



**Promoting Positive Mental Health and
Recovery in Young People:
Evaluation of the UThink Project**

FINAL REPORT FOR RETHINK

April 2010

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Foreword

We are pleased to present this final report of our evaluation of the Uthink pilot project. We are extremely grateful to colleagues at Rethink for their invaluable support throughout the project: in particular Cathy Street, John Larsen, James Gorman, Jo Loughran, and of course the Recovery Officers in the three sites, without whose consistently good-humoured support and willingness to share their knowledge and their experiences, warts and all, our task would have been impossible. We are also very grateful to all the other professionals, young people and family members in the three pilot sites who gave us their time and the benefit of their knowledge and experience.

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1. Executive summary

- This evaluation of the Uthink 'recovery learning project' was commissioned by Rethink in November 2008, with funding from The Big Lottery. The purpose was to examine the impact of the project in national and local context. Rethink's own research division undertook a concurrent evaluation of outcomes of participation in the project for individual young people. Research began in January 2009 and concluded in February 2010.
- The study used two models of evaluation: Pawson and Tilley's model of *realistic evaluation*, a flexible methodology which assumes real causal relationships in open systems about which participants have relevant views, and which focuses on the links between *context*, *mechanism* and *outcome*; and Donabedian's quality assessment framework for health services research, in which structure-process-outcome links are traced in relation to six dimensions of quality.
- Data came principally from project documents, local audit and evaluation, and discussions with stakeholders in each site. Specific methods included a combination of visits to the three localities for individual and group interviews, augmented with telephone interviews, email communication and locally available documentation. Analysis was reflected back to research participants during the process, and shared at key points with Rethink's research team. All field research was carried out directly by the authors.
- The model of service in the UThink programme is based on a concept of 'recovery' and underpinned by a view of young people with emotional or mental health issues based on strengths rather than on pathology, and a focus on learning rather than treatment. The aim of the 'recovery learning project' was to test and establish this model of working, with a view to offering the UThink programme to commissioners of mental health services across England.
- The core programmes are a six-month programme for 19-25 year olds and a shorter programme for 14-18 year olds. Other elements include a residential learning activity programme, a leadership programme and a mentoring

programme. All the programmes are based on group activity and group learning, with emphasis on an enjoyable and rewarding experience and building positive relationships with project workers and other group members.

- The report includes a detailed study of each of the three regional sites in Sections 6-8, which we do not attempt to summarise here. The researchers visited each site on several occasions, making direct contact with workers, professional colleagues and group members and observing programme activities. This was supplemented by telephone interviews with a range of stakeholders in each region.
- The researchers engaged in face to face discussions with the project workers as a group, and with Rethink national officers. We also had the benefit of access to outcome data produced by Rethink staff *via* the research division.
- Analysis of the findings from the three sites showed common themes as well as local variations, which are analysed in depth in the report. Using the quality assurance framework offered by Donabedian, the project scored highly on acceptability, appropriateness, accessibility and equity. The research was not designed to measure effectiveness and efficiency, but the evidence available in these respects was positive.
- The project did not offer a model of the causes of mental health problems, but did have a clear ideology of how to help and support young people in recovery, and of the weaknesses of existing services in this respect.
- *Mechanisms* at work included the content of the programme, the opportunity for contact with other people, the chance to try new activities, the break from isolation, helpful relationships with project workers, positive encouragement to engage and a focus on 'person, not patient'. There was evidence that all these mechanisms played a part, in particular the contact with other people.
- Key *contextual* factors included the receptivity of local professionals, the culture of a voluntary organisation, the skills of the workers, the ethos of 'strength' and 'recovery', the preparatory work with participants and the funding for the project. Some of these factors were constants in the project, while others varied across sites and programmes.

- Potential *outcomes* for group members included improved confidence and self-esteem, richer social life, new skills and interests, educational aspirations and reduced stigma. We saw evidence of all these outcomes to some degree in all programmes. There was no clear evidence of variation in the extent to which different sites achieved these outcomes.
- A full analysis of *context-mechanism-outcome* configurations is in section 10 of the report. In summary, the outcomes achieved were a product of enthusiastic and talented project workers finding the limits of their freedom to succeed. Those limits were set by the extent to which dominant forces in the statutory services were willing to embrace the innovation or resist it.
- The Uthink project was a success on all three sites. Good relationships were made with local service providers, the programmes were successfully run as planned, and the outcomes were satisfying to the young people who took part and to those working with them. The receptivity and responsiveness of local providers to this innovative offer makes a critical difference to its success.
- In conclusion, this project would have a high likelihood of success in other localities, if funding can be secured. In the current climate this will of course be difficult. However, it is clear that the Uthink project represents a very effective and helpful service for severely disadvantaged groups of young people whose needs are not responded to by current services.

2. Context and purpose of the study

The UThink Project was established in 2007 by Rethink, the leading mental health charity, with funding from the Big Lottery Fund. The aim of the project was to deliver and test a range of activity-based programmes to promote positive mental health and recovery in young people. The project was based in three areas of England – the South East (Southampton), the South West (Bournemouth, Poole and Dorset) and the East Midlands (Derby and Nottinghamshire). The project began in 2007 and ran for three years. Programme delivery commenced in June 2008 and concluded in February 2010.

The wider context of the initiative is one in which the quality, availability, focus and ethos of mental health services for young people have received close attention from professional and policy communities for some time. Successive reviews of CAMHS (Child and Adolescent Mental Health Services) have drawn attention to significant weaknesses, with services often provided in ways that are not acceptable to young people, frequent long waiting lists for appointments, and historically an absence of provision for 16-17 year olds (although this appears to be changing; National CAMHS Review, 2008). National initiatives such as TaMHS (Targeted Mental Health in Schools) are intended to provide accessible help in ways that are easier for young people who are troubled, or having emotional difficulties, to take up without feeling stigmatised. For young adults with more serious problems, the development of EIS (Early Intervention Services) for those experiencing a first episode of psychosis is relevant, as is the growing interest in strengths-based and recovery-focused approaches to intervention. Third-sector agencies have been at the forefront of innovation, and there is some suggestion that they may find it easier than statutory services to adopt such approaches and to provide services in ways that encourage take up by young people.

