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In Community

Practical lessons in supporting isolated people to be part of community

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Published in 2009 by HSA Press, 34 Broomfield Road, Heaton Moor, Stockport SK4 4ND
in association with In Control Publications.

Distributed by HSA Press.

A catalogue for this book is available from the British Library

ISBN: 978-1-906514-25-9

Printed in the UK by scotprint.

Helen Sanderson Associates

Helen Sanderson Associates is a development training and consultancy team. HSA works with people to change their lives, organisations and communities through person-centred thinking and planning. There are HSA teams in the UK, Australia, Canada and America.

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Social inclusion work in mental health: using life domains and the *Inclusion Web*

Previous chapters have described a range of community-building approaches used in working with some of the most marginalised groups in the country.

This chapter outlines other original approaches used in work with people with mental health issues. One of these is the *Inclusion Web*. The authors describe how *'The Web creates a rich picture of the person's life. It records both qualitative and quantitative information in a graphic format that can be read at a glance.'*

Many who support marginalised people to be involved in their communities would agree that measuring progress can be difficult. Positive developments in relationships and connections can be hard to quantify. The *Inclusion Web* offers an important means of creating a clear assessment of progress.

The authors suggest that the Inclusion Web is significant '*because there is a lack of evidence linking improvement in mental health with inclusion in mainstream settings'.*

Introduction

Our conversations started in Liverpool in the early years of the new millennium.

Peter Bates had been developing socially inclusive projects in mental health for some years, had found a home for his work with the *National Development Team*[1] and was in Liverpool to help commissioners establish a local inclusion project.

Jo Seddon was recruited as the first team leader for this service, which was called *Mainstream*. It was run by Imagine[2], an organisation that supports people with mental health issues '*to live a full and independent life*'.

Antony Dowell began working as a Bridge-Builder on the team shortly afterwards. Between us, we have had the privilege of spending time with many hundreds of people using services, front line staff, commissioners and policy people. Our observations in this chapter are largely personal reflections formed in our roles in organisational development, management and delivery. Our recent work has featured the use of ***Life Domains*** and the ***Inclusion Web***, both of which are considered in this chapter.

The problem

People born with disabilities are subject to excluding processes almost from the moment of conception. Others, such as people with mental health issues, offenders and homeless people may only find themselves at risk of exclusion as teenagers or adults.

Around four million employees in the UK have mental health difficulties[3]. Poor support means that some 70 million working days a year are lost due to mental distress.[4] This means that employers (like many others in the wider community) are already responding to people with common mental health issues in both positive and negative ways. So, inclusion work with many people revolves around retention of jobs, education courses, homes, families and friends.

Exclusion hits hard in times of crisis. There are certain times in life when roles and networks are at severe risk of collapse. These moments include: when someone becomes unemployed; the end of a long-standing relationship or job; becoming homeless or entering a prison, psychiatric hospital or long-term residential care.

Early intervention services in mental health sometimes make contact early enough in a person's crisis to actually see this collapse in progress. The person may have stopped going to school or work. Family life may have become strained. Regular Friday nights out with friends have been replaced by evenings alone in the bedroom.

Exclusion hits hard in times of crisis

Although Anna's childhood home was high in a tower block, she grew up amongst people whose aspirations were low. She left school as soon as she could, but eventually returned to teach in the local secondary school. Later, she developed a bipolar disorder and the mood swings, combined with bullying from others, led to the loss of her job.

For Anna, unemployment meant losing her sense of achievement, her fight for citizenship, her access to justice and all her confidence. She was convinced that this had very little to do with her illness and everything to do with society's intolerance towards people who experience mental illness.

Flexible and responsive services have the potential to safeguard the person at least partially from this sudden plunge into exclusion. Practical, timely inclusion support can engage with the family, help to get the job back (or find a new one) or negotiate an extension to the deadline for submitting homework. Such practical support can even assist in helping someone reconnect with friends and social activities.

When mental health issues become severe and enduring, people can be subjected to wide-ranging and systematic exclusion. For them, promoting inclusion is likely to mean building first-time opportunities to work, learn and socialise with citizens beyond the mental health system.

