NHS
Education
for
Scotland

The 10 Essential Shared Capabilities for Mental Health Practice: Learning Materials (Scotland)

2011 version

Contents

Welcome!

Welcome to the Ten Essential Shared Capabilities (10 ESCs) Learning Resource (Scotland) 2011 version.

The learning resource is based on initial pilot learning materials developed in England. NHS Education for Scotland (NES) worked with an expert group consisting of service users, carers and representatives from voluntary and statutory mental health sectors to produce a version of the learning resource that was specific to the Scottish context.

NES launched the first version of the Scottish materials in 2007. We then commissioned a 'training for trainers' programme that prepared and supported individuals drawn from across mental health services in Scotland to further disseminate and cascade the 10 ESCs training within their organisations. An independent evaluation of the learning materials and the dissemination of the ESCs learning in Scotland was published in 2010.

The 10 ESCs training and learning has been widely disseminated in Scotland, particularly among mental health nurses as a result of *Rights, Relationships and Recovery: the report of the national review of mental health nursing in Scotland.*[1] Thousands of mental health nurses have now taken the training.

We are pleased that the learning has reached so many participants and some examples of how the learning has brought about positive changes in practice can be found on the NES website.[2]

The 2011 revised version

This updated and revised 2011 version of the learning resource builds on the successes of the original Scottish learning resource. It has been informed by findings from the evaluation and has been updated to reflect the evolving policy and legislative context driving improvements in mental health care in Scotland.

The main emphasis of the learning resource continues to focus on supporting cultural change in services (alongside a number of initiatives we will discuss later) by promoting rights-based, recovery-focused practice.

The learning resource has been designed to meet the learning needs of a wide range of people with an interest in mental health in Scotland, including mental health professionals, workers, service users, carers and the people who support them.

The learning resource is also action focused, as we believe there is little value in learning that does not translate into developing better services for service users and carers. To that end, the activities that appear throughout each of the modules will play a key part in helping you further develop the knowledge, skills and attitudes that are central to the delivery of rights-, recovery- and values-based mental healthcare and services.

Acknowledgements

We would like to thank the members of the working group who have contributed to the development of the 2011 version of the resource:

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References

[1] www.scotland.gov.uk/Topics/Health/health/mental-health/RRRmentalhealth
[2] www.nes.scot.nhs.uk/initiatives/mental-health/our-work#values

Introduction to the learning resource

Contents

Introduction to the learning resource

1 What are the 10 Essential Shared Capabilities (10 ESCs)?

The 10 ESCs were originally developed and published by a partnership involving the Department of Health, the Sainsbury Centre for Mental Health, the National Institute for Mental Health in England and the NHS University in 2004. It is important to note that these organisations worked closely with service users and carers to develop the ESCs to ensure that they reflected their priorities.

The 10 ESCs are listed below and are explored in much more detail in Module 1.

The 10 ESCs

1. Working in partnership
2. Respecting diversity
3. Practising ethically
4. Challenging inequality
5. Promoting recovery
6. Identifying people's needs and strengths
7. Providing service user-centred care
8. Making a difference
9. Promoting safety and positive risk taking
10. Personal development and learning

The aim of the 10 ESCs is to set out the shared capabilities that all staff working in mental health services should achieve as best practice. In addition, it is intended that they will enable service users and carers to have increased awareness of what to expect from staff and services.

The 10 ESCs:
- are about attitudes, behaviours, expectations, and relationships;
- describe the values and principles that should be demonstrated in the way mental health services are commissioned, planned and delivered;
- are derived from, and reflect, how people who use mental health services and those who support them want to be treated, and the way they expect to be treated;
- outline values and principles that should influence the actions and outcomes that people working in mental health services should be seeking to achieve.

The ESCs learning remains important in the wider mental health policy, legislative and service development context in Scotland, and we make links to these wider agendas throughout the learning resource. In particular, they support the delivery of:

- the quality ambition of person centredness that is central to Scotland's health policy;
- *Rights, Relationships and Recovery: the report of the national review of mental health nursing in Scotland;* [3]
- the focus on recovery and personalisation in Scotland's mental health and social care policy and service developments;
- Scotland's human rights-based mental health (and wider) legislation;
- *Realising Potential – the action plan for allied health professionals in mental health in Scotland;* [4]
- *The National Framework for Pre-registration Mental Health Nursing Programmes in Scotland.*[5]

The content of the learning resource is designed to be stimulating, engaging and accessible to those who are new to mental health work and to those who are more experienced. The learning outcomes for the modules and the learning activities have been written to reflect Level 8 of the Scottish Credit and Qualifications Framework. The focus is on practical applications of the ESCs and reflective practice. Each module includes links to further learning for people who choose to explore issues in greater depth.

2 Introducing our characters

The learning materials introduce four people and their families and friends. While these characters are fictional, the circumstances of their lives and the challenges they face are considered representative of those encountered by people who access mental health services.

Jim (67) and his wife Mary (65)

Jim is a retired joiner and Mary did lots of part-time jobs in-between raising their two children. They have three grandchildren. Mary has Parkinson's disease, which limits her mobility and creates some problems with her dexterity. Generally, however, she manages the condition pretty well.

Jim plays bowls regularly, an activity he has pursued all his adult life, and is secretary of the committee at his local bowling club. Jim has also enjoyed reading and likes to keep up to date with politics and current affairs. He is a keen gardener and has an allotment which he enjoys. Jim has won competitions in the past for the fruit and vegetables he has produced.

He is finding, however, that he has gradually worsening short-term memory loss, which is leading him to feel very down in mood. Jim and Mary have no previous contact with mental health services.

Pete (35)

Pete is a 35-year-old art history graduate who has been in contact with mental health services since his early twenties. Pete has a strong interest in photography and travelled extensively when he was younger. He worked as a curator in a small gallery until his late twenties but has not been in paid employment since. He has recently started attending college. Pete lives in supported accommodation and has a brother, John, and his close friend is Colin.

Mina (26)

Mina is a 26-year-old Pakistani Scottish woman who married Aasim a year ago and is now pregnant with their first child. She's a practising Muslim. On her marriage, Mina moved from a city in central Scotland to live with Aasim and his parents and extended family in a remote and rural area of the country, some distance from any of the major cities. Mina misses city life and the circle of friends and activities she previously enjoyed and feels quite isolated. She is a qualified pharmacist and really values her job. She currently works part time in a community pharmacy in her local town. Mina has been feeling very anxious recently and has been referred to mental health services via antenatal screening.

Jenny (19)

Jenny is 19 and works in a local supermarket. She was in care between the ages of 13 and 16 but now lives with her mother, Margaret, who has had addiction problems in the past, and her little sister, Megan. She used to have a wide circle of friends. She has had an on–off relationship with Billy, who is significantly older (40), since she was 17. The relationship is not always positive and Billy has frequently subjected Jenny to gender-based violence. Jenny started self harming a year ago and has been treated at accident and emergency three times as a result of overdoses with over-the-counter medications. It has also been noted that she has a number of scars and more recent cuts on her arms. Margaret is very worried about Jenny's state of mind, her behaviour and her relationship with Billy.

We will be following the stories of Jim, Mary, Pete, Mina and Jenny as we move through the programme. You will note as you do so that some of the characters seem to 'age' at a different rate from others – this has been done deliberately to maximise your learning opportunities from the characters' stories.

3 How to use the learning resource

The ESCs learning resource consists of five modules and this introduction. **It is important that the modules are studied consecutively, as each module builds on and develops the one preceding it.**

Facilitated or self-directed learning?
We have designed the resource so that it 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**.

The modules are shown below.

The learning resource modules

Module 1 The Ten Essential Shared Capabilities
Module 2 Values-based practice
Module 3 Involving service users and carers
Module 4 Equality and diversity – respecting difference
Module 5 Developing socially inclusive practice

You should complete the modules consecutively

4 Links between the learning resource and other initiatives

The Scottish Recovery Indicator (SRI)[6]
The SRI is a mental health service development tool designed by the Scottish Recovery Network to help mental health services ensure that their activities are focused on supporting the recovery of the people who use their services. In doing so, it highlights issues in relation to inclusion, rights, equalities and diversity. The tool helps generate conversations within teams about recovery-supporting environments and person-centred approaches.

The SRI covers 8 dimensions with 19 indicators. The dimensions the SRI explores are:
- Meeting basic needs
- Personalised services and choice
- Strengths-based approach
- Comprehensive service
- Service user involvement/participation
- Social inclusion and community integration
- Advance planning
- Recovery focus.

Undertaking the SRI requires commitment and time, but feedback from services suggests that using the tool can lead to improvements in practice. In adhering to the principles that underlie recovery, the SRI has been developed in a way that promotes ownership and responsibility.

There is a close match between the SRI and the ESCs learning resource. We explain in each module how undertaking the ESCs learning while concurrently assessing and developing practice and services using the SRI are complementary processes.

Note that you will need to register online to use the tool.

Realising Recovery learning materials

The *Realising Recovery* learning materials[7] build on the 10 ESCs learning to address ESC 5 – Promoting recovery, in more detail. 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 in which they live.

The modules in *Realising Recovery* include:

- Understanding recovery
- Using self to develop recovery-focused practice
- Enabling self direction
- Providing person-centred support
- Sharing responsibility for risk and risk taking
- Connecting with communities.

We make links to *Realising Recovery* throughout the ESCs modules to enable some areas to be explored in more depth.

5 Notes for trainers and facilitators

Support for learners

We strongly support group discussion/facilitation as the preferred method for delivery of this learning. 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, reflection, team meetings or away days.

Learning support and opportunities to consider issues in supervision should be provided for the duration of the programme where possible.

Learning can be greatly enhanced if different groups of disciplines, workers, practitioners, service users and carers can come together to learn and discuss issues that the learning raises. The direct involvement of services users and carers in delivering some of the materials and facilitating learning groups will also enhance learning.

We also suggest that if you are intending to use the SRI to examine and develop your team and service, you will find that undertaking the ESCs and *Realising Recovery* learning materials will be an important aspect of this process and will help with achievement of some of the indicators.

6 Notes for learners

Why study the ESCs?

We have a range of policies and rights-based mental health legislation in Scotland which focuses on improving the experiences and outcomes of care for people who use mental health services and their families/carers. In Module 1, we will explore how developing your practice in the 10 ESCs can support this drive and provide the basis for high-quality, person-centred care in mental health.

All workers in mental health services, whatever their role, have an important part to play in promoting positive mental health practice. The ESCs are equally applicable to the way we work with colleagues as they are to the way we work with people who use services, people who care for others and people within the voluntary, independent and all other care settings.

During the learning, reflection on your own practice is essential. This will help you to reinforce and build on existing good practice, uncover practice that is not beneficial and take action to change this.

Using the internet

It is worth making use of the internet as you study the ESCs – it provides a good way of getting access to information quickly. There are literally thousands of web sites devoted to every aspect of mental health, with more appearing every week.

If you insert the name of each of the 10 ESCs into an internet search engine, you will find lots of relevant and useful material, including some from sites that do not have a specific mental health focus. This can help to stimulate fresh thinking and new ideas.

We have listed a number of web sites you may find interesting throughout the learning resource. These are not exhaustive lists, and you should be aware that NES is not responsible for the content of external websites.

If you do not have access to a computer and are keen to learn how to use the internet, go to a learning centre or your local public library. All public libraries in Scotland have computers linked to the internet that can be used free of charge. They are often in demand and may need to be booked in advance, but most librarians will help people to get started and show them what to do.

Learning activities

Learning activities are a feature of all the modules throughout the learning resource.

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.

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.

The first two learning activities below are examples.

Activity I.1

The importance of recognising and respecting differences between us while 'owning' our own personal hopes, concerns and values is a theme running through the ESCs. In addition to Respecting Diversity (ESC 2), this is also the key to Working in Partnership (ESC 1), Promoting Recovery (ESC 5), and Providing Service User-centred Care (ESC 7). Values-based practice, which is introduced in Module 2, gives us the skills to do this.

To start the process, please answer these two brief, but important, questions.

Hopes and concerns

Consider your hopes, personal values and goals – the things you hope to get from this programme and why it is important for you:

Consider your concerns – things you may not like, or may find difficult:

Note: if you can, share some of your concerns with group facilitators or your supervisor.

Activity I.2

Coming into mental health work Why did you first become interested in mental health work? Consider the experiences that influenced your interest in mental health:
What was your main goal in becoming involved?
What will help you to achieve this goal?
Learning experiences in mental health Experiences of mental health at work will not be confined to mental health services. Mental health is a part of everyday life and so it is helpful to think about experiences of mental health in a broader way. What is the most important thing you have learned about mental health work?
Please note some good learning experiences in your current or previous roles:
What do you hope to get from working through this ESCs learning resource?

Having completed this activity, you may want to talk to your line manager, supervisor or mentor about creating (or updating) your own personal development plan.

Now that you have completed this introduction, you are ready to move on to Module 1: The 10 Essential Shared Capabilities.

References

[3] www.scotland.gov.uk/Topics/Health/health/mental-health/RRRmentalhealth
[4] www.scotland.gov.uk/Publications/2010/06/15133341/0
[5] www.nes.scot.nhs.uk/media/5853/preregframework.pdf
[6] www.scottishrecoveryindicator.net
[7] www.nes.scot.nhs.uk/media/5825/13875-nes-mentalhealth-coverintro.pdf

Module 1

The Ten Essential Shared Capabilities

Contents

Welcome to Module 1

This module introduces you to each of the 10 Essential Shared Capabilities (10 ESCs) and acts as the foundation for all other modules.

The 10 ESCs framework provides the fundamental building blocks for the education, training and continuing development of all mental health workers. It is designed to be applicable to all people involved with delivering mental health in practice and support roles, regardless of setting.

The 10 ESCs are:

- Working in partnership
- Respecting diversity
- Practising ethically
- Challenging inequality
- Promoting recovery
- Identifying people's needs and strengths
- Providing service user-centred care
- Making a difference
- Promoting safety and positive risk taking
- Personal development and learning

The 10 ESCs are the foundation on which good mental health practice is set.

On a surface reading, all capabilities will probably seem sensible and may reflect your current attitude and practice. Reflecting on yourself, your role and your practice in relation to the ESCs can be challenging, but it will provide you with a greater insight into mental health work and will enable you to explore and reflect on the basis of mental healthcare. We use the word 'care' here in its fullest sense, not in a narrow service or professional definition. We care for each other as 'persons' whatever role we perform, either in work, at home or in social settings.

We will work through each of the ESCs in this module, defining what they mean and using reflective activities to help you think about the ESCs in relation to yourself and your experiences in mental health practice.

Learning outcomes

After completing this module, you will be able to:
- describe the 10 ESCs and how they relate to mental health work;
- reflect on yourself and your practice in relation to the ESCs;
- understand how the ESCs relate to and support the delivery of mental health policy and legislation in mental health practice in Scotland;
- start to think about further developing your practice in line with the ESCs and recognise how they can help you to improve your experience of mental health work and the experiences of the people you work with.

1 Working in partnership

Working in partnership involves developing and maintaining constructive working relationships with service users, carers, families, colleagues, lay people and wider community networks.

It also involves working positively with any tensions created by conflicts of interest or aspiration that may arise between partners in care.

Working in partnership is about the engagement of all those involved in receiving or providing mental healthcare, maintaining helpful and productive working relationships and bringing them to an appropriate end. It is about viewing people who use services as partners in care, rather than passive recipients of services. And it is about multidisciplinary team working, cross-boundary working and working with wider community networks.

To work in partnership you need to:
- value service users as partners in their care and treatment;
- acknowledge the positive part families, friends and carers can play in the service user's support network;
- engage people as partners in care in a way that maximises their role in decision-making and making choices.

One of the principles of the Mental Health (Care and Treatment) (Scotland) Act 2003[8] is 'participation', which is closely linked to the idea of partnership (the principles are explored in more detail later in the module). This means people should be involved to the extent of their abilities in all aspects of their care, treatment and support, with their past and present wishes being taken into account. They should also be provided with support and information to enable them to participate fully.

Other principles of the Act are equally relevant. 'Respect for carers' means that people who care for service users on an informal basis should be afforded respect for their role and experience, should receive appropriate information and advice, and should have their views and needs taken into account.

Activity 1.1

Reflecting on the above, think of a personal experience you have had of using health services. This could be a consultation with your GP, going for a hospital appointment or supporting a family member or friend who is using health services.
Did the professionals with whom you came into contact take steps to 'work in partnership' with you?

What positive steps did they take?

What could they have done differently to make you feel you (or your family member or friend) were an equal partner in care?

Think about the responses you have made to your own experience. How do you think service users and carers you work with would respond to the questions above?

What changes could you make in your own practice to develop partnership working?

To work in partnership, you need to be able to explain in an understandable way your role in mental health work and the boundaries within which you work.

You also need to understand your role in relation to the other people you work with within a multidisciplinary or multi-agency team setting and know how your role contributes to the wider mental health of service users, carers, colleagues and other people you come into contact with.

Activity 1.2

This activity could usefully be carried out in the team in which you work.

Imagine you have started a conversation with a stranger who knows nothing about mental health work and is interested in what you do. How would you describe your role – what are the main things you do, and what is the purpose of the service in which you work?

Who are the key people you work with and alongside?

How does the team or service you work with link with other mental health services and agencies and wider community networks?

We will continue to explore working in partnership while looking at the other ESCs. Several of the modules in this learning resource will also help you to reflect on and develop your capability in 'working in partnership', particularly:

- Module 2 – Values-based practice;
- Module 3 – Involving service users and carers;
- Module 5 – Developing socially inclusive practice.

2 Respecting diversity

Respecting diversity is about working in partnership with service users, carers, families and colleagues to provide care and interventions that not only make a positive difference, but also do so in ways that respect and value diversity, including age, race, culture, disability, gender, spirituality and sexuality.

'Respecting diversity' means working with service users, carers, families and fellow workers to provide care and treatment that accepts each person for who he or she is, treating him or her well regardless of age, disability, gender identity, race, ethnic or national origin, religion or belief, sexual orientation or socioeconomic background.

Delivering equitable, person-centred care requires a culturally competent health service that will eliminate discrimination and promote equality of opportunity for everyone.

The principles of the Mental Health (Care and Treatment) (Scotland) Act 2003 are also relevant here, particularly the following two principles.

- **Equality** There should be no direct or indirect discrimination on the grounds of disability, age, gender, sexual orientation, language, religion or national, ethnic or social origin.
- **Respect for diversity** Service users should receive care, treatment and support in a manner that accords respect for their individual qualities, abilities and diverse backgrounds and properly takes into account their age, sexual orientation, ethnic group, gender and social, cultural and religious background.

Respecting diversity means you need to be aware of, and take steps to challenge, inequalities and ensure that the care you provide takes account of the unique background and lifestyle of each individual service user.

Activity 1.3

Identify someone you know or have worked with whom you think might experience inequalities. What is the nature of these inequalities?

Why have you identified this person as potentially experiencing inequalities?

What did you know about his or her background, life circumstances and aspects of identity?

How does this knowledge help you to provide care for the individual concerned?

Leaving his or her potential ‘inequality’ aside, what issues was the person facing?

The other modules in this learning resource will help you to reflect on and develop your capability in ‘respecting diversity’, particularly Module 4 – Equality and diversity: respecting difference.

3 Practising ethically

Practising ethically involves recognising the rights and aspirations of service users and their families and carers, acknowledging power differentials and minimising them whenever possible. It also focuses on providing care and treatment that is accountable to service users and carers within the boundaries prescribed by law and professional, national and local codes of ethical practice.

Practising ethically means:

- recognising the rights and hopes of service users and their families;
- observing codes of practice and good practice guidelines;
- working within the law.

Activity 1.4

Identify what guidelines are relevant to you and enable you to practise within an ethical, legal, honest and non-judgemental framework.

Are these guidelines straightforward and easy to follow?

What opportunities do you have to discuss such guidelines with colleagues or supervisors?

When you complete the learning in Module 2 – Values-based practice, you will recognise that a range of complementary (and sometimes competing) frameworks exist to direct our behaviours and actions as people involved in mental healthcare and services. They include:

- the law – the Mental Health (Care and Treatment) (Scotland) Act 2003 and other relevant pieces of legislation;
- codes for professional groups like nurses and social workers, such as the Nursing and Midwifery Council Code;
- professional values statements, including those set out in *Rights Relationships and Recovery – the review of mental health nursing in Scotland*;[9]
- importantly, our own individual values and beliefs.