Rethink is seeking to develop its role as an innovative provider of services, and the Uthink initiative is an important component of this strategy, in particular because of the focus on young people, a relatively new one for the organisation. Accordingly, evaluation has been a key element of the project. Rethink's own research division undertook a concurrent evaluation of outcomes of participation in the UThink Project for individual young people. To complement this, Rethink invited tenders for an independent evaluation to examine the impact of the project as a whole in its national and local context, with particular attention to:

- The effect, if any, of the existing local environment and health and social structures on the success of each local model.
- The contribution of the programmes to supporting multi-agency collaborative working, including any local initiatives to develop 'comprehensive' CAMHS or to improve access to primary care level adult mental health services.
- How the programmes fit with relevant national policy priorities.
- The strengths and weaknesses of what has been developed and whether programmes have helped to address gaps in local services.
- From the perspective of key stakeholders in other local services, whether the programmes have played a useful role in supporting their work with young people with mental health problems.
- What involvement in the programmes has meant for young people, parents and carers and the staff actually delivering the programmes.
- Analysis of what sort of infrastructure needs to be in place for the successful delivery of a programme (e.g. good inter-agency links; well-established voluntary sector; good local awareness of the different ways young people's recovery and emotional well-being can be supported).

The authors of this report submitted the successful tender. Our overall aims, as defined in our original proposal, were:

1. To provide a rich picture of the three pilot projects.

2. To understand the extent of the success of each project in the context of other local services.
3. To draw conclusions, within and between the pilot projects, about potential success in new contexts.

Specific objectives were:

1. To identify the conducive conditions for each project.
2. To describe each project in depth, in terms of its operation in practice.
3. To analyse the context of each project, in terms of other services and local factors.
4. To understand stakeholder experiences of the three projects (staff of the projects, workers in other services, young people and their families).
5. To identify the intended outcomes for each project, drawing on a range of stakeholder perspectives.
6. To evaluate the success of each project and its contribution to local systems, and to offer hypotheses about how this could be generalised to other contexts with equal or greater success.
7. To take account of any emergent events or processes in the projects during the course of the evaluation, including unintended outcomes.

In Section 3 of the Report we explain our methodological approach more fully. Our evaluation began in late January 2009 and concluded in February 2010. We shared key responsibilities for the work as follows:

David Pilgrim: field research in South East; field research in South West.

Nigel Thomas: field research in East Midlands; overall project management.

3. Methodological approach

This evaluation used a model of *realistic evaluation* (Pawson and Tilley, 1997). This provides a flexible methodology, which assumes real causal relationships in open systems, about which participants have relevant views. It focuses on the links between *context*, *mechanism* and *outcome*, seeking to understand how particular mechanisms are perceived to produce particular outcomes in particular contexts. As opposed to the traditional logic of a closed-system evaluation, in which theories and hypotheses lead to observations which produce empirical generalisations, in realistic evaluation the underlying theory of mechanisms, contexts and outcomes is used to generate hypotheses about what might work for whom in what circumstances. This leads to multi-method data collection and analysis, producing provisional conclusions about programme adoption and potential for spread to other locations and settings. We considered that to apply this approach to the three pilot sites would enable us both to generate conclusions about each site and to permit comparisons to be made across the whole project. **Figures 1** and **2** overleaf indicate the difference between a traditional approach to service evaluation and our realistic approach.

We were also influenced by the quality assessment framework for health services research established by Donabedian (1992). Within this framework, structure-process-outcome links are traced in relation to six dimensions of quality: acceptability, appropriateness, accessibility, equity, effectiveness and efficiency.

We accordingly adopted a flexible mixed-methods approach, which would enable an appropriate range of data to be generated in each case and interpreted in the context of local organisational features. The focus was on six domains of information, summarised below.

Figure 1: Traditional logic of closed-system evaluation

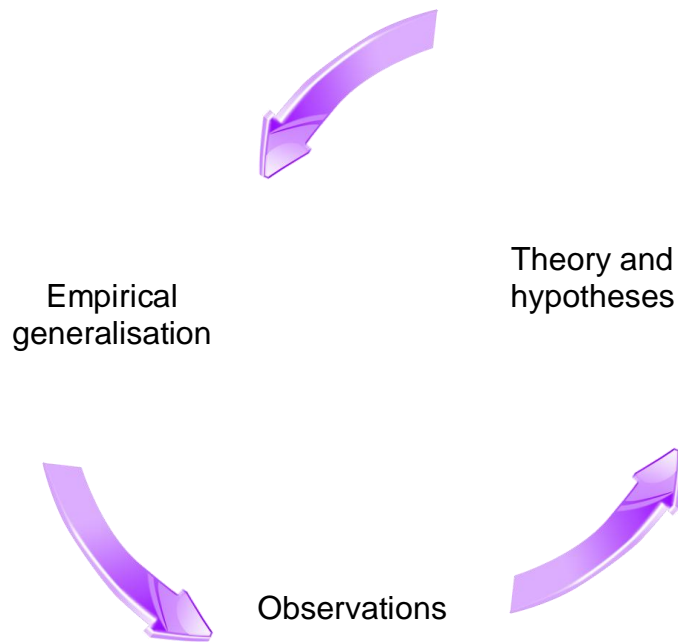
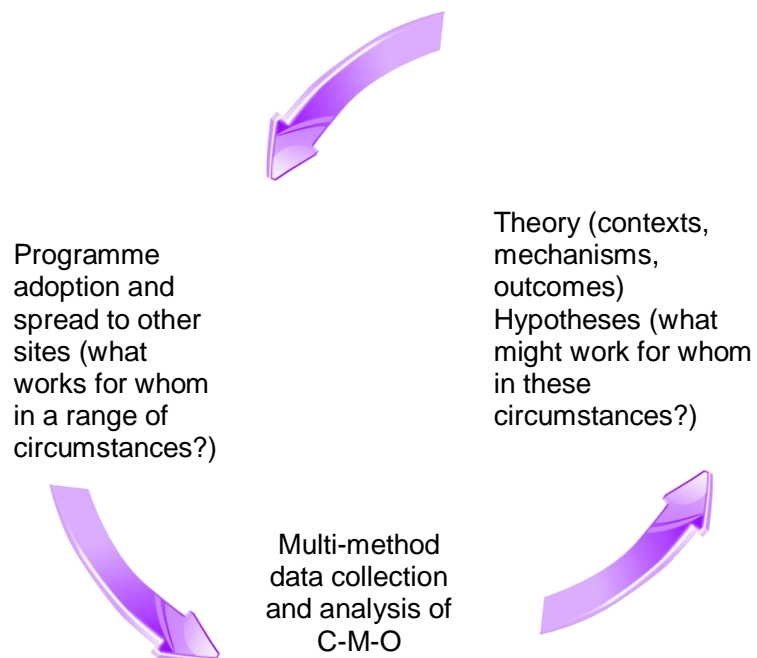


