Developments in mental health service provision: views of service users and carers

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Abstract
This paper reports on a study in two NHS Mental Health Trusts in England in 2008-2009. Data were collected from staff, service users and carers to inform service and workforce developments. The findings reported relate to service users and carers and concur with staff views. They relate to modernisation of services, the challenges of a multiplicity of stakeholders and organisations, as well as the need to involve users and carers in developments. The findings resonate with national and local policy with a move away from traditional psychiatric care to integrated person-centred community care with a focus on recovery, rehabilitation and self care.

Keywords: Mental health, service users, carers, service delivery, organisation

Introduction

Development of mental health services has been a policy priority for health services over the last decade in the UK, along with requirements for its workforce (DH 2000, 2004a; DH/Care Services Improvement Partnerships, 2005; NIMHE, 2005; DH, 2006; NHS North West, 2008). An additional stimulus has been provided through the quality review of the NHS with a focus on quality care for all (Darzi, 2008). The more recent cross-government mental health strategy for England makes explicit the focus on mental health services and cross-agency working with prevention, outcomes and recovery for all within populations being requirements (HM Government, 2011 a,b,c).

Mental ill health is a substantial cause of disability accounting for 22.8% of the total burden in the UK compared to 16.3% for cardiovascular disease and 15.9% cancer (WHO, 2008). The economic costs of mental illness in England have been estimated to be £105.2 billion per year including direct costs of services, lost work productivity as well as reduced quality of life (Centre for Mental Health, 2010). For 2008/2009 the NHS spent 10.8% of its annual secondary healthcare budget on mental health services which accounted for £10.4 billion (DH, 2010). The service costs which included NHS, social and informal care accounted for £22.5 billion in 2007 in England (McCrone *et al*., 2008).

Relocation of mental health services from hospitals to also include integrated community care, the involvement of service users and carers in design and delivery of services, and the increasing development of evidence-based interventions, have directly impacted on service delivery and the workforce (SCMH, 2001; DH, 2006). For example, increasingly varied service provision and evidence-based care relies on a workforce that engages with a range of agencies across primary care, housing and social services, as well as specialist mental health and learning disability services (Reilly

et al., 2007). In addition, the review of Mental Health Nursing (DH, 2006) acknowledged the implications of new roles for nurses (for example, nurse consultant, modern matron, nurse prescriber, the development of the advanced practitioner), and new ways of working for psychiatrists and psychologists (DH, 2005a). 'Gateway workers' (DH, 2003a), 'support, time and recovery' workers (DH, 2003b), graduate primary health care workers (DH, 2003c) are novel and were further augmented by the requirement for 'talking therapies', such as counselling (HM Government, 2011d). As well as health and social care policy focusing on patients and care outcomes, there has been a drive for greater involvement of service users and carers as well as the empowerment of clinicians to innovate and improve services (SCIE, 2007; DH, 2010).

As part of a joint initiative and collaboration between two NHS Mental Health Trusts and a University partner, a needs analysis was commissioned to inform future workforce development strategies. A systematic review of policy and literature identified key drivers of mental health service provision that related to contextual issues surrounding mental health care services provision, general education and training and mental health specific education (Jinks *et al.*, 2008). Subsequently, the views and perspectives of staff and service user and carer representatives, within the NHS Trusts, on current and future mental health services provision and development were obtained. This paper reports the findings from service users and carers relating to modernisation and service development compared with those from staff perspectives and serves to inform the development of mental health services in context with the policy literature.

Methods

The objectives of this study were:

1. To identify the main challenges for future mental health service provision

and their implications for workforce development and service provision.
2. To explore service user and carer representatives' views on service provision and their future development.

Design
Evaluation research involving iterative working of the project team including service user representation was used. An evaluative framework was adopted which used qualitative research methods, involving semi-structured interviews and focus groups (Polit *et al.,* 2001).

Populations and samples

Samples
Each respective NHS Mental Health Trust partner identified potential purposive samples based on existing organisational service structures and functions and the project timeframe. Key executive director stakeholders from each Trust were identified for interview. Staff who participated in Learning and Development forums as part of the existing consultative arrangements were identified from each of the Trusts to participate in focus groups. Staff were representative of the professional groups providing services employed by the Trusts. Service user and carer representatives who provide user views as part of routine consultations to each of the Trusts were also identified to participate in service user and carer focus groups. Composition of the groups indicated that all the professional groups were represented on the forums and by virtue of being members of the group were committed to service and workforce development. Similarly, members of the service user and carers' forum were committed to improving service delivery.

