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1. Introduction

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

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

We will now examine some of these issues in more detail in this module.

2. Values concerning inclusion, service users and communities

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

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

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

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

Connecting with our own experiences

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

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

Activity 6.1

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

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

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

For each area of your life you have represented on the diagram, try to recall the history of your involvement. If it is an informal friendship, how did it start? Who introduced you? What happened to deepen that connection? What were the barriers, problems or conflicts that inhibited the growth of the friendship? If it is a formal activity, what started it? What keeps it going?

The narrative project (Brown and Kandirikirira, 2007) found there were six environmental factors that helped to promote recovery journeys. They are slightly edited below (by the addition of items in brackets) to emphasise the universality of these needs that we all seem to share.

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

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

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

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

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

Recovering hope for communities

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

- community as a rich oasis of opportunity and potential connection (Rapp and Wintersteen, 1989)
- community as a barren desert in which valued roles are rare and few people know one another
- community as an ice age where people need to huddle together for warmth after their short but courageous forays out into the harshness and hostility of the outside world
- community as rough terrain where there are many opportunities and good connections, but also barriers and access difficulties.

Images rather like these may be hidden “between the lines” of people’s experience of community life. For example, our narrator begins her account of her own recovery journey with a description of isolation (the desert) and ends with a rich and varied set of opportunities and connections (an oasis), while acknowledging her own challenges and successes in returning to paid employment and building friendships (rough terrain).

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

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

Activity 6.2

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

Check out the notice board, posters and other information available in any spaces that people occupy while using your service – waiting rooms, corridors, meeting places. What can you discover from this about the way that the community beyond mental health services is being presented? Is it visible at all?

Check the list of useful telephone numbers in the office or in your diary to see which organisations are represented.

Ask people in your team about their community contacts.

Listen to yourself and your colleagues when you discuss community opportunities with service users. Is this hopeful talk?

Activities like this and the images people use may help us to examine our beliefs, but it is important to avoid a simplistic approach. The one certain thing is that each individual's understanding will be personal to them, will be complex and multi-layered and will probably include contradictions. Women and men may have different experiences, as may people from diverse cultural backgrounds, those with different experiences of education, those who live in different neighbourhoods, and so on. It is therefore important to respect this diversity of opinion and experience.

The policy context

Building local communities in which people using mental health services can find a place, participate as equal citizens and make a contribution is the clear goal of sections 25–31 of the Mental Health (Care and Treatment) (Scotland) Act 2003.

The Scottish Government publication *With Inclusion in Mind* (Scottish Government, 2007) guides local authorities on how to meet their obligations under this part of the Act, in partnership with their NHS board and colleagues from community organisations. People who have mental health issues, personality disorder or learning disabilities have the same rights as other citizens to a respectful welcome and all reasonable adjustments to enable full and equal participation. So responsibility for eliminating barriers and reaching out to provide access to all, including those people who use mental health services, lies with the whole community.

The guidance offers two audit tools. First, there is a “mystery shopper” framework for use by groups of mental health service users who wish to capture, organise and feed back their experience of using community venues, such as leisure centres, colleges or neighbourhood associations. This audit may have particular relevance for groups who may face multiple exclusion, stigma and discrimination, such as women from minority ethnic communities who also have mental health difficulties.

The second audit offers an opportunity for key stakeholders interested in specific aspects of community life to work in partnership.

3. Promoting inclusion through your work with service users

Curiosity and disclosure

In Module 4, we outlined person-centred approaches that emphasise curiosity, arising from recognition of the uniqueness of the individual and a commitment to be person centred. When conducted in an atmosphere of hope, such inquiries assist the person and the worker to obtain a shared sense of what wellness means, and so promote recovery.

We need to take care, however, that we do not underestimate the difficulty of uncovering a true sense of another human being's ambitions and hopes for their life and what inclusion might mean for them. As Joe Bidder wrote:

"I never told the truth about those days; hid reality behind smugness and false confidence. Never let on I'd been inside. Never spoke about the eight shots of ECT, doses of chlorpromazine, the pain and degradation. Too afraid of the label, afraid of losing my friends, my self-esteem, my job. My family didn't help – they denied their history; and so it went on and on. One generation mirrors the one before. So I tried to live a life of denial; crept furtively from work to visit the psychiatrist, went to the toilet to take my dose of lithium and shovelled sleepers at bedtime when the speed came so fast and sleep too slow. I hid the manic rushes to reduce marital stress ..." (Thompson, 2006)

This "culture of silence" is found in many places. It can occur when:

- the cultural expectation in a whole country or geographical region favours "putting on a brave face" rather than acknowledging personal difficulties – Parr et al (2004) have suggested that this is a particular issue in Highland Scotland, but many smaller communities, workgroups (such as the emergency services, for example) or neighbourhoods may share this approach
- people with mental health problems feel obliged to keep their experiences secret from neighbours, associates, work colleagues or friends (we looked at some of the reasons for this in Module 1)
- mental health workers confine their inquiries to certain times, settings or topics; speaking about symptoms or debt may be more acceptable than disclosing life ambitions, and pressure of work may reduce levels of expressed curiosity.

