



“Integration of Health and Social Care”

Promoting social care perspectives within
integrated mental health services

Notes from SPN Study Day 20th April 2004

SPN paper 6

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1 ABOUT SOCIAL PERSPECTIVES NETWORK

- Judy Foster, Co-Chair, SPN

The Social Perspectives Network was set up by a group of enthusiasts to support the current changes in mental health services while making sure that the value of social factors were not forgotten. With the increased emphasis on psychopharmacology, all professions risk underestimating the importance of relationships in improving our mental and emotional well-being. Specialist groups of staff can deal with change far better if they are confident about their contribution in the work place. SPN wants to remind people of the skills and knowledge they already use that are valued by service users and carers.

Through regular national study days – this is our sixth – we aim to provide a space for debate and creative thinking, when practitioners, users and carers, academics and managers can talk and reflect on particular issues. We are really pleased that the East Midlands has taken the initiative in setting the agenda today by asking ‘What will integrated services mean for those that use them?’ We are also delighted that Tony, Peter and Ann have joined us to contribute their experience to a vital discussion on a way of delivering services that is being introduced around the country prior to any evaluation.

As well as study days like this, we have published a number of discussion papers, have an accessible website (www.spn.org.uk - do look), link to a large number of statutory, voluntary and regional networks, encourage user and practitioner led research, respond as a ‘critical friend’ to major policy initiatives like ‘Delivering race equality’ and ‘Every child matters’ and cover all aspects of mental health and mental distress from mothers and babies to extreme old age.

I’d like to welcome you all here today and point out you are now all ‘members’ of SPN – it’s as easy as that!

2 INTRODUCTION TO THE STUDY DAY

- Joel McCann – Service User Worker, Assertive Outreach, Leicestershire Partnership NHS Trust

- Ian Redfern – Consultant Social Care, Leicestershire Partnership NHS Trust

Since 1st April 2003 services for adults of working age experiencing mental distress in Leicestershire have been provided by an integrated health and social care organisation. Staff from three local authorities have been seconded to the NHS Trust, which now manages them. Similarly around the country there are other mergers and integrations, some more established such as Somerset, some still at the discussion stage, possibly (sensibly?) waiting to see if it works!

For all the policy guides insisting on evidenced based mental health services, it is interesting to note that there is no evidence base for this crucial area of policy. The agenda is to break down the “Berlin Wall” between health and social services. Locally however my experience was that there was no such wall. On the whole, health and social care have worked well together for several years. Despite this there was conflict at times, particularly over who should pay for things or who should provide a particular service. It is probably fair to say that although there was no Berlin Wall we all carried small portable walls ready to be erected from time to time.

Of course none of this “tribalism”, as our first speaker Tony Gardner calls it, makes any sense at all from a service user’s or a carer’s point of view. The integration of health and social care is common sense. It has the potential to deliver many gains: a simpler life for service users, carers and referrers as they have one organisation to go to; an expert organisation; pooled budgets and streamlined decision making....

With these potential benefits though, come risks. Will social perspectives be lost; will local authorities forget about their responsibilities to promote mental well-being; will relationships with child-care, older persons and learning disability teams in social services be lost? These potential gains and losses are explored by our speakers.

In Leicestershire, as elsewhere, a great deal of effort is being put in to ensure that the outcomes of integration are positive and that social care remains strong. The fact that different areas were all dealing with these issues and that there were committed people all trying to ensure social care was protected and strengthened through integration was one of the main drivers for this Study Day. The aim was to bring knowledge and experience together to share ideas and to generate new solutions and then to make them available through SPN.

The three speakers provided us with different perspectives, each looking at integration from different angles. Tony Gardner has been the Chief Executive of Cornwall Partnership NHS Trust since its inception in April 2002. The Trust provides health and social care mental health and learning disability services to adults and children. Prior to this he was Director of Mental Health with the Avon and Wiltshire Partnership Trust, his main achievement being drawing together of mental health services from three NHS Trusts and two Social Services Departments to form an integrated Mental Health and Social Care service supported by a joint commissioning process.

Peter Gilbert is the National Institute for Mental Health England and Social Care Institute for Excellence Fellow in Social Care. He is a visiting Professor in Social Care and Health at Staffordshire University. He was Director of Social Services for Worcestershire and a qualified social worker with thirteen years of direct practice. His most recent book, *The Value of Everything: Social Work and its importance in Mental Health*, advocates strongly for social care to remain at the heart of mental health services.

Ann Davis is Professor of Social Work at the Institute of Applied Social Studies at the University of Birmingham. She is the Chair of the Association of Professors of Social Work UK. She is a member of the mental health workforce group for England and a member of Suresearch; a Midlands based user-led network of service users and their allies. She trained as a psychiatric social worker and researches and publishes on service user experiences and mental health, poverty and social exclusion.

Following each presentation there was an opportunity for questions and comments from the people attending the Study Day. In addition to the speakers, the workshops provided a way of involving all those concerned with integration; service users, carers, professional from all agencies and academics. They aimed to gather the crucial knowledge and experience of the Study Day attendees.

When putting the Study Day together, we began to be concerned that the subject matter was an area where the views of the government, academics and professionals seemed to dominate. Each of the speakers has worked with service users in different ways to try and overcome this problem. In particular, Ann Davis's work as a member of Suresearch, attempts to take on this issue directly. There is a danger that too much of a focus on integration as an issue can detract from the delivery of good quality services. A great deal of time can be spent on structures and professional concerns and a key theme, which came through strongly on the day, was not to see integration as an end in itself. What matters most are the outcomes for people using the service.

As Joel said when opening the study day, some themes are generally accepted:

- We need to improve the satisfaction levels for the recipients of acute services and prove we are listening to concerns. It's felt that there is a lack of social care being delivered.
- The workforce needs to employ suitably skilled persons, delivering whole person care in recovery-oriented services. Service users should be employed in the workforce.
- Service user training needs to be offered and they need to be trained to provide input in staff training for both health and social care staff.

Service user involvement has advanced part of the way, but, surely, can only be viewed as successful when services and resources are managed in an equitable way, when governance, planning and decision-making is truly democratic, representative, guided and influenced by the experiences people have of the mental health system and not by the media and there is robust and honest evaluation leading to, if necessary, a reduction in statutory control and gate keeping of resources.

3 THE INTEGRATION OF HEALTH AND SOCIAL CARE: SOME THOUGHTS FROM THE WEST COUNTRY!

- Tony Gardener, Chief Executive, Cornwall Partnership Trust (summary taken from presentation)

My most recent experience of the integration of health and social care has been as Chief Executive of the Cornwall Partnership NHS Trust, which provides services across the county for adults and children with mental health needs or learning difficulties. Previously, I was Director of Mental Health in Wiltshire with the Avon and Wiltshire Partnership Trust which was one of the earliest implementers of the integration of mental health services using Health Act flexibilities. Before that I was Assistant Director of Social Services so I am one of that small, and possibly strange, band of senior managers who has worked across health and social care and seen the frustration of users and staff alike on both sides at services that are not integrated, or at least well co-ordinated.

Having been through the 'interesting' process of integration twice now, it is clearly my belief that integration ultimately leads to improved services for users. However, it is from bitter experience that I am only too aware that there are dangers that some see integration as a panacea for all the challenges of the previous thirty years in mental health! I'd like to begin with a few words of caution and give you some indication of what integration **is not**.

An end in itself...getting to the point where you have integrated only gets you a ticket to the game! The hard work starts from there to ensure that it begins to make a real difference to those who use services....and that's the ultimate test of success!

- *The solution to all problems....some longstanding problems will still be there after integration...you will just have fewer excuses not to tackle them!*
- *A reason to distract us from doing the basics well....the process of integration can be mind numbingly slow and time consuming and one needs to be alert to keeping 'the show on the road' whilst the integration happens.*
- *A quick fix to wicked problems....if they were tough before then they will be tough after!*
- *A capitulation of one culture to another...integration works because it brings together the best of two traditions and cultures. Mental Health needs them both if it is to be any use in the 21st century.*
- *Assimilation....avoid like the plague any talk of turning everyone into some strange homogenous beast. Integrated services need diversity!*

However, notwithstanding the words of caution and based on my experience of two very different examples of integration I have few doubts that it is the right way forward. We all have an overload of political and professional rhetoric and sound-bites but I do think the following Ministerial statement hits the mark in suggesting that more integrated working should help us to:

“...make good some of the failings of the present system, improve the quality and consistency of services and increase efficiency across the board. The NHS and Social Services can work more closely together and so provide an effective integration of treatment and care. These reforms mark a new beginning for mental health provision...”

