



**MENTAL  
HEALTH  
PROVIDERS  
FORUM**

Voluntary Agencies  
Working Together to  
Improve Mental Health

# Better mental health in a bigger society?

Mark Brown and David Floyd

## Acknowledgments

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The work that led to this publication, *Better mental health in a bigger society?* was originally commissioned by the National Mental Health Development Unit from Social Spider CIC, a social enterprise with a reputation for effectively examining and communicating the impact of policy changes on mental health and the experience of those with mental health difficulties.

The implications of the Big Society agenda for mental health were explored in a wide range of semi-structured discussions with groups of people involved in mental health from different perspectives, including those with experience of using services, those who provide them and those responsible for commissioning them.

The ideas that emerged have been developed by Mark Brown and David Floyd of Social Spider CIC into a compelling paper that may challenge many of our preconceptions about Big Society, particularly where it can be related to some of the key progressive principles in mental health, and as such shows that it will require a much more considered response than it has typically provoked to date.

The Mental Health Providers Forum has been pleased to work with the Mental Health Network of the NHS Confederation to support Social Spider CIC in developing and disseminating these ideas in order to enable a wider debate about the potential implications of this major policy initiative in mental health.

This paper is a helpful contribution for local (emerging) health and wellbeing boards as they begin to plan for local health and wellbeing strategies. This work will help them in approaching how they take a broader community approach to improving the health and wellbeing of people living with and recovering from mental health difficulties

Social Spider CIC are the social enterprise publishers of *One in Four* magazine, the national magazine written by people with mental health difficulties, for people with mental health difficulties.

ONEinFOUR

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## A thought experiment

Think about your own experiences either as someone involved in the provision of services, someone in receipt of services or someone involved in the design and planning of services. How do you feel about the following questions? What do you think would happen?

- What if a local community group wanted to run a new group for people experiencing mental health difficulties?
- What if a local group of people with mental health difficulties wanted to run a new group?
- What if users of a particular service asked for that service to be provided in a different way?
- What if a service actually implemented the feedback it received?
- What if people with mental health difficulties decided that they wanted to use their personal budgets to buy things that weren't what was expected?
- What if a local voluntary service was better at providing support to people with mental health difficulties than a state service?
- What if voluntary, community, peer-led and state services tried to work more closely together?
- What if your colleagues on a project for people with mental health difficulties were people with mental health difficulties?
- What if state services made a decision to support local community, voluntary and social enterprise services?
- What if someone came to you with a great idea for making mental health services better?
- What if people with mental health difficulties collectively decided to do things for themselves without asking for permission?

All of the above are Big Society and mental health questions.

## Foreword – better mental health in a bigger society?

We live in hard times. Everywhere we hear news of services being merged, downsized and closed. It is all too tempting for those of us who rely on services to respond simply by saying “no cuts”, defending the services that we have against the onslaught of recession. Yes, it is critically important that we defend the resources necessary to enable us to live our lives and actively participate in our communities, but does this really mean defending the services that currently exist?

*Better mental health in a bigger society?* suggests that there may be another way, and many of the ideas and principles contained in its pages have a long tradition within the mental health service user/survivor movement.

It is 35 years since Judi Chamberlin’s groundbreaking book *On our own*<sup>1</sup> was published in the USA, yet the wisdom contained in its pages is as relevant now as it was then. Judi argued that, when times are hard, there is a temptation to ask for more of the same, call for more experts and more of their services, unable to acknowledge that it is the system itself that is the problem. To be sure, some people have found help through the mental health system but, as Judi says: *“Needles have been found in haystacks, too, but this does not recommend haystacks as good places to store needles.”* The real issues are ones of power and control: the power to define our own reality, take control over our own destiny and the support we need to live our lives. The real alternatives, she argues, lie not in more experts, or in the alternative prescriptions of the ‘radical’ professionals bent on liberating us from the structures and strictures of traditional psychiatric services, but in ‘patient-controlled’ services *“in which all the basic decision-making power is in the hands of those the facility exists to serve”*. The creation of such alternatives *“is not a job that can be turned over to the experts”*, neither is it an issue for people with mental health conditions alone – *“it is a task that must be done by all of us, ordinary citizens, working together...”*

Thirty years later, in New Zealand, Mary O’Hagan<sup>2</sup> echoed and extended these ideas. She described how mental health services, and the professionals who inhabit them, perpetuate exclusion in a kind of vicious cycle. People with mental health problems believe that experts hold the key to our difficulties, our nearest and dearest believe we are unsafe in their untrained hands, and we all become less and less used to finding our own solutions and embracing distress as a part of ordinary life.

*“People with mental health problems, as well as communities, need to start believing they hold most of the solutions to human problems instead of professionals and services. We need to start viewing mental health professionals and services, as the carriers of technologies that we may want to use at times, just like architects, plumbers*

1 Judi Chamberlin, *On our own*. First published in the USA in 1977, published in the UK by Mind in 1988.

2 O’Hagan (2007) Parting Thoughts in ...*Mental Notes*, Mental Health Commission, New Zealand.

*and hairdressers... [the mental health system] needs to hand over control to service users and communities, through fostering service-user leadership in recovery and in services, integrating with other sectors, and engaging in community development and social inclusion work.”*

Over the last 40 years, peer-controlled alternatives have begun to emerge in many parts of the world, yet, with some notable exceptions, they have been slow to develop in England. The belief that people with mental health conditions cannot be trusted with the money and the door keys remains deeply entrenched. Perhaps we now have an opportunity to remedy this.

The coalition Government’s ideas about ‘Big Society’ strike fear into the hearts of many people, and I do not deny that there are real dangers. We could be both denied services and further excluded from the communities in which we live. “Opening up public services” could simply transfer service provision from the state to large private sector providers. Personalisation could be a recipe for individualism and isolation. The whole thing could just be an excuse for taking resources away from those who most need them, but if those cuts are happening anyway, shouldn’t we find better ways to use the money available?

Mark Brown and David Floyd are not ignorant of these dangers, but they also see possibilities to create real user-controlled alternatives. ‘Big Society’ is about changing the balance of power between the state and citizens. Could this include changing the balance of power between the mental health system and the people it serves? There is talk of passing power and influence back to individuals and communities. Could this include individuals with mental health problems and our communities? Could we pool our personal budgets to create the collective services we want? Could opening up public services facilitate the development of peer-controlled services? Could promoting social action – encouraging and enabling people from all walks of life to play a more active part in their communities – include us?

We could simply argue “no cuts” and try to preserve what we have got, but maybe, as Judi Chamberlin said all those years ago, the time has come to acknowledge that it is the system that is the problem? In the pages of this important publication Mark Brown and David Floyd challenge us to seize the opportunities and achieve the real alternatives that so many have sought for so long.



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## **Executive summary**

The specific determinants of mental health difficulty are hard to pinpoint. What we do know is that life situations play a large part in how ‘well’ someone is within the context of their condition. The Big Society presents opportunities for new ways of working with individuals and communities to foster greater recovery when people do become unwell and build greater wellbeing in the community as a whole.

Big Society is a new idea in government but, in many local areas, the NHS and local authorities are already supporting – and in some cases delivering – services and projects that use a Big Society approach to support people with mental health difficulties.

By supporting the development of community groups, local charities and social enterprises either directly or via other bodies, the NHS has already been laying the foundations for people with mental health difficulties to make things happen for themselves away from state services.

How can the NHS and local authorities become enablers for people and communities to take forward their own visions of mental health and wellbeing?

### **Personalisation**

The demand, “Nothing about us without us”, captures the essential shift in the relationship between services provided by the state and people who use them. This new dynamic should underpin the changes underway in mental health. Giving real spending power directly to service users through personal budgets and personal health budgets makes personalisation a Big Society approach in itself. They will be deciding what services they receive. Beyond that, however, greater personalisation, both in social care provision and ultimately within the NHS, offers significant opportunities for user-led groups to develop new services.

For personalisation to work people must feel that they have real choices to make and new services must be able to come forward to meet their needs.

In the field of social care, work by local authorities to prepare existing user-led organisations for the coming of personalisation has been distinctly patchy. There is potential for the NHS and local authorities to play a greater role in supporting these organisations to bring their services to the market.

The Big Society ideal for personal budgets is that service users end up with a wide choice of options for meeting their needs, including sustainable services provided by user-led organisations and opportunities for people to use personal budgets to ‘do their own thing’ and work out solutions that meet their needs and aspirations outside of a structured framework of service provision.