Figure 2: Logic of realistic evaluation



Six domains of information

1. Conducive conditions: What evidence can be established about the extent of conducive conditions in practice for success in each of the three localities?
2. Ontological depth: What is the lived reality of each project from the perspective of the stakeholders involved?
3. Mechanisms: What are stakeholders' understanding of (i) the mechanisms producing mental health problems and (ii) the mechanisms at work in their efforts to help?
4. Outcomes: What outcomes were intended from the work of the project and which were achieved; are unintended outcomes also emerging, and if so what value is placed on these?
5. Context-mechanism-outcome patterns: Are any patterns emerging across the pilot sites which have implications for spreading innovation in mental health projects?
6. Open systems: What evidence exists in each locality about changes in the context because of new processes emerging which may be relevant to project success?

We envisaged that data relevant to the six domains would come principally from project documents, local audit and evaluation, and discussions with stakeholders in each site. Specific methods included a combination of visits to the three localities for individual and group interviews, augmented with telephone interviews, email communication and locally available documentation. All field research was to be carried out directly by the authors.

Analysis of the data would be ongoing throughout the project, thematic, content-driven and focused on the objectives and domains identified above, framed by an understanding of policy drivers and other contextual factors and using the theoretical frameworks indicated. This analysis would be reflected back to research participants during the process, and shared at key points with Rethink's research team.

Ethically this was a sensitive project: (i) because actors in the local environment were being invited to comment on the programmes as they proceeded; (ii) because it was dealing with mental health issues, which at a personal level may be associated with anxiety, shame and stigma. The research therefore had to be undertaken sensitively, with appropriate assurances of confidentiality. Informed consent was obtained from all participants, and the research plan was approved by the Ethics Committee of the Faculty of Health and Social Care at the University of Central Lancashire.

4. Research design and organisation

The evaluation took place in two phases: Phase 1 ran from January to August 2009, and Phase 2 from September 2009 to February 2010.

We met with the lead Rethink staff Cathy Street and John Larsen at the beginning of Phase 1, which was helpful in giving a clear focus to the research. Following this we made contact with the recovery officers in the three pilot sites, in order to form an initial picture of each site and to begin to identify key local contacts. We studied relevant documentation and project records, and began to schedule conversations with key informants. Initially we used telephone interviews; later in Phase 1 we made extended visits to each site where we were able to conduct face-to-face interviews and informal conversations as well as being present as observers at programme events. The focus in this phase was on understanding the operation of the project in each site, forming a picture of the local context, and generating questions and initial working hypotheses that could then be tested further in Phase 2. We met again with Cathy Street and John Larsen towards the end of Phase 1, and submitted our Interim Report in August 2009.

In Phase 2 the focus was on developing and refining our initial working hypotheses in further discussion with project staff and other professionals, and also in individual and group conversations with young people who took part in the programme. To this end we made further visits to all three sites, as well as undertaking further telephone interviews. On two occasions (October 2009 and January 2010) we met all the Recovery Officers for an extended group discussion, and this was very helpful in enabling us to clarify assumptions and develop our analysis. In December 2009 we presented our research at a seminar in the University, which was also helpful in clarifying our ideas. Further details of the field work in the pilot sites are given in Sections 6 to 8 of this Report.

5. The UThink programme

The model of service in the UThink programme is based on the concept of recovery and explicitly underpinned by a view of young people with emotional or mental health issues that is based on strengths rather than on pathology, and a focus on learning rather than treatment. The aim of the Big Lottery 'recovery learning project' was to test and establish this model of working, with a view to offering the UThink programme to commissioners of mental health services across England.

In the words of the Rethink website, the Uthink programme 'seeks to reach out to young people between the ages of 14-25 who are at risk of developing, have, or are caring for someone with, a mental illness.' Key aims are to enable young people to enjoy and achieve new skills and experiences, to increase their confidence and self esteem and instil the belief that recovery is possible, to understand and manage the effects of mental illness, make a positive contribution to the support and care they receive, and access good information and advice on mental health issues.

The core programmes are:

- a six-month programme for 19-25 year olds who have experienced psychotic or other serious mental health difficulties;
- a shorter (one-week or eight-session) programme for 14-18 year olds who are subject to concern for their emotional wellbeing.

Other elements in the project include

- a residential learning activity programme;
- a leadership programme;
- a mentoring programme.

Detailed programme design was undertaken by the team of Recovery Officers prior to programme delivery. All the programmes are based on group activity and group learning, with an emphasis on creating an experience that is enjoyable and

rewarding, and on building positive relationships with other group members as well as with project workers and other group leaders.