Activity 1.5

We will draw on one framework in the following activity – that provided by one of our mental health laws in Scotland.

You should note that the Mental Health (Care and Treatment) (Scotland) Act 2003 contains much more than simply legislation for people using mental health services under compulsion. Its underpinning principles should apply to all people who use mental health services and should influence our practice accordingly.

Consider the principles of the Act in Box 1.

Box 1 The principles of the Mental Health (Care and Treatment) (Scotland) Act 2003

Non-discrimination	People with mental health problems should, wherever possible, retain the same rights and entitlements as those with other health needs.
Equality	There should be no direct or indirect discrimination on the grounds of physical disability, age, gender, sexual orientation, language, religion or national or ethnic or social origin.
Respect for diversity	Service users should receive care, treatment and support in a manner that accords respect for their individual qualities, abilities and diverse backgrounds and properly takes into account their age, sexual orientation, ethnic group and social, cultural and religious background.
Reciprocity	When society imposes an obligation on an individual to comply with a programme of treatment or care, it imposes a parallel obligation on health and social care services to provide safe and appropriate services and ongoing care.
Informal care	Wherever possible, care, treatment and support should be provided without the use of compulsory powers.
Participation	People should be fully involved, as far as they are able to, in all aspects of their care, treatment and support. Their past and present wishes should be taken into account. They should be provided with support and information to enable them to participate fully.
Respect for carers	Those who provide care to service users on an informal basis should be afforded respect for their role and experience, should receive appropriate information and advice, and should have their views and needs taken into account.
Least restrictive alternative	Any necessary care, treatment and support should be provided in the least restrictive manner and environment compatible with the delivery of safe and effective care.
Benefit	Any intervention under the Act should be likely to produce for the service user a benefit that cannot reasonably be achieved other than by the intervention.
Child welfare	The welfare of a child with mental health problems should be paramount in any intervention imposed on the child under the Act.

Imagine you have been admitted to an acute inpatient mental health unit. Which applied principles would you consider to be of particular importance to you in your care and treatment, and why?
Reflect on a person you know who is using mental health services. To what extent are the principles being applied to his or her care and treatment?
What are the successes in applying the principles?
What are the barriers to applying the principles?
What could you do to influence this?

Several modules in this learning resource will help you reflect on and develop your capability in 'ethical practice', particularly:

- Module 2 – Values-based practice;
- Module 3 – Involving service users and carers;
- Module 4 – Equality and diversity: respecting difference.

4 Challenging inequality

Challenging inequality involves addressing the causes and consequences of stigma, discrimination, social inequality and exclusion for service users, carers and mental health services. It also focuses on creating, developing or maintaining valued social roles for people in the communities in which they live.

Challenging inequality is about helping to overcome unfair treatment and unwelcoming attitudes that affect service users, carers and mental health services and helping people to play an active part in their own community.

To challenge inequality, you need to understand the effects of exclusion and discrimination.

We have many drivers to help challenge inequality in Scotland. One of the principles of the Mental Health (Care and Treatment) (Scotland) Act 2003, for example, is 'non-discrimination', meaning people with mental health problems should, wherever possible, retain the same rights and entitlements as those with other health needs.

Mental health service users and carers have identified stigma as a key problem that contributes to the inequalities they face. Challenging stigma and stereotyping is therefore an important part of challenging inequalities.

The 'See Me'[10] campaign was launched in October 2002 as part of the former National Programme for Improving Mental Health and Wellbeing in Scotland. The campaign aims to challenge stigma and discrimination around mental ill health in Scotland through national publicity programmes and local and national anti-stigma action, and was developed in partnership with like-minded groups and individuals across all sectors of Scottish life. Individuals who have experienced stigma are involved in many aspects of the campaign, including people who are prepared to talk to the media about the impact stigma has had on their lives.

If a service user believes he or she has suffered discrimination (that is, has been treated less favourably than a person who does not share a particular characteristic like race or gender, or does not have mental health difficulties or other impairment defined legally as 'disability') in employment, education or in the provision of goods or services, he or she may be able to pursue this in law under the Equality Act 2010.[11]

Activity 1.6

The language used in society (and in mental health services) in describing people with mental health problems is crucial in challenging stigma and discrimination. We know that derogatory and negative terms are often used.

We introduced **Pete** on page 2 of the Introduction. Look back on the information we provided about Pete, then consider the following statements made by mental health workers to describe him.

1. Pete is a chronic schizophrenic with severe negative symptoms and a poor prognosis.
2. Pete has severe and enduring mental health problems and is likely to require supported accommodation for the rest of his life.
3. Pete is a graduate in art history and a keen photographer who enjoyed travelling. He has a diagnosis of schizophrenia.

If you were Pete, which of the descriptions would you prefer was used about you. Why?

Look back at your responses to Activity 1.2. What language did you use to describe your role and the people you work with? Is there anything you would change in the light of this exercise?

One of the best ways of countering stigma and encouraging people to be more open about mental health in general is through providing relevant information. For example:

- one in four people in Scotland will experience a mental health problem at some point in their lives;
- depression and anxiety are the most common mental health problems – most people recover fully from both;
- almost three-quarters of people in Scotland know someone close to them who has been diagnosed with a mental health problem at some point.

The National Programme for Improving Mental Health and Wellbeing was launched in October 2001 and ran until 2008. Its vision was to:

> *"…improve the mental health and wellbeing of everyone living in Scotland and to improve the quality of life and social inclusion of people who experience mental health problems."*

To help inform the work of the National Programme, the-then Scottish Executive commissioned the first National Scottish Survey of Public Attitudes to Mental Health, Mental Wellbeing and Mental Health Problems in 2002. The survey was repeated in 2004, 2006 and 2008, with minor changes made to the questionnaire on each occasion.

Findings from the 2008 survey, *Well? What do you think?* **[12], indicate:**

- a quarter of those who had experienced a mental health problem had experienced difficulties in terms of other people's attitudes;
- one in ten had been discouraged from participating in social activities, and roughly half this proportion had experienced discrimination at work or had been refused a job;
- a quarter of those who had personal experience of a mental health problem had chosen to avoid a social event because of the way they thought people would react to their problem; this is significantly higher than the proportion who said they had *actually been discouraged* from participating in a social event, suggesting that self stigmatisation is an issue;
- for the most part, attitudes towards mental health problems in Scotland were unchanged from 2006;
- significantly, the proportion of people agreeing with the statement, 'If I were suffering from a mental health problem, I wouldn't want people knowing about it', remained stable, despite decreasing gradually over previous waves of the survey;
- attitudes tended to be more negative than average among older respondents (aged 75 and over), people with no qualifications, people living in the most deprived areas and those with no personal or proxy experience of a mental health problem;
- with regard to public attitudes to mental health problems, the findings indicated that positive trends identified over previous waves of the survey may have at best plateaued.

We also know that:

- stigma and discrimination against people with mental health problems is pervasive;
- mental health professionals may have low expectations of what people with mental health problems can achieve;
- people who use mental health services face barriers to engaging in the community;
- people from black and minority ethnic communities, young men, parents with mental health problems and adults with complex needs face particularly challenging barriers.

In relation to people from black and minority ethnic mental health communities in Scotland, you should read the findings from the Glasgow Anti-Stigma Partnership report *Mosaics of Meaning*.[13] The report is a summary of research undertaken between 2005 and 2007 to address the stigma associated with mental health problems among black and minority ethnic communities in Glasgow.

The *Mosaics of Meaning Handbook*[14] was published by NHS Greater Glasgow and Clyde in 2010. This guide for health improvement practitioners describes how a series of interventions delivered by the NHS, voluntary sector and user-led organisations in Glasgow sought to tackle stigma in mental health with black and minority ethnic communities.

Gender, age, ethnicity, sexuality, poverty and deprivation affect mental health and wellbeing, people's experiences in the mental health system and their recovery from mental health problems. The former National Programme for Improving Mental Health and Wellbeing commissioned a report, *Equal Minds*,[15] with a view to tackling these inequalities. We will explore many of the ideas developed and the impact they should have on practices and services in later modules.

Activity 1.7

We have described some large-scale plans and programmes to challenge inequality in society. Health and social care services and mental health workers will have a role in many of these initiatives.

On an individual level, think of a situation in which you have been able to challenge inequality and discrimination within your organisation.

Describe the situation briefly:

On which key strengths did you need to draw to act in this way?

Looking back on the situation now, is there anything you would want to do differently?

Several modules in this learning resource will help you reflect on and develop your capability in 'challenging inequality', particularly:

- Module 4 – Equality and diversity: respecting difference;
- Module 5 – Developing socially inclusive practice.

5 Promoting recovery

Promoting recovery involves working in partnership to provide care and treatment that enables service users and carers to address mental health problems with hope and optimism and to work towards a valued lifestyle within and beyond the limits of any mental health problem.

A number of factors contributed to the development of what is known as the 'recovery approach', initially in the United States and then more widely. These included:

- research into long-term outcomes for people with mental health problems;
- service user activism;
- sharing experiences and stories;
- social models of mental health.

In Scotland, the Scottish Recovery Network (SRN)[16] plays a key role in supporting this agenda. The SRN aims to develop our understanding of recovery and build the capacity of mental health services and related programmes to support people's recovery based on the following key principles:

- people can and do recover from mental health problems;
- recovery is a process or journey, rather than an end point;
- the concept of 'recovery' encompasses more than just recovery from illness or an absence of symptoms.

A recovery approach requires that we learn as much as possible from the experience of people with lived experience of mental health problems. This sounds like an obvious thing to do, but it can lead to asking some pretty fundamental questions about our roles as professionals and to examine the knowledge, skills and values we bring to our supporting role.

The following quotations are useful in helping us come to an understanding of recovery.

> *"It is about giving people the tools to become active participants in their own healthcare – it is about having a belief, drive and commitment to the principle that people can and do recover control in their lives, even where they may continue to live with ongoing symptoms."* (SRN)

> *"What matters in recovery is not whether we're using services or not using services, using medications or not using medications. What matters in terms of a recovery orientation is, are we living the life we want to be living? Are we achieving our personal goals? Do we have friends? Do we have connections with the community? Are we contributing or giving back in some way?"* (Pat Deegan)

Activity 1.8

Think of a time in your life when you have recovered from something. It could be an illness, a loss, bereavement, or the end of a relationship.
What things helped your recovery?

What things hindered it?

Discuss your answers with others. Are there common themes and issues?

Do you think the helpful things you identified are also relevant to the people you work with?

It is important to note what recovery does *not* mean. **It is not:**

- cure;
- something mental health workers ‘do’ to people;
- a new word for ‘rehabilitation’;
- a model;
- “something we have always been doing anyway”.

The keys to working in a recovery-focused way include:

- hope, one of the most important factors in recovery;
- a belief in recovery and knowing that recovery happens;
- holding and demonstrating values and practices that reflect this belief;
- working from people’s strengths and abilities rather than focusing only on problems and deficits;
- developing support so that service users can increase their role in directing their own care and treatment;
- recognising that people with experience of mental health problems are ‘experts by experience’ with unique knowledge and insights to contribute;

- recognising that while there are common themes, recovery is a unique and individual experience – consequently, our support must be person centred and holistic;
- being creative and flexible in your approach and considering the role of positive risk taking;
- the importance of relationships to recovery – how practitioners communicate and behave can impact on recovery;
- the use of tools such as person-centred planning, strengths-based approaches and Wellness Recovery Action Planning (WRAP).

Activity 1.9

One of SRN's main aims is to learn more about the sort of things that help people to recover.

This has included a narrative research project to gather, analyse and share recovery stories from over 60 individuals who have experienced long-term mental health problems. The content of the *Realising Recovery* learning materials[17] was significantly informed by this research.

Twelve stories from the narrative project have been shared in the *Journeys of Recovery* booklet[18] at **www.scottishrecovery.net/View-document-details/81-Journeys-of-Recovery.html**

These highlight several main themes that have been influential in people's recovery, including:
- 'meaningful activity and contributing';
- 'relationships and support';
- 'services and treatments';
- 'identity and self';
- 'turning points';
- 'finances and housing'.

You should access and read this booklet now via the link above. Select and reflect on two people's stories.

What did you learn from reading these people's accounts of their recovery journey?

Identify three things from this learning that will influence your practice.

-
-
-

Activity 1.10

Some NHS boards and other organisations are producing organisational statements or strategies concerning recovery.

There may also be local resources on which you can draw: some areas have local recovery networks, for example.

Finding out what is happening in your area is a good way for you to start thinking about recovery and what it means for your practice.

All of the other modules in this pack and *all* of the other ESCs will help you reflect on and develop your capability in 'promoting recovery'. This will also be further supported by the learning provided in the *Realising Recovery* learning materials.

You cannot work in a recovery-focused way unless you involve service users and carers, practice in a values-based and socially inclusive way, respect diversity and address inequalities.

6 Identifying people's needs and strengths

Identifying people's needs and strengths involves working in partnership to gather information to agree health and social care needs in the context of the preferred lifestyles and aspirations of service users, their families, carers and friends.

This is about working with others to agree what people's needs are in all areas of their life, keeping in mind the way people like to live and the things they, their family, carers and friends hope for.

To identify people's needs and strengths, you need to:

- carry out (or contribute to) assessments that focus on the strengths and needs of the person using services and family, friends and carers who support him or her;
- work in a way that acknowledges the personal, social, cultural and spiritual strengths and needs of the person;
- work in partnership with the person's network to collect information to assist understanding of the person and his or her strengths and needs.

Activity 1.11

Think about your own strengths and talents.
List the three or four of which you are most proud.

Look back on the information we introduced about **Jenny** on page 3 of the Introduction. Think about what you know about Jenny so far – how might her background influence her strengths and needs?

Now think of a person who uses the mental health services with which you are associated – preferably someone you are working with. What needs does the person have? Be descriptive and positive rather than prescriptive in answering this question.

What strengths does the person have? Consider all the person's abilities, interests and talents – everyone has strengths and talents.

What about the person's support network? To help with this task, perhaps spend some time talking with the person and other members of his or her support network. It may also be helpful to think about your own support networks (friends, families, colleagues) when answering this question.

Note: Please ensure you anonymise any information you write down.

Several modules in this pack will help you reflect on and develop your capability in 'identifying people's needs and strengths', particularly:

- Module 3 – Involving service users and carers;
- Module 5 – Developing socially inclusive practice.

7 Providing service user-centred care

Providing service user-centred care involves working alongside people to identify meaningful goals, primarily from the perspective of service users and their families and carers. It also involves influencing and seeking the means to achieve these goals and clarifying the responsibilities of people who will provide help, including evaluating outcomes and achievements.

This means working towards identifying goals that fit with the service user's, family's and carers' aspirations, rather than focusing on what mental health workers think people need. It then focuses on helping to work out what needs to be done, who will do what, and how progress and success will be measured.

To provide service user-centred care, you need to:

- support the person using services to describe his or her wants and needs in a way that is meaningful;
- support the person using services to identify and use his or her strengths to achieve goals and aspirations;
- work with the person to identify the strengths and resources within his or her wider network that can play a role in supporting goal achievement.

Activity 1.12

Identify anybody, or anything, you found helpful or supportive at a time in your own life when you were distressed.

The SRN undertook a major narrative research project that aimed to further promote understanding of 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*[19] was published in 2007 and details the findings of this major research study.

Some of key issues from the report are highlighted in Box 2.

Box 2 Key issues from *Recovering Mental Health in Scotland*

Recovering identity

- Confidence
- Hope and optimism
- Self acceptance, responsibility, belief and esteem
- Self-efficacy
- Self-awareness
- Growing beyond the label
- Reclaiming power and self-determination
- Belonging – cultural, social and community identity
- Activism
- Spirituality

Engagement and finding meaning and purpose

- Being valued – giving back
- Meaningful roles
- Volunteering, employment and education
- Learning about self and condition
- Community and social engagement
- Communities and housing
- Exercise and creativity

Relationships

- Friendships
- Supportive family relationships
- Intimate relationships: partners
- Parenting
- Peers
- Pets
- Service professionals – a critical friend
- Mutual trust and recognition
- Hopeful relationships

Treatments and supports

- Feeling informed and in control
- Continuity and flexibility
- Treatments and therapies
- Security
- Peer support
- Relationships, attitudes and power
- Housing and community supports
- Financial security

Pacing and turning points

- Coping
- Other people’s experiences
- Taking control
- Changes in thinking and being
- Narrating your story

You can see from Box 2 the range of issues that were seen to be helpful. Some are offered by mental health services, but many more are beyond the current scope of most services.

In 2011, the SRN will be revisiting the narrative research by conducting follow-up interviews with some of the people who took part in the original research. You should continue to check the SRN website, as new information will continually emerge.

Remember to think broadly when supporting people to help them to describe goals, identify strengths and develop their own recovery strategy.

All of the other modules in this learning resource will help you reflect on and develop your capability in providing service user-centred care.

8 Making a difference

Making a difference involves facilitating access to and delivering the best quality, evidence-based, values-based health and social care interventions to meet the needs, goals and aspirations of service users and their families and carers.

'Making a difference' means making sure that service users, their families and carers have access to a range of high-quality care and treatment options that work well for them, are delivered appropriately and meet their needs and hopes for the future.

To make a difference, you need to understand the notions of evidence-based and values–based 'best practice'. Values-based practice is explored in detail in Module 2.

What evidence should be informing practice? Basically, we are looking at:
- research;
- clinical guidelines;
- best practice statements;
- integrated care pathways;
- importantly, the lived experience and expertise of people who have experienced mental health problems and mental health services and the experiences of their families and carers.

NHS Quality Improvement Scotland (NHS QIS) (part of Healthcare Improvement Scotland from March 2011) was a special health board that led on improving quality of care and treatment delivered by services across NHSScotland. NHS QIS produced a number of clinical guidelines and best practice statements relevant to mental health. It also developed a programme of work on integrated care pathways as part of the commitments laid out in Scotland's mental health policy.

There are many definitions of an integrated care pathway (ICP). ICPs are both a tool and a concept that embeds guidelines, protocols and locally agreed, evidence-based, person-centred best practice into everyday use for individual service users. They also enable differences from planned care to be recorded in the form of variances, which enable us to compare planned care with care actually given.

In simple terms, an ICP aims to have the right people, doing the right things, in the right order, at the right time, in the right place, with the right outcome – all with attention to the service user's experience.

The Healthcare Improvement Scotland website[20] contains a wealth of information on clinical guidelines, best practice and the mental health ICP work.

Evidence into Practice[21] is a new resource launched by NES in 2010. It helps NHS staff to find, share and apply evidence to practice to deliver the best-quality care. It aims to equip NHSScotland with the knowledge and tools to deliver a world-class health service and facilitate change in practice at the front line by providing:
- access to the evidence base for safe, effective, person-centred care;
- tools and support for creating, sharing and disseminating knowledge through communities and networks;
- tools and outcome measures to support, record and monitor improvement in practice;
- learning resources and guidance for quality improvement science.

Alongside evidence generated by scientific research studies such as clinical trials, it is also crucial to attend to what service users, families and carers say makes a difference. A wealth of literature is available in this area: we have previously mentioned the narrative research undertaken by the SRN, and *Finding Strength from Within* [22] is a report about how black and minority ethnic communities experience and understand mental health, wellbeing and recovery based on three community development projects in Edinburgh.

These are excellent examples of the quality material that is available. This type of evidence can highlight factors that make a difference to service users and carers that are somewhat different from the factors outlined in clinical guidelines, such as specific treatments or medications.

Activity 1.13

Reflect on one person you have worked with for whom you believe your care and interventions made a real difference.
Bearing in mind we are defining evidence broadly here, what 'evidence' helped guide your decisions around the support and interventions you undertook with this person?

What values influenced your choices?

Did you use any evidence-based clinical guidelines?

What sources of evidence did you use to inform your practice?

It is essential for best practice in mental healthcare that we always seek the views of the people we are working with to gauge how helpful our support and interventions are to them.

Activity 1.14

What means and processes are currently used in your team or service to gain feedback from service users and carers about their experiences of the quality of the service?

What are the strengths and limitations of the approaches currently used?

How do you gain feedback about your support and interventions from service users and carers you work with?

What steps could you take to enhance opportunities for people to be involved in giving feedback about their experiences of the quality of the service you work in and what you provide for them as a worker?

All of the other modules in this learning resource and *all* of the other ESCs will help you reflect on and develop your capability in ‘making a difference’.

