Welcome to the Realising Recovery learning materials
These learning materials have been developed by NHS Education for Scotland (NES) and the Scottish Recovery Network (SRN).

NES helps to improve care by providing educational solutions for workforce development. It does this by designing, commissioning, quality assuring and, where appropriate, providing education for NHS Scotland staff.

SRN is part of the National Programme for Improving Mental Health and Wellbeing. The SRN aims to raise awareness that people can and do recover from long-term and serious mental health problems and to build an understanding of what helps people recover.

In September 2007, NES and SRN published Realising Recovery: a National Framework for Learning and Training in Recovery Focused Practice (NES/SRN, 2007), which outlined the knowledge, skills and values that mental health workers need to develop their practice in recovery focused ways. This framework was one of a number of actions identified in the first review of mental health nursing in Scotland – Rights, Relationships and Recovery: the Report of the National Review of Mental Health Nursing in Scotland (Scottish Executive, 2006). The Realising Recovery Framework included a commitment to develop national learning materials.

The Realising Recovery learning materials build on The 10 Essential Shared Capabilities (Scotland) (ESC(S)) learning materials published by NES in 2007 (NES, 2007). The 10 ESC(S) learning materials provide a firm foundation for the values base for mental health workers in Scotland. The modules in this pack build on these foundations and address in more detail ESC 5 – Promoting Recovery.

Together, these learning materials offer all mental health workers opportunities to develop their knowledge, skills and values in ways that maximise the involvement of service users, embrace the belief that recovery is possible and facilitate new relationships between people who use services and the communities they live in.
Acknowledgements

We would like to thank and acknowledge the contribution made by the following people in developing the learning materials.

**The module authors**

**Module 1, Understanding Recovery**
Allison Alexander, NES/SRN

**Module 2, Using Self to Develop Recovery Focused Practice**
Craig Hutchison, Health in Mind

**Module 3, Enabling Self-direction**
Simon Bradstreet, SRN and Susanne Forrest, NES

**Module 4, Providing Person-centred Support**
Anne Conner, Outside the Box and Dr. Donald Macaskill, Equal and Diverse

**Module 5, Sharing Responsibility for Risk and Risk-taking**
Rachel Perkins and Kim Goddard, South West London and St George’s Mental Health NHS Trust

**Module 6, Connecting with Communities**
Peter Bates, The National Development Team

**The expert group who guided the development of the materials**
Allison Alexander   NES/SRN
Simon Bradstreet   SRN
Derek Barron   NHS Ayrshire and Arran
Scott Dyker   NHS Grampian
Susanne Forrest   NES
Bob Goupillot   Penumbra
Rona McBrierty   Peer Specialist Support Worker and Trainer
Dale Meller   NHS Health Scotland
Ivor Smith   NHS Forth Valley
Craig Stewart   NHS Ayrshire and Arran

**The editorial group**
Allison Alexander   NES/SRN
Simon Bradstreet   SRN
Susanne Forrest   NES
Alex Mathieson   Freelance Writer and Editor

And finally, we would also like to thank the narrators who shared their experiences of recovery in the SRN narrative research and whose quotes appear throughout. Thanks also to Graham Morgan and Tig Davies for generously allowing us to use their accounts in these learning materials.
References
www.nes.scot.nhs.uk/mentalhealth/work/#values


www.scotland.gov.uk/Publications/2006/04/18164814/0
Introduction

The Realising Recovery learning materials have been designed to support mental health workers to develop their recovery focused practice. They build on The 10 Essential Shared Capabilities (Scotland) (ESC(S)) learning materials and are designed to provide further learning to enable mental health workers to work alongside service users as they create their own unique recovery journeys.

The learning materials will also be useful for mental health service users and carers either in their role as trainers involved in delivering the learning or as learners exploring and developing their understanding of recovery focused practice and what they can expect from mental health workers and services.

We drew on literature and evidence from a wide range of sources from across Scotland, the United Kingdom and internationally in developing these learning materials. Most importantly, however, the design of the learning has been shaped by the lived experience of people in Scotland who identify themselves as “in recovery” or “recovered”.

The findings of the Scottish Recovery Network’s 2007 narrative research report – Recovering Mental Health in Scotland – have been used extensively in these learning materials. Direct narrator quotes from this research are presented in dark blue coloured font. We have also drawn on other accounts produced by people with lived experience, which are also presented in dark blue coloured font.

The learning materials are practical and action focused and provide links to wider reading and resources should you wish to explore issues in more depth.

The learning materials are about:

- enabling workers to make changes in their practice: we know that sometimes even small changes can have a hugely positive impact for workers themselves and on the experiences of service users and their friends, families and carers;
- supporting change by presenting key topic areas in relation to recovery and practical guidance to help workers develop new roles, relationships and ways of working with service users and wider communities.
Realising Recovery – the modules

The learning materials consist of six modules.

At the start of each module, we estimate the number of hours it should take to complete. We also indicate how the level of study involved in the module links to the Scottish Credit and Qualifications Framework (SCQF). The module content and learning outcomes have been developed to reflect a level of learning that equates with Level 9 on the SCQF. This is equivalent to the level of study you would undertake in the third year of an ordinary degree programme.

Realising Recovery modules

Module 1 – Understanding Recovery
Module 2 – Using Self to Develop Recovery Focused Practice
Module 3 – Enabling Self-direction
Module 4 – Providing Person-centred Support
Module 5 – Sharing Responsibility for Risk and Risk-taking
Module 6 – Connecting with Communities

We recommend that Modules 1, 2 and 3 be studied first and in numerical order. The remaining modules may be studied in order of preference.

What is the best way to undertake this learning?

We have designed the materials so they can be studied in a way that involves elements of self-directed study and reflection, but we strongly recommend that opportunities for group discussions should be offered to help learners put individual experiences into a broader context and enhance learning.

While the materials could be delivered as an intensive, facilitated course delivered over a block of days, learning will be enhanced if the materials are studied over 6–8 weeks with “space” between modules for people to reflect on their learning in the context of their workplace.
Notes for learners

We hope that you find the modules interesting and enjoyable and that ultimately, undertaking this learning is just the start of your own journey.

Being able to work alongside people who use services in a way that enables them to be in the “driving seat” is what recovery focused practice is all about. We hope these learning materials will provide you with new knowledge, skills and values and the courage to implement new ways of working with service users and wider communities in your future practice.

Some aspects of this learning process may be challenging, as you are required to reflect deeply on yourself and your past and present practice. It is therefore important that you think about the support you need to maximise your own learning. Being part of a study group or undertaking facilitated learning is likely to be most helpful, as this will give you the opportunity to benefit from mutual support, share your learning and gain insights from other people’s experiences.

We listed the modules and the order in which we advise you to study them on page 5. It is important that you follow this; otherwise, you will miss out on some of the key ideas that are introduced in the earlier modules.

Before you begin these modules, you should have already completed The 10 Essential Shared Capabilities (Scotland) (ESC(S)) learning materials, as the modules presented here build on the ESC(S). If you have not already completed the ESC(S) learning materials, you can access these at: www.nes.scot.nhs.uk/mentalhealth/work/#values

Reflection on your own practice is essential during the learning, with the goal of reinforcing and building on existing good practice and uncovering practice that is not beneficial. As you undertake these reflective activities, you may want to make notes about how you might change your practice in the future and share this with your supervisor or a colleague so that you do not lose this learning. We provide space at the end of each module for you to do this before moving on to the next module.

You will also find that throughout the modules, but especially in Module 2, you are asked to think about various aspects of yourself and your own identity. This may be difficult initially if this is a new experience for you, so we suggest you seek out and use support while undertaking these activities.

If you are planning to access further study (at a college or university), the learning you undertake in these modules may support your application. Potential students are sometimes asked to demonstrate that they have the ability to study at their chosen level or may have the opportunity to submit evidence of prior learning and prior experiential (work-based) learning for consideration in relation to their course of study.\(^1\)

You may also find that your learning assists you in future personal development planning.

---

\(^1\) You should note that accreditation of prior learning is offered at the discretion of individual further and higher education institutions. You should contact your target college or university for further information and advice.
Using the internet
We have listed a number of websites you may find interesting throughout these learning materials. These are not exhaustive lists, and you should be aware that neither NHS Education for Scotland nor the Scottish Recovery Network is responsible for the content of external websites. We have done everything we can to ensure links are accurate at the time of publication.

Learning activities
Learning activities are a feature of all the modules. You may complete these activities on your own, but you will find it helpful to discuss your ideas with others. You may be able to do this through:

- a learning group
- meetings with your supervisor, line manager or mentor
- an informal arrangement with a colleague or peer
- facilitated learning opportunities.

You will find on discussing your ideas with others that although they may share many of your own hopes, concerns and values, there may also be surprising differences. For some of the learning activities, it is essential that you work with others to complete the activity.

We hope you find these learning materials useful and are ready to embrace the opportunities that recovery focused mental health practice offers.

Notes for facilitators and managers
As well as the benefits for learners, service users and their friends, families and carers previously outlined, these learning materials can be linked to the use of the Scottish Recovery Indicator (SRI) tool. We anticipate that they will aid interpretation of the tool and help practitioners address findings associated with using SRI. SRI may also offer additional ideas and approaches for recovery focused practice not covered in these modules. In addition, the completion of both The 10 Essential Shared Capabilities (Scotland) (ESC(S)) learning materials and these materials can be recorded when completing the SRI process as an example of recovery focused training.

Support for learners
We strongly support group discussion/facilitation as the preferred method for delivery of these materials. Learning will be significantly enhanced if people have a chance to share and discuss ideas with others.

This can be achieved through:

- setting up a learning group
- using existing opportunities such as supervision, team meetings or away days.

Learning support and opportunities to consider issues in supervision should be provided for the duration of the learning where possible.
Learning will be greatly enhanced if different groups of disciplines, workers, practitioners, service users and carers can come together to learn and discuss issues the learning materials raise. The direct involvement of service users and carers in delivering some of the materials and facilitating groups will also enhance learning.

Most people will take 6−8 weeks to work through all six modules, allowing time for reflection and application of learning in the workplace. Facilitators and managers may want to leave support sessions relatively open and allow learners to set the agenda by raising specific issues relating to modules or sharing their experiences of learning.

Learning group sessions should be held after people have completed the relevant module(s) so they come with recent experience of thinking about the topic on their own.

Additional notes for facilitators
To successfully facilitate the Realising Recovery learning, you will need to have (and be able to demonstrate) a passionate commitment to recovery and an ability to create and sustain a safe learning environment.

Every effort should be made to ensure that participants feel safe to articulate thoughts and feelings. A balance that enables people to reflect critically on their own professional practice without feeling their experience is being challenged or undermined must be struck. To address this, it is necessary to establish ground rules at the start of any session and to revisit these throughout.

Self-disclosure may also be a challenge. The experiential nature of the learning materials asks learners to draw on and share their personal experiences. These experiences must be gathered and managed so that everyone feels safe and does not subsequently regret having shared something with the group. This principle applies equally to facilitators. While there is nothing as powerful as the voice of lived experience, no one should be left feeling vulnerable and exposed.

Facilitators may find sessions personally demanding and it is important to attend to your well-being and be aware of whatever strategies have proved effective for you in the past. You should build-in opportunities for debriefing after the training, either with a co-facilitator if possible or in the context of support and supervision.
Module 1

Understanding recovery

Welcome to Module 1
Promoting Recovery is one of the 10 Essential Shared Capabilities. You were introduced to the concept in Module 2 of The 10 Essential Shared Capabilities (Scotland) (ESC(S)) learning materials, which also introduced you to the Scottish Recovery Network and some of the factors that can help or hinder recovery.

In this module, we will look in more depth at recovery, with a particular focus on the role of mental health workers and the uniqueness of the recovery journey for each service user or person “in recovery”. This should give you a broader understanding of recovery and what it means for mental health service users and mental health workers before you embark on the other modules.

Learning outcomes
After completing the module, you should be able to:

- demonstrate an understanding of the background to the development of recovery in mental health practice
- evaluate the factors that may help or hinder recovery and critically reflect on your own practice in relation to these
- appreciate that recovery is possible and that it is a uniquely personal journey
- demonstrate an understanding of identified key themes in relation to recovery focused practice
- critically reflect on your own current practices and how these help or hinder recovery.

Estimated time to complete learning activities: 5 hours
SCQF Level 9

Module author
Allison Alexander, NES/SRN
## Contents

1. Introduction .......................................................... 11
   The Scottish Recovery Network .............................. 13

2. Recovery – a unique journey .................................. 16

3. The role of mental health workers in recovery ............ 21
   Being alongside .................................................. 21
   Inspiring hope .................................................. 21
   Talking about recovery ....................................... 24
   Connecting people and communities ...................... 28

4. Conclusion .......................................................... 30
   Learning into practice ......................................... 31

Resources to support further learning ...................... 32

References .................................................................. 32
1. Introduction

While we know that people have always recovered from mental health problems in Scotland, the idea of using recovery as a concept around which to align support and services for people with mental health problems is fairly new, although it is more firmly established in other countries, notably the United States and New Zealand.

The emergence of recovery in the United States was influenced by the work of user activists (Chamberlin, 1988; Deegan, 1988). The US Surgeon General issued a report in 1999 recommending that all US mental health policy and services should have a recovery focus (US Department of Health and Human Services, 1999). This was reinforced in the President’s New Freedom Commission on Mental Health (2003).

Considerable work has been undertaken to develop and train workers in New Zealand to work in a recovery focused mental health system. The Mental Health Commission in New Zealand published a set of competencies for all mental health staff which present the skills and attitudes required to work with service users in ways that support them as they undertake their own recovery journey (Mental Health Commission, 2001).

Increasingly, people involved in mental health policy and service development in Scotland are making reference to recovery. But what exactly do we mean by “recovery” in relation to significant mental health problems?

Recovery in other health contexts is understood to mean getting back to the way you were before illness or accident affected you, or getting back to normal. While we know that people with long-term mental health problems can and do recover in this sense, recovery as it has been promoted internationally over the last 20 or so years (primarily by the service user movement) describes a broader, more holistic interpretation of the word. This is summarised by Anthony (1993) as:

“... a way of living a satisfying, hopeful and contributing life, even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness.”

So recovery in this sense provides an empowering message of hope which says that regardless of symptoms, people with serious mental health problems should be given every opportunity to lead a fulfilling and satisfying life. As the New Zealand Mental Health Commission (1998) states, it is about much more than the absence of symptoms:

“Recovery is happening when people can live well in the presence or absence of their mental illness and the many losses that may come in its wake, such as isolation, poverty, unemployment, and discrimination. Recovery does not always mean that people will return to full health or retrieve all their losses, but it does mean that people can live well in spite of them.”

Recovery by its very nature is complicated. While there may be common themes and experiences, no two people’s recovery journeys will be identical. We all have very different interests, needs, dreams, motivations and desires; our background, culture, gender, age and past experiences also impact considerably on our experience of recovery.
While recovery is often described as a “journey”, it is important to emphasise that this does not necessarily mean that it has an end-point. People tend to see recovery as a lifelong journey of growing and learning, managing setbacks and celebrating successes.

There have been numerous attempts to define the key elements of recovery (see, for example, Anthony, 1993; Curtis, 1997; Repper and Perkins, 2003). The following list, while not exhaustive, highlights the most commonly agreed key components.

**Hope** is universally seen as key to recovery. There can be no change without the belief that a better life is both possible and attainable.

**Meaning and purpose**: different people find meaning in very different ways. For example, some people may find spirituality important, while others may find meaning through the development of stronger interpersonal or community links.

**Control and choice** are central to recovery. People who use mental health services are sometimes denied an adequate level of involvement in their own care and treatment. The existence of compulsory powers underlines this power imbalance.

**Self-management** techniques enable service users to take more control of their own mental health and develop their understanding of periods of distress and wellness.

**Risk-taking** is required if service users are to embark on a recovery journey. Recovery focused practice requires practitioners to move beyond narrowly focused, service-defined notions of risk.

**Relationships** are key in all of our lives, so friends, partners, family members, peers and paid support staff all have a role to play in supporting people in recovery.

**Inclusion**: recovery is about much more than mental health services and people in recovery need to be able to access the same opportunities, services and resources as any other citizen.

In this module and the other modules in these learning materials, we will be exploring the above elements in much more detail to define how you as a mental health worker can enable recovery. We will introduce you to new ways of thinking about the relationships you have with service users, techniques you can develop to ensure that the support you provide is centred on the people you support, and how you can contribute to the inclusion of service users beyond mental health services.

It is nevertheless important to stress that these learning materials do not constitute a “recovery model”. Attempting to introduce recovery as a model would be in direct conflict with the need for service users to embark on their own unique recovery journey.
The Scottish Recovery Network
The Scottish Recovery Network (SRN) – www.scottishrecovery.net – has had a central role in developing our awareness and understanding of mental health and recovery in Scotland.

Since its launch in late 2004 as part of the National Programme for Improving Mental Health and Wellbeing, the SRN has aimed to raise awareness that people can and do recover from long-term and serious mental health problems and to build an understanding of what helps people recover and stay well. It is also working to encourage local and national action around recovery with a range of different groups. The lived experience of service users underpins all of the work of the SRN.

Increasingly, the SRN is involved in policy and practice developments that support mental health recovery, including the creation of a new category of mental health worker – peer support workers. Peer support workers have lived experience of mental distress and use their experience to support and inspire other service users. We explore this innovative new role in more detail in Module 4.

Another new initiative supported by the SRN is the Scottish Recovery Indicator (SRI). This is a tool that enables services to gauge their recovery focus in relation to a range of criteria. The tool requires information to be gathered from a variety of sources and for service users and staff to be involved in assessing the service. Although in its early stages, early indications are that the SRI is a helpful tool that allows mental health workers to reflect on their practice, identify good practice within their own service and highlight areas for development.

The SRN has undertaken a major narrative research project that aims to understand further the lived experience of service users in recovery in Scotland. The research involved over 60 individuals living in Scotland who identified themselves as recovered or in recovery from mental health problems. Recovering Mental Health in Scotland, Report on Narrative Investigation of Mental Health Recovery (Brown and Kandirikirira, 2007) was published in 2007 and details the findings of this major research study. An accompanying booklet, Routes to Recovery, provides a brief summary of key messages aimed at service users.

Recovering Mental Health in Scotland has been used as the primary evidence base for these learning materials, as it is only from listening to those with lived experience that we can really develop an understanding of what recovery in mental health is really about. Listening and responding to the service users you work with will be crucial as you develop your recovery focused practice.
Some of key issues from the report are highlighted in the box below.

**Key issues from Recovering Mental Health in Scotland** (Brown and Kandirikirira, 2007)

<table>
<thead>
<tr>
<th>Recovering identity</th>
<th>Relationships</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confidence</td>
<td>Friendships</td>
</tr>
<tr>
<td>Hope and optimism</td>
<td>Supportive family relationships</td>
</tr>
<tr>
<td>Self-acceptance, responsibility, belief and esteem</td>
<td>Intimate relationships: partners</td>
</tr>
<tr>
<td>Self-efficacy</td>
<td>Parenting</td>
</tr>
<tr>
<td>Self-awareness</td>
<td>Peers</td>
</tr>
<tr>
<td>Growing beyond the label</td>
<td>Pets</td>
</tr>
<tr>
<td>Reclaiming power and self-determination</td>
<td>Service professionals – a critical friend</td>
</tr>
<tr>
<td>Belonging – cultural, social and community identity</td>
<td>Mutual trust and recognition</td>
</tr>
<tr>
<td>Activism</td>
<td>Hopeful relationships</td>
</tr>
<tr>
<td>Spirituality</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Engagement and finding meaning and purpose</th>
<th>Treatments and supports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being valued – giving back</td>
<td>Feeling informed and in control</td>
</tr>
<tr>
<td>Meaningful roles</td>
<td>Continuity and flexibility</td>
</tr>
<tr>
<td>Volunteering, employment and education</td>
<td>Treatments and therapies</td>
</tr>
<tr>
<td>Learning about self and condition</td>
<td>Security</td>
</tr>
<tr>
<td>Community and social engagement</td>
<td>Peer support</td>
</tr>
<tr>
<td>Communities and housing</td>
<td>Relationships, attitudes and power</td>
</tr>
<tr>
<td>Exercise and creativity</td>
<td>Housing and community supports</td>
</tr>
<tr>
<td></td>
<td>Financial security</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pacing and turning points</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Coping</td>
<td></td>
</tr>
<tr>
<td>Other people’s experiences</td>
<td></td>
</tr>
<tr>
<td>Taking control</td>
<td></td>
</tr>
<tr>
<td>Changes in thinking and being</td>
<td></td>
</tr>
<tr>
<td>Narrating your story</td>
<td></td>
</tr>
</tbody>
</table>
**Activity 1.1**

In Module 2 of the ESC(S) learning materials, Activity 2.8, you were asked to think about your own experience of recovering from something and compare your experiences with colleagues. Retrieve your answers to that activity now and compare the lists you made to the issues identified above.

<table>
<thead>
<tr>
<th>Make a note of the similarities and differences.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

It must be stressed that this research does not provide a blueprint or textbook for mental health recovery in Scotland. As each individual is unique, so too will each individual’s recovery journey.

To illustrate this, here are two contrasting quotations from the research report about employment:

- “I found my jobs difficult generally. I am still scared of doing a paid job.”
- “That made me feel good, that I wasn’t, you know living off benefits, and I was, you know, going out to work, and I was you know contributing something.”

Clearly, these two individuals had completely different experiences of work and as a consequence viewed how paid employment might help or hinder their own recovery journey very differently. We will now explore further this issue of the unique nature of mental health recovery.
2. Recovery – a unique journey

In this section of the module, we are going to explore in more depth just how different each person’s recovery journey is and the implications this has for mental health workers and mental health services.

As we saw above, something (in this case employment) which one person identifies as helpful in their recovery might be considered unhelpful by another person.

Activity 1.2

In this activity, you are provided with some information about three people – Molly, Jamila and Jake. Have a look at each of the descriptions and then answer the questions that follow. We recommend that you also discuss this activity in a group setting.

Of course, what is important for each individual is whether they identify themselves as “in recovery” or as living a life that is satisfying in which they have purpose and meaning and feel connected to the world around them. This kind of activity, however, is useful in examining our own values and the assumptions we may make about people and the situations they find themselves in. In doing so, we may be less likely to impose these assumptions on real people in real situations in our practice.

Molly Williams

Molly Williams is 69 years old and has lived in sheltered accommodation since the death of her husband three years ago. Molly was initially very depressed when her husband died, but appeared to respond to antidepressant medication. She is able to wash and dress herself but needs some assistance with her medication and appears to be confused at times. She uses a Zimmer frame when she goes out.

She chooses to have her meals in the communal dining room as she enjoys the company of some of the other women and they often stay in the dining room and play card games in the evening. When she is in her room, Molly listens to music and likes to watch soap operas on television.

She attends a local history group in the community centre on Tuesdays. Molly’s family visit regularly and she enjoys these visits, especially when her grandchildren come.

Based on the information you have been given, would you describe Molly as “in recovery”?


<table>
<thead>
<tr>
<th>What aspects of Molly’s life led you to give your answer?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>What do you think recovery might mean for someone over the age of 65? Is that different to what it means for a younger person?</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

**Jamila Kureishi**

Jamila Kureishi is a former school teacher who has been unable to work for over two years after she separated from her husband and her family disowned her. Jamila lives in a local authority flat in a housing estate which is quite far from the city centre. She knows no one in the area. Jamila frequently visits her local GP who considers her to be “mildly depressed”.

Jamila feels that her depression and anxiety are very disabling and she is frightened to leave her home because she feels she stands out as not being from the area and that the local children laugh at her.

<table>
<thead>
<tr>
<th>Based on the information you have been given, would you describe Jamila as “in recovery”?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>What aspects of Jamila’s life led you to give your answer?</td>
</tr>
</tbody>
</table>
Jake McGinn

Jake McGinn is a computer programmer with an international IT company. He has worked with the company for three years. Jake sometimes hears voices but feels that the medication he takes, combined with attending a voice-hearing group, enables him to cope with the voices most of the time.

Six months ago, Jake met a man at a club and although their relationship is a very happy one, Jake hasn’t been able to tell his partner about his diagnosis of schizophrenia as he is frightened about how he might react.

If you were supporting Jamila, how might aspects of her cultural background interact with her recovery journey?

Based on the information you have been given, would you describe Jake as “in recovery”?

What aspects of Jake’s life led you to give your answer?

What impact do you think decisions about disclosing or not disclosing mental health issues has on an individual’s recovery journey?
As we stated earlier, this activity was designed to help you test your own values and assumptions about recovery in mental health. We must stress, however, that it is not the role of mental health workers to decide who is in recovery or what recovery means for that individual.

Practitioners often question the relevance of recovery to people over the age of 65. This may be influenced by two things: firstly, the mistaken idea that “recovery” in mental health is equivalent to “recovery” from physical health problems; and secondly, the high number of older people in mental health services with a diagnosis of dementia.

In the example above, did you think that Molly could be described as “in recovery”? From the information provided and our earlier definitions of recovery being based on having a satisfying and meaningful life, it would appear that Molly could easily be described as someone “in recovery”. She engages in a range of activities that should give her life purpose and meaning and has a variety of people to whom she is connected.

Of course, not everyone over the age of 65 will have the same interests or aspirations as Molly, but crucially, everyone (irrespective of their age) has some interests and aspirations – they might just be a little more difficult to access. Some of the tools in Module 4 could potentially be very useful in working with people who are over 65 and can be adapted for use with people who have limited communication.

Respecting diversity is crucial when providing support to anyone (including Molly, Jamila and Jake). When we meet someone we identify as being culturally “different” from ourselves, there is a danger that in an effort to be “culturally sensitive”, we actually impose more assumptions onto our view of that person (Sainsbury Centre for Mental Health, 2002). For example, we often make assumptions about what religious group a person from a black or minority ethnic group might belong to, the model of family the person may have experienced or what behaviour may or may not be acceptable within the person’s culture.