I have already mentioned that the process of integration in Wiltshire and Cornwall were very different. This is an important point to highlight as most places need to find processes that suit local situations and local people. Histories and traditions are different and I doubt whether wholly imported processes work well. Indeed, I have the scars to prove it! However, there are also elements that are universal and one would be foolish not to listen and learn from colleagues who have lots to share. In all cases users and carers should be the driving force. In both Wiltshire and Cornwall I believe user needs and aspirations helped to shape the joint commissioning process and the development of integrated service provision.

In addition to integration helping us to correct some of the failings of the past it should help to meet people's demands for better outcomes and remove unhelpful barriers. By providing a constructive framework within which to develop “Whole Life” solutions that offer greater social inclusion and moving beyond old service boundaries, people should have a better chance of ensuring that their wider needs and aspirations will be met, including housing, employment, leisure, education and general well being. The “Whole Life” approach has the potential to transcend the limits of the past. Integration also offers real opportunities to drive out some of the bad habits of single agency working including cost-shunting, the patrolling of outmoded agency boundaries and ‘theological posturing’. In doing so there can be a fresh force for improvement, strengthening, cohesion and dynamism in mental health.

Integration provides a better chance of delivering national policy, but also responding to local pressures for better joint working and sound commissioning strategies which put the needs of people who use services first. People who use services, their carers and staff want to see one care system and not two. That one care system can challenge traditional assumptions about choices and services and recognise that people want ‘Whole System’ solutions to problems which don't see people having to accept treatment or services that do not best suit their individual needs and wishes. By ensuring more straightforward systems for gaining access to wider range of support, people are likely to be far more involved and empowered. In turn there is a promotion of citizenship, recovery and inclusion. Improving accessibility of services is more likely to be achieved as one moves to more single points of access to integrated services.

Carers also benefit, with greater potential for involvement where a single care system promotes partnership rather than the paternalism of the past. And for staff, a single organisational culture can promote a consistent vision for the future and increase the potential for staff to influence that future. To fully achieve this there is a ‘given’ of valuing the best of both health and social care (...and in the process, driving out the worst of both!!) By harnessing the varied skills, culture and training of all health and social care staff and giving them greater organisational influence there is a greater

opportunity for staff to have a more rewarding working environment and better career development.

Of course, all this presupposes, and indeed requires, that there is transparency, a clear focus on the needs of service users and carers and a willingness to communicate. There must be no 'winners' or 'losers' in terms of status within the partnerships and there is no room for empty rhetoric...integration has to deliver better outcomes and mustn't propound the myth that if it is new it must be better. Partnerships should be built on what has been shown to work well...and then improve that that hasn't. All this doesn't happen by chance or by good luck but requires effective programmes of change management coupled by the identification and development of the 'champions' of partnership and the enlisting of 'doers' who get things 'finished'!

I started by talking about what integration is not and hopefully given a sense of what it might achieve. It's not 'Rocket Science' but there are 'Booby traps' and ambushes to watch out for, whether it be in the form of timidity or losing sight of purpose or slipping into talking shops or allowing a loss of ownership of the task at hand. Falling to the lowest common denominators and the temptation of triumphalism must be avoided. Games of power and influence will weaken the efforts as will spending months wrangling over 'academic' cultural or ideological niceties that add no value. Longstanding personal rivalries will also diminish the capacity to succeed.

For those who really are concerned that social care values will somehow become subsumed or colonised by less than progressive conservatism within the health system I believe that there has never been a better moment to grasp some of the values that have been evident in social care for many years. The momentum towards greater social inclusion, recovery, early intervention and choice offers a mental health landscape with more opportunity than before.

We should also remember that in these days of ratings and stars, it is service users and their carers who will tell us when we have got it right. They know that improvement takes more than structural change. It is about hearts and minds and partnership working based upon action and change.

Integration is merely the beginning of a process to ensure that we respect the whole lives of the people we work with. 'Whole systems' work best when planned and delivered with - and accountable to - local communities. More integrated working and partnerships that put people at the centre of our thinking offer real opportunities to consider life beyond NHS Trusts and local authority social services as we know them. Perhaps mental health can move beyond the notion of Foundation Trusts to genuinely develop 'Co-operative' and 'Mutual' ways of working, framed around real people and real communities. It's worth thinking about?

Tony Gardner

COMMENTS, QUESTIONS AND ANSWERS

- It sounds like you've made more progress in Cornwall than we may have in Leicestershire. Though we have done well because we do have an integrated management structure and I think it's starting to work quite well. But for me the big bugbear is that Social Services as a Department is still the biggest barrier to proper integration because there's a lot of reluctance to surrender control over their staff....

I don't think you can plan everything from above and impose a system. I think you have to involve frontline staff and to a considerable extent allow the experiences to drive how you develop services... You have to set up an organisation which is capable of learning and evolving.

TG If I had invited Ian Redfern to talk to Cornwall, to talk about it, he could do what I've done. If I asked my frontline staff to talk, they would have a different take to me. I think the key thing is commitment to flagging up issues and putting them on the table.

- There are various structures, Chief Executives and senior managers. I think we are struggling with core budgets. We're still trying to get information systems working. Part of the local authority's worry is that they will lose performance.

TG We had to show Cornwall SSD very clearly and give assurances. The Trust has to spend a lot of time showing that systems can be relied on because their performance depends on our performance. If we can do it there we can do it anywhere, because they're obsessed with performance.

- Malcolm's point about how you involve frontline staff and then service users?

TG We do a lot of staff involvement. I think you have to do a lot of personal stuff. I went out and met with all staff at least 4 or 5 times during the year and incoming staff I met regularly, and I think people have to feel involved from top to bottom. Service users were part of the Integration Board. We have 4 service users on a Board of 8 people. Service users also have their own forum to discuss issues. It's about finding structures so that you can recognise what's going on wherever you are in the organisation.

- I heard you say that service users tell you when you've done it right. I didn't hear you say you'll listen and accept when service users say you've got it wrong. They're two different things.

TG I think one slide did say, "Listen, Hear and Act". There's not much point in listening if you don't act. It's about accountability. Service users sit on the Commissioning Board and hold commissioners and providers to account. Where what's required is not delivered, they get pulled up. Individually, it's very hard to ensure that every single member of staff carries through these values. This is stuff about culture. Listening,

acting and empowering people to take control. That's a 'wicked' problem that's been around a long time. What we can do is to try to get better and better.

- I don't hear 'recovery' used a lot in Leicestershire. Social inclusion is something I hear a lot about. What I don't see is it being done, implemented, working towards it and there is not a complete understanding of the barriers towards social inclusion.

TG The Cornish health community is in dire financial problems. One of the things we've had to do is ask serious questions. We've employed social inclusion workers attached to the recovery service. We've had to look at the skill mix and so we've created these through downsizing other groups. We had a large number of CPNs doing stuff they were over-equipped to do. Service users in the recovery service feel STR and social inclusion workers are making a real difference. Within the recovery service we've adopted a set of service user outcome measures. It's a self-assessment of whether they've achieved various outcomes they were looking for and so it's beginning to give some results.

- We've started to talk about things done well and things done badly. In Leicestershire sometimes there are unpopular decisions, for example regarding voluntary sector activity. How do you think health seems to be able to budget better, maybe, than local authorities?

TG I think the clear thing is to be honest and transparent about what the options are. Look at how we use things. Some jobs we had very qualified people doing stuff where they weren't required. We have some superb people, not professionally qualified but doing what service users want them to do. It's interesting – not every task in social care has to be done by a social worker. Things like our sanctuary house are run by service users, and voluntary organisations are getting more money because the big money is in health. You have to look at the totality and how you resource services, e.g. inpatient beds which are not necessarily of benefit to the service users. I think you have to have that bit about what sort of workforce is required to deliver the services that service users want.

- Lots of places have people with a role like Ian's (Social Care Lead). What's your view on this and have you used people like this?

TG We took a decision to employ a Head of Social Work, because the National Health Service is an organisation full of professions. It's my responsibility to ensure all perspectives are delivered. We have a Head of Psychology and a Head of Nursing. For the first time social workers now have a professional head of service. It's important to recognise that social work has values. You need a professional line of accountability so that the values and training are supported within the organisation. We don't have a Director of Social Care because of the danger of it being

separated out. I think it's unhelpful to have rigid boundaries but it is important to preserve professional identities.