A potential sample of eight stakeholders who were executive directors responsible for strategic and overall management of each Trust was identified. A potential sample of 120 staff (60 in each Trust) and 24 service user or carers (12 in each Trust) were also identified and contacted to participate in 10

staff focus groups and two service user and carer focus groups (5 staff and 1 service user focus group per Trust). One Trust contacted staff that participated in their Learning and Development forums and members of the service user and carer forum, while the other Trust widened potential involvement and sent out a general initial invitation to all staff via their intranet as well involving members of the service user and carer forum.

Methods of data collection

Data were collected from October 2008 to April 2009 and took place within locations in each of the Trusts. Analysis and write-up was undertaken from May to August 2009. Project management and data collection were undertaken by University staff, with liaison, coordination and access for data collection within each Trust by the respective NHS staff on the team. Invitation letters, project information sheets and informed consent sheets were sent to each potential participant and their willingness to participate in the project was requested by returning a completed slip in a pre-paid envelope or via email.

Interviews
Semi-structured digitally recorded interviews lasting up to 45 minutes were conducted with the key stakeholder directors. Information was collected on their current role, title, qualifications, local and national policy for mental health services organisation and delivery, current provision of learning and development, skills required by staff for future provision of mental health services and challenges.

Focus groups
A series of 12 focus groups were held (5 staff groups and 1 service user and carer group for each Trust), each lasting around an hour. Staff groups were either inter-disciplinary or uni-disciplinary. Participants were drawn from the professional groups employed at the Trusts including: nurses, psychiatrists, occupational therapists, social workers and clinical psychologists. Service users and carers were recruited from the Trusts' service user and carer meetings and their expenses were met and an honorarium available as part of Trust policy.

Two members of the University team acted as lead facilitator (LF) or note taker at each focus group. There are recognised limitations to the use of focus groups such as when more vocal members predominate (Jinks & Daniels, 1999). However, such difficulties can be circumvented by experienced facilitators, as in this study. The focus groups were tape recorded and adhered to recognised good practice (Morgan, 1993; Silverman, 1993; Cresswell, 1998).

Prior to data collection, informed consent was obtained from all participants. Semi-structured guides were used for both sets of focus groups (Figures 1 and 2). Before the staff focus groups were conducted participants completed an anonymous semi-structured questionnaire regarding their job title, location of work, academic and professional qualifications and any organised educational activities they had attended in the previous 12 months.

Figure 1 Questions Used in the Staff Focus Groups

1. What is your understanding of how services are going to evolve over the next five to ten years?

2. What skills do you think you will need in order to deliver these services?

3. How would you prefer to engage in the education/training evolving in order to meet your needs?

Figure 2 Questions Used in the Service User and Carer Focus Groups

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1. What skills would you like staff to have?

2. How can we improve the care that a service user would receive?

3. How do you think services should be developed over the next five to ten years?

4. What skills and learning development do you think staff will need in order to deliver these services?

5. From your role in this forum, what do you think are your skills and learning development needs?

Ethical considerations

Ethics approval for the project was obtained via the National Research Ethics Service from a Local Research Ethics Committee prior to commencement of data collection. Research Governance complied with existing University procedures and each Trust's R&D Committees as required by the NHS.

Written informed consent was obtained prior to data collection, to ensure participation in the study was voluntary, and assurance given that data were confidential and identities anonymous. Written informed consent was also obtained for the use of any direct quotes.

Data management and analysis

Data from the staff focus groups relating to participants' job titles, locations of work, academic and professional qualifications and any organised educational activities they had attended in the previous 12 months were collated and reported as frequencies. All recordings were transcribed and thematic content analysis of the qualitative data performed to identify key themes and sub-themes using the initial questions as an analytical framework (Denzin & Lincoln, 1998; Krippendorf, 2004). A minimum of two members of the project team undertook the thematic content analysis to identify the themes. These themes were discussed and agreed by three members of the project team and saturation of the data agreed. The themes identified relate to both interviews and focus groups.