Just as at childbirth and after disasters, a mental health crisis can provide a '*crucible experience*'. Strong bonds of solidarity form between people who experience the event together. This unifying effect has underpinned the strong self-advocacy groups that service users have formed over the last thirty years or so.

Many of these groups are vibrant campaign centres for reform. They follow government encouragement to develop user-run services[5]. However, they may not have embraced the social inclusion agenda. Perhaps this is because the peer support in such groups appears more comfortable and positive than relationships in the unfamiliar community outside the mental health system. Hostility and discrimination can seem rife in this '*outside world*'. Indeed, some advocacy groups have campaigned successfully against changes in the mental health service that would otherwise have increased opportunities for inclusion.

Inclusion work in mental health is about combatting stigma and discrimination and building pathways into community life, but it also emphasises the thoughts and feelings of the person who has been excluded. The recovery movement in mental health[6] focuses our attention on those kinds of participation that are meaningful to the person, on self-directed supports and on the idea that inclusion is a lifelong journey rather than a settled state.

For some people involved in self-advocacy groups, the world beyond mental health services can seem hostile

One small group of day centre members, for example, refused to consider any change in activities at the centre. However, over the next eighteen months, most of them gradually discovered that doing things outside the mental health service could be non-threatening and enjoyable.

For example, one member, Sam, had attended a mental health drop-in centre every day for twenty years. Now he helps others at the local church's lunch club. This might never have happened if the group's perceptions hadn't been gently challenged.

This, then, is the context for our efforts: helping people to retain the positive roles and relationships that they enjoy and to build new ones; safeguarding against catastrophic losses; growing user-run supports and the external development of opportunity. All these things only become valid when the individual concerned attributes meaning to the participation.

What we tried

We have been constantly listening, thinking and learning about how to conceptualise our work. We reflect constantly about what is effective and what might go wrong. We have burrowed into the literature on inclusion in our own field and frequently glanced over the wall into neighbouring fields to see what we can learn.

Thinking about community one aspect at a time in '*life domains*'

We found out early on that gaining a comprehensive understanding of the whole community is just too hard, especially if we have spent a lot of our time around services. Instead, attending to a single sector of community life such as the world of the arts, employment or faith communities has advantages: those who are interested in supporting individuals and community organisations to get to know each other better can talk the right language, negotiate the right openings and build sustainable relationships that deliver change in the long term. We call these community life sectors '*life domains*'.

Focusing on particular life domains offers a targeted approach that has enabled the mental health service in England to build alliances with a diverse array of mainstream organisations. These include local libraries, the Football Association, BT and Tate Modern. These alliances have helped individuals to gain access,

but they have also begun to shift attitudes and practices at a strategic level in those sectors – from local agencies right up to government departments. Using this multi-level approach, inclusion work has influenced and changed spending decisions at the Treasury, policy decisions at the Department of Work and Pensions and priorities at the Cabinet Office.

Life domains

Training and supporting staff in inclusion and life domains

Much of our work has been with mental health services wanting to evolve by retraining and developing their existing staff teams. Helping traditional services to become more inclusion-minded has been a consciously optimistic approach. We believe in the potential of staff to change. Taking this approach enables innovation to go quickly to scale and we don't have to wait for others to recommission services.

From time to time, this process has been hampered by pessimistic attitudes and resentment towards change; staff were sometimes reluctant participants in the new service. On the other hand, we have delivered inclusion training to newly commissioned teams from the first day of their new roles, and feedback tells us that the training was of enormous value in establishing the vision, optimism and energy of the new service.

Some of these new services focus explicitly on promoting inclusive lifestyles. They employ staff from a variety of backgrounds, including those with direct experience of using services, the mental health professions and the relevant life domain. For example, one team included an experienced mental health worker, a qualified fitness instructor, a careers officer and a religious education teacher who had personal experience of caring for a family member with mental health problems.

Taking an optimistic approach about staff members' ability to become more inclusion-minded can lead to rapid change

When a contract was won by a new organisation, the service specification gave a new priority to community building. The employer insisted that, in order to transfer, current staff had to meet a number of basic conditions. They had to be person-centred, enthusiastic and eager to challenge injustice.

