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Introduction

The social inclusion agenda challenges mental health services to find new ways of promoting service users' access to mainstream life opportunities beyond services, which are essential to an individual's recovery. However, the social capital of "the community" remains stubbornly elusive to many mental health service users.

This paper reports on a social inclusion action research (AR) project in Bristol, UK, which asked service users of an assertive outreach (AO) service what had worked for them. Qualitative interviews explored their experiences of community participation and inclusion; and this learning was then fed into Bristol's multi-agency social inclusion forum where it was used to inform joint planning between mental health services and a further education (FE) college, aiming to maximise the inclusivity of FE locally.

In the interviews, service users described how AO practitioners helped them engage in mainstream activities and how this re-connected them with cherished roles, achieve long-standing goals, and develop feelings of self-efficacy, self-belief, belonging, and wellbeing.

A full report on the qualitative interviews is provided in the *British Journal of Occupational Therapy* by Fieldhouse (2012a) (copyright held by the College of Occupational Therapists) and the implications of the findings for inter-agency work in the Community Involvement Subgroup (CIS) of the social inclusion forum are explored in the *Community Development Journal* by Fieldhouse (2012b). This paper aims to promote discussion about community mental health practice as a social issue – one requiring inter-agency co-operation. It is co-authored by the lead researcher of the AR (J.F.) and a service user researcher (A.-L.D.) who, as former co-ordinator of Bristol MIND's [See Note1]User Focused Monitoring Project (UFM)[See Note 2], was involved in the project as co-interviewer, and data co-analyst.

Participation and inclusion

Adults with mental health problems are one of the most socially excluded and stigmatized groups in society (Office of the Deputy Prime Minister, 2004). Burchardt *et al.*'s (2002) definition of social exclusion as non-participation in the key activities of the society in which a person lives suggests that community participation can address this problem. It is also clear that the task of promoting participation is one that should be shared by both community agencies and mental health services (Seebohm and Gilchrist, 2008).

Action Research

The idea for the AR emerged when AO practitioners (occupational therapists, nurses, social workers, psychologists, psychiatrists, and support workers) noticed that service users greatly appreciated the social contact of *doing things* with them. It helped tackle service users' sense of exclusion, such as through "being able to go to pubs or cafés like other people" (Griffiths *et al.*, 2002, p. 36). Service users built on this social relationship and started to participate in ordinary community-based activities, such as voluntary work, leisure activities, or FE. This was highly significant because the AO model was designed to help people with multiple, long-term needs who cannot, or do not wish to, engage with services (Department of Health (DH), 1999); people often labelled *hard to engage*.

AR was chosen to explore this phenomenon further because it is research *with* people, not *on* people, bringing together different perspectives to appreciate an issue in its entirety and effect change in the thick of the action (Heron and Reason, 2001). The AR aimed to gather service users' stories of successful community participation, to use this learning to develop more accessible, community-embedded services, and to reflect on the CIS's work so this too could be enhanced.

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Interviewing (so-called) "hard to engage" people

Access to an authentic service user voice was achieved in a number of ways:

1. Project steering: the research steering group included two service users with experience of using AO services (who were not interviewees) supported by two Trust-Based Service User Development Workers.
2. Redressing the interviewer-interviewee power imbalance: the likely power imbalance of having a former AO practitioner (author J.F.) as an interviewer was mitigated by sharing the interviewer role with mental health service user researchers from Bristol MIND's UFM who also acted as co-designers of the interview schedule and as data co-analysts.
3. Solution-focused data collection: in designing the interview schedule, great care was taken not to allow the negative assumptions associated with the "hard to engage" label to stigmatise interviewees. A solution-focused approach positively reframed being *hard to engage* (a problem) into being *information-rich* (a potential solution) in relation to the learning that was sought. Similarly, interviewers emphasised their role as learners, and the participant's role as the expert of their own lives. The interviews had one overarching main question:Looking back over the last few months/years, what do you think were the main events or milestones that have made a positive difference in your life?This question aimed to find out what participants were now doing that they had not felt able to do before. Follow-up questions focused on supportive relationships, and personal identity:Think of the most important people in your life. If they were here, and I asked them what was most noticeable about your progress, or what they saw you doing differently that told them things were getting better for you – what do you think they might say?This particular question borrows a *video talk* technique from Brief Solution Focused Therapy (Iveson, 2002) to by-pass a person's difficulty in conceptualising change in their own life. It asks them to describe what someone else (who knows them well) might notice about them.
4. Not so *hard* to interview: the usual practicalities of arranging interviews did not create any particular obstacles for participants. Patience and flexibility on the interviewers' part paid off. In fact, rather than being "hard to engage" in the interview process, participants clearly wanted to "tell their story". No-one had asked them to do this before. Some also made extraordinary efforts to be present and punctual for the interview, challenging the cliché that AO service users are not capable of keeping appointments without support. This willingness to talk mirrored the willingness to engage in *doing things* with team members. It was a question of opportunity, as noted in an e-mail from J.F. to the UFM co-interviewers:

   > *It strikes me how the interviewing process mirrors the service provision process […]. It's proving quite tricky to actually set up interviews because several individuals don't really "do" appointments, but it's patience and flexibility that seems to do the trick. But not "doing" appointments does not seem to be a reflection of any unwillingness to be interviewed. In fact my impression is that interviewees have wanted to tell their story. In the same way, many clients referred to the outreach team were deemed to be "hard to engage" because they kept missing appointments […] but in fact this didn't mean they did not want a service […] more that they did not, or could not access, the service as it was being offered. I think this is probably an interesting "finding" in some way; one of those unpredictable, but serendipitous outcomes that qualitative methods can uncover.*
5. Collaborative, reflexive data analysis: this was an opportunity to use reflexivity to explore the different assumptions that J.F. (a mental health practitioner), and the two UFM researchers (mental health service users) had. This was influential in the process of theme building, which was about finding common ground that was not only acceptable to all parties but that also genuinely reflected what interviewees had said.

Service users as service evaluators

The appreciative AR ethos sought to re-cast service users as active agents in local service development. In practice, however, the AR raised a fundamental question: How can the views of the

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disempowered come to have an influence with those who are powerful? This question remained largely unanswered but, arguably, its complexities became better understood.

Service user input into the planning and delivery of services has long been a requirement (Department of Health (DH), 2000) and a patient-led NHS has been advocated (Department of Health (DH), 2005, 2007, 2012). However, it is unclear how far the NHS guidance and policy are being implemented within mental health services specifically. Critics suggest the service user role rarely progresses beyond consultation (Lester and Glasby, 2006), arguably reflecting a traditional paternalistic service position whereby the service user is allowed to take part in a decision-making process, but one that is ultimately owned by professionals; as opposed to a genuine role of influence, partnership, or control. Consequently, a tension exists between service users' wish and right to be genuinely involved in service development, and the worry that their input can be sought by services in a tokenistic way. It may be that the new commissioning framework will improve this with the mandatory requirement for patient participation, including at Clinical Commissioning Group level (DH, 2012).

Interview findings

Participants said they enjoyed rewarding social relations through engagement in mainstream activities. Their relationships with AO team members – based on trust and *doing things* – was the conduit towards these opportunities. Crucially, these supportive one-to-one relationships were combined with advocacy and close partnership working (on the part of AO) with the relevant community agencies. Once engaged, participants felt they belonged in their community as capable, connected, contributing citizens; and they felt this was qualitatively different to engagement with mental health services. Prior to this newfound connectedness participants often felt they were excluded and not entitled to do the same things as the other people they lived amongst:

> Matthew: *I'm not doing what I want to do […] because a lot of the time, I misses out on being with just the people in the area, y' know, in the locality, and it makes me think: Well that's not right, that I should sort of stay away from them, because they are part of where I am.*

These psychosocial barriers are not as well understood as the barriers encountered by people with physical disabilities. Whilst there is wide societal acceptance of the principle of inclusive design of buildings and services (ensuring they are accessible to everyone including people with physical disabilities) there is arguably much less awareness or acceptance of the need to address a disabling psychosocial environment, and to uphold similar access rights for people with mental health problems (Beresford *et al.*, 2010). This paper highlights this phenomenon and presents some potential solutions discussed within the CIS.