## Co-production

According to NESTA's Public Services Lab, co-production is organising services with people rather than doing services to people.

Co-production by its very nature is about getting ideas, expertise and people out of their silos and isolated positions in services and the community and bringing them together in new ways. It's about people collaborating to make services and projects that meet their needs and the needs of people like them. It can seem a localised process initially lacking the ability to make sweeping changes across whole services. However, it can lead to small innovations that in turn have large impacts over time when implemented.

Co-production is already happening and the NHS and other mental health services have the potential to be the catalyst for helping co-production to develop and flourish in mental health practice.

## Peer services

In many senses, peer services are the purest forms of service user involvement and community self-help. They were Big Society before the Big Society approach was developed. They are about people who have or are experiencing a challenge providing services and support for those experiencing similar.

Many such services grow from groups of individuals coming together voluntarily in the community to address needs that, based on their own experiences, are not currently being met. They often run on a combination of passion, pragmatism and bloody-minded commitment.

A key outcome of a Big Society approach to mental health will be increasing numbers of services delivered by individuals with direct experience of the life needs that the service meets.

## Community engagement

Traditionally, the NHS and local authorities have waited for the community to come to it by setting up opportunities for involvement or funding, then awaiting response. We have a unique opportunity to remake this relationship. The Big Society challenge for the NHS and local authorities is not just to find better ways to engage with existing service users – although this is important – but to engage with the wider community to create an environment that promotes greater wellbeing.

### Engaging with service users

In a traditional sense, service user involvement is the by-product of being a user of services. This has been the main form of involvement in the form of asking users of services to 'feed back' their experiences or to act as representatives of a collective of other users of services.

This has often led to both frustration and incomprehension on the part both of the involved service user and the representatives of the service itself. The Big Society view is that this frustration arises for two reasons: from an invitation to be involved that does not allow opportunity to actually change things; and not feeling that one has a real stake of ownership in the thing in which one is involved.

In some areas it will be a matter of engaging with a broad range of existing organisations, services and groups that people with mental health difficulties use. In others there will be a focused effort to engage people with mental health difficulties 'where they are at'.

A Big Society approach to improving mental health and wellbeing will involve supporting ethnic, national, faith-based or sexuality-based communities to support people with mental health difficulties. This will involve going to people where they are and working with organisations, institutions and groups that they already trust and use. In many cases these will not be organisations that specialise in mental health, but established community groups, including faith groups and other established forces active in communities.

### Engaging with the wider community

Part of a Big Society approach to mental health is building up a storehouse of knowledge in the wider community of the impact of mental health difficulties on those who experience them and the ways that people can be supported. Building greater community understanding will help to avoid mental health difficulties being taboo and, in doing so, help to reduce many of the social factors that increase the impact of mental health difficulties on people's lives.

The key to this form of engagement is a flexible approach: meeting people where they are and delivering information in a way that engages them by answering the questions that they have – as opposed to reeling off a list of facts. Local organisations and relationships will be vital in this.

By using people and relationships, the NHS and local authorities can use a locally driven Big Society model to raise awareness and bring about change. The approach can be fitted to the people to whom it is speaking.

## Key issues

### How do we open up the landscape and work together?

In the context of reduced overall spending, the NHS and local authorities must be able to work strategically with local organisations to make sure that needs and aspirations are met, at a time where demand for mental health support and services will rise and where budgets will be stretched.

### Where's the money?

Many organisations whose services support the work of the NHS and local authorities have previously been funded through block grants from local councils. They are now having funding cut, often with the expectation that they will be ready, willing and able to sell their previously grant-funded services to service users with personal budgets. How will these organisations be funded in the future?

### Oppositional relationships

A Big Society approach means ensuring that involvement is meaningful. Involvement is not an object that a service possesses, but a process that it is undertaken and a principle at the heart of its structure.

Where this does not happen, a small group of vocal service users will take any opportunity for engagement with NHS and local authority decision makers to 'speak to power'. Simultaneously, the NHS and local authorities refrain from greater involvement based on the views of the small vocal group which it most usually encounters. It's a deadlock that stops either side from unlocking the potential of the other.

### Risk

The NHS and local authorities tend to see their roles as 'looking after' people with mental health difficulties. This focus on risk and safety, while often welcome when deployed in the right situations, can lie like a stifling blanket over the possibilities for people with mental health difficulties to do what they choose to do with their lives and with their time and energy.

The Big Society approach is the belief that people with mental health difficulties are better placed to decide what they should do than the state.

## Introduction

The Big Society is an attempt to pass power and influence back to communities and individuals by decreasing reliance on state solutions to social problems and building new ways for people to get involved and make a difference in their communities.

*Building a stronger civil society*, published in October 2010, outlines the three core components of the Big Society policy agenda:

- **Empowering communities:** giving local councils and neighbourhoods more power to take decisions and shape their area.
- **Opening up public services:** the Government's public service reforms will enable charities, social enterprises, private companies and employee-owned co-operatives to compete to offer people high quality services.
- **Promoting social action:** encouraging and enabling people from all walks of life to play a more active part in society, and promoting more volunteering and philanthropy.

The ongoing launch of Big Society coincides with the plans for significant NHS re-organisation outlined in the Health and Social Care Bill 2011, the new mental health strategy for England – *No health without mental health* – changed priorities in public health, changes to local council responsibilities and budgets and alterations to the benefits system.

A number of established and long cherished principles within mental health fit very well with Big Society ideas:

- **Personalisation, the recovery model and wider wellbeing**, all of which require a new relationship between individuals and the services they receive.
- **Co-production**, where professionals that work on a service collaborate with those who will use that service to design it and make it work, requires new approaches to involvement and new ideas of ownership of both practice and services.
- **Peer services**, where people who have experienced a particular situation use their experience to deliver support to others experiencing similar also present an opportunity that meshes well with Big Society ideas of self-determination and community problem solving.
- **User-led organisations**, where people with mental health difficulties lead and manage their own organisations and services.

- **Developing choice and putting those who use services in control**, where people with mental health difficulties have a real choice in the support they receive and real influence over the support available.
- **Supporting people in their communities**, where the needs of people with mental health difficulties are met by organisations and services that grow from their community and the challenges they face rather than being imposed on them.

However, it is no secret that the Big Society and the context in which it is being enacted have raised anxieties for people as well as inspiring them.

People with mental health difficulties are concerned that a Big Society approach could leave them further marginalised. The feeling is that opportunities to take power into their own hands will not be extended to them in the same way as it is to people who do not experience mental health difficulties.

People with mental health difficulties are particularly anxious that existing stigma against them may leave them excluded from wider community activities stimulated by the Big Society. They worry that they may be 'included out' by the communities of which they are part.

The challenge in mental health is to ensure that, as the roles of the public sector changes, people with mental health difficulties are enabled to be active agents in shaping their own lives and active participants in a wider Big Society.

# 1. What are the opportunities for better mental health in a Big Society?

The Big Society grows from a number of different traditions of thought drawn from many different parts of the political spectrum. Its heritage ranges from the working-class mutual traditions of the co-operative movement, notions of community organising drawn from American radical thinkers like Saul Alinsky to conservative thinker Edmund Burke's belief in the 'little platoons' of self-help activity that people belong to in society.

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In *Building a stronger civil society*, published in October 2010, the Government outlines the three core components of the Big Society policy agenda:

- **Empowering communities:** giving local councils and neighbourhoods more power to take decisions and shape their area.
- **Opening up public services:** the Government's public service reforms will enable charities, social enterprises, private companies and employee-owned co-operatives to compete to offer people high quality services.
- **Promoting social action:** encouraging and enabling people from all walks of life to play a more active part in society, and promoting more volunteering and philanthropy.

While there is still debate about what form the Big Society will actually take, there are general common points which run through the majority of expressed Big Society ideas:

- Communities can find solutions to their own problems given the space and support to do so.
- People coming together voluntarily can create solutions that contribute towards meeting needs traditionally met by public sector provision.
- Decision making, wherever practical, should be local and inclusive.
- Any form of monopoly provision creates difficulties.
- Communities value structures in which they have an ownership stake.

For the NHS and local authorities the Big Society coincides with great changes. These include: NHS re-organisation outlined in the Health and Social Care Bill 2011; the new mental health strategy for England – *No health without mental health*; changed priorities in public health; changes to local council responsibilities and budgets; and alterations to the benefits system.

The challenge in mental health is to ensure that, as the roles of the public sector changes, people with mental health difficulties are enabled to be active agents in shaping their own lives and active participants in a wider 'Big Society'.