- What do you say to a Chief Executive of a Trust who says they have no power to influence other local community services, i.e. a new hospital being built. Responsibility for community services in the area lies with Social Services. They therefore don't feel they can do anything about it.

TG I think that's about the strength of the partnership. You have to keep going back to the table. We don't want the local authority saying "Goodbye, thank you – Go!". Our Joint Commissioning Board simply has the 3 PCT Chief Executives and the local authority. Everything goes through that, strategically, and if something isn't working they are responsible. You need to tie in the partnership on a number of levels. I think the real 'jewel in the crown' is integrated commissioning.

- Integration is still very much around health issues. A whole life project should be about using local facilities ...?

TG We don't have day hospitals. We have social care day services but we're trying to make our facilities more outward looking, have more individual budgets, One project is called 'Wecan', run by a couple of OT's. It's helping people to access community provision, but we've had to devolve money and separate other things. Budgets are not integrated to leisure and education budgets in local authorities. This is a starting point. District Councils sit around the planning table with us and that's got a lot better. The idea is to try to take integration beyond health and social care.

- Your links with Housing and Education: I think often service users live in poor accommodation and don't have access to education. If you improve this, you can keep them out of the system.

TG Our STR workers have been working very actively on the links. We have given 3 people surfing lessons and bought them equipment – they were people for whom traditional services did nothing and they needed something specifically for them. Their peer group are locals who surf. Regarding accommodation we have a very creative arrangement with a local housing association which buys houses and lets us use them. What I'm really interested in is the Whole Life Project which will give us a real opportunity to do things very differently.

4 INTEGRITY AND INTEGRATION: PRODUCING BETTER OUTCOMES FOR SERVICE USERS AND CARERS

- Professor Peter Gilbert, NIMHE/SCIE Fellow in Social Care (Policy and Practice) and Visiting Professor in Health and Social Care at the University of Staffordshire

Some years ago, I was climbing in the Italian Alps, and one day, found myself as the middle climber of a group of three, roped up and traversing a difficult ledge. Stu, the front guy, had traversed the ledge successfully, but unfortunately, as I moved across it, it gave way leaving me dangling in mid-air and looking at the jagged rocks 800 feet below! It was a profound moment. I don't remember my life passing before me; I think I was much too frightened for that! But I do want to dwell on what saved my life and why. It is an issue of integration: we were a multi-disciplinary, and indeed multi-national team of three (the anchor man was a Welshman, imaginatively called 'Taffy!'), and of course the systems and structures were an important part of my not ending up 800 feet below and dead. The rope held, the harnesses held, the structural grouping of three people was just right. But more important than the systems and structures, were the people and relationships. We had worked together for several weeks; we trusted each other; we had worked through the cultural issues – which included quite different use of language for some pieces of equipment; we knew where we complemented each other, and weren't envious of another when their skill level in a particular area was higher; we were committed to safeguarding and developing each other; and we wished to achieve our objectives as a team – keeping mission, team and individual in close alignment. All of us have probably worked for someone who would have been more inclined to cut the rope than to hold it!!

One of the current problems with the debate around integration – whether it be for children or for adults - is the preoccupation with structure as an end in itself. In fact, structures are a means to an end; they are never the destination. Structure, as the word suggests, is a framework for delivery, it is not delivery in itself. A prime example of this is the recent scandal over Rowan Ward for Elderly people with Mental Health needs, within the Manchester Care Trust. Stephen Ladyman, the Minister, speaking at the recent Summit on Mental Health and Older People, commented wisely that, in his opinion, having read the report on Rowan, Manchester had attempted to resolve problems with relationships, through a structural 'solution', which left the vital issues around relationships and services unattended to – resulting in poor standards for very vulnerable people. At times Care Trusts seem to have been considered as the acme of care structures, as though purely attending to this one element will sort out every other. In fact, management writers, such as Charles Hampden-Turner, set out at least seven elements which need to be addressed: shared values, strategy, skills, staffing, structures, systems, style of leadership. The importance of focusing on the *raison d'être* of why we are here, was constantly stressed by Denise Platt, during her time as Chief Inspector of the Social Services Inspectorate:

“Being ‘joined up’ means recognising the wholeness of peoples lives. Many people who use Social Services rely heavily on other public services: Health, Housing, Employment Services and Benefits Agencies. The problems that people experience are connected ... Service delivery needs to be integrated such that our services move around the person, not the person around the service. People should

experience their services as being well co-ordinated as well as making a difference to the quality of their lives”. Social Services Inspectorate (2000), *Modern Social Services – A Commitment to People*, 9th Annual Report of the Chief Inspector of Social Services, London: DoH. The Association of Directors of Social Services (ADSS) and NIMHE were so concerned about the loss of focus, and the perceived tendency of some new organisations to lose their whole persons and whole systems perspective; and also of Local Authorities to see new partnership arrangements as a way of abdicating their responsibilities in the Mental Health field, that a guidance paper was produced and issued jointly by the two organisations [ADSS/NIMHE (2003), *Briefing for Directors of Social Services on the Integration of Mental Health Services* (Gilbert and Joannides) – available on both the ADSS and NIMHE websites].

Most of the Care Trusts and Partnership Trusts with a Mental Health focus do, of course, take the social perspective, Social Care and Social Work (including the Approved Social Worker) role very seriously indeed, and have reflected this focus in their structures. It is important to bear in mind here that there are perfectly sensible differences of opinion as to whether having a ‘Director of Social Care’ gives a proper focus to this important aspect of the work, or whether it boxes it in to a particular person and encourages other parts of the organisation to say Social Care is down to Person X! It is an irony of the current situation that while Service Users and Carers are increasingly clear that Social Inclusion and Social Care is where they are at, and Social Work has a vital perspective to play in gaining an independent view of their treatment and care. Many Social Workers and Social Care Workers feel squeezed out and de-valued in the current context in which we work, including the formation of the new Mental Health Act. It is essential that we see the individual both in their own right, but also in the context of their family, intimate relationships, communities, neighbourhood, culture, faith communities, and the wider societal environment.

Diagram 1: The Individual in Society



from P. Gilbert (2003) *The Value of Everything: Social Work and its Importance in the field of Mental Health*, Lyme Regis: Russell House Publishing.

Social Workers often find themselves as a relatively small number, or often a sole practitioner within a large multi-disciplinary team. Their contribution, however, is immensely valued by Service Users and Carers; and increasingly seen as vital by other professionals, as community-orientated services become ever more crucial. As David Joannides, former Director of Social Services for Dorset, and recent Chair of the ADSS Mental Health Strategy Group put it:

“Social work can make a particularly valuable contribution to improving the quality and delivery of services, given that the causes and consequences of poor mental health are significantly influenced by the environment of which we are all a part. Social Work is, by nature, holistic in approach and views the individual within a wider context of their personal, familial, cultural and socio-economic circumstances. Its ethos is on empowerment and promoting independence through a focus on ‘working with’ rather than ‘doing to’ which helps to increase personal achievement, self-fulfilment and create a much stronger sense of citizenship”.

Quoted in P. Gilbert *op cit*

Research demonstrates that Service Users primary concerns are around:

- Living conditions
- Work and occupation
- Relationships
- Ethnicity, culture, gender and sexual orientation, and society’s acceptance or non-acceptance
- Finances
- Inclusion and citizenship
- Well-being
- Appropriate medical treatment and choice
- Respect for them as “whole persons”
- Access to mainstream services: Education, Health, Leisure, etc.

(see Macdonald and Sheldon, 1997, and Mental Health Foundation, 2000).

The recent work by John Glasby and Edward Peck on new structures (J. Glasby and E. Peck 2004) stresses the centrality of values and culture. All the evidence from private as well as public sector mergers and acquisitions is that unless there is clarity about the value-base from which organisations are working and the culture which binds the organisation and its members together, the outcome will be chaotic. To make a football analogy, Arsenal have had a more successful, championship-winning season with a one-culture team, while Chelsea have sometimes appeared to struggle with the effort of combining the original pre-Abramovich side, and the new acquisitions!

BASW’s original Code of Ethics, formulated in 1975, and stressing respect, integrity and self-determination, now allied to the emancipatory values, outlined in 2002: social justice, citizenship, partnership and empowerment, provide a value-base which Service Users identify with and welcome. Working with Service Users across the country, I am struck by their recognition that defensive practice will often occur in a risk-averse society, but they desire to have as much choice as possible; something I appreciated greatly when I experienced a depressive illness, and felt very empowered by my general practitioner’s attitude to the use of medication in my care and treatment.