Activity 6.3

Think about a person you know well who uses services. List the ways in which your service has both facilitated and inhibited that person's self-disclosure over the course of their involvement with mental health services.

Does your service sometimes inadvertently encourage people to hide the truth about themselves? Is it different for people in hospital, those subject to compulsory powers or people in touch with community services? Focus particularly on disclosure about how that person currently lives their life beyond the mental health service, and how they would like to do so in the future.

Check out your observations with the person.

Assessment

The worker's curiosity and the person's self-disclosure ease the process of assessment, which aims to:

- replace hidden and stereotypical assumptions with an explicit guide and systematic approach for getting to know the person
- organise observations into a cause-and-effect explanation
- validate the existence of problems
- help us choose who to help and how to help
- enable the person, mental health workers and others to communicate with one another about what is happening
- keep us curious rather than complacent, while identifying what is relevant and deliberately seeking this and nothing else – protecting the individual's right to privacy.

In contrast with sophisticated approaches to symptom assessment, formulation and diagnosis, anything that might be broadly described as a formal inclusion assessment is in its infancy, although the Scottish Recovery Indicator⁴ has made a valuable contribution.

The lack of recognised tools, combined with the belief in some mental health services that "*it's no ma job*", increases the risk that people will rapidly lose vital social roles and relationships, especially at times of crisis.

⁴ Access at: www.scottishrecovery.net/content/mediaassets/doc/SRI%20ConfVers180407.pdf

Activity 6.4

Jimmy Wong was admitted last Friday at 6.30pm. This is his first contact with psychiatric services. He has hardly moved since then, sitting frozen still, apart from his frightened-looking eyes that dart to and fro. He is 20 years old and understands English, but has not spoken to the nursing team or other service users, apart from on Sunday afternoon when he spoke Cantonese non-stop for 20 minutes with a visitor. The visitor left hurriedly without speaking to any of the staff.

How would you find out about Jimmy Wong's present life in the community and what social inclusion might mean for him in the future? What would you do straight away and what would you leave for later?

Perhaps most importantly, the way in which mental health workers relate to service users and the way in which professional assessment blends with self-assessment can make all the difference. Recovery is promoted when staff offer effective support without disempowering the person and when they continue to try and find out what has meaning, relevance and significance to the person. One person cogently summarised the importance of finding a lifestyle that holds personal meaning like this:

"I was always attempting suicide and stuff like that because I hated myself so much whereas now that doesn't happen because I've found something that I actually enjoy doing and that I get feedback from." (Secker et al, 2007)

Detailed inclusion assessment

While some individuals will have strong social networks and enduring roles in the community, others will need careful support to move towards their goals.

Each of these areas of life can benefit from its own specific approach to assessment, enabling the worker to avoid stereotypical assumptions and to obtain a sufficiently detailed profile of the person's strengths, resources, goals and need for support to achieve them. The involvement of the individual is of paramount importance in any assessment.

It turns out that Jimmy Wong's Sunday visitor was from the Chinese church, so obtaining a more detailed understanding of the meaning and value of this connection was important. The following box provides an illustration of the sort of questions that might help to clarify how he has been living and how he wants to live in the future in relation to this aspect of his life in the community.

Questions for a spirituality assessment (White, 2006)

Meaning and purpose

- What things give you a sense of purpose?
- Do you have a specific aim that is important to you at the moment?
- Do you believe in any kind of existence after this life?
- Has your illness changed your attitude to the future?
- What bothers you most about being ill?

Security and hope

- What are your sources of strength and hope?
- Who do you turn to when you need help? In what ways do they help?
- What inner resources do you draw upon?
- Where do you go for comfort and support?
- Who or what do you depend on when things go wrong?

Religion and spirituality

- Do you consider yourself religious or spiritual?
- How does this affect you? Has being ill changed this?
- Is prayer helpful to you? Can you talk about how?
- Is there anything we can do to support your spiritual or religious practice?