9 Promoting safety and positive risk taking

Promoting safety and positive risk taking involves working with people to decide the level of risk they are prepared to take with their health and safety. It encompasses working with the tension between promoting safety and supporting positive risk taking, including assessing and dealing with possible risks for service users, carers, family members and the wider public.

One of the quality ambitions for NHSScotland concerns 'patient' safety. It aims to ensure there will be no avoidable injury or harm to people from healthcare they receive and that an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times. The Scottish Patient Safety Programme (SPSP)[23] has been established in general acute hospitals for some time and there are plans to roll out this programme in mental health from 2011.

There are sometimes tensions in mental healthcare between promoting safety and supporting positive risk taking. 'Positive risk taking' is *not* about neglecting risks and compromising people's safety. Rather, it involves:

- weighing up the potential benefits and harms of exercising one choice of action over another;
- developing plans and actions that reflect the positive potentials and stated priorities of the service user;
- using available resources and support to achieve the desired outcomes and to minimise potential harmful outcomes.

Short-term heightened risk may need to be tolerated and managed to secure longer-term positive gains.

Risk is often defined in terms like 'danger', 'loss', 'threat' and 'damage', or in mental health services' behaviour resulting in suicide, self-harm or aggression and violence. Steve Morgan[24] has worked extensively in this area and points out that one of the problems with this negative loading of risk is that it can dissuade us from considering positive aspects of risk, such as accepting a challenge or an opportunity to gain something.

Activity 1.15

Taking risks is something we all do frequently in our lives, sometimes to *develop*, because we see the potential for opportunity rather than failure (learning to swim, for instance), and sometimes to respond to issues outwith our control, such as making changes to your life after a relationship has ended.

Think of a time when you have taken a risk in either your personal or working life. What factors enabled you to take this risk?

The issues you identified in Activity 1.15 might have included:

- having enough information to exercise choice and make decisions;
- holding some control over the direction of your destiny;
- having a degree of power and control;
- being able to work with others positively to inform your decisions;
- having options to make constructive use of opportunities;
- having autonomy;
- having opportunities to learn from experiences.

These are no different from the opportunities service users need to be supported through positive risk taking.

Sometimes mental health professionals feel that their job is to protect the people they work with – protect them not only from physical harm, but also from failure. But if any of us are to do the things we want to do, we have to risk the possibility of being unsuccessful.

For example:

- none of us would have friends or partners if we had not risked the possibility of being rebuffed or rejected;
- none of us would have qualifications if we had not risked the possibility of failing our examinations;
- none of us would have jobs if we had not risked the possibility of being turned down.

The quotation from Morgan below, made in 2000, suggests there is often a culture in mental health services that prevents positive risk taking:

> *"'Tick the box and cover your back, after all you are working in the culture of blame'. In this scenario, risk assessment seems less concerned with formulating good clinical judgement, and more focused on providing 'defensible' decisions. Risk assessment seems overly preoccupied with completing the paperwork, and less on the activity of risk management."*

Activity 1.16

Does the 2000 quote from Morgan tally with your experience of mental health services now?
If your answer was '**yes**', give examples of how and why this is still the case.

If your answer was '**no**', what has enabled any positive changes to happen?

Morgan has also identified factors that need to be in place to enable positive risk taking to happen in mental health services.[25] These involve the following.

- **A focus on people's 'strengths'** This provides a more positive base on which to build potential plans. It involves considering the strengths and abilities of the service user, of his or her wider network and social systems, and of the wide-ranging services potentially available (statutory and voluntary sectors and, most important, non mental-health resources).
- **Partnership working** This involves a clear understanding of the responsibilities that service users and services can reasonably hold in specific situations, providing opportunities for people to take chances, learn from their experiences and understand the consequences of different courses of action.
- **A willingness on behalf of all people involved in a team or service to engage in positive risk taking** If parts of the wider network are not signed up, confidence in being able to sustain positive risk taking becomes undermined. Fears associated with a 'blame culture' are more likely to permeate thinking and threaten the implementation of creative ideas.
- **High-quality supervision and support** This must be in place as it is essential for discussing and refining ideas.
- **The development of appropriate crisis and contingency plans** These will aid prevention of some harmful outcomes and will minimise others. Risk taking needs to be undertaken in a context of promoting safety, not negligence.
- **It should become part of the culture of training** Risk taking should not be seen as a one-off experiment. It should be a natural line of thinking. Whole-team training will be essential if the approach is to be fully understood and practised by all team members as a routine part of its culture.
- **Adequate resources to enable creative work** Creative work should take precedence over 'what usually just happens'. Resources are never open-ended, but true innovation needs organisational support to sustain its development and positive impact.
- **Limiting the duration of the decision** This means working to shorter timescales and with smaller goals broken down.
- **Having team and service mechanisms** These should be in place to check on progress. They provide an ability to quickly change previous decisions when needed, including intervening in a more restrictive way when necessary.
- **Individual and collective accountability and responsibility is clearly defined** Individual practitioners can reasonably be expected to be accountable to the standards of conduct set out by their professional body and for the roles they play in local implementation of guidance and legislation. But there are also collective responsibilities for information sharing, decision making and care planning that belong more with the team than with the individual in isolation. This includes the need for positive and efficient systems of verbal and written communication being in place.
- **The 'organisation' also holds responsibilities** It must ensure adequate support and set the tone for the development of a culture that will enable all the above points to happen.

Activity 1.17

Some of the factors above are clearly influenced by organisational and whole-team commitment, but some could be influenced at an individual worker level.

What changes could you influence to create a climate that supports positive risk taking?

All of the other ESCs will help you reflect on and develop your capability in 'promoting safety and positive risk taking'. Other modules in this learning resource will develop this, particularly:

- Module 2 – Values-based practice;
- Module 3 – Involving service users and carers;
- Module 5 – Developing socially inclusive practice.

The Practice Based Evidence website[26] provides useful information in relation to positive risk taking in mental health practice. You may also want to refer to Module 5 in the *Realising Recovery* learning materials – Sharing responsibility for risk and risk taking – which explores this area in more depth.

10 Personal development and learning

Personal development and learning involves keeping up to date with changes in practice and participating in lifelong learning and personal and professional development opportunities for self and colleagues through supervision, appraisal and reflective practice.

This means:

- keeping up to date with changes in the way services are delivered and the policies, strategies and legislation that inform service developments;
- taking part in learning throughout your life;
- making sure you (and the people you work with) can access advice and support through supervision, regular reviews of progress and opportunities to think about the way things are done.

To promote your personal development and learning, you need:

- access to education, training and other personal development opportunities;
- a personal/professional development plan that takes account of your hopes and aspirations and which is reviewed regularly;
- to understand the responsibilities of the service in supporting you in meeting goals set out in the development plan;

- to understand your personal responsibility to achieve the goals set out in your development plan;
- to recognise the importance of supervision and reflective practice and integrate both into everyday practice;
- to be proactive in seeking opportunities for personal supervision and personal development and learning.

Supervision

Supervision is of particular importance in mental health work and in undertaking the 10 ESCs learning.

Supervision is a term used to describe regular meetings with a supervisor in which mental health workers are able to discuss and reflect on the work they do and their own learning and development needs.

The person supervising the worker listens, advises and helps the worker to develop his or her practice. Other forms of support, such as mentoring, coaching and group meetings with colleagues, are provided in some settings in addition to, or instead of, individual supervision sessions.

The supervision process includes evaluation of specific pieces of work with service users and carers. This helps to ensure that workers are using effective, evidence-based approaches and have the skills, knowledge and experience they need to cope with changing demands.

If you do not have opportunities to engage with support or supervision in relation to your practice, you should talk to your manager or a senior person in your organisation as soon as possible. It is very difficult to put new learning into practice without the help of a supervisor, and you need the opportunity to discuss any difficult issues that arise from the work you do.

Action into practice

If you receive clinical supervision, what qualities of the experience make it positive and helpful?

From what you've learned so far about the ESCs, what are your first thoughts? You may want to look back on this when you finish the programme.

What kind of support might you require to complete the 10 ESCs learning and take your learning forward to develop your practice in a positive direction?

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Module 2

Values-based practice

This module is based on work originally developed by Bill Fulford, Professor of Philosophy and Mental Health, University of Warwick/Honorary Consultant Psychiatrist, Department of Psychiatry, University of Oxford/National Fellow for Values-Based Practice at CSIP/NIMHE and Kim Woodbridge, who worked at the Sainsbury Centre for Mental Health. We gratefully acknowledge their contributions.

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Welcome to Module 2

Values-based practice is a way of working positively with diversity and differences of values.

Learning outcomes

After completing this module, you will be able to:

- explain what values-based practice means in mental health and social care;
- describe the 10 pointers to good process in values-based practice;
- explain the relationship of values-based practice to the 10 ESCs;
- begin to apply values-based practice in your work.

We will explore values-based practice using Pete's story. We introduced Pete earlier – here is a reminder of the information you have about him so far.

Pete

Pete is a 35-year-old art history graduate who has been in contact with mental health services since his early twenties. Pete has a strong interest in photography and travelled extensively when he was younger. He worked as a curator in a small gallery until his late twenties but has not been in paid employment since. He has recently started attending college. Pete lives in supported accommodation and has a brother, John, and his close friend is Colin.

1 What are values?

Before exploring values-based practice, it is useful to clarify what we are referring to when we use the word 'values'.

Activity 2.1

Please answer the following questions. This activity will help you to identify what values mean to you. There are no 'right' or 'wrong' answers.

What are values?

Compare your answer with what other people said in Box 3 – do you match with a particular group, or have you said something new or different?

Box 3 What are values?

List 1

Delegates at a recovery conference

- Core beliefs
- Principles – cultural, individual
- Anything that's valued
- Quality of life
- Right to be heard
- Social values
- Self respect
- Valuing neighbours
- Your perspective on the world

List 2

Managers/chief executives

- Right and wrong
- Belief systems
- Ideals and priorities
- Things that govern behaviour and decisions
- Morals
- Principles
- Standards
- Conscience
- Fluid/changeable

List 3

Trainee psychiatrists

- What you believe in
- Self esteem
- Principles
- Integrity
- Openness/honesty
- Personal motivating force
- Primary reference points
- Ethics
- Virtues

You will have thought about what you mean by values in completing this activity. You will also be aware that the word may mean different things to different people.

Activity 2.2

Reflect on what kinds of things have influenced your values.
You may have considered things like parents, siblings, school friends, the media, relationships – in other words, there is a whole range of factors that can influence your values.

2 The importance of values

Values have a key role in today's mental health services, in the experiences of people who use services, and in the experiences of their families and carers. Here's an account from Pete, who has used services since he was in his early twenties. We will revisit Pete's story later in the module.

Pete's account (1)

My name is Pete. I'm 35 and I live in a room in a house that I share with four other people who have mental health problems. I live in one of the rooms on the top floor. My friend Colin lives in the other one. I should have a key to lock my room but the key's broken. The light bulb's gone on the stairs so it's very dark in the hall.

I shake a lot and sometimes dribble. I try to wipe my mouth before I dribble but I'm not always quick enough. I wish I didn't dribble, it's embarrassing when I talk to people. I've seen the GP, but he says there's nothing he can do about it. I wonder if the chemicals I use cause it?

My brother John visited today. He was really upset when he saw me. He'd come to take me and Colin out for lunch. I had someone else's trousers on and I had to hold them up as they were too big for me. I told my brother I didn't wear underpants – I do, but I didn't have any and he was already upset. All my clothes go into the laundry and get lost. I just have to wear what I can find.

John, me and Colin went to the shopping centre. We bought some new clothes, then we went for lunch. I can't chew, so I had the soup. I think it's my tablets that make it difficult for me to chew.

On the way back in the car I was teasing John. He has satellite navigation. Colin was teasing him as well, I don't think he minds – we all laughed.

I like photography. I go to a course at college and develop my own pictures. I want to take landscape photographs. I showed my brother my photos, and he wants to frame them they're so good.

It's my birthday tomorrow. John left me some presents, some tobacco and a bottle of lager. Colin told him we can't have alcohol in the house. I know my brother cries sometimes after he visits me.

Activity 2.3

Think about Pete's account and reflect on these questions:
What is your initial reaction to Pete's account? How does it make you feel?

What do you see as the main issues in Pete's account that need to be addressed?

What do your responses to the above questions say about what you value?

Drawing on the above, list some of the values you bring to your work.

Common answers to this question include: honesty; reliability; humanity; caring about other people; tolerance; enthusiasm. Sometimes answering this question reminds people why they chose to do the work they do.

It would be useful to discuss your responses in this learning activity with others who have also completed it.

3 Professional value statements

We will explore in this section many statements of values that should determine mental health workers' actions. The principles underpinning the Mental Health (Care and Treatment) (Scotland) Act 2003 could be seen as defining in law some of the values that should underpin mental health practice (see Module 1). The Mental Welfare Commission for Scotland has developed a Principles into Practice Network[28] that aims to promote care and treatment complementary to the principles of Scottish mental health law. The network provides opportunities to share practical tools, opinions and experience of principles-based care.

Some professional groups have also articulated statements of common values. *Rights, Relationships and Recovery: the report of the national review of mental health nursing in Scotland*[29] produced the values statement shown in Box 4. The statement was written jointly by mental health nurses, people from other agencies, service users and family/carers' representatives.

Box 4 The values base for mental health nursing

Relationships	■ Putting positive working relationships supported by good communication skills at the heart of practice. ■ Maximising time to build relationships and challenging systems that detract from this. ■ Recognising when relationships are unhelpful and taking steps to address this.
Rights	■ Based on principles in legislation, safeguards and codes of conduct.
Respect	■ For diversity of values and placing the values of individual users at the centre of practice. ■ Listening to what people say and not basing practice on assumptions about what people need. ■ Seeing the whole person and not just his or her symptoms. ■ Seeing the person as the 'expert' in his or her experience. ■ For the contribution of families and carers. ■ For the contribution of other professionals and agencies. ■ For the social context of people's lives.
Recovery	■ Promoting recovery and inspiring hope – building on people's strengths and aspirations. ■ Increasing capacity and capability to maximise choice.
Reaching out	■ To make best use of resources available in the wider community. ■ To other agencies involved in mental health care. ■ Being proactive about opportunities for change and mobilising opportunities to work with others to bring about change.
Responsibility	■ At corporate, individual and shared levels to translate the vision and values into practice by evolving current frameworks for practice and challenging and shaping institutional systems and procedures to accommodate this.

The 21st Century Social Work Review in Scotland was commissioned to examine how social work services can adapt to meet present and future needs. A new direction for social work services in Scotland is set out in the report *Changing Lives,*[30] which aims to reinvigorate social work's core values (Box 5).

Box 5 *Changing Lives*

Core values of social work in Scotland:

- respecting the right to self determination;
- promoting participation;
- taking a whole-person approach;
- understanding each individual in the context of family and community;
- identifying and building on strengths.

We can see that there are areas of similarity and difference in the two professional values statements in boxes 4 and 5. You may want to discuss them with others. You may also want to look back at Pete's account (1) on page 39 and consider how applying these values statements could determine how mental health nurses and social workers should support Pete.

Realising Potential[31] was published by the Scottish Government in 2010 and is a three-year action plan for allied health professionals (AHPs) working in mental health in Scotland. While not setting out an explicit value statement for AHPs, statements about the values that underpin AHPs' work in mental health and the difference they can make to promote recovery are found throughout the report.

Whatever stakeholder group we believe we belong to, we all need to recognise and understand others' values. Mental health work involves a range of different disciplines, agencies and organisations. Differing values held by groups (as well as those held by individuals) will influence how we work together and relate to each other.

Activity 2.4

Ask a person you work with about the values statement for their discipline, agency or organisation. Complete this activity in a learning group or in the team in which you work, if possible.
Be creative when thinking about who you might ask. Consider your own role and define which person you would benefit most from learning more about. He or she could be a psychiatrist, an occupational therapist, an advocacy worker, a psychologist, someone from a service user or carer group – the list of potential candidates is very long. It will be interesting to note if people are able to easily answer your question.

What are the areas of similarity and difference between what the person told you and the values **you** hold as an individual?

What are the areas of similarity and difference between what he or she told you and the values **your discipline, agency or organisation** holds?

What opportunities or challenges might this create for working together?

You will appreciate that we hold common and different values as individuals and as groups.

Not all professions, agencies or organisations will have values statements. Sometimes looking at things like the 'purpose', 'mission', 'vision' or 'aims' of organisations/agencies can give us an idea of the values that might underpin their work and purpose.

Additionally, many professions have codes of conduct. These codes are statements about the values and (more importantly, some would argue) behaviours expected from a particular profession, providing practitioners, professionals from other disciplines and the public with solid indicators of how they should behave in certain situations.

Activity 2.5

If applicable, *look at the code that applies to your profession; alternatively, you could look at your organisation's/agency's 'purpose', 'mission', 'vision' or 'aims'.*

Look at Pete's account (1) again (page 39). If you were involved in supporting him, how should you respond to ensure you comply with your professional code or organisation's/agency's 'purpose', 'mission', 'vision' or 'aims'?

Having done this, look again at your responses to Learning Activity 2.2.
Is there any conflict between your own values and what is expected of you under the code or organisation's/agency's 'purpose', 'mission', 'vision' or 'aims'?

4 Values-based practice

Just as it is difficult to agree on one definition of the word 'values', so values-based practice can be defined in different ways.

Values-based practice might mean following a code of values; we explored what this means for some people in the preceding section. As we saw, it might be a national framework of professional values, such as those developed in nursing and social work in Scotland, or a local values framework developed by a housing association or voluntary organisation.

In fact, values-based practice means something quite different:

- it is about working in a positive and constructive way with differences and diversity of values;
- it means putting the values, views and understandings of individual service users and carers at the centre of everything we do;
- it means understanding and using our own values and beliefs in a positive way;
- it is about respecting the values of the other people we work with and being open and receptive to their views.

In this module, values-based practice is defined as:

> *"the theory and capabilities for effective decision-making in health and social care that builds in a positive way on differences and diversity of values."*

This is quite a difficult definition. In practice, it means that working in a positive way with differences and diversity of values depends on good process – in other words, good ways of engaging with others on an equal basis, rather than telling people the values they should have.

Woodbridge and Fulford[32] have identified 10 'pointers' to good process in values-based practice. We will look briefly at these 'pointers' in the next section and start to identify some of the ways in which they contribute to the 10 ESCs.

5 Values-based practice and evidence-based practice

The 10 pointers to good process in values-based practice are summarised in Box 6. The pointers cover:

- key practice skills;
- a model of service delivery that is user centred and multidisciplinary;
- strong links with evidence-based practice;
- partnership in all areas of health and social care.

Box 6 The 10 pointers to good process in values-based practice[33]

Practice skills

- **Awareness**: being aware of the values in a given situation
- **Reasoning:** thinking about values when making decisions
- **Knowledge**: knowing about values and facts that are relevant to a situation
- **Communication:** using communication to resolve conflicts/complexity

Models of service delivery

- **User centred:** considering the service user's values as the first priority
- **Multidisciplinary:** using a balance of perspectives to resolve conflicts

Values-based practice and evidence-based practice

- **The 'two feet' principle:** all decisions are based on facts and values; evidence-based practice and values-based practice therefore work together
- **The 'squeaky wheel' principle:** values shouldn't just be noticed if there's a problem
- **Science and values:** increasing scientific knowledge creates choices in healthcare; this can lead to wider differences in values

Partnership

- **Partnership:** in values-based practice, decisions are taken by service users working in partnership with providers of care

The term evidence-based practice, incidentally, has different meanings, just like the term values-based practice. Here is one example:

> *'Evidence-based practice means being aware of the evidence that relates to your practice and how strong that evidence is.'*

6 Using values-based practice

It is easier to understand and remember the 10 pointers to good process if you apply them and link them with the 10 ESCs. The next activity will help you to do this. But first, read Pete's second account.

Pete's account (2)

Things are looking up for me now and I am getting on better. My new key worker is really nice and put me in touch with Bob, who is an advocacy worker, and between the three of us we have been getting some stuff that was worrying me sorted out.

I am moving into a new flat and will be sharing with my freind Colin. It's really nice and is provided by an organisation that is about helping folk get back on their feet. There are staff who give you help and support when you need it and you can contact them when you want.

My course at college is going really well and they are putting on an exhibition of my landscape photographs as my tutor says they are really good – I feel really proud about this. I have also got friendly with a woman called Jane from my class and we have been out after class for a coffee a couple of times.