### 1.1 What does the Big Society mean for mental health?

Commonly, people with mental health difficulties complain that they lack the ability to influence the treatment they receive and face a lack of choice of non-medical support services. Many are left with an overall feeling of getting to where they want to despite the support they receive rather than because of it. For some, the experience of interacting with services that are inflexible and over which they can exercise little control in fact contributes to the overall sense of disempowerment they feel during a period of mental ill health.

Within mental health there has been a perceived paternal orientation towards 'you'll get what you're given', compounded by limited resources and high demands for services. The Big Society approach provides an opportunity to challenge this unhappy and uncomfortable situation.

The Big Society approach recognises this experience as one shared by many recipients of public services and in doing so presents a number of opportunities for remaking the ways in which we think about the provision of services for people with mental health difficulties.

These can be broadly grouped into three themes:

- New forms of involvement and community engagement.
- New forms of relationship between individuals, communities and the state.
- A new landscape for provision where the NHS and local authorities increasingly become actors amongst many in meeting the needs of communities.

There is potential to develop these three broad Big Society themes in ways that mutually reinforce each other based on a direction of travel wished for by many people with mental health difficulties themselves.

A number of established and long cherished principles within mental health fit very well with Big Society ideas. At an individual level, **personalisation, recovery** and **wellbeing** require a new relationship between individuals and the services they receive.

At a service delivery level, **co-production**, where professionals that work on a service collaborate with those who will use that service to design it and make it work, requires new approaches to involvement and new ideas of ownership of both practice and services.

**Peer services**, where people who have experienced a particular situation use their experience to deliver support to others experiencing similar, also present an opportunity that meshes well with Big Society ideas of self-determination and community problem solving.

Big Society presents possibilities for advances in the way that people who are experiencing mental health difficulty are supported. It also suggests pathways towards people with mental health difficulties escaping from the position of being passive recipients of services and becoming true partners in defining the direction of the support they receive.

## 1.2 Mental health – a whole community approach

As *No health without mental health* makes clear, mental health is an area of public health that does not respect boundaries, professional divisions or silos. Mental wellbeing is an issue that concerns individuals, communities and the services that support them.

While provision of timely and appropriate treatment is vital for the mental health and wellbeing of individuals, it is one part of the life experience of a person with mental health difficulties. Paradoxically, many individuals with enduring mental health difficulties express that while this treatment is vital, it is also one of the least important aspects in what they feel keeps them well.

When the role of the NHS in the provision of mental health services was conceived, mental health was a very different beast and so was the NHS. As understandings of mental health difficulty have changed and aspirations of those with mental health difficulties have risen, new responsibilities have been bolted onto the NHS's core job of providing treatment.

This has led to a kind of historic mistake, where the NHS has spent money on providing services that it is not best placed to provide – non-medical services that support people’s wellbeing in the community. Allied to this, the NHS has often been reluctant to support organisations who can offer these services because of their inability to offer an evidence base as expected for a medical intervention.

A Big Society approach challenges the NHS, working with local authorities, to develop their role as enablers of individual and community action as well as a provider of core services. In doing so, the NHS can act as a catalyst for the creation of mental wellbeing in communities rather than occupying a position as the final port of call when all other options have been exhausted.

One of the most radical possibilities of Big Society is the breaking down of barriers and divisions between different types of people working towards a common social good. Often public services, charities and community groups have worked in their own separate spheres, only coming together when each needs something from the other. Big Society suggests ways these different forms of organisation can work together as peers, aware of the different role each has, but finding exciting new ways of bringing those roles together to best meet the wishes of those that need them.

Some people with mental health difficulties may want to work together to form their own organisations and informal groups to support their mental health and wellbeing. The Big Society approach challenges the NHS and other state actors to support these organisations as partners, rather expecting them to adapt and conform to existing approaches to service delivery.

As people with mental health difficulties are given the opportunity to determine what forms of support they find most useful, we may find that some of the things that develop don’t even resemble what a medical model of support would have suggested would be the form they would take.

In fact, people may decide that what is most useful for their recovery and ongoing wellbeing isn’t medical at all.

## **1.3 Big Society concerns**

It is no secret that the Big Society and the context in which it has been enacted have raised anxieties for people as well as inspire them.

As a section of society disproportionately dependent on both health services and the wider welfare state, people with mental health difficulties are understandably worried about the impact of reductions in public sector budgets on the services and support they receive.

While many people with ongoing health needs welcome the move towards personalisation – in both health services and social care – many are concerned about whether the personalised market will develop in a way that actually provides them with the choices of services that they want and need.

More broadly, people with mental health difficulties are concerned that a Big Society approach could leave them further marginalised. The feeling is that opportunities to take power into their own hands will not be extended to them in the same way it is to people who do not experience mental health difficulties.

People with mental health difficulties are particularly anxious that existing stigma against them may leave them excluded from wider community activities stimulated by the Big Society. They worry that they may be ‘included out’ by the communities of which they are part. Some also worry that they will be expected to ‘sort their own problems out’ without support.

As a group that are already more likely to experience unemployment, other health difficulties and social exclusion, there is a concern about what a Big Society approach could mean. As it is rolled out in geographical communities, people with mental health difficulties may find themselves disenfranchised or, at worst, actively acted against.

Even where community activity is directed towards supporting people with mental health difficulties, many people with mental health difficulties are concerned that the Big Society may focus too heavily on volunteering.

Volunteering is generally understood to mean giving your time and labour for free to something that already exists and is run by someone else, rather than coming together with others to use your time and labour on something you have created and in which you have a real stake.

Many people with mental health difficulties engage in volunteering and benefit from the positive work of community organisations supported by volunteers. The problem is that conventional forms of volunteering do not enable people with mental health difficulties to move from being involved in structures set and defined by others to being active agents in shaping their own lives and their own communities. People can remain defined as “that service user who volunteers in our service user volunteering project”.

For the purpose of this paper, we will be focusing more closely on the activity that can be described as voluntarism or community self-help. In practical terms this is **people coming together voluntarily to undertake actions that benefit themselves and/or others.**

### Concerns and questions

‘Big Society’ is a term that arouses strong feelings for many. How do we make sure that our actions help people to see the opportunities in Big Society while setting to rest some of their fears?

Big Society is a contentious term and one that is impossible to extricate from the current political and economic moment. In many cases, its strongest critics as a political idea have also been those already most committed to many of the things that it represents. How do we position ‘Big Society’ ideas in ways that generate positive action and which retain local ownership?

## 2. Opening out the service landscape – new collaborations

In the current economic climate, it is evident that budgets and resources within the NHS and local authorities will be stretched over coming years. Mental health has, in the eyes of many, been a traditionally under-funded area of activity.

The direction of travel in policy terms is the opening out of the provision of services to ‘any qualified provider’, creating a landscape where the NHS is one provider of services amongst many.

This process will open opportunities for communities to create new services and shape existing services to meet local need and ensures choice and agency for those in receipt of them.

As *No health without mental health* argues, mental health and wellbeing is not just the responsibility of individual walled-off services but something where a variety of different types of service can have a great impact.

Linking with personalisation, recovery and wellbeing, this creates a landscape where individuals with mental health difficulties have the potential to be involved in a far more direct way in determining the types of services they receive, the kinds of organisation from which they receive them and, ultimately, the form that these services take.

This will be a process of evolution, where the NHS remains a major player in an increasingly colourful and varied landscape, and where new bodies will have increasing influence over services and decisions.

The NHS and other medical providers deliver medical services well. Few community organisations and other user-led groups are in a position to compete for or replace these services. However, a key Big Society challenge for the NHS is to ensure that the introduction of ‘any qualified provider’ does not coincide with a situation where non-medical services – previously supported through either commissioning or grant funding – disappear completely.

Conceptions of mental health and wellbeing have evolved greatly since the creation of the NHS, as have the expectations and aspirations of those experiencing mental health difficulties. In some senses, there is an inherent conflict for the NHS between providing specialised care and treatment in mental health and taking a holistic approach to mental wellbeing. Smaller, more flexible, non-medical projects and organisations can meet these needs where the NHS cannot.

Similarly, innovation in service delivery is a vital but expensive business. Within large organisations innovation is expensive. Small community based organisations and projects are less likely to carry expensive overheads and have more flexibility in how they resource projects. They do not carry the weight of the NHS on their backs.