Each worker also had to have a passion, a lifelong skill that fitted in with one of the life domains. It turned out that Bob had been a dancer, John has faith links and busks and Margaret has volunteering experience.

A practical way to monitor progress – the *Inclusion Web*

In the early 1990s, Peter Bates was leading a team that promoted socially inclusive approaches in a mental health service while a human geographer evaluated the work of the team. One of the outputs from this work was the *Inclusion Web*.

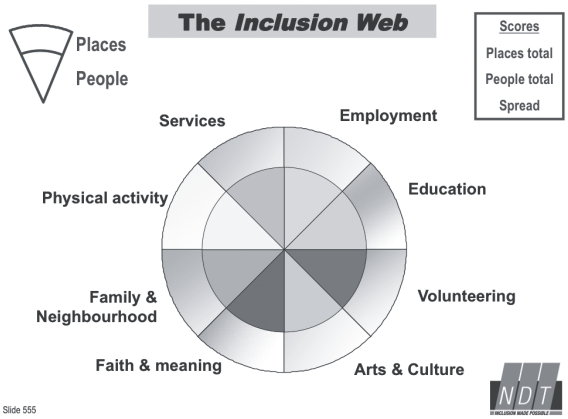
The *Inclusion Web* is an easy-to-understand tool based on the life domains that are considered above. Service users can use the *Inclusion Web* to map out their contacts in their local community. They can use it to find out how the contacts and places that are important to them change over time.

The *Inclusion Web is* significant because there is a lack of evidence linking improvement in mental health with inclusion in mainstream settings[8]. Social inclusion initiatives are intended to promote choice in living a desired life in the community. Such initiatives emphasise involvement in community life. However, living a desired life in community tends to be measured in relation to paid work. A focus on paid work ignores the fact that for many socially excluded people, paid work in mainstream settings is not automatically a positive option[9]. Paid work can often be temporary, stressful, uncertain and likely to increase poverty and dependence because of the difficulties associated with stopping and starting benefits.

Quality of life for those in mainstream society does not depend on work or involvement in a large number of community groups[10]. There is a real danger in subjecting people with mental health problems to a view of normal or healthy life that is not representative of mainstream society itself. We need to pay more attention to shared perspectives and to hearing what people themselves aspire to in relation to work, relationships and recovery.[11]

The *Inclusion Web* reflects this belief. It is essentially user-led. Each person uses their personal definition of the significant people and places in their life, rather than these being predefined. The *Web* creates a rich picture of the person's life. It records both qualitative and quantitative information in a graphic format that can be read

at a glance. Information recorded on the *Inclusion Web* can be used to inform person-centred planning, encouraging the person to make their own plans and review changes.

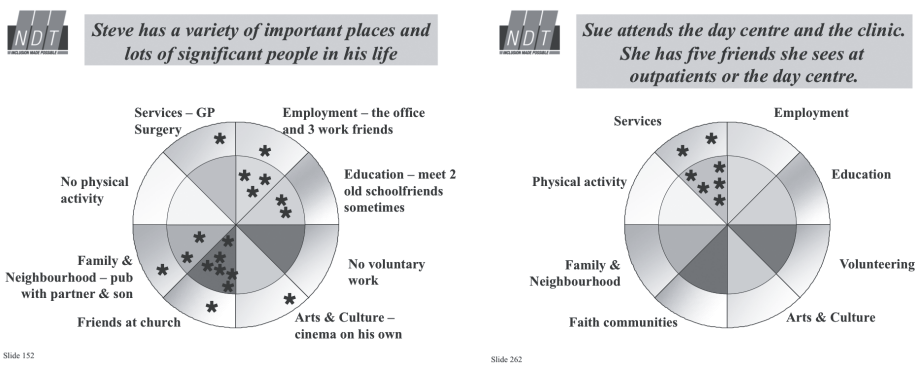


The Inclusion Web

The *Inclusion Web* has two scales: **People** covers personal relationships; **Places** covers where the person goes in their community. **Clockspread** is a summary measure of both of these scales. Information about people and places is recorded within the eight sectors shown on the outside of the circle (the life domains). Summary numbers of people and places are recorded for each section of the diagram. An increase in personal relationships and participation in more diverse community events and locations indicate greater community inclusion.