So integration of Health and Social Care has to be seen within the context of creating more coherent, comprehensive and comprehensible services for those who use those services and their Carers – and indeed those who might use the service in the future. The policy context on integration has a long provenance, but perhaps the most influential report was the Audit Commission's *Making Reality of Community Care*, published in 1986, which proposed that services would be improved by clearer systems of agency accountability. Bob Hudson gives an admirably clear overview of the history of all of this in Glasby and Peck *op cit*. The advantages of integration as I see them, are as follows:

- Management and service delivery can be more cohesive and congruent.
- The organisation is easier for Service Users and Carers, and potential referrers to understand – one door of entry to services.
- Specialist expertise is created – knowing “the business”- and we have to acknowledge from a Social Services point of view, that very few Social Services Departments gave Mental Health the attention it deserved and required.
- A co-ordinated approach to staff development, skill-mix and skill sharing
- The encouragement of appropriate specialisms within an overall framework
- Economies of scale
- A recognised centre of specialist expertise
- The management “clout” to get things done
- Social Care engaging in the culture of evidence-based learning so as to inform both practice and service development.

But because every structure has boundaries to it, there will be some challenges as well as gains through integration:

- The new organisation could become divorced from the wider citizenship, social inclusion and regeneration agenda; and specific services such as Housing, Environmental Health, Criminal Justice, etc.
- Accountability for effective commissioning of services and delivery of the “quality of life” duty on Local Authorities remain important duties for elected members in the context of their scrutiny role.
- The Social Work/Social Care workforce could feel isolated as a relatively small component in a new organisation. Issues around value-base, style and culture are very important.
- The performance agenda on Local Authorities, and preoccupations with childcare and hospital discharge may encourage Local Authorities to lose focus on and commitment to Mental Health.
- In some areas, significant groups of staff have spoken of being “cut adrift” or “abandoned” by their previous host organisation, the Local Authority.
- Professional development may not be sufficiently addressed.
- Approved Social Workers may not feel sufficiently independent, and their ongoing independence and that of their potential successor, the AMHP, may not be safeguarded.
- Boundary issues with Children and Families’ Services and Education and Services for Older People require attention.
- Specialist services always face historical and sociological challenges in avoiding isolation.
- Services for People with Learning Disabilities, drug and alcohol problems and other areas of dual diagnosis need attention.

To gain the proper outcomes from integration there needs to be effective leadership, with a clear commitment to using the full range of skills and expertise from a range of professionals to the best use for better outcomes for Users and Carers.

'Leadership' is an ancient concept, from a time when a reliance – perhaps one should say over-reliance – on technical solutions was not possible. It has connotations of path-finding or steering a ship, and working with people to achieve common goals. In essence, leadership is about:

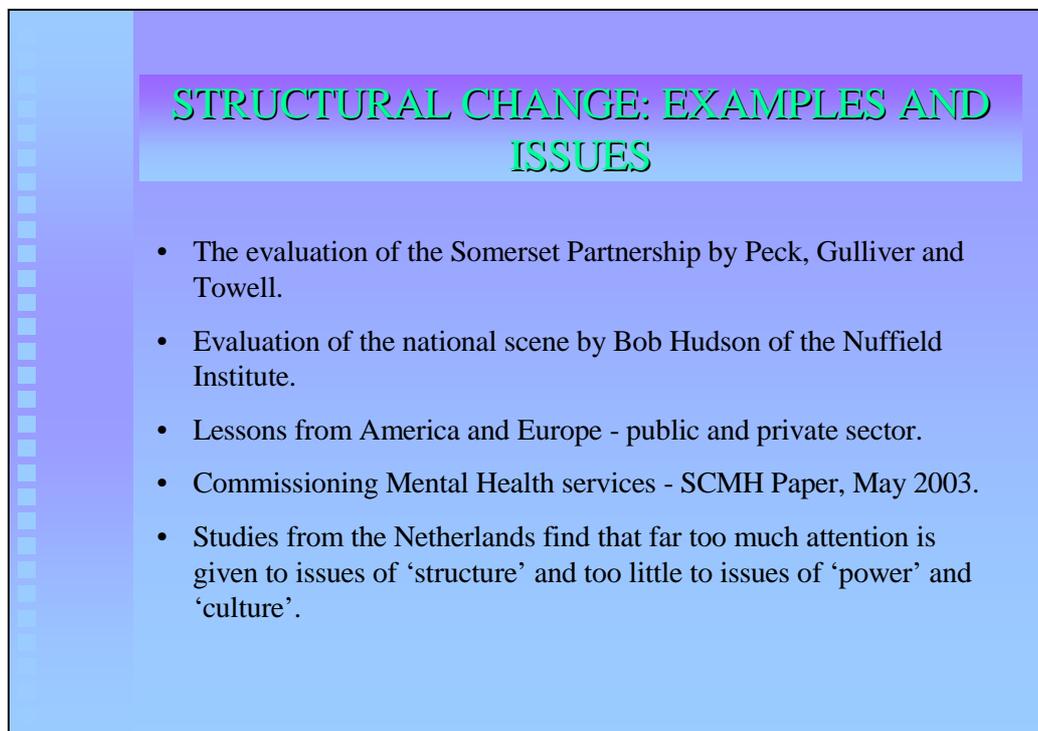
- Having and demonstrating personal *integrity* and a *value-base*.
- Setting and maintaining *direction* through formulating a vision of the future and setting out achievable steps to get there.
- Creating the right culture; *orientating* and *inspiring* people.
- *Delivering* the agreed outcomes and maintaining focus on *performance*.

In services which require a strong value-base, those values have to be shared and demonstrated by Senior Managers. Leaders who talk about valuing Service Users and Carers as people; about being race and gender aware; about being culturally sensitive, are shown as mere carpetbaggers if the reality does not follow the rhetoric. To achieve positive outcomes for Users and Carers in dispersed settings, means adopting a style of shared leadership. This, however, doesn't always fit with our culture. As a leader of a world-wide organisation remarked recently:

"A crucial part of leadership is giving up power ... but in the West, we live in a culture of control (Timothy Radcliffe).

To ensure that Users, Carers and communities are gaining the best from integration, leaders have to strive to achieve a better sense of identity and integration.

Diagram 2: Identity and Integration



Gilbert (2005, forthcoming)

Leaders need to strive to do better than the situation depicted on a recent Radio 4 programme, where a despairing Carer in the North-West of England, bemoaned the fact that, although the Trust described itself as integrated, when she rang the Community Team, she was often re-referred on to a range of other professionals, rather than the Team member co-ordinating the approach for her and her son. A strong sense of personal and professional identity should lead to a more secure approach and an ability to work alongside other professionals, so all the range of skills are at the disposal of those that need them. Celia Davies (Davies 2003) writes about the new professionals being/having:

- A strongly connected individual with a sense of self in connection with others.
- Reflective application of knowledge: blending knowledge and experience in a specific context.
- Engagement: involvement of self and acknowledgement of emotions.
- Team practice: welcoming and valuing the contributions of others.
- Specificity: acknowledging unique expertise and experience of all.
- Multiple identities.
- Calling on the specificity of team members experience as a resource for clients.

To end, I make a leap to one of my other roles, which is running workshops on Spirituality and Leadership at the Benedictine Abbey of Worth in Sussex. The wisdom of St. Benedict's guidance is that he speaks of leaders needing to remember who they are, why they are in a position of leadership, and whom they serve. Structures are not about power, or about peoples personal ambitions; they are not about being an end in themselves; they are about doing good things with other people. To lead, as a practitioner or as a manager, we have first to serve.

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COMMENTS QUESTIONS AND ANSWERS

- There is still a sense of 'us and them' between services and service users, and one of my concerns about integration is that there's still an 'us and them'. When we bring in the Whole Person Project it was very focused on looking at the service user and the parameters people are subject to, but there's not enough looking at ourselves and working services as whole people also.

When you talk about partnership and the relationships, then a genuine partnership between worker, service user and services, this still doesn't seem to exist.

PG I think that's hard to do and I feel that if one is working and representing an organisation working with a user and carer, then your essential humanity needs to come across and we need to focus upon it. A worker in the Whole Person Project was involved in research with staff who had experienced mental distress and taken the medication. They had blocked off their experiences from the service users. This can be a result of over-professionalism and I think organisations need to think about this – where we can allow people to be human. When I went to see my GP I didn't realise how ill I was, but she saw it and her first words were 'This is shit'. I thought this was brilliant. She just wanted to say that the situation was shit, so her expression of humanity was probably more important than anything else. When we talked about medication she gave me a lot of choice about it. So I think we need to be doing some more work on this. I hope the Spirituality Project will help us look at this. Health services need help on this. Business organisations are getting into this whole thing about spirituality, humanity and shared leadership but we should lead on it.