As it appears that Jimmy is more comfortable speaking Cantonese at this time, an interpreter may enable him to engage with staff in a more meaningful way in this assessment. Every effort should be made to secure a professional interpreter rather than relying on friends, family or other visitors to take on this role.

Some services have employed staff to focus on just one area of community life (chaplains, vocational specialists or healthy living advisers). These individuals gradually discover the most fruitful questions and most useful approaches in assisting people to obtain and retain the inclusive connections they need. Indeed, any team could share out responsibility for exploring the community as a simple way to continuously improve effectiveness and make a positive difference in the lives of service users.

Activity 6.5

Select a particular area of community life (employment, education, volunteering, arts, sports, spiritual organisations) for some concentrated learning. Either choose an area that is of long-standing interest to you or perhaps try to develop an area you feel you have a lot to learn about.

Make a list of all the questions you think may be helpful in conversation with a service user about their experience and ambitions in relation to this area of community life. Go beyond the practical arrangements to the person's motivation, emotion and interactions with others in the setting.

Over the next few weeks, and as opportunity arises, try out your questions with service users, friends and colleagues. Observe which questions are helpful and note any new ones you generate spontaneously. Refine the list of questions you consider effective and feel comfortable using.

Community mapping

Once you have found out about the person's ambitions and hopes, you need to ensure you have a good knowledge of community opportunities. The amount of time and number of connections you can maintain with mainstream community organisations will partly depend upon your role in the mental health service, but all staff are expected to adopt a hopeful attitude, be aware of some oases and support people in navigating the rough terrain. The next activity is intended to assist you in developing community mapping skills.

Activity 6.6

Each member of your staff team will already have some specialised knowledge of a neighbourhood or an area of community life. They may be a football supporter, a resident of a particular village, a keen allotment holder, active in the local history society or a regular face at the quiz night at the local pub. Draw up a list of these specialist areas of knowledge represented on your team.

Now identify areas of community life that are missing from the list. You may have no-one involved in volunteering, political groups or gay networks, for instance.

Some of these areas of community life seem to be “neutral” while others evoke strong feelings from staff who are enthusiastic, suspicious or nervous of making a connection with the group or activity. Take some time to explore these feelings – why do they arise and are they justified?

Set yourself a target for finding out about one of these “missing links” over the next month.

The Department of Health in England has developed a strategic approach to workforce and team development that is based on a similar methodology to the one you have just used in Activity 6.6. Their Creating Capable Teams Approach (Department of Health, 2007) requires multi-disciplinary and multi-agency teams to reflect on and review their existing skills mix alongside service users and carers to ensure they best meet their needs.

Building an inclusion plan

You were introduced to a seven-step framework for building an inclusion plan in Module 6 of the ESC(S) learning materials (see box below).

Seven-step framework for building an inclusion plan.

1. Get to know the person’s aspirations for inclusion.
2. Get to know what is available in the community.
3. Ensure that colleagues in the health and social care system are signed up to the plan.
4. Assist the community group or organisation to offer a suitable opportunity.
5. Ensure that other issues (such as family influences or financial worries) do not block the plan.
6. Make good arrangements for getting to the activity, being introduced and settling in.
7. Deepen the participation and overcome any difficulties that arise.

This framework helps to cover all the relevant aspects of the plan, but it does not do justice to the complexity of issues that need to be addressed from time to time. Take the following scenario as an example.

Activity 6.7

Beverley has been in touch with a community mental health service for some years and, having just completed a computer course at college, has decided to look for employment. She has seen an administrative post advertised in the local newspaper and has contacted the employer for an application pack.

Beverley spoke with you at your most recent meeting about the application form. She is unsure about completing it and in particular isn't sure whether she should state that she has a disability. She has asked you if she should state that she has a disability and what she should say about her mental health if she does.

Make a note of your own thoughts on the following issues then discuss with the group.

What do you think might be the advantages and disadvantages of Beverley disclosing her mental health problems on an application form?

If she does disclose, are there words you think she should avoid using? What do you think she might say instead that might seem more positive?

The issue of disclosure of mental health issues to employers (and, for that matter, to others) is complex. People with experience of mental health problems may not perceive themselves to be "disabled" or may worry that any mention of mental health difficulties may lead to immediate rejection.

On the other hand, some companies do state that failing to disclose relevant information on a job application form can lead to instant dismissal. Additionally, disclosing mental health problems may offer legal protection under the Disability Discrimination Act (1995 and as amended 2005).⁵

⁵ Further information about the DDA can be found at the website of the Equality and Human Rights Commission: www.equalityhumanrights.com

The Disability Discrimination Act (DDA) defines disability as:

“... a physical or mental impairment which has or has had a substantial and long-term adverse effect on [a person’s] ability to carry out normal day-to-day activities.”