Reliability and validity

Initial interviews and focus groups constituted pilot work to establish the feasibility of sample recruitment and methods of data collection. No changes were required to either the interview or focus group schedules. Validity was assured during the interviews and focus groups by ensuring lines of inquiry verified the accuracy and consistency of responses. Members of the project team were experienced in data collection methods and analysis, which also contributed to both reliability and validity. Reliability of the analysis was further assured by independent reading of the interview and focus group transcripts followed by discussion and agreement of the themes and sub-themes until saturation was obtained. The non-NHS institutional affiliation of the focus group facilitators and stakeholder interviewer added to the validity and reliability of the analysis and the interpretation of findings (Krueger & Casey, 2000; Wall, 2001).

Findings

The findings reported in this paper relate to the focus groups (FG), in particular those of service users and carers (SUC) and overlap with those of staff (S) related to the themes of modernisation and service developments.

A total of 64 respondents participated in the focus groups (50 staff; 14 service users/ carers) giving an overall response rate of 47%. Table 1 shows individual response rates. Due to the different approaches to recruitment/invitation to participate in the focus groups, a valid comparison between Trust response rates was not realistic although individuals expressing an interest did appear to maximise participation.

All clinical areas were represented in the staff focus groups with the majority coming from high secure or forensic services, elderly adult services and acute adult services. Staff participants came from a range of clinical, managerial or administrative roles providing a range of staff from each Trust, with the highest proportions holding nursing, non-professional or operational management roles. Most participants in the focus groups held nursing qualifications and were graduates. Service users and carers were representatives who regularly participated in each of the Trusts' routine involvement and consultation forums.

Modernisation
The theme of modernisation emerged from all respondents. For example, service users and carers articulated concerns about the type of service required in relation to user needs:

> *... if I ever get admitted again, I want a service that is going to work for me. The service that I want: something that's got more things to do on the ward; more therapies; more activities; something that doesn't let my brain go stagnant and make me feel more mentally ill... so there's always challenges I think for everyone when they have an illness; it's about maintaining this level and feeling good about yourself I think.* (Respondent, SUCFG1)

One service user's comments resonated with this by stating:

> *Less psychiatry and more psychology.* (Respondent, SUCFG1)

In addition, ideas for service re-design were suggested that involved existing services provided by other professionals and organisations:

> *I'd like to see a new family service for all the people that are affected, not, you know, when somebody becomes ill... there's a lot of grief left behind within the family which needs to be solved. But it needs to be solved by somebody other than the person that's dealing with the patient. You need to give people an opportunity to explore what's happened within the family, how it's affected different members and what the support needs are, particularly with reference to children... a lot could be done in the six, seven week summer holidays for kids with a little bit of support through the education systems which are already there. It's not that we have to set up something new that's going to cost a*

Table 1 Response rates for Focus Groups according to Trust

Focus Groups	Trust 1			Trust 2		
	Numbers Invited	Numbers Attended	% Response	Numbers Expressed Interest	Numbers Attended	% Response
1	35	9	26%	7	6	86%
2	12	6	50%	12	7	58%
3	12	6	50%	4	3	75%
4	12	5	42%	7	2	29%
5	14	2	14%	4	4	100%
6	12 *	8	67%	6 *	6	100%
Total	97	36	37%	40	28	70%

Key * = Service User and Carer Focus Groups

fortune, the thing is already there within every education service... You could provide structured activities for young people and children with your junior trainee psychologists, educationalists... to give them a general background... then you will begin to do a lot more so that when the person is being treated... and they're then returning (if that's what's going to happen) to the family, there'll be a lot more of a cushion because people within the family will feel more comfortable about what's happened. (Respondent, SUCFG1)

Some focus group respondents held views on service deficiencies and what users want in relation to psychosocial interventions and talking therapies. (For example, Table 2, quote 1). This view was also reflected in terms of striking a balance between episodic and longer-term rehabilitative interventions with the need for psychological therapies as opposed to containment, evidenced by an interaction between two focus group respondents (Table 2, quotes 2).

Service users' and carers' perspectives about episodic treatment may be different to the perspective of staff, for example, in relation to the effectiveness of short term therapy (see Table 2, quote 3). This approach was also reflected by other focus group respondents working directly with service users in the community to help build their psychosocial capabilities (Table 2, quote 4). This renewed social focus was also evident in parts of the services where the perception was of imbalance between notions of containment and rehabilitation, for example (Table 2, quote 5).