- It occurred to me that a lot of this is about really strong partnerships. Doesn't this really mean that if services were good and we had really good partnerships, then integration is a structural by-product which we shouldn't get hung up on?

PG I think I largely agree with that. If I had been Tony Blair talking about health I wouldn't have said 'Education, Education, Education', I would have said 'Partnership, Partnership, Partnership'. I think relationships and partnerships are the heart of this. I think Bob Hudson says that all these attempts at partnership, because people have different agendas, this sometimes forces people apart, so sometimes you have to put structures in place. Somerset is a good example where integration came after a long and productive partnership. I think we have to look at this and revisit it. You can't use structure as a solution to poor relationships. I went to the Summit on Older People and Mental Health, and there were hundreds of czars there. The Minister had just received the report on Rowan Ward in Manchester. He was so shocked by that. He thought clearly that a trust was formed as a way of short-circuiting the long-term relationship problems and we mustn't do that any more.

- A brief quote which I think is topical: Alan Yates:
Chief Executive of Mersey NHS Trust, to social care staff:

"The problem with you social workers is that you are obstreperous, bolshie and always looking to change the system you work in, and that's why we need you in this Trust."

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- What I would agree with is that the battle wasn't won because it hasn't even started. I have to say that until we have social staff as equals at the table, then the battle definitely hasn't begun and if you're in any doubt that we need social care staff in our lives in psychiatry, then look no further than ASWs and how they support us in the legislation angle. The care issue, I have a 30-year orthopaedic history and I have used health services for a whole variety of elements, and it's an absolute disgrace. I don't know how a section of the health services can separate out treatment and care. It's not done in general medicine, why is it in psychiatry? Until psychiatry accepts that care is at the core of treatment we're not going to solve this habitual attitude that the minute you're defined as ill, the health service is in control. I would finish by saying the social services workforce has got to say 'how do we take this agenda forward?' We're still not getting a result. If you have any doubt about including service users and carers in the arguments, look no further than what's happening today where service users, who you would never think are the bedfellows of carers, are beginning to say 'let's do things differently'. Where they have come together they've been almost untouchable. The social care workforce needs to say 'we'll equip you with the knowledge, come and join us and we'll make the difference about getting the social care dimension in psychiatry.'

PG I agree with a lot of that and I think again, because as you know, we are doing some work with psychiatrists on the new ways of working and in a sense a lot of these are people who want to move. If you look at that series on TV the other day about surgeons, you can see that some are moving in much more human way and I think that's a really good challenge to psychiatrists – don't get left behind, even from a private point of view, don't get left behind by other parts of the medical profession in taking a whole person approach to an individual.

5 INTEGRATION – WHAT’S IN IT FOR SERVICE USERS?

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Introduction

The government publication ‘Positive Approaches to the Integration of Health and Social Care in Mental Health Services’ was issued in 2002 to provide guidance to health and social services. It states that ‘Integration of health and social care in mental health has been a central plank of government policy for a number of years. Most importantly service users have consistently said that they value receiving services from one integrated organisation’ (NHS:2002).

In considering the advantages of integration for twenty first century mental health services this publication claims that if integration is established it will achieve outcomes that place ‘service users and carers at the heart of the service’ and ‘Service models which focus on the whole person in the context in which they live’. In other words it is a notion that has the potential to transform the world of mental health for service users. In outlining the elements that are vital if this is to be achieved this publication points to the importance of evidence-based learning to inform the changes required in practice and service development in the mental health field. In this paper I want to consider what Integration has to offer mental health service users, by reviewing the evidence base which has emerged from user focussed mental health research. Research that has asked service users what service responses help and what hinders their recovery and mental well being. In doing so I want to see what lessons we can learn and apply in working towards integration in active partnerships with service users.

Learning from the past

As someone who has been involved in practice, teaching, consultancy and research in the mental health field for over thirty years, I can personally vouch for the claim that integration has been with us for a long time. When I was being trained as a psychiatric social worker at the Maudsley Hospital at the beginning of the 1970s mental health services were being delivered from both a health base- the old asylums and a few new district general hospital units and the local authority mental welfare services. The importance of working together as professionals across this divide between health and social care was part of the agenda then. My entry to this world was as a social work student being trained to be a psychiatric social worker in a hospital setting. I remember this training being dominated by psychiatrists who, as the perceived experts, taught me all they knew about diagnosis and medication for the range of what they then called mental illness.

When I applied for social work training the people who interviewed me were not convinced that I would succeed in qualifying as a social worker. At my interview they asked why I wanted to enter this specialism. I explained that my interest in this field had grown because my father and my grandmother had longstanding mental health problems. When they were in crisis they had experienced treatment, against their wills, in two of London’s largest asylums. When I had visited them as a child I had been so shocked by the conditions in which they were being treated that I had decided that I wanted to play a part in changing mental health services. There had to

be, in my view, 'a better way' to work with people in mental distress. The interviewing panel was alarmed by my disclosure. They did not consider that such close contact with mental illness was a positive factor for entering social work. They told me that, given my family background it was likely that I too would experience mental illness and this meant that I was not a good candidate for professional training. Although they saw no value in the experiences that I was bringing with me they decided to take a risk. But warned me that I would be subject to close supervision to ensure my suitability for professional practice (Davis:2003).

What I discovered during my training was that most of the service users that I worked with experienced difficulties with stigma, discrimination, poverty, poor housing, unemployment and isolation compounded by their mental health difficulties. When I asked my supervisor about how I could engage with these issues I was left in no doubt that these were matters that should not concern me. Both the social work and health professionals at that time considered that my focus should be on diagnosis and compliance with medication. I found this a difficult direction to follow. What service users taught me was that life could not be reduced to these issues alone. What was preventing them from resolving their difficulties and living life as fully as possible was far more complex and they needed people who could work with them in addressing these complexities. This experience left me with a view that concerns about integration were important but would have a limited impact on service users unless mental health professionals across the health and social services divide were able to acknowledge and engage with the realities of service users lives.

Needless to say, when I qualified, I left the world of the mental hospital and went to work in a local authority social services department. These new departments created in 1971 as a result of the Seebohm Report, directed their concerns on the problems facing communities, families, groups and individuals. As social workers we were expected to work across the range of what was troubling people regardless of how they were labelled by the services. I was lucky, my team leader had no previous experience in local authority social work. He had worked for many years for a mental health voluntary organisation The Richmond Fellowship and taking the values of Seebohm seriously encouraged me and other social workers to work in and for our local community.

I worked in an office without the physical or electronic barriers that are part of social work offices today. It was open to the local community and responded to the concerns that were brought to us. As a result I discovered that some of the people who I worked with mental health problems were also playing an active part in the local community as tenants leaders, members of local community and parents groups. When they needed my support and advocacy in relation to their mental distress I was able to inform our work together with the knowledge I had of their strengths, aspirations and abilities. At the same time my knowledge of local community resources meant that there was a range of resources on which I could draw that were outside the health and social services. Some of these met the needs of people in mental distress and an early enough stage to prevent them having to use mental health services. They were resources that did not come with stigmatising service labels and so provided opportunities for employment and inclusion in ordinary activities.

Looking back it was this experience that taught me most about what integration can mean. It can be a way of delivering a response to individuals through a relationship based on mutual regard and respect. An approach that works from the positives that people have to offer at times when they were seeking assistance in the management of their lives. An approach that seeks to utilise ordinary life experiences as well as specialist resources in order to promote the mental well being of those who use mental health service users. It encompasses far more than the joining up of given services it is about the pursuit of a valued life that sustains mental health. When in 1973 hospital based social workers were integrated into local authority social services departments it made a lot of sense to me and the people I was working with. After all it was becoming clear that the majority of people with mental health problems would be living most of their lives in the community not in hospitals and that is where resources needed to be based and developed.