6. Findings for the East Midlands

This part of our report is based on:

1. interviews and other conversations with the Recovery Officers;
2. study of documents, including the final Report on the first 19-25 group;
3. participation in an Advisory Group event at the end of the first 19-25 group;
4. face-to-face interviews with four professionals, and telephone interviews with six professionals;¹
5. telephone interviews with three service users;²
6. two whole-day observations of the second 19-25 group, including informal conversations and a brief focused group discussion;
7. two whole-day observations of 14-18 groups, with informal conversations;
8. a brief survey of members of the 14-18 groups.

The Recovery Officers on this site were Sarah Bramley (19-25 and overall lead), Louisa Long (14-18 lead until September 2009) and Danielle ('Elly') James (14-18 lead from October 2009). The project was based at the Rethink office in Sutton-in-Ashfield, and operated across Nottinghamshire and in the City of Derby.

The initial plan had been to offer the pilot project mainly in Derby, and contacts were initiated with the relevant services: education services and young people's mental health services for the 14-18 programme, and early intervention in psychosis (EIP) services for the 19-25 programme. The initial reaction from the EIP service in Derby was not encouraging. It appears that key professionals were hesitant about the project; the view reported to us was that existing services were relatively well resourced, and that the Uthink offer was not substantially different from the services already provided in-house. At that stage it should be said that the detailed

¹ Staff interviewed in person or by telephone included (in Derby) a school nurse, a social worker, a YPSS worker and a clinician in early intervention services, and (in Nottinghamshire) six care coordinators (OTs and CPNs) in early intervention teams.

² These were a former member of the 19-25 group, a former member of the 14-18 group, and a parent of a former member of the 14-18 group.

programme content had not been developed. In Nottinghamshire key staff were more immediately receptive to the proposal, and the decision was taken to offer the 19-25 programme there instead.³

The 14-18 service remained centred on Derby, where a positive relationship was quickly made with the Young People's Specialist Service provided by Derbyshire Mental Health Services NHS Trust, which works with young people of 16 and 17 who fall between CAMHS and adult services.⁴

Activity in the East Midlands

14-18 programme (all in Derby City):

- August 2008 (one week, in summer holidays)
- October 2008-January 2009 (weekly sessions after school)
- April 2009 (one week, in Easter holidays)
- July-September 2009 (weekly sessions in summer holidays)
- October 2009 (one week, in half term)
- November 2009 – January 2010 (weekly sessions in special needs school)
- February 2010 (one week, in half term)

19-25 programme:

- Six-month programme, June – December 2008 in Nottingham City

³ 'This service is for people aged 18-35 experiencing their first onset of psychosis. Once accepted service users can remain with the team for up to 3 years. The aims include: early detection, assessment and treatment of symptoms; to have optimistic views about recovery focused interventions; provide a wide range of psycho-social interventions and support; provide support and intervention for family and carers; to work in partnership with a range of statutory and non-statutory services. Referrals are made via Community Mental Health Services.'

(www.nottinghamshirehealthcare.nhs.uk)

⁴ 'The team provides a specialist mental health service to young people aged 16 and 17 years in Derby. The ethos of the team is reaching out to young people in distressed and vulnerable circumstances, who may be at a point of transition in their lives. There is a "no waiting" policy, supported by specialist service weekly triage, and robust multi-agency support, advice, consultation and training, with young people being helped by a network of professionals. The views of young people inform the development of the service through two user groups and the team uses performance data to identify gaps and improve service delivery.' (www.tin.nhs.uk)

- Six-month programme, February-September 2009 in Nottinghamshire County
- Five 'residential' in collaboration with Bournemouth (three in 2008 and two in 2009)
- Two-day leadership programme, February 2009 with Nottingham City

Mentoring:

- Mentoring training for six University students to assist with the 14-18 programme, August 2008
- Peer-to-peer and leadership training (four weeks combining mentoring and leadership), January-February 2010 for seven 14-18 year olds.

Other activities:

- Schools packs sent to approximately 30 schools in the East Midlands
- Young people supported to talk at two CAMHS conferences – more to follow
- A mental health promotion stand for year 10 pupils in Leeds and a health promotion tour as part of the Leeds Festival 2009
- Living Libraries stand, and various stands at CAMHS conferences

Operation of programmes

The 14-18 programme first ran in August 2008 as an intensive summer holiday programme with five young people, and again in November 2008 as an eight-week after-school evening programme with nine young people. It was repeated in April 2009 as a one-week intensive Easter holiday programme, with a group of 17 young people from a wide range of agencies (YPSS, CAMHS, Connexions, Family Services, Psychology). A fourth group in summer 2009 was focused mainly on YPSS referrals, with 15 young people attending. A fifth group in October half term was co-ordinated with the PMHW service and YPSS to cover the whole age range and meet needs and gaps across young people's services in Derby. This was intended to be a small group of young people with challenging behaviour, ADHD, etc, although in fact the number was comparable to the earlier groups (12 at the session observed). The earlier

groups mainly recruited young people with problems of confidence and social isolation, in many cases with experiences of bullying. The sixth group was again delivered on a weekly basis, this time in a special needs school. The seventh group was another one-week group, co-led by peer supporters who had been trained following their participation in earlier groups. We were able to be present at one session of the fifth group and one session of the seventh group.

The 19-25 programme ran first in Central and South Notts from September 2008 to March 2009. A full report was produced by the project workers, which included detailed feedback from group members and referrers. The group was attended by 22 young people in total, ten of whom attended regularly throughout the six modules. We were able to attend the advisory group celebration event at the conclusion of this programme. The second programme in North Notts began in March 2009 and finished in October 2009, with similar numbers of participants. Most participants in both groups had diagnoses, typically of schizophrenia or bipolar disorder, and some had been socially isolated for a considerable time before joining the programme. According to project staff, many young people in the area have few qualifications, limited prospects and poor communication skills – particularly in Nottingham, where there are significant problems of knife crime, drugs and poverty, and where the first programme was based. Participants in the second programme were mainly from rural areas and this gave a different flavour to the group. We were able to be present at the opening and closing days of the second programme.

Perspectives of project staff ⁵

The recovery officers clearly saw the aims of the project as distinctively different for the two age groups. The 14-18 programme was seen as primarily for those who are at risk of developing difficulties and has an educational focus on building resilience.