The big downside is my shaking and I am still dribbling and having problems with my swallowing – it's embarrassing and I am worried it will put Jane off going out with me. I know this is about my tablets, because when I went to my GP he said it was 'side effects'. I think I would like to stop them, but Dr Brown, my psychiatrist, says they are important and keep me well. I told my brother John as well and I know he is worried and reminded me that when I have stopped taking them before, I have ended up in hospital.

Activity 2.6

Reflecting on Pete's account (2), Pete appears to be going through a period of positive change in his life, but there are concerns about his wish to stop his medication.

In this activity, you need to imagine that you are Pete's key worker.
John has been in touch with Dr Brown as he is very worried that Pete is going to stop taking his medication. Dr Brown has scheduled a meeting for all the people involved in Pete's care and treatment, including Pete, yourself, Dr Brown, John and Pete's social worker. Pete has requested that Bob, the advocacy worker, come with him to the meeting.

Using the 10 pointers to good process in values-based practice (see Box 6), use the table below to show which pointers will be particularly important in the team working with Pete. Note your reasons for these choices and see if you can make a link between the pointers you identify and one or more of the ESCs.

Pete's account (2)

Ten pointers to good practice	**Does this apply?**	**Why is this important?**	**Number(s) of relevant ESCs**
1 Awareness			
2 Reasoning			
3 Knowledge			
4 Communication			
5 User-centred			
6 Multi-disciplinary			
7 'Two-feet'			
8 'Squeaky wheel'			
9 Science and values			
10 Partnership			

When you have completed this activity, you may like to look at the example overleaf which illustrates how the 10 pointers could have been applied.

Pete's account (2) ***Example of application***

Ten pointers to good practice	Does this apply?	Why is this important?	Numbers of relevant ESCs
1 Awareness	✓	*We need to understand and respect why Pete is making this decision and recognise what values are informing his choices.*	1, 3, 4, 5, 6, 7, 8, 9
2 Reasoning	✓	*We need to look at the values held by* all *involved in this scenario and how this will impact on how they feel about Pete's decision. This could involve values being influenced by a particular model of understanding mental health problems, or a particular personal stance on issues like people's rights. There is a need for open discussion about how these influence decisions.*	
3 Knowledge	✓	*As above.*	
4 Communication	✓	*This is a complex situation and everyone will need time to discuss the issues and reflect on their values.*	
5 User-centred	✓	*Pete's values are the first priority.*	
6 Multi-disciplinary	✓	*There needs to be a balance of perspectives while valuing different standpoints.*	
7 'Two-feet'	✓	*Knowledge of medication effects vs. distress and embarrassment being experienced by Pete.*	
8 'Squeaky wheel'	✓	*The meeting has been called because of Pete wanting to come off his medication and this is being perceived by others as a problem.*	
9 Science and values	✓	*The key here is Pete's choice. His current medication is not acceptable and he feels his only option is to stop it. Offering information about evidence related to the pros and cons of changing or stopping medication, or exploring different therapies, will assist him in making informed choices.*	
10 Partnership	✓	*In values-based practice, decisions are taken by service users working in partnership with providers of care.*	

All the ESCs could be seen as relevant, but we have selected only those that are particularly pertinent.

There is an obvious connection between the values-based practice pointers of service user-centred care and partnership and ESC 1 – Working in partnership, and ESC 7– Providing service user-centred care. The relationship between the pointers to values-based practice and the ESCs identified in the example of application can be further explained by seeing values-based practice as the process that can help achieve the ESCs.

Values awareness, reasoning, knowledge of values and communication are all skills that can be used to promote equality and recovery, identify people's needs and strengths and promote safety and positive risk taking.

7 Conclusion

Now that you have completed this module, you should have an understanding of values-based practice and should have considered how to start to apply the 10 pointers to good process. You have also had the opportunity to think about how these link with the ESCs.

We hope that you will continue to think about values-based practice as you work through the rest of the ESCs learning resource. Here are some questions that will help you to apply values-based practice with your own role.

- What are the values of the team/network/group you work with?
- How are differences in values resolved in your team/network/group?
- How do the 10 pointers to good process relate to your everyday work and fit with your development plan?

Action into practice

Apply the 10 pointers to good practice to a person you are working with, or to a situation that might be challenging you or your team.
This would best be achieved either in your supervision session or through discussion with your team.

From what you've learned, what changes do you plan to make in relation to providing person-centred care and to developing partnerships?

References

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Module 3

Involving service users and carers

Contents

Welcome to Module 3

Involving service users and carers is about promoting people's ability to lead their own care and treatment and to be involved in partnerships to develop services. This module aims to support you to develop service user and carer involvement locally.

It is important to recognise that service users and carers often have quite different needs that may call for different levels of understanding from services and different approaches to ensuring needs are met. This is discussed within the module.

Learning outcomes

After completing the module, you will be able to:

- describe the links between service user involvement, carer involvement and the 10 ESCs;
- discuss service user and carer involvement at individual, organisational and strategic levels;
- explore local approaches to increasing service user and carer involvement in their own care and in service design;
- describe the approach to service user and carer involvement you would like to see developed in the team, service or project in which you work;
- present ideas on how this improved approach can be achieved, defining the role you and your immediate colleagues can play.

We will explore service user and carer involvement in relation to a number of stories of the people we introduced earlier. Here is a reminder of what you know about them so far.

Jim (67) and his wife Mary (65)

Jim is a retired joiner and Mary did lots of part-time jobs in-between raising their two children. They have three grandchildren. Mary has Parkinson's disease, which limits her mobility and creates some problems with her dexterity. Generally, however, she manages the condition pretty well.

Jim plays bowls regularly, an activity he has pursued all his adult life, and is secretary of the committee at his local bowling club. Jim has also enjoyed reading and likes to keep up to date with politics and current affairs. He is a keen gardener and has an allotment which he enjoys. Jim has won competitions in the past for the fruit and vegetables he has produced.

He is finding, however, that he has gradually worsening short-term memory loss, which is leading him to feel very down in mood. Jim and Mary have no previous contact with mental health services.

Pete (35)

Pete is a 35-year-old art history graduate who has been in contact with mental health services since his early twenties. Pete has a strong interest in photography and travelled extensively when he was younger. He worked as a curator in a small gallery until his late twenties but has not been in paid employment since. He has recently started attending college. Pete lives in supported accommodation and has a brother, John, and his close friend is Colin.

Mina (26)

Mina is a 26-year-old Pakistani Scottish woman who married Aasim a year ago and is now pregnant with their first child. She's a practising Muslim. On her marriage, Mina moved from a city in central Scotland to live with Aasim and his parents and extended family in a remote and rural area of the country, some distance from any of the major cities. Mina misses city life and the circle of friends and activities she previously enjoyed and feels quite isolated. She is a qualified pharmacist and really values her job. She currently works part time in a community pharmacy in her local town. Mina has been feeling very anxious recently and has been referred to mental health services via antenatal screening.

Jenny (19)

Jenny is 19 and works in a local supermarket. She was in care between the ages of 13 and 16 but now lives with her mother, Margaret, who has had addiction problems in the past, and her little sister, Megan. She used to have a wide circle of friends. She has had an on–off relationship with Billy, who is significantly older (40), since she was 17. The relationship is not always positive and Billy has frequently subjected Jenny to gender-based violence. Jenny started self harming a year ago and has been treated at accident and emergency three times as a result of overdoses with over-the-counter medications. It has also been noted that she has a number of scars and more recent cuts on her arms. Margaret is very worried about Jenny's state of mind, her behaviour and her relationship with Billy.

Additional notes for this module

- You should use some of the time you spend on this module finding out about local service user and carer groups, their contacts, activities and priorities.
- The module looks at both service user and carer involvement. It recognises that the needs of the two groups may differ, but that there is also much similarity between them. Each group wants a mental health service that is modern, up to date, well resourced and staffed by hopeful workers who listen and respond to their needs.

1 Introduction

Policy, legislation and strategies related to service user and carer involvement

Policy developments in Scotland since devolution have encouraged public sector bodies to be more accountable to service users. NHS boards have a legal duty to involve the public in planning and developing services, and the *Changing Lives* implementation plan[34] means service users and carers have a big say on social work service improvements. Service user and carer involvement is now central to the work of a range of statutory bodies.

Mental health services have been required through policy to involve service users and their carers for a number of years. The development of community planning partnerships aims to ensure that people are included in making decisions about public services across the sectors. The Mental Health (Care and Treatment) (Scotland) Act 2003 puts service users and their carers at the centre of the mental healthcare and treatment system, with *Caring Together: the carers and young carers strategy for Scotland 2010–2015*[35] being launched in 2010. We will explore the implications of these policies, legislation and strategies throughout this module.

Involving people in designing and delivering services is admirable, but the services they contribute to, and the experience of people within them, have to be shown to be improving. Scotland's national service-user organisation, Voices Of eXperience (VOX),[36] was formed to deliver improvements in people's experience of services, strengthen their voice and influence planning and practice.

This could be considered by thinking through:

- organisational factors;
- values-based factors;
- care and treatment-orientated factors;
- other factors – please describe.

2 Exploring service user and carer involvement

Activity 3.1

Thinking about your own practice, how do you currently support service users to be involved as partners in their care?

Thinking again about your own practice, how do you currently involve family members/carers as partners in supporting service users?

What support do you think service users need to be involved?

What support do you think carers need to be involved as partners in service users' care?

In your view, what positively promotes service user and carer involvement?

over ▶

In your view, what are the barriers that can prevent service user and carer involvement?

This could be considered by thinking through:

- values-based factors;
- care and treatment-orientated factors;
- other factors – please describe.

2.1 Levels of involvement

Service user and carer involvement can happen at different levels and in different ways.

Below we identify three levels where service user and carer involvement can take place.

Individual

People being involved in their care and treatment in ways that meet their needs, reflect their desired outcomes, give them choices and control, and involve them in all steps of the process. Equally, carers want to be recognised, listened to and supported as partners in providing care.

Organisational

Service users and carers being able to influence services, projects or organisations by ensuring they are designed and delivered to meet their needs and outcomes, rather than them having to fit into an existing structure or system.

Strategic

Service users and carers being able to influence politicians, policy and service developments at all levels and in all relevant spheres, not just mental health planning, to make sure law, policy and services reflect the experiences, expertise and needs of service users and carers. Often it is about influencing the government, service commissioners, multi-agency planning partnerships and committees (such as community planning partnerships) and local funding bodies.

Activity 3.2

Do you have examples of involvement at any of these levels? If so, describe them.

You will be able to compare the examples you have identified with those provided later in the module.

2.2 Involvement at an individual level

In 2010, the Scottish Government, in partnership with COSLA, launched the *Self Directed Support Strategy for Scotland.*[37] Self-directed support (SDS) is the support individuals and families have after making an informed choice on how their individual budget is used to meet the outcomes they have agreed. SDS means giving people choice and control.

SDS can include direct payments systems: these are the most obvious example of people being facilitated to choose what support they would like through directly purchasing services necessary to meet their needs. The Scottish Government has an ambition to change the law on SDS and direct payments and develop a new law to ensure that people are always able to exercise this choice. You should check the Scottish Government website[38] to keep up to date with progress on SDS legislation.

We will revisit and explore SDS in more detail in Module 5 (Developing socially inclusive practice).

Another example of personal involvement can be found in making an 'advance statement' (as recognised by the Mental Health Act), which is an agreement on what happens if the person becomes unwell. A service user who has made an advance statement said:

> *"Writing an advance statement has made me feel that I have taken control of my care and treatment. I feel more empowered and the whole process has given me an opportunity to think through my mental health history and what works for me."*

For examples of preparing and using advance statements, see the guidance on advance statements produced by the former Scottish Executive,[39] by the Consultation and Advocacy Promotion Service (CAPS)[40] and Advocard,[41] two independent organisations based in Edinburgh.

It would be useful for you also to access guidance on advance statements produced by service user, carer and advocacy organisations in your local area.

An independent advocacy worker[42] can enable people who use mental health services to have more say in their care and feel more able to make choices about support options on offer.

Example ***Involvement at an individual level***

You may recall that Pete has an independent advocacy worker – Bob. During a conversation with Pete, Bob speaks about the fact that Pete hasn't developed an advance statement and might want to think about the benefits of developing one.

As we saw previously, Pete was keen to have his medication adjusted to help him avoid unwanted effects. With support from Bob, he negotiated a reduction of his medication with his GP and psychiatrist, although it was accepted that there were risks in this approach – the last time Pete had had his medication reduced substantially, an admission to hospital was eventually required.

But on discussing the risks with Bob and the mental health team, and with his brother, he felt that the risk was worth taking, as reduction of the medication would be likely to have a significant positive impact on his life, particularly in terms of attending his college course and his growing friendship with Jane.

Pete has now written his own advance statement, with support from Bob and his brother, using a person-centred planning approach. He has given a copy to all those involved in supporting him. It now means that if he wants to review or alter his care, Bob and he will meet with the professionals involved to agree changes.

Involvement in care and treatment planning

It is essential to actively and meaningfully involve people in assessments, reviews and decision-making about their care, support and treatment.

Core components of effective service user involvement have been identified. They include people:

- having the information they need to be involved;
- knowing what options and choices are available to them;
- feeling free to express views, wishes, goals and desired outcomes;
- being listened to and understood and having their views respected;
- being able to influence what happens and make decisions that matter.

Activity 3.3

We are going to use a rating system to explore involvement in care and treatment planning in your team or service.
This will help you think about what promotes people's involvement and the ways in which service user and carer involvement can develop at an individual level.

What is your experience in your current role or setting with regard to each of the statements given in the left column below? (tick)

Service users:	**Always**	**Sometimes**	**Rarely**
Know what is written in their assessments, care plans and reports	☐	☐	☐
Write in their care plan	☐	☐	☐
Have regular opportunities to discuss their care and treatment with their key worker	☐	☐	☐
Have the information they need to be involved and know what their options and choices are	☐	☐	☐
Are able to express their views and wishes in their care plan and in their own words	☐	☐	☐

What actions could you take personally to increase service users' involvement in care planning?

You may also find it useful to gauge your current practice against the SRI dimension *Service user involvement/participation*. This part of the SRI asks services to assess the extent to which they involve people who use their service in planning their own care and treatment and in making decisions related to how the service operates.

Person-centred planning

Person-centred planning focuses on what individuals at the centre of care and treatment want and on their strengths, rather than weaknesses.

Its success depends upon a willingness to come up with solutions that are not always traditional. Programmes and services need to be geared to assisting the individual, rather than people being asked to fit into the service's approach and structure. It takes account of particular requirements people may have, such as shortage of money, health issues, safety, legal orders and the rights of carers.

Key characteristics of person-centred planning include:
- a focus on the individual and his or her whole life, not just health or social care needs;
- control being with individuals, their advocacy workers and carers.

You can find out more about providing person-centred support in Module 4 of the *Realising Recovery* learning materials.[43]

There is a close link between person-centred values and approaches and effective involvement of individuals in their care planning.

Some other approaches, such as Wellness Recovery Action Planning (WRAP),[44] have been developed to enable service users to manage their own care more effectively. WRAP is a self-management tool that is now used in many countries around the world to help individuals take more control over their own wellbeing and recovery. It emphasises that people are the experts in their own experience and is based on the premise there are no limits to recovery. The Scottish Recovery Network has been supporting the use of WRAP in Scotland.

Overcoming barriers and maximising opportunities for service user and carer involvement at an individual level

Barriers can occur at several levels:

- **individual:** for example, people lose hope and confidence through their period of mental health problems or lose touch with friends, relatives and communities and may feel excluded (carers may experience similar difficulties);
- **service-related:** some service users and their carers have had previous negative experiences of mental health and other statutory services and previous contacts with professionals;
- **societal:** the stigma of mental health problems may mean that people are discriminated against, for example when looking for a job. Discrimination and setbacks can have negative effects on someone's desire to keep trying to engage in activities related to their wellbeing and in contributing to service development. Many carers also report feeling stigmatised, particularly by mental health services, and this can affect their ability to engage meaningfully with efforts to involve them.

The 10 ESCs highlight things you can do to overcome barriers to service user and carer involvement:

- ESC 3 – Practising ethically, by 'acknowledging power differentials and minimising them whenever possible';
- ESC 6 – Identifying people's needs and strengths, by 'working to agreed needs … preferred lifestyle and aspirations';
- ESC 9 – Promoting safety and positive risk taking, by 'empowering the person to decide the level of risk they are prepared to take with their health and safety'.

Actions that can contribute to developing people's confidence include:
- listening and responding to their needs and aspirations;
- providing accessible and comprehensive information;
- working to develop constructive relationships with people;
- basing assessments and plans on individuals' strengths;
- always including people in planning.

Service users and carers have often said they are not always given all the information they need to be able to take a full part in making decisions.

Carers often say they are not given the respect or information they need to be partners in care. As well as giving carers the right to have their views taken into account, the principles of the Mental Health (Care and Treatment) (Scotland) Act 2003 outline the need for carers to be provided with the information and support they need to enable them to fulfil their caring role.

Carers also have a right to an assessment of their own physical and emotional needs and to get the right information to enable them to access services and provide the best possible care and support. The Scottish Government outlines in *Caring Together*[45] an intention to develop a Carers' Rights Charter which will consolidate existing rights in one place and will set out key principles of support to carers and outcomes. The Scottish Government will consider whether further rights should be enshrined in law. You should check the Scottish Government website[46] to chart the progress of this commitment and the impact it may have on your practice and services.

In 2010, Support in Mind Scotland (formerly the National Schizophrenia Fellowship Scotland) launched *It's Their Job, It's My Life*,[47] reporting findings from a survey of 214 carers known to the organisation. The survey asked about carers' experiences of communication and contact with professionals involved in the care and treatment of the person they support. The report contains a wealth of personal testimonies of what helps and what hinders carers supporting someone experiencing mental illness. It also compares carers' experiences now with the findings of a similar survey undertaken by the organisation in 1999.

Support in Mind Scotland found that while some things have improved, they were disappointed that in light of the many legal, policy and practice developments since then, many carers continue to report that they are still not receiving the kind of information they feel they need to help them in their role. You should download and read the full report at
www.supportinmindscotland.org.uk/files/It's%20their%20job,%20it's%20my%20life.pdf
and consider any implications for your service or practice.

Consider this in relation to the example given below.

Example ***Jim and Mary***

Jim, whom we met earlier, has found that his short-term memory problems are worsening, which is worrying him greatly. Mary feels he really should see his GP to discuss it, and eventually he agrees. Accompanied by Mary, he describes to the GP the problems his memory lapses are presenting, the effect it is having on his and Mary's life, and how 'down' all this is making him feel. The GP refers him for specialist assessment at a mental health memory clinic, where he receives a diagnosis of dementia.

The team at the memory clinic prescribe some medication that they assure Jim and Mary will help, which pleases Mary greatly. But both she and Jim are aware that medication on its own won't be enough – they are going to have to work hard to make sure Jim stays engaged and interested, which, they realise, will not be easy, especially given how down his mood has been in recent weeks.

Mary feels she is about to face a major challenge. Her first thoughts are about who to tell – what will she say to her family? – and what can she do to try and ease the situation.

One thing she is very concerned about, even at this early stage, is the thought of Jim entering a care home, even just for a few days to give her a break. Mary's mother now lives in a care home, and it has not been a positive experience for her or Mary.

Jim's thoughts at this point are very much about the future. What will happen to Mary if he's no longer able to look after himself ?

Activity 3.4a

Drawing on what you know about Jim and Mary so far:
what issues do you think Jim would prioritise in terms of support and information?

what issues do you think Mary would prioritise in terms of support and information?

why did you opt for these issues?

What practical steps could you take to help them access the support and information they need? Think of as many possible means as you can.

Jim was quite happy for Mary to be involved in his care and for information about him to be shared, but this is not always the case. Consider the example below.

Example ***Jenny***

As we learned earlier, Jenny is 19 years old, works in a local supermarket and lives with her mother and sister. On three occasions, commonly after arguments with Billy, her boyfriend, she has taken overdoses of paracetamol after drinking alcohol and inflicted some cuts on her arms. On her most recent admission to A&E, she was seen by the mental health liaison team for assessment. A follow-up appointment was made with mental health services.

Jenny's mother, Margaret, accompanies her to the appointment, but Jenny does not want Margaret to know too much about her relationship with Billy and does not allow her to sit in on the consultation.

Jenny is seen by a psychiatrist and community mental health nurse for an assessment.