These kinds of assumptions can have a very negative impact on the support and care people are offered and can greatly hinder their recovery journey. This was found to be the case in one particular instance investigated by the Mental Welfare Commission. They concluded in their inquiry into the care of Mr J (an Indian-born Punjabi speaker) that the care he had received was severely compromised because of failures to identify and meet his cultural needs (Mental Welfare Commission, 2002).

It would be easy to make lots of assumptions about Jamila Kureishi based on her name alone, assumptions that might not be accurate. The best person to tell us how Jamila’s cultural background might interact with her recovery journey is, of course, Jamila herself.

One of the interesting aspects of the description of Jamila’s situation was the mismatch between the GP’s perspective (that she was “mildly depressed”) and Jamila’s assessment of her situation (that her depression and anxiety were very disabling). If you were working alongside Jamila, whose perspective would be more important to you?

Clearly, in working in a person-centred, recovery focused way, Jamila’s perspective would shape the work you would do together. As services are currently construed, however, it is unlikely that Jamila would be able to access the level of support she thinks she needs while her GP considers her “mildly depressed”.
Jake, on the other hand, would be much more likely to be able to access support solely because of his diagnosis of a “severe and enduring” mental health problem (schizophrenia). Yet if you look at the description of Jamila and Jake, which one appears to have the more satisfying life?

Jake uses a mixture of traditional mental health treatment (medication) and a self-management technique (the voice-hearing group) to maintain his mental health (we explore self-management techniques in more detail in Module 3).

The issue facing Jake in relation to disclosing his mental health status is an interesting one. Generally, we only think about disclosure in relation to job applications (explored in Module 6), where there are legal requirements and entitlements. There are a number of ways to look at Jake’s decision not to disclose. The first might be to think that Jake is developing an identity beyond that of a user of mental health services, and we know that this is important for recovery. As one of the narrators in Recovering Mental Health in Scotland put it:

“There’s also something about having other things in my life away from mental health issues, away from support workers, away from, and actually finding a different channel.”

Another way to look at this might be to think that Jake is in some way ashamed of having a diagnosis of schizophrenia, or is worried about how his partner might react given the stigma and discrimination experienced by people with mental health problems. As another narrator put it:

“It’s not until you have experienced stigma that you realise how important and how discriminated against and how bad and how guilty you can feel about having a mental health problem. Being seen as different is not good for you.”

Others might see Jake’s decision not to disclose to his partner as a denial of a significant part of his identity. For some people, declaring their mental health status is part of reclaiming their identity within their recovery journey, almost as a political, as well as a personal, act:

“We need to come out (those that will and can) we need to stand up and say, yes I am manic and proud.”

This discussion about the issue of disclosure is a useful reminder of how many different ways we can view an issue. Just as there are multiple views on this single aspect of an individual’s life, so too are there multiple ways of being “in recovery”. The descriptions of Molly, Jamila and Jake have served to demonstrate that recovery belongs to the individual, and just as no two individuals are alike, so no two recovery journeys are alike.

In the following section of this module and the modules that follow, we examine the role of mental health workers and the contribution you can make to individuals’ recovery journeys.
3. The role of mental health workers in recovery

We begin this section by considering how the role is different in this context from more traditional models of mental health practice, which are often focused on deficits (what the person on the receiving end of support is unable to do) and in which desired outcomes tend to focus on the maintenance of service users in a “stable” situation in relation to their “mental illness”. Such traditional models place less emphasis on the person as a whole and fail to harness the resources, hopes and aspirations the person may have. As the NES/SRN Realising Recovery framework (NES/SRN, 2007) puts it:

“If recovery is a journey then the role of nurses [mental health workers] is to provide some guidance and signposts on that journey without taking control away from the service user they travel alongside.”

Being alongside

Workers may worry that an increased emphasis on how service users can create their own recovery journeys may limit the scope of their own role. This is not the case, although recovery focused practice does require a change of role.

Historically, mental health nurses (and other mental health workers) have been perceived as “doing to” people who use services; more recently, this has shifted to a desire to “do with” people who use services.

The challenge within recovery focused practice is to “be alongside” as service users take the lead in creating their own recovery journey. The role of mental health workers therefore becomes that of “facilitator”, a resource person able to provide information and support to enable service users to identify their own goals and to take the steps to achieve them, recognising that at times this may be more difficult than at others.

The whole notion of “being alongside” in many ways goes against our human and professional instincts to “help” or to “sort out problems”, particularly when someone is experiencing distress. Taking a step back from this more active role takes skill and patience and requires us to have trust in, and respect for, the service users we work with. It is only through demonstrating this faith in the individuals we work with that they in turn will develop confidence in their own abilities to manage the situations they find themselves in.

As you work through the other modules, you should develop more confidence in what it means to “be alongside” and the knowledge, skills and resources you can use to develop new, recovery focused relationships.

Inspiring hope

The literature on recovery emphasises the central role of hope. Service users, friends, family members, carers and mental health workers all need, firstly, to believe in a future, and secondly, believe in the potential for that future to be more positive and worthwhile. As Paul Reed\(^2\) comments in his recovery story:

“When you have a purpose you have hope. Light at the end of the tunnel. There is always hope if you look hard enough.”

\(^2\) You can read Paul’s complete recovery story at: www.scottishrecovery.net/content/mediaassets/doc/0512_Paul_Reed_PRS.pdf
This can, however, be a real challenge for everyone involved, particularly at times of great distress.

The concept of hope is one that is difficult to define. We rarely articulate our hopes for the future beyond superficial statements like “I hope I win the Lottery”. Yet hope is central to all our lives, not just to the big decisions we make such as choosing a life partner (who we hope will make us happy at least most of the time, if not all), but also to the smaller decisions we make on a day-to-day basis – like getting out of bed each day in the hope that we will have a productive, enjoyable day.

But for many people who use mental health services, this is not the case.

### Activity 1.3

Make a list of the reasons people who use mental health services might lose hope.

<table>
<thead>
<tr>
<th>Make a list of the reasons people who use mental health services might lose hope.</th>
</tr>
</thead>
</table>

In your current practice, what are the opportunities and barriers to explore these with the people you support?

<table>
<thead>
<tr>
<th>In your current practice, what are the opportunities and barriers to explore these with the people you support?</th>
</tr>
</thead>
</table>

What impact does working with people who have lost hope have on you?

<table>
<thead>
<tr>
<th>What impact does working with people who have lost hope have on you?</th>
</tr>
</thead>
</table>

Repper and Perkins (2003) suggest that hope-inspiring relationships involve the following:

- valuing the person for who they are
- believing in the person’s worth
- seeing and having confidence in the person’s skills, abilities and potentials
- listening to and heeding what is said
- believing in the authenticity of the person’s experience
- accepting and actively exploring the person’s experiences
- tolerating uncertainty about the future
- seeing problems and setbacks as part of the recovery process and helping the person to learn from and build on these.
It can be incredibly draining and stressful to work in an environment where people (sometimes staff as well as service users) are without hope. At times, you may need to remind yourself why you chose to work in this field (see your responses to ESC(S) Activity 1.2). Support from your peers and your supervisor is also key.

You will have an opportunity in Module 2 to think in more detail about working with people in a way that inspires and maximises hope and the impact that working with people who have no hope can have.

**Activity 1.4**

Daniel is a 36-year-old man who was admitted six weeks ago to an acute ward and was subsequently detained. Daniel was unemployed before coming into hospital and spent most of his time playing pool with his friends in a local pub. He has not been in touch with his friends since his admission as he does not want them to know about his mental health problems.

Daniel spends most of his time in the ward watching television. Although allowed to leave the ward for short periods, he rarely does so, other than to visit the hospital shop. The ward occupational therapist has made contact with Daniel and has given him information about the activities he could be involved in, but Daniel has told him that he is not interested; all he wants is to be allowed to go home and have nothing more to do with mental health services. Daniel's only visitor has been his older sister, who has only been able to visit twice as she lives in another city.

If you were one of the staff supporting Daniel, how might you engage with him in a way that would inspire hope?

How would Daniel’s detention impact on how you would approach this?

Although it appears that Daniel may be in a fairly hopeless frame of mind, there is one desire he has that could be built on and worked with: his wish to leave hospital. This suggests that Daniel has some sense of a future; it may be that by building on this, and with Daniel identifying what he needs to do to secure his discharge, hope will be maximised.
In general, working with people who are subject to compulsory powers in a recovery focused way is difficult and complex, especially within secure settings. Much of what is written about recovery emphasises the need for service users to be in control and take responsibility for their own mental health and well-being. It may therefore seem contradictory to say that recovery is possible in all mental health settings, but it is.

**People subject to compulsion should still:**
- be able to be involved in decisions about their care and treatment
- have their hopes and aspirations listened to and respected
- be able to control some aspects of their lives, albeit within the restrictions of the settings in which they find themselves.

An important starting point might be to discuss with people who are subject to compulsory powers how they feel about these powers being used, while also emphasising the areas in which they can still have choice. Referring to other people who have been in similar situations and have managed to recover may also inspire hope, as might the presence of peer support workers (we explore the peer support worker role in Module 3).

You will have further opportunities to think about the concept of hope, its importance in relation to recovery and how you can develop hope-inspiring relationships in your practice in the modules that follow.

**Talking about recovery**

The language we use to communicate with each other is incredibly important, but rarely do we take time to reflect on how the words we use impact on those around us. The way in which we speak and the words we choose convey our beliefs and values about the world and the people we interact with.

In Module 2, Activity 2.6 of the ESC(S) learning materials, you were asked to think about how the language used by mental health workers can impact on service users, particularly around describing service users by a diagnostic label or by their symptoms rather than who they are as a person. We will now explore this in more detail and think about how the language you use can help or hinder people in recovery.

Imagine that you have just had an annual appraisal with your line manager. In the course of the meeting, your line manager has given you feedback that includes the following.

1. You have excellent report-writing skills.
2. You are very observant.
3. You could make more of an effort to get on with other team members.
4. You use your initiative well.

If you were given this feedback, which of the above statements do you think you would be most likely to remember afterwards?
It is most likely that you will remember statement number 3. We all tend to remember negative feedback more than positive feedback, especially if the person giving us the feedback is in a position of authority, or is someone we think has more knowledge than we have, or is someone we admire and want to please.

Mental health service users are no different. If anything, they are more likely to remember criticism or negative messages as they are more likely to already feel negative about themselves and their self-worth. As a result, information, advice and feedback from mental health workers is likely to be closely attended to by service users and their friends, family and carers.

Some negative messages may be conveyed unwittingly in mental health settings. Take, for example, the following phrase: “We’ve always got a bed here for you”. At one level, it could be argued that this is a positive and supportive message that says if things become difficult for the individual in the future, support is always available. An alternative understanding of the comment is that the person is not expected to recover, and that they will return at some stage.

**Activity 1.5**

Thinking about the example above and how messages can be interpreted, spend some time thinking about hopeful messages you convey (or could convey) in your contact with service users. This includes not only what you say, but also the environment in which you say it.

Focus your thinking on the messages you and your service provide on first contact (as we are all well aware that first impressions do last!).

In the above activity, you were asked to think not only about what you communicate as an individual, but also about what your service communicates, as not all of the messages we receive are of a verbal nature. Many aspects of the environments we find ourselves in also convey messages, such as:

- receptionists sitting behind glass partitions, conveying a message that reception staff need to be protected from the public
- the provision of “staff toilets” and “patient toilets”, highlighting a “them and us” separation
- notices on the wall stating that violence against staff will not be tolerated, not only suggesting that service users are likely to be violent, but also that they are less-significant victims of violence than staff.
Attention needs to be paid, therefore, not only to verbal communication that conveys a positive message, but also to the environments in which we work. Mental health services need to be welcoming and attractive to instil hope; they have to provide environments where people feel valued.

Activity 1.6
At work in an acute ward, you overhear a colleague telling Jane that she needs to be realistic about what she can achieve in life now that she has mental health problems, so going back to university is not really an achievable goal.

What impact do you think this interaction might have on Jane’s recovery journey?

How might you challenge this kind of pessimistic attitude if this was a colleague in your workplace?

Often when the word “realistic” is used, we are identifying the need to lower our expectations. But if we only did “realistic” things, the world would be a very different place. When Christopher Columbus set out to prove the world was round rather than flat, many people would have dismissed his ideas as fanciful and his expedition to prove them as far from realistic. Similarly, people in recovery from long-term mental health problems tell us that they often achieve things that neither they nor the people around them ever thought were realistic to expect.

In completing the activity above, did you feel you could speak to your colleague directly about the message they were conveying to Jane? It can be difficult to directly challenge our peers, especially if we are working in a difficult environment where pessimism is the prevailing attitude. A less-direct approach might be called for, which could include:

- speaking with your supervisor
- acquiring some SRN literature and posters and distributing them to colleagues
- facilitating a team discussion about the link between hopeful messages and recovery
- exploring opportunities for people in recovery to visit your workplace and speak to staff about their recovery journeys
- making links with community services that support people in education and employment.
Activity 1.7
Later the same day, Jane approaches you and asks to speak to you. She is very upset. She tells you she has had an awful day as she has been told that she cannot go back to university. Then another service user told her she might go back to university when she is “in recovery”. Jane says she is annoyed with the service user, as she seems to think that Jane is an alcoholic – otherwise, why would she be “in recovery”?

In this particular instance, Jane’s concerns are focused on a misunderstanding. It is important to acknowledge, however, that not all service users are comfortable with the notion of recovery and may have concerns about what it means for them and the support they receive.

Common concerns about recovery might include worries about support or services being withdrawn, fear of failure and concerns about the impact on welfare benefit entitlement of being “deemed recovered”.

It is therefore crucial that mental health services and workers do not force “recovery” on people, but work in a way that enables service users to develop their skills and interests, a hopeful outlook and a sense of control over their own lives at a pace that is right for them.
Connecting people and communities
In the last activity, we ended on the suggestion that a staff member in an acute ward could encourage links with a community-based service to raise awareness of the kind of support on offer. Recovery focused mental health workers need to be able to act as a resource for service users.

Activity 1.8
Maureen is a 55-year-old woman who has recently moved into the area. She previously lived in another town with her partner, but decided to move when this relationship broke down. Maureen has no friends or family in the area she has moved to. She has had periods of depression in the past and had contact with mental health services a number of years ago.

Maureen has visited her GP a number of times since the move and has become increasingly distressed. The GP is concerned that Maureen might harm herself and has therefore referred her to a community mental health team.

You are a member of the community mental health team and have just visited Maureen. She was able to identify some things she has enjoyed doing in the past that she would like to do again, but does not know how or where to access them in the area she now lives in. The things Maureen has identified are:

- going to the library
- going to afternoon bingo sessions (Maureen does not like going to evening sessions as she does not like being out on her own in the dark)
- attending line-dancing classes.

How would you and Maureen go about finding out about these activities together?

What information and support do you think Maureen might need to be able to participate in these activities?

Some of the activities that Maureen would like to take part in would be easier to find than others (looking in a local telephone directory, for instance, would identify the library and possibly the bingo hall). You might know where to start looking for the line-dance classes if you had worked in the area for a long time, although Maureen may find it difficult to attend if classes were only available in the evening.
Assuming you have found details (name, address, telephone number, days and times of opening), do you think this information would be enough to enable Maureen to access these facilities? Armed with this information, would you feel able to go along and make use of these resources?

It can be difficult for anyone to go along to new places and participate in activities with strangers, and even more difficult if they are feeling low and anxious or are worried that people may somehow be able to tell that they have mental health problems. You therefore need to sit down with Maureen and the information you have gathered and spend some time to enable her to identify the support she feels she might need to be able to attend the various places. You might also be able to provide additional information about local befriending schemes that could assist her, if she thinks that would be useful.

You will have an opportunity to think in more detail about your role in relation to enabling people to connect with communities in Module 6.
4. Conclusion

The aim of this module was to develop your understanding of recovery in mental health practice, identify the factors that can help and hinder recovery from mental health problems, and define the contribution you can make as a mental health worker. In the course of the module, we have highlighted that:

- recovery is an ongoing journey, not a destination
- recovery means different things to different people
- there is no right or wrong way to recover
- mental health workers need to be alongside the people they support
- hope is central to recovery, and we all have a role to play in ensuring that we give positive and optimistic messages
- recovery is relevant to all, irrespective of the mental health setting people may be in or their legal status
- recovery is about more than mental health services – leading a full and satisfying life necessarily involves more than any mental health service offers.

We have seen examples of some of the kinds of connections people need to give their lives purpose and meaning throughout the module.

You completed a range of activities in the ESC(S) learning materials that encouraged you to think about diversity and challenging inequalities. While we have touched on some of these issues within this module and the modules that follow, we cannot emphasise enough the need for you to provide support that takes account of diversity, the inequalities experienced by some groups and the impact that discrimination and social exclusion can have on people. Failure to do so may hinder recovery.

You will have further opportunities to build your knowledge and skills in relation to recovery as you work through the other modules. As you do so, and as you begin to think about implementing some of your learning in practice, try wherever possible to do so with hope and optimism.

It may be difficult to work in a different way, it may be challenging to work in a recovery focused way with people who have been in the mental health system for a long time, and it may also be difficult when you find yourself having to challenge the practices and procedures around you. But just think how these difficulties compare to the obstacles that people who have experience of mental distress grapple with and fight to overcome as they embark on their own recovery journey.
Learning into practice
Before moving on to the next module, spend some time reflecting on what you have learned in this module. You may be reassured by some of the things you have encountered in this module. It is worth taking some time to think about how your existing practice matches what we have discussed in the module.

Some of what you have learned may be new to you or perhaps more challenging. Make a note of the changes you will make to your practice now that you have completed this module.
Resources to support further learning
The website of the Scottish Recovery Network has a range of resources relevant to this and the other modules. For this module, you might want to look at the Stories section of the website and the narrative research report:
www.scottishrecovery.net

www.healthscotland.com

References

www.scottishrecovery.net/content/mediaassets/doc/Methods.pdf


www.mwscot.org.uk/web/FILES/mrjsummary.pdf


Module 2

Using self to develop recovery focused relationships

Welcome to Module 2
This module examines how we can bring our personal values, beliefs, experiences and characteristics to our professional relationships in a helpful, recovery focused way. It will question the meaning of professionalism in mental health practice and explore ways we can behave professionally and constructively without withdrawing behind a neutral, cold or dispassionate “professional” front.

While intended for all mental health workers, we will particularly consider the appropriate use and monitoring of self when working with people who have experienced trauma to illustrate key points.

Learning outcomes
After completing the module, you should be able to:

- critically reflect on your self-awareness and values and how these impact on your relationships with others
- judge when and how to use aspects of your own life to inspire hope and recovery in others
- listen to and support service users when they speak about experiences of trauma
- build positive, hope-promoting relationships with individual service users and negotiate the parameters within each relationship
- work alongside service users to enable them to make sense of their experience of mental distress and of using mental health services (including how the use of compulsory powers has impacted upon them).

Estimated time to complete learning activities: 6 hours
SCQF Level 9

Module author
Craig Hutchison, Health in Mind
Contents

1. Introduction 37

2. Increasing your self-awareness 38
   Understanding your personal qualities 38

3. Use of self in recovery focused relationships 43
   Recovery competences for mental health workers 43
   Developing your interpersonal expertise 45
      Being professional rather than behaving like “a professional” 45
      Becoming a “critical friend” to service users 46
      Focus on the individual 49
   Offering hope – personal belief in, and encouragement for, change 50
   Staying on the see-saw: pacing, timing and balance 53
   Developing our interpersonal expertise: key skills 56

4. Continuing personal and professional development 62
   Supervision and support 62

5. Conclusion 65
   Learning into practice 65

Resources to support further learning 66

References 66
1. Introduction

“The desire for professionals to relate to people on a human basis rather than a professional one is echoed in numerous studies … Professionals who project messages of hope have been found to help clients … Most have found that for professional relationships to work both service user and provider must actively participate in the relationship and have something to give that is valued.” (Brown and Kandirikirira, 2007)

In Module 1, we discussed the role of mental health workers in relation to recovery. We introduced various aspect of this, including the need to “be alongside” service users.

In this module, we will help you to think about ways you can constructively use your personal qualities and experiences to foster and support meaningful recovery. You will be encouraged to think about your personal values, beliefs, characteristics and qualities to bring greater self-awareness to your helping relationships, and you will consider the use and monitoring of self when working with trauma in mental health practice.

You will be asked to look at your values, beliefs, personal experiences and characteristics. As you are being asked to engage in self-exploration and some self-reflective work, it is important that you have access to support in case you encounter any personal difficulties. Before we start, identify three people you could talk to if you found any of the activities personally distressing or challenging.

You also need to know you can stop or take a breather if any of this is too much for you. Talk to your supervisor or the facilitators if you need to take a break from the module.
2. Increasing your self-awareness

“Overarching elements of positive relationships seemed to be that they were based on trust and willingness (as opposed to obligation) and were supportive, understanding, consistent, reciprocal and mutually beneficial … Negatively perceived relationships occurred in situations where individuals felt that they were not being listened to or were experiencing stigma, excess criticism or emotional detachment.” (Brown and Kandirikirira, 2007)

Understanding your personal qualities

Like everybody else, people who have experienced mental health problems value opportunities to work with helpers who keep appropriate professional boundaries while also demonstrating personal warmth, sensitivity, integrity, empathy, honesty and respect. It can be frustrating and demotivating to work with people who hide behind organisational bureaucracy or their professional role, or who seem personally distant or uninterested.

It is essential to understand something about who we are and how others might experience us if we are to offer constructive helping relationships. In this section, we will build on ESC(S) activities 2.11 (your strengths and talents) and 4.2 (your personal values) to examine some of the other personal qualities you bring with you in your helping relationships.

To start, we are going to go through a fairly comprehensive activity focusing on you.

Activity 2.1

Make responses to the following questions, then compare them to the example given below.

<table>
<thead>
<tr>
<th>1. Describe your physical characteristics.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
</tr>
<tr>
<td>Age</td>
</tr>
<tr>
<td>Appearance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Describe your personality.</th>
</tr>
</thead>
</table>
| For instance, are you: outgoing, quiet, direct, diplomatic, scatty, serious, pragmatic, idealistic, anxious, posh, cheerful, caring, confident, thoughtful, gregarious, analytical, competitive, shy, funny, down to earth? There are no “right” answers – be honest about characteristics you might initially think “negative”.

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
</table>
3. What “face” do you show to the world?

4. How might others describe you? Ask for feedback from others.

5. Culture and environment.
Describe the key values of the culture and of the household environment you were raised in (for instance: honesty, openness, strong work ethic, laissez-faire, discipline, toughness, respect, hierarchical).

How does this fit with what you value now?

How would you describe your current work culture or environment? What is encouraged and what is discouraged?
6. **Personal experiences.**
Think about key experiences, good and bad, that have helped shape who you are now. This might include childhood experiences, family, important relationships, experiences of crisis and turning points. Name a few key experiences here.

7. **Meaning and purpose to your life and your work.**
Do you have any religious, spiritual or philosophical beliefs? Please describe them here.

What gives your own life a sense of being meaningful? What is the driving force that helps you get up in the morning?

What is in this work for you? What do you gain from being involved in mental health work?

8. **What feelings do you prefer to avoid when others demonstrate them toward you?**
For example: anger, love, fear, sadness, admiration, attraction, suspicion...
Read over your responses to the questions above. How might these personal qualities and values impact on service users you work with?

<table>
<thead>
<tr>
<th>Potential positives:</th>
<th>Potential negatives:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Now compare your responses with the example below

“I’m a quiet and thoughtful person, and I do not like confrontation because I grew up with a very angry father. I’m physically quite small and slight and shy away from direct eye contact. I have a strong, traditional Christian faith that informs all my work.

“Potential positives: I make space for other people and do not overpower them with my own ideas and thoughts. I try to be diplomatic and accommodating with others and I try not to offend. My faith helps me appreciate human frailty and brokenness so I can engage with and bear people’s suffering with compassion and understanding more easily.

“Potential negatives: some people might think I’m not interested in them because I do not say a lot. I sometimes avoid challenging or questioning people because it’s scary for me, even though it might be helpful or appropriate. Sometimes I do not talk when I might have something useful to say. Some people might worry they are too much for me and that I can’t cope with them – that I might be scared of them if they were angry. I can find it difficult to work with people who are angry at God and I might find it difficult to feel as warmly toward gay and lesbian people because of my beliefs.”
Activity 2.2

Consider to what degree you show and use your personal qualities in your work. To what degree would you try to hide or restrict them? Discuss with others why you chose to show or hide these different parts of yourself.
3. Use of self in recovery focused relationships

Recovery competences for mental health workers
Schinkel and Dorrer (2007) conducted research for the Scottish Recovery Network (SRN) which focused on encouraging service users, carers and mental health workers to describe possible “recovery competencies” for mental health workers. As a result of their interviews, they were able to draw up a list of desirable qualities, which is paraphrased in the box below.

Desirable qualities for mental health workers (Schinkel and Dorrer, 2007).

- Listening (active listening, interactive and critical listening).
- Interpersonal qualities (caring, patience, humility).
- Belief in and encouragement of change (positive attitude, belief that recovery is possible, encouragement to keep trying).
- Focus on the individual (understanding they were a person before a symptom, travelling at the same pace as the individual, personally appropriate support).
- Empathy (understanding, empathising with people from different backgrounds, realising that empathising is not sympathising).
- Knowledge about illness, interventions and resources (knowledge about mental health, having clear insight into the illness).
- Bringing out the person’s strengths (valuing potential, using skills to get the best out of people, encouraging appropriate risks).
- Life experience (good life skills and experience, personal experience of recovery).
- Non-judgemental attitude (being open-minded and non-judgemental).
- Sense of humour.