⁵ The Recovery Officers appointed at the start of the project, Sarah Bramley and Louisa Long, had a background in mental health services, in Sarah's case as an OT. Elly James, who replaced Louisa, came from a background in sport and leisure but for some time previously had worked for Rethink on a sessional basis.

The aim was seen to be building confidence, encouraging young people to start to talk about things and feel more comfortable doing so, to meet and make relationships. The 19-25 programme was perceived to be more about empowering people who were already in receipt of mental health services. Peer support and making relationships were seen as a crucial aspect of this – ‘one of the few opportunities to talk to people who are going through the same thing, to check things out’.

Asked to consider what problems or gaps the project was intended to address, responses pointed to the lack of services for younger people, especially the 16-18 group who ‘fall between stools’ of CAMHS and adult services, and the need more generally for services that enable people to find their own solutions rather than being prescriptive. It was pointed out that NHS services tend to have specific targets, a narrow focus, and few resources for running social groups. By contrast, the Uthink project ‘can do real social inclusion’ and is also able to offer educational components such as learning support, a more creative approach based on fun and games. It was also suggested that Rethink has a radically different approach to the NHS, marked as it is by wards, medication, a high level of structure (and chaos) which serves to constrain what can be offered, and that Uthink has been able to open up young people’s view of mental illness by taking a ‘recovery’ approach. The use of the peer group is seen as a crucial element in this – project staff do not claim to have all the answers.

Asked what had helped the programmes to be accepted by professionals and to engage young people, staff suggested that being in the voluntary sector gave more freedom to work in different ways. Young people were able to be more open and trusting, and workers felt able to share their own lived experience, including, where appropriate, experience as service users. Other service providers were aware of the gaps in current provision and wanted to be able to offer something different.

In particular, in Nottinghamshire the professional climate was very receptive to the message around ‘social inclusion’ and ‘education’ underpinning the 19-25

programme. Service providers were grappling with the problem 'If you have someone sitting at home, what do you do with them?' and could see that it had to be something that was fun in order to persuade isolated or disengaged young people to emerge and take part. In Derbyshire there had been a different response from professionals in early intervention services, some of whom could not immediately see how the Uthink project was different from what they currently offered; although there were signs of more receptiveness later with the availability of richer information on the 19-25 programme.

Obstacles to success were described as including: for the 14-18 programme, getting referrals in the first place, although this became easier as momentum built up, and some issues working with a younger age group which was a new experience for both workers; for the 19-25 programme, getting young people actually to attend, establishing and maintaining motivation, and for individuals a few mental health and drug problems which could disrupt the programme if not dealt with.

Programme (or 'course') content was seen as successful from the start, although it was also adapted during the early months, in subtle ways, particularly as a result of contact with the other pilot sites. For example, whereas the first 19-25 programme used more of a mental health approach, while encouraging people to find their own solutions, the second programme took more of a 'youth work' approach designed to deliver positive experiences ('pump you full of goodness') and extend participants' 'comfort zones'. In first programme the focus had been more on course content, and relationship-building had been something that happened in the breaks, whereas the second time around relationships were more central to the focus.

Perspectives of other professionals

Most of the ten interviews were recorded on digital audio-recorder and subsequently transcribed. The remainder relied on contemporaneous notes. Participants were asked a range of questions that varied somewhat between

interviews, reflecting the position of each in relation to the project and also the stage we had reached in our enquiry. Key questions concerned: the aims of the programme; what problems or gaps it was intended to address; why mainstream services were unable to meet those needs; what helped the programme to succeed; what were the obstacles to success; and whether the Uthink approach represented a challenge to existing services.

Professionals described the aims of the 19-25 programme as:

- to socially engage, with a view to recovery;
- to promote peer development, social skills and self-advocacy;
- to provide an opportunity that doesn't exist elsewhere, focused on recovery, peer support, development and awareness of self, and that is integrated in the community;
- to work 'out of the box' in ways that de-medicalise services, and to reduce stigma and avoid oppressive practice;
- to build self esteem using a diverse range of activities, focus on psychoeducation and support recovery;
- to increase people's confidence, link them with things that would be useful for them, learn from other people's experience, promote self esteem and self worth and give insight (not so much into their condition, but into ways of helping themselves).

The aims of the 14-18 programme were described variously as:

- to raise self-esteem through low-level intervention;
- to enable young people to cope better, and reduce feelings of stigma;
- to use activities to open doors, build confidence, and enable work to be done on difficult issues in a natural way;
- to provide a forum outside school, based on contact with other young people facing similar difficulties (defined as 'troubled' children or 'victims' rather than those with overt behaviour problems).

When we asked what problems or gaps the project was intended to address, participants referred to the absence of recovery-based courses, of 'adrenalin-based' activities, and of educational support that gave an opportunity to study in a non-threatening environment.

Views differed on why mainstream services were unable to meet those needs. Some suggested that the difficulties were practical: the education service had to cater for wide range of young people, and mental health services lacked the funding for this kind of work. Others appeared to think that the difficulties were more fundamental, to do with the culture or philosophy of existing services, which did not make the effort to engage, were risk-averse or had the wrong priorities. It was suggested, for example, that the clinical, therapeutic approach of CAMHS services was often rejected by young people, and also that young people need a lot of support to keep attending (frequent reminders, help with transport) which conventional services were less good at providing. Similarly, in relation to the older group with more severe problems, one participant said:

It's all the things I want to do but haven't got the expertise, the time, or the right environment. Often when people meet with me because I'm a nurse and there's baggage from hospital, they're a little scared of the things I'm offering. I know one person who's very fearful that what he says may put him back in hospital.

On the other hand, another colleague reflected:

I think if statutory services were resourced, there's no reason why they couldn't deliver that type of intervention at all. It would be about practitioners making that the focus among competing demands. Time and resources certainly wouldn't allow us to shoehorn that into our current schedules.