It is vital that the NHS alongside local authorities and GP commissioners can recognise where resources are needed and where services and organisations from various sectors can contribute significant benefits. The task is for the NHS and local authorities to be able to deploy the right help, support or resources to enable a particular project, service or opportunity to happen.

A significant area of difficulty lies in the funding, resourcing and supporting of groups and organisations led by people with mental health difficulties or which have been built upon co-produced lines. These groups may be in a position to be contracted to deliver services, but need additional support and expertise to do so effectively. Seeing them solely as additional means of service delivery can neuter their potential to deliver real innovation and change.

Often the process of securing service delivery contracts lies beyond the reach of groups that have come together to meet specific community needs. Reconfiguring these groups or organisations as service deliverers often removes their potential to remain flexible and to innovate.

The objective must be to create the optimum situation for these organisations to grow and develop as these groups that will increasingly be the conduit between the NHS and the community, will enable the NHS to meet goals within mental health that otherwise would be difficult to achieve.

An under-examined area of opening out services is the goal of changing culture within services from “It’s not my job to help” to “How can we help make this idea work?” Greater collaboration across professional and community boundaries will require a new approach to engagement where those within organisations feel free to reach beyond traditional boundaries and silos.

### Concerns and questions

Given the current shifting state of commissioning and ongoing changes to decision making with the NHS and local authorities, how can we make sure that we support the development of local service landscapes that offer real choice and quality to people with mental health difficulties?

How will the ‘new’ NHS and social care work with local organisations to get things to happen? Will new structures be needed?

Will the ‘new’ NHS and social care move from commissioning services to enabling action and how will value and results be measured? How will quality be guaranteed in a more diverse landscape of services?

### 3. Remaking the relationship between individuals and the services they receive

The specific determinants of mental health difficulty are hard to pin point. What we do know is that life situations play a large part in how 'well' someone is within the context of their condition.

The services that help, support and enable in the rest of life outside of the consulting room or hospital, they make people feel they are getting somewhere with life. These are the areas where the NHS can struggle and where, at a time of upheaval, a Big Society approach can be most helpful.

Big Society is a new idea in government but, in many local areas, the NHS and local authorities are already supporting – and in some cases delivering – services and projects that use a Big Society approach to support people with mental health difficulties.

By supporting the development of community groups, local charities and social enterprises either directly or via other bodies, the NHS and local authorities have already been laying the foundations for people with mental health difficulties to make things happen for themselves away from state services.

Developing the Big Society in mental health means learning from existing work that uses Big Society approaches while also understanding the potential impact of new developments in service provision, particularly the move towards personalisation.

Based upon the fact that the Big Society is local people responding to local conditions, the Big Society in mental health will feel less planned and more chaotic, but this is the reality of creating services and activity from the 'bottom up'.

In many areas, the pieces are already in place to facilitate a new relationship between people with mental health difficulties, service providers and the NHS and local authorities. The challenge for the NHS is to recognise this and enable these relationships to survive and flourish.

The question is how we move to a more open attitude where "How can we help make this idea work?" is more prevalent than "It's not my job to help"?

The historic division between services, communities and individuals creates barriers to successful outcomes. Traditionally, involvement of service users in services has meant inviting people to comment on what help and support they might need and to feed back upon what they and others are already receiving. The Big Society approach suggests a far more radical solution: supporting people to make their own choices and develop their own ideas, projects and services.

Personalisation, recovery and wellbeing are previously existing ideas that fit comfortably within a Big Society approach to mental health, extending the frame of reference for mental health services beyond traditional boundaries. All three place individuals at the centre of remaking the delivery of services by:

- People receiving services that suit them, their needs and their aspirations increasingly using personal budgets to achieve this **(personalisation)**.
- Defining their own measures of progress and defining their own path towards the best life possible **(recovery)**.
- Seeing mental health not as primarily a medical issue, but one that has determinants across the whole of someone's life, both as an individual and part of a community **(wellbeing)**.

Co-production and peer services provide models for people with mental health difficulties to be active agents in service delivery rather than passive recipients of services. In supporting these models, the Big Society approach provides a way to make sure that people who experience mental health difficulties do not become submerged in an identity as a patient or service user.

In doing so, it has the potential to move the provision of support and wellbeing related services outside of traditional NHS and local authority structures and into a community-based, vibrant, organic landscape of different opportunities, organisations and groups.

## 3.1 Personalisation

Personalisation, or ‘nothing about us without us’, will mean that individuals will be recipients of care and support that meet their needs and aspirations. It means that no longer will users of service be passive, accepting a standard offer. In each case, service responses will be melded to meet unique individual needs through an equal partnership of the service user and professional. Increasingly, people will achieve this as the direct purchasers of services through the use of personal budgets.

While there are ongoing national pilots of personal budgets within the NHS, some of which involve people with mental health difficulty, the major short-term impact of personal budgets is in the field of social care.

As of April 2011, anyone assessed by their local authority as having social care needs should, in theory, be offered a personal budget to spend on services or support to meet those needs.

In giving real spending power directly to service users, personalisation is part of a Big Society approach in itself, however personal budgets are spent. Beyond that, greater personalisation, both in social care provision and ultimately within the NHS, potentially offers significant opportunities:

- For user-led organisations **and** peer services to provide services that can be purchased through personal budgets.
- For user-led organisations **and** peer services to provide services to support people with mental health difficulties in spending their personal budgets to meet their needs.
- For groups of people with mental health difficulties to pool some of their personal budgets to pay for services (or other support) that meet their needs.

This potential has been recognised by government in the launch of the Strengthening Disabled People’s User-Led Organisations (DPULOs) programme in July 2011.

In the field of social care, work by local authorities to prepare existing user-led organisations for the coming of personalisation has been distinctly patchy. There is potential for the NHS to play a greater role in supporting these organisations to bring their services to the market.

The Big Society ideal for personal budgets is that service users end up with a wide choice of options for meeting their needs including sustainable service provided by user-led organisations. It also envisages opportunities to use personal budgets to ‘do their own thing’ and work out solutions that meet their needs and aspirations outside of a structured framework of service provision.

Possible examples include:

- A group of people who had previously used a day centre which was closing due to reduction of funding, pooling some of their individual budgets to pay for the continuation of some of the services it delivered.
- A group of people with mental health difficulties, in collaboration with a local group or organisation, using elements of their personal budget to support the development of a service that they’d really like to use.
- A group of people with individual budgets setting up and running their own activities, buying in professional support – such as the services of a support worker and transport – to help them to explore their local area and visit places of interest.

This would, very directly, put individuals and groups of individuals in the driving seat of remaking services at a more local level and would be helped greatly by a “How do we make this work?” enabling attitude.

### Concerns and questions

The NHS Confederation report *Personal health budgets: the views of service users and carers*, found that only a minority of service users surveyed would take up personal health budgets. There was a strong thread of dissatisfaction with current services but also a lack of belief that mental health services were ready to let people decide services for themselves. They found “skepticism over how effective this policy can be at challenging established clinical and organisational cultures. Participants thought that mental health services would have to first become much more person-centred if personal health budgets were to work.”

What will make this culture shift happen and how will people with mental health difficulties know?

## **3.2 Recovery**

The recovery model goes hand-in-hand with personalisation in delivering a Big Society approach to changing the relationship between people and the services they receive. The recovery model is based on the idea that people must find ways out of the disempowering role of patient or passive recipient of support and look towards building an autonomous and meaningful identity that is not defined by their condition.

Rather than the conventional idea of clinical recovery, the recovery model is based on the concept of personal recovery; finding a meaningful and satisfying life after a period of mental health difficulty, whether you are still experiencing symptoms or not. It was developed by people who had experienced mental health difficulty in answer to the clinical recovery model.

Definitions of this form of recovery differ but most agree on the following four components:

- Finding and maintaining hope.
- The re-establishment of a positive identity.
- Finding meaning in life.
- Taking responsibility for one's life.

This form of recovery is not about returning 'back to normal' after a period of being unwell, but finding new ways of being and living that take into account the fact that your experiences of mental ill health might have changed you and how you feel about life.

The recovery model puts the individual at the heart of defining what the outcomes for her or his treatment should be. It takes as its very principle the proposition that services should not try to judge where an individual should end up. Rather they should support them in their journey toward the point that they define, which may encompass far more than medical measures of freedom from symptoms. In actuality, recovery represents a way of acknowledging that the needs of individuals with mental health difficulties may change over time and fluctuate depending both on conditions but also life situations.

Bringing recovery and personalisation together is the perfect antidote to the disempowering experience of 'get what you're given' services.