In relation to the personalisation agenda, staff focus group respondents' awareness of the change towards partnership working was set against real world constraints. For service users, an individual focus was seen as paramount:

... every client requires an individual relationship, there isn't a one method will fit all model and it's down to the skill of the particular employee as to how they first initiate that reaction in the client and then manage the onward progression and support because you know we don't always progress forward, sometimes we take two steps... but from that point on every individual requires an individual relationship. (Respondent, SUCFG1 emphasis added)

For some respondents, the earlier shift towards using psychosocial interventions in mental health services alongside other forms of intervention has helped create a positive context for implementation of the personalisation agenda.

Crucially, the personalisation agenda was found to be strongly promoted by those staff in community settings, whose objective is to focus on the individual and their needs, using a non-stigmatizing and non-pathological approach (see Corbett & Westwood, 2005; Kowlessar & Corbett, 2009). Integration of care was reported in relation to the perception of the increasing number and complexity of co-existing diagnoses, such as drug misuse, alcohol misuse, personality disorders, or self harm. However, from the perspective of service users and carers, a singular focus on the psychiatric diagnostic label may skew the clinical focus of the attending physician. Service users' accounts show that more pressing care needs can be overlooked when greater attention is paid to their psychiatric diagnosis as opposed to physical health needs (Table 2, quote 6).

The multiplicity of stakeholders and future service provision
The theme of multiple stakeholders emerged in relation to the increased involvement of service users and carers and was seen as a positive driver for future service provision and the development of new approaches to care and treatment.

Table 2 Direct quotes from participants in the Focus Groups according to theme

Focus Group	Quote
Modernisation	
SFG6 **Quote 1**	There's a lot of service user frustration and disappointment in kind of the limits really of the medical approach in helping people with psychosocial difficulties. And that's not you know necessarily the fault of the medical approach. It does its best… But nevertheless I hear enough complaints from service users about a lack of time; a lack of talking therapies; huge waiting lists for talking therapies. And I just think that there's going to be much more demand and expectation for time to talk, you know, talking therapies, skills based groups and less of this kind of almost containment, of long-term chronic patients-review kind of based, risk focused interventions. *People want more than that.* (Respondent, SFG6, emphasis added)
SFG 6 **Quotes 2**	Respondent 2: ... care planning, you know training, rehabilitation programmes. *And we're not encouraged to do that. We're encouraged to do the one to one therapy and it's something about, there's something about the assumption, it's almost like the primary care model of people with moderate, mild difficulties is wrongly applied to us in secondary care. It's like well ten [to] twenty sessions of CBT will fix this person but actually that mindset and model does not fit and the kind of psychiatric model doesn't always fit. They kind of medicate and sedate away people's distress. They need more long term skill development and rehabilitation and we're not that good at that really and we need much more of a rehabilitation mindset and skills development and how do you help people with long term trauma, untreated trauma.* And that's the other frustration that I hear... we see people who've been in the system for donkeys years and they've just had a purely medical containing approach, kind of reviews, encouragement, support but no psychological therapies for example and we get that all the time don't we, we meet people years and years and years along the line who have become chronic career patients. Now we want to get away from that obviously… Respondent 1: ... absolutely. (Respondents, SFG 6, emphasis added)
SUCFG1 **Quote 3**	And after your six weeks it's bye, ok you're alright now ... you've had no feedback, you've had nothing. And it might work for a minority but anybody I've spoken to... and I think it's just your GP's way of getting you away from his desk. Counselling, there's the answer. And it doesn't answer your problems, because you're still churned up inside and you can't go and see a stranger for six sessions and open your heart to them. You just can't do it. Not if you're not getting any feedback. (Respondent, SUCFG1)
SFG7 **Quote 4**	Respondent 1: I do think there seems to be more of a focus now on getting people involved in social, meaningful social activities rather than just medication. That's a big part of my role. I take quite a

