring to both the community and the teams we work in), it is likely that we will enhance the effectiveness of our practice in innovative ways.

HARNESSING THE RESTORATIVE POTENTIAL OF THE COMMUNITY

This section now concentrates on how an occupational perspective of the community can guide therapists in unlocking its restorative and therapeutic potential, and includes an exploration of how community partnerships can facilitate this. It also explores an occupational perspective of social inclusion and recovery as these are central themes in the College of Occupational Therapists' Mental Health Strategy (COT 2006a).

Occupational science

Occupational science can be influential in community mental health practice because of its emphasis on the role of the environment in the creation and maintenance of mental health problems, through occupational risk factors. This offers practitioners an inclusive language and portrays the essentially occupational nature of society and communities.

Occupational risk factors

There is growing evidence that the incidence and course of major mental health problems like schizophrenia are affected by environmental factors at individual, domestic and societal levels (Warner 2000). Occupational risk factors –occupational deprivation, occupational alienation and occupational imbalance (Wilcock 1998a) – offer a way of understanding the impact of broad-based issues such as poverty or racism on individuals' occupational opportunities and also the vulnerability of particular populations and groups. These factors describe disruptions to the relationship between an individual's occupations and his or her health, and the ongoing unresolved stress that this causes (Townsend & Wilcock 2004, Wilcock 1998a, b).

Significantly for community practitioners, this disruption can arise at any or all of the four interconnected, but distinct, levels at which occupation is organised and has meaning: the individual, the family, society and the population (Molineux & Whiteford 2006). This underlines the importance of macro- and micro-level clinical reasoning and intervention which is now strongly advocated within our professional literature. Krupa et al (2002), for example, describe three roles for therapists in creating occupational opportunities for individuals. These are: one-to-one work with service users and their social networks, brokering within mental health resources and, most importantly, working with the broader community.

Language

Using the terminology of occupational risk factors not only clarifies and legitimises a complex set of ideas and experiences as a coherent topic, but does so in an inclusive way that can be understood by non-occupational therapy colleagues (van Niekerk 2005). The term 'occupational deprivation' may not have the same depth and resonance for a social worker, nurse or psychiatrist as it would for an occupational therapist but it is, in the author's experience, an accessible concept that allows different bodies of knowledge about mental health and deprivation to converge. It fosters the cross-pollination of ideas within a team and can support interprofessional and interagency working, as explored later.

The occupational nature of the community

Wilcock (1993, 1995) has described how early humans, through their occupations, built communities and society over evolutionary time and how occupations are therefore built-in or implicit to social relations, and to communities themselves, as a result. Communities consist of people who do things together. This has implications for how occupational therapists answer the fundamental

question, 'How do I ensure I'm using meaningful occupation with service users?'.

Negotiating meaning

The wide range of occupational forms available to community-based therapists includes, effectively, whatever is out there in the community. This allows the therapist to go with the service user's interests and frame his occupational choices as therapeutic media, using activity analysis.

The analysis of an occupational form involves considering its performance components and their complexity, understanding how they are sequenced, and acknowledging the social and cultural associations in order to evaluate its therapeutic potential (Duncan 2006). Once analysed in this way, a range of approaches can be applied so that, effectively, any occupation can be harnessed to meet therapeutic ends.

The efficacy of naturally occurring occupations is one the greatest assets which the community-based therapist has (Yerxa 1994). They often carry particular social and cultural resonances for individuals, which can give the meaningfulness of the occupation, the transferability of skills acquired, and hence the effectiveness of the therapy, a huge head start;

> The knowledge and skill that is gained during the intervention will better carry over to life when it is gained in the natural setting. Therefore our interventions typically take place in the consumer's home, at a local grocery store, or other community settings. (Wollenberg 2001, p108)

These locked-in meanings not only act as a powerful motivator to engage but, once unlocked by the doer, can also become a powerful intrinsic reward to carry on doing, offering much reinforcement of an individual's personal and social identity. Because meaning is therefore both ascribed and derived from the occupation in a uniquely personal way (Kielhofner & Barrett 1998), it cannot be bestowed by the therapist alone. It has to be negotiated and verified jointly.

Using natural settings also helps therapists answer a second underlying question: 'Should the goal of occupational therapy be to help clients acquire the discrete skills and behaviours needed to manage in the community first; or should it be to help clients acquire those skills by living in the community?'.

The former approach is usually characteristic of inpatient or day hospital programmes, where synthetic occupations are created with specific therapeutic outcomes in mind, such as addressing deficits in specific performance components. The latter approach is usually the approach adopted by community therapists and is based on naturalistic or real-life occupations in their normal, mainstream settings (van Niekerk 2005) which may also be more acceptable because they are less stigmatising. It brings person centredness and skilled activity analysis to the fore and supports socially inclusive practice.

SOCIAL INCLUSION

Adults with mental health problems are one of the most marginalised, stigmatised and socially excluded groups in society (Office of the Deputy Prime Minister 2004). Social inclusion for mental health service users has long been advocated by the service user movement (Dunn 1999). It is now a government priority (Care Services Improvement Partnership 2006b) and a professional one too (College of Occupational Therapists 2006a).

Burchardt et al (2002) describe social exclusion as non-participation in the key activities of the society in which a person lives. This not only suggests that inclusion is an essentially occupational phenomena, echoing Wilcock (1993, 1995, 1998b), but highlights that solutions to the problems of social exclusion must involve the whole of society. Socially inclusive mental health practice is just one piece of the jigsaw puzzle. Equally important is macro-level work aimed at creating more accepting communities, and much leverage (described later) exists to support therapists in doing this. In this sense social inclusion relates closely to occupational justice (Townsend & Wilcock 2004) because it is about recognising and providing for the occupational needs of individuals and communities as part of a fair and empowering society.

It is particularly important now, while national agendas are focused on social inclusion and mental health, that these ideas should be embraced

by occupational therapists and put to work. Our professional theory and skills equip us well for this task, and for taking up the challenge to operate confidently and effectively as political animals (Richards 2005). An overview of social networks and social capital may help to illustrate this.

Social networks

MIND (2004) has shown that 84% of people with mental health problems feel socially isolated, compared with 29% of the general population.

Social networks can have a protective effect, acting as buffers to stressors and adverse life events, can promote help-seeking behaviour, validate and develop an individual's self-concept, enhance a person's self-esteem, mood and world view and provide a structure within which skills can be learned, adapted and reinforced (Langford et al 1997, Nolan 1995).

This efficacy depends on the relationships within a network being reciprocal or two-way (Bates et al 2000, Mitchell & Trickett 1980) so the individual perceives himself as a significant network member who can receive and give support. It also depends on the individual's sense of the connections being built and maintained by his own efforts.

Social networking through occupation implicitly promotes these features and may well be more engaging and more effective than traditional programme-based social skills training. Furthermore, because specific occupations often support their own communities or social networks, this clarifies an otherwise hazy notion of what the community actually means. Without an occupational basis, it may mean very little. In *An Open Letter to Mental Health Professionals*, Hart (2003) writes:

> Some people talk glibly about moving on – out into the community. Most sufferers from mental distress don't have a community to go out to, especially when we've been marginalized for years, not only by the general public but also by the very services that purport to help us. (p15)

Occupational engagement can therefore transform the notion of community from being a community of mental health professionals, often the sad truth for many service users (Bates et al 2000), into something more real and self-determined.

Social capital

Social capital is the glue that holds communities together (Cameron et al 2003). It comprises the networks that are woven into the fabric of a society, the personal identity arising from membership and the norms of trust, support and reciprocal help that gradually build up from participating in them (Puttnam, cited in Sainsbury Centre for Mental Health 2000).