Reading this list, you can see that the key qualities participants described as important are largely interpersonal and relational, and that they relate well to the 10 ESCs.

The emphasis is more on the person of the worker and on how they interact with the service user than on any specific qualifications or roles. These recovery competencies rely more on our interpersonal expertise than our technical knowledge or interventions. They are based on our ability to develop relationships with service users which are both professionally supportive and personally engaging. As Schinkel and Dorrer (2007) put it:

“The basis for recovery oriented practice is the ability to build up respectful relationships with service users, in which the worker has a genuine interest in the person, sees them as an individual, and takes them and their experiences seriously. Only within such a relationship is it possible for trust to be established.”
Activity 2.3

Looking at the qualities listed on page 43, which of these are your particular strengths?

Which qualities could you develop and improve?

What do you need to help you develop these?
In the following sections, we will consider ways you could develop and use your “interpersonal expertise” in recovery focused relationships.

**Developing your interpersonal expertise**

**Being professional rather than behaving like “a professional”**

“Helpful relationships with health care professionals comprise a re-orientation of what being a professional means ... that is, to develop a dedicated and mutual relationship with individuals and to work collaboratively on treatment plans, to have a genuine interest in, understanding of, and empathy for people’s situations and listen to individuals offering them hope as well as support.” (Brown and Kandirikirira, 2007)

As we have seen above, the view that we have to remain emotionally detached and personally distant to be a competent professional is not supported by the people we work with.

Research with service users has instead described the value of relationships with professionals who are personally engaged, who listen to service users’ views and experiences and who engage in meaningful consultation. Workers who emphasise our common humanity and who have the humility to realise that they can learn and develop through having the opportunity to work alongside service users can make an enormous difference in supporting individual recovery journeys.

Ideas of “professional distance” have, in the past, served to maintain a false “us” and “them” barrier between service providers and service users, sustaining the pretence that there is something fundamentally different about the people we work with.

**Activity 2.4**

Louise has been admitted to an acute admission ward following a suicide attempt. She has a history of serious self-harm, including cutting and burning herself. She is very distressed at being detained and believes she is being punished. She feels desperately hopeless and unhappy and imagines the psychiatrist dislikes her. She sits quietly and appears very withdrawn in her meeting with you.

What might you want if you were in Louise’s shoes?

What is your professional role with her? What would you want to achieve if you were working with Louise?
Becoming a “critical friend” to service users

Participants in the SRN research talked about the importance of workers who functioned as a “critical friend”. This is, as Brown and Kandirikirira (2007) describe it:

“... someone who believes in you and champions you, who lets you talk and listens to you, who creates a space for you to reflect, and helps you to get things under control, helping you make informed independent decisions at your own pace.”

Being a “critical friend” doesn’t mean that we criticise: it is about helping service users to think things through in manageable chunks, using critical thinking to analyse the advantages and disadvantages of a course of action and looking together at alternative perspectives and ideas. Module 3 offers more information on working alongside service users to tackle problems.

The SRN research narrators identified that the “critical friend” role required:

“... trust, honesty and constructive dialogue between the person on the recovery journey and the service staff. While they were aware that they were developing professional relationships, narrators felt that it was particularly important to be able to trust and communicate with professionals, and feel comfortable with them and that professionals appeared to understand or empathise with what they were going through.” (Brown and Kandirikirira, 2007)

As you can see, working as a critical friend means we move away from monologue (professionals “talking at” or “doing to” service users) towards dialogue (listening, consulting and negotiating with). It is useful to think about service users as experts on their own experience, while you can contribute your technical expertise, information, support and encouragement.

What might encourage you to engage personally with Louise rather than creating a “professional distance”?

What might prevent you from wanting to do so?
Activity 2.5

Louise, who we introduced in Activity 2.4, was sexually abused by her older brother from infancy until she was in her early teens. She has not told anyone because she feels confused about her experiences and is scared of what her family might do if the secret gets out. She experiences disturbing flashbacks and feels embarrassed and uncomfortable around men. She does not like it when she is in hospital because people come into her room at night, and she feels awkward and embarrassed when male staff wear their name badges clipped to their trouser pocket, because then she has to look below their waist.

In what ways has your attitude to Louise changed now that you know a bit more about her background and history?

Now read the Yes You Can! booklet. You can download it from: www.scotland.gov.uk/Publications/2008/04/07143029/13

Now that you understand Louise’s background a bit more, how do you think she would feel if she came into contact with your normal working environment? What would she see, hear, smell, feel?

How might Louise feel if she was working with you? Which of your personal qualities and characteristics might make it easier for her?

Which might make it more difficult for her?
How might compulsory detention feel to someone who has experienced Louise’s personal history and past traumas?

List three things you could do to make it easier for Louise to feel comfortable.

One approach to supporting Louise is shown below.

*Jamal notices that Louise appears anxious and distracted on the ward. He approaches her slowly and within her eyeshot so as not to startle her. Nestling down beside her, he asks how she is feeling at the moment. When she says she is scared, Jamal asks if there is anything that might make it less scary for her. Louise has a favourite cuddly toy which gives her a sense of safety and security, which was left at home when she came in. Jamal asks whether it would be helpful to arrange for someone to bring it in with them when they next visit. In the meantime, he asks her what else might help.*

*Jamal notices that Louise appears anxious and distracted on the ward. He approaches her slowly and within her eyeshot so as not to startle her. Nestling down beside her, he asks how she is feeling at the moment. When she says she is scared, Jamal asks if there is anything that might make it less scary for her. Louise has a favourite cuddly toy which gives her a sense of safety and security, which was left at home when she came in. Jamal asks whether it would be helpful to arrange for someone to bring it in with them when they next visit. In the meantime, he asks her what else might help.*
Focus on the individual

In the *Yes You Can!* booklet (Nelson and Hampson, 2008), you read about some major effects of sexual abuse which could bring adult survivors of abuse into contact with mental health services, including:

- dissociation
- personality disorder
- depression
- suicidal thoughts and behaviour
- post-traumatic stress symptoms
- alcohol or drug use
- self-harm.

These presenting issues or symptoms can draw our immediate attention because of their strong emotional “charge” or their potentially harmful consequences for service users and others around them. Like many other people who use health services, however, survivors of abuse and neglect can find it frustrating when workers only engage with them as carriers of “symptoms” or problematic behaviours that need to be addressed, rather than as people who experience these symptoms or who behave, at times, in these ways. They can feel that mental health services do not want to hear about their original trauma experience (their “story”) and instead focus exclusively on its consequences.

As you saw in ESC(S) Activity 2.11, it is important to develop a personal relationship with service users – to see them as individual people rather than as “types”, and to value their strengths and abilities rather than exclusively addressing problematic symptoms or difficult behaviours.

Sometimes it can feel easier to see the person in their “sick role” rather than as an individual with different experiences. This “sick role” means that we, as mental health workers, can use our technical knowledge and expertise to address problematic symptoms or behaviour (and consequently feel that we are trying to be the “helpful expert”), but possibly at the expense of using our interpersonal expertise to relate to service users as individual people or to hear their personal testimony and experiences.

Changing our focus from symptoms or problems toward understanding the person can mean that an individual’s behaviours and symptoms can take on a different perspective – they can become understandable and potentially meaningful. We then hear different things, which can then inform the work we undertake together.

If you work with people who are subject to powers of compulsory detention, it can be helpful to imagine how they might experience their treatment and to ask them what this is like for them. Some service users have described themselves as “survivors” of the psychiatric system precisely because they were not engaged with as people, asked their views about the origins of their problems, consulted about their treatment or asked about their experiences of using the mental health system or receiving treatments.
Offering hope – personal belief in, and encouragement for, change

Activity 2.6
In the first activity you completed in Module 1, you retrieved your notes from ESC(S) Activity 2.8; you need to look at these again now and answer the questions that follow.

What role did hope play in your own recovery?

Were there times when you felt hopeless during your recovery? What helped you keep going and “stick in there” at those points?

How can you use your own experience of recovery to help you stay optimistic about the potential for constructive change in the people you work with?

Is there anything that makes it difficult for you to remain hopeful about the potential for meaningful recovery with service users?
Service users appreciate workers who offer positive and hopeful messages about the potential for change and who give constructive feedback. Messages like “I do not think you’ll ever work again” can disempower service users by emphasising negatives and pessimistic outcomes rather than offering a realistic appreciation of the potential for constructive growth or future change.

Service users can sometimes find it difficult to feel hopeful about recovery and can struggle to see anything positive in their lives, particularly if they have been experiencing problems for a long time. It can be enormously important at these times to have people around who truly empathise with how difficult things are, but who also help service users see the things they have managed to achieve and who “hold on” to hope until service users feel able to engage again.

Hope is a difficult thing to define, but can partly be about exploring service-users’ motivation to move forward. While for much of the time service users might be thinking about the problems they are trying to get away from (depression, family problems, hurt), it can sometimes be helpful to reframe by thinking about the things they might want to move towards (intimate relationships, meaningful activity).

Hope might be imagined as a lantern when service users are going through a long, dark tunnel where the end is not obviously in sight. They may feel despondent and hopeless at times, want to drop the lantern or feel too tired to keep going. At those times, workers who offer to hold on to the lantern until service users are ready to pick it up again can be invaluable.

**Activity 2.7**

Look at the dictionary definition of hope. Now think of your own metaphors for “hope” – “seeing the oak in the acorn” and “light at the end of the tunnel” are examples.

List three things you want to “get away from” in your own life.

Bearing these three things in mind, try rephrasing them in terms of the things you want to “move towards” rather than those you want to “get away from”.

We looked above at the importance of hope and optimism during service users’ recovery journeys. But at the same time, we need to be careful to fully recognise and appreciate the very real difficulties service users are experiencing and to genuinely empathise with them about the things which have not been good in their lives, as the following quotation illustrates.

“Well, for some of us, we do not need to be told that – it is, to some people, just plain insulting. If your life has been devastated and wrecked by illness, your job has disappeared like a rush of leaves, you are seen as unfit to look after your children, you have no friends, nothing to do, almost no money and the professionals do not even seem to understand your distress, well, sometimes it can feel as though our lives have been wrecked without any hope of repair – the journey is fractured and unwelcome and its end the only bright solution.

“Then in this situation we may not welcome some bright person coming along to empower us on our journey of recovery, we may get downright angry when the end of the day is the furthest we can possibly look to, and yet we are being encouraged to develop hope and optimism. There may be an instinctive, ‘How dare you underestimate my despair?’, ‘How dare you ask me to find the slightest degree of hope in the poverty of my life?’” (Morgan, 2007)

Hope is not a panacea or a “magical solution” to very real problems and should not be used as a way of avoiding or denying feelings or sadness service users might experience and which might seem overwhelming. Moving towards being hopeful can also feel very frightening to some people, as it can increase the possibility of disappointment – they do not want to “get their hopes up” only to see them crashing down again.
Staying on the see-saw: pacing, timing and balance

Emphasising the interpersonal rather than technical aspects of the helping relationship means we more often have to think “on the hoof” in our relationships with service users.

Rather than having clear-cut technical activities to engage in, we instead have to make swift decisions when faced by alternative courses of action, or interpersonal dilemmas. Dorrer and Schinkel (2008) have described the need for workers to embrace ambiguity:

“Our research revealed tensions between different competencies that require workers to deal with a high level of ambiguity. For example, participants told us that it is very important for professionals to work in a recovery focused way, even when people themselves do not have hope or motivation for recovery. At the same time, service users said that sometimes it is not possible for them to feel positive, and that mental health workers should accept this, rather than try to force them to have a positive outlook at all times. When professionals were overly optimistic, service users felt under pressure to recover, and that they were not being understood. There can be a real tension, then, between expressing a belief in recovery and taking people’s experiences seriously.”

Developing our interpersonal expertise to work in a recovery focused way can be a bit like standing on a see-saw, constantly adjusting our balance in response to the changing weight on the other side. Particular tensions to be managed and discussed in recovery focused relationships include pacing and the maintenance of appropriate boundaries.

Pacing Recovery can sometimes be a long journey, even an arduous one, requiring numerous “pit stops” along the way. If we imagine recovery as a mountain, we could not just run straight up without stopping. We will need to take an occasional breather, recharge our batteries, assess our current position and identify the best way forward. Sometimes it helps just to know there is someone encouraging us to go on while holding on to our “guide-ropes”.

When working with service users, we will need to make informed judgements about when to support and when to challenge, when to encourage forward movement or responsible risk-taking, and when to “hold ground”, withdraw or “catch our breath”. We also need to manage the tension between listening to and genuinely empathising with the hopelessness, suffering or despair the person feels, and emphasising the strengths, hope and positive achievements in their lives.

Holding the tension between support and challenge can be particularly tricky. For challenge to be valuable, it has to be based upon a trusting and supportive relationship – otherwise, why should service users listen to you or value your opinion? Being challenging before the relationship has been based on a supportive foundation means people may feel you do not understand and could undermine the service user’s confidence in themselves. Being too supportive, however, can mean that the relationship lacks “teeth” – that you are not really present as an individual, just half-heartedly nodding along with the service user or taking a patronising or disempowering parental role.
Activity 2.8

Thinking of the recovery experience you described in ESC(S) Activity 2.8 again, draw your process of recovery as if it were a journey through an imagined territory or landscape. Are there swampy bits? Mountains? Green fields? Was it all uphill? Were there crossroads? You can describe this landscape if drawing is not easy for you.

Think about your own experience of pacing during this journey. Where were the points where you were racing ahead, where you were wading through treacle, where you rested, where you had to come to a stop? At what points did you need someone to “gee” you along? At what points did you need to take a breather?

Now read the personal recovery story at:
www.scottishrecovery.net/content/mediaassets/doc/Lorraine_mountaineer_article.pdf
Maintenance of appropriate boundaries The section above looked at managing the difficult tension between support and challenge. The person-centred therapist Dave Mearns (2003) talks about the importance of being alongside rather than “on the side of” the service user. This is about empathising with service users while getting the right balance between over-involvement and under-involvement.

To take the example of hope, which we looked at above, being “on the side” of the service user may mean we become over-involved and empathise so strongly with them in their hopelessness that we end up feeling hopeless ourselves. But being under-involved may mean that we disengage with them completely, seeing them as a “lost cause”, or that we ignore their current difficult feelings and solely emphasise the positives in a frustrated attempt to make them “snap out of it”.

Maintaining professional boundaries means being a “critical friend” rather than a “personal friend” – staying in a clearly boundaried role while also being personally engaged with the service user. This requires us to creatively manage the tension between over-involvement and under-involvement (see box below), to be “alongside” rather than “on the side of” service users, and to be clear, fair and honest about what we will and will not do.

<table>
<thead>
<tr>
<th>Over-involved</th>
<th>Under-involved</th>
</tr>
</thead>
<tbody>
<tr>
<td>■ Unclear or stretched boundaries</td>
<td>■ Resenting time or attention given</td>
</tr>
<tr>
<td>(time, role)</td>
<td>■ Avoiding service-user contact</td>
</tr>
<tr>
<td>■ Chasing service user for contact</td>
<td>■ Boundaries used punitively</td>
</tr>
<tr>
<td>■ Violations of personal boundaries</td>
<td>■ Complete personal secrecy</td>
</tr>
<tr>
<td>■ Unhelpful personal disclosures</td>
<td>■ Only provides challenge without support</td>
</tr>
<tr>
<td>■ Collusive, only provides support with no challenge</td>
<td>■ Detached, uncaring, cold</td>
</tr>
<tr>
<td>■ Chummy, cosy, collusive</td>
<td>■ Worker presents as personally uninvolved and disinterested</td>
</tr>
<tr>
<td>■ Worker’s needs being met before service user’s</td>
<td></td>
</tr>
</tbody>
</table>
**Activity 2.9**

Jennifer is a community psychiatric nurse (CPN) in the middle of a messy divorce. She is experiencing considerable stress at home and feels insecure about her future.

She has been working with Cindy, a rape survivor who experiences intrusive flashbacks and anxiety, for about three months. Jennifer often cries in sessions with Cindy. Jennifer believes Cindy’s needs are so great that she has started increasing the length and frequency of meetings, but without discussing this with her line manager or with Cindy. She has also been sharing some of her personal difficulties with Cindy as they have a “good relationship” and Jennifer wants to show Cindy that they are “equals”. Cindy has asked Jennifer whether they can become friends once their working relationship is over.

Discuss the boundaries of Jennifer’s relationship with Cindy. Do you think she is balancing over- and under-involvement appropriately? What might be influencing her? How might she reconsider the balance?

---

**Developing our interpersonal expertise: key skills**

**Active listening** It is very easy to underestimate the value of listening attentively and respectfully to another person. Workers sometimes describe this aspect of their work as “just listening” and give it low status in the list of helpful activities in which they engage. But service users are consistently clear about how important it is to have space to talk, and of the value of being heard.

Listening is the starting point of a solid working relationship and helps service users build relationships based on trust and understanding, as the following quotation highlights:

“My doctor didn’t seem to listen to me … I couldn’t speak so I asked [social worker] to come with me to my GP. And he did … He made the appointment, took me in and my doctor was quite annoyed that, ‘Oh, why are you bringing your social worker in?’ And I said ‘I really can’t speak to you very well, I do not feel you are really listening … I am sorry I can’t speak any more, I am too distressed.’ And, uhm [social worker] took over explaining everything … From that day on my GP, there has been a whole change of attitude, he now looks at me and he listens.” (Brown and Kandirikirira, 2007)

Active listening is about making space for the service user, about listening to the verbal content of what is being said as well as noticing the subtext – the music which accompanies the words. It is also about reflecting back to the service user what you are hearing – both the verbal and the emotional content. This is not parroting back the same words, but is about understanding the underlying meaning of what the person is saying and checking this out with them. In reflecting back what we are hearing, we may also have opportunities to reframe and to focus on possible strengths.
In saying this, it is important that service users feel heard, valued and acknowledged in their pain and that we do not simply jump into reframing or offering hope as a means of avoiding or minimising the suffering the person experiences, as discussed above. To properly hear means to show that we understand the difficulties, alongside helping people break these down into manageable chunks.

Our basic listening is filtered through the “lens” of our individual perspective (the way we view the world). It can be helpful to imagine a “feedback loop” that can influence the direction our interactions take (see figure).

**Negotiating and compromising** Developing our interpersonal expertise and moving toward recovery focused relationships means that we involve service users in decisions about their care and treatment and work in partnership with them (ESC 1). Consequently, we have to recognise that service users have their own views, ideas and opinions, and that these might sometimes be very different from our own.

Moving from monologue to dialogue means we have to take personal responsibility for our own opinions and ideas rather than hiding behind a bureaucratic professional front. We need to be able to say clearly and honestly, “Well, I think…” rather than “You must…”, and work in partnership with service users to find a way forward through differences of opinion or impasses. We are sharing our informed professional view, rather than dictating absolute truths. This is typified in this quotation:

“*Their [staff] approach was just amazingly different. They were actually offering [CBT] to you, they weren’t saying, ‘Well, what do you think you need?’ because you do not know … [They were] putting things in front of you and saying, ‘We think this could be beneficial, what do you think?’ and that made a big difference. They gave you a bit of choice.*” (Brown and Kandirikirira, 2007)
This shift from monologue to dialogue, or from technical to interpersonal expertise, also means that we are willing to “own up” to our mistakes and to make efforts to repair “interpersonal” breaks or disagreements when they happen. As a general rule, it is good to suggest that you both talk about what is happening in the relationship between you to try to resolve any differences, or to appreciate that you have differences and try to work with or around them.

**Activity 2.10**

In ESC(S) Activity 2.1, you examined personal experiences of health services “working in partnership” with you. In activities 3.1 and 3.3, you considered how you currently involve service users in their care and how you might increase service-user and carer involvement in care planning. Review your answers to those questions now. You will look again at working in partnership later.

**Self-disclosure** We might sometimes choose to share some of our own experiences with service users, but it is important to think through why we are doing this and the possible advantages and disadvantages for the service user, before we take any action. Disclosures which are made out of self-interest, or which are given as a professional “technique” rather than as an honest, interpersonal human sharing, are likely to miss their mark.

**Unintentional disclosures** We cannot always choose the things we disclose about ourselves: our physical appearance, dress and mannerisms may “give away” some details of our lives whether we want them to or not (wearing a wedding ring, having a “class” or regional accent or our choice of clothing, for instance). In addition, we may sometimes unintentionally disclose our emotions or reactions through our body language, manner or facial expressions by, for example, frowning slightly or looking tired.

**Intentional disclosures** You considered some of the personal experiences that help shape who you are in Activity 2.1. Having experienced similar things to the people we work with can increase our ability to empathise or understand, and can help to build relationships based on mutuality and respect. Some service users have described positive occasions in which workers have shared experiences or details of their life in a way that emphasises our common humanity and increases mutuality. On the other hand, some have received unhelpful self-disclosures from workers:

“[T]here is helpful and unhelpful self-disclosure. For example, although service users felt that they get on better with somebody who is willing to give away something about themselves, it is unhelpful if workers project their own experiences on the service user or self-disclose in such a way that the service user feels they need to provide support. Self-disclosure was seen to be helpful if its objective is to offer reassurance about workers’ perspectives and backgrounds or when the related experiences can be used as a mirror for the service users’ current difficulties. Again, the need to be attuned to the service user and to have established a trust relationship in order to be able to judge when the offering of personal experiences can contribute to a person’s progress of recovery was highlighted.” (Schinkel and Dorrer, 2007)
Some positives and negatives of self-disclosure are set out in the box below.

Positives of self-disclosure

- It can be equalising and non-hierarchical, increasing reciprocity and emphasising our common humanity.
- It can offer an example of hope and optimism that recovery is possible.
- It can help service users feel implicitly understood.
- It can help service users feel that they do not have to explain or “translate” their experience into language for someone who might not initially understand.

Negatives of self-disclosure

- It can shift the focus of attention from the service user and their needs to you and your needs.
- The service user might feel that you are a “damaged” or vulnerable person who needs to be looked after.
- The service user might compare themselves unfavourably to you, and can feel like a failure for not being “successfully recovered”.
- Some things that might be helpful to consider, articulate and explore go unsaid because they are believed to be implicitly understood.
- It is understandable that service-users might sometimes be curious about aspects of your life (who you are, what you do when you are not working, what relationships you have), but this information may not be of help to them on their recovery journey.

If our own experience is still too emotionally “raw” (through, for instance, trauma or divorce), we may not be able to hear what the other person is saying without our own perspective getting in the way. We need to have sufficient awareness of, and distance from, our own traumas before we will be able to hear clearly what is similar and what is unique in the other person’s experience. It is therefore best to have some emotional distance and ease before sharing factual details of our own experiences.

While we tend to think of self-disclosure in terms of external “facts” about our lives – I am married, I experience depression, I was brought up in an orphanage, I like cars – there is another form of self-disclosure which is often more helpful: sharing our empathic emotional responses to the service user’s story and predicament.

It is also important to pay attention to the reactions and responses we have with service users. If we reduce the “professional distance” between ourselves and service users, we will be affected by the people we work with. We will at times be moved, upset, frustrated, hopeful, despondent or pleased about things that happen in service users’ lives or in their relationship with us. It is important to be aware of what we are feeling so that we can choose what to helpfully disclose and also to think about what we may unintentionally be disclosing and how it may impact on the service user.
Activity 2.11
Chris has a diagnosis of schizophrenia. He recently became aggressive towards another service user and had to be physically restrained. During the restraint, he experienced flashbacks of his childhood abuse. He often criticises workers and says that no-one tries hard enough. He angrily threatens to leave whenever challenged or when unhappy with what is being said.

Imagine you are sitting with Chris. Now write down with complete honesty your:

<table>
<thead>
<tr>
<th>Initial thoughts …</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feelings …</td>
</tr>
<tr>
<td>Beliefs/ideas …</td>
</tr>
<tr>
<td>Bodily reactions …</td>
</tr>
<tr>
<td>Likely actions or behaviours …</td>
</tr>
</tbody>
</table>

Responding, not reacting As we have seen, the idea that the worker is an antiseptic professional who keeps their emotional distance from the service user is unrealistic and unhelpful. There is increasing recognition that mental health practice means working with people and that we, as workers, are consequently going to be emotionally affected by our interactions.

There is an understanding that it is important for workers to recognise their emotional responses and that these can sometimes provide useful information to help them engage constructively with the service user. Not fully recognising our responses can mean that we act unhelpfully on them without meaning to!

One simple way of illustrating this is the example of anxiety. Think of times when you have been sitting with an anxious person. Many people find that the anxiety “rubs off” on them – that they end up feeling jittery and anxious themselves. Like gazelles in the wild, if one senses danger and lifts its head to sniff the air, all the nearby gazelles anxiously lift their heads to check whether they are safe; if one jumps, the whole group can panic and take flight! Their feelings directly affect one another. Paying attention to your feelings can sometimes give you important clues about what is “in the air” at the time.
There may be times when we are “pulled in” by strong emotions and find ourselves reacting in ways we later find confusing or embarrassing, possibly including acting on negative or “unprofessional” feelings. When there are strong emotions around, it is helpful to take a step back, to slow down and listen for the music behind the words, to try to see the situation from a new perspective rather than getting completely caught up in the emotional or verbal content of what is happening. Instead of having a knee-jerk reaction, which may distance us from the person we are working with, we can take a moment to imagine what they are feeling or what they might be expressing through their current behaviour.

These feelings may be unspoken at the moment, and our task is to help them come out “into the open”. We may then sometimes choose to share something of our own genuine emotional responses to help service users identify their needs, to make links between past and present, and to help them think critically about their emotions and behaviour.

**Activity 2.12**

Look again at your responses to Chris in Activity 2.11. How might you use some of these responses to engage with Chris so he can feel understood, rather than reacting by distancing yourself as a result of his behaviour? Write down three possible comments you could make to Chris which would demonstrate your desire to work with him in a constructive and recovery focused way.