The DDA makes it unlawful to discriminate (treat less favourably) against a disabled person in education, employment and the provision of goods and services. The Act also requires that employers make reasonable adjustments to enable disabled employees to access or retain employment.

Let us look at the implications of disclosing mental health problems and making reasonable adjustments at work for Beverley, who was introduced in Activity 6.7.

Activity 6.8

Beverley was successful in her application and started in her new post. Despite finding it tiring and stressful to begin with, she has enjoyed working again and has made friends with a few of her colleagues.

Twelve months later, Beverley’s mother died suddenly and Beverley found this very difficult to deal with. She has had two months off work and is beginning to feel better. She would like to return to work, but is not convinced that she could cope with the demands of her job. Her GP has suggested that she speak with her line manager about the “reasonable adjustments” that could be made to enable her to return to work without jeopardising her mental health.

Beverley is unsure about what the term “reasonable adjustments” means or what adjustments she could ask for, and comes to you for advice.

How would you explain “reasonable adjustment” to Beverley and what examples might you give her of adjustments that might be useful for her? Make a note of your own thoughts then discuss with the group.

When we think of making adjustments to accommodate people with disabilities, we generally tend to focus on physical access (such as availability of lifts or ramps) or equipment. It can be more difficult to think of adjustments that might be made for people with mental health problems. There are, however, a number of things that might be useful to Beverley, including:

- a phased return to work, starting off part-time and then building up to full-time hours
- working at home for some or all of the time (if her job can accommodate this)
- starting work later in the day and finishing later (this might be useful to counteract the effects of some medications)
- having time off to attend appointments with a bereavement counsellor
- regular meetings with her supervisor to discuss progress and talk over any difficulties.

The Scottish Association for Mental Health (SAMH) has a useful publication on reasonable adjustments for people with mental health problems which can be accessed from their website: www.samh.org.uk/assets/files/197.pdf

Taking action

People on their recovery journey need to balance competing risks when making decisions about disclosure, but the topic also challenges mental health workers. As the seven-step framework indicates, it is not enough for workers to merely provide a leaflet about college courses or put up a poster showing where the local gym is to be found.

Rather, you will be required from time to time to visit community settings, talk to representatives of community organisations, negotiate changes that will enable people to participate, and sometimes provide information about mental health problems and services. You may be involved in collaborative problem-solving with employers, friends and others.

Activity 6.9

Judith has attended the drop-in centre since 1987. She is now 62 years old and lives alone. She says that she does not see anyone apart from her friends at the drop-in centre. She tried the over-60s club at the community centre a couple of times but soon gave up as she did not feel welcome.

Day centre managers have proposed that the drop-in will be closed in two months time due to a combination of factors – eligibility criteria have been tightened, there is a new focus on therapeutic sessions with measurable outcomes, and the social inclusion agenda.

From your perspective, is this the right decision? What stages would need to be put in place in a good plan for Judith and for the centre? Who else needs to be involved and what should they do? How would you manage the timing?

One of the biggest organisational changes taking place in response to the social inclusion agenda is occurring within day services, although all parts of the mental health system need to address the challenges of supporting recovery and inclusion. Broadly, day services are offering fewer sessions within their own buildings and more support to people who wish to engage in mainstream community activities alongside the general public.

Accessing mainstream services might be easier, however, for some mental health service users than others. We have already identified in this and previous modules that some people are at risk of multiple discrimination – people from black and minority ethnic communities who experience mental health problems, for example. People in secure mental health settings are arguably the most at risk of exclusion and often face the greatest barriers when attempting to make community connections.

Activity 6.10

Alan is 38 years old and has lived on his own in a housing association flat since his discharge from a medium secure unit 12 months ago. He was transferred to the medium secure unit after spending four years in the State Hospital after being convicted of a number of offences committed while he had been unwell. These were relatively minor offences that did not involve violence to others.

Alan has made few friends since moving to his flat and generally spends his time at home watching television, listening to music or painting. He is a talented painter and would like to study art at college with a view to expanding his skills. He is fearful of meeting new people, however, and is worried about people asking questions about his past, as he feels very ashamed about the fact that he has been in the State Hospital. He thinks that if he told people about his past they would assume he had been sent there because he was violent.

If you were working with Alan, how would you support him to realise his ambition?

What work might you do with Alan to develop his self-confidence and come to terms with his past? Is there anyone else you might involve?