Supportive "scaffolding"

The aspects of the AO team's work that participants found most supportive are gathered here under the term *scaffolding* (originated by Vygotsky, 1978) which describes the flexible, temporary, psychosocial space co-constructed by the AO practitioner and service user to support the individual's community participation. Scaffolding comprised the following components (see Figure 1):

1. Identifying personal investment in change – eliciting personal goals.
2. Grading goals and pacing goal attainment – allowing the experience of success to filter in through internalised stigma, and diminished self-belief:

   > Matthew: I got to do it myself […] but I think the assertive outreach makes it easier for me.
   > Interviewer: *How do they make it easier for you?*
   > Matthew: *Oh! They got the car outside [laughs]. All I got to do is walk down to the car, get in, and we're away.*

3. Therapeutic use of self – allowing each participant to feel that he was engaging with another

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person rather than with a mental health service:

> Stanley: *Because at the end of the day, when [the AO team member] comes and sees me […] [those] guys are, like, coming over so genuine, I got to be genuine back […] That's what I like about the honesty, [their] honesty. It goes a long way.*

4. Person-centred care planning – extending care-planning to encompass activities in the mainstream community and the supportive, non-stigmatising relationships that existed there. Stanley could be a "student", not a "patient":

> Stanley: *Staff at the college is absolutely – she's amazing, she's so relaxed, she's brilliant, brilliant.*

5. Community mapping – going beyond the habitually used community supports (which narrowed the focus on services) and exploring ordinary life opportunities, which could be cultivated:

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

6. Being a "travel companion" – working alongside service users and negotiating flexible *ad hoc* support, rather than acting as a 'travel agent' who merely makes bookings or referral (Deitchman, 1980 cited Morgan, 2004).
7. Creating affirming environments – creating micro-psychosocial environments characterised by empathic, non-judgemental relationships which can increase individuals' confidence to engage with others and experiment with new roles (Rebeiro, 2001).
8. Positive risk management – trusting participants, so they felt they were given a chance to try new things.
9. Harnessing social capital – enabling social connections to be built and maintained by the individual's own efforts, fuelling a sense of competence and acceptance:

> Interviewer: *So, it's a long working day [at the Green Gym] […] but your friends are there?*
> Rahim: *My friends are there, yes […]*
> *Interviewer: So, how do you get that balance between the work and "having a laugh"?*
> Rahim: *It all comes together in one package.*

10. Advocacy, lobbying, and partnership working – partnership working across health and non-mental health agencies. This brought together a micro-level appreciation of the daily challenges facing service users and a macro-level public health awareness of social exclusion and occupational deprivation (Wilcock, 2007). This partnership working was explored in the next phase of the AR: reflecting on the CIS' work.

The CIS' experience

CIS membership cut across mental health professions, health and social care, voluntary and statutory sectors, and the service provider/service user divide (see Box 1). This diverse group engaged in a participatory AR process combining co-operative inquiry, which stimulates collective reflection on an issue in order to explore it fully and effect change (Heron and Reason, 2001), and appreciative inquiry, which promotes change by instilling in people a sense of organisational innovation (Cooperrider and Whitney, 2005). The application of these inquiry models to community mental health practice is examined by Fieldhouse and Onyett (2012).

The CIS reviewed 18-month's work. Initial progress had been slow because each agency had its own culture, language, and assumptions about what the CIS' focus should be. Was it the accessibility of community opportunities? Or, the community-embeddedness of statutory mental health services? The CIS learned that it had to be both. A community-orientated mental health service was only viable in

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conjunction with a "community" that was accessible to mental health service users, and understanding the solutions that had worked for the interviewees allowed the CIS' task to crystallise around practicable goals – initially focused on access to FE. The action research time-scale did not extend to testing these ideas in practice, however, so reporting on outcomes is beyond the scope of this paper.