Here’s an example of what might be said.

“Chris, I was pretty scared by how angry you were yesterday. I thought you might end up hurting Sally, Jane, or even yourself. You know that we can’t let that happen. The more I’ve thought about it, the more I realise how angry you feel in general that what happened to you in the past and what’s going on just now is not fair. And I want to say that I think you’re right – what happened to you really wasn’t fair. It shouldn’t have happened, and I feel really sorry that you were treated so badly in the past. You didn’t deserve it. No wonder you’re angry! So how can we move forward from here?”

**Use of humour**
Being recovery focused doesn’t have to be a completely serious business where we trudge around looking po-faced. In fact, our sense of humour and sharing a laugh with service users can (among other things) build trust and can stop us getting too “caught up” in ourselves. We must, however, carefully judge when and how to use humour to avoid offence.

Louise accidentally spills water on one of the chairs in the meeting room. She freezes and looks anxious and embarrassed.

Jamal [laughing]: “Do not worry about it – that’s probably the best wash that seat has had in three years!”
4. Continuing personal and professional development

Using the self in recovery focused relationships means that we are engaged in a lifelong activity that will require ongoing personal and professional development.

We will continue to grow, learn and develop throughout our life as workers and as people, have new experiences and find ourselves in new situations. We never become a “done deal”! Being professional is not about knowing everything; it is about recognising that we are always “a learner”, no matter how experienced we are.

Supervision and support

As such strong feelings can be around in mental health work, it is important to have access to supervisory support with someone who will help you consider what is happening in your relationships with service users so that you can engage more effectively and can manage over- and under-involvement.

You will need a place to talk about the impact of your work and your current learning and development needs. Not having this can make workers more vulnerable to cynicism, helplessness, burnout or withdrawal. For example, working with people who have experienced unpredictable and frightening traumas can make workers more aware of their own vulnerability. People working regularly with traumatised service users without adequate support have noticed that they can end up feeling anxious and traumatised themselves, perhaps becoming more fearful or suspicious than they usually would.

Being able to talk through your feelings in a supportive team and/or with a supportive supervisor who is willing to listen can protect against the potentially damaging impact of engaging with people in severe distress.

Activity 2.13

Who do you contact for consultancy, support and advice about your work?

<table>
<thead>
<tr>
<th>0</th>
<th>5</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all honest</td>
<td>I can only share some reactions</td>
<td>I can share all my reactions</td>
</tr>
</tbody>
</table>

How honest can you be with your supervisor about your reactions to service users and your feelings about working with them? Mark on the following scale:
Sometimes we will come up against our personal limits when working with service users, such as difficulties working with particular issues or groups of people. For example, if we have been abused in the past then we may find it too painful to listen to someone else’s experience of abuse. In these situations, it can be professional to recognise our limits and make an informed onward referral. However, we may be able to use supervision, training, personal therapy or other development activities to work through our limitations and to “stick in there” with service users.

**Activity 2.14**

Think about issues or people you might find it difficult to work with. Name three things you could do to help you develop your ability to engage with these issues/people.
Activity 2.15

Louise feels very vulnerable in relationships and can find it difficult to trust others. At some points she feels very dependent on particular workers as she doesn’t have many other reliable people in her life who she can talk to. She has an outgoing personality, enjoys having a laugh and takes pride in being “the joker”. If she thinks that the worker doesn’t like her, she experiences huge anxiety and fear about rejection. At these times she feels she can’t cope and calls the worker continually, asking to speak to them.

Imagine you are getting several panicky phone calls a day from Louise asking you to call her back immediately, due to her worry that she might have said something to offend you.

Bearing in mind what we have discussed, how might you set appropriate boundaries with Louise? How might you involve her in a discussion about her needs and what you can realistically provide? By paying attention to your own feelings and reactions, how can you use them to engage with Louise in a helpful way? How might you help Louise consider whether there are links between her present behaviour and her past experiences?

Write down what you might say to Louise to constructively change things here.

Discuss this activity with others.
5. Conclusion

We hope that by working through this module, you have begun to realise (if you didn’t already know it) just how valuable you are when you are alongside people on their journeys of recovery. We hope you can see how your empathy, warmth, honesty and integrity can combine to be a powerful force that service users can tap into and take hope from.

Relationships are at the heart of mental health work and can be complex, fragile, challenging things. When relationships between mental health workers and service users are negative and untrusting, service users can find themselves isolated in their despair and sidetracked on their journey of recovery. But where there is genuine empathy, respect and regard, and where relationships are developed in a helpful, recovery focused way, the potential benefits for service users and mental health workers alike are enormous.

Learning into practice

Before moving on to the next module, spend some time reflecting on what you have learned in this module. You may be reassured by some of the things you have encountered in this module. It is worth taking some time to think about how your existing practice matches what we have discussed in the module.

Some of what you have learned may be new to you or perhaps more challenging. Make a note of the changes you will make to your practice now that you have completed this module.
Resources to support further learning


www.scotland.gov.uk/Publications/2008/04/07143029/13


References

www.scottishrecovery.net/content/mediaassets/doc/Methods.pdf


www.scottishrecovery.net/content/mediaassets/doc/GMorgan%20Speech.pdf

www.scotland.gov.uk/Publications/2008/04/07143029/13

www.scottishrecovery.net/content/mediaassets/doc/Towards%20recovery%20competencies.pdf
Welcome to Module 3
This module explores a central issue for recovery – enabling self-direction.

You explored service-user and carer involvement in Module 3 of The 10 Essential Shared Capabilities (Scotland) (ESC(S)) learning materials. Enabling self-direction takes the issues you explored there much further.

In this module, we will explore:

- the importance of identity in recovery
- peer support and self-directed care and self-management
- the barriers to self-direction in mental health services
- the role workers can play in overcoming these.

Learning outcomes
After completing the module, you should be able to:

- demonstrate an understanding of the importance of self-determination, ownership and identity in recovery
- evaluate a range of self-help approaches and self-management tools
- enable service users to take a lead in planning support, recognising and respecting their expertise
- appreciate the benefits of informal and formal peer support
- examine the relationship between enabling self-direction and the potential impact of the power imbalance between mental health workers and service users, particularly in situations involving compulsory powers
- critically reflect on the barriers to implementing self-direction within mental health services and how these might be overcome.

Estimated time to complete learning activities: 6 hours
SCQF Level 9

Module authors
Simon Bradstreet, SRN and Susanne Forrest, NES
Contents
1. Introduction 69
   Understanding identity 69
   Identities of illness and wellness 70
2. Supporting self-directed recovery 73
3. Tools to support self-determined recovery 78
   Self-help 78
   Self-management and WRAP 80
   Formalised peer support 84
   Direct payments for self-directed support 88
4. Conclusion 91
   Learning into practice 91
Resources to support further learning 92
References 92
1. Introduction

Many studies have described the importance of identity within the recovery process. This was confirmed in the Scottish Recovery Network (SRN) narrative research, which states:

“From the narratives gathered in this project it was evident that much of the subject of identity appeared to be about the issue of personal growth and development and internal change ... Re-finding and re-defining a sense of identity and self-confidence that has potentially been eroded by institutionalisation or ill health was often the first step on a recovery journey.” (Brown and Kandirikirira, 2007)

Let us now consider why identity seems to play such a central role in recovery and consider the implications for you as a mental health worker. To do this, we must first consider what identity means in our lives.

Understanding identity

We all have an identity. It can be understood as a sense of self or a set of determining characteristics by which we perceive and understand ourselves. A great many factors influence our identity and it is not necessarily fixed, with our view of self liable to change over time and be influenced by a number of external and internal factors.

Activity 3.1

In Module 2, Activity 2.1, you completed an extensive exercise that required you to reflect on a range of issues that contribute to your sense of identity, such as your appearance, your personality and what gives you meaning and purpose.

Look back on the responses you gave to this activity and discuss with others.

This activity should reaffirm that your sense of self or identity shifts over time and is governed, defined and influenced by a variety of internal and external factors.

It is important to highlight at this stage that concepts of self and identity may differ between different cultures, faiths and ethnic groups. For example, personal identity in Chinese or Pakistani communities may be more strongly linked with “connectedness” to others than it is in other communities, as the quote below demonstrates:

“It’s more community back home if you have children you are visited and all are equally concerned if something goes wrong. And here [Scotland] everyone has own life, it’s very much individualistic whereas Pakistan community – this individualistic way makes them feel more isolated – they don’t have anyone popping in to say hello how are you, live by themselves, then children are busy, everyone busy they’re all alone.” (NHS Health Scotland and University of Central Lancashire, 2008)

We need to be conscious of the fact that identity is partly “culturally constructed”, so we need to be wary of assuming that personal autonomy is always the main driver for well-being.
Identities of illness and wellness
Consider the following quotes from the SRN narrative research (Brown and Kandirikirira, 2007).

“\textit{I think sometimes, certainly myself, the thing that prevented recovery was that I didn’t know anything else. I’d got a mental illness. There’s some safety in being ill, although I hated every minute of it, there was still some security in that.}”

“\textit{There’s more to me than my mental health.}”

Where people experience significant mental health problems, particularly over a long period of time, it can be so overwhelming and consuming that it can become a central component of identity. The sense of self can become dominated by the experience of illness, the losses which come in its wake and the accompanying support and treatment it may necessitate. This can be simplistically and crudely described as an identity of illness.

Graham Morgan is a prominent mental health activist who has educated and informed our approach to mental health issues in Scotland for some time through his work with Highland Users Group. He addressed the Scottish Recovery Network’s national conference in 2007, where he described the relationship between identity and illness in his life.

“\textit{I define myself as different – I don’t trust ordinary people, instead I light up when I meet those that have been through similar experiences. I feel a bond with the world of mental illness which provides me with identity, security, friendship, acknowledgment, communion and respect. It makes my life at times wonderful – and this is where I worry about the world of recovery.}”

“\textit{I don’t want to leave my world behind, my identity of illness and difference has been informed by my experiences over the last two decades. These years have reinforced the message that this is the safest place to be. It’s where I find my friends, it’s where I earn my income, it’s where I meet people who understand me – I really really don’t want to leave it, I fear a world without illness. And yet a big part of me says take that risk, step out into the real world, engage with those normal people that you are so frightened and sceptical of, cut through all the strings of restriction that you have wound so tightly about yourself, that you can’t breath the bright fresh air where new worlds beckon.}” (Morgan, 2007)

This demonstrates the complexity of identity. An identity of illness suggests entirely negative self-perception, but Graham Morgan clearly describes some of the positive aspects of what he calls an identity of difference. For him it offers respect, income and companionship and provides security and warmth. At the same time, however, he has a nagging curiosity towards an alternative identity.

Later in this powerful and extremely honest speech, Graham went on to describe the impact of having his diagnosis of schizophrenia questioned by a psychiatrist who had heard him speak on a previous occasion.

“\textit{Initially I was very offended – it just seemed inappropriate to say such things. Also, I have grown so used to this diagnosis that to throw it away in a casual conversation seemed quite demeaning – but it made me think. I have hung on to the idea of illness for so long, it is a huge part of the way that I define myself and view myself – is it possible to get caught in a world that, though comfortable, traps you and smothers your growth?}”

He later used this initially offensive statement from the psychiatrist as one means of questioning both
his identity and whether he was indeed in recovery:

“The request I had found offensive became a token to light my way and provide new invigorating ways in which to see the world, to take that big leap in self-definition and see myself as whole rather than damaged and shattered.”

Activity 3.2
In completing Activity 3.2, you might have thought about the following.

From your own experience and from these excerpts from Graham Morgan’s speech, consider how the experience of living with mental health problems could impact both positively and negatively on identity.

<table>
<thead>
<tr>
<th>What opportunities do you have to discuss identity with the people you work with? How would you introduce the subject?</th>
</tr>
</thead>
</table>

Looking forward, what steps could you take in your work with people to focus more closely on the role of their identity in relation to their recovery?

<table>
<thead>
<tr>
<th>What opportunities do you have to discuss identity with the people you work with? How would you introduce the subject?</th>
</tr>
</thead>
</table>

Sometimes as mental health workers, we can inadvertently confirm an identity of illness. When we describe people as “patients” or “service users”, we mark them out as “different” and define their identity by their use of service.
This need to differentiate people is well documented and is understandable, given our need to order things in a complex world. It becomes more threatening, however, when people are described by, for example, their diagnosis – “a bipolar” – or by their experience of illness.

The meaning and interpretation of identity has been debated across psychological, philosophical and social science literature for many years, but there is no doubt that we all have a sense of self which evolves and develops over time depending on our circumstances, how we see ourselves, and how others see us. It is also clear that for people experiencing mental health problems, a shift in identity (or self-perception) can be a powerful driver for recovery.

But how as mental health workers can we support and encourage a shift in identity to promote recovery? The process through which people change the way they perceive themselves, their capacities and potential is clearly an internal process, but it is also one that can be recognised, supported and encouraged by recovery focused mental health workers. We will move on to explore the role mental health workers can play in this process in the next section.
2. Supporting self-directed recovery

Look at these two quotations from the SRN narrative research (Brown and Kandirikirira, 2007).

“Me ... that’s what’s changed ... it was a control thing ... There was an unconscious release of control on my part. [For 20 years] I let other people control what I was doing and what I wasn’t doing. I let the symptoms of my illness become the centre of my universe, and the symptoms of my illness aren’t the centre of my universe.”

“If you’re not actually actively taking choices, you’re not taking responsibility, and then you create into a sort of, you walk into the victim’s role.”

You can see that the following are central for the people quoted in moving towards recovery:

- taking control
- making a shift from illness being central to identity to being peripheral
- discovering self-direction and self-determination.

In this part of the module, we will consider some tools and approaches that might help mental health workers promote self-direction.

Self-determination can be defined as the process by which a person controls their life.
### Activity 3.3

Look at the table below and record the extent to which you are in control of each of the life domains shown, following the example given.

<table>
<thead>
<tr>
<th>Life domain</th>
<th>Extent to which you are in control/able to direct this aspect of your life (rate 1-5)</th>
<th>What factors limit your control of this life domain?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home and family life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health and well-being</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Now think about the things you could do or have done to ensure that you have more control in each life domain.

<table>
<thead>
<tr>
<th>Life domain</th>
<th>Extent to which you are in control/able to direct this aspect of your life (rate 1-5)</th>
<th>What factors limit your control of this life domain?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home and family life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health and well-being</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Reflect on the issues you identified as limiting your control and the things you could do to ensure you have more control. If possible, discuss your answers with others who have completed this activity.

Many of your answers will be no different to the issues that people who experience mental health problems would identify as limiting or enabling their ability to control their lives. But they might also experience other constraints and limiting factors that could impact on their ability to take control. These could include the use of compulsory treatment, the fear of becoming unwell and the stigma, discrimination and inequalities they may experience, both within and outwith mental health services.

**Activity 3.4**

Alex has used mental health services for most of his adult life; this has been under compulsion until very recently. He is now almost 60 years old and is living in a “long-stay” mental health unit. His social networks are very limited and made up largely of people who work in or use mental health services. He has told you before that he doesn’t want to make choices or to be more in control; he is happy with the way things are.

**What might be the barriers to working with Alex in a way that enables him to self-determine?**

**What steps could you take to overcome these?**

Recovery comes from within the person. People will get to what recovery means to them in their own time and in their own way. Some of the people a worker or team are supporting may not yet be ready for recovery, but this does not mean that they will not be ready at some point in the future.

The implication of this (as we noted in Module 1) is that you cannot do recovery to someone. This was described in Module 2 as the need to understand balance and timing – to manage the tension between support and challenge. If a person is not ready, or if they feel out of control, then the danger is that well-intentioned professionals could actually hinder recovery by forcing the issue.
Considering the change process can help us better understand the increasing importance of self-determination and how mental health workers may be able to assist self-directed recovery.

**Supporting the change process for recovery**

<table>
<thead>
<tr>
<th>Stage</th>
<th>When people are just starting to think about recovery – the possibility of recovery may seem neither possible nor desirable.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ Hearing or reading other people’s stories of recovery.</td>
</tr>
<tr>
<td></td>
<td>■ Introducing them to other people in recovery who have been in similar situations.</td>
</tr>
<tr>
<td></td>
<td>■ Introducing ideas and information about recovery.</td>
</tr>
<tr>
<td></td>
<td>■ Encouraging people to think about their life experiences and to start to think about what they want from life (see Module 4).</td>
</tr>
<tr>
<td></td>
<td>■ Creating space for people to talk about recovery and to think about what it means for them.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage</th>
<th>Making plans – getting ready.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ Working together to identify hopes, fears, dreams and goals.</td>
</tr>
<tr>
<td></td>
<td>■ Introducing the person to recovery planning tools (explored in depth in Module 4 and later in this module).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage</th>
<th>Supporting action.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ Helping and supporting the person with achieving their plans.</td>
</tr>
<tr>
<td></td>
<td>■ Working alongside people to recognise and build on their success and try out alternatives where things don’t seem to be working – creativity and perseverance are key components of recovery and recovery focused practice.</td>
</tr>
<tr>
<td></td>
<td>■ Supporting people in informed risk-taking (explored in detail in Module 5).</td>
</tr>
<tr>
<td></td>
<td>■ Acknowledging that mistakes are a normal part of life and that they can help us learn.</td>
</tr>
<tr>
<td></td>
<td>■ Working alongside people to plan for success and considering the possible impact of recovery – what will it feel like if things change?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage</th>
<th>Moving forward.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ Continuing to develop person-centred support and planning (see Module 4).</td>
</tr>
<tr>
<td></td>
<td>■ Looking for and establishing or maximising existing opportunities for informal and formal peer support.</td>
</tr>
<tr>
<td></td>
<td>■ Building on “community connection” and social networks (see modules 4 and 6).</td>
</tr>
<tr>
<td></td>
<td>■ Discussing setbacks and how they need not been seen as “failures” – what can be learned from them as part of longer-term recovery?</td>
</tr>
<tr>
<td></td>
<td>■ Continuing to explore and develop self-help and self-management techniques.</td>
</tr>
<tr>
<td></td>
<td>■ Being available to the person – recovery should not necessarily mean the removal of all services and supports.</td>
</tr>
</tbody>
</table>
It is important to restate that recovery is not necessarily a linear process, and that setbacks can be part of the longer-term recovery process. The table shown above is purely for illustrative purposes and will not reflect all people’s recovery experiences or the supporting role that mental health workers can play. The important point (looking back on Alex’s situation in Activity 3.4) is that even when people appear not to want to take more control of their recovery, or are unable to take a lead role, there are still some steps workers can take to support people to think about recovery.

We have explored in this section the concept of self-determination and considered some of the challenges associated with promoting self-direction. We should note that mental health workers’ roles in enabling self-direction may be limited, as this is a uniquely personal process of growth and change for the person embarking on their recovery journey. Mental health workers can, however, have a key role in working to facilitate this process and in challenging obstacles and practices that detract from it.

In the next section, we will explore in more detail some of the tools that can support self-directed recovery.
3. Tools to support self-determined recovery

Self-help
For many years, groups of people who experience mental health problems have been meeting in groups to offer mutual support and understanding. These self-help groups sometimes become formalised and are supported by voluntary or statutory service providers.

Probably the best-known self-help groups in Scotland are those supported by Depression Alliance Scotland, the Bipolar Fellowship Scotland and local Hearing Voices Network groups. The website addresses of these groups are shown in the “Resources to support further learning” section at the end of the module.

Some of the things these networks or groups hold in common are:

- they were developed and led by people with experience of mental health problems
- they offer an opportunity for people to get together to offer mutual support and encouragement
- they follow a set of underlying principles, applying tools and techniques developed by group members
- group membership is defined by personal experiences, such as experiencing depression or voice hearing.

While self-help groups might be of benefit to some people, others may not value this approach, as is illustrated in the following quotes from the SRN narrative research (Brown and Kandirikirira, 2007):

“Well the main thing, initially … especially on diagnosis, was learning about the illness … I tended to attend self-help groups … and I suppose I just found it helpful that, surprise surprise, I’m not the only one with manic depression … I’m hearing their stories, their experiences and relating really, really well to them … So I found it a very refreshing way to learn about my illness … I think it was just my thirst for knowledge for what was up with me.”

“[I] don’t know if I want to be endlessly frustrated by going along to meetings or being seen as a service user all the time.”
Activity 3.5

From what you have read, what do you think people might gain from attending a self-help group?

Why might some people prefer not to get involved?

Describe the self-help groups that are available in your area.

Increasingly, self-help groups are being complemented by self-help tools designed more for individual use, such as internet-based or written resources. Online forums and chat rooms offer an opportunity for people to share experiences and offer support without the need to attend group sessions. Therapeutic interventions are being made increasingly available on the internet with, for example, self-guided cognitive behaviour therapy (see, for instance: www.livinglifetothefull.com).

Self-help groups and resources promote self-direction. We will now go on to consider self-management, looking in particular at a tool called Wellness Recovery Action Planning (WRAP).
**Self-management and WRAP**

Supporting people who experience long-term conditions to better manage their health and well-being has become an increasingly important policy goal for governments, with a recognition that better self-management can not only reduce the strain on hard-pressed health and care providers, but also promote self-direction and responsibility (Scottish Government, 2007).

People have been looking at how best to cope with the experience of living with mental health issues for some time. Mental health workers have worked with service users to develop psychosocial interventions designed to promote educational and other approaches to managing distress. These have generally helped to create a situation where responsibility is shared between service provider and service user, but are perhaps limited by the extent to which the approaches are developed and owned by the person experiencing mental health problems.

Recovery and wellness planning calls for a more holistic and self-directed approach to enable people to integrate all their life goals and needs. One such tool based on this approach is the Wellness Recovery Action Plan, better known as WRAP.

WRAP was developed in the United States by Mary Ellen Copeland.3 Through networking with other people in recovery, she uncovered key ideas and strategies that can promote the ability to create positive life changes. At the heart of this simple approach is the belief that recovery is possible. It does not necessarily replace other treatments or supports, but can be used to complement them.

Addressing a seminar in 2006, Stephen Pocklington, Executive Director for the Copeland Center for Wellbeing and Recovery, who support and develop the use of WRAP internationally, said:

> “I really encourage the people on the service side to think about how wonderful it will be to have people who are truly empowered to take control in their lives and who are truly empowered to do things to keep themselves well. What happens when people are in that position is that I now come to the professionals for the things that the professionals are actually equipped to help me with. I’m focused on the things that the professionals can really serve.” (SRN, 2006)

---

3 For more information on Mary Ellen Copeland and WRAP, visit: [www. mentalhealthrecovery.com](http://www.mentalhealthrecovery.com) and [www.copelandcenter.com](http://www.copelandcenter.com).
WRAP is described by the Copeland Center as the actualisation of five key recovery concepts.

1. Hope – helps you see yourself as an agent for positive change in your life.
2. Personal responsibility – being proactive and using your freedom and power to move in the direction you want in life.
3. Education – learning all you can about yourself so you can make good decisions about your mental health and your life.
4. Self-advocacy – being able to speak up for yourself and expressing yourself clearly and calmly.
5. Support – developing and keeping a strong support system.

It is based on the premise that people know what helps them and the key is to organise these wellness tools into action plans. These unique and individual plans include:

- a personal wellness toolbox
- a daily maintenance plan
- identified triggers and an action plan for responding to triggers
- identified early warning signs and an action plan for responding to those signs
- identified signs that things are breaking down and an action plan for responding to those signs
- a personal crisis plan for how other people can support you through life’s most challenging moments
- a post-crisis plan.

WRAP is best understood as a life plan, so it is important that you are able to develop it yourself. The next activity below is designed to encourage you to think about the things that would be in your own life plan.

**Activity 3.6**

Take some time to think about what might be in your personal wellness toolbox. Think about the things to which you turn to stay well or to get well. This could be anything from listening to your favourite music to making sure you have time alone.
What things do you need to do on a daily basis to maintain your wellness?

<table>
<thead>
<tr>
<th>What things do you need to do on a daily basis to maintain your wellness?</th>
</tr>
</thead>
</table>

What are the things that knock you off balance and take away your control?

<table>
<thead>
<tr>
<th>What are the things that knock you off balance and take away your control?</th>
</tr>
</thead>
</table>

Do you think there are subtle signs that things may not be going well for you – are there any early warning signs? Perhaps not sleeping well or becoming irritable?

<table>
<thead>
<tr>
<th>Do you think there are subtle signs that things may not be going well for you – are there any early warning signs? Perhaps not sleeping well or becoming irritable?</th>
</tr>
</thead>
</table>

Planning in this way is incredibly simple, but potentially transformative. In taking these first initial steps towards thinking about what might be in your own WRAP, you will notice that what you have written down is unique to you.
Activity 3.7
You took the first basic steps to developing your own WRAP in Activity 3.6. The next steps in the process involve developing your own plans for taking as much control as possible at times of distress. Aspects of this are similar to crisis planning and to Advance Statements, as recognised in the Mental Health (Care and Treatment) (Scotland) Act 2003.

<table>
<thead>
<tr>
<th>What are the advantages and disadvantages of this type of advanced planning?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Why do you think some people might be reluctant to plan for periods of crisis?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

Anticipating and planning for periods of crisis can promote control and self-direction, but it is easy to see why people may prefer not to do it. Having to look back at the most difficult times could feel counterproductive and may bring back unpleasant and distressing memories. One way of supporting people in this process is to share examples in which people have found advanced planning to be helpful. The quotation below is from someone who wrote an Advance Statement under the Mental Health (Care and Treatment) (Scotland) Act 2003:

"... it is good to know that if I become ill again in future this document will be there for me to go back to ... Being able to write an Advance Statement was a real opportunity to say ‘this is who I am’. “ (www.principlesintopractice.net)

People need training and support to properly develop their WRAP. It is something that should be done over time and in conjunction with peers and supporters. The examples given here are purely illustrative. A number of people have been trained in Scotland as WRAP facilitators to offer support to people to develop their own plans – it might be useful for you to find out who are the WRAP facilitators in your area.