The direction that social service departments took in the 1980s and 1990s moved social work away from close contact with local communities. Whilst social work training remained generic, government policy was driving social services into delivering through specialist teams, driven by targets, audits and performance indicators. Services became increasingly concerned with making short term, risk oriented interventions in the lives of those assessed to be in greatest need. The result was that as the large mental hospitals were closed and community based mental health services slowly evolved, social workers found themselves working in social services departments that were distancing themselves from contact with the local communities that they were employed to serve. In many parts of the country service users, carers and social workers found the bio-medical approaches and institutional psychiatric cultures of the old hospitals transplanted into the new community service settings. The potential of integration as an approach that was person and whole life centred was often lost in professional and managerial concerns with territory, specialisms and status delivering on government concerns with targeting scarce resources on those who were assessed to be at greatest risk.

When the first New Labour government introduced the Modernising Social Services white paper it failed to take an opportunity to redirect social services. While it stated that 'Social Services are for us all' (Secretary of State for Health:1998:1) it did not reconnect social service departments with local communities by engaging with social exclusion and poverty. Health, education and voluntary sector services were given this task. Government reinforced the prescriptive performance driven managerial approaches to social services. They were left to deliver a limited set of services to a given population assessed by professionals to be in greatest need.

The results of these policies are all too clear for those receiving services and those working on the front line of mental health services. In a report published last week by Rethink 'Lost and Found' evidence is presented that suggests that recent reforms that have concentrated on the young and most acutely ill have left behind a generation of people, estimated to be 50,000 whose condition is medically stable but whose quality of life is poor. Services are largely unavailable to those considered to be 'too well'. As a result people with severe mental illness are unable to access a range of psychological and talking therapies, a choice of professionals and treatments, decent accommodation, regular and sufficient income, meaningful occupations and opportunities to build social networks. In all too many cases this

report suggests, older family carers have been left to cope without proper support or long term planning for what is going to happen when they have gone (Rethink:2004). Those services based in the voluntary and state sectors that have tried to buck the dominant trend by providing responses based on respect for service users, listening to what they say and want and working with strengths rather than notions of deficit are the exception. What is more the evidence we have suggests that they are not growing in number. As a result the current claims by government to be pursuing integration as a way of placing people in their whole life context at the centre of mental health services needs to be regarded with scepticism. In too many parts of the country integration is as far from reality as it was when I began to work in the services. This suggests that if we are to realise the full potential of integration major changes are needed.

In looking to the past in order to learn from our experiences it is important to be clear about what has changed as well as what remains the same. We are still working in the mental health field in a context of limited resources, considerable stigma, discrimination, social exclusion and the dominant concerns of health and social service professionals and managers with territory, status and service structures. These factors continue to be as they have always been formidable barriers to achieving integration. However it is important to note that there have also been some important breaks with past traditions.

Learning from service users expertise

In my view the most significant shift has been that in the last twenty or so years we have witnessed the increasing voice of service users, carers and their organisations. This is evidenced by the growth of a number of service user led organisations who have focussed their concerns on the abuse of power in health and social care systems (Barker & Peck:1997; Barnes & Bowl:2001; Rose: 1996; Rose: 2001). In pursuing these concerns service user organisations have campaigned against the discrimination and neglect experienced by those using health and welfare services. A number of these organisations, in the mental health field, have challenged the stigma, social exclusion and discrimination experienced by service users who are denied their full membership of society because of their diagnosis. (Brandon, 1991; Campbell, 1996; Sayce:2000).

In focussing on the civil, political and economic and social rights of service users, these service user organisations have raised questions about the practice and the impact on service users of the paternalism of politicians and professionals delivering policy and provision. In doing so they have argued that it is important to view service users not as passive recipients of services but as active, knowledgeable agents with considerable expertise based on what they have learnt from using and surviving; (Campbell:2001; Davey,B.1999). Working for the empowerment and inclusion of service users these organisations have directed their energies to societal and service change. A small number have also pursued their concerns for service change by entering the marketplace of health and welfare provision as providers, developing user led alternatives to community based services. (Barker & Peck:1997; Lindow:1994).

In speaking out about their lives and what works and what does not work for them when they need support with crises and recovery service users have begun to make

a difference. In some parts of the country the expertise of these groups has been harnessed in working partnerships with professionals and service providers trying to build better services. This was missing from the world that I entered in 1970 and for me this is a change that holds the potential for transforming the services that we are receiving and working in today. A change which government documents recognise when they claim that at the heart of the integration exercise are the experiences and expertise of service users. 'Integration of health and social care in the field of mental health promises major gains for users, carers, staff and communities. But this will only be achieved if whole persons and whole systems approaches, with an accent on citizenship and recovery, are the driving values and precepts' (NHS:2002).

The evidence from the growing body of research based on service users experiences that has emerged over the last decade provides strong indicators about the direction that integration should take. This evidence highlights not only the priorities and service designs that should be driving integration. It also points to the vital importance of the values that need to be embraced across the mental health workforce if integration is to make a positive difference to service users and carers lives. It suggests that integration is not just about providing a single door or seamless service it is about working with service users in ways that build respect, understanding self esteem and confidence in service users as well as workers. (Davis:1996;Wood:1994)

To take a few examples. In the People First survey national undertaken by MIND in 1990 service users shared with researchers what it felt like to be on the receiving end of services. What emerged from this piece of research was that most people saw their difficulties as rooted in the context of their life experiences rather than being a matter of symptoms of an illness. Because of this many experienced the responses of health professionals in primary and specialist settings as too narrow to engage with their most urgent concerns. Services close to and building on people's normal living arrangements were valued as well as services that engaged with issues related to housing, income, employment, isolation, relationships and meaningful occupation. The evidence led the researchers to conclude that 'users' needs are best framed broadly in personal and social rather than medical terms' (Rogers et al:1993:190). Such evidence has been reproduced in a range of other national and local user based research projects. A study of mental health service users in Westminster in the late 1990s cited financial difficulties (nearly 90% of service users were unemployed and living on benefits) family relationships, accommodation, social isolation and practical problems as of pressing concern to them. They valued social workers and other professionals who took these issues seriously and at the same time treated them with respect. (McDonald & Sheldon;1997). A similar survey undertaken in Leeds revealed that service users valued talking, listening and counselling services provided by social workers highly, followed by advice on benefits. (Leeds Mental Health Unit: 1997).

Other work in this area has more recently confirmed that what is identified by service users as being helpful to people in recovering from mental health crisis and distress are services that recognise the importance of assistance with income, employment, decent housing, discrimination, poverty, safe communities and personal relationships alongside information about choices of medication and treatment. (Beresford, 2000; Beeforth & Wood: 2001; Davis & Hill: 2001;Mental Health Foundation: 1997; Mental Health Foundation: 2000; Thornicroft et al: 2002).

This substantial and consistent evidence base from service user focussed research challenges the ways in which mental health professionals and researchers have traditionally viewed services and their impact. Most professionally driven research has seen the reduction of symptoms and psychiatric service use as the prime measures of the success of mental health interventions. Evidence from the service user literature suggests that many service users 'see these as but side issues to their 'real' problems which they locate as being able to participate in society, support themselves and to enjoy feelings of well being. Hence many users of mental health services see their principal needs much as others do-they would value employment, a decent income, decent housing and a chance to make and sustain social relationships, These and symptom reduction are not always mutually exclusive but they may conflict' (Barnes and Bowl, 2002, 95).

This suggests that in developing integrated mental health services fit for the twenty first century the established psychiatrically driven service priorities need to be widened to accommodate a focus on the totality and complexity of individual's lives, rather than just symptomatology and psychiatric service use. This is more than a matter of health accommodating social care interests. It is a matter of health and social care professionals and researchers recognising that service user experience and expertise needs to be acknowledged and actively worked with in delivering on the Integration agenda set by government (Morgan et al:2001; Repper & Perkins:2003; Dunn:1999; Sayce:2000).

At the same time the service user focussed literature clearly indicates what works for service users when they are in contact with mental health workers. Regardless of professional designation it is professionals who treat service users with respect, listen to what they are saying and work with them over time in relationships built on trust and mutual regard on priorities that make a positive contribution to service users realising their aspirations and an improved quality of life.(Gilbert:2003) Knowing what we now know about what integration could deliver for service users the challenge for us all as service users and workers in the mental health field is to work to make these aspirations real. How might this happen.? How could we begin to realise a form of integration that works for service users and carers? There are many approaches to this but I would like to share one approach that is currently being developed in the West Midlands.

Learning from a local user led research project

The Transforming Lives; Changing Services project is being undertaken by Suresearch a user led research and training network of service users and their allies, based at Birmingham University.(Davis & Braithwaite:2001). This project began four years ago when Suresearch was commissioned by The Policy Development Panel: Remodelling of Mental Health Services in Birmingham to contribute to the development of joint commissioning and joint provision across the local authority and health service. The project was designed by service users to gather data about how people who live with mental health problems have experienced and currently experience the mental health system. It is also concerned with exploring how jointly provided services might, in the future, in Birmingham achieve better outcomes for service users.