It therefore makes sense to look at new ways of providing support and services that build in flexibility, choice and involvement.

## CASE STUDY: RECOVERY COLLEGE

South West London and St George's Mental Health Trust opened their Recovery College on the Springfield Hospital site in Tooting, London on 20 September 2010.

It aims to pioneer new ways empowering people with mental health difficulties to be experts in their own recovery, live well and make the most of their skills and talents.

The college represents a first step in co-production and peers services, with courses which are delivered by mental health professionals as well as former service users. The courses range from teaching people about specific mental health conditions and approaches to managing them, through to ones aimed at supporting people into employment. Courses are also open to staff and carers (including family and friends).

The college provides opportunities for people with mental health difficulties to develop and deliver training courses on a level playing field with professionals and creates a space that is responsive to the needs and wishes of people with mental health difficulties.

The trust sees that the college will be central to training staff in their roles and providing development for them, often provided in partnership with people who experience mental health difficulties themselves.

### 3.3 Wellbeing

The gradual move to a wellbeing-focused approach represents a fundamental reconfiguration of the way in which the NHS regards its role in the lives of the people who use it. Rather than asking the question "What do we do for people who are ill?", it poses the question "What do people need to be well?"

In a mental health context, this presents a number of challenges and opportunities:

- The first is the challenge already recognised by *No health without mental health* and its emphasis on early intervention. Early intervention takes a reorientation of services to recognising what needs people have and meeting them as quickly and efficiently as is possible.
- The second challenge and opportunity is that a wellbeing approach extends the terms of engagement in mental health far beyond the walls of the consulting room, GPs surgery or ward. Wellbeing is about helping people to make changes in their lives.

One element of a Big Society approach to mental health is supporting services that promote greater mental wellbeing in the community as a whole and working with people and organisation that are close to communities. It will take moving mental health out into the community in new ways.

### CASE STUDY: MINDAPPLES

Mindapples is a social enterprise that builds on the '5-a-day' idea – that encourages people to eat five servings of fresh fruit and vegetables per day – to encourage people to undertake five daily activities to look after their mental wellbeing.

Mindapples invite us to join an online community of people sharing their '5-a-day for the mind' and supporting each other to promote better mental wellbeing. The aim is to normalise the idea of taking care of your mind, making it "as natural as brushing our teeth".

The Mindapples approach is currently being piloted in the waiting rooms of a small number of GP surgeries in South London. Patients are invited to write their 5-a-day for the mind on a paper leaf and attach it to a Mindapples tree. The responses are being collated to give a picture of approaches to mental wellbeing and those who chose to provide an email address can receive follow-up support in improving their mental wellbeing.

## 3.4 Co-production

For NESTA, whose public services lab is currently looking at the role of co-production in public services, co-production means moving away from 'doing public services to people' to 'organising public services with people'.

NESTA's six suggested features of (most forms of) co-production are:

- Recognising people as assets.
- Building on people's existing capabilities.
- Mutuality and reciprocity.
- Peer support networks.
- Blurring distinctions (between professionals and recipients).
- Facilitating rather than delivering.

Many ideas within a Big Society approach could be seen to involve elements of co-production, and co-production principles can be used to modify existing services and develop new ones.

Co-production is not about building a service then asking people what they think of it. Co-production is about finding ways of working with people to develop things over which there is a shared ownership. It is not co-production if any of the individuals involved in the process cannot influence its outcome, its aims and its direction.

Co-production by its very nature is about getting ideas, expertise and people out of their silos and isolated positions in services and the community and bringing them together in new ways. It can seem a very small process initially lacking the ability to make sweeping changes across whole services, but it can lead to small innovations that in turn have large impacts over time when implemented.

Typically, co-production will involve a process that features the following stages:

- Sharing of perspectives on a particular issue or objective.
- Reflecting on ideas brought to the co-production project.
- Capturing emerging ideas and then developing them.
- Establishing new viewpoints (finding ways of stepping out of entrenched positions).
- Facilitating dialogue between co-producers and relevant potential stakeholders.
- Creating prototypes of new 'products'.
- Finding and establishing backing from those who have an interest in taking ideas forward to the testing stage.

The NHS and local authorities have the potential to be the catalyst for helping these forms of co-production to develop and flourish in mental health practice. This will mean finding ways of applying established models in new settings in order to put people in control.

While the NHS or local authority may not end up as the sole 'owner' of the finished project, idea or innovation they do have the potential to create co-produced projects that help meet their overall mental health objectives.

## CASE STUDY: STAR WARDS

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Star Wards is a purposeful 'bottom up' initiative to change mental health inpatient care for the better. It is based on the idea that ward staff together with patients can make inpatient wards better places to be and that working together they can take change to decision-makers.

The initial Star Wards target is the implementation of 75 different small changes to practice, all based around moving the culture and practice of the ward toward meeting the needs of patients rather than meeting the needs of the running of the ward.

It harnesses a 'can-do' spirit by inspiring small changes from the 'shop floor' which meet the needs of patients directly. It is an excellent example of the way that ideas from 'outside' of big management structures can unlock the individual initiative of people to get things to happen. Star Wards describes its unique features as:

- Patient-led initiative.
- No 'baggage' in relationship so easier for wards to identify with and feel warmly towards ability to make and implement decisions very quickly.
- Ability to get (and spend!) funding from a range of charitable, private and statutory sources relatively swiftly.
- Can be unorthodox, innovative/risky, fun, personal/warm.
- Unswerving emphasis on what's going well in services – comparable to 'appreciative enquiry' approach, and infectious nature of this positivity and 'can do' approach.
- Easy accessibility, for example, membership, events, first set of publications all free of charge.
- Style of information, events very friendly, attractive and intelligible.

Marion Janner, the force behind Star Wards has mental health difficulties herself. As she says: "I've got borderline personality disorder, and my mental illness and occasional hospitalisation enable me to run Star Wards, but also seriously impedes my ability to do so. The incapacitation and self-destructiveness that accompany BPD place a considerable strain on colleagues, the organisation and supporters. Star Wards was inspired by my first admission to St Ann's in Tottenham."

According to their 2010 impact report, 80 per cent of wards in the country are currently Star Wards members. Star Wards-related activities have reportedly improved ward atmosphere on over 85 per cent of wards, with over a quarter (26.6 per cent) reporting a 'big' or 'massive' difference. Involvement with Star Wards has led to an increase in patient-focused activities on over 83 per cent of the 188 wards, with over a third (36.2 per cent) reporting a 'big' or 'massive' difference. Respondents describe a wide range of creative, innovative initiatives and new facilities that have been introduced.

### 3.5 Peer services

In many senses, peer services are the purest forms of service user involvement and community self-help. They were Big Society before the Big Society approach was developed.

They are about people who have personal experience of a particular situation or condition delivering services to others in a similar position. When these services are run by people with mental health difficulties themselves they are known as User-Led Organisations (ULOs).

Many such services grow from groups of individuals coming together voluntarily in the community to address needs that, based on their own experiences, are not currently being met.

They often run on a combination of passion, pragmatism and bloody-minded commitment. They feel that their lived experience and everyday proximity to the lives of the people that they support better places them to see what it is 'really going on'. Organisations that come together in this way may lack some of the professional experience and resources to make the jump quickly into providing contracted or commissioned services, but this is by no means uniformly the case.

Running alongside the development of these self-help peer services are peer services created or seeded by state services themselves. Some of these will always remain part of the services that created them, relying on the parent service for administrative and professional support, while others will spin out into autonomous services themselves.

A key outcome of a Big Society approach to mental health will be increasing numbers of services delivered by individuals with direct experience of the life needs that the service meets. The Strengthening Disabled People's User-Led Organisations (DPULOs) programme in July 2011 can be seen as the first flowerings of this commitment.

Peer services do not have to be entirely staffed or delivered by people with direct experience. People with lived experience can and do develop organisations that use the skills, resources and experiences of people who do not share their lived experience to build, develop and deliver services.

Changes to funding models (see Personalisation on page 21) mean that those peer services that have been dependent on grant-funding or other public support may be at risk. If successful peer services cease to operate, this will be a significant barrier to success of Big Society approaches to mental health provision.

It is within the power of the NHS and local authorities to lend expertise and support peer services so they can attain the stability and continuity that they need to deliver the services that they define as important in a consistent and sustainable way.

### CASE STUDY: THE CLUBHOUSE MODEL

The Clubhouse model brings together co-production, though it may not call it that, and peer services. It generates the kind of fluid opportunities for involvement that community-based projects can develop.