WRAP is a particularly important tool for peer support workers. They use it not only to help support the people they work with, but also to maintain their own mental health and recovery.
Formalised peer support

We shall now go on to consider peer support as one means of promoting self-directed recovery. *Delivering for Mental Health* (Scottish Executive, 2006) committed the Scottish Government to supporting the development of a new peer support worker role.

Peer support is a system of giving and receiving help founded on the key principles of respect, shared responsibility and a mutual agreement of what is helpful (Mead et al, 2001).

It is a model of provision that champions the use of personal knowledge and experience of a particular issue to help and support others who are experiencing that same issue. Of course, this already exists in a number of mental health settings. Some is informal – the type of mutual support many people describe from friends and acquaintances who have had similar experiences, for example, as described in the quotation below:

“The most help I got was from the other people in the ward who had gone through similar experiences. And this does generally go on when you are sectioned. The nurses, they’re great but you find, or I find – you asked for my personal experience – the best people that helped me were other people that had been through psychosis, had some little pointers, were grounded, that’s the thing.” (Brown and Kandirikirira, 2007)

People who identify as having experienced mental health problems are often involved in providing mental health services, perhaps most notably in organisations providing advocacy, befriending and self-help type services. But “formal” peer support differs from these examples in that it involves creating specific roles within existing mental health services which are designed to be filled only by people who have experienced significant mental health problems – this in effect is their qualification. These “peer specialist” posts are open to people who have completed an accredited training programme.

Peer support workers perform a specific, clearly defined role within the service:

“Every day at work is rewarding ... I work side by side with others, peer to peer. I offer strength, support, experience, lend a listening ear, but most of all, I get paid to spread hope.” (Peer support worker, quoted in Ashcraft and Anthony, 2005)

This approach to service provision is not intended to replace existing services or professional roles; rather, it is designed to complement them. Service users benefit from a recovery focused approach and there are also clear benefits for people who become trained and employed as peer specialist workers.

The relationship between the peer support worker and the service user is central to the approach, with a high degree of empathy and mutuality. Peer specialists are supported to share part of their own lived experience to offer hope and practical assistance of recovery to others.
Activity 3.8
The list below shows some of the potential benefits of peer support. Try and sort this list in terms of benefits to the following.

1. The person receiving peer support.
2. The peer support worker.
3. Organisations and services.

Discuss your responses with others.

- Increase in self-esteem.
- Instil hope by modelling recovery.
- Opportunity to develop skills and use experience.
- Offers employment and inclusion.
- Mutual relationship with peers – been through the same as you.
- Can guide you according to their experience.
- Trust.
- Promotes a change of mindset.
- Equality of relationship.
- Could help create culture where others feel more able to disclose experiences.
- Doing something for selves, not being “done to”.
- Learning.
- Putting money where mouth is with regard to involvement.
- Expand the range of services and offer alternatives.
- Provide better “engagement”.
- Empowerment.
- Adds new skill set to the workforce.
- Change of values.
- Fits Scottish policy context.
- Recovery approach in action.
- Lived experience seen as an asset.
- Seeing recovery promotes hope and expectation.
- A chance to contribute and “give back”.
- Promotion of self-management skills.
You will see from completing this activity that many of the benefits of formalised peer support are felt across the board. The whole approach is based on mutuality and shared experiences and learning. A unique aspect of this approach is that peer support workers are actively engaged in supporting not only the recovery of the people they work with, but also their own recovery. This ensures a strong working partnership, as the following quotation illustrates:

“Peer support assumes full reciprocity. There are no static roles of helper and helpee. Although this may not be surprising, reciprocity is the key to building natural community connections. This is an enormous shift for people who have learned to think about community as a series of services.” (Mead and Macneil, 2005)

Activity 3.9
From what you know of the peer worker role, what do you think its benefits would be:

- to the service you work in?
- to the wider service system?

Peer workers can fulfil a number of roles in numerous contexts and settings. Some key aspects of their approach include:

- following a recovery approach throughout
- promotion of self-direction and strengths emphasised, particularly in language
- using own story and experience of recovery – modelling recovery
- ensuring a forward-looking, wellness focus
- using recovery tools and techniques, such as WRAP.
There are many examples of peer workers in the United States, where peer support services are well established. The role seems to add particular value:

- where people most need hope
- at times of transition, including admission and discharge from services
- with people who find it hard to “engage” with existing services
- in advance planning, such as developing Advance Statements.

Evidence for peer support approaches is developing (see box below). It seems that peer-provided services in the United States are equally if not more effective than non-peer provided services. There is further evidence that outcomes for service users are enhanced when peer worker specialists are added to existing mental health teams (Solomon, 2004). One of the measures most commonly used in evaluating peer support is reduced hospitalisation. Consistently positive results on this measure clearly imply a cost saving, as hospitalisation is the most expensive means of providing mental health services (Solomon, 2004).

**Developing evidence for peer support**

Recovery Innovations, Inc. is a major provider of peer-run services in the United States (www.recoveryinnovations.org) that has supported work in Scotland to develop a new peer worker role to complement existing services.

One of its projects placed peer workers in nine wards in county hospitals in Arizona. It took six months for the peers to become accepted as integral team members. They worked with service users to develop recovery discharge plans and in the first year, they saw a 56% reduction in readmissions and a 48% reduction in restraint. This project is now the subject of a randomised controlled trial.
Activity 3.10

A new peer support worker role is being created in your team. What challenges might need to be overcome to make this a success?

What support and preparation will the existing team members need?

Discuss with your team members.

Peer support offers one approach to enabling self-directed recovery, but it will not necessarily suit everyone. As we emphasise throughout these modules, recovery is a unique and individual journey, which means that people will find different things helpful at different times. In the next section, we move on to examine another approach to promoting self-directed recovery – the use of direct payments.

Direct payments for self-directed support

The Community Care (Direct Payments) Act 1996 enabled local authorities to give money to people in need of community care services to enable them to make arrangements and pay for their own support, either instead of or in addition to a local authority service.

The direct payments scheme was intended to increase the independence of recipients and support the social inclusion of people requiring community care services. It was envisaged that rather than using local authority services, people with particular difficulties would be enabled through direct payments to choose to engage with mainstream activities: they might choose, for instance, to access the support they require to take part in a range of activities in their chosen community rather than using a local authority-run day service.
Direct payments can be used in this way to fund a range of support opportunities, including:

- the employment of personal assistants or support workers
- help with activities around the home
- one-to-one emotional support when services may be closed
- support to access and maintain employment, education, volunteering or leisure activities
- respite breaks
- talking and complementary therapies

Since their introduction, direct payments have mainly been accessed by people with physical disabilities who have generally used them to employ one or more personal assistants. This support has enabled people with disabilities to engage in a wide range of activities and to contribute to the communities in which they live and work.

To access direct payments (also sometimes referred to as “individual budgets” or, in the latest Scottish Government guidance, “self-directed support” (Scottish Government, 2007a)), individuals need to take part in a process of assessment with a care manager (this might be a social worker or health worker, depending on local arrangements). The assessment should involve a self-assessment by the person who requires support. A care plan is then jointly developed and decisions made about whether some or all of the support required should be provided by a direct payment arrangement.

Most areas have independent, user-led organisations that are able to provide information and support to service users managing their own care package in this way (the majority of these organisations tend to be aimed at people with physical disabilities using direct payments to employ personal assistants, but they have transferable expertise). For further information about these services in your area, see www.scdps.org.uk

The uptake of direct payments among mental health service users in Scotland has been very low, but the 2007 guidance from the Scottish Government stresses the need to ensure that payments are routinely offered to mental health service users and recognises that self-directed support offers opportunities for greater independence, an increased sense of control and greater chances of social inclusion, all of which can contribute greatly to an individual’s recovery.
Activity 3.11
Reflect on your role as a mental health worker employed by an organisation.

If you were fulfilling the role of a support worker employed by a service user under a direct payment arrangement, how might this impact the nature of your relationship and the service you provide?

Discuss with others.

Clearly, this shift in relationship, from user and service provider to employer and employee, has considerable implications for both parties and has the potential to overturn the power imbalances that have at times dominated relationships.

As with all of the tools and techniques discussed in this module, it is important to stress that a direct payment approach to purchasing support may not suit everyone. While some people may welcome the opportunity to be in control of their own care package, others may see this as an additional stressor. What is important is that people are offered information about this method of organising their own support package, and from there can make their own choices.
4. Conclusion

In Module 1, we described mental health workers’ roles in promoting recovery as being alongside people as they take the lead role in their own unique journey. In Module 2, we went on to examine recovery-enhancing relationships and to consider use of self as a tool for promoting recovery. In this module, we have looked in more detail at the elements of the recovery journey that could be described as internal and self-directed. We have examined the role of identity, considered stages of change and looked at some tools and approaches to support self-directed recovery.

We have seen that a shift in identity can be a profound experience of transformation and growth. Supporting and encouraging this process, which is not necessarily linear, is vital. Service providers and service systems which are not prepared to, or are unable to, embrace the new possibilities provided as people take the lead role could hinder recovery.

Self-determination is by definition about people taking control and assuming lead responsibility for managing their recovery and wellness. This requires that mental health workers have the confidence to step back at the appropriate time to allow people to take on that lead role and move forward, with or without their support.

Learning into practice

Before moving on to the next module, spend some time reflecting on what you have learned in this module. You may be reassured by some of the things you have encountered in this module. It is worth taking some time to think about how your existing practice matches what we have discussed in the module.

Some of what you have learned may be new to you or perhaps more challenging. Make a note of the changes you will make to your practice now that you have completed this module.
Resources to support further learning

Self-help and support groups
Bipolar Fellowship Scotland: www.bipolarscotland.org.uk
Depression Alliance Scotland: www.dascot.org
Intervoice (International community for hearing voices): www.intervoiceonline.org

Formalised peer support
Peer Support and Peer Run Crisis Alternatives (Shery Mead Consulting): www.mentalhealthpeers.com/
Recovery Innovations: www.recoveryinnovations.org/

Advance Statements

References


Module 4

Providing person-centred support

Welcome to Module 4
The purpose of this module is to explore person-centred support within the context of recovery and to examine the use of person-centred planning tools and approaches as means of delivering this support.

Learning outcomes
After completing the module, you should be able to:

- practice in ways that maximise opportunities for all service users, including those subject to compulsory powers, to make choices about how they live their lives and have those choices respected and acted upon wherever possible
- work alongside people to identify their strengths and explore their skills and interests to develop self-defined goals
- demonstrate an awareness of the principles of person-centred approaches to support and a range of methods used
- apply two recognised person-centred methods to plan and deliver support, recognising that recovery is a uniquely personal journey
- understand the ways in which person-centred methods of providing support differ from more traditional approaches to care planning.

Estimated time to complete learning activities: 6 hours
SCQF Level 9

Module authors
Anne Conner, Outside the Box and Dr. Donald Macaskill, Equal and Diverse
# Contents

1. Introduction 97  
   Thinking about person centredness 97  

2. Key concepts informing person-centred planning 100  
   A focus on strengths and abilities 100  
   A focus on gifts 102  
   A focus on dreams 105  

3. Approaches to person-centred planning 108  
   The process of planning 108  
   Involving key people in the person’s life 109  
   The facilitation role 109  
   Graphic facilitation 109  
   Person-centred planning methods 110  
   Personal Futures Planning 111  
   Circles of Support 115  

4. Conclusion 120  
   Learning into practice 120  

Resources to support further learning 121  
References 121
1. Introduction

In this module we will:

- explore person centeredness and how this links to recovery
- examine key concepts underpinning person-centred planning
- explore person-centred planning tools and approaches, examining two approaches in depth.

One of the key principles of using person-centred tools and approaches is that we should have undergone and experienced them ourselves if we use them in our work with people.

To enable this to happen, many of the activities in this module involve you using some of the tools and approaches to look at yourself in a personal and reflective manner. We recommend that many of these activities are undertaken in a group supported by facilitation.

Thinking about person centredness

We explored the unique and individual nature of recovery in Module 1. It means different things to different people; what helps one person might not necessarily help another. This reality makes it vital that people are able to identify what outcome they are working towards – what recovery will look like and feel like for them.

Activity 4.1

Read and reflect on the following extract from Tig Davies’ recovery story. It would be useful to read the full version of Tig’s story, which can be downloaded at: www.scottishrecovery.net/content/mediaassets/doc/0605_Tig_Daves.pdf

“I was in my 30s and at university, having somehow sustained what was probably a three-year massive high when the Grim Reaper himself appeared to take over my life! One minute in the student’s union building, the next Room 1, ‘H’ ward, acute psychiatric unit!

“I had experienced a previous and very unsuccessful three-month admission to a psychiatric unit in my late twenties, but I wish to tell you about this next experience because of its eventual positive impact upon my recovery.

“Needless to say the first eight months of this admission had no positive impact! Three months at home ended with me in hospital being told my liver would never take another overdose, a psychiatrist telling me I would never work again, being offered life in a therapeutic community and being told to keep taking the medication – oh, and please stay in the hospital!

“At that point, I truly believed that life as a ‘well person’ for me was over. I was mad and that was that. I was totally devastated but physically and mentally powerless to react. I collapsed into a passive world of nothingness. However, it was to be during the next seven months in hospital where my recovery journey finally began!
“I was heavily medicated, hideously underweight, incapable of thought, desire, motivation or social interaction. My mind was full of dread, fear, voices demanding that I harm myself, that I was dead in all but disgusting body and that this state would remain until death.

“Upstairs at the hospital there was a small patient/visitor café run by Dee. She is probably one of the most genuine, empathic, supportive and fun mental health support workers I have ever met. They called her the ‘coffee shop assistant’. She took ‘serving people’ in that café to new heights. Dee didn’t just serve coffee, she served people. She talked, she shared, she asked, she listened, she cried, she laughed, she spoke the truth as she saw it, she hugged when appropriate, kept her distance when it was right to do so. She joined people to communicate, she took no crap from people, she sought and found understanding of difference – oh, and she made a great mug of coffee! And all of this despite her fear of being in trouble for talking at work! The café and time with Dee became a place of solitude, light and hope for me.

“I was in the café one morning when the new ‘welfare rights worker’ came in – Dave. It transpired we had known each other years before. We talked. He had previously met me during a ‘high’ time in my life and yet being faced with a walking corpse, while upsetting him greatly, brought out in him the most person-centred approach to an individual you could imagine.

“He, Dee and I sat and drank coffee. Then he simply looked at me and asked the most simple and yet profound question I had ever been asked. ‘What do YOU think would help YOU to get well again?’ I was blown away – no one had asked before and I had always been led to believe that the pills, the nurses and the psychiatrists had the plans and the answers. After all, they had written me a care plan!

“I embraced the question in my desperate state and, feeling I had nothing to lose, told Dave and Dee the threads of a dream I had known before. I wanted to be well, I wanted relationships with my family and friends back, I wanted to go home to my flat, and I wanted to work. At the end of this talk I ate and, equally important, ‘enjoyed’ toast and jam and a full mug of chocolate milkshake. At that point I hadn’t eaten more than one digestive biscuit and half a glass of milk a day for over three months! I also smiled. And that felt great. ‘Hope’ had finally returned. I talked. I dreamed. I planned”.

Tig Davies. Mental Illness to Recovery – We Hold our own Journey Plans!

Tig, while experiencing the depth of what she describes as her “desperate state”, identifies ways in which Dee and Dave helped her embark on her recovery journey.

Looking back on Tig’s account, what was it about Dee and Dave’s approach that you would identify as person centred? Discuss this with others.
It is important to note that we are not suggesting that the work mental health workers already do is not centred on people. The difference with person-centred approaches and the features that characterise them are that the orientation and direction of the work is altered and shifted. From Tig’s story, it appears clear that both Dee and Dave were relating to her in a way that she saw as being different from her other experiences in mental health services, and which prompted a turning point that started her journey to recovery.

Person centeredness is a means of supporting people that can include the use of particular tools and approaches:

- **person-centred support** is about helping people work out what they want, and person-centred approaches focus on how this is delivered
- **person-centred planning tools** provide the basis for, and promote, ways of commissioning, organising and providing services grounded in listening to what people want. They are based on principles of rights, strengths, independence, choice and inclusion.

In this module, we will explore the key principles behind person-centred planning tools and approaches and what characterises them as distinctive and potentially useful within a recovery focused working context. But in common with all other approaches that workers may draw on when supporting people, the choice of which approaches will be of help is made by the person.

---

There are other issues raised in Tig’s account that suggest that the support and treatment she received during her admission was not person centred. What are these issues?

How could things have been approached differently?
2. Key concepts informing person-centred planning

A focus on strengths and abilities

The heart of all person-centred approaches is moving from seeing the negative (the problems and deficiencies) in people and recognising and releasing people’s potential (strengths and abilities).

We all struggle to articulate our strengths, but usually have no problem with identifying our deficits and perceived problems. But focusing on deficits as opposed to strengths can be a disheartening experience.

Remember that people who have been in contact with mental health services over a long period become well-versed in describing their deficits as they recount their story of illness to a succession of mental health workers. One negative consequence of this is that people’s self-image can become deficit focused (as we discussed in Module 3). We need only look back to Tig’s story to illustrate the destructive power of this process.

Finding ways to highlight and work to the strengths we all possess can be a powerful driver for change, growth and recovery. Many of these ideas are articulated in the Strengths Model.

The model was developed in the United States by Charles Rapp and colleagues (Rapp and Goscha, 2006). It is an approach to case management that originated in social work services but is now being applied in a range of service settings around the world, including assertive outreach, inpatient and peer-provided services.

The key principles of the Strengths Model are the following.

- The focus is on strengths, not diagnosis, symptoms, problems, or perceived deficits.
- The community is viewed as an “oasis of resources” (this is explored further in Module 6).
- The service user is the director of the support process – self-determination is central (as discussed in Module 3).
- The service user-service provider relationship is primary.
- Community (assertive) outreach is the preferred way of working.
- We all continue to grow, to learn and change.

Sometimes a focus on needs or problems can also lead to mental health workers categorising people: for example, someone who self-harms or has a label of “personality disorder” (you have explored this previously in The 10 Essential Shared Capabilities (Scotland) (ESC(S)) learning materials). Categorising people in this way can lead to them developing negative reputations which might then follow them around for most of their lives.
There are some important points to consider when thinking about reputations.

- Sometimes people have qualities and traits that other people dislike or which can be seen negatively in a particular context. For instance, someone may be described by some people as “pig-headed”, “insecure” or “selfish”. People who like the person or who know them in a different context might see these same qualities differently. They may say that the person is “committed and determined”, “keen to please”, “good at making time for themselves” or “clear about what they want”.
- Sometimes the way someone behaves can be seen as a symptom rather than an understandable response to their situation. For example, others describe the person as having “challenging behaviour” or being “attention seeking” or “self-isolating”. If the people around the person see them in this way, they can end up trapped in their reputation.
- Sometimes the way someone behaves is misinterpreted or taken out of context and the reactions and responses based on this misunderstanding make the person’s behaviour worse.

Situations can go on like this for some time, with each new behaviour viewed as further evidence that reinforces negative “reputations”. Part of person centeredness is about changing some of the ways we commonly think of people – seeing the person and the world through different lenses.

To achieve a person-centred way of working, we need to move from seeing people through the lenses of:

- what other staff say, anecdotes and stories
- labels and descriptions
- an assumption of fundamental difference.

Instead, we need to move towards seeing people through the lenses of:

- a sense of justice and decency
- a recognition of the negative impact of past experiences
- seeing people in another context
- respecting diversity and valuing difference
- appreciating the person’s perspective.
Activity 4.2
This activity builds on previous ones you completed when looking at your strengths in Module 2 of the ESC(S) learning materials and moves you on from thinking about your personal strengths to the strengths and challenges you face working in mental health.

You will need two pieces of paper to complete this activity

Think of an area of your work with people which you find a particular challenge or difficult to do. Spend some time reflecting on this area and write down words on one of your pieces of paper to detail what it is about this that makes it challenging or difficult.

Then, on the other sheet of paper, identify what you would consider to be your strengths and abilities in the work you do with people.

Now put both pieces of paper together and draw lines between the words on the “strengths” sheet and the words or phrases on the “challenges” or “difficult” sheet.

You should see that while some issues are left, there are also some areas of your strengths that will directly impact on some of your challenges or things you find difficult.

Discuss how you could adapt this exercise to help people you work with to start to think about their strengths.

A focus on gifts
The expression “giftedness” is used in person-centred planning, but it is important to realise that this is not meant in the conventional way. It does not mean someone is a “gifted” pianist or painter (although some of the people we meet might be).

Rather, a gift is a “unique attribute” – something about you that creates a possible hook or connection with at least one other person. Discovering a person’s gifts requires us to really know them and understand their situation, which can only be achieved through spending time with them.
Activity 4.3
Another framework for focusing on people’s strengths and abilities is to do a “Who am I?” poster with them.

The framework outlined in the “Who am I?” activity presents a series of good questions to ask which, when taken together, will give a rounded and positive view of the person you are working alongside.

This is how to facilitate or take part in the activity. You need to work in a facilitated group to undertake it – this is a crucial part of the learning for this module.

The group leader gives each person a sheet of flipchart paper and a number of pens and talks through the outline of the poster (see poster outline on page 104). Participants are invited to work with someone they feel comfortable with.

One person asks the other open questions to gather the information requested and then draws or writes the information on the sheet. Make sure that nothing is shared that participants would be unhappy for others to know about. People might prefer to use drawings/images as well as words when developing their poster.

There are four corners, each with a question attached to it.

**What’s my identity?**
This includes information about age, gender, job titles and important roles in the person’s life.

**What are my hobbies, interests and passions?**
This should list all the areas and interests the person has, as much as possible in their own words and in as colourful detail as possible.

**What are my skills, talents and resources?**
List everything the person can do, is good at and enjoys, together with any equipment or resources they have access to.

**What are my gifts?**
This can be difficult for people to do themselves. What do these people say about you? Why do they like you? What attracts them to you? If you were not here, what would be missing by your absence?

Everyone should be given the chance to complete their poster with their partner at their own pace. This might take as much as 45 minutes each – don’t rush it!

After everyone has finished their work, hang the posters on the wall and let people walk round and see what others have put up. This gives them an informal opportunity to see what the skills, abilities and contribution of other people might be.
Gifts poster outline.

Identity

Hobbies, interests and passions

Skills, talents and resources

Gifts
A focus on dreams

Person-centred planning is based on the premise that people want to make positive changes in their lives.

The idea of dreaming is a crucial concept in helping people to do this. If you look back to Tig’s story, you will see she talks about how Dave’s question triggered her ability to recognise and share her dream – to be well, to have relationships back, to go home to her flat and get back to work.

Our dreams are a vital source of energy. We are drawn towards our dreams and try our best to steer well-clear of the nightmares. Person-centred planning taps into this source of energy to give direction to the process of making changes and to give the person impetus to follow things through.

People dream in different ways, and dreams can change and grow with a person. For instance:

- people who are excluded and oppressed may have a very modest dream – to have some peace and quiet, to be able to come and go
- others may have difficulty accessing their dreams – thinking about what they would do if they won the Lottery can be a useful exercise to assist people identify their dreams
- some people dream about external things – things to do, places to visit
- others’ dreams might be more about a state of mind or their spirit.

The dream expresses some essence of them as a person. The same person might have more than one kind of dream at the same or different times in their lives.

Person-centred planning enables the person’s dream to become as vivid and detailed as possible, while also allowing it to be heard by other people. This can create a real sense of direction and purpose about the changes to be made. It is important in such a process, of course, to hold on to those things in a person’s life they value now and use these as a foundation for the future.
Activity 4.4
Here is an example of a tool that can help people describe their dreams.

A postcard from the future
Draw a postcard.

You are somewhere in the future, writing back to your past.
Say where you are (you might want to draw this).

What are you doing?

Who are you with?
Let your imagination go!
Now share your answers with others – to the extent that you feel comfortable.

What did it feel like to do this exercise?
3. Approaches to person-centred planning

One of the benefits of using person-centred planning tools and approaches may be that they help people identify practical supports and actions to support their recovery and avoid the ones that may hinder.

Generally, person-centred planning tools:

- enable each person to work out the plan they need at a particular time (each person’s plan will be unique)
- emphasise that the person owns the plan – the process of creating the plan reinforces the message that it is the person who is in control
- cover all the aspects of the person’s life that are important to them and which they have decided can help them as part of their recovery
- are specific and action-focused – each one will list the actions the people involved in creating the plan agree to take (actions the person asks someone else to take, or stop taking, can also be included)
- are both continuing and renewed – they can include elements that people want to continue over many years, and elements that people may want to review after a few months, or a year, or a few years – whatever timescales make sense to them. The plans therefore reflect the very personal and complex timeframes that people find their recovery takes.

When person-centred planning works, it builds a desirable future for the person and engages the energy, commitment and ingenuity of others to make that future happen.

The process of planning

The process of the planning is as important as the approach or tool being used. Whatever the approach to person-centred planning used, there are some essential elements.
Involving key people in the person’s life

Often (but not always), key people such as family members and friends can play an important role in person-centred planning. In this, we are focusing on the people the person regards as key.

We need to note that not all family relationships are positive, which makes it important to focus on the people the person defines as key to their lives and wants to include. We also need to remember that for some people, family experiences have been abusive or exploitative; even using the term “family” may be unhelpful. Some people may have no one they regard as “family”, or even as friends.

This will influence the selection of the tools that are going to be most helpful in each person’s situation. Some of the tools described in greater detail later can be useful in helping identify ways in which someone can build up relationships with more people and start activities from which true friendships might emerge.

