How day services can meet government targets of social inclusion and recovery while retaining buildings-based services

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Abstract
This article describes the approach to modernisation of adult mental health day services taken in Sandwell, which retains a building-based element to provide for attachment and belonging, while developing community-based models that promote social integration and recovery.

Key words
Social inclusion; Recovery; Attachment; Buildings-based services; Community-based services; Day services

In 2004, the Social Exclusion Unit published a seminal report that unveiled the government’s intention to ‘transform day services into community resources that promote social inclusion through improved access to mainstream opportunities’. The action plan within this landmark report comprised six key functions.

1. Access to supported employment opportunities where appropriate.
2. Person-centred provision that caters appropriately for the needs of all individuals, including those with the most severe mental health problems.
3. Developing strong links and referral arrangements with community services and local partners.
4. Providing befriending, advocacy or support to enable access to local services (including childcare services).
5. Involving people with mental health problems in service design and operation.
6. A focus on social inclusion and employment outcomes. (Social Exclusion Unit, 2004)

Another reform in mental health practice in recent years has been the introduction of a model of care based on the philosophy of ‘recovery’, a philosophy that conceptualises mental distress within a discourse of natural human experience, as opposed to the medical model of disability and illness (Masterson...
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& Owen, 2006). Thus, recovery describes an individual’s journey of self-development towards the attainment of a purposeful, meaningful and fulfilling life, rather than concentrating on the alleviation of psychiatric symptoms (Meddings & Perkins, 2002; Repper & Perkins, 2003).

The ethos of recovery, in emphasising the enablement of people to aspire beyond the confines of mere survival with the support of services, resonates strongly with the social inclusion agenda. The publication, Redesigning Mental Health Day Services – A modernisation toolkit for London (Care Services Improvement Partnership et al., 2005), incorporated both the social inclusion and recovery agendas in its view of an effective, modern-day service. The report proposed a number of components considered vital if day services are to succeed in promoting social inclusion and facilitating recovery.

- **Developing social networks.** Mental health problems impact on people’s social relationships, frequently leading to reduced contact with family and friends. While social networks based within services are acknowledged to be important, developing a strong, wider network is considered to be integral to the recovery process.
- **Intensive day care.** Providing a time-limited crisis support and treatment service in conjunction with the work of crisis and home treatment teams, community mental health teams and inpatient services.
- **Therapeutic interventions.** Provide person-centred therapeutic services and access to self-help literature and information.
- **Accessing mainstream creative and leisure activities, education and training.** Facilitating access to community-based arts, leisure or educational provision; this may include advising people about direct payments, arranging taster sessions or providing support with obtaining benefits.
- **Volunteering and employment.** Voluntary and paid work promote social inclusion and benefit mental health. Day services need to provide support to enable people to access and then retain work and negotiate the benefits system.

**How have day services tried to meet these objectives?**

**Community services**

Throughout the country, providers are faced with the challenge of how to redesign day services in line with promoting social inclusion and facilitating recovery. Some providers have addressed this challenge by closing day centres and cutting costs by offering groups at community venues, for example libraries and community centres. This means people are less separated from their local community, in keeping with the ethos of Care in the Community, but included as far as they feel able to be. The idea is to reduce stigma and to help people maintain links with the wider community, so that it is less difficult to reintegrate after being supported by specialist mental health services.

However, this model does not make allowances for individuals who do not feel able to attend community venues – who, for example, have been bullied at home, at work or in their community and do not feel part of society. This model also does not provide a service for those that need somewhere to return to in times of need.

**Buildings-based services**

The other model is to provide the traditional buildings-based model, which at its worst has been described as part of the psychiatric ghetto where people go to drink tea and smoke cigarettes (Bryant, 1995). This is seen as providing an institutionalised setting where the focus is on ‘bums on seats’ rather than on helping people to ‘recover’. It has been proposed that (day) services unwittingly inculcate and perpetuate a ‘sick role’ identity, which does not enable and empower people to assume responsibility for their recovery (Millward et al., 2005).