Julia Perry, manager of Newcastle Clubhouse, a collaborative project in Newcastle Upon Tyne's west end spoke to One in Four magazine in February 2009:

“Newcastle Clubhouse is a service for people with mental health needs where staff and members run the Clubhouse together and share the decision making.

“We aim to be part of an individual's journey to recovery and not the final destination. We want members to feel part of our community, to gain support from one another, have the confidence to take control of their own lives and find new experiences outside of mental health services.

“Each day at the Clubhouse can be so different. Sometimes I'm working alongside members to get the midday meal ready, other times I'm looking at new projects for the Clubhouse to get involved with like trying to set up a community garden. Other days it's spending time with a member going through a difficult spell and trying to look for ways forward.

“Being able to work and having a job that keeps me motivated has been so important to my own recovery from mental health difficulties. I love being in a job and working as a team to help people discover meaning and purpose in their life and find their own way to recovery.

“If you visited our Clubhouse you would find members work with staff to run reception, cater for the main meal and refreshments in the kitchen, take care of all aspects of the building in the maintenance unit, keep us supplied with fruit and veg on the allotment or help promote the Clubhouse and deal with enquiries in the Information unit.

“We also have two social enterprises, The Sweet Centre and The Mad Sandwich Co., offer training in our computer suite, and run both formal and informal training courses as well as inviting other agencies in to run information sessions and surgeries. We currently have 120 active members. Coming to the Clubhouse is about confidence and having something to get out of bed for. Some people come to us feeling that they are not capable of doing anything and haven't any idea of what they want their future to be, they just know they want to do something.”

### Concerns and questions

It is clear that empowering people to take a Big Society approach to mental health will require a mixture of bravery, common sense, flexibility and determination. These qualities will be needed as much by people with mental health difficulties as they will be those providing them services.

How can the NHS and local authorities embrace the exciting opportunities for bottom up change that comes from people with mental health difficulties already engaged with services?

What opportunities are there in existing models to change levels of involvement?

What can the NHS and local authorities do to unlock problem solving and innovation from the bottom up?

How can the NHS and local authorities support the development of best practice while maintaining the flexibility to develop local solutions to local problems?

Where can mental health services learn for the practice in other fields? How can people come together in new ways to build new things and modify old ones?

How will we involve professionals, service users, carers and communities in this process?

## 4. Community engagement

Traditionally, the NHS and other public sector providers have waited for the community to come to them by setting up opportunities for involvement or funding, then awaiting response. We have a unique opportunity to remake this relationship. Instead of inviting people and organisations into the tent of the NHS or other large public sector organisations, we can build a new relationship with the communities of which they are a part.

The Big Society challenge is not just to find better ways to engage with existing service users – although this is important – but to engage with the wider community to create an environment that promotes greater wellbeing.

### 4.1 Engaging with service users

In most places in England people with mental health difficulties are involved in some consultation, some service co-design or co-production via community or charity organisations that provide services, provide advocacy or lobbying or which do a bit of both.

In a traditional sense, service user involvement is the by-product of being a user of services. This has been the main form of involvement in the form of asking users of services to ‘feed back’ their experiences or to act as representatives of a collective of other users of services.

Many involved as ‘service-user representatives’ or ‘voices of lived experience’ have found it difficult to see where their contribution has made a difference. At the same time many working closely with users of services have found it frustrating trying to take their views and needs to decision makers. There is a massive gap marked ‘involvement’ that has been difficult to fill for some services. Often there is a feeling that the people who use services and those who commission them are both speaking languages in which the other is not fluent.

This has often led to both frustration and incomprehension on the part both of the involved service user and the representatives of the service itself. The Big Society view is that this frustration arises for two reasons: from an invitation to be involved that does not allow opportunity to actually change things; and not feeling that one has a real stake of ownership in the thing in which one is involved.

Where involvement is successful there is often a broader range of voices at the table and work in place to engage with more. This is a matter of engaging with a broad range of existing organisations, services and groups that people with mental health difficulties use and a focused effort to engage people with mental health difficulties ‘where they are at’.

### CASE STUDY: COMMUNITY OPTIONS

Community Options is a London-based charity founded in 1990. Originally providing residential services to people with mental health difficulties it has grown through its lifetime to provide a range of support and activities.

In Tower Hamlets, Community Options runs a service user network funded by Tower Hamlets Adult Health and Wellbeing which supports 23 service user-led groups. These range from men’s and women’s groups providing a variety of different activities and support to specific communities (Bangladeshi, Somali, African Caribbean), to THEIS (Tower Hamlets Early Intervention Service), H.U.S.H (Hidden Universe of Self-Harm), Thursday Out Of Hours Group and THACMHO (Tower Hamlets African and Caribbean Mental Health Organisation).

Individual service users and groups are supported by Service Users Involvement Project (SUIP), which is funded by Adult Health and Wellbeing with the PCT and managed by Community Options. Groups can apply for funding and support.

The team also supply training, information that promotes recovery, and development and a wide variety of involvement opportunities to anyone on the Community Options mailing list. There is a quarterly forum called ‘Your say, your day’ facilitated by SUIP where people come to hear inspirational speakers, gain information on new developments, network and have the opportunity to put questions to a panel of service providers.

Through their existing position in the community, Community Options has been able to support the development and continuation of local groups that have arisen to meet very specific mental health needs.

## 4.2 Engaging with diverse communities

Mental health and wellbeing are perceived differently by different groups within society, and different groups of people in communities have very different views of NHS mental health services.

A Big Society approach to improving mental health and wellbeing will support ethnic, national, faith-based or sexuality-based communities to support people with mental health difficulties. This will involve going to people where they are and working with organisations, institutions and groups that they already trust and use.

The NHS and local authorities can work better with diverse communities through engagement with community organisations who already know the ‘lie of the land’. These organisations understand the hopes, wishes, ideas and beliefs of their communities, enabling them to frame mental health and wellbeing messages more effectively than the NHS or local authorities may be able to. In many cases these will not be organisations that specialise in mental health, but established community groups, including faith groups and other established forces active in communities.

### CASE STUDY: COMMUNITY DEVELOPMENT WORKERS

Sucaad Odowa-Nielsen was employed as a community development worker by Voluntary Action Camden as part of the national community organising programme Delivering Race Equality (DRE) in mental health which ran from 2005 to 2010. She spoke to One in Four in May 2009:

“My work is specifically with people of Somali descent – the second largest ethnic minority group in the London Borough of Camden. I am from Somalia myself, so I speak the language and am familiar with the culture. That’s a great advantage in my work, making people more comfortable around me and when accessing mental health services.

“Part of my work is as a change agent, identifying gaps in services or if services are not being accessed. I set up the Somali Mental Health Network, linking together ten different Somali community groups; we meet bi-monthly, and we discuss how issues around mental health are affecting the community. Community development work is all about partnership, and we invite people who provide mental health services in to speak with group members, to figure out how they might do a better job of helping members of the Somali community.

“One of the most important things that I discuss is the stigma attached to mental health in the Somali community. The only types of mental health difficulty recognised in the community are the more severe forms of schizophrenia and other problems which lead to psychosis and delusions. There’s very little acknowledgment of depression, anxiety, compulsive disorders or any mental health difficulties which people may have – and all of these can worsen over time if they are ignored.

“In any typical week I’ll be talking to Imams and community leaders, and providing what I call ‘Mental Health First Aid Training’ – two-day courses in how to understand and handle mental health difficulty.”

## 4.3 Engaging with the wider community

Part of a Big Society approach to mental health is building up a storehouse of knowledge in the wider community of the impact of mental health difficulties on those who experience them and the ways that people can be supported. Building greater community understanding helps to avoid mental health difficulties being taboo and, in doing so, help to reduce many of the social factors that increase the impact of mental health difficulties on people's lives. In the long term, changing attitudes will allow mental health difficulty to become an accepted normal life experience, reducing the prevalence of people engaging with services only at a point of crisis.

### CASE STUDY: TEA AND TALK

Helen Hutchings, a registered mental nurse from Devon, was given a new perspective on mental health and stigma when she began to experience mental health difficulties herself. "Some people found the idea of a mental health nurse being treated for mental health difficulty unbelievable," she says. "For me, being on the receiving end of treatment was a real wake-up call."

This led her to develop her own project for taking mental health awareness into workplaces, including workplaces within the NHS. In November 2009 Hutchings and her then project partner, Laura Newton, received funding from Open Up, the part of national anti-stigma campaign Time to Change that supports people with mental health difficulties making grassroots projects happen.