Collecting this information is not expected to be a neutral exercise; both the service user and staff member can be actively involved in open-ended and wide-ranging conversations. The *Inclusion Web* generates a map of someone's personal network of places and relationships and, through repeating this exercise, enables the person and staff member to monitor change together.

The illustrations above show how two people have recorded information about the meaningful people and places in their life. Steve's shows how he has a variety of supportive places and people in his life while Sue's Web shows how all her connections are in the services sector.



Two examples of how the Inclusion Web is used to capture information

The *Inclusion Web* was employed extensively with people using the Mainstream project in Liverpool. The Mainstream project assists people with long-term mental health problems to engage with community activities. Staff do not run groups or buildings themselves but rather advise and support people to locate places and people beyond the mental health system where personal connections might be made. The project was established in 2001 by Imagine, a voluntary sector organisation with funding from the local mental health NHS Trust.

A hundred and forty nine men (67% of the total) and women (33%) filled in an *Inclusion Web* and then completed it again six months later. We wanted to evaluate whether the service had made an overall significant difference in people's community inclusion.

What we learned

Inclusion and recovery go well together

In general, the inclusion agenda in learning disability services in the UK has been twinned with the introduction of **person-centred approaches**[12] and in mental health with **recovery**. In each area, the two strands have generally complemented each other very well; each has helped to ensure that the other does not become narrowed or weakened. However, crossover between the learning disability field and mental health continues to be weak.

One sign that '*silo-thinking*' continues is the fact that person-centred planning, as developed in the learning disability field, has made little impact in mental health. The mental health market place is already crowded with assessment tools developed by the recovery, psychosocial interventions and cognitive behaviour therapy schools, some of which share the values of person-centred planning.

It appears that the success of any movement for change is partly based on the amount of room judged to be available for new ideas and the extent to which key opinion formers view a new idea as coherent with those that are already dominant. This judgement is often based on superficial analysis; the point that person-centred planning is not '*assessment*' becomes of minor importance in the struggle for influence. Government, however, is continuing to include the terms '*person-centred*' and '*personalised*' in its guidance documents and this may lead to an increase in the level of interest. We have learned to embed person-centred and community-focused approaches into other processes.

The approach taken to social inclusion work in mental health has been informed by mental health promotion and community development interventions. Over 400

community development workers, for example, have been appointed to increase access to mental health services in the black and minority ethnic communities. This means that the citizenship of mental health service users is arrived at equally from the community perspective as it is from the individual perspective. Rather than just building community one person at a time, the mental health approach has aimed to do this alongside efforts to build a community worth joining. It is this twin-track approach that we believe offers the best hope for long-term success.

Only some staff do well

We have learned that not all existing staff seem suited to this work. While we continue to be committed to the evolution of current services, our expectations have been confirmed that community building with mental health service users is a new role. Those who served competently in traditional services are not necessarily suited to inclusion work. Managers need to commission high-quality training and support for staff to enable and support the transition, hold people to account for meeting the new expectations and, where necessary, find respectful ways for people to move into alternative jobs.

The bridge-builders who do well have big personal networks. During training, we sometimes give people ten minutes to match a list of surnames with people that they know. These '*some-people-I-know*' scores range from below 20 to nearly 300 (only one third of our sample scored above 100 and only 2% above 200). Anecdotal evidence suggests that the most successful bridge-builders are people who love to network, who seem to know and like everyone – the people Malcolm Gladwell[13] describes as '*connectors*'. Initial training for a new team draws on these personal networks to begin a database that eventually contains hundreds of possible connections.

We need to find out exactly what works

Building community relies on a good understanding of the diverse ways in which people like to belong. This understanding has been developed by, for example, gathering and collating over 100 ways to support the inclusion journey[14] and using an evaluation tool such as the *Inclusion Web* for assessing whether these interventions work[15]. These resources have helped people to acquire new ways of working and been especially useful for those who work best with concrete examples.