The facilitation role

The role of the facilitator is crucial in person-centred planning. Facilitators have two main tasks: to encourage the exchange of views and knowledge among the people involved in the planning process, and to ensure that the focus on the individual is never forgotten.

The role of the facilitator is always to listen attentively, affirm and validate what is said and to ensure that the views of the person, their family and friends are heard.

Graphic facilitation

Graphic facilitation may be familiar to many people, as it has long been used as an aid in all kinds of meetings. It has several advantages:

- it encourages participation and is fun
- the proceedings of the meeting are recorded in a way that is easy to remember – people are more likely to remember ideas when images are allied to words
- everyone can see what is being said and agrees with the record as it goes up – the minutes are not typed up and possibly disputed later
- the record serves as a reminder during the meeting of what was said earlier
- it helps the group stay focused
- it can record feelings as well as ideas and statements
- previously unrecognised patterns and influences can be identified
- it encourages people to think creatively and in a different way
- position, colour, shape and arrows can be used to show connections between ideas.

For an example of graphic facilitation, see the “Resources to support further learning” section at the end of the module.
Person-centred planning methods
A range of person-centred planning approaches exist, and there is no single “best” way of doing it. A selection of approaches are briefly described in the box below, but we will focus on two approaches in particular – “Personal Futures Planning” and “Circles of Support”.

Examples of person-centred planning approaches

Essential Lifestyle Planning (ELP)
ELP is a tool that lets you know how someone wants to live and shows you how they would like it to happen through an extremely detailed action plan. ELP lets you discover what is important to people who use services and what support they need (from their perspective) to remain healthy and safe. A good plan reflects the perceptions of the person and those who love and care about them.

ELP looks at:
- what people like and admire about the person
- what is important to the person
- communication
- how to provide support
- identification of successful methods
- how to solve problems.

Using ELP is a good approach to starting to get to know someone and working out what they feel is needed to support them on a day-to-day basis. It does not focus on “dreams”, unlike some of the other methods.

Planning Alternate Tomorrows with Hope (PATH)
PATH is a fast-moving tool that is usually graphically presented and has a powerful impact on those involved. It focuses mostly on the process of change and helps a group of people who are committed to the person to understand the plan and how it will progress. This is not so much about gathering information, but planning action. It focuses on the “dream” and works its way back from there, mapping actions required along the way (Forest et al, 1993).

Making Action Plans (MAPS)
MAPS is similar to PATH in that it focuses on desirable futures or dreams and how service users might try to achieve these. It covers people’s history and identifies their gifts.

To find out more about ELP, PATH and MAPS, see the “Resources to support further learning” section at the end of the module.
Personal Futures Planning

Personal Futures Planning (PFP) is similar to ELP. It is a way of describing life now and looking at what the person wants in the future (Mount, 2000).

PFP has several stages in its process that are described below.

Getting to know a person – developing a personal profile This is the first step in the PFP process and involves developing a series of maps that help give a positive and accurate picture of who the person is. Maps can be drawn graphically in the first part of the meeting.

There are five core maps that are almost always used:

- Relationship Map
- Places Map
- Background Map
- Preferences Map
- Dreams Map.

Relationship Map

This is an essential part of getting to know a person. By dividing the map into at least three sections – family, friends/community people and paid providers – and placing those who have the deepest and strongest relationships to the focus-person closest on the map, we can begin the process of getting to know them.

The Relationship Map can:

- identify who could make a contribution to the personal profile and/or planning process – friends, allies and important people
- identify relationships that could be developed or strengthened – for example, with friends or other community people
- show the balance of family, friends and paid workers in the person’s life.

Places Map

This identifies those places where the person regularly spends their day or week, paying attention to time spent in segregated service-type settings and the ordinary community places they may go. The map should clearly divide these off and be explicit about how much time the person spends in each place, so that once again the balance becomes evident.

The Places Map:

- shows how the person spends their time
- identifies the balance between the world of services and the world beyond services
- highlights some opportunities for increasing time spent in ordinary community settings.
**Background Map**
An overview of what life has been like for the person from their own perspective is developed on this map. It can help illustrate positive experiences from the past to build on, but also appreciates and acknowledges some of the loss, grief and trauma that may have been around in people’s lives. It is developed by drawing a time-line usually from the person’s birth to the present time and recording the events and experiences they feel are most significant and relevant.

The Background Map:
- keeps people in touch with the person’s history beyond their immediate past or their life in touch with services
- identifies experiences that must not be repeated
- celebrates achievements
- identifies positive experiences and opportunities that might be built on in future.

**Preferences Map**
This map is very like the Gifts Poster (see Activity 4.3) and describes the person’s personal preferences, interests and gifts. It tries to identify those things the person likes and dislikes and draws all the ingredients into patterns that identify the potential and unique contributions of the person.

The Preferences Map:
- shows what the person enjoys, is good at and can contribute to
- identifies things they may want to do more often
- show which situations and experiences should be avoided.

**Dreams Map**
An individual is asked to be explicit about their hopes and fears and how they feel about the opportunities and obstacles that might lie in their path. It is vital that the person does this from their perspective and that those contributing to the process try to do likewise.

The Dreams Map:
- helps to develop a sense of the lifestyle the person would like through their eyes
- identifies what the person is most afraid of happening or going wrong
- helps to set the agenda for the planning meeting itself.

In addition to the five core maps, other maps may also be used when relevant. Below we highlight three further maps that might be used when working with people using mental health services.

**Choices Map**
This should clearly show what decisions the person makes in their life and which are made by other people. This gives a good picture of how much genuine autonomy the person has in their life and which areas might be worked on to give them more control in future. The map may be potentially challenging to use with people who are subject to compulsory powers, but could be a useful way to introduce discussions about the choices the person retains (as discussed in Module 1) and how to maximise them.
Health Map
This map should describe what helps and what damages the person’s health. It should clearly specify the things that need to happen to keep the person healthy and safe and what things need to happen to make them healthier in future. One or more of the tools and approaches (for example, self-help groups and WRAP, described in Module 3) might be included here if the person feels they would be of benefit to them.

Respect Map
This should illustrate what helps people to value the focus-person and what things may be a barrier to this happening. It should acknowledge those positive aspects of the person which enhance respect.

Facilitators may need to devise further maps to fully get to know the person they are working with.

When the personal profile is completed, the various maps can be summarised by drawing them into themes that describe the person’s strengths. This is then fed into a Personal Futures Planning Meeting (see box).

The Personal Futures Planning Meeting – basic steps

- Review the personal profile.
- Find desirable images of the future.
- Generate ideas for achieving the vision.
- Establish priorities to start with and make commitments to action.
- Set time and date of next meeting.
Activity 4.5
For this activity, you will need to work with a colleague you think you know well and trust.

Firstly, based on the information above, develop your own Relationship Map. Then develop a Relationship Map for your colleague.

Secondly, based on the information above, develop your own Preferences Map. Then develop a Preferences Map for your colleague.

Now both of you get together and look at the maps you have created.

Are there a lot of similarities between the maps you have created and the ones your colleague has created about you?

Are there major differences?

How does it feel to involve someone else in personal areas of your life in this way?

PFP may be a tool you can use in your work of supporting people. It may be of particular use when working with people who have been in mental health services for a long time and are beginning to think about moving on. Using one or two of the maps rather than the whole set may also assist people to look at particular areas of their lives they would like to develop.
Circles of Support
This approach draws on the tool initially developed by Marsha Forest, Jack Pearpoint and Judith Snow and on the experience over the past 15–20 years of the Planned Lifetime Advocacy Network in British Columbia, Canada (Snow, 1998). It is a particularly helpful way of understanding and building relationships, tackling social exclusion and addressing long-term practical difficulties. Circles of Support has been adapted widely in the UK and elsewhere to build support for people in a wide range of circumstances (see www.circlesnetwork.org.uk).

Identifying the people who can or do provide support is an important part of recovery for many individuals. This tool can help us think about which people are part of our lives. It can also help us see areas of our lives where we have few people to help us and where it may be useful to recruit some additional support.

It should be noted that while the tool has been developed by an advocacy network, this is very different from the independent advocacy provision generally available to mental health service users in the UK. An independent advocate may choose to become part of a Circle of Support if invited by the person they are advocating for, or may feel that such involvement could create a conflict of interest.

There are two stages in Circles of Support.

Stage 1. Identifying the current circles of support We can use this to show our relationships (see page 116).

Circle of intimacy
This is the innermost circle and includes the people closest to you. It represents the people you cannot imagine not being around, even if you don’t see them all that often. This may include family members and close friends.

Circle of friendship
The second circle includes the people we think of as friends in the real sense of the word. People we confide in, rely on, borrow money from, laugh and cry with. Sometimes it is people who almost made the first circle.

Circle of participation (or association)
The third circle includes all the people we meet on a daily basis, people who work in our office or whom we used to work beside, old school friends, people we meet when following our hobbies or interests, people who always say “hello” even though we don’t know their first name.

Circle of exchange
This outer circle includes all the people who are paid to be in our lives – either directly by us or because they provide us with a service. This might include our doctor, dentist, childminder, hairdresser and plumber.

When using this approach, it is not uncommon for people to list mental health workers in one or other of the first three circles. Without disrespecting the positive nature of many such relationships, it is worth reflecting on why this might be the case. For instance, would these workers remain in contact if they moved job? Do they chat on the phone late at night or invite the person to dinner or to see a film?
Sometimes people have so few valuable relationships that workers are closer to them than anyone else, but adding names of staff into a circle to which they may not belong paints a misleading picture.

Circles of Support organises around the person at the centre of the circle – the focus-person. The people in the circle do the things that come naturally to true allies. They listen – not in the way that people do when consulting, but in the way that friends do. They help people solve problems by thinking together, bouncing ideas around, checking things out and by going back to the drawing board over and over again. They pull in favours, put themselves out, and use their contacts. Sometimes they act together and sometimes each person works alone. A circle that works effectively can pool skills, ideas, and connections. Most problems are more-easily solved this way.

Stage 2. Building a circle for the future Once you know who is in someone’s Circles of Support, you can look at the gaps.

Adding the types of people who are missing
We usually find life easier when we have a few very close friends and a larger number of associates.

- Does this person have people in each of the circles?
- If someone has very few intimate friends, these people are likely to emerge over time from within a bigger pool of associates.
- People have found that starting with someone’s hobbies and interests, then contacting groups who share these interests, is a good way to build up networks of associates.
Most of us get on better in life when we have a mix of people who share our circumstances and people who have different backgrounds. This is the difference between “bonding” social capital – friends who share our background or circumstances – and “bridging” social capital – people who have different connections and so can put us in touch with or draw on their wider social networks.

- Does this person’s circle have a mix of people from similar backgrounds to themselves and people from other backgrounds?
- Again, these contacts often come through friendships built around a hobby or interest.

Looking at the range of experience and interests
Are there people in the circles who can help the person with the range of issues that are important to them at this stage in their recovery? For example, if someone wants to get a job, are there people who can help them think about employment, prepare for it, present their experiences and strengths in a positive light and support them when they start work? If someone wants to get fit and improve their physical well-being, are there people who are interested in physical fitness? Do some people know about local sports facilities? Is there someone who will go with the person as they start getting involved in new activities?

- What are the issues that are important to this person?
- Are there people in the circles – as friends or paid – who share an interest and can provide support?
- Do they need someone with particular expertise?
- Members of a person’s circle can be asked to draw on their social and work contacts to help make new connections.
Activity 4.6
Fill out your own Circles of Support and share your reflections with your friends or colleagues.

Think about someone you support – what would their Circles of Support look like?
How would you go about recruiting individuals to fill in the gaps?

Circles of Support may be of particular use when working with people who are especially at risk of exclusion or of having their views ignored.
4. Conclusion

Person centeredness is an integral part of recovery focused practice.

The essentials – centring on the person, starting with gifts and strengths and not deficits, seeing people through positive lenses – apply in any situation.

The more detailed tools that help someone describe or plan what they want are designed to work in particular situations, and some thought is needed to ensure that they are the best option for this person at this time and in these circumstances.

Using person-centred approaches draws on people’s experiences (that is, the experiences of all involved) and skills from many parts of their lives.

On the face of it, this may not seem to be so different from more traditional approaches or other ways of describing or thinking about recovery. But person centredness, and person-centred planning, are fundamentally different from many other approaches because they start from a different place, placing the person at the centre and focusing planning on achieving the hopes and aspirations identified by the person. As a result, they can be expected to challenge the values and actions of mental health workers and of organisations.

There is a risk that people will start using person-centred approaches, but then pull back because it feels too uncomfortable or is too challenging. As a result, the potential benefits for people who have fewer opportunities in their lives get lost.

It is the values and approaches of person centeredness that support and sustain people as they start working in this way. Remember your gifts and strengths; get friends and other people who can help around you, and think of the bigger picture and the longer term.

Learning into practice

Before moving on to the next module, spend some time reflecting on what you have learned in this module. You may be reassured by some of the things you have encountered in this module. It is worth taking some time to think about how your existing practice matches what we have discussed in the module.

Some of what you have learned may be new to you or perhaps more challenging. Make a note of the changes you will make to your practice now that you have completed this module.
Resources to support further learning
The Person Centered Planning Education Site, Cornell University
The Person Centered Planning Education site has a free-to-access person-centred planning course. The course content covers all of the planning tools referred to in this module and includes information, activities, quizzes and further reading. www.ilr.cornell.edu/edi/pcp

Circles Network
This is a UK-based voluntary organisation providing Circles of Support. A particular section of their website provides brief information about person-centred planning tools with some examples that include graphic illustration. www.circlesnetwork.org.uk/what_is_person_centred_planning.htm


In this document, Pete Ritchie provides further information about the values underpinning person-centred planning. The document includes a case study that features a man with mental health problems (living in Edinburgh) and describes the difference person-centred planning has made to his life. www.scmh.org.uk/pdfs/wfsi_person-centred+planning.pdf

References


Module 5

Sharing responsibility for risk and risk-taking

Welcome to Module 5

This module aims to help you explore the interface between ESC 5 – Promoting Recovery and ESC 9 – Promoting Safety and Positive Risk-taking. It will also build on the ideas explored in Module 2 of The 10 Essential Shared Capabilities (Scotland) (ESC(S)) learning materials.

Learning outcomes

After completing the module, you should be able to:

- evaluate service-led approaches to risk and risk management and the impact they have on recovery focused practice
- critically reflect on perception of risk from a service user’s point of view compared with organisational definitions of risk
- recognise the importance of risk-taking within the person’s recovery journey
- involve service users in decision-making about organisational risk and risks identified by the service user
- provide support and encouragement to service users during periods of risk-taking, particularly when things do not go as planned.

Estimated time to complete learning activities: 6 hours

SCQF Level 9

Module authors

Rachel Perkins and Kim Goddard, South West London and St George’s Mental Health NHS Trust
Contents
1. Introduction 125
2. What influences judgements about risk? 127
3. Beyond violence and suicide: the range of risks in everyday life 129
   Differing perspectives on risk 129
   Inter-relationships between risks 132
4. Organisational approaches to risk 133
5. Sharing responsibility for risk 137
   Risk-sharing at an individual level 137
   Risk sharing at an organisational level 140
6. Supporting someone in taking risks 142
   Adopting a problem-solving approach 142
7. Conclusion 146
   Learning into practice 146
Resources to support further learning 147
References 147
1. Introduction

In Module 1, we identified “risk-taking” as one of the key elements of recovery and highlighted the need for a shift away from a service-defined approach to risk. In this module, we will explore this further and examine:

- differing perceptions of the nature of risk
- different risks people encounter
- ways of involving people in decision-making around risk
- helping people to maximise success
- supporting people when things do not work out as planned.

When we think about “risk” in relation to mental health problems, the danger that a person may pose to other people – aggression, violence, homicide – and the risk the person poses to him or herself – self-harm, self-neglect, suicide – are often the first things to spring to mind.

Rarely does a day go by without newspapers talking about increasing levels of violence in our communities, and headlines linking violence to mental health problems are rife (Philo et al, 1996). Here are some examples:

“Knife maniac freed to kill. Mental patient ran amok in the park”
Daily Mail, 26 February 2005

“Maniac on the loose. Town in terror”
Glasgow Evening Times, 27 January 2005

“Nothing could stop me killing Nanette. Inside the mind of a maniac: twisted Mone’s letters to his young victims”
Scottish Daily Record, 19 December 2007

People with mental health problems are actually at much greater risk of being attacked or raped and are far more likely to be victims of violence. The proportion of murders committed by people with mental health problems has fallen substantially since the introduction of care in the community, but this is not the prevailing perception.

Mental health services are under considerable political pressure to minimise the perceived dangers people with mental health problems might pose to others or themselves. This leads to a preoccupation within organisational policies and procedures on minimising risks of violence, aggression, self-harm and suicide to the exclusion of other types of risk that may be important in the context of recovery, such as vulnerability to exploitation or abuse and social isolation.
The result is the creation of a culture in which individual staff feel blamed if things go wrong. They
then become averse to taking risks of any sort, at the expense of attending to the individual and his
or her situation, wishes, concerns and aspirations. Risk aversion produced by this cultural climate
often goes well beyond issues of physical danger to encompass well-meaning but misguided efforts
to “protect” people from the risk of failure. As Repper and Perkins (2003) state:

“The logic runs that people with mental health problems have often experienced many
failures, which have eroded their self-esteem. Further failures must therefore be avoided as
these would further diminish their confidence.”

People who have experienced serious mental health problems may understandably be reluctant
to take risks for fear of worsening their problems and encountering prejudice from people outside
services. They may also fear losing what little they have, such as losing their welfare benefits if they
take the risk of going to college or seeking work. Families may also fear that their loved ones
might relapse if they try to do challenging things and be concerned that ideas about recovery may
create “false hope”.

Yet one of the biggest barriers to recovery is low expectations (Social Exclusion Unit, 2004). It is all
too tempting to give up on yourself if everyone around you thinks you will never amount to much.
Without hope, there can be no recovery.

Mental health workers’ low expectations around topics such as the ability of people with mental
health problems to find employment can be particularly destructive of hope (Perkins, 2005). The
likely result is that few people with mental health problems will be in work, completing a vicious
circle of low expectation leading to low achievement.

Mental health workers’ expectations in this field, however, are not accurate. In one study, 40% of
people with mental health problems who were in employment had previously been told by a mental
health professional that they would never be able to work again (Rinaldi, 2000).

Rogers (1995) claims that this kind of self-fulfilling prophecy does great damage, stating:

“when people are told they are worthless, they believe it. By the same token, tell people they
are valuable members of society – at least potentially so – and that is what they will believe.”

The avoidance of risk too readily leads to people having no roles other than that of “mental patient”,
and no contacts outside mental health services. Our job must therefore be to support people in
taking positive risks.

Recovery necessarily involves taking risks. People cannot explore their possibilities and potentials
or pursue their dreams and ambitions without taking risks. If we see our role as protecting people
from risks, rather than supporting people in taking risks, we are not helping them in their journey of
recovery.

Recovery involves being in the “driving seat” of your life. If we see our role as assessing and
managing risk for people, rather than helping people to evaluate the risks they are taking and work
out ways of minimising them, we are not helping them in their recovery journey.
2. What influences judgements about risk?

The box below sets out a number of factors that may affect our judgements about risk-taking.

- **Existing knowledge** about the risks associated with different events and courses of action. “Ignorance may be bliss” in some circumstances, but lack of information also stops us making informed choices.

- **The particular circumstances.** You may not be fearful of going out at night on your own, but a spate of muggings in your area might cause your judgement of the risk to change.

- **Prejudices and preconceptions.** Our attitudes and preconceptions can influence the judgements we make (as we explored in Module 2). Additionally, media stereotyping often makes people scared of people with mental health problems in general and some groups in particular.

- **The degree of control you have over risks.** If you are driving a car, you have more control over what happens – and may therefore be prepared to take greater risks – than if you are a passenger.

- **Previous experience.** If you have had a bad experience in the past, you are likely to be wary of taking a similar risk in the future. On the other hand, if everything has turned out right for you up to now, you may underestimate the possible downsides of your actions.

- **Whether others are affected.** You may be more wary of taking risks that affect other people. Many people are prepared to face the risks of smoking, but not if it affects others, like their children.

- **Proximity and timescales.** You may know that it is sensible to save for a pension for retirement, but retirement seems a long way off when you are young and the risk of not saving for your pension seems small.

- **Skills, confidence and self-esteem.** You may be more likely to take risks if you are confident in your abilities.

### Activity 5.1

You are about to get in a car and drive to work. List the things that might influence your judgement about the risks involved in doing this.

You may have included how confident a driver you are, how long it is since you had an accident, whether you are tired or had been drinking the night before, the condition of the car, the condition of the roads and so forth. You might also have considered more general risks, such as the impact of car journeys on global warming.
Judgements about risks are always influenced by individual circumstances and perceptions – and everyone’s perceptions and circumstances differ. We should therefore:

- consider individual concerns and circumstances
- explore perceptions of risk from the individual’s perspective.

Your perceptions, values and beliefs are critical in your judgement of risk. The risk of failure may seem worse if you are particularly ambitious. Increasing your carbon footprint may be important to you if you believe global warming is a danger. And your judgement about the risks posed by particular “signs” might be affected if you are superstitious.

But what if you have beliefs and perceptions that no-one else appears to share – those things often labelled “delusions” and “hallucinations”? You may then view risk differently from others. You might be wary about turning on the TV if you believe it is inserting thoughts into your head. Or you might want to refuse food in hospital if you believe you are being poisoned.
3. Beyond violence and suicide: the range of risks in everyday life

It is often assumed that risk is a “bad thing” to be avoided wherever possible. This is not the case. We all face risks every day of our lives. If we avoid the risk of being turned down for a job, we would be permanently unemployed. If we avoid the risk of being rebuffed, we would never have any friends.

The challenge we all face, whether or not we have mental health problems, is not to avoid risk, but to maximise our chances of success and manage possible negative consequences should they occur.

Differing perspectives on risk

Typically, risk assessments in mental health services are conducted by mental health workers. Other people involved – service users, their friends, family and carers, managers, politicians, the general public – may all identify very different risks.
Activity 5.2

In considering risk and risk-taking, it is important to understand things from the point of view of the different people involved, and we frequently have to balance different perspectives.

Think about your contacts with service users, their friends, family and carers, direct care staff, managers and directors of mental health services, politicians and the general public. If you were to ask each of these groups of people, “What do you think are the three most important risks associated with mental health problems?”, what do you think they would say?

| What might be the three major risks associated with mental health problems? | From the point of view of service users. | 1. |
| | | 2. |
| | | 3. |
| | From the point of view of friends, family and carers of people with mental health problems. | 1. |
| | | 2. |
| | | 3. |
| | From the point of view of direct care staff in mental health services. | 1. |
| | | 2. |
| | | 3. |
| | From the point of view of managers of mental health services. | 1. |
| | | 2. |
| | | 3. |
| | From the point of view of politicians. | 1. |
| | | 2. |
| | | 3. |
| | From the point of view of the general public. | 1. |
| | | 2. |
| | | 3. |

Service users might identify prejudice and discrimination from other people as a major risk, while the general public may identify fear of perceived threats of violence from people with mental health problems. Friends, families and carers might focus on the disruption to relationships mental health problems can cause and may be concerned that their loved one will refuse treatment. Direct care staff might feel that they are so bogged-down in paperwork that they cannot give service users the care they need, while managers might worry that staff are not doing the paperwork to the standards required by commissioners and inspectors. And politicians may worry about the cost to the NHS of providing a mental health service, and the cost to their political careers if too many “bad news” stories linking mental health and crime find their way into the media.
Different evaluations of risk can lead to different – and sometimes incompatible – ways of managing risk.

The “general public”, for instance, may demand that vulnerable people are kept in a safe place so they can receive care and the risk of violence to other people is minimised. But this may not be compatible with service users’ desire for self-determination (which is compromised by compulsory hospitalisation), or with politicians’ aims to reduce the cost of mental health services.

Conflicting judgements about risk and the way it can be minimised can mean that mental health workers are faced with multiple and seemingly contradictory demands.

Take, for example, a young woman who is attending a day centre but really wants to go back to work.

Mary is adamant that she wants to make something of her life and start earning some money so she can get her own place and travel. She rightly believes that her problems are well under control, feels that she is ready to move on, and is asking staff to help her to try and find work.

But her parents are worried about the idea of Mary seeking work. She was working when she developed her mental health problems and they are convinced that the demands of her job caused her difficulties in the first place. They are fearful that the stress of seeking work may exacerbate her problems and that she will be left worse off because she will lose her benefits. They appeal to staff not to assist her in her quest for work.

Or take the example of James, an inpatient on a ward.

James’ parents want his girlfriend to be banned from visiting him because they are worried that she may be giving him illegal drugs. Hospital managers are similarly concerned about the risks drugs may pose to James’ health and are also aware of the risk of stories about drugs on wards appearing in local newspapers.

James understands some of these concerns, but his primary focus is on quite different risks. He is worried about the risk of losing his regular supply of drugs and is also worried about the risk of losing his girlfriend. If she is not allowed in to see him, maybe she will dump him and go off with someone else. He is right to worry: social isolation exacerbates mental health problems.

While the risks identified by James’ parents and hospital managers may be different, they agree on the solution: banning the girlfriend from visiting. But this is not compatible with James’ wishes. The example shows that there can be conflict between organisational and service-user perceptions and approaches to risk.
**Inter-relationships between risks**

Every course of action carries risk, and minimising one risk is likely to increase others.

To take the example we used above, banning James’ girlfriend from the ward will reduce the risk of him using drugs while in hospital, but other risks will be increased. For instance:

- the risk that he will lose his partner and become socially isolated
- the risk of him absconding so he can see his girlfriend
- the risk that his relationships with staff will deteriorate
- the risk that he will become reluctant to accept help with his difficulties, including his drug problems
- the risk that he will take drugs again on discharge because he has not learned ways of dealing with situations in which he is offered drugs.