Effective inter-agency working

Based on clear task definition and shared goals, a round table ethos emerged that encouraged open discussion and the evolution of a common language. One CIS member described feeling "as if a wall was being dismantled from both sides". It counteracted habits of organisational silo-working and revealed the common ground shared by the mental health social inclusion agenda and the learning community's widening participation agenda (Learning and Skills Council, 2006). From this point, three options for improving service users' access to FE emerged:

1. mental health support worker assistance to FE learners with mental health problems;
2. training for FE staff around mental health difficulties and access issues; and
3. "transitional" or "bridge-building" groups in FE colleges that would have input from mental health staff and be open to existing day service users.

Despite many unresolved questions about how to secure senior managerial support for these proposals, a number of potential benefits were anticipated.

(1) Community bridge-building

Practitioners saw their role as promoting service users' skill acquisition in the real life settings where the new skills were most applicable, and where they would support new, socially valued roles; such as "student" instead of "patient". This emphasises that stigma is not the stigmatised individual's problem to solve, but society's:

> *I prefer not to use the term stigma, because it attaches to the person. We don't talk about the stigma of race. We talk about racism. The problem with anti-stigma campaigns is that they identify the class of people by their impairment* (Perkins, cited O'Hara, 2010, p. 3).

(2) Generating new skills, knowledge and attitudes among practitioners

Instead of regarding access to FE as a discharge pathway out of mental health services (though it could be that too) the transitional groups were located within a mental health care-planning framework using the Care Programme Approach (DH, 1999). It cast ordinary mainstream services in a restorative role, transcending the distinction between "care" and the social capital of the community.

It was anticipated that this would oblige mental health staff to re-appraise their professional role. CIS members acknowledged the potential dangers of community embedded day services, for example, if they merely re-located "old" habits of imbalanced power dynamics in practitioner-service user relationships (Popperwell, 2007). Indeed, CIS members felt that community development work should challenge practitioners, and that this would trigger a reflective process – helping to deconstruct medicalised thinking and develop more recovery-orientated services. This is clearly important. While the Time to Change campaign has recorded some recent improvements in public attitudes, for example, it also showed that this was not the case among mental health professionals (Brindle, 2013).

(3) Accommodating a widened range of stakeholders

CIS members' community-orientated work developed their appreciation of the richness, complexity, and restorative potential of community participation. They recognised the interviewees' initial perceptions of living in an *excluding* community and that – through participation – *the community* was experienced as something tangible, with navigable routes into its social networks and social capital.

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Bates (2010) has argued that the parameters of mental health work need to be expanded beyond the idea of one-to-one "care" and personal recovery (which is still about "the individual") to a conceptual framework encompassing citizenship. This extends the range of stakeholders in community mental health practice beyond mental health service providers. The service user movement (World Network of Users and Survivors of Psychiatry, 2013) contends that any concept of citizenship should be strengthened by the implementation of human rights, in particular the UN Convention on the Rights of Persons with Disabilities (United Nations, 2006) which actively promotes a social model of disability.

AO and "hard to engage" service users

The AO team's capped caseloads are likely to have been crucial to its success. Facilitating community participation was underwritten by the team having time to develop relationships with service users and mainstream agencies, time to gain service users' trust as "holders of hope", and time to work carefully towards real milestones of goal attainment. Also, a longer-term perspective of individuals' repeating patterns of relapse and hospital re-admission meant these could be addressed.

In recognising the progress achievable with time, it becomes clear that *hard to engage* describes a feature of certain service users' relationship with services, not a characteristic of service users themselves (Priebe *et al.*, 2005). It would be more accurate to see the underlying problem being "un-engaging" services.

Significantly, during data analysis, the UFM researchers observed that the supportive, trusting relationship between AO and its service users, and the genuine and creative connections this fostered with the community were not widespread features of community mental health practice. Their own experience was that services they had used had been more limited; often patronising and unambitious. This highlighted the potential that AO had for person-centred practice and raised a concern that important qualities could be lost as the AO model becomes diluted.