From attendance to belonging

For some, it is enough to nod to others and sit in companionable silence in a '*third place*' where little is demanded[16] while others seek fun, friends or soulmates[17]. Sometimes, our own preferences intrude and we inadvertently impose our own vision of what community should be on those we love or support. So it is crucial

Effective bridge-builders are curious about neighbourhoods and build big personal networks

Peter, the Faith Communities Bridge Builder, was out in his High Street. He spotted a crystal shop and went in to ask the shopkeeper about his business. At first, the shopkeeper was sceptical about people with mental health problems taking part in spiritual activities but, after a chat, acknowledged that some people might find it helpful.

The shop had a notice up about a spiritual drumming group in a local house and this was the only advert that had been placed anywhere. So within ten minutes, Peter had a new '*convert*' and had opened up a previously hidden community opportunity..

to check constantly that we are supporting the person's own goals. Sadly, workers sometimes reduce community participation to mere attendance or possession of a membership card. We have learned something of the importance of making new connections where the person's engagement can deepen from attendance to belonging and they can gradually move into a situation where their gifts are so vital to the community that, if they are missing, they are missed.

Mapping local opportunities

We have learned that communities vary from place to place and the approaches used in one setting may not work elsewhere. In dozens of local neighbourhoods from the Clyde to the Cam, the authors spent an hour wandering around, seeking out posters and notice boards advertising festivals, groups and organisations. For example, an hour spent in Eccles, a suburb of Greater Manchester, yielded 45 activities, including weekly recitals at a Wurlitzer organ museum; a Sunday volunteer clean-up of the train station; health promotion staff willing to assist local residents to attend the gym; and the 100th birthday celebrations of the public library. In contrast, a fifteen minute walk through the busy shopping centre in Finchley, north London, yielded information about just three organisations – the Korean, Catholic and Baptist churches. Londoners probably advertise their activities using other media or bring people together from a wider geographical area, or perhaps the shops are charging too much for window exhibition space. We found, though, that Finchley's community-builders had no shortage of organisations and groups with which to link.

The importance of tracking progress using the *Inclusion Web*

We learned that the *Inclusion Web* is a helpful way to track progress. The research in Liverpool showed that there was a statistically significant increase in scores for both *people* and *places,* and in the combined measure, *clockspread.*

Service users had an average of six places and 18 people in their *Inclusion Web* over all the domains, and this increased to eight places and 28 people when the *Inclusion Web* was completed for the second time (34% and 54% increase respectively).

When introduced to the *Inclusion Web*, some staff suggested that its use might cause distress to people who are profoundly isolated and suicidal because it would draw a stark picture of the lack of activities and connections in the person's life. However, most service users seem fully aware of the reality of their lives and prefer an honest conversation about how to move forward. The *Inclusion Web* can motivate people or awaken them to a need for change. For others who are currently isolated, it can be a helpful framework for exploring past experiences and future aspirations.

The *Inclusion Web* from the user's point of view

It helps you see

'It's useful visually...it helped magnify the activity in my life...it's helpful when you're struggling...you see your capabilities and hope for the future...it helped prevent work taking over [my life].'

Getting Connected

Soon after graduating from university, Adam was admitted to a psychiatric unit. On discharge, he was referred to John, a Community Bridge-builder. Initially lacking confidence and self-esteem, Adam was positive about using the *Inclusion Web* as he had been unable to specify his areas of interest. Spending time on the *Inclusion Web* led to an exploration of Adam's previous roles and experience, including his old passion for sport.

The *Inclusion Web* helped Adam recognise that, despite his current isolation, he had led an active life as a student and he revived his interest in becoming a sports coach. He began participating in a basketball league, obtained a coaching certificate, passed his driving test, began to sell basketball sessions to schools and began work on setting up his own coaching business. Starting one new activity led on to a whole range of possibilities.