The challenge is to evaluate the costs and benefits of different courses of action. These depend on individual circumstances, preferences and ambitions and the likelihood and impact of things failing to turn out as we hope.

We should note that this conflict is not always characterised by service users wanting to take risks while mental health workers avoid risk-taking. For example, sometimes service users will request a higher level of support at times when they feel unsafe. For some service users, recovery itself may be perceived as a risk that might involve losing support, developing a new identity and moving beyond familiar mental health services.
4. Organisational approaches to risk

“A focus on professionally led approaches to risk assessment and management may ... ignore or underplay risks that many service users see as important, such as the disempowering aspects of much mental health provision and the over-emphasis on medication to support individuals experiencing distress.” (2004, Langan and Lindow)

Health and safety requirements and policies on risk that guide organisational practice have generally been based on past events. When an untoward incident occurs, a new set of policies and procedures is developed to try and prevent it happening again. We must all learn from experience in our personal and professional lives, but this approach is not without its problems.

There is also a tendency in organisational approaches to confuse “risk” with “certainty”. It is assumed that if you have done your risk assessment and instituted an appropriate management plan, “bad things” will never occur. This is a mistake: risk can never be reduced to zero, no matter how hard we try.
Activity 5.3

In previous modules, we have identified some of the factors that are important in promoting recovery:

- **Hope** – helping people to believe it is possible for them to live a decent life
- **Control** – being in the “driving seat” of your life and becoming an expert in your own self-care
- **Opportunity** – having the chance to do the things that are important to you.

Think about some of your organisation’s policies and procedures for managing risk. It may have an “absent without leave (AWOL)” policy, for instance, stating what to do if someone leaves the ward or fails to return when expected, or a “did not attend (DNA)” policy specifying what to do if someone fails to turn up for their appointment. If the organisation you work in has neither of these policies, you might want to locate another policy example such as a “lone working policy”.

Select one of these policies and think about ways in which it might:

- make people feel more hopeless, rather than more hopeful
- reduce people’s control over their life and problems
- prevent people from doing things that are important to them.

<table>
<thead>
<tr>
<th>Policy title</th>
<th>Ways in which this policy makes people feel more hopeless.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Policy title</th>
<th>Ways in which this policy might reduce the control people have over their life and problems.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Policy title</th>
<th>Ways in which this policy might prevent people from doing the things that are important to them.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you looked at the “did not attend (DNA)” policy, for example, you might have thought about:

- ways in which the policy might reinforce the “patient role” and the belief that people are unable to look after themselves
- how the policy takes control away from people by removing choice over attendance, reinforcing the idea that someone is monitoring what they do rather than helping them to manage their own problems
- how attending the appointment may have stopped the person doing something else, such as going to work or going on holiday.
Mental health workers, however, cannot simply help people to do whatever they want regardless of the consequences; nor can we ignore organisational concerns. As Morgan (2000) states, risk-taking is not negligent abdication of clinical responsibility. Rather, it is about “making good-quality clinical decisions to support and sustain a course of action that will lead to positive benefits and gains for the individual service user.”

As mental health workers, we can explore how policies can be made more sensitive to individuals’ safety needs and assist them in their recovery. When monitoring of a person’s mental state is required, for instance, we could involve the person in the monitoring process. The person would consequently gain more control over their difficulties and learn to better manage problems in a way that assists, rather than detracts from, the recovery journey.

We could agree, in a way that is meaningful to the person, what signs of deteriorating mental health might be important. For example, “loss of concentration” might be experienced as “not being able to read a magazine” or “flicking through the television channels and not being able to sit through the whole of a programme you usually enjoy”. The person’s self-monitoring is likely to be more accurate if they are monitoring signs that are relevant to them.

Activity 5.4
Think about the policy you explored in Activity 5.3.

<table>
<thead>
<tr>
<th>How might you be able to implement this policy in a way that ...</th>
<th>fosters hope?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>helps people to take back control over their life and problems?</td>
</tr>
<tr>
<td></td>
<td>enables people to do some of the things that are important to them?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>How would you recommend that this policy be changed to address the concerns of the organisation and better ...</th>
<th>foster hope?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>help people to take back control over their life and problems?</td>
</tr>
<tr>
<td></td>
<td>enable people to do some of the things that are important to them?</td>
</tr>
</tbody>
</table>
If you looked at the “did not attend (DNA)” policy, you might have considered:

- ensuring people understand that monitoring of attendance will not always be needed, and agreeing why it might be helpful to monitor for a while
- making it easier for people to ask for help outside regular appointments and negotiating appointments around other commitments (like college, work, childcare, social occasions, faith activities and holidays).

And to better promote recovery and address the concerns of the organisation, you may have considered:

- ensuring that the policy explicitly recognises the way in which monitoring might be seen as demeaning and disempowering, rather than supportive
- including explicit reference in the policy to agreeing with the service user indicators that monitoring is no longer needed
- putting a requirement in the policy that people be given a choice over appointment times and identifying other commitments so that appointments can be made around these
- including a requirement to negotiate with the person how they can tell when things are going wrong and how to seek help between appointments.
5. Sharing responsibility for risk

Traditionally, mental health workers have been concerned with compliance – ensuring that people with mental health problems follow the advice and prescriptions of the professional experts, especially in the area of medication. Indeed, therapies have been developed to increase compliance (Kemp et al, 1996).

Ideas about compliance are rooted in a kind of “medical paternalism” in which the expert tells the patient what is best for them. This is incompatible with recovery.

Having completed some of the other modules, you will be well aware that our task as mental health workers is to help people to become experts in their own self-care, to assist them to explore what they want to do and to identify any help they need. An essential element of the support we provide is to help people to evaluate the risks associated with different possible courses of action, assist them in working out ways to maximise their chances of success, minimise the disruptive impact on their lives if things do not go as planned and support them in taking the risks involved in pursuing their ambitions.

But services may not be geared to this kind of approach, as the following quotation from Journeys of Recovery (SRN, 2006) suggests.

“The thing that hindered me the most on my recovery is mental health services as they are. Services are geared towards care and containment and to prevent you becoming a danger to the public. It’s not about making you a fully functioning member of society; it’s about making you compliant … I never had a life before, but I’ve taken more chances in the past two years than I’ve ever done. I always swore I’d never ever live with anyone again, I’d never go out with anyone again, never have sex, never do anything! Just be a boring old maid, the spinster of the parish! But I did, I fell in love, got a job, a full-time job mind you!”

Mental health workers and service users must work together. Many mental health workers are involving service users in aspects of treatment and support, but risk assessment and management too often remains a professionally-led affair. Service users consequently may not even be aware that risk assessment and management is part of their treatment.

Service users need to be involved in decision-making at individual and organisational levels. This means they must be involved in risk assessment and individual risk management plans, with mental health workers and service users jointly identifying the risks associated with different courses of action and seeking ways to enable the person to gain control and do the things they want to do. They must also be involved in decisions about the development of policies and procedures, design of buildings and implementation of legal requirements and regulations.

Risk-sharing at national level is also important. People should be encouraged to become involved in the development of national policies and guidance relating to risk.

Risk-sharing at an individual level

Mental health workers should be able to speak frankly with service users about risk and risk assessment. Some mental health workers may find this difficult, especially when it relates to risk to others and suicidal intentions (Langan and Lindow, 2004).
Activity 5.5

Think about some of the people with whom you have worked.

Why might it be desirable to talk to someone about risk and risk assessment?

Why might it be difficult to talk to someone about risk and risk assessment?

<table>
<thead>
<tr>
<th>Reasons it might be desirable to talk to someone about risk/risk assessment.</th>
<th>Reasons it might be difficult to talk to someone about risk/risk assessment.</th>
</tr>
</thead>
</table>

Make a note of your own thoughts and then discuss your views with others.

Langen and Lindow (2004) suggest a number of reasons for frank discussions around issues of risk. These include:

- increasing understanding of any triggers
- helping the person to understand the reasons for professional involvement
- assisting in a collaborative relationship to minimise risk
- creating better understanding of likely risk
- understanding risks the person may see as important that the worker might not otherwise have considered.

They also indicate a number of reasons why mental health workers find such frankness difficult. These include:

- lack “insight” (does not agree with the worker about the risks)
- think that the worker is concerned only about risk rather than support or care
- disengage from services, with discussion of risk alienating the person
- feel that discussion of risks increases feelings of stigma
- feel that discussion of risks may encourage the person to act on them (for instance, that discussing suicidal feelings may increase the likelihood that the person will act on these feelings)
- have fears about their own safety.
The way in which risk is discussed with a person may also be important. The location, timing, language and range of issues discussed must all be considered.

Activity 5.6

Think about things you could do to make it possible to have frank discussions with a service user about risk – when to talk about it, where, what and how?

You might have included things like:

- ensure privacy – do not have conversations where others can hear what is being said
- do not talk about risk when the person is very distressed
- make it clear that everyone has a risk assessment and you are not singling out the individual
- discuss and record ALL risks – those you identify and those the person identifies
- think about the language you use – maybe put the service user's behaviour in context and/or explain how others may see the person; for example, you might say “because you are a big bloke, some people may be frightened of you when you get annoyed or shout, even if you don’t mean them any harm”
- try to discuss and understand why the person may have behaved in the way they did (perhaps they felt disrespected, or frustrated, or angry about being in hospital)
- include the person’s own account or explanation of their behaviour
- discuss the context of the risk – some risks are only present in certain situations or when the person is very distressed
- establish the accuracy of information about risk, and its severity, as far as you can.

Understanding why the person behaved as they did is important in helping them reduce risk, whatever risk that might be (violence, exploitation, self-harm). In drawing up a plan to manage the risk, we must consider not only what staff might do, but also what the person might do to minimise the risk. This can be achieved as part of enabling a person to develop a personal recovery plan, perhaps a Wellness Recovery Action Plan (WRAP) that we discussed in Module 3.

There may be some occasions when things continue to escalate and the person will need help from others to keep safe. Individuals can continue to share responsibility for the treatment and support they need at such times by drawing up an Advance Statement outlining the sort of help they would like if they are not able to look after themselves and need help to keep safe.
Risk sharing at an organisational level

The box below sets out a number of areas in which people who use services might usefully share in decision-making about risk at an organisational level.

**Operational decisions.** People who have experience of using services can contribute a great deal to the identification of risks and development of policies, procedures and ground rules for different parts of the service. For example, former inpatients might have important ideas about how safety can be increased on wards, how the availability of drugs might be controlled, how access to tea and coffee-making facilities can be improved with minimum risks to safety, how information-sharing protocols and rules governing leave can be developed and what procedures should be followed if a person misses an appointment.

**Audit and inspection of safety and policy compliance.** Service users are often in the best position to report how policies are implemented, identifying adverse, unintended consequences of policies and procedures and suggesting ways to minimise their effects. For example, it is common practice to search people’s possessions for potentially dangerous objects when they enter an inpatient facility. This can feel a very prison-like procedure for those on the receiving end. It is obviously important to ensure that dangerous objects are not available on wards, but service users are well placed to advise on how searches can be conducted in a sensitive manner as part of the process of helping a person to settle in. They can also contribute to local audit and inspection arrangements.

**Investigations into incidents.** Investigations and enquiry panels established to investigate serious incidents are generally seen as the province of professionals, but once again, service users – with the different perspective on services they bring – often have a significant contribution to make. Training that workers undertake to prepare them for these tasks should also be offered to service users.

**Strategic decisions.** Those who have used services can make important contributions to considerations of risk in, for example, the design of new inpatient and residential facilities (balancing a homely and welcoming environment with safety considerations, for instance).

**Training.** The importance of involving service users in staff training is widely recognised, but it does not always extend to training on risk assessment and management, de-escalation of difficult situations and the management of violence and aggression.
Activity 5.7
Think about any training you have received in risk assessment and management, de-escalation and management of violence and aggression.

If service users were not involved in this training, consider the different ways they could have been and what you might have gained from this involvement.

If service users were involved, think about how they were involved, how it could be extended or improved and what you gained from this involvement.

<table>
<thead>
<tr>
<th>How might service users have been involved or how could their involvement be extended and improved?</th>
</tr>
</thead>
<tbody>
<tr>
<td>What might/did you gain from this involvement?</td>
</tr>
</tbody>
</table>

Often it is assumed that service-user involvement should take the form of presenting examples of their own experiences to learners, but there are many other possibilities. They can be involved as consultants or facilitators within education and training sessions, reflecting on different suggestions and approaches, running aspects of the programme and taking part in role plays.

Direct delivery of training is not the only useful contribution service users can make to staff education. They can also be involved in:

- designing courses
- preparing course materials (including the preparation of DVDs)
- evaluating the performance of trainees as part of the assessment process
- evaluating the content and delivery of courses from a user perspective.

Compton and Morrill (2006) provide a good example of service user involvement in education. They evaluated staff training in “risk assessment and management” and “control and restraint” that involved service users attending the training programmes and making recommendations for change. The service users, whose recommendations were subsequently implemented, saw that the focus of the training was almost exclusively on risk to others from the person and suicide risk. They called for vulnerability to exploitation and abuse by others and self-neglect to receive equal weight; indeed, they suggested that the training be renamed “vulnerability and risk assessment and management”.

The service users also noted that while the need for staff debriefing after a violent incident was covered by the training, the need for debriefing of the individual concerned (for whom restraint would be a traumatic and devaluing experience) and for others who may have been in the situation (who may find witnessing violent incidents frightening and traumatic) was not included.
6. Supporting someone in taking risks

Risk-taking cannot be avoided in the recovery journey, and people who are on that journey often find support useful not only during the process of taking risks, but also at a number of different stages, including:

- **at the start of the process**, when the person is deciding what to do, how important it is to them, the courses of action available and the relative risks involved in each, and ways of maximising chances of success and mitigating risks
- **at the end of the process**, when the person reviews what went well and what did not, and identifies what can be learned from the experience.

People with mental health problems may look to friends, family and carers for this kind of support, but mental health workers also have a significant role to play. Supporting people during periods of risk-taking is essential if mental health workers are to actively promote recovery.

**Adopting a problem-solving approach**

Once a person has decided on their goal, there are likely to be various options for moving forward. The challenge is to weigh up the benefits and risks and decide which route to take.

A modified version of a basic problem-solving approach might be useful for this (Falloon et al, 2007). It involves a number of stages.

1. **Identify the goal to be achieved.** This may be in any area of life, like taking a college course, getting a pet, going on holiday, moving into a flat or approaching someone and asking them out.
2. **Identify the different possible courses of action to achieve this goal – including deciding not to do it.** Before deciding how to proceed, it is sensible to help the person to think through all the different things they could do to pursue their goal. It is best not to be selective at this stage – write down every possibility.
3. **Consider the benefits and possible risks associated with each course of action identified.**
4. **Decide on which course of action looks most promising to try first.** This can be achieved by looking through the lists of benefits and risks and seeing which might have the greatest benefits and the least risks.
5. **Think about the ways in which the success of the chosen option can be maximised and the impact of risks minimised if things do not turn out as expected.**
6. **Make a decision whether to proceed.** The person might decide that the benefits are too improbable and the risks too great – in which case you can go back to the list you developed in Stage 2 (above) and think through a different option.
7. **Make detailed plans for proceeding with that chosen option.** Agree what the person is going to say and do, when, where and how, and set up the supports they will need.
8. **Review and further action.** If things turn out as hoped, it is important to recognise and learn from the success and decide what to do next. If things do not work out, it is important to identify what can be learned and support the person to recognise that it is not the end of the world, and that they can either try again or try something new. Support is vital at this stage: people need someone to believe in them and mental health workers have an important role to play in doing this.
Activity 5.8

As mental health workers, we may be faced by situations in which someone wants to do something that has not worked out in the past. Take a look at the following example.

John really wants to go overseas to spend a week with his family. He has contacted them and they are happy for him to visit. He is doing well at the moment and his mental health worker, Andy, can see no reason why he should not visit.

However, when Andy discusses this with his team they feel John should be dissuaded from going. They tell Andy that when he visited his family overseas three years ago, it was “a disaster”. He did not take his medication (he said he had forgotten about it) and when he came back, he relapsed and spent the following two months in hospital. As he is doing so well at the moment, they are fearful that visiting again would set him back.

John, however, remains keen to go.

There is obviously no one “right way” of proceeding in John’s case, and there are clear risks and benefits associated with any course of action.

In this situation, Andy took the approach of discussing with John:

- the benefits and risks of visiting his family (seeing his family and becoming closer to them, versus risk of relapse, hospitalisation and damaging the progress he had made)
- the benefits and risks of not visiting them (consolidating the progress he had made, versus becoming further estranged from his family and feeling more socially isolated).

John decided that he really would like to proceed with the visit, so Andy explored ways of decreasing the risks. This involved looking at the support he had received during his last visit and considering, with John, things that he felt might reduce the risks and increase the chances of a successful visit. They decided to:

- arrange for the visit to be shorter
- create a specific plan for dealing with any crisis that might occur during the trip
- try a “dosette” box for John’s medication to aid his memory; John had also decided to discuss his medication with his family
- give Andy’s number to John and his family so they could call if they were worried or had any problems, and a local number to call in case of emergencies
- have Andy go with John to the airport and meet him on his return
- set up a visit from Andy during the week after the visit to discuss how the trip had gone.

Think about the approach you would take in this situation and what you might do.
The team cautiously agreed to these arrangements. Although John found the visit stressful at times, he was really pleased to have done it and feels more confident about future visits.

In the learning activity below, a service user has identified an activity that she feels is important for her recovery but needs some support to achieve.

**Activity 5.9**
Sharon is a 20-year-old woman who currently lives in supported accommodation. Support workers visit her three times a week and support her with budgeting, shopping and cooking. The organisation that provides support for Sharon uses person-centred planning to enable them to provide the support that Sharon needs.

At a recent review of her support plan, Sharon stated that she felt some of the tasks the support workers had been helping her with were now things she could do on her own. However, she feels that she needs some support to enable her to pursue the things she used to really enjoy. In particular, Sharon would like a support worker to go with her to a nightclub that she used to go to regularly. She had previously enjoyed nights out at this club with friends but had subsequently lost touch with these friends and is worried that she might find the noise and crowd difficult to handle.

You may want to use the problem-solving framework we discussed on page 142 when thinking about the following questions. We recommend that you discuss this activity in a group.

In the above scenario, what do you think are the risks involved from Sharon’s perspective of:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. going to the nightclub;</td>
<td></td>
</tr>
<tr>
<td>2. not going to the nightclub.</td>
<td></td>
</tr>
</tbody>
</table>
As we stated in Module 1, recovery involves more than mental health services. Being able to pursue interests and make use of facilities in communities is key to recovery and it would appear in this instance that going to the nightclub is important to Sharon at this point on her recovery journey.

Situations like this, however, really test staff and organisations’ ability to support service users to achieve their goals. While some organisations may be prepared to allow staff to accompany Sharon, the majority are more likely to say that this would be outwith the remit of their organisation and look for other ways to support Sharon with this.

While in this instance it might be better to enable Sharon to find other sources of support, this kind of scenario reminds us that “sharing responsibility for risk and risk-taking” is not just about organisations being more open about how they perceive and deal with risk, but is also about working in partnership in ways that recognise the importance of risk and risk-taking for everyone involved.

What do you think the risks involved in accompanying Sharon would be from the point of view of the organisation supporting Sharon?
7. Conclusion

Positive risk-taking is central to recovery. Recovery involves taking back control over your life, your destiny, your problems and the support you receive. It is also about taking back control of the risks you take and the ways you manage them.

The following conclusions can be drawn about risk and risk-taking.

- Risk and recovery are intimately intertwined, and there are no easy solutions or “right answers” in risk-taking.
- Risk is not a “bad thing” to be avoided at all costs. Risk is part of everyone’s life, and it is only by taking risks that we grow, develop, fulfil our potential and pursue our ambitions.
- Risk in relation to mental health is not all about violence and suicide. It is also about social isolation, institutionalisation, prejudice, discrimination, exploitation, the risk of failure, failing to fulfil potential and use talents – the list is almost endless.
- Risk cannot be eliminated. Assessment and management of risk is a matter of judgement. Decreasing one risk increases other risks, but there are things we can do to help a person to maximise their chances of success.
- Two heads are better than one. If risk assessment is viewed as a purely professional enterprise, we may ignore risks that are centrally important for the person we are trying to support.

Managing risk effectively involves not one expert, but two: the mental health worker, whose expertise comes from training; and the service user, whose expertise comes from their own lived experience. By sharing our respective information and by collaboratively working out the best way of maximising the chances of success while minimising negative impacts when things do not turn out as hoped, we put ourselves in the best position to work out how to enable people to make the most of their lives and pursue their ambitions.

Learning into practice

Before moving on to the next module, spend some time reflecting on what you have learned in this module. You may be reassured by some of the things you have encountered in this module. It is worth taking some time to think about how your existing practice matches what we have discussed in the module.

Some of what you have learned may be new to you or perhaps more challenging. Make a note of the changes you will make to your practice now that you have completed this module.
Resources to support further learning


Langen J, Lindow V. (2004) *Living with Risk. Mental Health Service User Involvement in Risk Assessment and Management*. York, Joseph Rowntree Foundation. This publication reports the results of a research study into the extent to which users are involved in the assessment and management of risk. It comments on users’ and workers’ views about such involvement and provides guidelines for workers, informed by service users, about risk assessment and management.


References


www.scottishrecovery.net/content/default.asp?page=s5_4_10

Module 6

Connecting with communities

Welcome to Module 6

We began these modules by identifying in Module 1 that recovery involves more than mental health services. It is key for people in recovery that they are able to access the same services and community resources as every other citizen.

This final module builds on Module 6 of The 10 Essential Shared Capabilities (Scotland) (ESC(S)) learning materials. It reflects the fact that we each have our own unique way of being included which changes over time and may be more or less satisfying to us. Imposing a particular lifestyle or a particular pace of development on someone will not achieve their inclusion.

Recovery and inclusion is enhanced when we live and work in a place where people see beyond our difficulties, where those around us believe in our potential and recognise our achievements, and where we have access to good support while having our choices accepted and validated. The module focuses on how we can adopt an inclusive approach, which demands that we seek out and talk about the places where community is thriving, and work optimistically to strengthen community life.

Learning outcomes

After completing the module, you should be able to:

- recognise and appreciate the role that community resources (beyond mental health services) can have in relation to recovery
- develop knowledge about resources within the community in which they work and in the communities service users identify with and establish links
- evaluate the barriers that might prevent service users connecting with communities and propose solutions
- demonstrate a commitment to anti-discriminatory practice, respect for diversity and the need to challenge inequalities.

Estimated time to complete learning activities: 6 hours

SCQF Level 9

Module author

Peter Bates, The National Development Team
Contents
1. Introduction 151

2. Values concerning inclusion, service users and communities 152
   Connecting with our own experiences 152
   Recovering hope for communities 154
   The policy context 156

3. Promoting inclusion through your work with service users 157
   Curiosity and disclosure 157
   Assessment 158
   Detailed inclusion assessment 159
   Community mapping 161
   Building an inclusion plan 162
   Taking action 165
   Subtle support 167

4. Conclusion 169
   Learning into practice 171

Resources to support further learning 172
References 172
1. Introduction

In Module 6 of The 10 Essential Shared Capabilities (Scotland) (ESC(S)) learning materials, the concept of social inclusion was presented as assisting people to gain or regain the ordinary things that most of us value in our own lives. Aspects addressed included the following.

- Many people recovering from mental health problems find themselves disadvantaged and excluded – unemployed, isolated, in poor housing and impoverished. Some individuals also experience additional discrimination because of the way other facets of their life are perceived, and this can lead to dual or multiple discrimination. This was examined in Module 5 of the ESC(S) learning materials.
- The social inclusion agenda requires mental health services to find out what kind of participation in the wider community would have meaning and value to the people who use their services and to assist them to engage in these ways.
- Social inclusion needs to be part of your work with people right from the start, and not just added on later. Some people may simply need information and encouragement, while others will require a detailed plan and intensive support to retain, build or rebuild their life.
- This includes supporting participation in communities beyond mental health services and assisting people to engage with mental health services, other helping agencies and peer support.
- Mental health services need to build links with key community organisations such as the local college, Jobcentre Plus, neighbourhood associations, religious groups, voluntary organisations and cultural associations to assist these organisations to provide useful opportunities to people recovering from mental health problems.
- Growing your inclusion-related knowledge and skills should be part of your professional development.

We will now examine some of these issues in more detail in this module.
2. Values concerning inclusion, service users and communities

We introduced you to the Scottish Recovery Network (SRN) narrative research *Recovering Mental Health in Scotland* (Brown and Kandikirira, 2007) in Module 1. One of the outcomes of this research project was the publication of a collection of people’s stories of recovery in *Journeys of Recovery* (SRN, 2006). Below is an extract from one of these stories.

“My recovery started when I ended up in hospital after having taken an overdose. I was in a job that I wasn’t coping with anymore and I had been given one month’s notice. Fairly soon after the actual end of my contract I took an overdose. I was in hospital for four and a half months ... They said it looked as if I had been depressed for the whole of my adult life, which is probably true. Probably since I was 14 or 15 years old. The thing about being in hospital was that the people were nice to me. That may sound really simplistic, but I didn’t have to try. I didn’t have to put on a front because they just seemed to understand how I felt. It also meant I wasn’t on my own anymore.” (SRN, 2006)

The narrator’s account began with an overdose triggered by losing a stressful job and after what appears to have been a considerable period of social isolation. She goes on to describe her own recovery journey towards a full life that includes volunteering, hill walking, shopping, a photography group, friendships and paid employment, alongside a personal development programme, counselling, setting personal challenges and recording achievements.