Although ‘institutionalisation’ and the lack of clear exit strategies for users have been levied as criticisms of the traditional day service, this model does have strengths in terms of helping people feel safe enough to go somewhere outside their home and providing somewhere where people can start to build relationships and develop attachments and a sense of belonging. These service elements can be important. In an evaluation of day services in Sandwell conducted in 2006 (Walters, 2006), service users identified how important it was to attend a place where they do not feel ‘different’ and where people understand and do not make assumptions about them, such as ‘you look alright therefore you must be alright, you just need to pull yourself together’. If it were that easy, surely people would have done it by themselves.
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We are, therefore, left with two main ideas of day service provision in the UK. The traditional buildings-based model, which focuses on attachment and belonging, and the community-based model, which is based on social integration and recovery. It could be argued that neither meets the full range of need. The question is: have service providers inadvertently set up a dichotomy between these two models? Some providers have tried to provide a ‘modernised’ service from a buildings-based service. However, little literature is available that provides guidance on how to turn an institutionalised setting into a ‘dynamic’ community resource (with little or no increase in the budget). We propose a model that can address these two sets of needs and service aims – recovery and reintegration and attachment and belongingness.

**Our approach in Sandwell**

Research has suggested that service users are active agents in the quest for a respected middle ground between full exclusion and full inclusion, a process that includes seeking valued roles outside of the prevailing culture of employment (Pinfold, 2000). Our idea in Sandwell is that a buildings-based service can provide a place to start to build confidence and friendships (attachment and belonging), and skills to manage symptoms (recovery), especially for people who do not feel able to attend wider community venues. Such individuals want a place to go, to drop in, where they feel they can belong and have a sense of connectedness.

The building and the staff can provide a safe haven from which to build up trust, which is essential when taking risks in moving away from the centre (Pinfold, 2000). From here people can go on to develop other safe havens (integration). Often it is only through the embodied experiences of learning to trust, that people can start to challenge their abusive experiences and start to go outside their comfort zone with some feeling of confidence. The building and staff also provide a place to return to in times of need, essential for feelings of confidence and security during difficult transitions:

‘I don’t attend the centre very often anymore, but it’s very valuable to know that the staff are still there for me.’ (Walters, 2006)

Some of the challenges around buildings-based services have been the cost, and how can one service fit all – ie. different generations, abilities, severity of symptoms – with a limited number of staff? And how can a buildings-based service help people to develop a sense of efficacy without institutionalising them? As with many services, it is usually those who shout the loudest, or who provide the most job satisfaction that get the most attention. What about those who feel unable to ask? Or those whose needs are not met by the service? How can an equitable, person-centred service be provided that will be attractive to all? We will go on to discuss below how we have attempted to provide such an individualised service, tailored to need, with a focus on recovery and integration.

**Recovery Centres**

In 2006, the adult mental health day services then provided by statutory agencies in Sandwell were viewed under the umbrella term of ‘support’, which we thought was neither helpful to staff or consumers. The word ‘support’ might be seen to suggest that keeping people in one place forever, which embodies the more traditional pattern of day services, and is not representative of what is being provided in Sandwell today. A key feature of the recovery model is that the individual, not services or practitioners, owns the recovery process (Masterson & Owen, 2006). Indeed, service providers must be aware of the danger that a sanitised ‘professionals’ version of the recovery model may create an underclass of people who either do not ‘recover’ according to the criteria chosen by workers or whose mental health problems are deemed less severe and enduring than those of other service users (National Institute of Mental Health in England, 2005).

Through identifying what the service actually provided (eg. emotional and practical interventions, crisis intervention), we described our service philosophy as:

*To help people keep their head above water (support), to lift them up a bit if they are sinking (crisis management,) and to help them learn to swim (recovery).*

We also found that the purpose of attending day centres or groups within centres was not always
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explicit. In the evaluation of our day services conducted in 2006 (Walters, 2006), only six of the 102 people that took part (9%) across the two centres identified their attendance as being part of their ‘recovery’ or to help them get better. Sixteen people (24%) stated that they attended for their mental health.