The aims of the project were to:

- Explore users' experiences of transitions through the mental health system
- Identify the points at which interventions proved helpful in enabling service users' to pursue their lives and aspirations and what it was about the interventions that proved helpful
- Examine points at which the mental health system acted as a barrier either in terms of access or recovery and what made those interventions unhelpful
- Identify points within the system that caused confusion or uncertainty
- Develop user-defined criteria which can be used in monitoring and evaluating services commissioned and jointly provided between the NHS and the City Council of Birmingham.
- Pilot a methodology which could be applied elsewhere to explore user experiences of mental health systems

60 people who had used mental health services in Birmingham were interviewed by service users from the Suresearch network. The people interviewed were aged 25-70 years. 20 people described themselves as coming from minority ethnic communities, 32 were women, 28 were men.

The main findings were that:

- Service users expected that contact with services would assist them in managing their mental health problems/diagnosed mental illness through times of crisis and recovery
- Some services were experienced as hindering people to pursue their lives, aspirations and recovery. These were services in which people found they were treated as passive recipients, offered little information about what was on offer and few opportunities for exchanges with staff about their hopes and fears for the future.
- Some services were experienced as supporting people to pursue their lives and aspirations. These were services that valued people as experts on their own lives, connected with them as individuals and worked with them to transform their lives and support recovery.

The services that were valued by users provided:

- Opportunities for users on an individual and group basis to talk about their hopes, fears and aspirations for the future.
- Information about issues and concerns of importance in users' lives e.g. medication, life changes, treatment options, relationships, income, housing, employment, education.
- Advocacy in relation to key life areas as well as access to and exit from services
- Relationships with staff and other users' based on respect, mutual valuing and growing trust.

The survey findings were discussed in two user-led focus groups. From these discussions a set of user-generated criteria were developed as a means of evaluating and monitoring mental health services in the future.

These criteria represent seven key characteristics of services that users consider enable recovery and life planning. They are:

Valuing users-as people and experts in their own lives

Listening to users

Learning from users

Engaging with users on key issues relating to their lives, e.g. employment, housing, income, personal and family relationships, treatment and care options.

Working with users through exchanges directed at planning for change in their lives to support recovery

Connecting users to sources of specialist and community based advocacy and advice

Involving users in service development and staff recruitment

In discussing the outcomes of this project with the local Mental Health Trust

Suresearch suggested that the next stage should be to use the criteria generated by this project to work actively with staff and service users in the City to move services in the direction of what service users want.

Suresearch members who are service users are now working on selected service sites with service users and staff, using the service user generated criteria as a basis to evaluate the existing service and stimulate exchanges between staff and service users about what needs to change to make services more responsive to users needs. So far we have found that services are making a variable response to user agendas. Those who, in the view of service users, are meeting most of the criteria demonstrate that it is possible in the current structures to work in user responsive ways. Those who are not meeting most of the criteria have been able to identify changes in both style and service design that could make a big difference to service users.

However, one of our major findings is that in a climate of service change (Birmingham has recently merged three mental health trusts and brought the social work workforce into the new Trust), managers and planners have, as they struggle to achieve more integrated structures, created difficult situations for staff who feel unsupported and uncertain at this time of major change. This has had a negative effect on the morale and creativity of front line staff which is not working in service users' interests.

We are hoping that in disseminating the results of this project later this year with Trust staff and service user forums that we can learn from our work and develop it across the Trust. As a step towards this next phase Suresearch has been asked to deliver a day on user focussed research for the Trusts Research and Development Team.

Conclusions

In working to make Integration work for service users we need to remember that we have a substantial and coherent body of evidence from users experiences and expertise to guide our work nationally and locally. This work points to the importance of professionals establishing common values and goals for services that make direct connections with what service users value. Locally it is important that work on delivering integration is based on this evidence and rooted in what is happening and what could happen if local services and professionals open up their current agendas

so that service users are actively involved as partners. It is by working in this way from the bottom up that we will have a chance to make Integration work for those who turn to mental health services for support.

- For more information about Suresearch contact the author

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COMMENTS QUESTIONS AND ANSWERS

- Do you think there's been a shift in the new Trust in Birmingham in valuing people? How is your research disseminated? Is the structure in place in the organisation?

AD I think Birmingham has been very good since the 1980's in funding a number of service user organisations. The people working for integration thought they needed to know something and funded research with service users (Suresearch). We've finished the first phase of research. Money for the second phase was given by the then Trust and labelled a contribution to clinical governance. The Trust no longer exists, and that group has changed so much that we don't know who we'll be speaking to. So from June to December we'll be knocking on doors, telling them we've finished the work and disseminating the information locally and more widely through events like this. We will keep on doing this so that we get it on the agenda. The strength of working from Suresearch is that when you meet with the people running services, most of the people around the table are using those services. That brings service users into the centre.

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- Do you have any contacts in the South?

AD Suresearch started as a West Midlands-based organisation. It's now spread to the East Midlands. We have been asked to give presentations and do research in other parts of the country, and we're also doing work on the training side now. We're very happy to make links.

- I would just like to say I have lost count in the last 3 years of how many people I have heard "speaking on my behalf" on this subject. This is the best I've ever heard.
- A point about the evidence base: when we had the first meeting of NIMHE Values Research Group, which was very connected with the Social Perspectives Network, we found that people don't know about stuff already out there. One of the main aims was to try and search for what's already been done as well as encourage new research.
- One problem I see with consulting users and carers and taking on board their ideas, we have a Government which thinks they can run everything centrally. I think there's a clash between being free to take on board what local service users are saying they want and being tied by Government directives and performance indicators. So there is very little freedom for us to deliver services that people want.

Directors are subject to being measured, and you're right but there are always gaps and ways of working, and exposing the contradictions. Some very powerful service user presentations to government have pulled out these contradictions better than any campaign group could.

- I would like to say thank you for fighting on behalf of the people who are in poverty. People don't realise what carers and users go through. Thank you for fighting on our behalf.

AD For a number of years I've spent a lot of time around the Social Security system and mental health. We were looking at trusts, about involving local authorities etc – for me the big thing has always been, where is Social Security in all this? We know it's not just about levels of benefit but about the rules and regulations that exclude people continuously. People with mental health problems have an unemployment rate of 88%. There are a lot of very creative people who want to work and could contribute, but the benefits system stops them. That's an issue alongside the issue of how anyone lives a full and engaged life on the benefits level. All Suresearch members involved get paid the rate for the job, but sometimes we have to find ways around the systems.

- Where is the bit of evidence from carers, and can a similar network be set up for carers who may have different needs which are not being addressed.

AD This really interests me. Amongst the people in our network there are people who are carers as well as service users. It seems to me that there's been work done around some of these issues about carers but it doesn't seem to be as well developed as the evidence around the user stuff. When we talk to local carer networks it often seems to be that people do think this work is important. The issue for organisations is there are so many calls on their time, it's about prioritising this alongside other work they're doing. I do think it's an important gap that needs to be filled.

- I don't think it's at the level of service user research but there is a bit of evidence which led to the Carers Act so we need to use that and shift services to recognise carers. Locally we've started to do some work on that but it's been interesting in integration that we've come up against large parts of services which don't recognise carers and there's a lot of work to do.
- On the issue of employment, people with enduring mental illness now have pathways. The big challenge is people taking a risk and I've found it very rewarding. I'm sure the opportunity needs to be expanded to a lot more people but it's very challenging. There may be issues about relapse and the risk of offering a better quality of life for only a limited period if this happens.

6 WORKSHOPS

1. The experience and expertise of service users and carers

Joel McCann facilitated this group and reported that most members felt that the experience of service users and carers was very different, needing different approaches in order to enable both groups. Service users have first-hand experience of services, and carers primarily contribute to improve the care of the person for whom they care. The group felt that this was a general concept and not unique to integrated care services.