And one commented:

A little bit of me felt threatened by it, because I would have liked to do it myself.

Asked about what helped the project to succeed, the most frequent comments concerned the skills, approach and personal qualities of the project staff: their confidence, the ease with which they made rapport with young people, and the energy they put into recruiting, preparing and supporting them to attend and in engaging with referrers ('You don't get successful courses if you don't engage the workers who are supporting people to go on the course').

The other main set of comments concerned the quality, range and attractiveness of the activities on offer, ('it was the thing that hooked people in') combined with the generous feel of the programme – that everything was paid for, and good food and drink provided. For some professionals the fact that the educational component was formally accredited was of crucial importance, and meant a great deal to the young people, many of whom lacked educational qualifications and confidence.

Asked about obstacles to the success of the programme, several people referred to the upper age limit for the 19-25 programme. This 'felt uninclusive', when early intervention services work with young people up to 35 – and in particular when there were young people of 26 or 27 who could clearly have benefited from the programme. Other suggestions were: that single parents would find it hard to take advantage of the group; that without workers of different ethnicity some young people could feel uncomfortable (this applied to the 19-25 programme, where at least one potential client who was African-Caribbean found it too much of a barrier to feel confident in joining – it was suggested that peer support or 'buddying' might help in future); and that the 14-18 programme had little to offer to some young people if family problems lay at root of their difficulties, and was best suited to those who needed 'drawing out'.

Interviewees reported extremely positive feedback from young people who had taken part in the programmes, and also from their families, especially in relation to

increased confidence. It was telling that professionals from Nottingham and South Nottinghamshire, where the first 19-25 programme was delivered, expressed powerfully their regret that the pilot project was not to be repeated in their area (because it had been agreed that it would transfer to the North of the county for the second year).

Returning to the question whether the Uthink approach is distinctively different from existing services and perhaps represented a challenge to them, one person responded:

It's non-medical for a start and it's recovery-focused. My service always has the baggage of the medical model, medication, hospital, the Mental Health Act. In the background there's that fear. You don't carry that baggage if you're not from mainstream services. You're offering something as a completely different organisation. It's a challenge in the sense that we're not able to offer that and we should be – the way services are configured and resourced don't allow us to do this sort of work.

Comments of programme participants

Telephone interviews were conducted with one former member of the 19-25 programme and with one former member of the 14-18 programme. Interviews were recorded on digital audio-recorder and subsequently transcribed. Both young people were asked: what they felt about the programme as they reflected back; what had persuaded them to sign up for the programme; what they had expected to get out of it; what had been the benefits for them; what had been the most useful aspects of the programme for them; what it was about how the programme was run that had made it successful, and could it have been better; how things had gone since, whether they felt that the benefits of the programme had continued, and what would help to sustain improvement in the future.

The young person who had attended the 19-25 programme said that the programme had 'done a lot for' him. He had been able to end his connection with the Early Intervention Team, and 'My life's still better as a result of Rethink.' He credited his keyworker with persuading him to sign up in the first place ('She was quite clever: 'if you back out you won't get another chance'').

Interestingly, when asked 'What were you expecting to get out of the programme?' he commented:

Wasn't really sure it was a programme – I went on the residential and then they give you a ring and say 'there's something else on, do you want to do this?' I went recently with them and I'm not even part of the programme.

The key reason for the benefit for him had been:

Human interaction is the key, that's priceless; they [the NHS] can't offer that, you don't get that with home visits. You're with a lot people who are in the same boat, around the same age group, same stage of recovery.

He also attributed the success to the project staff:

wicked, good people skills.... They work quite hard, they have to be patient, some difficult people there.

The range of activities was an important attraction:

some of it not that expensive – don't underestimate bowling! Laser was a treat – everyone laughing and smiling – the best thing people had done all year.

For this young person the project was critically important in helping him to give up drugs and give his life a sense of direction. He was now planning to visit relatives in the USA and then go to university.

The young person who had attended the 14-18 programme looked back on with some regret that it was over: 'Life's dull without it.' It was one of his friends who had first told him about the group, after which he talked to a project worker. He had needed some convincing because he was 'a bit anxious', but thought he 'should give it a try'. Although it was difficult at times being the youngest there, he had enjoyed it and became 'more confident in going out more' – in fact was now planning to go to New Zealand, something he would 'definitely not' have taken on before the programme.

The key element of the programme for him had been the staff, and especially the project leader:

Unlike some workers I've seen she's much easier to talk with – you can talk about stuff more casual.

When asked if he felt the benefits of the programme had continued, he said that he was not going out not so much, but still found it 'much easier to talk to people'. Asked what would help to sustain improvement in the future, he said that he would like to do something again with the project leader, 'because I think there's still room for improvement there.'

One telephone interview was also conducted with a parent of a young person who had attended the 14-18 programme, using an adapted version of the same questions.

The programme had, she said, been 'really good' for her daughter:

She's a completely different person... it's boosted her confidence – she's more outgoing... She's a different kid.

The Young People's Service had originally referred her daughter. Asked what had persuaded her to sign up, the mother said:

I think she was on the borders of having depression, and she could see that. I think it was a way of crawling back out of where she was. I don't think she knew how to get out of what she was in. We kind of cajoled her into going the first couple of times... Once she started going she loved it... They'd done quite a bit of work with her before she actually went down, sort of talking to her and that... I don't think she'd have gone without that – she could identify herself with Louisa [project worker] 'because she's an arty person too, so there were similarities and she's a really nice person.

Asked what she thought her daughter was expecting to get out of it, she replied:

Confidence. The ability to mix again with people, to stand up on her own feet without feeling that she was incapable of doing anything... Her life was just lying in bed and not getting up.

The fact that this expectation was met she attributed very clearly:

She got her confidence back because they treated her as a person, not as a number. I think they took what [her] abilities at the time were and they built on it. You know, instead of saying 'right, you've got to do this', it was 'if you can do it do it, do what you can'; and I think that worked better. She was just a normal child from a normal school, from a normal background.