Having somewhere to go, having something to do, being with people and having a sense of belonging and connectedness were all incredibly important. The agenda of staff, however, was to help people cope with their mental distress and discharge them from services.

Therefore, in order to help service users understand what the centres were trying to offer and help them connect with their aims, in January 2007, they were renamed Positive Choices: Recovery Centres. Service users selected the term Positive Choices after a debate and vote. Staff wanted the term ‘Recovery Centre’. This rebranding of the centres, together with an overhaul of the services they offer, emphasises an intended shift in focus from the alleviation and management of symptoms to helping people to find meaning and purpose in their lives, the philosophy at the heart of the recovery model (Meddings & Perkins, 2002).

We found it was also important to recognise that many service users have very low expectations in terms of their mental health, and may not have accrued the experiences that foster a sense of personal empowerment; this is crucial in helping them and others to be able to take risks and extend themselves beyond the confines of the building. There have been many anxieties around how to help people bridge the gap between services and community, such as where to start, whether it can be done and whether staff might lose their jobs if they do not succeed? Mental health support workers together with each centre manager and the staff have had to think very creatively in terms of: finance; finding community venues; developing the confidence and competence of staff; and convincing senior management and commissioners about the potential offered by day services.

Psycho-educational groups

We identified that we were very good at providing occupational groups, however psycho-educational groups to help people think about their recovery and move forward was a gap within the service (Wilkinson, 2006). This helped staff to engage with the process of developing a comprehensive talking group programme. We have undertaken a lot of training and supervision in relation to this, and staff are now able to design groups to meet client need, evaluate these groups, and use action research to redesign them in line with feedback from service users. Staff also receive ongoing monthly supervision from a clinical psychologist, where we discuss clients and identify needs for training. Our next training session will be on attachment styles and on how to manage the dynamics of empowering people, rather than inculcating the sick role by doing things for people.

We have also undertaken training in relation to assessment and recovery and now use the Mental Health Recovery Star (Burns et al, 2008), which is easy to use for both staff and service users to identify where they are and what they would like to work on.

Poor relation

However, day services in Sandwell are still seen as the ‘poor relation’. They are the only service delivered by the Sandwell Mental Health and Social Care NHS Foundation Trust that is not inputting their contacts into the local auditing system (Oasis), they are not part of the Care Programme Approach, and they cannot directly refer to the crisis team. It seems that it is very difficult for some individuals to see us as a useful part of the wider service or our potential, no matter how much we...
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sell ourselves. Are we selling the wrong stuff or are people just too overloaded to think about us? What we hope to deliver are services that are not already provided, especially in terms of the talking therapy group programme, which could help to reduce work significantly in the more specialist teams. We are currently working with primary care and the hospital to try to further develop these links. Having good relationships with staff in these services helps with this, however battling against entrenched and traditional ideas of day services is incredibly difficult.

Staff
Providing a service that promotes social inclusion and facilitates recovery relies on the knowledge, skills and values of frontline staff in supporting individuals to engage with a challenging new agenda. What has been unacknowledged, however, are the skills of ‘unqualified’ staff at centres who are able to contain people who are very distressed and have very complex needs, through providing clear and consistent boundaries and giving feedback to help people become more self-aware.

We have also had to face the reality that service users have become very comfortable at the centres and some do not see a future outside this. We are now working on trying to create an atmosphere of ‘this is a place where you come to get better, you can achieve more if that is what you want to do’. We have found that by focusing more on what recovery is to the individual, helping people to understand their mental health and offering hope through developing coping strategies and service users co-facilitating psycho-educational groups has helped people think differently about themselves and the Centres. We have done most of this work through the group work that we provide, both occupational and psycho-educational.