	few service users to different gyms in the borough that I work in, support them with that. Get them motivated and working towards them going independently. Other service users I take playing five-a-side football in groups. Others I go bowling with. (SFG 7)
SFG9 **Quote 5**	... we've... identified that there's a need for a *step downward* which is different to a pre-discharge ward, which we have at the moment, but looks at preparing people for transfer to other facilities, or back into the community... we've identified... from the service model that the social component of treatment, rehabilitation, management or (not even rehabilitation but) habilitation - because lots of them come from impoverished backgrounds and go back to impoverished existences - we've identified there's a need certainly to be *more inclusive of a social component in in-patient services* and I suppose rather than being a treatment modality it's more an inclusive approach around those needs. (Respondent, SFG9, emphasis added)
SUCFG1 **Quote 6**	... but *because there's like a label* then somehow the rest of it... and I'll give you an example. It was last year... I went off to see my GP and I'd been on repeat meds for a few years... and all the rest of it…I rolled up yet again and sat down and he was on his computer screen and typing away and I'm sat there and... he's going through all these [questions]: Am I suicidal? Am I still taking this medication? Blah de blah de blah. So a few minutes of this and he's a nice GP, you know I quite like him, or whatever, but he was there and he got to the end and he sits back and says: So what can I do for you? I said well actually my finger has got infected, I don't know how... I just phoned and actually I could get in so, access not a problem whatever, and I do feel an idiot but actually it's getting really bad. I don't know how it's happened, I must have banged it or whatever, the two fingers and, and it's really, it's getting all pussy and whatever. Oh no, no right you know... And there was an example that I'd rolled umpteen times over the years and I was on all these... you have on the screens and the physical side (is missed)... And, and so because of the *label* and whatever I think we forget... they're somehow going to ignore you, it's the attitude that's wrong or whatever... (Respondent, SUCFG1)
The multiplicity of stakeholders and future service provision	
SFG8 **Quote 7**	But really the shift is around *enablement, around recovery*, and I think staff need to be able to almost like take a step back and know when it's their turn to give, you know like advice on medication or monitor a process of going through benefits, you know, I think. But it's also a time to know [when] to enable somebody. There's *a different approach required* and it's about tapping into what's out there. It's about tapping into the individual skills, family networks and to be able to say to staff that assessment is key to be able to write up, you know, recovery plans is the key. But actually doing it all is changing, that's my personal view. I think if I was a nurse now on, on the

	road, *my approach would be different, using very similar skills*, assessment care planning, risk management. (Respondent, SFG8, emphasis added)
SUCFG 2 **Quotes 8**	Respondent 2: And I suppose the big driver in terms of mental health has been much, my surprise, is around recovery... and it's basically it's open season... everything from definition to you know all the various elements were kind of open to debate and I suppose really ultimately it's a case of the Trust... aspiring to be recovery focused. *The question is what does that mean? ...* I keep having plenty of debates as to what recovery means because *recovery to staff and organisations is they've got their own ideas. And recovery from our perspective there's a bit of a mismatch at the moment* and so I just wonder whether maybe that's something... Respondent 1: Well recovery is really important but for some people. Where that's not possible but management is, and I think managing a condition if you're living with it long term, *I think that's just as important.* It shouldn't be getting you complete, some people will never be fully recovered, they might need medication but it's controllable and I think management is just as important as recovery as a focus. (Respondents, SUCFG2, emphasis added)
SFG6 **Quote 9**	I think that's part of the risk underpinning risk culture, isn't it that we're being pushed to the episodic all the time and just do very short, discreet episodes of care. But for people in fact staying involved in their lives in some way maintains them to be as well as they can be. (Respondent, SFG6)
SUCFG2 **Quote 10**	But equally it's something around what messages Trusts and the government give. I'm tongue in cheek but actually come to use it a few times now I say, we've talked about the Department of Health guidelines you know, all these things you mentioned away from the medical model to that *wider integrated recovery*, whatever... whatever. Yet here's a Trust, they've all got them, a *Medical Director*, we don't have a *Director for Recovery*, yeah. (Respondent, SUCFG2, emphasis added)
SFG8 **Quote 11**	... whereby people can do it because it's all well and good talking about recovery and it's all well and good saying to people you've got the skills within you but if that person has got that *dependency on services* we need to do an awful lot of work around removing that dependency in the first instance I think. (Respondent, SFG8, emphasis added)

Key: SUCFG = Service User and Carer Focus Group; SFG = Staff Focus Group

Respondents saw this future as being defined by self care, users developing their own care plans, undertaking their own needs assessments and service planning:

> *Rather than them doing what the PCT has decided they want a service for, to actually go out and tell the PCT this is the service you should be funding and I'd like to see users and carers getting involved in planning the service we would like and then go and sell that service to get the funding for it. Not the other way about.*
> (Respondent, SUCFG1)

Staff respondents thought such changes could be achieved through joint (learning and development) activities involving service users and carers as teachers or peer recipients of professionals. All of these changes were seen to require significant effort, a change in professional culture from paternalism to enablement and empowerment, with the health sector lagging behind such developments in social care:

> *Staff are not geared up for that because staff see themselves as "we're here to do the assessment", "we're here to listen to your needs and tell you what your needs are and here are the resources I've got". We're moving to where somebody rings up and you say "right well here, here's the assessment form, you write down your needs and I can be creative with the resources". We are nowhere near ready for staff to be able to do that but in a social care arena they are doing that. You ring up social services and they'll post you out a self-assessment and you send it back, they'll look at it and allocate resources to you and health is moving in the same, similar direction.* (Respondent, SFG1, emphasis added)

This changing service focus resulting from trying to embed recent policy was seen as influencing a cultural change within NHS providers (for example, see Table 2, quote 7). Embracing enablement or recovery concepts were seen by some respondents as problematic in that different definitions of recovery exist and moves towards shorter and more discrete interventions may not suit all service user and carer needs. For example, see Table 2, quotes 8, where two respondents deliberate on the issues and existence of different definitions of recovery and perspectives between staff/service users, as well as the need for long-term management. Other staff respondents echoed that there was a balance to be struck between episodic or maintenance types of intervention and recovery (see Table 2, quote 9, for example).

A more fundamental point was articulated about the rhetoric of recovery and the need for consistency between policy and operational delivery (Table 2, quote 10). Some staff respondents pictured a shift in dealing with the dependency previously created by professionals, through partnership working with change achieved at a mutually satisfactory pace (Table 2, quote 11). The therapies were reportedly better at embracing the recovery model and its associated expectations and that service users may be seen by those professions as having potential to recover, albeit, in a limited way for some with longer term conditions. Some respondents reported the need to acknowledge that people with psychosis or severe personality difficulties require continuing support and not necessarily recovery. Better operational definitions of the concept of recovery were requested yet were also seen as difficult given the public push for 'fixing people' via 'talking therapies' such as cognitive behavioural therapy. The latter emerged in context of a general move away from rigid frameworks that label and thus stigmatise people with psychiatric pathologies ('schizophrenics' etc, see Kowlessar & Corbett, 2009) towards an approach involving understanding abstract/ complex information and transmitting it in a way meaningful for care planning and service users. This was seen to require translation and understanding of information to something more intelligible and less traditionally pathological for service users and staff. Similarly service users/carers had a nuanced understanding of the issues surrounding the implementation of a recovery model. For example, the following interaction between three service users/carers:

> *Respondent 3: ... you're giving false hope to people when you say about recovery because especially if you've got somebody who's got a severe enduring mental illness such as schizophrenia or bipolar or whatever... unfortunately they're going to have to be maintained on medication and... they need to have some hope without being [given] false hope where*

everybody['s] saying, "we aim for recovery". They are going to be aiming for...
Respondent 1: For management.
Respondent 3: Yes.
Respondent 1: So they can have a normal life as normal as they can.
(Respondents, SUCFG 2)

Similarly, different definitions of recovery exist amongst service users and carers; for example:

Respondent 3: I personally would like to see that modernised, if you like, and person centred, and not actually called recovery, called something, you know, that is more suited to that person's needs.
LF: So is that around the management of patients rather than...?
Respondent 3: Yeah because, because recovery does mean you know you look at the other side of the scale when you talk about people with organic conditions and medical conditions you know, you give them a few tablets and they then go on to recover from the flu or whatever. But you know in certain situations people are never going to recover but they are going to be managed and they are going to be able to enter and have a normal active life within society. And that's what we aim for.
(Respondents, SUCFG2)

Service user and carer learning and development
There was evidence in each organisation of involving professionals and service users and carers in workforce learning and development activities and employment interview panels. Individual learning was recognised as being required by service users and carers in order to recover, get better or remain stable:

I feel like I'm learning every single day and I feel like I've learnt to deal with my ups and downs and that I've learnt to be a bit more open in certain areas about what happens and what goes wrong and potential, even the worse things I can do. I've learnt to be more honest and

recognise them and I just feel like every day is a challenge, every day I've got to challenge myself and my attitude sometimes because I can be as prejudiced about something as the next person but for me it's all this process... it's more about what I do for my own learning needs, how I can build up my own skills and how I can get better every day and try and remain stable. (Respondent, SUCFG1)

Discussion

Limitations of the study
Working within the Trusts' existing consultative mechanisms meant that the range of views incorporated into the focus groups were limited to those of members of the existing consultative forums and self selecting staff groups and may not be fully representative of all employees, service users or carers. However, by virtue of the fact that the focus group participants were members of these forums, they had particularly expressed interest, commitment and expertise in service provision. Interviews with key stakeholders, a convenience sample of directors, provided a broader strategic context to also inform, compare and contrast the themes and issues raised. Use of direct quotes to illustrate themes has allowed 'voices' of staff and service users and carers to be heard and to contribute to future workforce and service development.

Modernisation, integration and outcomes
Incorporating principles of quality, efficiency and effectiveness to underpin service delivery is a requirement for health and social care services and individual staff (Darzi, 2008). Mental health providers and commissioners are also recommended to focus on outcomes that are meaningful to service users and carers (NHS North West, 2008; HM Government 2011 a,b,c). Evidence is required for the continual review of quality of services experienced by users and carers linked to payment by results, market competition, and for establishing effective delivery (Darzi, 2008). All respondents supported creating a 'modernised' service that focused on users

and carers, persons and families by optimising resources and integrating care congruent with national and local policy (NIMHE, 2005; Darzi, 2008; Department of Health, 1999, 2000, 2003a, 2003b, 2003c, 2004, 2005, 2006, 2009; NHS North West, 2008; Bradley, 2009; Skills for Care, 2009; Skills for Health, 2009; HM Government, 2011 a,b,c). Findings from staff concurred with those of service users and carers in relation to the need for modernised services and involvement of multiple stakeholders in their development and delivery.

A key requirement that was identified was the need to balance, on the one hand, the current drive towards episodic, 'quick-fix' interventions with, on the other, the need to provide longer term rehabilitation and maintenance interventions, based on recovery models and self care, with measures and outcomes including perspectives of both clinicians and service users and carers (NHS North West, 2008). Whilst the former may require professional knowledge and analytical skills, the latter require more supportive engagements where clinicians deploy rehabilitative, care planning and case management skills within psycho-socially focused partnerships with service users and carers, evident in the practice of community support workers. This re-focus on recovery, rehabilitation, care planning and case management was thought to raise important issues for service delivery and locally based workforce development (Reilly *et al.*, 2007; Imison *et al.*, 2009).

A further imperative identified was the complexity of co-existing clinical needs around lifestyle issues, such as drug or alcohol misuse, personality disorders and self harm that required particular workforce development and adoption of more integrated approaches to care and partnership working between agencies (Skills for Health, 2009; Skills for Care, 2009). For example, the need for assessing and treating both physical and mental health needs. Given that prior knowledge of a psychiatric diagnosis may skew the focus of care, there is a need to

challenge existing practices by reappraising how physical assessments of people with psychiatric diagnoses are undertaken in primary and secondary care (see Time to Change 2009 cited in NHS North West, 2008, p.27). As embedding recovery is reportedly problematic, and complicated by different understandings and definitions from staff and service user and carer perspectives, use of recommended tools for assessing service performance and outcomes for recovery are advocated (NHS North West, 2008).

Recovery, rehabilitation and re-ablement
The findings from service users, carers and staff were in agreement on shifting the focus of services and care to recovery, rehabilitation or re-ablement with talking therapies identified as being under-provided. The latter is being addressed by national policy so that more people can access talking therapies as part of a national programme (HM Government, 2011d). Within the Trusts there is evidence of arts and humanities based activities also being available, for example reading groups (see The Reader Organisation, 2011). Although not traditional therapies, they may be therapeutic by engaging people socially and culturally, allowing their expression as individuals and within groups (Clift & Hancox, 2001; Morrison & Clift, 2006, 2007; Morrison *et al.*, 2008).