Whilst stretching out through a community, social capital actually relies on the personal and idiosyncratic social contacts and activities that make up a person's day-to-day life, however mundane they may seem. Again, it is an occupational phenomenon.

The social inclusion traffic lights

The National Development Team's inclusion traffic lights system (Bates 2005) was devised to clarify thinking about the relative social inclusiveness of the various settings where mental health staff work with service users. Red refers to places used only by mental health service users and providers such as inpatient units or day hospitals; amber refers to service user sessions taking place in venues regularly used by the wider community (such as a day service sports group at a local leisure centre); and green refers to activities where clients are shoulder to shoulder with the general public.

It is perhaps most helpful to view the function of these metaphorical traffic lights as being the same as the real ones, which is to facilitate movement and allow people to make their journeys successfully. Because each colour will have particular qualities regarding issues of safety, supportiveness, opportunity, challenge and integration, it follows that all three colours are necessary. For some individuals there will need to be a continuum that allows movement and progress. So, arguably, the most accurate answer to the question, 'What colour is inclusion?' would be that it is brown; that is, all the colours combined.

Occupational therapists as travelling companions

Occupational therapists are well equipped to accompany service users on a recovery journey through the traffic lights because occupation, in being both a means and an end of therapy, can be the consistent vehicle for that journey. Its emphasis can change from having a primarily therapeutic function to ultimately acting as a conduit for social participation, perhaps through adult education, vocational training, volunteering or employment, as the service user makes progress.

Deitchman (1980, cited in Morgan 2004) suggests service users want a travel companion because they can share experiences with them, as opposed to a travel agent who merely gives directions and makes bookings. In practical terms, this often means doing things alongside service users; that is, sharing an occupational engagement with them. As an informal assessment process, this not only allows therapists to get to know service users and their occupational performance well, and in a way that appears to be more equal from the service user's perspective, but it also allows the therapist to understand some complex psychosocial challenges that can arise for them on the journey.

Understanding stigma

Influential work on social stigma by Goffman (1968) highlighted the complex dilemma facing many mental health service users in the community:

> ... it is not that he must face prejudice against himself, but rather that he must face unwitting acceptance of himself by individuals who are prejudiced against persons of the kind he can be revealed to be. (Goffman 1968, p58)

This description of walking a knife's edge between participation and the possibility of provoking a stigmatising response creates enormous tension for many people. The constant vigilance for potentially disclosing information, or stigma management (Goffman 1968), is not only stressful but can be (quite literally) preoccupying, in that it can prevent occupational engagement.

Whilst the occupational therapy profession is familiar with environmental adaptation, assistive technology and antidiscriminatory legislation in promoting the occupational engagement of people with physical challenges, these complex psychosocial barriers are comparatively less well understood (Rebeiro 2001, van Niekerk 2005).

Affirming environments

Rebeiro (2001) has shown that a key feature of affirming environments, where these barriers are lowered, appears to be the empathic and accepting attitudes of the other people also present. Significantly, it is other people who are felt by an individual to share his stigma who are uniquely qualified to provide this. People appear to value the opportunity to undergo a gradual and reciprocally supportive destigmatising process at their own pace, which in turn promotes experimentation and skill acquisition.

So, in addition to social inclusiveness, therapists need to consider this affirming and restorative dimension of environments in their clinical reasoning and care planning.

COMMUNITY PARTNERSHIPS

As well as a wide range of occupational forms available to harness in the community, there are many opportunities to forge community partnerships across the sectors and agencies that host occupational opportunities in the community. This kind of macro-level work, creating access points for service users, can create a range of colleagues with new skills, perspectives and material resources and can be very rewarding. It can, in the author's experience, feel as if a wall is being dismantled from both sides.

There are several reasons why managers may support therapists' time commitment to project work like this. For example, a therapist tackling the occupational deprivation of her clients may find this occupies common ground with a widening participation agenda within the local further education (FE) community. The perceived added value, to the therapist's time, in co-working with partners outside statutory services may be a decisive factor in managers' support. Similarly, there

is an economy of scale. If a project builds a bridge with a local college, the bridge can be used by more than one service user. It adds to the resources of the team by creating a move-on pathway that would otherwise require time-consuming casework on an individual-by-individual basis. Collectivising the need is an example of working with a population. Furthermore, such work may open up opportunities for joint bidding for funds from, for example, the government's New Deal for Communities or national bodies such as the Learning and Skills Council (LSC) or charities.

The potential benefits for service users are substantial. The experience of doing a pottery session, for example, as a student may be more meaningful and more motivating than doing pottery as part of a day service programme, where the patient status is reinforced (Westwood 2003). Also, introducing non-mental health staff into the team's resources can diversify and normalise an individual's support network. Through joint working the relative amounts of therapist/tutor input can be graded to offer both amber and green (traffic light) environments in the college setting so the therapeutic dimensions of the session are retained. The key to service users taking such a step may well be the availability of an amber starting-point or base camp, which can be affirming in the ways described and allow people to acclimatise and prepare for the next step. The skill of the therapist may lie in asserting the need for this, if the overall project is to work.

Crucially, there are also incentives for the education service, which is effectively drawing in expert assistance in fulfilling their remit of widening the participation of local citizens as learners. Indeed, the LSC specifically aims to build the capacity of the FE system to support the learning of people with mental health problems (Learning and Skills Council 2006).

Developing the rehabilitative function of the normal, mainstream community is a fundamental social inclusion issue (Care Services Improvement Partnerships 2006a). It extends the navigator or travel companion role and involves the therapist straddling the divide from services to occupations with her clients. Working with the community in this way is likely to assist therapists in developing new skills which may be highly useful to service users, and also highly valued by managers and commissioners of services.

RECOVERY

Recovery is not a therapy, or an intervention, or a type of team (Perkins 2005). It is another aspect of the paradigm shift in mental health away from an overexclusive focus on treatment, to an emphasis on the individual's subjective experience. It does not mean service users should not also be offered the most effective psychiatric treatment that is available, but it does focus on the context in which that happens.

Recovery has been described as the lived experience of people as they accept and overcome the challenge of their disability and experience themselves recovering a new sense of self and of purpose within and beyond the limits of their disability (Deegan 1988).

Historically, people diagnosed with serious mental health problems have been seen as suffering with lifelong disabilities. However, it has been shown that many people are able to recover and lead satisfying lives. Much of the evidence for recovery has come from the personal accounts of service users who have described their journeys from despair to empowerment (Ralph 2004). Mancini (2006) notes the contrast between descriptions of institutional care, characterised by diagnostic labels and a passive patient role, and descriptions of a recovery process, rich in metaphors of growth and transformation, characterised by an active participation in treatment, engagement in occupations and a renewed social life. Indeed, social inclusion has been described as the culmination of a recovery-orientated health service (Sayce 2000).

Deegan (2001) describes how her own renewed identity had to be asserted in the face of unwitting stigmatisation by practitioners (including occupational therapists). She highlights a simple truth about the unproductiveness of this stigmatising process: 'Of course, the great danger of reducing a person to an illness is that there is no one left to do the work of recovery' (Deegan 2001, p9).

Recovery involves committing to a process rather than setting an endpoint as a goal (Deegan 2001).

This point is frequently taken up by service users who perceive that the term 'recovery' is sometimes used by services as a cloak to cover up cuts or to discharge people inappropriately from overstretched and underfunded teams; they have felt threatened by professionals' adoption of recovery because they fear it will mean an additional and unwelcome expectation is placed on them (Roberts & Wolfson 2004). Consequently, recovery needs to be seen in terms of hope and opportunity.