"We started Tea and Talk because we wanted to help reduce workplace stigma and discrimination in a meaningful way," says Hutchings. "We needed to do something short and effective to make people feel comfortable about opening up and we got the idea of bringing people afternoon tea. They started offering training services to local workplaces, arriving armed with teabags, cake stands and a lot of information about mental health. "People come into the room and they feel instantly welcome. They can have a cup of tea and there are cakes arranged on beautiful cake stands. I even string out bunting – it's a very visual experience, and an instant icebreaker, which is important, because the sessions only last an hour. It creates a positive, open atmosphere right from the start. In Devon, where we're from, people take teatime seriously!"

Hutchings believes that training about mental health in the workplace needs a new approach. "Training doesn't always look at attitudes and values in a meaningful way. Tea and Talk is partly about getting supervisors and team leaders to stop thinking about managing people and start thinking about supporting people," she says. "It's also about building positive relationships in the workplace, so if someone does start having difficulties, there can be more openness and understanding."

The key to this form of engagement is a flexible approach: meeting people where they are and delivering information in a way that engages them by addressing their concerns. There have been some excellent examples of this approach being used in IAPT (Improving Access to Psychological Therapies), but tied to other Big Society ideas it could become a mainstream practice.

Traditional awareness and engagement campaigns based upon large volumes of leaflets and posters can only deliver information in a fixed form to an implied audience. They only push information out. By using people and relationships, the NHS and local authorities can use a Big Society, locally driven, model to raise awareness and bring about change. The approach can be fitted to the people to whom it is speaking.

### Issues and concerns

How can the NHS build strong relationships with community groups, organisations and institutions and find ways of working together to raise mental health and wellbeing?

How 'new' will these relationships be and what will need to change in terms of organisational culture and operational practice to make them work?

## 5. Key issues

### 5.1 How do we open up the landscape and work together?

A Big Society approach can only be delivered properly if the NHS, local authorities and the voluntary and community sector work more effectively together.

In times where there has been ‘enough’ funding to go around, it has been possible for voluntary and community organisations to operate in parallel with NHS and local authority organisations with minimal interaction.

What interaction has taken place has often been based primarily either on public services needing help in carrying out consultation or engagement, or voluntary or community sector groups wishing to access funds.

In the context of reduced spending, the NHS and local authorities must be able to work strategically with local organisations to make sure that aims and aspirations are met, at a time where demand for mental health support and services will rise.

#### CASE STUDY: MENTAL HEALTH NORTH EAST (MHNE)

In the North East of England a range of organisations and individuals have responded to the need for joined-up action between the roles of state and voluntary sector agencies and understanding of how they relate.

At a regional level, Mental Health North East (MHNE) is a small umbrella organisation that was formed in 2005 to use the combined voice of voluntary sector organisations providing mental health services to represent the sector to government agencies.

MHNE works with locally based networks and forums to ensure that voluntary sector providers, including smaller user-led organisations are not ignored by commissioners and policy-makers.

At a local level, Newcastle-based Launchpad is an organisation that offers the chance for people who use services to have their voice heard by the people who run those services. An essential part of fulfilling that role is for Launchpad’s team to understand the landscape in which services are delivered.

That means attending all relevant meetings and committees with the local authority, local NHS agencies – knowing who is responsible for deciding what and on what basis – and creating opportunities for service users to make their voices heard to the right people in a way that is most likely to effect positive change. Says Alisdair Cameron of Launchpad: “We’re service users ourselves and fully understand that people need peer support, peer advice, impartial and honest signposting, a place where people feel safe in talking, a group not afraid to tell it like it is, a platform for taking concerns to the powers-that-be, an early warning system for flagging up ominous changes to mental health services, a space to work out what’s going on and what the best direction collectively and individually might be.”

### Issues and concerns

How will we begin the process of opening out and working strategically with community, social enterprise and charity partners?

How might it work in practice and how will it differ from what exists now?

## 5.2 Where's the money?

For any debate to remain credible when discussing how Big Society ideas might help develop and shape new ways of supporting people with mental health difficulties, it is impossible to avoid the discussion of money and resources.

With honourable exceptions, local authorities are themselves unsure about the practicalities of providing personal budgets. This has seen a severe lack of practical support available for groups who have been providing services funded by block grants but will in future need to sell their services to individual service users spending personal budgets.

NHS medical services have increasingly been responsible for provision of other sorts of services related to mental health. It has meant that many mental health-related activities have been thought of in medical terms (symptom/cure) rather than in social or responsive ways (need or aspiration/fulfilment).

To an extent, the process of securing resources within the NHS has necessitated framing non-medical activities in terms of medical outcomes (we are a medical organisation; therefore we must measure how medical our outcomes are).

For example, funding is more likely to be available for arts projects that specifically attempt to deliver therapeutic outcomes than for arts activities that have no specific therapeutic aim in themselves but may enhance wellbeing through enabling people to take part in a regular activity that they enjoy.

This has made it extremely difficult for the NHS to release money to organisations and projects where people with mental health difficulties have determined the aims or where services are being delivered based around mental health needs, but which are not, in themselves, medical.

As has been mentioned above, many organisations that have previously been funded through block grants from local authorities are now having funding cut, often with the expectation that they will be ready, willing and able to sell their previously grant-funded services to service users with personal budgets.

Many organisations, services and groups outside of the NHS run a significant risk of being unable to survive long enough to form the new kinds of relationships with service users and the NHS and local authorities that is needed to take forward a new patient-centred approach to delivering mental health.

This presents two major challenges for better mental health in a Big Society:

- 1. Withdrawal of state funding to refocus on ‘the frontline’:** With a reduction of funds available, it is natural that large state providers of services will want to bunker down and protect the vital services that they provide. While this protection of the frontline is essential and honourable, it effectively smothers at birth the possibilities inherent in Big Society ideas.
- 2. Reduction of reach and effectiveness:** Current relationships between the NHS and local authorities and the voluntary and community sector are predominantly based on having blocks of money which are provided to Voluntary and Community Sector organisations (VCS) in exchange for discharging some of its responsibility to provide services meeting an agreed set of targets.

A Big Society approach necessitates genuine partnership between the NHS, local authorities and VCS that extends beyond the NHS putting out a tender and VCSs putting in a bid – where the NHS and local authorities actively approach user-led VCSs in particular to find out about the people they work with and their needs, then work with these organisations to provide a combination of funding and support for the work they do.

### CASE STUDY

Service users of a small local charity have a great idea for a new project that would help people with mental health difficulties in their area.

The charity’s director approaches the person responsible for mental health at the local council, and they say: “That sounds great, we’re running another round of voluntary sector grants next year, why don’t you apply?”

She then approaches the person responsible for involvement at the local NHS mental health trust who says: “That’s a great idea, why don’t you raise it at next month’s consultation meeting for our new strategic plan.”

The results is that the manager of the small charity either doesn’t take their project forward, or does, but receives no support from the state agencies to do so – and has no reason to work in partnership with state agencies as the project develops.

### Issues and concerns

How can the NHS and local authorities promote a vibrant landscape of services, groups and organisations so that real choice exists for people with mental health difficulties?

How can funding community organisations, social enterprises and charities be used to enable new forms of working relationships?

## **5.3 Involvement and oppositional relationships**

Due to the historic evolution of involvement and decision-making in mental health, linked to a situation of limited resources, long waiting times and inflexible service delivery, there is a small but vocal movement of active service users.

These are people who have often become frustrated, not without reason, with the shortcoming of the current and past mental health systems.

Some but not all of these people with mental health difficulties see mental health services as uncaring, inefficient and morally compromised. They consider themselves to be engaged in a form of liberation struggle on behalf of themselves and other people with mental health difficulties.

The 'service user movement' in this form is a mirror of the inflexibility of older ways of NHS delivery and involvement and vice versa.

As underlined throughout this paper, a Big Society approach means ensuring that involvement is meaningful. Involvement is not an object that a service possesses, but a process that it is undertaken and a principle at the heart of its structure.

Where this does not happen, a small group of vocal service users will take any opportunity for engagement with NHS and local authority decision makers to 'speak to power'. Simultaneously, the NHS or local authorities refrain from greater involvement based on the views of the small vocal group which it most usually encounters.

There is a large 'silent majority' in mental health. It is vital in the evolution of the 'new' mental health (Health and Wellbeing Boards, Health Watch) that decision-making and involvement is not limited to a small, unrepresentative group of people with mental health difficulties.