Margaret asks to speak to the psychiatrist who has seen Jenny, but she has to decline discussing Jenny's case with her as Jenny has instructed her not to do so.

When told this, Margaret says she finds it hard to believe and feels it is an indication of just how unwell her daughter is. She tells the psychiatrist that she is finding it increasingly difficult to support Jenny while she is being completely shut out in this way.

Activity 3.4b

How do you think Margaret might be feeling?

What support do you think the care providers can offer Margaret in this situation?

How can care providers best support Margaret at this stage to support Jenny?

Difficulties arising from 'confidentiality' have been a constant source of concern for carers over many years. They often feel that confidentiality is presented as a barrier to them getting the information they need to be involved in people's care.

While individuals' confidentiality must always be respected, guidance on the issue of confidentiality and carers has been developed by the Mental Welfare Commission for Scotland.[48] The Royal College of Psychiatrists has also provided useful information about carers and the issue of confidentiality.[49]

Creating an environment for involvement

Providing information alone is not enough for partnership. An environment in which people are encouraged to speak up and take part is equally important.

Values integral to creating this sort of environment are reflected in several of the ESCs. For example:

- ESC 2 – Respecting diversity, which is about working with individuals, families and carers, accepting each person for who he or she is and celebrating and embracing differences;
- ESC 3 – Practising ethically, which highlights the importance of recognising the rights and aspirations of service users;
- ESC 4 – Challenging inequality, which highlights the need to address the causes and consequences of stigma, discrimination and social inequality, all of which can be barriers to service user involvement.

Promoting service user and carer involvement means that service users and their carers should be treated as equals, but existing or historical relationships of unequal power between service users/carers and service providers can present a barrier to this.

Activity 3.5

Keep in mind ESC 3 – Practising ethically, and ESC 9 – Promoting safety and positive risk taking as you read through the scenario below.

Jenny's admission

Things have continued to go badly for Jenny. Her relationship with Billy remains volatile and she is back in A&E for the fourth time following another overdose.

Jenny has been seen as an outpatient by the mental health team, but she now believes she needs to be admitted to hospital – she feels everything is getting out of control. She is interviewed by a mental health liaison nurse in the early evening in A&E.

From the start of the interview, the nurse advises Jenny that her best course of action is to return home and maintain contact with mental health services through outpatients. Jenny is not keen to go home – she does not want to be near Billy again and fears she might take another overdose.

After the interview with the nurse, Margaret, Jenny's mum, insists that Jenny must be admitted. Margaret speaks to Jenny's psychiatrist, who decides to get Jenny admitted to an inpatient unit. She is eventually admitted around midnight.

Here are some questions to consider.
What might have been the mental health liaison nurse’s reasoning for suggesting Jenny should not be admitted? *You might find it helpful to think about the 10 ESCs when considering the mental health liaison nurse’s reasoning.*

What could the nurse have done that would have been helpful?

Why did Margaret have greater influence than Jenny in terms of persuading the mental health team that an admission was necessary?

How might this experience impact on Jenny’s future engagement with mental health services?

Power is an important issue in involving service users and carers. Misuse of power by workers leads to poor experiences for service users and carers.

Activity 3.6

Think of times when you have power, or lack power, in your current role in mental health services.
I have power when:

I lack power when:

Discuss where there may be a tension or conflict relating to power in your relationship with carers and service users.

How can you use your power to help others become empowered?

Reflect back on Jenny’s admission in the scenario above. Who had power in the situation,
who didn’t, and why?

Another way of overcoming barriers to promoting service user and carer involvement is linked to ESC 6 – Identifying people's needs and strengths, which is about acknowledging and building on individuals' strengths and supports in your work. This is explored in more detail in Module 5.

2.3 Involvement at an organisational level

People have opportunities to work with others who also use services or support people who use services in, for instance, an active service user/carer group, collective advocacy group, public/patient involvement group or service management or planning group. These forums give people an opportunity to speak up about concerns, evaluate services, suggest improvements and decide on action. If involvement is effective, changes will result.

Example ***Involvement at an organisational level***

The complaints officer of a general hospital realises that the hospital has received a number of complaints recently regarding the care of people with dementia in general wards. She raises it at her senior management meeting, where the senior nurse suggests that a group of staff from across the service, former patients who have dementia and their carers be brought together to develop a set of standards for care of people with dementia in the hospital. The nurse manager suggests that a person from Alzheimer's Scotland be invited to facilitate the group. She also identifies a senior charge nurse in the medical unit who has a particular interest in the care of older people generally, and people with dementia in particular, who she will approach with a view to adopting a 'dementia champion' role across the hospital, advising colleagues, liaising with patients and carers and driving good practice.

We are going to use the same rating system we used above to help us think about ways in which involvement can happen at the wider organisational level.

Activity 3.7

Reflecting on your experience in your current role or setting… (tick)

To what extent are service users and carers able to:	**Always**	**Sometimes**	**Rarely**
Design and take part in surveys/audits/ research on care issues?	☐	☐	☐
Join self-help, service user or campaigning groups which raise issues and are consulted by service providers?	☐	☐	☐
Become representatives on management, clinical governance or planning groups?	☐	☐	☐
Take part in learning events for people from across the mental health community?	☐	☐	☐
Find employment in mental health services?	☐	☐	☐
Find employment in mental health services in which their lived experience is a key skill and attribute necessary for the job, such as a peer support worker?	☐	☐	☐
Interview and help to appoint staff?	☐	☐	☐
Be involved in finance, policy and activity planning for a service(s)?	☐	☐	☐
Run services?	☐	☐	☐

What could you do to influence the areas where this is only occasionally or rarely happening?

With whom might you form alliances to bring about change?

The Scottish Health Council (SHC)[50] was established in April 2005 to promote 'patient focus and public involvement' in NHSScotland. An aim of SHC is to support achievement of a 'mutual NHS' in which the NHS works in partnership with patients, carers and the public and NHS boards listen and take account of people's views.

One of SHC's functions is 'participation review', which focuses primarily on two areas of participation:

- how NHS boards are involving people in the general design of services;
- how they are consulting them in relation to major service change.

From 2011, NHS boards will be required to self-assess against a new 'participation standard'.[51] The standard covers three aspects of participation:

- **patient focus** – care and services are provided in partnership with patients, treating individuals with dignity and respect, and are responsive to age, disability, gender, race, religion or belief, sexual orientation and transgender status;
- **public involvement** – there is supported and effective involvement of people in service planning and improvement;
- **governance** – robust corporate governance arrangements are in place for involving people, founded on mutuality, equality, diversity and human rights principles.

If you work in the NHS, you may also want to find out about how your organisation plans to progress implementation and self assessment against the participation standards. Find out who leads for patient focus and public involvement in your organisation, who will be able to provide this information.

Mental health services have made some headway in recognising the strengths and contributions of people who have experienced mental health problems and are using mental health services by introducing peer support worker roles into the workforce. Peer support workers are employed in recognition of their experience of mental health problems and the value of the knowledge, skills and values they can bring in providing care and support to others in recovery. Their work is based on developing mutual, empathic and empowering relationships in which peer and peer worker can share learning and recovery. The workers are trained, salaried, supervised and supported members of care teams who perform a range of functions.

The SRN helped in developing Scotland's first peer support service and was also involved in the pilot programme to employ peer support workers in a number of health board areas across Scotland. This pilot programme was part of the Scottish Government's plans for mental health service improvement. SRN is now working with the Scottish Qualifications Authority to develop and share a newly accredited training award for future peer support workers.

Activity 3.8

Read this journal article about peer support in Scotland, which you can download from the SRN website.
www.scottishrecovery.net/Download-document/306-Developing-peer-support-worker-roles-reflecting-on-experiences-in-Scotland.html[52]
Having considered the information you have read about peer support on the SRN website, what positive impact do you think peer support workers might have in relation to service user involvement in your service?

2.4 Involvement at a strategic level

This level of involvement is about influencing policy, strategy and planning through, for example, local planning committees or national forums. It is important to ensure that when people are invited to be involved, steps are taken to ensure their involvement is meaningful rather than tokenistic.

Activity 3.9

Imagine you have been invited to represent your organisation on a strategic planning group with senior civil servants from the Scottish Government and chief executives from NHS boards and local authorities.
What sort of support and preparation would you need to be meaningfully involved in this group?

Compare your answers with the good practice points below.

Good practice in strategic involvement
Examples of good practice in strategic involvement show that time and effort spent in facilitating individuals' and groups' active participation results in better-informed contributions and stronger partnerships.

For example, networks or groups looking for strategic involvement should work with individuals who take part in strategic planning to:

- support organisations that help individuals to be involved;
- set up meetings at convenient times and locations;
- acknowledge individuals' backgrounds and circumstances, including diversity of age, culture, race, disability, gender, sexuality and spirituality, and take these into account when asking for involvement;
- find out about training and development opportunities that will facilitate greater involvement;
- be aware of and use person-centred approaches to commissioning services;
- provide information in a timely and accessible manner;
- set out tasks clearly;
- run meetings and events in ways that promote participation;
- allow enough time in meetings for debate and consultation;
- involve service users and carers in decision-making processes from the beginning and make it clear how, where and when decisions are made;
- have a jointly agreed approach to involving service users and carers which covers practical aspects, such as payment and expenses, and difficult points such as ways of resolving differences of opinion.

Example ***Involvement at a strategic level***

Examples of strategic involvement exist throughout the country in the work of service user groups, like the Highland User Group (HUG).[53]

Launched in 1996, HUG now has around 350 members and 13 local branches across the Highlands. HUG's main aim is to improve the way in which users of mental health services are treated by campaigning to improve the rights, services and treatment of people with mental health problems and to challenge stigma and discrimination.

HUG's work is split into two complementary projects.

- **Speaking Out (collective advocacy)** – this focuses on consulting HUG members on a variety of subjects and campaigning locally, nationally and internationally about these issues to influence change. As part of this work, HUG produces reports that are widely read by professionals and policy-makers as well as by members.
- **Communications Project** – this aims to reduce stigma and raise awareness and understanding about mental health issues, including:
  - delivering mental health awareness training;
  - working with young people and schools;
  - producing DVDs about members' experiences.

A national mental health service user organisation called Voices Of eXperience (VOX)[54] was set up by service users in Scotland in 2006 with the aim of strengthening the collective voice and influence of people who experience, or have experienced, mental health problems.

The Scottish Dementia Working Group (SDWG)[55] is an independent group set up and run by people with dementia. The purpose of the working group is to campaign to improve services for, and improve attitudes towards, people with dementia. One of their key objectives is to influence public policies that impact on the lives of people with dementia and their families. They were a major influence in dementia becoming a national priority and are represented on the Scottish Government's Dementia Forum, which drives forward and monitors progress on key national initiatives relating to dementia. They played an important role in campaigning for and determining the priorities outlined in *Scotland's National Dementia Strategy*,[56] launched in June 2010.

VOX has drawn together a statement of good practice in service user involvement, which you can access at **www.voxscotland.org.uk/Publications**[57]

Activity 3.10

What is the name of your local mental health service user organisations or collective advocacy organisation(s) which work with people who have mental health problems? Give examples from your own experience of the work these organisations do.
Choose one group you are not already in touch with who may be useful to the people with whom you work. Make a list of what you'd like to find out from them (this might include their aims and objectives) and get in touch as soon as possible to make a link and ask for information that you can pass on.
What is the name of your local mental health carer organisation or collective advocacy organisation(s) which work with carers who support someone with mental health problems?
Give examples from your own experience of the work these organisations do.
Choose one group you are not already in touch with who may be useful to the carers with whom you work. Make a list of what you'd like to find out from them (this might include their aims and objectives) and get in touch as soon as possible to make a link and ask for information that you can pass on.

2.5 Developing skills in involvement

Activity 3.11

This is a chance to think about the skills and opportunities you and your service already have and those you'd like to acquire to facilitate involving service users and their carers at the different levels we have discussed in this module (individual, organisational and strategic).

Describe the skills and opportunities that help you and your service to promote service user and carer involvement.

What areas could be developed further?

Set a small achievable goal that will support developments.

Undertaking the SRI will also help you gauge and develop you practice in service user and carer involvement. The following dimensions of the SRI are particularly relevant.

- **Personalised services and choice** This part of the SRI asks services to reflect on whether they provide a personally tailored service and whether they have mechanisms in place that promote choice.
- **Strengths-based approach** This part of the SRI asks services to consider how they integrate the person's strengths into overall care and treatment. The identification of strengths and abilities can promote hope, an essential part of recovery. At the same time, it can promote resilience and prepare people to deal better with periods of difficulty. A focus on strengths can encourage positive relationships in which both parties are aware of what they can do, rather than concentrating on deficits.
- **Service user involvement/participation** This part of the SRI asks services to assess the extent to which they involve people who use their service in planning their own care and treatment and in making decisions related to how the service operates. There are many benefits related to involvement and participation, not least of which is that it promotes individual recovery.
- **Advance planning** This part of the SRI looks at the ways in which the service supports and helps advance planning. The use of advance planning in relation to wellness and periods of illness promotes involvement, self direction and control, all of which are key aspects of recovery.

3 Levels of influence and evaluating involvement

People's involvement will have varying levels of influence. One way of analysing existing involvement in your area, with a view to increasing service users' and carers' influence, is to consider where current examples of involvement sit on a continuum of involvement and participation.

Goss and Millar[58] developed a continuum to promote the development of service user and carer-centred community care. It works towards the goal of **equal partnership**. Figure 1 uses this continuum as a basis to show variations in involvement in two aspects of developing services and service-providing organisations – gathering information and defining need, and analysing/considering information and making decisions.

Figure 1. Continuums to promote equal partnership

1. Gathering information and defining need

Increasing

1 No involvement	**2** Information collected	**3** Start of communication	**4** Listening and responding	**5** Partnership
Staff define issues. Staff 'speak for' users and carers. No information gathered from users and carers.	Information on people's needs collected remotely, e.g. by survey, but staff define issues.	Limited information collected from talking with users and carers. Staff define issues.	Wider ranging, open consultation on issues and problems.	All parties pool and share information. Together, staff, users and carers define issues.

2. Analysing/considering information and making decisions

Increasing

1 No involvement	**2** Information collected	**3** Start of communication	**4** Listening and responding	**5** Partnership
Staff develop solutions.	Staff use information collected to develop solutions.	Staff develop options and consult with users, collate feedback and decide on solutions.	Users and carers involved in analysing problems and discussing options.	Users, carers and staff work together to analyse problems, discuss options and decide and implement appropriate solutions.

Activity 3.12

Look at the continuums in Figure 1 and discuss with colleagues and/or fellow learners which level (1–5) the example(s) you gave in Activity 3.3 correspond to, and why.

Discuss and make notes on what needs to be done to improve service user and carer involvement in the examples you have given.

We have to keep in mind that while service user and carer organisations and individuals in many cases want to move towards a position of partnership, some people may not want this. They might prefer to be consulted but not included in decision-making (Level 3 of influence). The implication is that people must be given choice about the extent of their involvement.

Activity 3.13

The impact of service user and carer involvement on the experience of service users and carers can be evaluated in a number of different ways.
Is the impact of service user and carer involvement currently evaluated locally? To investigate this, talk to your local service user and carer groups, Patient Focus and Public Involvement (PFPI) representatives and service managers.

If so, what methods are being used?

What methods do you think would be useful for the areas you work in?

If there is no recent evaluation of the impact (nor one planned), think of something practical you can do to promote a participatory evaluation of the impact of service user and carer involvement in the areas in which you work.

Many of the Modules in Realising Recovery build on the issues we have discussed in this module, particularly:

- Module 2 – Using self to develop recovery-focused practice;
- Module 3 – Enabling self-direction;
- Module 4 – Providing person-centred support.

Hopefully, this module has given you time to reflect on how your own and your organisation's current practices promote service user and carer involvement and how they can be improved to strengthen involvement.

It will take time to put into effect the learning you have gained. You should regularly review progress towards the goals of increasing partnership working and improving experiences for service users and their carers.

Activity 3.14

Partnership is a theme across the 10 ESCs – there are strong links between developing the capabilities and strengthening service user and carer involvement.

Concentrating on the level of involvement your work most closely relates to (individual, organisational or strategic), which capabilities when applied to your work would do most to promote service user and carer involvement?

We hope that you will continue to think about partnership and service user and carer involvement as you work through the rest of the ESC learning resource. Here are some questions that will help you within your own role.

- What are the barriers and opportunities to involving service users in their own treatment?
- What are the barriers and opportunities to involving carers as partners in the treatment and care of the person they support?
- What practical ways could be employed to involve service users and carers in local planning and consultation?
- How can you take this forward in your work? What support do you require to take it forward?

Action into practice

Which existing process(es) could you use to practise developing your skills in service user and carer involvement?
When, and how often, can progress reviews take place?
How can you (or your team or organisation) support and develop opportunities for shared training and learning with service users and carers and with service user and carer organisations?

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Module 4

Equality and diversity: respecting difference

Contents

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Welcome to Module 4

Every person, whatever his or her background, should expect to receive a high standard of care from mental health services. Delivery of high-quality mental health services is to a large extent dependent upon staff understanding and putting into practice some key values and behaviours.

This module will support your understanding of what equality and diversity mean and how practice can be developed to tackle inequalities. It relates to all of the ESCs, but especially to:

- ESC 2 – Respecting diversity;
- ESC 4 – Challenging inequality.

Learning outcomes

After completing the module, you will be able to:

- reflect on what equality and diversity mean to you;
- describe current issues in inequalities in Scotland that impact on mental health;
- examine equality and diversity issues in relation to mental health services in Scotland;
- discuss broader issues in relation to health inequalities in Scotland that are relevant to mental health;
- reflect on your own experiences and practice in relation to equality and diversity issues.

We will explore equality and diversity issues in relation to the stories of the characters we introduced earlier. Here is a reminder of their stories, with some ‘updated’ information.

Mary

Mary is the 65-year old partner of Jim, who has been diagnosed with dementia. Mary has Parkinson’s disease, which limits her mobility and creates some problems with her dexterity. Generally, however, she has managed the condition pretty well.

Pete

Pete, the art history graduate, is now 36. He has been in contact with mental health services since his early twenties. Pete has a strong interest in photography and travelled extensively when he was younger. He worked as a curator in a small gallery until his late twenties but has not been in paid employment since. He has started attending college. Pete lives in supported accommodation and has a brother, John, and his close friend is Colin.

Pete has gone through a period of positive change in his life with his college course, new supported accommodation and new relationships. His life and confidence was previously negatively impacted by unwanted effects from his medication. He has recently changed his medication to address this. A very positive step in Pete’s life has been his growing relationship with Jane, who he met at college. Pete and Jane have now been going out together for a year.

Mina

Mina is a 26-year-old Pakistani Scottish woman who married Aasim a year ago and is now pregnant with their first child. She's a practising Muslim. On her marriage, Mina moved from a city in central Scotland to live with Aasim and his parents and extended family in a remote and rural area, some distance from any of the major cities. Mina misses city life and the circle of friends and activities she previously enjoyed and feels quite isolated. She is a qualified pharmacist and really values her job. She currently works part time in a community pharmacy in her local town. Mina has been feeling very anxious recently and has been referred to mental health services via antenatal screening.

Jenny

Two years on, Jenny is now 21 and is unemployed. She still lives with her mother, Margaret, who has had addiction problems in the past, and her little sister, Megan. She used to have a wide circle of friends. She continues to have an on–off relationship with Billy, who is significantly older (40). The relationship is not always positive and Billy has frequently subjected Jenny to gender-based violence. Jenny was first referred to mental health services when she was 19 following a series of overdoses and self-harm episodes. Since then she has had a series of admissions to inpatient care and extensive contact with secondary care mental health services. She now has a diagnosis of having a personality disorder.

1 What do we mean by diversity, equality and discrimination?

We are all different as individuals. Even so-called 'identical twins' exhibit differences and unique characteristics. We also have different experiences of health and wellbeing, and of mental health services. We can talk about all this as representing the 'diversity' of individuals and communities in Scotland.

'Diversity' is a word that is now used frequently. It is considered an important factor in a wide range of public services across, for example, health, social services, education and justice sectors.

The springboard for diversity and equality work in NHSScotland was *Fair for All – the Wider Challenge*,[59] published in 2004, which aimed to ensure that services work to eliminate discrimination and promote equality of opportunity for everyone.

Within mental health services, the principles of equality, respect for diversity and non-discrimination also underpin the Mental Health (Care and Treatment) (Scotland) Act 2003, and are reflected in other mental health-specific policies.