Hope and opportunity

The recovery literature highlights hope and opportunity as the resources that fuel an individual's journey, and describes the important role of other individuals in being holders of hope on the recovering individual's behalf. This role can only exist within a non-hierarchical relationship based on an in-depth knowledge of the person built up over time. Glover (2001) describes the need for a delicate balance within a robust relationship:

> Getting the balance right is the difference between mollycoddling and helping people discover life in a way that they drive their own journey. Knowing when to do for someone... or with someone... and when to kick butt... are the intuitive competencies we must all learn to struggle with and fine tune. (p5)

For practitioners, Perkins (2004) suggests this all-important in-depth knowledge of a service user will include an awareness of his relapse signature, pre-agreed strategies for managing early warning signs, close liaison with crisis and other out-of-hours services when needed, in-reach with the hospital ward if the individual is admitted to hospital, and person-centred goal setting, which is explored in the next section.

Occupational therapy and recovery

There is much common ground between recovery and occupational therapy. Both are concerned with a fundamental, subjective, human experience that is unique for each person; both are responses to the dominant medical paradigm in health care; both cite 19th-century moral treatment as an influence; both focus on strengths rather than symptoms; both are person centred and promote self-management and autonomy; both stress the importance of choice; both are interested in an individual's story or personal narrative; and both describe themselves in terms of their transformative potential (see Chapter 22).

Rebeiro (2005) describes particular overlap on issues such as self-esteem, self-efficacy, empowerment, self-determination, quality of life, hope, insight, social support, spirituality, inclusion, belonging, friendships, community and affirming environments. Similarly, she observes that countering stigma is increasingly being acknowledged as a pivotal factor in community integration, meaningful occupation and recovery.

WORKING WITH SERVICE USERS

This section looks at ways of developing and maintaining a person-centred, facilitative approach to one-to-one work in community practice and begins with an outline of some of the issues on which there appears to be a consensus within the service user movement.

THE INFLUENCE OF THE SERVICE USER MOVEMENT

The *NHS Plan* (DoH 2000) advocates service user influence at all levels of the planning and delivery of NHS services, and the notion of a patient-led NHS is widely promoted (DoH 2005).

However, it is still unclear how far this is being implemented within mental health services (Rose 2001). A tension exists between service users' wish to be included in service planning in a real sense, and the worry that it can easily become tokenistic or caught up in the minutiae and cease being a critical eye on the bigger picture. As Alison Faulkner (an independent service user researcher and formerly of the Mental Health Foundation) has observed, when service users are invited to join committees or decision-making bodies:

> ... users will find themselves faced with long documents which they find really boring and all

> they will be able to do is comment on paragraphs 11 to 17. They won't be able to say 'Scrap it and start again'. The worry is that all we will be able to do is tinker at the margins. (Laurance 2003, p87)

A striking feature of the service user movement, and which arguably has no parallel in any other aspect of health care, is the strength of its opposition to many existing mental health practices. There is a consensus on what is perceived to be a general devaluing of the service user experience, in terms of both their accounts of living with mental health problems and of using and evaluating mental health services (Laurance 2003).

There is now an increasing obligation on mental health professionals to learn about service users' experiences of them, and to use that information to shape their own practice (Cameron et al 2003). Indeed, if occupational therapists value client-centredness, we will need to listen to the service user movement as well as our individual clients. Significantly, most professional literature on client-centred practice approaches it from only the professionals' point of view (Whalley-Hammell 2006).

WORKING WITH PERSONAL STRENGTHS

Often, the greatest asset to a therapist's work is the service user's own momentum and working with personal strengths gives this full rein. As enablers of occupation, therapists' work should primarily be based on the premise that, for each person or group of people, there will be things they need and want to do in order to grow, flourish, and experience well-being (Wilcock 1998a).

Consequently, any assessment of a service user's needs should also include what a service user wants. After all, in our personal lives we do not consider ourselves as having friends and partners as a means of support, primarily. Nor do we consider what activities will allow us to structure our weekend. Though mutual support may be a feature of the important relationships in our life, they do not owe their existence to needing support. Similarly, a common short-circuiting of therapists' clinical reasoning is when needs are automatically framed in terms of services, as Ryan & Morgan (2004b) point out:

> For example, a service user who is deemed to be socially isolated may be assessed as having 'problems socialising' and therefore 'needing' a social skills training group. This a service-led response in that a problem the client is perceived as experiencing is defined as being met by what the service has to offer, whether or not it is actually what the user themselves really wants, and regardless of the actual aspirations the user may have in terms of social contact. (p159)

PERSON-CENTRED GOAL SETTING

As described, recovery requires collaborative and person-centred goal setting. This process has implications for where expertise is perceived to exist or rather, whose expertise is most valued. Biomedical and earlier mental health models prioritised the professional's clinical judgement in prescribing interventions. However, if we accept the primacy of the service user's experience of living with his challenges, this places service users in their rightful position as experts on their own lives. Importantly, this can allow the expertise of the therapist to come to the fore too: 'The empowerment of the consumer empowers the occupational therapist to use his or her clinical reasoning to develop effective interventions' (Wollenberg 2001, p107).

It is a win–win situation that plays to the unique strengths of each partner in the relationship. Also, because goal setting springs naturally from situations where people feel their skills are being used effectively and can be mobilised at will (Forysth & Kielhofner 2006), person-centred goals are likely to breed more goals. It is one way of instilling and holding hope. Significantly, the occupational therapist's expertise is regarded as being the clinical reasoning not the selection of occupational form, echoing the point made earlier about framing and harnessing real-life occupations in the community.

WORKING WITH CULTURAL DIVERSITY

It may be tempting for occupational therapy to assume that, with person-centredness at its core, it would be less prone to slipping into service-centred practices. However, it has been noted that occupational therapy theory may, itself,

conceal tacit standards and ideals for what is considered good practice, but which may not be experienced as culturally safe by all our service users: 'Will our existing theories and methods of application, which reflect middle-class Western-centric norms, change to meet these diverse societal needs?' (Iwama 2005, p225).

It is widely acknowledged that services users from black and minority ethnic (BME) communities often carry the double burden of living with a mental health problem and discrimination by the very service providers whose help they need (Rankin 2005). Significantly, during the consultation process for the College of Occupational Therapists mental health strategy, most BME respondents had a negative view of occupational therapy and described being offered irrelevant activities, disconnected from their situation, in both hospital and community settings (College of Occupational Therapists 2006b).

Working with people from distinct and diverse cultural backgrounds, often in their own homes, requires not only awareness of diverse occupational forms but also an openness to different perspectives of what occupation can mean to different people. This may challenge one's assumptions about occupational therapy but it is an opportunity for reflection that must be grasped. It is an important way in which community occupational therapy can develop.

CONFIDENTIALITY

Confidentiality is, obviously, a precondition for trust and a therapeutic relationship and is always team confidentiality. In the community, working with a high degree of autonomy can expose a therapist to situations where a person may presume that an absolute one-to-one confidentiality exists. He may disclose sensitive information which the therapist knows should be shared with her team. This can place an unnecessary burden on the therapeutic relationship, particularly if the service user feels let down when he learns that what he believed to be a secret has been shared. Openness about team confidentiality from the beginning at least gives the service user the choice about what to disclose and provides clear ground rules for the relationship.

POSITIVE RISK MANAGEMENT

The role of mental health services is shaped by the society of which they are part, and it is important to acknowledge the different agendas they therefore serve. In addition to helping people with mental health problems, services also undertake a role in controlling or managing behaviour that is not socially accepted, such as posing a risk to oneself or others through violence or self-neglect (Onyett 2003).