At the final meeting of the second 19-25 group, a brief group discussion was held with the ten members present. They were asked as a group to comment on three simple questions: what had been most helpful; how the programme was different from statutory services; and what would help in the future.

Members considered that the most helpful aspects of the programme had been (mentioned in the following order): the support offered, the activities, the sharing, becoming closer together, and finding it easier to talk. It differed from statutory services in offering more individual attention, better funding, being consistent and

taking place every week. What would help most in the future would be communication, and further activities.

Informal conversation with members of two 14-18 programme groups also showed the importance of enjoyment in maintaining young people's commitment, and the importance of a supportive initial approach in persuading many of them to attend.

A survey of participants in the 14-18 programme, conducted at a recall day in January 2010, received 13 responses, including members from most of the different groups which had taken place to date. The survey employed a brief questionnaire which began by inviting them to respond to the following questions on a five-point Likert scale, and then to explain their responses:

1. Whether they knew exactly why they were going to the group.
2. Whether the group had turned out as they had expected.
3. Whether the person suggesting the group to them explained clearly why it might help.

Participants' ratings of responses were:

1. For question 1, mean 3.4, range 2-5, suggesting some degree of confidence. However, supplementary explanations indicated that slightly fewer than half of respondents had a clear sense of their reasons for attending, and the remainder were, at best, slightly unsure (eg 'I think it was because I needed more confidence and to meet people').
2. For question 2, mean 2.9 and range 1-5. Comments could be highly positive even when ratings were low: 'Much more awesome' (1); 'Better than I expected' (3); 'I expected it to help me cope with struggles + help me in life' (5).
3. For question 3, mean 3.2, range 1-5. Comments tended to be negative in comparison to ratings: 'Just something to do instead of being bored'; 'No real explanation. However, I wasn't concerned'; 'She is very airy-fairy' (!).

Members were also invited to indicate which of a number of factors influenced them most in deciding to attend the group. Frequency of responses was as follows:

- It sounded as if it would help someone like me (7)
- It sounded fun (5)
- The group leader seemed to be very nice (5)
- The group leader was someone I could trust (4)
- It was something to do to relieve the boredom (2)
- I couldn't think of any reason not to go (2)
- Any other reason? To help (1)

They were also invited to add anything else they wanted to say about how the group has turned out for them. Responses included:

- It was really fun, helped me make friends, try new things and gained confidence.
- It gave me more confidence to speak up about things.
- It gave me the experience of a life time making friends, having fun, and help myself get over wobbles. I wouldn't try and even trade the memories for anything.
- It has been a brilliant experience for me, and I have come out the other side.
- It's been really fun, I've had a great experience of things I haven't done before. I have made new friends that I can talk to and have had fun with and carried on our friendship outside of re-think. The group leaders are great to talk to, to have a laugh with and they give you confidence to overcome your fears.

It had been hoped also to make contact with young people who did not take up the opportunity to attend the programmes, but in the event this was not possible.

Observation of sessions

We were able to present at two sessions of the 19-25 programme (in March and October 2009) and at two sessions of the 14-18 programme (in October 2009 and

February 2010). We are grateful to the project workers for enabling this to happen, and to the programme participants for permitting it.

19-25 programme:

The opening session of the second six-month course took place at Sherwood Forest Country Park. A dozen group members were present (all white males apart from one young woman) together with four staff (the two project workers and two local EIP professionals). The session began with introductions and a series of 'icebreaker' exercises, with lots of breaks and lots of support. There was already some feeling of engagement, especially when a staff member shared her own personal history with the group. The group formed into teams for a quiz about famous people with mental health issues. Lunch provided an opportunity for informal chat and 'hanging around', as well as for a game of 5-a-side football. The afternoon activity consisted of an obstacle course, again in teams. What was noticeable about the day was the skill of the staff in supporting members to take part at a pace with which they felt comfortable, with a style of interaction that was non-threatening but open and encouraging.

The final session of the same group was held in a youth centre at Sutton in Ashfield and attended by ten members (eight of whom had also been at the opening session). Five staff were present, although only the project leader and one CPN took an active part in leading the session. The session was concerned with reviewing progress on the programme and thinking ahead to the future. Beginning with a 'How was your week?' exercise, it quickly moved on to 'Getting help when you need it', constructing a 'Wellness necklace', and then revisiting earlier work: 'tree people', goals, 'comfort zone'. The session concluded with a round of compliments and speeches, and then everyone went for a celebratory meal. The day was marked by a strong sense of individual and collective achievement, together perhaps with some nervousness about the future.

14-18 programme:

The middle session of the short course in October 2009 was held in a youth centre in Derby. More than a dozen members were present (a mixed group, mainly referred by CAMHS) together with six adults (the project staff and helpers from the YPSS). The session was based around games and activities, mainly on a theme of 'friends', with lots of low-level positive interaction and a friendly, affirming atmosphere. Informal conversations with group members during the breaks were all very positive. Although members had clearly come to the programme with mixed expectations, all were glad they had done so. (One young man spoke passionately of his struggle to avoid a life of violence, and how helpful the group was in supporting him to find new social contacts having been compelled to separate from his former companions.) Members particularly emphasised the social aspects of meeting new people, and also having fun. An ice-skating trip was planned for the afternoon, which was not observed.

The second observation was of the final day of another short course, held in the Rethink offices in Derby. About ten group members were present together with six 'peer mentors' who had been trained for this role after taking part in previous courses, and five adults (the project workers and their YPSS colleague, supported by a social work student and a nursing student). Observation began during the mid-morning break, which was followed by an exercise in matching occupations to traits, which did not seem to engage the group very effectively. This led on to an exercise in exchanging personal traits between group members, which was much more successful. The lunch break afforded an opportunity to chat with members of the group, including several peer mentors who had been present at the earlier observed session, and one very quiet member of group who had only attended on two days and was still taking stock of what it meant for her personally. After lunch an exercise in writing cards to oneself (to be read a month later) appeared to engage people strongly. This was followed by an activity of decorating T-shirts, continued from an earlier session. In the afternoon the whole group went quad biking, with great enthusiasm (including the researcher).