Conclusions

This action research shows that the harnessing of, arguably, the community's greatest resource – its social capital – is possible; and that mental health services can have a role to play in that process. The success of this approach depends on a combination of the person-centred support provided by mental health services, the restorative potential of the community, and effective joint working between mental health and non-mental health agencies. It is not enough for mental health services to know that social capital is "out there" in the community, they must actively engage with community partners and jointly develop routes into it.

Community development work, therefore, can build on traditional micro-level mental health practice (operating within the bounds of one-to-one client-practitioner relationships) and extend outwards to more collective community activity, aiming to tackle societal stigma and social exclusion.

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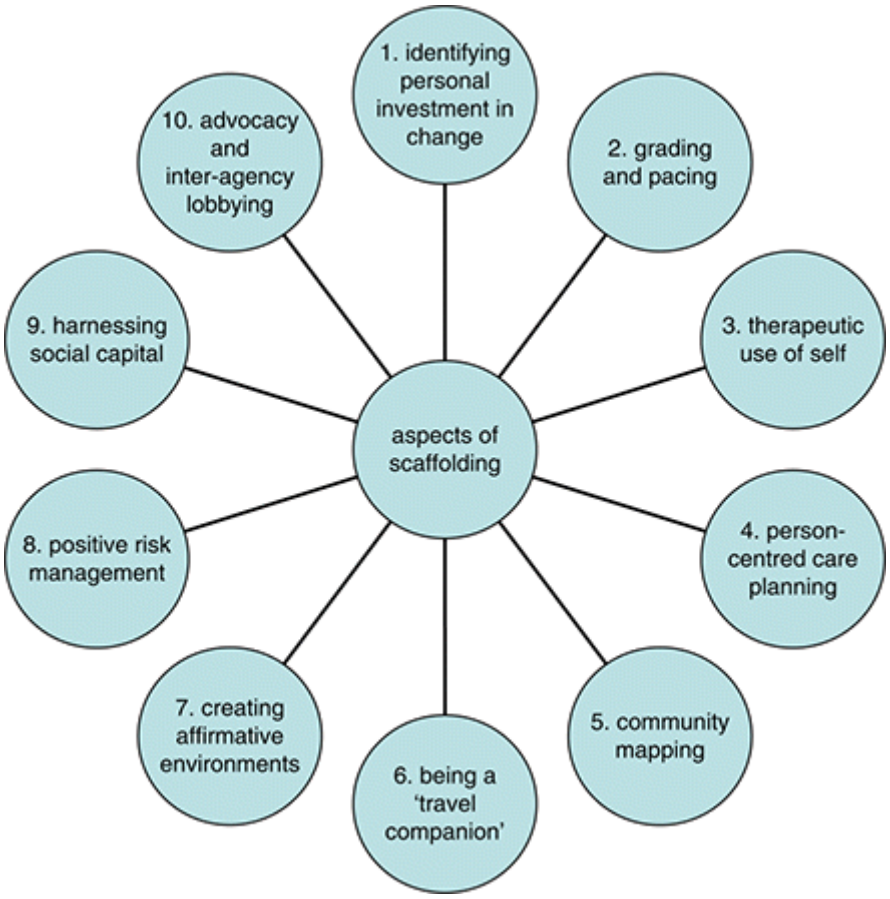

Figure 1 Ten key aspects of scaffolding

Box 1: Community Involvement Subgroup (CIS) membership

Colin – community mental health nurse from the AO team

Emily – service user researcher

Dave – Manager for a continuing needs mental health rehabilitation service

Kate – Manager for disability and mental health support services at city of Bristol College

Jon – Community occupational therapist with the AO team and lead researcher

Jenny – service user

Jon Fieldhouse

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Anne-Laure Donskoy

Notes

- MIND is a UK national mental charity with affiliated local branches in England and Wales.
- User Focused Monitoring is a user-led model of research and evaluation into local mental health services.

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