Services have tended to err on the side of caution and instinctively play it safe in terms of what clients are supported to do. Positive risk management acknowledges that some degree of risk, or challenge, is essential to skill acquisition, self-esteem and progress (College of Occupational Therapists 2006a). Positively managing risk does not mean being complacent about risk, but encourages a person-centred approach to evaluating it. Being risk averse can be seen as part of the lack of hopefulness on the part of practitioners and a barrier to recovery (Deegan 2001, Perkins 2004).

Risk management issues may arise in relation to working with service users in mainstream public settings or in the community partnership work described earlier. It is important that therapists clarify these quickly so services do not get stuck in the default position of being risk averse. The notion of public liability may be helpful to consider and trusts will have a risk manager (usually a senior manager at board level) who can advise on risk issues related to particular projects that therapists may want to develop in consultation with their team manager.

THE THERAPEUTIC USE OF SELF

> The therapeutic use of self is arguably the most important skill a therapist has. (Duncan 2006, p47)

The therapeutic use of self means knowing oneself and being oneself in a conscious and disciplined way so that personal qualities and attributes can be harnessed in the service of one's professional role (Hagedorn 2000).

Yarwood & Johnstone (2002, cited in Duncan 2006) list the establishment of rapport, respecting the client's wishes, personal honesty and good communication skills as the foundations for the therapeutic use of self and for developing a therapeutic relationship. Similarly, Parker (2006) notes that person-centred therapists are likely to be approachable, welcoming, genuine and spontaneous in their interactions with service users. They are able to instil a sense of security and trust, listen well and offer non-judgemental, non-authoritarian comments. They allow ownership of change to remain with the client and are able to acknowledge their own mistakes openly.

WORKING IN A POLICY CONTEXT

In considering potential new ways of working in mental health the College of Occupational Therapists notes the influence of the *National Service Framework for Mental Health* (NSFMH) (DoH 1999a), the *Social Exclusion Unit Report* (Office of the Deputy Prime Minister 2004), and the *Mental Health Policy Implementation Guides* (MHPIG) (DoH 2001, Ormston 2006).

A summary of each is presented here so that a knowledge of the policy context can help therapists identify allies and champions, levers and buttons in support of their role as political animals when lobbying for occupation. Similarly, an understanding of the overall structure of service commissioning should clarify where and how decisions about services are made.

It is always advisable to get to know the local structure within which one operates as a therapist but as a general overview, primary care trusts control about 80% of the NHS budget and cover all aspects of health care. They are local so they can understand and be responsive to the needs of their local community, whilst strategic health authorities monitor performance and standards. In all areas a local implementation team, bringing together the views of commissioners, providers and users of local mental health services, will be monitoring the implementation of the NSFMH by trying to develop services to match local needs (Cameron et al 2003).

NATIONAL SERVICE FRAMEWORK FOR MENTAL HEALTH (DoH 1999a)

The NSFMH set out a 10-year strategy to tackle issues of public mental health by not only seeking health improvements for service users, but also challenging stigma and discrimination and promoting understanding of mental health issues in the wider population. It lists seven standards spanning five areas: health promotion and stigma; primary care and specialist services; the needs of people with severe and enduring mental health problems; their carers' needs; and suicide reduction.

Its first standard on health promotion specified three levels to this work: strengthening the individual by building personal resilience; strengthening communities by increasing participation; and reducing barriers by increasing access (Sainsbury Centre for Mental Health/mentality 2001).

As a complex intervention (Creek 2003), with biopsycho-sociocultural dimensions, occupational therapy operates at each of these levels and the NSFMH provides ample leverage for occupational therapists to bring an occupational perspective to the fore in their own practice setting.

SOCIAL EXCLUSION UNIT REPORT (OFFICE OF THE DEPUTY PRIME MINISTER 2004)

In order to promote social inclusion, this report set out an action plan to challenge stigma and discrimination, to clarify the role of health and social care in promoting social inclusion, to promote employment, to support families, to promote community participation, to address iniquities in housing and finances and to develop a cross-departmental national programme to maintain the momentum of change (Office of the Deputy Prime Minister 2004).

This agenda covers many occupational therapy issues such as day service modernisation, education, volunteering, community participation and employment (Care Services Improvement Partnership 2006b) and there is an occupational therapist on the national programme team (seconded from the COT). It sets objectives to guide practice and offers much support for therapists' advocacy of an occupational perspective of social inclusion.

MENTAL HEALTH POLICY AND IMPLEMENTATION GUIDE (DoH 2001)

Mental health is a government priority for service improvement (DoH 2000) and a direct approach to shaping the local delivery of national policy is evident in this guide which provides team specifications, examined below.

WORKING IN TEAMS

The following overview of the teams described in the MHPIG (DoH 2001) sets the scene for the majority of therapists' practice in community settings. Additionally, this section looks at outcome measurement and care co-ordination from an occupational therapist's point of view, and examines some teamworking issues that may arise for therapists also.

TYPES OF TEAMS

There is a range of community teams and services to meet the specific requirements of service users.

Crisis resolution and home treatment teams

These teams provide a 24-hours/7days per week service offering an alternative to inpatient care, as far as possible, for working-age adults who are in an acute mental health crisis. They will also gatekeep by rapidly assessing people and referring them on as necessary. This may happen, for example, if the crisis is related to a primary diagnosis of alcohol or substance misuse or has occurred solely in the context of relationship problems. The aim is to respond to referrals rapidly and work with service users in the least restrictive environment possible – usually the service user's home, alongside their existing support and social networks. Practitioners will be aiming to maximise the service user's self-monitoring and coping strategies, and offering both education and practical assistance. Contacts are frequent (potentially several times per day) but the overall episode of care may be comparatively brief compared to the longer term input from other teams to which the service user may be referred once the crisis is resolved.

Assertive outreach teams

These teams are designed to cater for the small number of working-age adults within any population who have severe mental health problems and complex health and social care needs but who either do not wish to use services or have difficulty doing so. They also operate a 7-day per week service, with flexibility to extend out of hours where necessary.

Assertive outreach service users will often have entrenched difficulties in several areas of life and the input from teams may be intense in terms of both frequency of contact (sometimes daily) and duration (often years). This involves much commitment on the part of practitioners to the quality of their relationship with service users, which needs to be engaging and facilitative, and which requires a conscious focus on the therapeutic use of self.

Practitioners are likely to need a long-term perspective of recovery and social inclusion and may address needs related to accommodation, occupational deprivation and alienation, dual diagnosis, risks related to self-neglect, challenging behaviour or a history of violence or offending.

A generic, problem-solving process is funnelled through a whole-team approach which operates across professional boundaries and requires frankness and openness with colleagues so decisions can be owned by the whole team.

Early Intervention in Psychosis Service

These teams work specifically with people who are in the early stages of developing psychotic symptoms. The range of potential referrers includes Child and Adolescent Mental Health Services and GPs. Often, the onset of psychosis is at a crucial developmental stage in an individual's life (the majority occur between 14 and 35) and timely help has been shown to improve long-term outcomes and recovery. Interventions are aimed at minimising stigma and dislocation of valued social and familial roles and occupations, such as education and employment.

Skilled work is required to address early problems that may be indistinguishable from the normal emotional upheaval of adolescence, and possibly occurring in the midst of difficult family dynamics.

Primary care liaison teams (PCLTs)

As the name suggests, these teams are a support and resource to primary care (GPs) and have the option of referring on to more specialised tertiary services, such as those above, where necessary. They provide the bulk of care to mental health service users in the community. As CMHTs have prioritised severity of need, the role of GPs in treating people with a wide range of mental health problems has increased, and GPs will rely on a prompt referral and assessment relationship with the PCLT. This is via a single point of entry to the team as a whole and not to a specific profession. In some cases a full, needs-led PCLT assessment and advice is the main purpose of the referral, with the assessed person not actually being taken on by the PCLT at all.