The shorthand terms “social inclusion” and “the community” clearly embrace a vast array of potential roles and relationships, as well as masking a complex set of barriers, divisions and conflicts. The narrator began with a job, but it wasn’t working for her; after hospital, she was discharged to her flat in “the community” and gradually built up a network of roles in different groups and organisations (the volunteer place, the photography club), but these did not yield ready-made friendships and they continued to need focused attention.

**Connecting with our own experiences**

Like the narrator, most of us have found that the process of becoming socially included has been a long process in which formal and informal roles, activities and relationships intertwine. From time to time we take up new activities and meet new people, but we can also deepen our friendships, fall out or drift apart. It may take years to feel at home in a group, find meaningful ways to participate and acquire a sense of belonging.

If we are to support others who may need assistance in this process, then we need to understand how it has worked for ourselves. This will bring some important insights and also help to ensure that we do not inadvertently impose our experience on those we seek to assist.
Activity 6.1

What does “being included” mean to you? Discuss this with a colleague if you can.

Draw a diagram of your personal network of roles and relationships with others. You may wish to think about family relationships, work and non-work connections, people you know through mental health services and the community beyond the mental health system, formal groups and informal networks of acquaintances and friends.

Consider what your diagram would have looked like five or ten years ago. Guess what it might look like in the future.

For each area of your life you have represented on the diagram, try to recall the history of your involvement. If it is an informal friendship, how did it start? Who introduced you? What happened to deepen that connection? What were the barriers, problems or conflicts that inhibited the growth of the friendship? If it is a formal activity, what started it? What keeps it going?
The narrative project (Brown and Kandirikirira, 2007) found there were six environmental factors that helped to promote recovery journeys. They are slightly edited below (by the addition of items in brackets) to emphasise the universality of these needs that we all seem to share.

- Having friends and family who are supportive, but who do not undermine your self-determination.
- Being told recovery is possible (and/or that you have the potential to move towards your goals).
- Having your contributions recognised and valued.
- Having formal support that is responsive and reflective of your changing needs.
- Living and working in a community where other people can see beyond your illness (and/or any other problems you might have).
- Having your life choices accepted and validated.

You might like to consider how well the network of roles and relationships you have just described in Activity 6.1 meets these needs, and whether the presence or absence of these factors affects your level of satisfaction with this aspect of your life.

If you have had the opportunity of sharing your work on Activity 6.1 with others, this may have highlighted the uniqueness of each person’s journey, the variety of ways in which people can experience a positive sense of participation in the community and perhaps also something of the negative experiences of disappointment, conflict, discrimination or betrayal that can accompany attempts to join in.

A key message is that inclusion works when it is meaningful to the individual and suitably paced, rather than when it is prescribed by someone else. Who says that it must include being employed, engaging in education, attending the gym or having a certain amount of social contact? As another narrator commented:

“I know what I want from life and where I want to be and I am happy and content within myself. My lifestyle’s the way I choose it to be. And if I come up against any barriers I know how to break through them, to work through them.” (Brown and Kandirikirira, 2007)

**Recovering hope for communities**

Varied experiences and our different personalities will affect how we view community. Some of the following images may provide a shortcut to uncovering your own and other people’s beliefs about the wider community:

- community as a rich oasis of opportunity and potential connection (Rapp and Wintersteen, 1989)
- community as a barren desert in which valued roles are rare and few people know one another
- community as an ice age where people need to huddle together for warmth after their short but courageous forays out into the harshness and hostility of the outside world
- community as rough terrain where there are many opportunities and good connections, but also barriers and access difficulties.
Images rather like these may be hidden “between the lines” of people’s experience of community life. For example, our narrator begins her account of her own recovery journey with a description of isolation (the desert) and ends with a rich and varied set of opportunities and connections (an oasis), while acknowledging her own challenges and successes in returning to paid employment and building friendships (rough terrain).

Like the general public, people working in mental health services will express an array of viewpoints about the community in which they live. A strengths and recovery approach, however, challenges workers to choose a hopeful and optimistic mindset in which the positive attributes of both individual service users and of communities are recognised and valued.

It appears that a key step in the narrator’s recovery journey was when she abandoned the barren desert and ice age ideas and set out to find her own personal rich oasis by hopefully and courageously taking responsibility for negotiating the rough terrain. Similarly, mental health workers who are promoting recovery need to seek out and talk to others about the positive opportunities available within communities, while taking a hopeful view that new opportunities can be generated and access to existing ones can be improved.

**Activity 6.2**

People and organisations reveal their ideas of community in all kinds of ways.

Check out the notice board, posters and other information available in any spaces that people occupy while using your service – waiting rooms, corridors, meeting places. What can you discover from this about the way that the community beyond mental health services is being presented? Is it visible at all?
Check the list of useful telephone numbers in the office or in your diary to see which organisations are represented.

Ask people in your team about their community contacts.

Listen to yourself and your colleagues when you discuss community opportunities with service users. Is this hopeful talk?

Activities like this and the images people use may help us to examine our beliefs, but it is important to avoid a simplistic approach. The one certain thing is that each individual’s understanding will be personal to them, will be complex and multi-layered and will probably include contradictions. Women and men may have different experiences, as may people from diverse cultural backgrounds, those with different experiences of education, those who live in different neighbourhoods, and so on. It is therefore important to respect this diversity of opinion and experience.

The policy context
Building local communities in which people using mental health services can find a place, participate as equal citizens and make a contribution is the clear goal of sections 25–31 of the Mental Health (Care and Treatment) (Scotland) Act 2003.

The Scottish Government publication *With Inclusion in Mind* (Scottish Government, 2007) guides local authorities on how to meet their obligations under this part of the Act, in partnership with their NHS board and colleagues from community organisations. People who have mental health issues, personality disorder or learning disabilities have the same rights as other citizens to a respectful welcome and all reasonable adjustments to enable full and equal participation. So responsibility for eliminating barriers and reaching out to provide access to all, including those people who use mental health services, lies with the whole community.

The guidance offers two audit tools. First, there is a “mystery shopper” framework for use by groups of mental health service users who wish to capture, organise and feed back their experience of using community venues, such as leisure centres, colleges or neighbourhood associations. This audit may have particular relevance for groups who may face multiple exclusion, stigma and discrimination, such as women from minority ethnic communities who also have mental health difficulties.

The second audit offers an opportunity for key stakeholders interested in specific aspects of community life to work in partnership.
3. Promoting inclusion through your work with service users

Curiosity and disclosure
In Module 4, we outlined person-centred approaches that emphasise curiosity, arising from recognition of the uniqueness of the individual and a commitment to be person centred. When conducted in an atmosphere of hope, such inquiries assist the person and the worker to obtain a shared sense of what wellness means, and so promote recovery.

We need to take care, however, that we do not underestimate the difficulty of uncovering a true sense of another human being’s ambitions and hopes for their life and what inclusion might mean for them. As Joe Bidder wrote:

“I never told the truth about those days; hid reality behind smugness and false confidence. Never let on I’d been inside. Never spoke about the eight shots of ECT, doses of chlorpromazine, the pain and degradation. Too afraid of the label, afraid of losing my friends, my self-esteem, my job. My family didn’t help – they denied their history: and so it went on and on. One generation mirrors the one before. So I tried to live a life of denial; crept furtively from work to visit the psychiatrist, went to the toilet to take my dose of lithium and shovelled sleepers at bedtime when the speed came so fast and sleep too slow. I hid the manic rushes to reduce marital stress …“ (Thompson, 2006)

This “culture of silence” is found in many places. It can occur when:

- the cultural expectation in a whole country or geographical region favours “putting on a brave face” rather than acknowledging personal difficulties – Parr et al (2004) have suggested that this is a particular issue in Highland Scotland, but many smaller communities, workgroups (such as the emergency services, for example) or neighbourhoods may share this approach
- people with mental health problems feel obliged to keep their experiences secret from neighbours, associates, work colleagues or friends (we looked at some of the reasons for this in Module 1)
- mental health workers confine their inquiries to certain times, settings or topics; speaking about symptoms or debt may be more acceptable than disclosing life ambitions, and pressure of work may reduce levels of expressed curiosity.
Activity 6.3

Think about a person you know well who uses services. List the ways in which your service has both facilitated and inhibited that person’s self-disclosure over the course of their involvement with mental health services.

Does your service sometimes inadvertently encourage people to hide the truth about themselves? Is it different for people in hospital, those subject to compulsory powers or people in touch with community services? Focus particularly on disclosure about how that person currently lives their life beyond the mental health service, and how they would like to do so in the future.

Check out your observations with the person.

Assessment

The worker’s curiosity and the person’s self-disclosure ease the process of assessment, which aims to:

- replace hidden and stereotypical assumptions with an explicit guide and systematic approach for getting to know the person
- organise observations into a cause-and-effect explanation
- validate the existence of problems
- help us choose who to help and how to help
- enable the person, mental health workers and others to communicate with one another about what is happening
- keep us curious rather than complacent, while identifying what is relevant and deliberately seeking this and nothing else – protecting the individual’s right to privacy.

In contrast with sophisticated approaches to symptom assessment, formulation and diagnosis, anything that might be broadly described as a formal inclusion assessment is in its infancy, although the Scottish Recovery Indicator\(^4\) has made a valuable contribution.

The lack of recognised tools, combined with the belief in some mental health services that “it’s no ma job”, increases the risk that people will rapidly lose vital social roles and relationships, especially at times of crisis.

\(^4\) Access at: www.scottishrecovery.net/content/mediaassets/doc/SRI%20ConfVers180407.pdf
Activity 6.4
Jimmy Wong was admitted last Friday at 6.30pm. This is his first contact with psychiatric services. He has hardly moved since then, sitting frozen still, apart from his frightened-looking eyes that dart to and fro. He is 20 years old and understands English, but has not spoken to the nursing team or other service users, apart from on Sunday afternoon when he spoke Cantonese non-stop for 20 minutes with a visitor. The visitor left hurriedly without speaking to any of the staff.

How would you find out about Jimmy Wong’s present life in the community and what social inclusion might mean for him in the future? What would you do straight away and what would you leave for later?

Perhaps most importantly, the way in which mental health workers relate to service users and the way in which professional assessment blends with self-assessment can make all the difference. Recovery is promoted when staff offer effective support without disempowering the person and when they continue to try and find out what has meaning, relevance and significance to the person. One person cogently summarised the importance of finding a lifestyle that holds personal meaning like this:

“I was always attempting suicide and stuff like that because I hated myself so much whereas now that doesn’t happen because I’ve found something that I actually enjoy doing and that I get feedback from.” (Secker et al, 2007)

Detailed inclusion assessment
While some individuals will have strong social networks and enduring roles in the community, others will need careful support to move towards their goals.

Each of these areas of life can benefit from its own specific approach to assessment, enabling the worker to avoid stereotypical assumptions and to obtain a sufficiently detailed profile of the person’s strengths, resources, goals and need for support to achieve them. The involvement of the individual is of paramount importance in any assessment.

It turns out that Jimmy Wong’s Sunday visitor was from the Chinese church, so obtaining a more detailed understanding of the meaning and value of this connection was important. The following box provides an illustration of the sort of questions that might help to clarify how he has been living and how he wants to live in the future in relation to this aspect of his life in the community.
Questions for a spirituality assessment (White, 2006)

**Meaning and purpose**
- What things give you a sense of purpose?
- Do you have a specific aim that is important to you at the moment?
- Do you believe in any kind of existence after this life?
- Has your illness changed your attitude to the future?
- What bothers you most about being ill?

**Security and hope**
- What are your sources of strength and hope?
- Who do you turn to when you need help? In what ways do they help?
- What inner resources do you draw upon?
- Where do you go for comfort and support?
- Who or what do you depend on when things go wrong?

**Religion and spirituality**
- Do you consider yourself religious or spiritual?
- How does this affect you? Has being ill changed this?
- Is prayer helpful to you? Can you talk about how?
- Is there anything we can do to support your spiritual or religious practice?

As it appears that Jimmy is more comfortable speaking Cantonese at this time, an interpreter may enable him to engage with staff in a more meaningful way in this assessment. Every effort should be made to secure a professional interpreter rather than relying on friends, family or other visitors to take on this role.

Some services have employed staff to focus on just one area of community life (chaplains, vocational specialists or healthy living advisers). These individuals gradually discover the most fruitful questions and most useful approaches in assisting people to obtain and retain the inclusive connections they need. Indeed, any team could share out responsibility for exploring the community as a simple way to continuously improve effectiveness and make a positive difference in the lives of service users.
Activity 6.5
Select a particular area of community life (employment, education, volunteering, arts, sports, spiritual organisations) for some concentrated learning. Either choose an area that is of long-standing interest to you or perhaps try to develop an area you feel you have a lot to learn about.

Make a list of all the questions you think may be helpful in conversation with a service user about their experience and ambitions in relation to this area of community life. Go beyond the practical arrangements to the person’s motivation, emotion and interactions with others in the setting.

Over the next few weeks, and as opportunity arises, try out your questions with service users, friends and colleagues. Observe which questions are helpful and note any new ones you generate spontaneously. Refine the list of questions you consider effective and feel comfortable using.

Community mapping
Once you have found out about the person’s ambitions and hopes, you need to ensure you have a good knowledge of community opportunities. The amount of time and number of connections you can maintain with mainstream community organisations will partly depend upon your role in the mental health service, but all staff are expected to adopt a hopeful attitude, be aware of some oases and support people in navigating the rough terrain. The next activity is intended to assist you in developing community mapping skills.

Activity 6.6
Each member of your staff team will already have some specialised knowledge of a neighbourhood or an area of community life. They may be a football supporter, a resident of a particular village, a keen allotment holder, active in the local history society or a regular face at the quiz night at the local pub. Draw up a list of these specialist areas of knowledge represented on your team.
Now identify areas of community life that are missing from the list. You may have no-one involved in volunteering, political groups or gay networks, for instance.

Some of these areas of community life seem to be “neutral” while others evoke strong feelings from staff who are enthusiastic, suspicious or nervous of making a connection with the group or activity. Take some time to explore these feelings – why do they arise and are they justified?

Set yourself a target for finding out about one of these “missing links” over the next month.

The Department of Health in England has developed a strategic approach to workforce and team development that is based on a similar methodology to the one you have just used in Activity 6.6. Their Creating Capable Teams Approach (Department of Health, 2007) requires multi-disciplinary and multi-agency teams to reflect on and review their existing skills mix alongside service users and carers to ensure they best meet their needs.

**Building an inclusion plan**

You were introduced to a seven-step framework for building an inclusion plan in Module 6 of the ESC(S) learning materials (see box below).

**Seven-step framework for building an inclusion plan.**

1. Get to know the person’s aspirations for inclusion.
2. Get to know what is available in the community.
3. Ensure that colleagues in the health and social care system are signed up to the plan.
4. Assist the community group or organisation to offer a suitable opportunity.
5. Ensure that other issues (such as family influences or financial worries) do not block the plan.
6. Make good arrangements for getting to the activity, being introduced and settling in.
7. Deepen the participation and overcome any difficulties that arise.
This framework helps to cover all the relevant aspects of the plan, but it does not do justice to the complexity of issues that need to be addressed from time to time. Take the following scenario as an example.

**Activity 6.7**

Beverley has been in touch with a community mental health service for some years and, having just completed a computer course at college, has decided to look for employment. She has seen an administrative post advertised in the local newspaper and has contacted the employer for an application pack.

Beverley spoke with you at your most recent meeting about the application form. She is unsure about completing it and in particular isn’t sure whether she should state that she has a disability. She has asked you if she should state that she has a disability and what she should say about her mental health if she does.

Make a note of your own thoughts on the following issues then discuss with the group.

<table>
<thead>
<tr>
<th>What do you think might be the advantages and disadvantages of Beverley disclosing her mental health problems on an application form?</th>
</tr>
</thead>
<tbody>
<tr>
<td>If she does disclose, are there words you think she should avoid using? What do you think she might say instead that might seem more positive?</td>
</tr>
</tbody>
</table>

The issue of disclosure of mental health issues to employers (and, for that matter, to others) is complex. People with experience of mental health problems may not perceive themselves to be “disabled” or may worry that any mention of mental health difficulties may lead to immediate rejection.

On the other hand, some companies do state that failing to disclose relevant information on a job application form can lead to instant dismissal. Additionally, disclosing mental health problems may offer legal protection under the Disability Discrimination Act (1995 and as amended 2005).5

5 Further information about the DDA can be found at the website of the Equality and Human Rights Commission: www.equalityhumanrights.com
The Disability Discrimination Act (DDA) defines disability as:

“... a physical or mental impairment which has or has had a substantial and long-term adverse effect on [a person’s] ability to carry out normal day-to-day activities.”

The DDA makes it unlawful to discriminate (treat less favourably) against a disabled person in education, employment and the provision of goods and services. The Act also requires that employers make reasonable adjustments to enable disabled employees to access or retain employment.

Let us look at the implications of disclosing mental health problems and making reasonable adjustments at work for Beverley, who was introduced in Activity 6.7.

Activity 6.8

Beverley was successful in her application and started in her new post. Despite finding it tiring and stressful to begin with, she has enjoyed working again and has made friends with a few of her colleagues.

Twelve months later, Beverley’s mother died suddenly and Beverley found this very difficult to deal with. She has had two months off work and is beginning to feel better. She would like to return to work, but is not convinced that she could cope with the demands of her job. Her GP has suggested that she speak with her line manager about the “reasonable adjustments” that could be made to enable her to return to work without jeopardising her mental health.

Beverley is unsure about what the term “reasonable adjustments” means or what adjustments she could ask for, and comes to you for advice.

How would you explain “reasonable adjustment” to Beverley and what examples might you give her of adjustments that might be useful for her? Make a note of your own thoughts then discuss with the group.

When we think of making adjustments to accommodate people with disabilities, we generally tend to focus on physical access (such as availability of lifts or ramps) or equipment. It can be more difficult to think of adjustments that might be made for people with mental health problems. There are, however, a number of things that might be useful to Beverley, including:

- a phased return to work, starting off part-time and then building up to full-time hours
- working at home for some or all of the time (if her job can accommodate this)
- starting work later in the day and finishing later (this might be useful to counteract the effects of some medications)
- having time off to attend appointments with a bereavement counsellor
- regular meetings with her supervisor to discuss progress and talk over any difficulties.
The Scottish Association for Mental Health (SAMH) has a useful publication on reasonable adjustments for people with mental health problems which can be accessed from their website: www.samh.org.uk/assets/files/197.pdf

**Taking action**
People on their recovery journey need to balance competing risks when making decisions about disclosure, but the topic also challenges mental health workers. As the seven-step framework indicates, it is not enough for workers to merely provide a leaflet about college courses or put up a poster showing where the local gym is to be found.

Rather, you will be required from time to time to visit community settings, talk to representatives of community organisations, negotiate changes that will enable people to participate, and sometimes provide information about mental health problems and services. You may be involved in collaborative problem-solving with employers, friends and others.

**Activity 6.9**
Judith has attended the drop-in centre since 1987. She is now 62 years old and lives alone. She says that she does not see anyone apart from her friends at the drop-in centre. She tried the over-60s club at the community centre a couple of times but soon gave up as she did not feel welcome.

Day centre managers have proposed that the drop-in will be closed in two months time due to a combination of factors – eligibility criteria have been tightened, there is a new focus on therapeutic sessions with measurable outcomes, and the social inclusion agenda.

From your perspective, is this the right decision? What stages would need to be put in place in a good plan for Judith and for the centre? Who else needs to be involved and what should they do? How would you manage the timing?

One of the biggest organisational changes taking place in response to the social inclusion agenda is occurring within day services, although all parts of the mental health system need to address the challenges of supporting recovery and inclusion. Broadly, day services are offering fewer sessions within their own buildings and more support to people who wish to engage in mainstream community activities alongside the general public.

Accessing mainstream services might be easier, however, for some mental health service users than others. We have already identified in this and previous modules that some people are at risk of multiple discrimination – people from black and minority ethnic communities who experience mental health problems, for example. People in secure mental health settings are arguably the most at risk of exclusion and often face the greatest barriers when attempting to make community connections.
Activity 6.10

Alan is 38 years old and has lived on his own in a housing association flat since his discharge from a medium secure unit 12 months ago. He was transferred to the medium secure unit after spending four years in the State Hospital after being convicted of a number of offences committed while he had been unwell. These were relatively minor offences that did not involve violence to others.

Alan has made few friends since moving to his flat and generally spends his time at home watching television, listening to music or painting. He is a talented painter and would like to study art at college with a view to expanding his skills. He is fearful of meeting new people, however, and is worried about people asking questions about his past, as he feels very ashamed about the fact that he has been in the State Hospital. He thinks that if he told people about his past they would assume he had been sent there because he was violent.

If you were working with Alan, how would you support him to realise his ambition?

What work might you do with Alan to develop his self-confidence and come to terms with his past? Is there anyone else you might involve?

The interrelated issues of stigma and discrimination are common concerns for users of mental health services. Fear of rejection or of being ostracised or laughed at can become internalised, creating self-stigma. This internalisation of negative beliefs makes it difficult to socialise with others and hinders the recovery process (Brown and Kandirikiira, 2007).

It is therefore essential that mental health workers not only address the issue of stigma with the individuals they support, but also do all they can to challenge discrimination in the communities they work and live in.
Combating discrimination requires:

- education and persuasion that is targeted at each audience, is led by people in recovery and stresses the benefits of a fairer community
- contact that leads to people hearing one another’s stories and getting to know each other’s gifts and strengths, and which is based on equality and reciprocity
- legal sanctions and protest – engaging public support by collaborating with people who have the self-esteem and resilience to exercise their rights (Gibbons and Read, 2004).

Unless mental health workers get out among community organisations and engage with them in enhancing opportunities and combating discrimination, inclusive opportunities will be restricted to the most resilient and self-reliant people.

**Subtle support**

Finally in this section, we return to the basics. As services become more strongly focused on promoting social inclusion, there is an increased likelihood that mental health workers will be based in community locations supporting service users on a one-to-one basis. The task of providing subtle support to people in an unobtrusive way is challenging, especially if the person exhibits unusual behaviour.

The following box lists some general ideas about how to provide subtle support.

**Providing subtle one-to-one support in community settings.**

**Ask the person:** what they want to do; how to identify and overcome the barriers to participation; how they want to be supported; how to negotiate disclosure and positive risk-taking; what their needs for additional support or flexibility are.

**Think about:** who is the best person to provide support; meeting someone you know; managing your feelings about supporting this person; how you will deal with private matters in a public setting; what to do if the person is loud, visible or behaves differently; the impact of weather, schooldays, time or day.

**Plan:** introductions and explanations; what the person can do without support; transfer of support to other participants and discreet withdrawal by worker; any adjustments that need to be made by the activity provider.

**On the day:** how the person feels today; change of plans; keep your words, tone and body language calm and positive; be with the person and join in, but encourage them to make their own connections.

**Avoid:** being over-controlling; showing off as the person who is in charge; name badges and unsuitable clothes; doing your own shopping and phone calls.
While these suggestions may seem little more than common sense, many staff (especially support workers) will have experience of times when life seems to have moved far beyond the guidance available from their organisation’s policies on lone-working, information-sharing and positive risk-taking. Strengthening inclusive practice will require most agencies to improve their quality assurance, support and supervision mechanisms to respond well to these situations and their consequences. Similarly, as a worker in the service, you will need to build social inclusion into your plan for personal development and learning.
4. Conclusion

Every service development and innovation can be misunderstood or twisted into something harmful, so a positive focus on supporting inclusion requires vigilance to identify and correct these distortions and practise ethically. Use this final activity to check that the social inclusion agenda is being developed in a positive way by yourself and in your service as a whole.

Activity 6.11

Have you or your service (perhaps through its monitoring systems) decided what counts as inclusion for service users and begun to press them to live according to the service’s prescription for an included life, or do you listen to what people say about their own recovery journey?

Have you or your service reduced social inclusion to mere “common sense”, or do you explicitly include it in the service specification, job role, training programme and continuing professional development agenda?

Have you or your service passed the task of promoting social inclusion to specified workers or deferred it to the latter stages of the person’s recovery journey, or do you see it as everyone’s responsibility from day one?
This module has addressed the following themes:

- people with mental health problems are subject to many forms of exclusion in many areas of life, and this sometimes occurs alongside other kinds of discrimination
- achieving recovery and inclusion demands that opportunities are offered and taken up that are meaningful to the person and in which they can move at their own pace
- mental health workers need to take a hopeful approach to communities, looking out for the positive opportunities that can be found there while adopting a determined approach to overcoming the barriers
- creating an accessible and respectful community requires commitment and energy from right across the community
- both curiosity and detailed assessment tools are needed to understand the person’s aspirations for a life in the community and the community itself
- combating discrimination is a key aspect of the work and requires mental health workers to act in partnership with people in recovery and community organisations
- continuing professional development means that mental health workers will frequently reflect on their practice and find new ways of opening up and offering opportunities to people on their journeys of recovery and inclusion.
Learning into practice

Before moving on to the next module, or if you have now completed the learning materials, spend some time reflecting on what you have learned in this module. You may be reassured by some of the things you have encountered in this module. It is worth taking some time to think about how your existing practice matches what we have discussed in the module.

Some of what you have learned may be new to you or perhaps more challenging. Make a note of the changes you will make to your practice now that you have completed this module.
Resources to support further learning

Information about challenging stigma and discrimination in Scotland available from:
www.seemescotland.org

Further information about the Disability Discrimination Act and other equalities legislation is available from the Equalities and Human Rights Commission:
www.equalityhumanrights.com

www.scotland.gov.uk/Publications/2007/10/18092957/11


References

www.scottishrecovery.net/content/mediaassets/doc/Methods.pdf


www.scotland.gov.uk/Topics/Health/health/mental-health/section25-31/Localauthorityguidance

www.scottishrecovery.net/content/default.asp?page=s5_4_10