The *Inclusion Web* seems to be a very useful aid, but we still have a good deal to learn about how it can be most effective. We are planning to:

- carry out statistical work to test its validity and reliability
- gather field examples of how to record ambiguous or complex scenarios
- collect examples of mistakes, misuses and corruptions and produce an additional guidance paper called *'Tangled in the Web'*

- develop detailed training to overcome statistical inconsistencies and misuses
- explore data from groups such as black and minority ethnic, substance abusers and the general population to uncover variations in network development
- analyse whether pursuits such as physical activity and volunteering lead to employment at time 1, time 2, time 3, etc.; that is to say, what are the flows between life domains?
- explore the experiences of the person concerned – is it a helpful tool that promotes person-centred planning?
- consider how the *Web* can guide community mapping activities – how does it help? What tends to get missed?

What we are pleased about

Spending time on building community connections

Within local communities, mental health staff are spending more time visiting mainstream community groups to find out what is available and to say hello. Overcoming traditional British reserve, they initiate contact, smile and shake hands; and then are often surprised and pleased to discover previously unknown local resources and the warm welcome from people working in community centres, churches and bingo halls.

Barriers do remain, however, and inquiries are sometimes rebuffed. People may express suspicion or fear but the majority of visitors find that community organisations are eager to find ways to welcome newcomers, even when the new arrivals need support. The pace of change is inevitably uneven. Some mental health organisations struggle with the cultural shift that is required. Front-line staff ask for business cards and promotional literature to use on community visits; their managers sometimes find reasons to avoid making community visits themselves.

Changing public attitudes

Mental health inclusion work in Scotland has been ambitious in its plans to take the message out to communities. The media campaign *See Me* has been complemented by a 12-hour training course for members of the general public called *Mental Health First Aid* that has been completed by over 19,000 people in Scotland. These moves have coincided with an improvement in public attitudes towards people with

mental health difficulties. It is pleasing to see that negative attitudes towards people can be changed at a population level by concerted effort.

The contact hypothesis offers an explanation of how attitudes change. This idea suggests that negative attitudes and fear are reduced simply by increasing the amount of contact between people who might otherwise consider each other as different and to be feared. Common sense would suggest that the best conditions for reducing this fear and discrimination would exist when contact is respectful, where the positive attributes of each group come to the fore and where there are opportunities for reciprocal exchange. The bulk of the evidence suggests that, while desirable on ethical grounds, these conditions are not essential and almost any kind of contact, as long as it is sufficiently frequent, is enough to reduce antipathy between groups[18]. As someone wisely commented *'We do not fear those people whose stories we know.'*

Harnessing dream power

A lattice of alliances, good local intelligence about community opportunities and frequent contact only makes sense when these approaches align with the individual dreams and aspirations of someone needing support.

Buried treasure

Wendy barely spoke and did not seem to respond to ideas or suggestions. Right at the end of a fruitless discussion about how to support her, one of the staff observed *'She does like Abba!'*

This unexpected glint in the sand led to first-time questions about music, fashion, the seventies, clubs, and internet links. The team then thought about how they had missed this treasure in the sand of day-to-day challenges and communication with Wendy.

We are pleased about the positive response to training that helps staff take people's aspirations more seriously than was the case in many traditional services. We have been encouraged when staff have linked their new interest in people's aspirations to a renewed focus on their own hopes and wishes; and when managers have acknowledged the importance of this often neglected theme.

Some staff readily invest the energy needed to uncover and use the aspirations and dreams of the people they support and provide the commitment to turn these dreams into a reality. Other staff need time to grieve over missed opportunities with people they have known in the past.

What we are concerned about

User-run services may not reach their potential

It is right to focus on connections that people using mental health services have with positive roles and relationships in the wider community. However, this external focus must not be at the expense of connections between peers. The Commissioning Guidance for mental health day services enshrines this by promoting the formation of user-run services[19]. A few groups are gradually moving from just consulting or involving users in management decisions to fully user-run provision[20].

We are concerned about three aspects of this positive trend. Firstly, after 30 years of the advocacy movement, user-run services remain scarce. Secondly, few staff have so far developed a good understanding of how to support the emergence of user-run services. Thirdly, in some places, commissioners permit the development of badly designed, institutional or disempowering services simply because they are user-run and have not taken up their responsibility for monitoring service quality against inclusive outcomes.