PCLTs provide services to people with time-limited problems who can be referred back to their GPs after a few weeks or months and also to a substantial minority with serious mental health problems whose contact with the team may last for years, and whose care will be co-ordinated using the CPA.

PCLTs are expected to address the full spectrum of people's needs including physical and psychiatric care; practical help and advocacy with the whole range of basic living needs such as personal care, budgeting, shopping, income entitlements, and accommodation; help in accessing occupation, work, education and/or training; emotional support; liaison and support for families and carers; and specific psychological therapies if appropriate (DoH 2001).

About 80% of PCLT service users will be on an 'enhanced' level of CPA (DoH 2001). The team will comprise a skill mix that can address all the above interventions and be made up of practitioners whose sole responsibility is to work in that team. This would usually include 1 or 1.5 occupational therapists, 1 or 1.5 clinical psychologists, 2 or 3 social workers and 3 or 4 nurses, all of whom would act as CPA care co-ordinators. Other clinical team members such as medical staff and support workers would not normally undertake enhanced care co-ordination.

Other occupation-based services

The range of services employing occupational therapists is diverse and likely to diversify further. The College of Occupational Therapy's 10-year mental health strategy envisions extending occupational therapy's scope beyond statutory health and social care services (College of Occupational Therapists 2006a). Two aspects of current service provision which routinely employ occupational therapists, but which are not classed as CMHTs, are day services and vocational services. Here the emphasis is usually on providing a particular facility that may be incorporated into care planning, though a care co-ordination role may also be undertaken with people using the service over the long term.

Day services

These can serve the dual functions of acting as a bridge from inpatient units into the community and as a resource that may help an individual avoid a hospital admission. They usually offer an occupation-based programme aiming to help people retain or develop social roles and relationships, and access mainstream social, leisure and vocational opportunities. Much development work is focused on transforming traditional, buildings-based day hospitals into more outward-looking day services which can promote recovery and social inclusion, and develop the rehabilitative function of mainstream occupations (Care Services Improvement Programme 2006a).

Vocational services

Vocational rehabilitation refers to a range of approaches that may help a person overcome practical and psychosocial barriers in accessing, retaining or returning to work. It can take place in and across statutory and voluntary mental health services, mainstream employment services, and open employment. Vocational rehabilitation is prioritised as a social inclusion issue (Office of

the Deputy Prime Minister 2004) and, perhaps conflictingly, as part of the reform of incapacity benefits (Department of Work and Pensions 2006, Meacher 2006).

MEASURING OUTCOMES WITHIN TEAMS

The clinical governance and evidence-based practice agendas have a high profile in community mental health because serious mental health problems generate high degrees of disability and distress and draw heavily on the resources of health and social care (Brooker & Repper 2003).

All professions appear to encounter practical difficulties in measuring outcomes (Slade 2006). Godden et al (2006) found that factors influencing occupational therapists' use of outcome measures in mental health settings included perceived time constraints, ease of use, and the culture of managerial and peer support. Concerns about the client-centredness of the measurement tool, the nature of the therapeutic relationship this fostered, and the availability of specific training in outcome measurement were also factors.

Additionally, in the community, because multiprofessional teams offer a single co-ordinated package of care to individual clients, the question of which outcomes may be attributable to which intervention may be a difficult one to unpick.

To guide occupational therapists, Finlay (2004) has outlined four approaches to measuring mental health outcomes. These are: comparing progress against clear, specific behavioural objectives; employing a standardised measure; using quality of life measures, which are gaining ground within mental health generally and may also (because of their social and occupational focus) be appropriate for occupational therapists; and, finally, using person-centred, subjective measures, or self-ratings, of an individual's own perception of progress.

Although none of these approaches represents the elusive solution for resolving all outcome measurement dilemmas, any or all can be tried out locally. Significantly, the National Institute for Mental Health in England recognises the widespread difficulties in measuring outcomes and suggests that bottom-up solutions from the local level offer the best way to meet top-down policy requirements from government (National Institute for Mental Health in England 2005).

OCCUPATIONAL THERAPY AND CARE CO-ORDINATION

From the MHPIG (DoH 2001) it is clear that, as core CMHT members, occupational therapists are expected to take on a care co-ordination role. This has generated much discussion in our professional literature, often producing a rather polarised debate which may be bewildering for new graduates. So, in keeping with the stated aim of providing a navigational aid to inform therapists' own judgement, what follows is an attempt to contextualise care co-ordination within a broad occupational perspective of health. This brings into view several reasons why occupational therapists are entitled to feel confident and positive about taking on this role.

Skills required for care co-ordination

First, the skills needed to make a good care co-ordinator are not owned by any single profession but are, nevertheless, essential to a team's functioning, and are well within occupational therapists' reach. They are said to include: a therapeutic optimism and person-centredness when working with service users, including an ability to form empathic and effective partnerships with users and carers; a preparedness to focus on the minutiae of daily living; a flexible, solution-focused approach; an awareness of the need for positive risk taking; an ability to plan, implement and evaluate interventions; a capacity for holistically assessing needs, and for recognising changing needs; an ability to co-ordinate and review a care plan based on this; an up-to-date knowledge of relevant legislation; and the ability to make use of a team (Onyett 2003, Ryan & Morgan 2004b).

Congruence of roles

However, there is a second and more fundamental reason why a care co-ordination role can feature prominently in therapists' practice, which contains potential benefits to their teams, to their service users, to themselves as practitioners, and to their profession. It is the congruence between

occupational therapy skills and the needs of people with serious mental health problems. This is another facet of the evolution of community care, seen as the prioritisation of practicality (Morgan & Ryan 2004). A historical perspective may prove to be illuminating here. When community mental health teams were developing in the 1990s a review of existing practice stated:

> The presence of occupational therapists is strongly associated with activities of particular relevance to people with severe and long-term mental health problems, such as training in activities of daily living and assisting clients in achieving satisfying work and leisure...occupational therapists may offer the best model for professional input to CMHT's currently available. (Onyett et al 1995, p38)

Similarly Peck & Norman 1999 cited occupational therapy's focus on the functional consequences of illness and adaptive skill acquisition, its use of strengths to address deficits and its use of occupation as an assessment, intervention and evaluation medium as characterising its highly valued role in community mental health.

This congruence means that therapists do not have to regard decisions about how to combine profession-specific and team roles as an awkward dilemma or a dichotomous choice between polar opposites. Occupation is central to both roles and allows both roles to be mutually informing. Indeed, the most pertinent contemporary question might be 'How can an occupational perspective of health be integrated into the broader work of the CMHT?' (Corrigan 2002, Fowler Davis & Ilott 2002, Harrison 2003).

Integrating an occupational perspective into teamwork enables occupational therapy theory and practice to adapt and develop in harmony with national, evidence-based agendas, and to respond positively to the need for all professions to accommodate to new multidisciplinary environments (Ormston 2006).

The congruence between professional skills, service user needs and team goals is an asset to occupational therapists in a rapidly changing working environment. Allen (2005) suggests that some professions have sought care co-ordination roles because they have been liberating and offered a greater breadth of responsibility and autonomy whilst also allowing the perspective of the care co-ordinator to express itself. Where this is an occupational perspective, care co-ordination can become a powerful lens bringing diverse interventions into a single, practical focal point – that is, the service user's daily living and his aspirations about it.

Similarity of process

A third point of similarity between care co-ordination and occupational therapy relates to the process of each. Care co-ordination can be very similar to Hagedorn's (1992) notion of the triadic or triangular relationship between the service user, the therapist and the service user's occupations. Hagedorn suggests that, in contrast to other dyadic or two-way relationships between professionals and service users, occupational therapists have a third territory where the therapist can *do* with the service user, and be informed by both her observations and by the service user's reports on that doing. It is the same pattern in care co-ordination, except it is a triad formed between the service user, the therapist and the activities encompassed by the care plan which, as described above, is an essentially occupational domain.