Without the kind of new structures and relationships that this paper advocates this sterile and frustrating death dance will continue. It's a deadlock that stops either side from unlocking the potential of the other.

The example of the oppositional and suspicious relationship between independent ward visitors and the staff and management of wards they visit is a good example.

The motivation for these ward visitors often comes from their own experiences of poor care when in hospital themselves. They are an excellent example of the ways that NHS services might be improved by self-motivated people with mental health difficulties providing services to their peers. They can provide an excellent service to those in hospital while relaying 'bottom up' feedback to those that manage services.

In practice, there is often suspicion from existing staff on wards and a lack of clarity as to why the visitors come and what their role is. On the part of the visitors, there is a suspicion that their role is not respected, and that their feedback is avoided or ignored due to inflexibility in the way that hospital services are delivered.

While good outcomes happen in the present situation, more could be done to make further good things happen. This is a very real example of the community demanding to be let in to improve services and facing resistance in that process, but is also an example of oppositional attitudes confounding real benefits.

### Issues and concerns

What practical steps need to be taken to ensure oppositional relationships do not inhibit a Big Society approach to mental health?

How can NHS organisations change to better navigate relationships with communities and other organisations?

## 5.4 Risk

Risk is an idea that seems to hover over mental health like a dark blanket of cloud. Public discourse around mental health is suffused with it. It runs through every discussion of how mental health services might be better delivered.

Perception of risk and creation of extensive structures and processes to manage it are generally regarded as a major impediment to innovation in the public sector in a general sense. So much so that it often seems that the burdensome effects of risk management can be as negative as the potential dangers that they have been introduced to mitigate against. But perceived risk is a particularly significant issue in mental health, even when compared to the public sector as a whole.

Knowing that someone experiences mental health difficulties often brings into play a highly developed set of concerns about risk that would not be present if that person's mental health difficulties had not been disclosed.

The NHS and local authorities tend to see their role as a 'looking after' people with mental health difficulties, which can lead to a paternalistic concentration on preventing the possibility of harm to either themselves or others.

This focus on risk and safety, while often welcome where deployed in the right situations, can lie like a stifling blanket over the possibilities for people with mental health difficulties to do what they choose to do with their lives and with their time and energy.

We need a paradigm shift that addresses the question, “How can we accommodate risk when users make choices that challenge conventional solutions?” How can clinicians and other professionals find ways of managing risk without stifling possibility?

As we have discussed, at the heart of the Big Society approach is the belief that people are better placed to decide what they should do than the state. The Big Society challenge is that this is assumed to apply to people with mental health difficulties – as it is assumed to apply to others – unless there are specific reasons why it should not.

### **Issues and concerns**

How can we stop perceptions of risk from preventing innovation and from preventing people with mental health difficulties doing things for themselves?

## 6. What next?

The Big Society is, at its heart, about involving people more in the services they receive and helping them to see their own potential as individuals and communities to move beyond reliance on the state to meet all of their needs.

The Big Society will be local, it will be more responsive to ‘bottom-up’ influence, it will change how people think about the services they receive. To some this will feel like a welcome evolution, but only if it is backed up by practical, tangible actions.

To take on its role as enabler of change and action as well as deliverer, the NHS and local authorities must find ways of using its resources cleverly and responsively to make sure that people with mental health difficulties do not lose out.

Coming at a time of increased budget pressure for the NHS, local authorities and the public sector as a whole, it is impossible to duck the reality that new ways of making things happen need to be found.

The landscape is already a complex network of different forms of organisations, services and groups all working in some way toward the better overall mental wellbeing of the communities of which they are part.

People may be both patients **and** professionals, people may be working in the community but employed by the NHS or local authorities. Projects may be collaborations between different services. Individuals may spend some of their time working in peer services, some of their time working in more traditional roles. Solutions to problems may begin from a medical analysis of prevention, recovery or wellbeing but end up being enacted by a local church, a branch of an employment advisor, a small community group or a social enterprise.

What becomes clear is that for this mixture of different organisations to work together in a way that generates the greatest possible outcomes for all parties in a community, there must be something that stitches them together.

This paper tries to put on the agenda many of the ways in which a new relationship between people and services might be forged and the ways in which the NHS and local authorities can find new ways of making things happen in mental health. It does not seek to underestimate how challenging such a potentially radical change in roles may be.

If change is inevitable, how can the ideas in the paper make sure that this change delivers the best for people with mental health difficulties and for the mental wellbeing of the community as a whole?

How will NHS and local authority mental health services interact with the broader effects of Big Society? How will it bring people into its structures, but more importantly how will it open them out so that it is possible for normal people with mental health difficulties to make change happen?

Just how, and when and where will mental health 'open up'? How will the NHS and local authorities build on good ideas, find ways of supporting and enabling them and of making sure people with mental health difficulties get what they need and want?

And, as importantly, who will make it happen?

## 7. Conclusion

Throughout this thinkpiece we have pointed out that the Big Society idea is about more than volunteering.

It is about people coming together voluntarily to carry out actions for their own benefit and for the benefit of their communities. Many of our great social movements and innovations began with groups of people trying to make something happen.

One of the most exciting aspects of the Big Society idea is the potential for unleashing this can-do spirit in communities, be this through leadership, encouragement, service redesign or changed priorities. This will not happen spontaneously and will not happen without support and resources.

People with mental health difficulties are both part of a community of interest defined by their common needs and aspirations and also part of the wider communities in which we live. Putting people with mental health difficulties in control will involve more than asking for opinions on services already in existence.

Seeing people with mental health difficulties as people who can find solutions to their own challenges and ways of achieving their aspirations means taking a step on from seeing mental health simply as a range of conditions requiring care, support or treatment.

It is impossible to avoid the feeling that the landscape is shifting and this new landscape will require new solutions not 'more of the same'. Personalisation and the 'opening out' of public services provide potential mechanisms for this but do not necessarily provide a driver. One of the defining characteristics of innovation is that it can be stimulated and supported but is difficult to predict. It can sometimes be entirely new and sometimes the application of an older idea or practice in a new form or setting. The text messaging service on our mobile phones that we now find so indispensable was originally only a method for phone engineers to send service messages to each other. It was only when someone recognised the possibility of this as a method of communication that a company took a financial risk to develop it further with huge rewards for both them and for mobile phone users.

At the moment across the country there are similar flashes of brilliance in mental health that need to be nurtured and supported. Innovation happens in uneven and unplanned ways and comes from unexpected quarters. Investment recognises innovation where it finds it and supports it for mutually beneficial outcomes. The NHS and local authorities have significant resources to invest, not all of them strictly financial. Public sector bodies can choose to invest in people, ideas, projects, organisations or mechanisms.

If we are serious about our wish to transform the opportunities and outcomes for people with mental health difficulties, we need to support ways in which this can happen. It will be necessary to ensure that there is choice of existing providers of services and a wider range of different things from which to choose.

It will also be necessary to recognise that giving people greater control will involve more than just providing choice. It will involve understanding that the state may be the enabler of that choice without necessarily being the provider.

The question is not “How do we get people with mental health difficulties to help us make better services?” but “How do we make sure people with mental health difficulties and the communities which they belong to get the support, help and services that they want?”

We hope that the questions raised and the examples chosen here provide some ideas for making that happen and help to generate some more.

## 8. Appendix – the authors

### Mark Brown

Mark Brown originated and developed *One in Four* magazine, the lifestyle magazine written by people with mental health difficulties for people with mental health difficulties, and is its editor.

Mark uses his personal experience of mental health difficulty, unemployment and exclusion as a starting point for his professional work and is committed to innovation in mental health and to developing the capacity of people with mental health difficulties to make change for ourselves.

Mark is development director of Social Spider CIC, the small social enterprise that publishes *One in Four*. At Social Spider CIC Mark leads development of mental health related projects across a range of areas.

Mark is one of Community Care's Top 100 most influential social care tweeters 2011 and tweets prolifically about mental health as *@markoneinfour*.

Mark brings lived experience, knowledge of mental health policy and an intense enthusiasm and curiosity and drive to all of his mental health related work.

Mark was shortlisted for Mind Champion of the Year 2010.

### David Floyd

David Floyd is Managing Director of Social Spider CIC.

He is a trustee of Urban Forum and Voluntary Action Waltham Forest, a fellow of the School for Social Entrepreneurs and a member of the Council of Social Enterprise UK.

David writes the popular social enterprise blog, Beanbags and Bullsh!t:  
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