Not spending enough time building community connections that lead to change

Returning to the activities of those involved in community bridge-building, we have detected a common theme: few workers have a detailed sense of the aspects of community life that need to change if people with mental health difficulties are to have a fair chance. '*Better attitudes*' is an expression that comes quickly to staff's lips. However, specifying the organisational, resource and procedural changes implied is often much harder for workers to do. Building a better understanding of how to connect with communities is further inhibited by the reality that, in most services, spending time with the service user is counted in activity monitoring but time spent with community organisations is invisible and, by implication, worthless.

Some services are moving beyond a narrow definition of their role. Several have created individual cross-agency mentoring arrangements with individual community organisations. One has created a generic '*phone-a-friend*' service through which the mental health service offers a telephone helpline to a wide range of community groups that seek advice about how to support individuals.

Communities may offer the wrong kind of support

People with a diagnosis of schizophrenia who are surrounded by criticism, hostility and emotional over-involvement are more likely to relapse. Some of this unhelpful

behaviour can be motivated by well-meant feelings of care for the person and has been found both in families and in professional relationships with service users[21].

We are concerned that some community groups could easily begin to express their support for members with mental health issues in these ways, thus inadvertently contributing to their relapse. While such impact is unlikely in social groups where contact is superficial and infrequent, it is a real danger in groups that meet often and where relationships can be more intense – for example, the workplace; friendship groups at university; or intensive leisure groups that might meet several times a week. Training has sometimes been offered to families and staff teams to help them replace this damaging behaviour with more positive approaches. It may be helpful to offer similar training to selected community groups.

Suggestions for others

Work matters

Many of the lessons we have learned are already explained in this chapter. In addition, we want to make a comment about the importance of work. As Rowland and Perkins[22]neatly put it, you can't eat, sleep and make love for eight hours a day, every day; work plays an important part in most people's lives. People with mental health issues remain deeply excluded from the labour market but some progress is being made. In particular, a few mental health trusts are leading by example and, in one case, 15% or more of their new recruits are people with known mental health issues. The evidence accruing from this pioneering work about work performance, sickness absence rates and effective support is crucial in convincing employers in other sectors to follow suit[23].

Honest conversations

The issue of paid employment raises an important and sometimes neglected area of discussion about inclusion. While many workers have a disability that does not impair their work performance in any way, others have substantial difficulties in remaining in the same place for a working day, concentrating sufficiently to learn new processes or exercising due care and attention to safety matters. Mental health services in general – and sometimes even vocational services – can have difficulties in opening honest conversations about this issue and therefore will have subsequent difficulties in finding appropriate activities (whether vocational or non-vocational) and arranging suitable support. They may even deny opportunities to those who need them most.

Whether in locating community opportunities, challenging negative attitudes, reshaping environments, selecting suitable activities, designing support or managing risk, it is the person him- or herself who is almost always the best judge of what is appropriate and meaningful and who therefore should be the lead partner.

Monitor Progress

Think about outcomes and their measurement in the context of what matters to the person. The *Inclusion Web* offers a simple, practical way to do this. The early research on the *Inclusion Web* suggests that practitioners need to focus on increasing participation in the person's areas of interest, rather than increasing activity across all domains[24].

Growing a community of practice around the use of the *Inclusion Web* will help to explore the further potential and possible limitations of this approach.

Peter Bates

Peter Bates has been with the National Development Team since 1999, leading the work with mental health services, mostly around the theme of social inclusion. He previously worked in probation, the employment service, social services, the NHS and audit. He has recently underaken work for the National Social Inclusion Programme, Scottish Executive, Valuing People Support Team and many local services.

Antony Dowell

Antony Dowell has worked in voluntary sector mental health services for the last 11 years. Seven of these years have been with the charity, Imagine. He is currently Development Manager, tendering for and setting up new day services mainly in the London area.

As part of his work with day services, he has led on the development of the award-winning Mainstream Service, and worked with the National Institute for Mental Health in England, the Health and Social Care Advisory Service and the National Development Team on day service modernisation. In 2008-2009 he delivered a pilot for MerseyCare NHS Trust to offer one-off personal budget packages.