A final reason for promoting a care co-ordination role – which is pragmatic but nonetheless important – is that, as whole-team effectiveness is increasingly prized by purchasers and commissioners of services, the different professions' preparedness to undertake care co-ordination will increasingly inform recruitment decisions (Harrison 2003, Hyde 2002). It does not mean that professions' unique skills are not also prized, but simply that a balanced commitment to both is expected. Indeed, the New Ways of Working (NWW) initiative (www.nimhe.csip.org.uk), which aims to foster an evolutionary process among services, regards effective teamwork as the best way to deliver specialist input where it is needed most.

PERSON-CENTRED CARE PLANNING

To be effective, care planning must engage the service user as an active partner. Care planning usually means assembling a package of care that

co-ordinates input from a range of sources. For example, a particular individual's care plan may include the following:

- specific interventions from members of the CMHT
- input from the service user's GP
- a drop-in centre or support group, perhaps run by MIND (www.mind.org.uk) or by Rethink (www.rethink.org)
- a self-help group such as a Hearing Voices Group (www.hearing-voices.org)
- sessions with a vocational rehabilitation service
- some aspect of the service user's ordinary occupations, such as an adult education class or a local walking group
- the role of the support worker at the service user's housing association
- a particular input from the service user's family or carer
- the service user's own contribution and agreement to the plan.

The care plan should be recorded in straightforward language and the service user should be given a copy. At best, it can be written by the service user himself. Efforts to make the care-planning experience as user-friendly and meaningful as possible should include consultation with the service user about the time and place of the meeting; negotiation well in advance regarding who will attend; and the provision of an independent interpreter if necessary. In addition, it may be important to offer to get an independent advocate to support the service user if there are contested issues. Various organisations, such as MIND, run such advocacy schemes.

It is important to bear in mind that care planning is an approach to care. It is an ongoing cycle of planning, action, reflection and modification. Focusing all the efforts into a single and unnecessarily over-populated meeting can be damaging to the care-planning process and the therapeutic relationship. It must work for the service user and not become just another procedure of the service system (Ritchie 2000). However, and perhaps not surprisingly, it is often experienced as a daunting ordeal by service users. When done in a tokenistic way, care planning can degenerate into a 'rubber-stamping' process for professionals' input with the client obliged to remain passive and asked only to comment on a *fait accompli*.

The power dynamics of a heavily populated CPA meeting must be appreciated. Care should be taken that only those people directly involved in the care plan are present. It may also help to deconstruct the care-planning process into two or more sub-meetings. For example, the care co-ordinator and service user may need to meet the housing worker to iron out certain issues before the main meeting. This allows time for important preliminary discussions to take place fully whilst still feeding into the central care-planning process. Planning these meetings with the service user beforehand and giving feedback to the central CPA meeting afterwards will ensure this approach is helpful deconstruction rather than unhelpful fragmentation.

TEAM DYNAMICS, ROLES AND BOUNDARIES

Having established that a balance between profession-specific and team roles is needed, a further question might be, 'How can balance be achieved?'. There will undoubtedly be many different ways in which a balance is found. Much will depend on the individual therapists' abilities and preferences (Harries & Gilhooly 2003).

However, since it is likely that a CMHT will have a single therapist, or possibly two (DoH 2001), some reflections on the potential team implications of this balancing act are now offered because it can be a significant factor in therapists' job satisfaction (Parker 2001, Reeves & Summerfield Mann 2004).

As described, an occupational perspective of health encompasses and appreciates both roles. Acknowledging this broader view allows therapists to seize the opportunity to negotiate boundaries whilst committing to both rather than baulk at the choice. This chapter hopes to equip therapists with a greater understanding of the relevance of their knowledge and skills to the service's and team's goals so they can negotiate more confidently and gain clarity. Being flexible does not mean being muddled.

Failing to define one's occupational therapy role means it may be defined by others (Hughes 2001). This can marginalise therapists whose potential contribution to the team's work is then underestimated and/or misunderstood, and whose clinical reasoning is then absent from the main care-planning and decision-making forum of the team.

When occupational therapy clinical reasoning is expressed in team meetings, the team as a whole takes on an increasingly occupational focus. Not only is this beneficial for service users (Hughes 2001, Krupa et al 2002, Onyett et al 1995) but it also creates a benign cycle of job satisfaction and staff retention amongst therapists. In other words, teamwork is likely to have the occupational focus that a skilled practitioner brings to the team if that practitioner commits to the team.

Just as clarity is vital, so is the confidence to demonstrate utility. As Finlay (2004) suggests:

> We are being given an ideal opportunity to explore new ways of interprofessional working that aim to provide integrative, needs-led care. It is time to celebrate the way that occupational therapy ideals are being embraced across different health care professions and contexts. It is, also, more than time to end any angst about our role... It is time, finally, to replace defensive practice with defensible practice. (p19–20)

NEW WAYS OF WORKING

In response to the NWW initiative, the College of Occupational Therapists acknowledges that collaborative, flexible, recovery-orientated practice and widened professional roles are likely to be pointers to the future of occupational therapy in mental health, as long as they are consistent with the profession's ideals (College of Occupational Therapists 2006a, Ormston 2006). It lists these ideals or values as: a view of humans as occupational beings; an occupational perspective of health and well-being; a continued focus on the individual's potential, action, strengths and self-determination; and the centrality of client-centredness, positive risk taking, cultural sensitivity and ethical practice (Ormston 2006).

The intention of this chapter has been to illustrate the congruence between these values and the wider agendas and team structures of community mental health practice. Drawing again on the notion of open systems thinking, the form which occupational therapists' input will take in any given team should reflect the function of the team as a whole.

LOOKING AFTER YOURSELF

Having highlighted some of the potential pitfalls and stresses of teamworking, it may be helpful to consider some of the resources available to therapists to minimise these stressors and maximise the enriching experience that community mental health practice can be.

YOUR OWN TEAM

Working as a team, and the culture of support this can create among colleagues, is highly valued by community staff. Not only will a team's weekly round of formal clinical reviews help to support practitioners' clinical skills, but the more immediate need to spontaneously share the personal impact of challenging work is met, and indeed fostered, when teams work well together (Onyett 2003).

SUPERVISION

Individual professional supervision, as well as team management, will provide opportunities to discuss role issues (Craik et al 1999). The MHPIG (DoH 2001) states that, where there is only one member of a discipline in a CMHT, adequate professional support and supervision must be provided, and therapists are encouraged to demand it if it is not offered (College of Occupational Therapists 2006a). This can include the option of incorporating three-way discussions that include one's professional supervisor and one's functional manager together in the same room, perhaps as part of an appraisal process. This will promote congruence between roles, avoid role ambiguity and role conflict (Hughes 2001, Onyett 2003) and also avoid the stress associated with isolated clinical roles (Knapp et al 1992).

It will also be an opportunity to discuss an occupational perspective of health in relation to service users' needs, and to agree how occupational therapy will best fit the team's priorities and one's own skills. An occupational perspective of health may be unfamiliar territory for team managers who are not occupational therapists (Harries & Gilhooly 2003) but, if framed in the terms described in this chapter, connections can be highlighted between therapists' day-to-day practice and the key issues which all CMHTs must now address.

Significantly, many contributors to the debate on generic and specialist working identify the need for interprofessional training, and this may well be a professional development issue to take up in supervision (Harrison 2005a, b, Hughes 2001, Reeves & Summerfield Mann 2004).