The interrelated issues of stigma and discrimination are common concerns for users of mental health services. Fear of rejection or of being ostracised or laughed at can become internalised, creating self-stigma. This internalisation of negative beliefs makes it difficult to socialise with others and hinders the recovery process (Brown and Kandirikirira, 2007).

It is therefore essential that mental health workers not only address the issue of stigma with the individuals they support, but also do all they can to challenge discrimination in the communities they work and live in.

Combating discrimination requires:

- education and persuasion that is targeted at each audience, is led by people in recovery and stresses the benefits of a fairer community
- contact that leads to people hearing one another's stories and getting to know each other's gifts and strengths, and which is based on equality and reciprocity
- legal sanctions and protest – engaging public support by collaborating with people who have the self-esteem and resilience to exercise their rights (Gibbons and Read, 2004).

Unless mental health workers get out among community organisations and engage with them in enhancing opportunities and combating discrimination, inclusive opportunities will be restricted to the most resilient and self-reliant people.

Subtle support

Finally in this section, we return to the basics. As services become more strongly focused on promoting social inclusion, there is an increased likelihood that mental health workers will be based in community locations supporting service users on a one-to-one basis. The task of providing subtle support to people in an unobtrusive way is challenging, especially if the person exhibits unusual behaviour.

The following box lists some general ideas about how to provide subtle support.

Providing subtle one-to-one support in community settings.

Ask the person: what they want to do; how to identify and overcome the barriers to participation; how they want to be supported; how to negotiate disclosure and positive risk-taking; what their needs for additional support or flexibility are.

Think about: who is the best person to provide support; meeting someone you know; managing your feelings about supporting this person; how you will deal with private matters in a public setting; what to do if the person is loud, visible or behaves differently; the impact of weather, schooldays, time or day.

Plan: introductions and explanations; what the person can do without support; transfer of support to other participants and discreet withdrawal by worker; any adjustments that need to be made by the activity provider.

On the day: how the person feels today; change of plans; keep your words, tone and body language calm and positive; be with the person and join in, but encourage them to make their own connections.

Avoid: being over-controlling; showing off as the person who is in charge; name badges and unsuitable clothes; doing your own shopping and phone calls.

While these suggestions may seem little more than common sense, many staff (especially support workers) will have experience of times when life seems to have moved far beyond the guidance available from their organisation's policies on lone-working, information-sharing and positive risk-taking. Strengthening inclusive practice will require most agencies to improve their quality assurance, support and supervision mechanisms to respond well to these situations and their consequences. Similarly, as a worker in the service, you will need to build social inclusion into your plan for personal development and learning.

4. Conclusion

Every service development and innovation can be misunderstood or twisted into something harmful, so a positive focus on supporting inclusion requires vigilance to identify and correct these distortions and practise ethically. Use this final activity to check that the social inclusion agenda is being developed in a positive way by yourself and in your service as a whole.

Activity 6.11

Have you or your service (perhaps through its monitoring systems) decided what counts as inclusion for service users and begun to press them to live according to the service's prescription for an included life, or do you listen to what people say about their own recovery journey?

Have you or your service reduced social inclusion to mere "common sense", or do you explicitly include it in the service specification, job role, training programme and continuing professional development agenda?

Have you or your service passed the task of promoting social inclusion to specified workers or deferred it to the latter stages of the person's recovery journey, or do you see it as everyone's responsibility from day one?

Are activities and opportunities fragmented and disjointed, or is there a clear path by which each activity (such as a creative writing session on the acute ward) can lead through to participation in a community group attended by the general public?

This module has addressed the following themes:

- people with mental health problems are subject to many forms of exclusion in many areas of life, and this sometimes occurs alongside other kinds of discrimination
- achieving recovery and inclusion demands that opportunities are offered and taken up that are meaningful to the person and in which they can move at their own pace
- mental health workers need to take a hopeful approach to communities, looking out for the positive opportunities that can be found there while adopting a determined approach to overcoming the barriers
- creating an accessible and respectful community requires commitment and energy from right across the community
- both curiosity and detailed assessment tools are needed to understand the person's aspirations for a life in the community and the community itself
- combating discrimination is a key aspect of the work and requires mental health workers to act in partnership with people in recovery and community organisations
- continuing professional development means that mental health workers will frequently reflect on their practice and find new ways of opening up and offering opportunities to people on their journeys of recovery and inclusion.

Learning into practice

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

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

Resources to support further learning

Information about challenging stigma and discrimination in Scotland available from:
www.seemescotland.org

Further information about the Disability Discrimination Act and other equalities legislation is available from the Equalities and Human Rights Commission:
www.equalityhumanrights.com

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