According to *Fair for All*, diversity is about:

> *'… the recognition and valuing of difference'.*

In other words, it is about respecting and valuing the things that make us unique as individuals. These could include our physical appearance and size, our habits, preferences, beliefs, customs and traditions, our family background and upbringing, our dialect or language and so on. These variations are also reflected in the way individuals and communities think about mental health.

But respecting and valuing diversity stands for little unless we also respect and value everyone's right to the same life opportunities and the same standards of services.

This takes us further into the area of *equalities* and the need to tackle *inequalities* in Scotland.

Activity 4.1

What does the word 'equality' mean to you?

Do you feel you experience any inequalities in your life? Why?

The Equality and Human Rights Commission (EHRC) has defined equality as being about:

> *'… creating a fairer society where everyone can participate and have the opportunity to fulfil their full potential and no one is unfairly disadvantaged'.*

Inequality can arise in the form of:

- inequality of outcomes (the things in life that people do and achieve);
- inequality of process (reflecting inequalities in treatment through discrimination or disadvantage, including lack of dignity or respect); or
- inequalities of autonomy (the degree of empowerment people have to make decisions affecting their lives).

Activity 4.2

What are your views on the following statement?

"It doesn't matter to me what background people are from – I treat everybody the same."

The statement above reflects an '*equality and diversity-blind'* position as it assumes that equality is about 'treating everybody the same'. But as we have pointed out, we are all different, with different experiences of life, society and family, and have very different needs. We all struggle to have these differences heard, recognised and valued. We all want to be appreciated just for who we are. Being treated the same as everyone else somehow misses the point!

Equality is about *equal respect*, but not necessarily about having the *same treatment*. An individual's 'differences' are important aspects of his or her identity and life experience; denying their existence devalues the person's life experience.

Let's start by considering some examples of the inequalities that exist. Take a look at the following issues:[60]

- over 1 in 10 adults in England, Scotland and Wales report potential mental health difficulties;
- people with serious mental health problems have an increased risk of coronary heart disease and stroke before age 55;
- in 2007, 25% of people aged 16–74 in Scotland with a long-standing illness or disability had symptoms of mental distress, compared with 19% in the general population;
- mental health problems affect more women than men, and a relatively greater number of women experience depression and anxiety – women, however, may be more prepared to acknowledge difficulties and may seek help more readily than men, who tend to under-report depression and anxiety;
- people with physical disabilities and mental health problems report that in their experience, services are often unable to recognise or accommodate these dual issues;
- adults who provide 20 or more hours of care per week and those who have provided care for more than two years report higher rates of stress, anxiety and depression;
- from the age of about 65, older people have a much higher rate of depression than younger people;

- alcohol and drug misuse levels are higher in men, although rates of alcohol misuse among women are rising;
- the suicide rate among men is nearly three times that for women, and suicide is one of the leading causes of death among young men;
- some groups seem to be at greater risk of mental health problems – specifically, Pakistanis and Bangladeshis, lesbian, gay, bisexual and transgender people, Roma and Travellers, and asylum seekers; in some cases, there are signs that mental ill health may be linked to other disadvantages and pressures experienced by such groups;
- the rate of depression among gay men is as much as eight times that found in the general population;
- up to two-thirds of lesbian women have been found to suffer from depression; bisexual and transgender people are also at particular risk of depression;
- young people who are gay, lesbian or bisexual are 6–11 times more likely to attempt to take their lives than their heterosexual peers.

There are limited numbers of Scotland-specific studies and statistics on black and minority ethnic people's experience of mental health and services. The issues below, however, mainly drawn from information gathered in England, may reflect similar trends here:

- disproportionately high numbers of people from minority ethnic communities are subject to compulsory treatment and admission to mental health hospital inpatient units;
- Afro-Caribbean people have a 60% higher rate of depression than white people, with Afro-Caribbean men at twice the rate for white men;
- the incidence of attempted suicide and self harm among young Asian women is higher than it is among their English counterparts;
- black and minority ethnic people who declare their mental health problems speak of experiencing racism and discrimination on a recurrent basis;
- Pakistani and Bangladeshi women have higher rates of common mental health disorders (anxiety and depression) than white women.

It would be true to say that in our society, differences among people are not always valued and respected. Individuals, communities and services are all culpable in failing to respect difference and promote equality. Righting these wrongs, making the playing field level and creating the same opportunities for everyone is what tackling inequalities is all about.

Here's an important point for us to keep in mind as we move through the module and beyond. Tackling inequalities is *not* about making everyone the same or treating everyone in the same way. An individual's uniqueness becomes irrelevant in that kind of scenario, which serves to perpetuate a lack of respect for difference. This may actually result in experiences and outcomes that are even more unequal.

The real task in tackling inequalities (and creating equality) is to make sure all people have the *same* opportunities to shape their lives the way they want to, and have the *same* access to high-quality services when they need them.

Let's take a closer look at inequalities.

Exploring inequalities

Differences in health status among individuals and communities are real, present and widespread. The lower life expectancy and higher levels of mental health problems people in disadvantaged communities in Scotland face reflect the complex cultural, social and economic inequalities they experience every day, compared to their 'better off' fellow citizens.

Once established within a community, inequalities become stubborn and difficult to wipe out. Think of access to health services, for instance. There may be a wide range of reasons why people do not access services, which might include services not being in the right place at the right time. People may feel services do not meet their needs, or may be put off by (or even *fear*) some health or social care services based on previous contacts with authority. The result is that people fail to get the services they need, and inequalities widen.

Activity 4.3

From your experience, give some examples of the inequalities people with mental health problems can face in life.

What issues do you think cause people with mental health problems to experience these inequalities?

Inequalities in people's health, including their mental health, have been linked to:

- **socio-economic status** – living in poverty, for example, and/or living in a socio-economically disadvantaged community;
- **life circumstances** – being homeless, in care or in prison, for example;
- **social identity** – being a woman, being a man, coming from a black or minority ethnic community, being lesbian or gay, or being old or young;
- **health status** – illness or having a long-term health problem;
- **disability** – having an impairment that affects your ability to carry out day-to-day activities – this includes, for instance, physical disability and sensory impairment.

Inequalities can arise from the *discrimination, prejudice and stigma* people may face on the basis of some aspect of their identity. *Prejudice and stigma* reflect negative attitudes and views attributed to those differences of identity. Assumptions that underpin prejudices influence not only perceptions of individual people, but also of the social groups to which they belong, be they 'gays', 'blacks', or people with mental health problems.

Activity 4.4

Please note the following activity does not require you to disclose if you have experienced mental health problems.

If you do, or were to, experience mental health problems, how would you feel about disclosing this to your colleagues?

Why would you feel this way?

One issue you might have thought of if you were reluctant to disclose is a fear of discrimination. This has been identified as a reason for people not disclosing.

Discrimination, reflecting actions or behaviours based on prejudice and stigma, can be *personal or institutional*, but always results in people being treated less favourably.

Discrimination means treating an individual or group of people unfairly because of a particular characteristic, such as gender, disability, age, ethnic origin, skin colour, nationality, sexuality and/or religious belief. Within mental health services, it has been found that people who misuse alcohol and other substances and those diagnosed with borderline personality disorder tend to be more liable to encounter discriminatory behaviour and attitudes. This usually results in a negative, disempowering experience such as exclusion or blocked opportunities. Discrimination can also be described as putting prejudices into practice.

Discrimination can either be direct or direct, and can be intentional or unintentional – it does not matter, the effects are the same.

Discrimination has been legally defined through a series of legislative acts as unfavourable or less-favourable treatment on the basis of particular characteristics, which are known as the **protected characteristics**. They are often colloquially known as the 'equality strands' or 'inequality strands', which is the term we will use in this module.

Under the Equality Act 2010, the protected characteristics are defined as:
- age;
- disabilities (including mental health problems);
- gender reassignment;
- pregnancy and maternity;
- race (which includes ethnic or national origin, colour or nationality);
- religion or belief;
- sex (gender);
- sexual orientation.

Discrimination may be **direct** or **indirect**.

Direct discrimination can be described as less-favourable treatment on the grounds of particular characteristics, such as delivering an inferior service to someone because they are black.

Indirect discrimination is when a provision, criterion or practice is applied to an individual or group that would put persons of a particular characteristic at a disadvantage compared with other persons. For example, delivering a course at a time when it cannot be accessed by part-time workers might indirectly discriminate on grounds of gender, because the majority of part-time workers are women. Indirect discrimination typically arises when practices are apparently neutral, and often results from structural causes. This is because apparently neutral practices may unintentionally perpetuate the consequences of past discrimination.

Disadvantage and discrimination can arise not because of individual examples of prejudice, but because of the cumulative effect of the way organisations are structured, their workplace practices, social norms and cultural expectations. This is known as 'institutional discrimination'.

Discrimination sometimes arises as a result of inaccurate stereotypical images people hold of others – people believing, for example, that a particular gay man must be sexually promiscuous because of their perception that 'all gay men are sexually promiscuous', or that a woman from a minority ethnic community has poor command of English because their previous experience of people from a similar community suggested this would be the case.

Holding stereotypical images such as these demonstrates how people can fail to recognise and respect the *differences* between individuals, even among those who seem to belong to the same social group.

So far, we have talked about the impact of discrimination and stereotyping in society, but this also takes place within mental health services and can influence how we behave towards people who have been given a particular diagnosis or 'label'.

Activity 4.5

Remember Jenny? She's the now 21-year-old who has family and relationship problems and has had a series of admissions to inpatient care and extensive contact with secondary care mental health services following a series of overdoses and self-harm episodes. She now has a diagnosis of having a personality disorder. Remind yourself of Jenny's full story on pages 3 and 76 before continuing.

Read Jenny's following account carefully and then complete the associated activity overleaf.

Jenny's account

Basically, I've had a crap life. I was in care because my mum was addicted to drugs and couldn't care for me and Megan. I hated school – I got slagged off all the time because of my mum. I skipped school a lot.

Things went better for a wee while after I left care. My mum was 'clean' and things were OK. And I met Billy – he was great. He was the first person who really understood me. Sometimes we would fight, but he was always really nice to me afterwards.

I used to have lots of friends and a really close pal, Sharon, but Billy didn't like me hanging out with her. He doesn't like me being with other people, apart from at work – he even drives me to work and picks me up at the end of the shift.

Billy tells me how to dress because he says I look like a slut when I choose what clothes to wear. He seems angry with me all the time, especially when he's had a drink. So the fights have got more regular.

I took my first overdose because I just got fed up with the whole thing. I'm now on my fifth admission to the inpatient unit. I know the staff don't think they can help me – they think I'm a useless waste of space.

My cutting's got worse.

I know I've been difficult; I've been all over the place, my moods seem so extreme. I feel crap all the time and nobody seems to understand. People keep telling me to stop being so attention-seeking and take some responsibility for myself. The more they don't like me and ignore me, the more I want to hurt myself, and the more they say I'm attention seeking and 'being manipulative'.

I've been diagnosed as having a personality disorder – I don't know if they treat me the way they do because of how I behave or because they had been told my diagnosis. I just know it's a shit time and no one seems happy – me or them.

What stereotypes do you think could be applied to Jenny?

Drawing on your experiences of mental health services, what sort of discrimination could result from this stereotyping?

If you were working with Jenny, what sort of things could you do to ensure she is not being discriminated against within mental health services?

2 Mental health inequalities in Scotland – implications for mental health services and practice

Service users representing different equalities issues (or 'inequality strands') and the local and national organisations that focus on their areas of concern highlight several issues that are common to all and which negatively affect people's access to, and experience of, services. These are:

- discrimination and prejudice;
- lack of trust;
- inappropriate services;
- services' lack of cultural competence – in other words, their inability to understand individuals' backgrounds and the inequalities and discrimination they face;
- the need for services to give greater importance to service users' experiences;
- people's desire for more person-centred, holistic services.

We'll now look at mental health inequalities in Scotland in relation to each of the defined inequality strands and the implications for mental health services and your practice.

2.1 Ethnicity and mental health inequalities

Understandings of 'mental health' and mental health problems vary between cultures and individuals, as we all have different concepts of mental health and illness.

Minority ethnic disadvantage cuts across all aspects of deprivation. Taken as a whole, minority ethnic groups are more likely than the rest of the population to live in disadvantaged areas, be unemployed, have low incomes, live in poor housing, have poor health and be victims of crime. As a document from the Department of Health in England, *Inside Outside*,[61] puts it:

> *'There does not appear to be a single area of mental healthcare in this country in which black and minority ethnic groups fare as well as, or better than, the majority white community. Both in terms of service experience and the outcome of service interventions, they fare much worse than people from the ethnic majority.'*

In 2010, the Equality and Human Rights Commission published *How Fair is Britain?*,[62] their first triennial review of equality in Britain. The report, which is compiled from existing research and data, highlights some key inequalities in relation to mental health in Britain. In most cases, Scottish data are not available, but data from England indicate that:

- there are very few ethnic differences in the prevalence of common mental disorders once age is adjusted for;
- rates of admission and compulsory detention in mental health institutions are higher among black populations, and young black Caribbean and black African men have higher rates of suicide.

Activity 4.6

What are your views on the following statement?

"We don't have any black and minority ethnic community people around here, so it's not a problem."

Because the black and minority ethnic community in Scotland may not be as large as in other parts of the UK, there is a real risk that we do not see issues of ethnicity and mental health as a priority for us.

There is an assumption that racism exists only when people from black and minority ethnic communities are present in significant numbers – this is not true. Racism may be an even bigger problem when numbers of black and minority ethnic people are few.

This is compounded by the rural nature of much of Scotland. Isolation and the lack of their own community support systems mean racism and racial tensions can have a deeper impact on the health and mental wellbeing of black and minority ethnic people in rural communities.

Fair for All[63] acknowledges this general issue when it states:

> *'It has to be recognised that numbers alone are not the only determinants of priorities. Everyone is entitled to fair access to healthcare and the right to opportunities for better health – this is the founding principle of the NHS.'*

It is crucial to accurately identify communities and their needs to deliver appropriate and competent services. Let's take a better look at what we know, or don't know, about Scotland's minority ethnic population.

First, it is not large compared to that of England. The 2001 census provides the only national statistics on the black and minority ethnic population, but these are now out of date: for instance, there are recognised increases in the numbers of at least two groups – the refugee and migrant communities. Still, the census tells us that in 2001, minority ethnic people comprised just over 2% of the total population of Scotland, with a range of 0.5–4.5% between areas, the highest percentage being in Glasgow.

Second, the former National Resource Centre for Ethnic Minority Health (NRCEMH) identified that there were no substantial data collected on the use of mental health services by minority ethnic people. They recommended active monitoring of ethnicity by NHS boards at local and national levels.

To help boards and NHS staff engage in this vital component of improving mental health and wellbeing, NHS Health Scotland and ISD Scotland have developed resources to support NHS boards in monitoring ethnicity of service users.

Further information on collecting ethnicity information can be found at
www.scotland.gov.uk/Resource/Doc/253579/0075142.pdf
and the DVD training resource and equalities monitoring question guidance to support patient monitoring can be found at **www.isdscotland.org/equalityhappytoaskdvd**[64]

Activity 4.7

Find out what information your service holds about the minority ethnic populations in your area and how local services are responding to meet the needs of these populations.

Third, there is a lack of Scotland-specific data on the *prevalence* of mental health problems among people from minority ethnic communities, and national (UK) data have been described as 'patchy'. Other than the issues listed previously, however, we do know that:

- studies indicate a relatively high level of under-reporting of psychological distress from some minority ethnic communities, such as Asian communities;
- asylum seekers face particular mental health issues related to their experiences prior to arriving in the UK *and also while living in the UK as asylum seekers*; research has shown their levels of

psychological distress while in the UK may be higher than those experienced while imprisoned and tortured in their country of origin;

- there are lower rates of treatment for people from minority ethnic backgrounds who have some of the more common mental health problems;
- minority ethnic communities fare worse than people from the majority community in terms of experience of services and outcomes of service interventions;
- Roma and Travelling people are also subject to discrimination; women from these communities consequently report experiences of anxiety and distress.

Activity 4.8

Remember Mina? She is the 26-year-old Pakistani Scottish woman who married a year ago and is now pregnant. As we explained when we introduced Mina on page 76, she feels quite isolated since moving from the city to live with her in-laws in a remote and rural location. She has been feeling very anxious recently and has been referred to mental health services via antenatal screening.

Look back at Mina's full story on page 76 before reading her account below.

Mina's account (1)

The midwife thinks I'm depressed and has referred me to the mental health clinic for assessment. I can't even imagine what my mother in law will think of that – she already thinks it wouldn't be right for me to go back to work after I have the baby. Word will also get round this place really quickly.

I don't really have anyone to talk to about my feelings, but I'm not really sure mental health services is what I want.

Reflect on Mina's situation. What might be the reasons behind her reluctance to access services?

How could services be redesigned in a way that takes account of any barriers to access Mina might perceive?

There is some evidence to suggest that the 'shame' and 'stigma' associated with mental health problems may be felt even more intensely among some minority ethnic communities. This makes it less likely that people from these communities will present to mental health services, particularly if they are worried about issues around confidentiality.

We have already explored general issues around confidentiality in Module 3. Confidentiality for minority ethnic service users has additional angles. The 'comings and goings' of individuals in small communities are easily spotted and can provoke gossip. For instance, seen through the lens of stigma, an individual's appearance at a location known for its work with sensitive issues (such as mental health, HIV/AIDS, violence or abuse) can create many difficulties for that person, regardless of the purpose of the visit. So to gain the trust and respect of people wary of them, services must take the unique characteristics of life within a minority community into consideration.

Research with young women in Edinburgh using the counselling service at Saheliya[65] found that confidentiality was a vital issue, not just because 'news travels quickly', but also because the young woman's difficulties might be reported back to her family under some pretext or even at the request of the family. Subsequent hesitation delays the much-needed process of 'healing' or recovery for the service user; worthwhile outcomes will only accrue with the slow development of trust in the counsellor, worker and organisation.

Imagine Mina did not have a good grasp of the English language. There are particular issues around confidentiality when someone's first language is not English, or if the person chooses to express him or herself in another language. Fulfilling the statutory obligation to provide a translator has its implications.

Activity 4.9

What might some of the practical difficulties of working with translators/interpreters be **(a) for yourself**, and **(b) for Mina**? Where possible, draw on practical experience in your answer.

(a)

(b)

Awareness of, and willingness to understand, the complex family systems of minority ethnic communities is crucial in developing working relationships with individuals and their families. The management of language is a primary challenge within this priority.

Helpful guidance on working with interpreters has been produced by the Mental Welfare Commission for Scotland and can be accessed at **www.mwcscot.org.uk/web/FILES/Publications/MWC_Interpreter_highres.pdf** [66]

Activity 4.10

Mina's account (2)

I've been to a few sessions with mental health services now. They think I should have a course of CBT – they think I'm anxious about the pregnancy. I've tried CBT but it's really not working. I just think they don't understand the issue.

Reflect on Mina's second account. Why might the prescribed intervention not be helpful for her?

What does the person who is seeing Mina really need to understand to ensure that she gets the right support?

People from minority ethnic backgrounds also have to contend with a range of culturally specific factors. To better attend to their needs, services and their staff need to increase their awareness of what minority 'culture' is, its importance and potential impact on people's lives, on their health in general and mental health in particular, and on their understanding of what mental health is.

Services and staff must try to better appreciate the effect of communities' cultures on people's needs and what they perceive to be socially acceptable. In other words, services need to become more *culturally competent* and to support their staff to deliver *culturally competent care*.

Cultural competence relates to a set of practices, attitudes and approaches within an organisation that enables the organisation to work effectively with people from a diversity of backgrounds.

Saheliya,[67] the mental health and wellbeing support organisation mentioned above, is unique in Scotland. It works in a holistic way with women, girls and their families from all minority backgrounds, including asylum seeker and refugee communities. It has recently begun a programme that aims to increase the capacity of workers (minority or majority ethnic) to engage with minority issues and work with the mental healthcare of black and minority ethnic people.