SUMMARY

A clear-sighted occupational perspective of health and well-being combined with a person-centred approach is crucial in community mental health work. These characteristics will help to ensure that community occupational therapy practice continues to evolve from an appreciation of human occupation. In the rapidly changing field of community mental health, the occupational therapy interventions that worked in the past cannot be assumed to be applicable in the future.

In exploring the issues presented in this chapter; social inclusion, social capital, recovery and person-centredness, it is striking how, conceptually, they all converge and reinforce one another and how, in practice, they all have an occupational basis.

Translating this into occupational therapy is the challenge. A recurrent theme here has been the need to apply open, dynamic systems thinking to ourselves as community-based therapists, so that working with the community maximises our effectiveness within the community. This will, arguably, ensure the efficacy and acceptability of our practice to the widest range of service users, and promote it as a valuable asset to commissioners and managers of services.

References

Allen R 2005 Challenges of case management. In: Whiteford G, Wright-St Clair V (eds) Occupation and practice in context. Elsevier, Marrickville,NSW.

Bates P 2005 Accidents at the inclusion traffic lights: mistakes and misunderstandings in supporting people to achieve social inclusion. A National 2000 Development Team Emerging Themes Paper. Available online at: www.ntd.org.uk

Bates P, Miller C, Taylor P 2000 Defining things: defining inclusion. In: Bates P (ed) Working for inclusion: making social inclusion a reality for people with severe mental health problems. Sainsbury Centre for Mental Health, London,

Brooker C, Repper J 2003 Serious mental health problems in the community: future directions for policy, research, and practice. In: Brooker C, Repper J (eds) Serious mental health problems in the community: policy practice and research. Baillière Tindall, Edinburgh,

Burchardt T, Le Grand J, Piachaud D Degrees of exclusion: developing a dynamic, multidimensional measure. In: Hills J, LeGrand J, Piachaud D (eds) Understanding social exclusion, Oxford University Press, New York,

Cameron M, Edmans T, Greatley A, Morris D 2003 Community renewal and mental health. King's Fund, London

Care Services Improvement Partnership 2006a From segregation to inclusion: commissioning guidance on day services for people with mental health problems. Department of Health, London

Care Services Improvement Partnership 2006b National social inclusion programme: 2nd Annual Report. Department of Health, London

College of Occupational Therapists 2006a Recovering ordinary lives: the strategy for occupational therapy services 2007–2017 – a vision for the next ten years. College of Occupational Therapists, London

College of Occupational Therapists 2006b Recovering ordinary lives: the strategy for occupational therapy services 2007–2017 – results from service user and carer focus groups. College of Occupational Therapists, London

Corrigan K 2002 CMHTs: embedding the occupational perspective (letter). British Journal of Occupational Therapy 65(2): 100

Craik C, Austin C, Shell D 1999 A national survey of occupational therapy managers in mental health. British Journal of Occupational Therapy 62(5): 220-228

Creek J 2003 Occupational therapy defined as a complex intervention. College of Occupational Therapists, London

Deegan PE 1988 Recovery: the lived experience of rehabilitation. Psychosocial Rehabilitation Journal 11(4): 11-19

Deegan PE 2001 Recovery as a self-directed process of healing and transformation. Occupational Therapy in Mental Health 17(1): 5-21

Department of Health 1990 The care programme approach for people with a severe mental illness referred to the specialist psychiatric services. HMSO, London

Department of Health 1995 Building bridges: a guide to arrangements for inter-agency working for the care and protection of severely mentally ill people. Department of Health, London

Department of Health 1999a National service framework for mental health. Department of Health, London

Department of Health 1999b Effective care coordination in mental health services: modernising the care programme approach. Department of Health, London

Department of Health 2000 NHS national plan. HMSO, London

Department of Health 2001 The mental health policy implementation guide. Department of Health, London

Department of Health 2005 Creating a patient-led NHS: delivering the NHS Improvement Plan. Department of Health, London

Department of Work and Pensions 2006 A new deal for welfare: empowering people to work. HMSO 2006, London

Duncan EAS Skills and processes in occupational therapy. In: Duncan EAS (ed) Foundations for practice in occupational therapy, 4th edn. Elsevier, Edinburgh,

Dunn S 1999 Creating accepting communities – report of the Mind Inquiry into social exclusion and mental health problems. Mind Publications, London

Finlay L 2004 The practice of psychosocial occupational therapy, 3rd edn. Nelson Thornes, Cheltenham
Finlay L, McKay E 2004 Mental illness: listening to users' experience. Finlay L (ed) The practice of psychosocial occupational therapy. 3rd edn. Nelson Thornes, Cheltenham.
Forsyth K, Kielhofner G 2006 The model of human occupation: integrating theory into practice and practice into theory. In: Duncan EAS (ed) Foundations for practice in occupational therapy, 4th edn. Elsevier, Edinburgh.
Fowler Davis S, Ilott I 2002 Mental health update (letter). British Journal of Occupational Therapy 65(5): 251-252
Glover H 2001 A series of thoughts on personal recovery. Unpublished pamphlet
Godden A, McMahon S, Montgomery S, Taylor S, Smallbridge P 2006 An investigation of the factors that influence the use of outcome measures by occupational therapists practising in mental health. Unpublished BSc (Hons) dissertation University of the West of England, Bristol
Goffman E 1968 Stigma. Penguin, Harmondsworth
Hagedorn R 1992 Occupational therapy: foundations for practice. Churchill Livingstone, Edinburgh
Hagedorn R 2000 Tools for practice in occupational therapy: a structured approach to core skills and processes. Churchill Livingstone, Edinburgh
Harries P, Gilhooly K 2003 Generic and specialist occupational therapy casework in community mental health teams. British Journal of Occupational Therapy 66(3): 101-109
Harrison D 2003 The case for generic working in mental health occupational therapy. British Journal of Occupational Therapy 66(3): 110-112
Harrison D 2005a Context of change in community mental health occupational therapy: part one. International Journal of Therapy and Rehabilitation 12(9): 396-400
Harrison D 2005a Context of change in community mental health occupational therapy: part two. International Journal of Therapy and Rehabilitation 12(10): 444-448
Hart L 2003 Recovery? Let's get real: an open letter to mental health professionals. Openmind 124: 15
Hughes J 2001 Occupational therapy in community mental health teams: a continuing dilemma? Role theory offers an explanation. British Journal of Occupational Therapy 64(1): 34-40
Hyde P 2002 Occupational therapists as case managers: the service user's experience. Mentalhealth OT 7(2): 12-15
Iwama MK 2005 The Kawa (river) model: nature, life flow, and the power of culturally relevant occupational therapy. In: Kronenberg F, Algado SA, Pollard N (eds) Occupational therapy without borders – learning from the spirit of survivors, Churchill Livingstone, Edinburgh, pp213-227
Kielhofner G, Barrett L 1998 Meaning and misunderstanding in occupational forms: a study of therapeutic goal setting. American Journal of Occupational Therapy 52(5): 345-353
Knapp M, Cambridge P, Thomason C, Allen C, Beecham J, Darton R 1992 Care in the community: challenge and demonstration. Gower, Aldershot
Krupa T, Radloff-Gabriel D, Whippey E, Kirsh B 2002 Reflections on occupational therapy and assertive community treatment.. Canadian Journal of Occupational Therapy June: 153-157
Langford CPH, Bowsher J, Maloney JP, Willis PP 1997 Social support: a conceptual analysis. Journal of Advanced Nursing 25: 95-100
Laurance J 2003 Pure madness: how fear drives the mental health system. Routledge, London
Learning and Skills Council 2006 Improving services for people with mental health difficulty. Learning and Skills Council, Coventry
Mancini MA 2006 Consumer-providers' theories about recovery from serious psychiatric disabilities. Rosenberg J, Rosenberg S (eds) Community mental health: challenges for the 21st century. Routledge, Taylor and Francis, New York, pp15-24
McLaughlin Gray J 1997 Application of the phenomenological method to the concept of occupation. Journal of Occupational Science: Australia 4(1): 5-17
Meacher M 2006 Mental health problems – is employment the answer? Mental Health Review 11(3): 4-7
MIND 2004 Not alone? Isolation and mental distress. MIND, London
Mitchell RE, Trickett EJ 1980 Task force report: social networks as mediators of support. Community Mental Health Journal 16: 27-44
Molineux M, Whiteford G Occupational science: genesis, evolution, and future contribution. In: Duncan EAS (ed) Foundations for practice in occupational therapy, Elsevier, Edinburgh.
Morgan S The purpose and principles of a 'strengths' approach. In: Morgan S, Ryan P (eds) Assertive outreach – a strengths approach to policy and practice, Churchill Livingstone, Edinburgh,
Morgan S, Ryan P 2004 Assertive outreach – a strengths approach to policy and practice. Churchill Livingstone, Edinburgh
National Institute for Mental Health in England 2005 Outcome measures implementation best practice guidance. National Institute for Mental Health in England, Leeds
Nolan P 1995 Survey of the social networks of people with severe mental health problems. Journal of Psychiatric and Mental Health Nursing 2: 131-142
Office of the Deputy Prime Minister 2004 Mental health and social exclusion – Social Exclusion Unit Report. Office of the Deputy Prime Minister, London
Oliver M 1996 Understanding disability. MacMillan, London
Onyett S 2003 Teamworking in mental health. Palgrave Macmillan, Bristol
Onyett S, Pillinger T, Muijen M 1995 Making community mental health teams work: CMHTs and the people who work in them. Sainsbury Centre for Mental HealthLondon
Ormston C 2006 New ways of working for occupational therapists in mental health: the underlying value base for occupational therapy practice: a constant in a changing environment. Mental Health Occupational Therapy 11(3): 102-103