Jo Seddon

Jo has worked in the voluntary sector in a range of mental health services on Merseyside since 1983. Jo pioneered, managed and developed the first Community Bridge Building Teams in Liverpool in 2001 and promoted this approach nationally in her role as an affiliate to the National Social Inclusion programme.

For the past three years, she has worked as a Consultant Trainer for the National Development Team for Inclusion (formally National Development Team) and has worked with a cross-section of providers around the UK delivering the NDTI Social Inclusion Training Programme.

Notes

1. National Development Team: www.ndt.org.uk/
2. Imagine: www.imaginementalhealth.org.uk/index.php
3. *Budget Statement*, HM Treasury (2007) www.hm-treasury.gov.uk/media/73B/65/bud07_chapter4_267.pdf
4. *Mental health at work: developing the business case*, Sainsbury Centre for Mental Health, Policy paper 8. (2007) London.
5. *Vocational services for people with severe mental health problems: Commissioning guidance,* Department of Health, (2006a).
6. *Social Inclusion and Recovery: A model for mental health practice,* J. Repper and R. Perkins (2003) London.

7. The Life Domains were first referred to in: *Community connections and creative mental health practice*., P. Bates, and S. Butler: Chapter 5 in *Social Work Ideals and Practice Realities,* M. Lymbery and S. Butler (2004).
8. *From social exclusion to inclusion? A critique of the inclusion imperative in mental health*, H. Spandler (2007) *Medical Sociology Online* V2 (2) November 3 - 16.
9. Ibid.
10. *The Inclusion Web as a tool for person-centred planning and service evaluation*, S. Hacking and P. Bates (2008) *Mental Health Review Journal: Research, Policy and Practice.* Volume 13 Issue 2.
11. *Social Inclusion and mental health,* L. Sayce (2001) Psychiatric Bulletin. 25 121 - 123.
12. V*aluing People: A new strategy for learning disability for the 21st century,* Department of Health (2001) .
13. *The Tipping Point,* M. Gladwell (2000) London.
14. *Developing socially inclusive practice,* P. Bates in *The ten essential shared capabilities: Learning pack for mental health practice,* T. Basset, P. Lindley and R. Barton (2005, revised 2007) London: NHS University. Available at www.lincoln.ac.uk/ccawi/esc/default.htm
15. *Developing socially inclusive practice,* P. Bates (2007b) in NHS Education for Scotland (2007) *The 10 Essential Shared Capabilities for Mental Health Practice: Learning Materials (Scotland)* Available from www.nes.scot.nhs.uk/mentalhealth/work/documents/module6-Developingsociallyinclusivepractice.pdf
16. *The Inclusion Web as a tool for person-centred planning and service evaluation*, S. Hacking and P. Bates (2008) *Mental Health Review Journal: Research, Policy and Practice*. Volume 13 Issue 2.
17. *The Great Good Place,* R. Oldenburg (1989) New York.
18. *Rethinking Friendship: Hidden Solidarities Today*, L. Spencer and R. Pahl (2006) Princeton.
19. *A meta-analytic test of intergroup contact theory,* T. Pettigrew and L. Tropp (2006) *Journal of Personality and Social Psychology*, 90,751-783.
20. *From Segregation to Inclusion: Commissioning Guidance on Day Services for People with Mental Health Problems,* Department of Health, (2006b).
21. *Self-help alternatives to mental health services,* V. Lindow (1994) London.
22. *Expressed emotion of professionals towards mental health patients,* G. Van Humbeeck and C. Van Audenhove (2003) *Epidemiologia e Psichiatria Sociale* 12, 4, 232-237.
23. *You can't eat, drink or make love eight hours a day: The value of work in psychiatry - a personal view*, L. Rowland and R. Perkins (1988) *Health Trends* Vol 20 p75-79.
24. *Leading by Example: Making the NHS an exemplar employer of people with mental health problems*, P. Seebohm and B. Grove (2006) London.
25. S. Hacking and P. Bates (2008) Ibid.