Providing accessible services that meet the needs of minority ethnic communities continues to be a challenge. Experience of racism in (or as a result of) services is widely reported. The Bennett Inquiry in England in 2002 investigated the death of a black man in a secure unit in Norwich and presented 22 recommendations, mainly on racial issues. This has resulted in significant measures being implemented in England that, while not mandatory in Scotland, are relevant to us. The Inquiry concluded:

> *'Institutional racism is present throughout the NHS and greater effort is needed to combat it. Until that problem is addressed, people from black and minority ethnic communities will not be treated fairly. The cultural, spiritual and social needs of patients must be taken into account.'*

You should read and reflect on the issues outlined in the *Bennett Inquiry* report[68] and the response by the Department of Health in England. You can access the report at **www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4100773**

It is important to be aware that mental health workers also experience discrimination, prejudice and stigma. The MacPherson Report[69] and *Equal Services*[70] recommend that:

- all staff should receive training in cultural competency, awareness and sensitivity;
- services should have a written policy for dealing with racist abuse against staff members;
- the workforce should be ethnically diverse.

It is also crucial to remember that *people have a duty in law* to act on discrimination.

Activity 4.11

Read the scenario and below and consider it by putting yourself in the position of a team leader.

Julie

One of the valued members of your team is Julie, who came to work in Scotland from Zimbabwe three years ago. Recently, Julie has been subject to racial abuse from Kevin, a service user your team supports. The abuse has taken the form of serious verbal abuse, which Julie has experienced over the past week. This has caused her great distress.

As a team leader, how would you respond to the situation set out in the scenario:
to work with Kevin to address the issues?

to work with Julie to address the issues?

What policies relevant to your team or organisation can help you resolve this, and in what ways do they assist?

Is there any further action your team, department or organisation needs to take to achieve a satisfactory outcome all round?

2.2 Gender issues and mental health

'Gender' refers to culturally and socially determined differences between men and women. It is related to how we are perceived and expected to think and act as women and men because of the way society is organised, not because of our sex (which refers to biologically determined characteristics).[71]

We know that gender influences mental health. For example, look at some of the issues we presented in Section 1, and see the report *Equal Minds*.[72]

The reality of men and women's lives is different. It is different in terms of their life experiences and the socio-economic and environmental factors that affect mental health. For instance, we have to understand women's mental health issues in the context of the discrimination they face in society, which includes issues associated with sexism, living in poverty, being disproportionately responsible for caring for others and experiencing higher rates of gender-based violence.

Gender influences *perceptions* of mental health and wellbeing, what people need from mental health services, and how they *experience* health services.

Activity 4.12

Remember Pete and Jenny? Look back on their stories and accounts (Pete's on pages 2, 39, 46 and 75, and Jenny's on pages 3, 61, 12, 76 and 83), then reflect on their situations.
What role does gender play in their experience?

How does their gender shape what they need from the service?

We need more gender-sensitive services and responses to mental health problems that are based on recognition that the context of men and women's lives is different. People want services that acknowledge the gender-based issues underlying their mental health difficulties, not just the symptoms, and that respond to their particular needs. By not considering gender in service design or delivery, we risk creating services that are gender-blind.

Looking at issues impacting on men's mental health:

- rates of unemployment are particularly high among men, and men respond more negatively to unemployment;
- men tend to report poorer physical health;
- issues of masculinity may negatively impact on men's mental health; it has been suggested, for example, that higher rates of suicide among men have been linked to their reluctance to express distress.

Activity 4.13

Mental health services often consider men as being 'hard to reach'.

What could you do to make the project or service in which you work more accessible to men?

We need to make sure that mental health services for men:

- are flexible;
- focus on the whole person;
- avoid stereotyping men as being unfeeling or uncommunicative;
- build up trust, particularly through modelling values and behaviours around positive wellbeing.

The *Breathing Space* service, for example, ticks many of these boxes. It is a confidential phone service targeting young men who are experiencing difficulties and unhappiness in their lives. You can find out more about *Breathing Space*[73] at **www.breathingspacescotland.co.uk**

Now let's consider the issues for women. *Equal Minds* sets out the following key factors that may impact on women's mental health:

- women are more likely to be living in poverty;
- there is a higher proportion of women in lower grades in all professions in Scotland;
- women are at much greater risk of experiencing domestic abuse;
- estimates suggest 20–25% of women have experienced childhood sexual abuse, compared to 6–7% of men.

Since women often carry the bulk of caring responsibilities within families, there are fundamental issues around access to services that must be taken into account.

Further information about women and mental health is summarised in the Women and Mental Health factsheet, published by Mind.[74]

Activity 4.14

Consider the last two bullet points above in particular, and think about the service you work in.
To what extent are these issues acknowledged and attended to?

What more do you think could be done?

Scottish Ministers have identified the need to tackle gender-based violence as a key priority for gender equality. Further information about gender-based violence and health is available at **www.gbv.scot.nhs.uk**[75]

2.3 Religion, belief and spiritual care

Scotland is a religiously and culturally diverse country. We need to recognise this to address the spiritual and religious needs of people we support in mental health services.

According to the 2001 Scottish Census:

- just over two-thirds (67%) of the Scottish population reported currently having a religion;
- more than six out of ten people said that their religion was Christian (65%): 42% Church of Scotland, 16% Roman Catholic and 7% other Christian.

The 'other Christian' category includes a wide range of groups that can be very different from each other in terms of their approaches to key issues.

After Christianity, Islam was the most common faith with 42,600 people in Scotland describing their religion as Muslim. This is followed by people from 'other' religions (27,000), Buddhist (6,800), Sikh (6,600), Jewish (6,400) and Hindu (5,600). These groups each accounted for less than 1% of the Scottish population.

Twenty-eight per cent of the Scottish population identified themselves as having no religion.

Scotland has a history of Christian sectarianism, specifically conflict between Protestants and Catholics, which has led in some instances to religious discrimination. Nil by Mouth[76] defines 'sectarianism' as

> *'…narrow-minded beliefs that lead to prejudice, discrimination, malice and ill-will towards members, or presumed members, of a religious denomination.'*

They support educational and workplace programmes to combat sectarianism in Scotland.

Other religious communities also experience discrimination or lack of understanding. Smaller religious communities in Scotland often find that staff in the health service, local government, schools and other settings have very little knowledge of their particular religions. In *How Fair is Britain?,*[77] the Equality and Human Rights Commission reports that:

> *'... some analysis has shown an association between the experience of victimisation for different religious groups and poor mental health … [however] it is difficult to distinguish whether these experiences are due to religious or ethnic identity.'*

Religious belief, practices and ethics are relevant for understanding people's experiences of health and mental health.

Sometimes a person's mental health problem is expressed in a religious way or through religious terms. Having a sense of spirituality or belonging to a faith or belief system or a faith community can be a major help in supporting people through the recovery process.

You can resolve many of the issues arising from caring for people from a faith community or culture unfamiliar to you by simply *asking the person*, or his or her family and friends, how he or she wishes to be looked after and addressed.

NHS Education for Scotland produced an online multi-faith resource for NHS staff in 2006.[78]
It includes links to a wealth of other learning and support materials. You can access the resource at **www.nes.scot.nhs.uk/documents/publications/classa/multifaith/Interactive%20master.pdf**

Spiritual care is person-centred care which, through affirmation, enables a person to make the best use of all his or her personal and spiritual resources in facing and coping with the doubts, anxieties and questions that arise in a healthcare setting and which often accompany ill health and suffering. *Spiritual Care Matters*[79] is an educational resource for NHSScotland staff which focuses on developing skills and competencies for delivering spiritual care to people of any faith or none that you can access at **www.nes.scot.nhs.uk/media/3746/030309spiritualcarematters.pdf**

2.4 Sexual orientation and mental health inequalities

We noted in the first section of this module that the rate of depression among gay men is as much as eight times higher than that found in the general population. Up to two-thirds of lesbian women have been found to suffer from depression, and bisexual and transgender people are also at particular risk of depression.

Some research also suggests that lesbian and gay people may have higher levels of substance misuse, a higher incidence of eating disorders and be more likely to use recreational drugs. *How Fair is Britain?*[80] reports that:

- a meta-analysis of international data published in 2008 revealed that the risk for depression and anxiety disorder was at least 1.5 times higher in lesbian, gay and bisexual people than heterosexual people;
- lesbian, gay and bisexual people may have an increased risk of attempted suicide;
- two-thirds of lesbian, gay and bisexual students in Britain report being bullied.

Factors that may be causing higher rates of mental health problems among lesbian, gay, bisexual and transgender (LGBT) people include the following, which are highlighted in *Equal Minds.*[81]

- Experience of stigma, discrimination and homophobia. This can occur throughout an individual's life – in school, in the workplace, when accessing services and in local communities.
- LGBT people may be subject to abuse, bullying, violence and harassment because of their sexual orientation. Fifty-seven per cent of respondents in a study of gay men in Edinburgh said they'd experienced some form of harassment over the previous year. A study of lesbian women and gay men in Glasgow revealed 85% had experienced verbal abuse and 60% had been threatened with violence.
- Negative attitudes, discrimination and abuse have made it difficult for people to feel included and connected and have made it more difficult for people to disclose their sexuality, or 'come out'.

Activity 4.15

In what way do you feel the issues outlined on the preceding pages might impact on people's experiences in mental health services?
What does your service do to meet the specific needs of LGBT people?

There is a very definite fear of stigma/discrimination which acts to deter people from the LGBT community from accessing services. This fear may lead people to be less than open with health professionals about their sexuality due to concerns about discrimination and negative responses. Research suggests that these fears are not unfounded: for example, a survey in 2003 found that a third of gay men, a quarter of bisexual men and more than 40% of lesbian women had experienced negative or mixed reactions on disclosing their sexual orientation to a mental health practitioner.

2.5 Disability and mental health inequalities

Inequalities in this area can be considered in different ways as impacting on:
- people who experience mental health problems;
- people who experience mental health problems and sensory impairments or physical disabilities;
- people for whom having a sensory impairment or physical disability has negatively impacted on their mental health.

Although the concept of disability is often associated with 'physical impairments', the Equality Act 2010 encompasses people with physical or *mental* impairments with substantial and long-term adverse affects. This includes a broad range of circumstances, including physical impairments, learning difficulties, sensory impairments, some types of long-term illness and mental health problems. The legislation therefore provides important protections against discrimination toward people with a 'clinically well recognised' mental illness.

Disabled people with mental health problems can experience:
- social deprivation and poverty;
- poor nutrition, obesity, higher levels of smoking, heavy alcohol use and lack of physical activity;
- discrimination from healthcare providers – people with mental health problems report that their physical illnesses are not taken seriously, or that an assumption is made that physical problems are linked to their mental health problems.

All of this means that some people with mental health problems are at risk of poorer physical health and have a lower life expectancy than the rest of the population. Yet studies have shown that mental health service users are rarely provided with health promotion information or offered physical healthcare checks in primary care settings.

Activity 4.16

Think of one disabled person you support with mental health problems.
What health promotion advice, support and health screening is he or she currently being offered?

What role could you play in increasing his or her access to this?

People with mental health and physical health problems may experience multiple inequalities. For example, people might have difficulty accessing mental health services because of their physical impairments, but also have problems using physical disability services because of inadequate recognition of their mental health needs and negative attitudes among staff towards mental health issues. In addition, recognition and understanding of people's needs may be lost due to lack of communication between different services.

Across the health service, the outcomes for people with learning disabilities are systematically poor. *Tackling Indifference*[82] is a 2010 report by NHS Quality Improvement Scotland. A key finding is that NHS boards in Scotland need to get better at understanding the needs of people with learning disabilities to make sure they get the healthcare they need. The report states that NHS boards must make it easier for people with learning disabilities to get access to general health services.

People with hearing impairment face specific issues in relation to mental health. Studies have found that 38% of people with hearing impairment living in the community experience some form of mental distress. People with hearing impairment also experience higher rates of depression and anxiety than hearing people, although rates of diagnosed schizophrenia are similar across the groups.

There are suggestions that hearing-impaired people with mental health problems find it difficult to access services; when they do, they can experience problems around poor assessment and misdiagnosis. This may help to explain why hearing-impaired people are over-represented among psychiatric hospital populations. It is suggested that misdiagnosis arises because assessments are being undertaken by people with inappropriate communication skills. This problem may be compounded among people from black and minority ethnic communities.

Activity 4.17

Think of someone you work with who is disabled.
Which services/programmes/supports does he or she use in addition to the one in which you work?

How are the person’s holistic needs met within your service?

How could you improve the links between the services involved?

2.6 Age and mental health inequalities

Health issues impact most at the extremes of the age range. Children and older people are more likely to experience poor health and health inequalities.

Population trends in the UK and in Scotland show that the challenges are set to grow as our population ages. The importance of this is that while there are likely to be improvements in the future in the health and wellbeing of older people, the likelihood of poor health increases with age.

Here are some issues for you to consider:

- older people are more likely to live in poverty and isolation, with 2.5 million pensioners in the UK living in poverty;
- their ability to access services, in particular preventative services, is lower in comparison with other members of the population;
- issue-aware and culturally competent services for black and minority ethnic older people are severely limited, and the lack of language support may create serious risks in service delivery;
- depression affects 10–15% of people aged 65 years and above in the UK, increasing to 27% when people are living in long-stay hospital settings or care homes (it is also a major cause of suicide among older adults in Europe);

- there are more new cases of Alzheimer's disease in Europe each year than there are of stroke, diabetes or breast cancer;
- in some long-stay hospital settings, residents have no access to primary care services to meet their physical health needs and have to rely on mental health practitioners who have limited physical health training and expertise;
- the adverse effects of some mental health medications contribute to poor physical health among older people.

Older people experience ageism, discrimination and social isolation. Mental health problems may make older people more vulnerable to abuse in society, the community and in mental health services. Such abuse can take several forms, including psychological abuse, physical abuse, financial abuse, sexual abuse and neglect. For more information, see the Age Concern website at **policy.helptheaged.org.uk/_policy/AgeEquality/ElderAbuse/_default.htm**[83]

Activity 4.18

Mary

As we learned earlier, Mary has Parkinson's disease. She fell and fractured her hip 10 days ago, but has now recently returned home from hospital. She has personal care workers calling three times a day to get her up, give her and Jim lunch and put her to bed.

She talks to you about one of the care workers. She says the care worker 'jokes' to her constantly that Mary is a 'lazy lump' who could do a lot more for herself if she really tried. Mary says she thinks the care worker generally 'means well', but the comments are really getting her down. She is frightened to complain in case the worker gets into trouble or the care is withdrawn.

Consider the scenario above.
What sort of abuse is Mary being subjected to?

How would you respond to this situation?

Violating the dignity of service users may be a breach of human rights. The Scottish Human Rights Commission produced a training resource for care sector workers, *Care about Rights*, which includes materials relevant in mental health services that may be helpful for you to consider in relation to the learning activity above. You can access the resource at **www.scottishhumanrights.com/careaboutrights** [84]

The Adult Support and Protection (Scotland) Act 2007 came into force in October 2008 and aims to better protect adults who may be at risk of harm. The term 'adults at risk' refers to people who:

- are unable to safeguard their own wellbeing, property, rights or other interests;
- are at risk of harm;
- are more vulnerable to being harmed because they are affected by disability, mental or physical ill health.

The Act includes duties, powers and responsibilities particularly for local authorities, who have a lead role in adult protection. However, NHS boards, police forces and other public agencies have a duty to cooperate with all measures relating to adult protection.

If you suspect someone is being harmed or you observe them being harmed, you should report it to your line manager. Under the new legislation, your manager has a duty to report it to an Adult Protection Committee. These have been set up in all local authority areas across Scotland and are multidisciplinary committees with representation from various public bodies. You will find more detail on the provisions of the Act at **www.scotland.gov.uk/Topics/Health/care/adult-care-and-support/legislation** [85]

Similar to adult mental health, the mental health of *children and young people* is also affected by the circumstances in which they live.

Many children and young people are more vulnerable to mental health problems due to their birth/life circumstances, including those who are looked after or 'accommodated', those who have learning and/or physical disability, those who have been, or are at risk of, abuse, and those who have experienced living with racism, homophobic abuse, domestic abuse or homelessness.

The Scottish Executive published *The Mental Health of Children and Young People – A Framework for Promotion, Prevention and Cure*[86] in 2005. This framework was developed to assist all agencies with planning and delivering integrated approaches to children and young people's mental health. It includes advice on tackling mental health inequalities among children and young people.

2.7 Multiple inequalities

In this section, we have explored diversity, equality and mental health inequalities in relation to the different inequality strands that inform our policy and practice in Scotland – 'gender', 'race and ethnicity', 'religious and spiritual beliefs', 'sexual orientation', 'disability' and 'age'. But this is a bit of a false division: all these strands are inter-related, with issues like racism crossing all of them in what are known as *multiple inequalities*.

People with mental health problems can face stigma and discrimination, which can negatively impact on social inclusion, employment and opportunities for social development. But mental health problems can be compounded by other inequalities, such as poorer physical health.

People may experience double or multiple disadvantages, which exist in many guises. In fact, inequalities can sometimes proverbially be seen as being like an onion, with multiple layers of 'disadvantage' covering and containing the human being inside.

Black and minority ethnic people may be subjected to discrimination based on 'race', as described above. But other layers of disadvantage made up of some or all of the other inequality strands can also co-exist.

Let's explore this more by looking at the example below.

Multiple inequalities – example

A young woman in Scotland may:

- be born into a family of low socio-economic status;
- have parents who have had limited educational opportunities;
- have had no role models in her life to direct her through her teenage years and the transition into adulthood and employment;
- have experienced physical and emotional abuse;
- have a learning difficulty or physical impairment;
- have a long-term health condition such as asthma or diabetes;
- be from a black and minority ethnic community that faces racism and discrimination;
- have recognised that she is sexually attracted to other women.

The cultural values and expectations predominating how she had been brought up may serve to protect her in many ways; others, however, might not be helpful in a Western, Scottish society and may only serve to further isolate her.

As you can see, it is possible for multiple inequalities to accrue. The potential multiple disadvantages of this woman's life could cause her to be alienated from the lesbian community, from the rest of her female peers, from the majority community, from her own minority community, and from her family.

3 Equality and diversity – conclusions

Legislation and policy

Tackling inequalities is not optional – it is **statutory** due to separate pieces of legislation that establish positive duties for public bodies to tackle discrimination and promote equality and good relations.

These include:

- The Race Relations (Amendment) Act 2000, which established the race equality duty;
- The Disability Discrimination Act 2005, which established the disability equality duty;
- The Equality Act 2006, which established the gender equality duty;
- The Equality Act 2010 which, from April 2011, will establish a general duty in respect of age, disability, gender, gender reassignment, race, religion or belief and sexual orientation, replacing the previous equality duties.

These pieces of legislation have identified duties with which organisations such as the NHS and local authorities must comply as providers of services and as employers. General Duties require public bodies to have due regard to the need to eliminate unlawful discrimination and harassment to promote equality of opportunity and to promote good relations.

The Mental Health (Care and Treatment) (Scotland) Act 2003 also requires that anyone acting or considering acting within the Act has regard to the principles of equality and non-discrimination.

We looked in Section 1 at how people can be discriminated against directly because of their social identity. We also have to recognise that people can face indirect discrimination. Lack of access to childcare, for example, can mean some people, especially women who are mothers, may be unable to attend certain programmes and services; this is a case of indirect discrimination against women users of mental health services.

Discrimination contravenes the law

If you are working with service users who have been discriminated against, your service should be able to provide information and support to enable them to obtain legal advice to make a challenge. This could involve, as a first step, supporting and helping them to get in touch with an independent advocacy worker or solicitor.

Activity 4.19

You are working with Mina, the 26-year-old Pakistani woman who is now pregnant and who is accessing mental health services for anxiety (remind yourself of Mina's story on page 3).

She is now attending a local leisure centre to swim as a means of managing her anxiety, but the centre is insisting that she wears conventional swimwear and there are no women-only sessions. She asks you what she should do about this.

What can you do to support Mina?

We hope this module has increased your knowledge of what *diversity* and *inequality* mean, and why it is important to acknowledge them.

Understanding that inequalities exist, that they are unjust and that it is everyone's responsibility to mitigate their effects and work to ensure access to appropriate healthcare, is a starting point for future progress.

Activity 4.20

Why is it important to talk about issues of inequality and diversity within the workplace?

What 'safe spaces' are there within your work where you can talk about issues of inequality, such as incidents of racism, and discuss the ideas you have outlined in the above questions? Who can you talk to, when, and how often?

Action into practice

Think back on Mina's accounts (pages 87 and 89) and reflect on how:

- you could develop your practice in ways that respond to and reflect her needs;
- how the service you currently work in could develop in ways that respond to and reflect her needs.