General agreement was reached that there was a lack of training available from providers for carers, particularly in relation to understanding illness. Both groups – users and carers – continue to feel disempowered by the development of integrated health and social care services. Members of the group raised a number of issues:

- Who is in charge of integrated services?
- Information concerning the process of integration was often lacking or of poor quality
- The voluntary sector is felt to be under-represented.
- There was often felt to be a lack on information, or a poor flow of information, between health and social care organisations.
- The lack of “ownership” for anyone other than senior management

The group discussed the experience of service users and carers of frontline services. Carers felt that community workers lacked skills to deliver services that met the needs of service users. A general consensus emerged that CPA (Care Programme Approach) Audits by user organisations were increasingly being carried out across England. Members of the group wondered how these audits would be translated into action as service development strategies. Carers in the group felt that they needed to be more involved in the care planning process and that there should be audits of carer satisfaction to match those concerning user satisfaction. The group decided to devise a joint values questionnaire for health and social care staff to complete. This would allow the comparison of differences in outcomes. The findings would contribute research towards values for modern mental health services.

2. Promoting Social Care Perspectives

This workshop was divided into two, as it was over-subscribed.

(Group A) What works well at the moment/lessons already learnt:

- Need for clear and accountable professional leads infrastructure within integrated NHS Trusts, all the way up to Board level, taking in an Executive Director role for social care along the way. Importance of locally visible professional leads with a clearly defined role alongside integrated management. Examples given from Leicester City, West Sussex. Noted the importance of clear job descriptions for local leads, the need to sort out the basics about boundaries to the role, and accept that cultural change and adaptation to new roles and responsibilities takes time (not just for the social care professional leads themselves);

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- Integration has had a positive spin-off in terms of the development of a more assertive social worker practitioner base, and the emerging development of a collective professional caucus. (Example given from Leicester City);
 - Approved Social Worker practitioners value more highly the support infrastructures in their home local authority - whether just the ASW supervision bit (examples given from Leicester City, Leicestershire, West Sussex), all the way through to quarterly practice development fora and other Continuing Professional development opportunities and the maintenance in the home authority of senior manager expertise (example given from West Sussex);
 - Links with higher education providers are key to maintaining the social care perspective in course development opportunities such as MA/MSc Mental Health programmes (examples given from Northumbria, West Sussex);

Future development opportunities to consider:

- Development of integrated NHS Trust's Statement of Social Care Values and Principles (example given from West Sussex);
- Development of practice forum for all social care practitioners in an NHS Trust - not just the qualified social workers having an opportunity to meet (examples of: work currently under consideration in West Sussex; and anxiety expressed from Bradford, where integration is yet to happen, and from Leicestershire where mental health social workers feel cut off from social care colleagues in the integrated Leicester City NHS Trust);
- Development of local SPN groups - virtual or actual, and using SPN speakers to front local conferences on the social model (example given of work in Sussex, across two county councils, one unitary authority, and three mental health NHS Trusts);
- Development of NIMHE Development Centres' social care expertise and leadership role, in partnership with social care leads/Directors of Social Care in each NIMHE Development Centre region (example given from West Sussex);
- Development of a social care practice newsletter, produced and distributed by the integrated NHS Trust, and any other means of communicating the social care perspective such as use of the internet and intranet for the Trust, hosting an 'Excellence in Practice' conference... (examples given of work in progress in West Sussex).

(Group B)

- There is a need to be clear about what we mean by social care and perspectives.
- Need to be clear about the theory, research and evidence base. Need to encourage staff to be research minded.
- Be positive about social care and its strengths.
- Avoid seeing social care perspectives as things that the local authorities used to do.
- The integrated organisation needs to have social care within its values.
- Need for champions.
- Need to be realistic and concentrate on 2 or 3 "do-able" things. Changing the world (or the NHS) overnight will tire us all out.
- Working with service users as allies is key.

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- Through commonly held values and joint training, social inclusion, direct payments, housing, leisure etc. etc. will become everyone's concern.

3. Notes from 'Research and Development Group'

- Key values and principles of integration and service user aspirations are already known so,
 - why are they not universally applied?
 - are those service user aspirations realised in practice?
 - need research on outcomes of integrated services linked to process / systems / models e.g. how do organisations develop integrated services, how do they manage culture shift / change, how integrated is 'integrated'?
- Who undertakes the research and who is it for? Service users / practitioners / managers?
- Do we want research to be undertaken by academics, practitioners or service users or is it a partnership of all three?
- Need more emphasis on outcome-based research i.e. qualitative and not quantitative.
- Can one carry out effective research when changes are implemented at a rapid pace. Need time for consolidation to enable meaningful research to be undertaken
- Research is also needed into 'how are evidence based services implemented in reality'. Do they accord with the original model researched in the first place
- We need one, and only one, 'national information exchange' service that covers social perspectives in mental health.

4. Education and training

- Issues around budgets.
- Protecting monies for professional development vs legislative requirements
- Multi professional training requires skilled facilitation
- Involvement of service users at all points.
- Supporting service users and carers into the learning and development workforce.
- Payment
- Involvement in a variety of ways
- Needs to address the learning and development needs of the whole workforce, not just focussing on "professional" roles.
- Supporting people in involving service users.
- Developing standards
- Ensuring all trainers are trained
- Complexity of funding streams
- Issues around staff relief
- Strengthen links with CPD and learning and development
- Knowing what is out there
- Trading
- Being imaginative and innovative
- Local service and teams having an educational role
- Construction of training a partnership between health and social care teams.
- Making links to visions and strategies

5. Challenging the dominance of the medical model

Essence: signs and symptoms – label

Treating the label

Reductionist approach

Treatment – medication

Power of knowing which label to apply / applying a label

Final power of deciding treatment e.g. ECT

Why is the medical model dominant?

- “Elephantine” NHS
- Decision making power – risk
- Number of professionals
- History of NHS
- Dominance of pharmacological solutions
- Status as consultants, not employees
- Culture of quick fix solutions in society
- Has value for some people at some times.
- Accountability to management structure
- ASW power
- Solves problems for professionals with limited resources (in short term?)
- Budgets – difficulty in shorting balance between budgets
- Power of pharmaceutical industry. Research, evidence base etc.
- Western industrial society

Practical ideas:

- Increase access to knowledge / information
- Mental health promotion in the media.
- Supporting the voluntary sector
- Access to advocacy
- Engaging with doctors – seeing and ??? in medical model
- Integrated meetings / forums involving service users
- User led training

6. Involving partners

- Carers assessment done by contracted voluntary organisation
- Issues: Confidentiality. When a voluntary organisation is involved in a staff meeting.
- When the lawyers get involved.
- Where is partnership without trust
- Need for boundaries and clarity of expectation
- Differences in partnering: contracted vs. joint.
- Commissioning vs. being commissioned.
- Peter’s two pronged approach
- Everyone’s mental health improved, mental health promotion
- Mental health services

7 SPN ACTIVITIES AND CONTACT DETAILS

The Social Perspectives Network is an independent organisation which is open to anyone interested in looking at mental distress in terms of people's social experience – how social factors may both contribute to people becoming distressed, and play a crucial part in promoting people's recovery. Social Perspectives Network is open to practitioners of all disciplines, service users / survivors, carers, policy makers, academics, educators, service managers and others who may be interested in these issues.

SPN seeks to be inclusive. There is no assumption that there is one single social model, or that one social perspective is more valid than another. Instead different perspectives may all be seen as pieces of a 'jigsaw' that may gradually come together. SPN seeks to operate in a non-hierarchical way, so that everyone's experience, knowledge and skills are valued.

SPN receives funding and support from the National Institute for Mental Health in England (NIMHE) and the Social Care Institute for Excellence (SCIE).

SPN has a central base in London at the Social Care Institute for Excellence. From here, national initiatives are co-ordinated which focus on areas such as research, policy development, or more specialist areas of interest such as child and adolescent mental health. Alongside this, in order to influence policy and practice locally, SPN has local networks in nine English regions, working closely with each of the NIMHE Regional Development Centres.

SPN aims to:

- Develop and pull together the knowledge base – what we already know, or may need to research, concerning mental distress from a social perspective, what works in terms of service responses, self-help strategies, etc
- Support practitioners, users and carers in putting social perspectives into practice
- Influence the development of mental health policy from a social perspective

SPN has four main functions:

- It brings together service users, carers, practitioners, educators, policy makers and researchers to share experience, knowledge, ideas and perspectives
- It promotes the development of new ways of thinking (social models) and their application into policy and practice.
- It collates, publishes and disseminates knowledge, experience, research and practice guidance, so that it is accessible to all.
- It facilitates regional and national discussion on mental health issues so that collective views may be presented to policy makers, service commissioners and providers.

If you want more information or would like to become actively involved in any aspect of our work, please refer to our website or email the SPN network co-ordinator who can put you on SPN mailing lists and give you contact details for your regional co-ordinator.

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