Involving service users
It is, and will remain, crucial that the views of service users are heard. It is unlikely that the realisation of a redesigned day service can be achieved unless the individuals who use the service buy into and subscribe to its aims and tenets. A key principle underpinning the redesign and rebranding of our service has been better communication regarding the future direction of the service. Developing a good understanding of the views of service users and staff has been vital in this process, and will continue to be essential to the success of the Positive Choices: Recovery Centres.

Service users will also hopefully have a voice through monthly service user and staff meetings, and through the FIRST (Friends in Recovery Strong Together) Service User Group, which is involved in all discussions around service development. A Newsletter Group also publish a monthly newsletter.

At the moment we are also asking service users if they wish to be involved in a research group to look at the next service evaluation. We hope that if people enjoy this experience they will think about joining Sandwell Mental Health and Social Care NHS Foundation Trust service user research group.

We now have nine service users who facilitate both occupational and psycho-educational groups, including hearing voices, women’s and men’s groups, arts and others. They receive supervision once a month from a clinical psychologist and a training session every three months on a topic of their choice – for example, how to manage difficult situations, and how to ask questions. The facilitators group drafted a job description for service user facilitators and volunteers, as people wished to have some clear ideas about their roles and responsibilities. The Trust is also officially recognising service users for their contributions by asking service users who are in a facilitator role if they would like to be a volunteer employed by the Trust.

We were able to pay service users for their valuable services, however due to budget cuts we no longer have funding to pay people for their services and this is an ethical dilemma. However, we hope that the experience and confidence people gain from these activities will help them in the future.

Bridging the gap between building and community
We use a transitional model of care (see Figure 1, opposite) developed through focus group discussions during the service evaluation in 2006 (Wilkinson, 2006) to describe how to help people bridge the gap from our Centres to the wider community. Once people have developed a sense of attachment and belonging, we introduce the idea of recovery through recovery groups that use
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the Mental Health Recovery Star tool. People then identify their own goals towards their recovery. Each occupational group in the centre has a pathway to groups in the community, and so when people are ready we support them to attend leisure, creative and education activities. If people need support with this, a member of staff or another service user interested in the same group will attend with them.

This transitional model helps staff to keep in mind a pathway of care. All groups and interventions are designed with people’s
development in mind. If someone is attending a group, what is their aim? When have they achieved this? Do they want to work on something else? Each service user has a six-monthly review and the Recovery Star tool helps greatly with this, as it helps people to identify whether they are at the red (really stuck and not thinking about change), amber (gently moving towards change) or green (in recovery) stages. It then helps staff and service users to identify the level of support that they want/need and how they want to use this to move forward in the way that they want to. However, we think that we could improve on this and so are in the process of conducting another service evaluation – mentioned earlier.

A dynamic buildings-based model

**Figure 2**, p.45, is used by staff to help users think about engagement, level of need and people’s pathway through services. For example, sometimes it is less threatening for people to join an occupational group where they can develop attachments and a sense of belonging. This sense of security can then help those with very low self-esteem to join a psycho-educational group if they think it would be helpful. The Mental Health Recovery Star helps service users to think about their pathway and move on from services when they feel confident enough to do so. The transition model of care described earlier (**Figure 1**, p.45) then helps staff to help service users reintegrate back into the wider community, again when they are ready.

Day services have been traditionally used by people who ‘need something to do in the day, and who often feel terribly lonely and unable to do anything about it. We hope that our service will help to empower people to use the centres on their journey to recovery – whatever that means to them. We would like to bring more people with varying levels of mental health need into the Centres, which will hopefully give them more of a community feel and provide an atmosphere of ‘this is not it, I can have more’. We hope that better liaison with other local services, for example GPs, other services within the Trust and the volunteer sector, will help us with this.

We also hope that the service evaluation we hope to complete alongside service users over the next six months will help us to focus on our exit strategy. We want to have our first achievements awards, for people identified by staff and service users, in December 2010, which will be part of our exit strategy so that discharge is a celebration and acknowledgement of what people have achieved, whether it be attending a group or finding (voluntary) work. Winning the Trust Innovation and Creativity Award helped us to understand the importance of formally acknowledging achievement.

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