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Module 5

Developing socially inclusive practice

This module is based on work originally developed by Peter Bates, Senior Consultant (Mental Health) at the National Development Team. We gratefully acknowledge his contribution.

Contents

Welcome to Module 5

Module 5 explores the link between the 10 ESCs and developing socially inclusive practice.

Learning outcomes

After completing this module, you will be able to:
- challenge the processes that lead to inequality and exclusion;
- adopt assessments and interventions that are inclusion focused and user centred;
- understand the importance of working in partnership with mainstream community organisations.

We will explore social inclusion using the following stories of characters we introduced at the start of the learning resource and who you have followed through the modules. By way of a reminder:

Jim (67) and his wife Mary (65)

Jim is a retired joiner and Mary did lots of part-time jobs in-between raising their two children. They have three grandchildren. Mary has Parkinson's disease, which limits her mobility and creates some problems with her dexterity. Generally, however, she manages the condition pretty well.

Jim played bowls pretty regularly, an activity he has pursued all his adult life, and was secretary of the committee at his local bowling club. Jim has also enjoyed reading and likes to keep up-to-date with politics and current affairs. He is also a keen gardener and has an allotment which he enjoys. Jim has won competitions in the past for the fruit and vegetables he has produced.

Jim was diagnosed as suffering from dementia nine months ago. He has been prescribed medication and attends a memory clinic where he has been allocated a community mental health nurse. He also attends his GP as required.

Mary fractured her hip three months ago and this has reduced her mobility and ability to support Jim.

Mina

Mina is a 27-year-old Pakistani Scottish woman who married Aasim two years ago and is the mother of their first child, Assam, who is six months old. Mina is a practising Muslim. On her marriage, Mina moved from a city in central Scotland to live with Aasim and his parents and extended family in a remote and rural area, some distance from any of the major cities. Mina really misses city life and the circle of friends and activities she previously enjoyed and feels very isolated. She is a qualified pharmacist and worked part time in a community pharmacy in her local town. She really valued her job but she gave it up following her pregnancy and birth of her son. Mina was referred to mental health services via antenatal screening and was offered treatment for depression. She did not find the support offered that helpful and it has had the unintended consequence of making her feel shameful and stigmatised within her family and local community.

Jenny

Jenny, now 21, still lives with her mother, Margaret, who has had addiction problems in the past, and her little sister, Megan. She used to have a wide circle of friends. She continues to have an on–off relationship with Billy, who is significantly older (40). The relationship is not always positive and Billy has frequently subjected Jenny to gender-based violence. Jenny was first referred to mental health services when she was 19 following a series of overdoses and self-harm episodes. Since then she has had a series of admissions to inpatient care and extensive contact with primary and secondary care mental health services. She now has a diagnosis of having a personality disorder.

1 What does inclusion look like?

Activity 5.1

Reflect on the things that enrich your own life – things that are important to you personally and that give life a sense of meaning and value.

Now move on to consider your feelings and actions if:

- one or more of these were missing (imagine losing your home or a close friend):
- you had to face serious problems (such as major illness, a bereavement, redundancy) in the absence of these things:

The inclusion movement has been around for a number of years and challenges the historical practice of developing a 'parallel world' of segregated services for mental health service users, such as day hospitals and sheltered employment. Instead, mainstream community organisations should be redesigned for everyone, including people with mental health needs.

To promote inclusion, mental health workers should support people in ways that assist them to stay and, when necessary, get connected/reconnected with the wider community. On those few occasions when separate services are judged necessary, they should be transformed into stepping-stones to inclusion.

Many of the principles of the Mental Health (Care and Treatment) (Scotland) Act 2003 underpin promoting social inclusion – non-discrimination, equality, respect for diversity and reciprocity (see Module 1). The Act also places a duty on local authorities to provide, or secure the provision of, services that are designed to promote the wellbeing and social development of people who have mental health problems.

The social inclusion agenda therefore requires mental health services to pay attention to all aspects of a person's life and to assist the person to engage in things that make life rewarding. These can include leisure, recreation and cultural activities as well as support with relationships, lifelong learning opportunities, training, voluntary activity and assistance in obtaining or retaining open employment. All these things appear to be helpful, if not *critical*, to people's recovery.

2 Your focus and approach to assessment – a socially inclusive approach?

Activity 5.2

You will need a standard assessment form used in your service for this part of this activity.

Take a few moments to review a blank assessment form in use in your local service against the following checklist.

Is there a clear space to record the person's own viewpoint, or is it hidden behind phrases like 'agreed action plan'? (See ESC 3 – Practising ethically and ESC 7 – Providing service user-centred care)

Does the form identify everyone who cares about the person? Notice that this question is about caring *about* – a freely given, emotional response to the person as a whole – rather than caring *for*, which is about meeting needs. (See ESC 4 – Challenging inequality)

Does the form give space to explore what is working and what is not working about the person's home life, occupation, relationships and leisure? (See ESC 6 – Identifying people's needs and strengths)

Would a completed form give you insights into the person's history, long-term sense of what gives life meaning and his or her hopes for the future? (See ESC 5 – Promoting recovery, and ESC 6 – Identifying people's needs and strengths)

Good organisations can help to keep us on the right track, but sometimes the culture of a mental health service highlights other priorities. Pressure of work, responding to crises and defensive practice can all narrow the focus. Developing a social inclusion focus may demand action in all the following areas.

Narrowed focus	**A social inclusion focus adds the following dimensions**	**Review this by examining your work with one service user…**
State of the person's mental health as a user of mental health services.	The person's positive social roles, such as householder, employee, grandparent, parent, son, daughter, friend.	Does the care plan include actions to support the person in these roles?
Responding to crisis and coping with today.	The person's ambitions and goals for the future.	Are health and social care interventions designed to assist the person to identify and move towards, or maintain, his or her preferred lifestyle?
The person as a recipient of help.	The person as a contributor to society.	What opportunities does the person have to enrich the life of other people?
Community organisations that offer help.	Community organisations that offer positive status and roles outside the mental health service.	Do the people contacted by the care team represent helping or community organisations?
Growing strong teams within the mental health service.	Building new alliances beyond the mental health service.	*Thinking beyond this one service user now …* How much staff time is ring-fenced for spending with people from non-mental health agencies?

Activity 5.3

What were your answers to the questions in the right-hand column on the preceding page?

Let's revisit the experiences of Jim and Mary.

Jim and Mary

Since Mary's hip fracture, things have been more difficult at home for Jim and Mary. Jim's forgetfulness is becoming more problematic. For example, he has gone out for a walk on a couple of occasions and wasn't able to find his way home. He also started a minor fire in the kitchen when he put a frying pan on and then forgot about it. Mary is finding it hard to cope and feels on edge all the time. They have started to argue a lot. Mary's GP feels that Mary is no longer able to cope and feels that Jim should start to attend the day unit at the local community hospital.

Look again at the table opposite and reflect on Jim and Mary's situation in the context of socially inclusive practice.

Remember, social inclusion requires health and social care services to pay attention to all aspects of a person's life and to assist the person to engage in things that make life rewarding. Referral to the day hospital could be seen as the GP taking a 'narrowed' focus. The aim of socially inclusive practice is that people do not lose valued roles in the first place.

Scotland's strategy for self-directed support (SDS) was launched in 2010. The strategy aims to ensure as many people as possible can choose how their funding for social care support is spent and that a socially inclusive approach to care is fully supported.

Activity 5.4

Look at the Self-Directed Support Scotland website at www.selfdirectedsupportscotland.org.uk[87]

Please note that this website is constantly being updated but you will find the information for service users and professional and support organisations particularly useful.

Having read more about SDS, what 'socially inclusive' alternatives could be considered to support Jim?

You will probably have identified a number of opportunities for Jim to use SDS and personal funding, including, for example, costs for transport or employing a personal assistant to remain engaged in activities he values, such as:

- attending the bowling club
- working on his allotment
- keeping in contact with his grandchildren.

Reflecting on this, identify some ways you think you could be more socially inclusive in the work you do.

Before we leave this section, we need to think about two specific groups of people:

- people who choose to use segregated services at times where they meet with other mental health service users and staff – for example, a day centre;
- people who are considered to 'need' segregated services for their own or other people's safety or to give them the time and space to recover – in a therapeutic community, for instance.

Activity 5.5

How do people get into segregated services? Consider the influence of:
- the person;
- relatives and friends;
- schools and community organisations;
- people's experiences in mental health services, including their entry into services;
- health and social care services;
- police and criminal justice agencies;
- general public and the media.

Why might people choose to use segregated services at times?

What might help people choose to access less-segregated and more socially inclusive services?

The SRI has a dimension that relates to social inclusion and community integration. This part of the SRI asks services to consider the ways in which they involve social support networks in care and treatment and the extent to which they promote social inclusion. You may wish to consider working with others in your team to use the SRI to consider your service in respect of social inclusion.

3 The processes and power of exclusion

We need a good understanding of social exclusion, how it works in society and how it affects individuals (see also ESC 4 – Challenging inequality). The following three definitions describe distinct but inter-related elements.

- **Inclusion as access** People using mental health services should have access to the decision-making places where their personal care is reviewed and planned, where services are designed, managed and audited, and where jobs and promotions are offered.
- **Inclusion as standard of living** People using mental health services should have the same opportunities as other citizens to enjoy employment and income, healthcare, housing and community safety, civic and legal rights.
- **Inclusion as relationships** People using mental health services should have the same opportunities to establish and maintain respectful connections and friendships with a diverse array of other citizens.

Activity 5.6

Reflect back on Jenny's (page 83) and Mina's (pages 87 and 89) accounts and build up a detailed story of their potential journeys 'into an excluded life'.

Activity 5.7

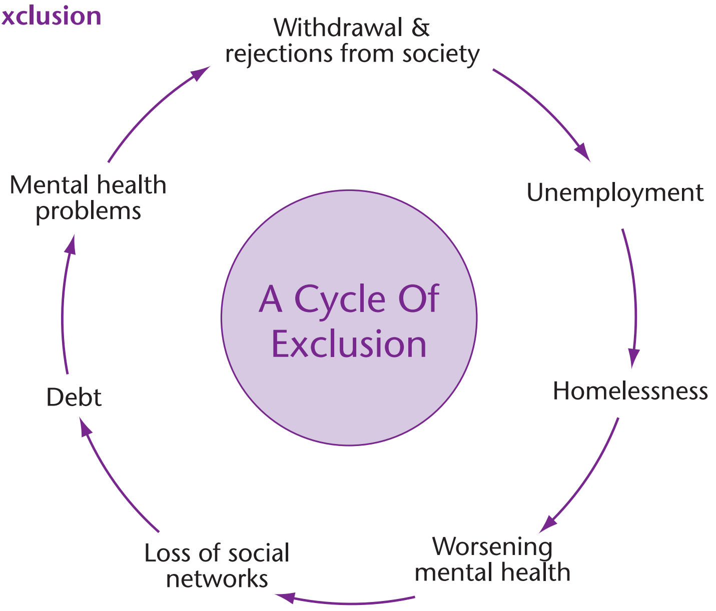
Again, reflecting on Jenny and Mina, consider the following.
Do factors such as age, gender, sexuality, economic status or ethnicity affect the journey?
(See ESC 2 – Respecting diversity)

Do mental health services sometimes make exclusion worse?

What do these services do to help the return journey?

While each person's journey into an excluded life is unique, the themes of access, standard of living and relationships often appear. An alternative way to think about this journey is shown in Figure 2. See how it works with the stories about Jenny and Mina that you have developed.

Figure 2. A cycle of exclusion



4 Working beyond the mental health service

There are many things that can be done to enable a person to get and keep his or her preferred lifestyle, and these will be explored in Section 6. First, we need to help communities to be more respectful and welcoming towards people who have experienced mental distress.

The 'viewing point' from which we look at the wider community may be similar to our view of people who use services. The Strengths Model (See ESC 6 – Identifying people's needs and strengths) acknowledges that people are a mixture – joy and despair, achievement and disappointment, love and selfishness – and then encourages us to pay extra attention to the person's positive talents and achievements.

Indeed, some people's so-called problems need to be recognised as strengths, especially when working with people who have had very lengthy contact with mental health services. While it would be naïve to think that people using mental health services (in common with most of us) have no problems, this deliberate focus on strengths is a way of restoring balance in a culture that can be preoccupied with symptoms, deficits and difficulties.

Activity 5.8

Think about a person you know who uses mental health services.
If you take notes or discuss this person with others, make sure you anonymise the name and any other personal details.

Find all the person's strengths and use only positive words – don't say 'but …' or 'despite …'.

Think carefully about any 'difficult', 'challenging' or 'unattractive' behaviour you perceive this person to display – think carefully about the strengths that are hidden inside these aspects of the person.

This same 'viewing point' can be adopted when facing the community. There is a harsh reality out there of discrimination, hate crime, negative stereotypes and fear that is directed towards people using mental health services. But this is only part of the story. Other citizens acknowledge their common humanity with people using services, promote equality of opportunity and offer respectful support.

The Strengths Model demands that we pay extra attention to the positive aptitudes and achievements of ordinary communities.

Activity 5.9

Consider your own experience and also find moments at work to collect positive stories from your colleagues and record an example of one of these here:

While there are already many allies in ordinary communities, a great deal can be done to create further improvements.

Activity 5.10

Select a specific community organisation (such as a local college, or a community centre) and work through the following questions.

Has your mental health organisation identified a worker to lead liaison with this organisation, and do you have regular contact with them? (See ESC 1 – Working in partnership)

Have you located champions within the community organisation who will support your efforts to improve opportunities?

over ▶

Do you understand the community organisation's targets, priorities, funding regimes and policies that may affect opportunities for people with mental health issues? Please say a little about this.
Have you delivered information, training or mentoring to people in the community organisation? Please say a little about this.
Have you seen increases in the numbers and satisfaction of people with mental health issues who are using the community organisation? Please say a little about this.

Finally in this section, there are three options for delivering support.

- Using mental health buildings where people meet other mental health service users and staff. This is the option that offers sanctuary or may promote exclusion (depending on your point of view). Examples include hospitals and day centres.
- Using buildings that are also used by other members of the community, but where the people with mental health issues remain together in a group. This is the option that offers geographical integration but may provide minimal social integration. Examples include separate college classes and group rooms hired in community centres.
- Offering 'community bridge-building' support to one person at a time to assist him or her to locate and join activities where he or she is shoulder-to-shoulder with the general public. Examples include supported employment and home treatment (ESC 5 – Promoting recovery).

Since mainstream community agencies have watched mental health services deliver their support largely through the first or second options, some will repeat that pattern by offering to set up segregated services in their own facilities.

Staff at the college or the sports centre may assume that the best way to meet the needs of people with mental health problems is to create a 'special' group, rather than support people to join in alongside the general public. Building effective relationships with allies in these settings will help them to create inclusive opportunities.

5 Getting and keeping inclusion

A comprehensive, inclusion-focused assessment will identify the preferred lifestyle of the person, as reflected in ESCs 5–9. It will also go some way towards identifying the person's inclusion history – perhaps of unsuccessful attempts to engage in educational, work-related or leisure activities. Acknowledging the feelings that attach to these experiences and finding the courage to try again is a key part of the journey of recovery.

Sometimes it is helpful to draw out the lessons that can be learnt from positive experiences with community organisations.

Activity 5.11

Think about the positive things you have heard, seen done, or perhaps have experienced yourself, that have supported people's access to community facilities.

Reflect on this and suggest practical changes that the community organisation might make.

It can sometimes be a gradual process with carefully thought-out steps to support people in their choices to reconnect with community roles and relationships. It requires creativity and building helpful relationships with the person, along with careful listening to the person's preferences about the areas he or she wants to connect with and the nature of the support he or she requires to do this.

A range of approaches can be used, and these can be grouped under the following headings.

1 **Getting to know the person** Good questions will help you to find out more about how the person thinks of his or her own recovery and what elements need to be in place to support that personal journey.

2 **Getting to know the community** Good local knowledge of the informal community is vital if we are to support people and avoid slotting them into unsuitable activities. Community development workers, voluntary sector agencies and health improvement workers can help with this.

3 **Building capacity in mental health services** Helping mental health services expand their knowledge of mainstream community organisations, the mental health benefits of inclusion and awareness of which support strategies are effective (see ESC 8 – Making a difference). This also demands replacement of the pessimistic predictions of the past (such as 'you will never work again') with recognition that people using mental health services can make a valuable contribution to their communities.

4 **Building capacity in community organisations** We need to build alliances, deliver training, dismantle barriers and highlight the benefits of reaching the mental health community.

5 **Support for the whole of life** An example of this would be making sure that medication is not altered the same day that the person returns to work. Family, friends, mental health services and colleagues in community settings all need to work together to help the person to get and keep his or her positive roles and connections (see ESC 1 – Working in partnership).

6 **Getting there and settling in** Assistance with choosing the right setting, getting ready to go, travelling and induction.

7 **Sustaining participation** This involves supporting the person to move on from attendance to participation. It is important for any problems to be dealt with before they lead to the breakdown of the activity. Support needs to be transferred from the formal mental health system to the natural arrangements in the community setting (see ESC4 – Challenging inequality, and ESC 9 – Promoting safety and positive risk taking).

Activity 5.12

In Jenny’s account in Module 4 (page 83), we heard how she was feeling isolated and ignored after being admitted to hospital for the fifth time. She has a right to access mainstream services and participate in her local community to support her recovery. What arrangements might you put in place to enable her to do so while addressing the seven areas on the preceding page?

- 1 Getting to know the person

- 2 Getting to know the community

- 3 Building capacity in mental health services

- 4 Building capacity in community organisations

- 5 Support for the whole of life

- 6 Getting there and settling in

- 7 Sustaining participation

Build a plan, listening hard for suggestions that come from the person you are working with. Use the work you have just done as a resource rather than as a way to take over or control things. If you cannot meet with the person, try to meet with someone who supports him or her – a support worker, a key worker or family member/carer.

6 Empowerment – unfinished business

Inclusion depends on a number of organisational factors. Consider the following and see if there is any action that needs to be taken with your team or line manager to create an environment where inclusive opportunities can flourish.

Activity 5.13

It may be useful to discuss the points in this Activity with your supervisor,[S] team[T] or manager[M].

Supporting people to regain empowerment is best done by people who feel empowered themselves. If you are feeling particularly powerless or pessimistic, this needs to be addressed.[S]

An inclusive lifestyle is unique to the person, resting on his or her own definition of recovery, but creative staff often support the journey. If staff are exhausted, creativity will never come to birth, and a blame culture will kill it.[S]

Inclusion demands that the policies and procedures of some services be reviewed and possibly redrafted. In particular, risk management policies or their local interpretations can have the effect of denying opportunities and reinforcing exclusion (see ESC 9 – Promoting safety and positive risk taking).[S,T,M]

Finally, working for inclusive opportunities is usually important but rarely urgent. This means that without ring-fenced time and resources, it will be squeezed out. What priority does the local mental health service really give to the inclusion agenda? [S,T,M]

We hope that you will continue to think about inclusion as you begin to apply the learning from the ESC learning resource to your practice. Here are some questions that will help you to apply socially inclusive practice within your own role.

- Can you say what 'inclusion' means to each person you work with?
- Is a detailed 'inclusion plan' part of their care?
- Where does 'inclusion' fit into your own personal development plan?

Action into practice

To further consider and develop your practice against socially inclusive practice, you could examine your practice against the SRI Dimension *Social inclusion and community integration*. This part of the SRI asks services to consider the ways in which they involve social support networks in care and treatment and the extent to which they promote social inclusion.

You can also build on the learning undertaken in this module by completeting Module 6 – Connecting with communities, in the *Realising Recovery* learning materials.

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[87] www.self-directed supportscotland.org.uk

Making a difference in the workplace

As we said in the introduction to this 10 ESCS learning resource, 'we believe there is little value in learning that does not translate into developing better services for service users and carers.'

So, now you have completed the learning resource, why not make a pledge with yourself to make a difference and change something for the better? You can use this form to help you focus on what you'd like to do – and good luck!

Making a difference: a challenge in the workplace

You are invited to identify a challenge in the workplace that you will work to achieve over the next few weeks.
What can you do that might make a difference to the way you and your colleagues promote the Ten Essential Shared Capabilities in the work setting?

Please write your challenge here.

This is what I'll do

....

This is when I will do it

....

This is how I will do it

....

This is who I will do it with

....

This is the support that I will need to do it

....

Please discuss your challenge with your immediate line manager,
for insertion into your personal development plan.

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