Parker D 2006 The client centred frame of reference. In: Duncan EAS (ed) Foundations for practice in occupational therapy, 4th edn, Elsevier, Edinburgh, pp193-215
Parker H 2001 The role of occupational therapists in community mental health teams: generic or specialist?. British Journal of Occupational Therapy 64(12): 609-611
Peck E, Norman IJ 1999 Working together in adult community mental health services: an interprofessional dialogue. Journal of Mental Health 8(3): 217-230
Perkins RE 2004 Recovery and rehabilitation. Paper presented at the Avon and Wiltshire Mental Health Partnership Annual Rehabilitation Service Conference, January 23, Vassal Centre, Bristol
Perkins RE 2005 Recovery and social inclusion. Workshop presentation at the Multi-Disciplinary Continuing Professional Development Workshop, February 25, University of Bristol Psychology Department
Perkins RE, Repper J 2003 Principles of working with people who experience serious mental health problems. Brooker C, Repper J (eds) Serious mental health problems in the community: policy, practice and research, Baillière Tindall, Edinburgh.
Ralph R 2004 Verbal definitions and visual models of recovery: focus on the recovery model. Ralph R, Corrigan P (eds) Recovery in mental illness: broadening our understanding of well-ness. American Psychological Association, Washington DC.
Rankin J 2005 Mental health in the mainstream. Institute of Public Policy Research, London
Rebeiro KL 2001 Enabling occupation: the importance of an affirming environment. Canadian Journal of Occupational Therapy 68: 80-89
Rebeiro KL 2005 Reflections on The recovery pradigm: should occupational therapists be interested?. Canadian Journal of Occupational Therapy 2(72): 96-102
Reeves S, Summerfield Mann L 2004 Overcoming problems of generic working for occupational therapists based in community mental health settings. British Journal of Occupational Therapy 67(6): 265-268
Richards S 2005 Keynote speech delivered to South West Region COT Conference at Buckfastleigh, Devon May 17.
Ritchie P 2000 Modernising services: person-centred planning. In: Bates P (ed) Working for inclusion: making social inclusion a reality for people with severe mental health problems. Sainsbury Centre for Mental Health, London,
Roberts G, Wolfson P 2004 The rediscovery of recovery: open to all. Advances in Psychiatric Treatment 10. Available online at: http://apt.rcpsych.org/
Rose D 2001 Users' voices: the perspective of mental health service users on community and hospital care. Sainsbury Centre for Mental Health, London
Ryan P 2004 The origins of and evidence for case management. In: Ryan P, Morgan S (eds) Assertive outreach: a strengths approach to policy and practice, Churchill Livingstone, Edinburgh.
Ryan P, Morgan S 2004a Targeting: who is the client? In: Ryan P, Morgan S (eds) Assertive outreach: a strengths approach to policy and practice, Churchill Livingstone, Edinburgh,
Ryan P, Morgan S 2004b Care planning and care co-ordination. Ryan P, Morgan S (eds) Assertive outreach: a strengths approach to policy and practice. Churchill Livingstone, Edinburgh.
Sainsbury Centre for Mental Health 1998 Keys to engagement. Sainsbury Centre for Mental Health, London
Sainsbury Centre for Mental Health 2000 On your doorstep: community organisations and mental health. Sainsbury Centre for Mental Health, London
Sainsbury Centre for Mental Health 2003 Primary solutions: an independent policy review on the development of primary care mental health services. Sainsbury Centre for Mental Health, London
Sainsbury Centre for Mental Health/mentality 2001 An executive briefing on mental health promotion: implementing Standard One of the national service framework. Sainsbury Centre for Mental Health/mentality
Sayce L 2000 From psychiatric patient to citizen: overcoming discrimination and social exclusion. MacMillan, London
Slade M 2006 Commissioning outcome-focused mental health services. Mental Health Review 11(3): 31-36
Stein LI, Santos AB 1998 Assertive community treatment of persons with severe mental illness. WW Norton, New York
Stein L, Test A 1980 Alternatives to mental hospital treatment: conceptual model, treatment program and clinical evaluation. Archives of General Psychiatry 37: 392-397
Townsend E, Wilcock A 2004 Occupational justice.In: Christiansen CH, Townsend EA (eds) Introduction to occupation: the art and science of living. Prentice-Hall, New Jersey.
van Niekerk L 2005 Occupational science and its relevance to occupational therapy in the field of mental health. In: Crouch R, Alers V (eds) Occupational therapy in psychiatry and mental health. 4th edn. Whurr, London,
Warner R 2000 The environment of schizophrenia. innovations in practice, policy and communications. Brunner-Routledge, London
Westwood J 2003 The impact of adult education for mental health service users. British Journal of Occupational Therapy 66(11): 505-510
Whalley-Hammell K 2006 Perspectives on disability and rehabilitation: contesting assumptions, challenging practice. Churchill Livingstone Elsevier, Edinburgh
Wilcock AA 1993 A theory of the human need for occupation. Occupational Science: Australia 1(1): 17-24
Wilcock AA 1995 The occupational brain: a theory of human nature. Journal of Occupational Science: Australia 2(1): 68-73
Wilcock AA 1998a Occupation for health. British Journal of Occupational Therapy 61(8): 340-345
Wilcock AA 1998b An occupational perspective of health. Slack, Thorofare, New Jersey
Wollenberg JL 2001 Recovery and occupational therapy in the community mental health setting. Occupational Therapy in Mental Health 17(3-4): 97-114
Yerxa E 1994 Dreams, dilemmas, and decisions for occupational therapy practice in a new millennium: an American perspective. American Journal of Occupational Therapy 48(7): 587-588