There was a consensus on a requirement for a more social focus in services and care as opposed to a traditional psychiatric approach that involved people and families with a view to social function, normalisation and engagement. This was thought to require staff and services to work differently and examples were cited of community support workers using these approaches. Some service users and carers thought recovery may not always be feasible, yet being able to function and engage socially was always possible by focusing on rehabilitation, self care and self determination. This acknowledges re-ablement, which is a feature of social care provision. There is still confusion around the terms used, rehabilitation being the term used in health care and re-ablement in social care

but essentially having the same meaning (Conroy, 2011). A further example of this was participants' suggestions and recommendations for more person-centred approaches related to individuals and families. Such approaches have long been a feature of dementia care and services (Kitwood, 1997). They also recommended that services and care should include physical health and well-being unlinked from a psychiatric focus and to also include lifestyle behaviours and support and recognition of the complexities of dual or co-existing diagnoses which require cross-agency working and integrated care. These recommendations also resonate with recent national mental health strategy and policy (HM Government, 2011 a,b,c).

Self care, needs assessment, care planning and service delivery
Professionals envisaged service users undertaking self care and being involved with their needs assessments and service planning, citing how social care already has individuals undertaking self-completed needs assessments. This is congruent with existing policies for managing long term conditions in the community, even for those with complex needs, in order to avoid unnecessary hospital admission and to provide community care using case management (Boaden *et al*., 2005; DH, 2005b,c; DH, 2006; Robertson *et al*., 2007; Russell *et al*., 2009). More specific and recent policy for mental health services recommends a re-focus on community care adopting a preventive, self care and case management approach to the promotion of mental health and well-being with integrated care and services that involve working in partnership with numerous stakeholders, service users and carers (Reilly *et al*., 2007; PSSRU, 2010). The shift in focus to prevention, recovery, self care and outcomes with involvement of service users, carers and families is opposed to traditional containment or limited time restricted interventions that have predominated (NHS North West, 2008; HM Government, 2011 a,b,c). These findings are in keeping with recent policy and there was agreement between staff, service user

and carer perspectives on these aspects of self care and service delivery.

Cultural changes and service development
The findings indicate a need to establish requisite workforce skills and competences for changing roles and environments as part of service development, rather than commissioning traditional skills sets as suggested by recent policy (NHS Modernisation Agency, 2005; Reilly *et al*., 2007; Imison *et al*., 2009). A multi-skilled workforce with transferable skills can achieve more responsive services through flexible, adaptable and integrated work roles or inter-disciplinary working rather than a traditional 'uni-professional' approach (DH, 2004). Better use of the broader or enhanced skills and competences of professional groups may deliver more value for money, for example, rehabilitation by those with generic or specific skills, or research led by those with enhanced skills. Such changes in roles and service developments require organisational and cultural changes by workforce and management to reconfigure services and care delivery. The enormity of this task should not be underestimated as it involves working creatively with service users and carers and other stakeholder organisations as partners to provide integrated services and care. Organisational structures alone do not ensure integrated practice and further work is needed to establish which factors promote or inhibit care coordination and management in terms of structure and workforce development (Reilly *et al*., 2007). In this regard, a recent national survey of community mental health services for older people reported changes with 60% of teams being multi-disciplinary and having an integrated care coordinator (PSSRU, 2010).

Involvement of service users and carers
Initiatives exist in each Trust for involving professionals and service users and carers in learning and development activities and staff recruitment, which are recognised strengths and in keeping with policy (NHS North West, 2008). Involving a variety of stakeholders in service development and research is

recommended, although it is recognised that there are different levels of involvement ranging from consultation to participation (Ross *et al.*, 2005; Caldwell *et al.*, 2008; INVOLVE 2009a,b). There is a need for consensus between different stakeholders (providers, staff, service users and carers) as to what constitutes service user and carer involvement and what form it should take. This would allow a local evidence base to be developed for optimising service user and carer contributions that are important for developing mental health services and locally-based workforce development (Imison *et al.*, 2009).

Conclusion

The range of issues identified by service users and carers and staff suggest that there are new ways of organising and delivering services, as well as promoting inter-agency and partnership working, staff development and service user and carer involvement. There was agreement of the need for person and family centred care with outcomes that are focused on prevention, mental health and well-being, recovery, rehabilitation, self care and case management, with an accompanying shift of focus from pathology to social function and engagement. Whilst their scope is broad and challenging, these provide opportunities to further develop mental health services and a workforce that are responsive to the needs of local populations and that are valuable and fit for purpose.

Acknowledgements

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