Observations on this occasion suggested that the group could be divided superficially into three categories:

- a) members who were highly engaged with activities – either because they wanted to cooperate or because they were genuinely interested;
- b) members who were challenging, provocative or simply bored, at least for some of the time;
- c) members who appeared less confident about their place in the group and who needed to be drawn out or coaxed.

Not only did the staff deal with all three types sensitively, but the peer mentors were also observed to help and support members of all three types. It was clear that the peer mentors had gained personally from the opportunity to work in this way.

Final comments

The success of the project in the East Midlands appears to be characterised by the following:

- a) Confident, able staff well supported by the organisation.
- b) Strong, positive alliances with key local providers.
- c) Some very effective work with service users before, during and after their participation in the programme.
- d) Very positive feedback from local providers.
- e) Very positive feedback from service users.

Both programmes were strongly supported by local care managers, who referred young people to the project, supported them in attending and in some cases assisted in running group sessions. It is clear from our research that the programmes developed by the Uthink project are seen as an extremely important addition to the resources available in the area, both for young adults with mental health difficulties and for young people with emotional well-being issues. The 14-18 programme is hoped to continue through a service agreement with the Young People's Specialist Service. The future of the 19-25 programme is unfortunately less secure. Although it

is very strongly supported by local professionals in the EIP service, it has not so far been possible to secure funding for a continuation.

7. Findings for the South East

This part of our report is based on:

1. Interviews and other conversations with the Recovery Officers;
2. Study of local documentation
3. Interviews with five local professionals
4. Two whole-day observations of the second 19-25 group, including informal conversations
5. Two whole-day observations of 14-18 groups, with informal conversations;
6. Access to routine evaluation forms supplied by group participants

Activity in the South East and operation of programmes

The following provides a record of the activities in the South East:

UThink 19-25 1st run Sept 08 – April 09

UThink 19-25 2nd run July -09 – March 10

UThink 14-18 1st programme February 09 – May 09 (School)

UThink 14-18 2nd programmes May 09 – July 09 (CAMHS)

UThink 14-18 3rd Programme Intensive August 09 (young carers)

UThink 14-18 4th Programme September – November 09 (Challenge and support)

UThink 14-18 5th Programme January (college)

Residential 1 – Oct 08

Residential 2 – Nov 08

Residential 3 – (Southampton only) Aug 09

Leadership programme 19-25 – May 09

Leadership programme 14-18 – Oct 09

The two project workers worked in tandem when preparing and reviewing group work, with one taking the lead for one age group and vice versa for the other. They also negotiated co-facilitation for groups with statutory staff members.

Perspectives of project staff

The two project workers Anna Dinnage and Fiona Kidd were appointed in February 2008. They spent the first few months of their work consulting local stakeholders and developing the programmes. They report an initial period of uncertainty and physical isolation. Basic administrative arrangements and resources were absent and this created a bootstrap or self-starting scenario, which was amplified by their sense of isolation from Rethink managers and structures.

This unsettled settling in period also contained a set of negotiations with the four workers on the other two sites about the style and content of the project work for the two age groups. They are now based in a multi-use building in Southampton, which also houses other disability services. In this initial stage, the two workers had to find a way of working together as a pair. They also had to establish a working relationship with colleagues in East Midlands and the South West, who had already started to work on some of the project content. The need to develop the 14-18 programme rapidly put a particular time pressure, and some stress, on the workers.

Turning to their view of their work, the project workers considered that many of the participants had had traumatic histories and so an ethos of personal affirmation was adopted deliberately to mitigate their effects, leaving new more functional options open for the young people. When asked about a more general view about causal aspects of mental health problems in young people, they were more ambivalent and less clear cut. However, this notion of earlier adversity of participants recurred as a theme, as did the struggles of people with emotional difficulties living with their consequent impairments, exclusion and stigma. There was also an emphasis on 'emotional health not mental health' and optimism about providing affirming

voluntary help to those in need. In particular they were keen to achieve the 'soft outcome of confidence building and improved self esteem' They acknowledged though that problems might arise about the need to break an agreement of confidentiality if any risk to self or other were observed. When asked about the process of this break with confidentiality it was indicated that it would only occur after discussing the matter first with the young person involved.

The workers reported a mixed reaction from prospective referrers and co-workers in the statutory sector. Much marketing was required to stimulate a referral flow. They discovered that there were some statutory services managers who were keen and supportive but suspected that unacknowledged resistance was also present (hence the need for strong marketing and an initial poor referral flow). Eventually referrals picked up and good working relationships were developed with local statutory workers.

The relationship with local stakeholders has been 'mixed'. At the outset referrers were ambivalent about using the services and it soon became evident that there were pre-existing tensions in the statutory services between relevant potential collaborators. For example, despite meetings Anna and Fiona had in early 2008 with the early intervention services in Portsmouth and Winchester they secured no interest. This meant that the workers had to market the project strongly for a while, which led eventually to referrals coming through. By now those who have referred recognise that the incipient UThink project would offer an important potential option for them as referrers and for young people with mental health problems.

Co-working was established in the group work and 'clinical supervision' was also obtained from the statutory sector. This connection has been very supportive for the workers and helped them feel confident in their role. The perceived need for this anchor function of 'clinical supervision', compared to the other two sites, may reflect the relative lack of on-site management support for the project workers. It may also reflect a slight variation in the personal ideologies of the workers involved (cf. the other sites). Although the work was formally about short term personal support with

psycho-educational rather than therapeutic emphasis, these two workers interpreted their involvement in terms that were nearer to ideologies of person centred therapy and recovery that might be found in statutory mental health services.

Finally in this section a point can be made from the workers about their own iterative account of doing the work. Whilst the initial phase was a struggle around getting started, forming relationships and stimulating appropriate referrals, once the work started the effort was experienced as well worthwhile. For example one of the workers noted after the young carers' intensive workshop:

...it was essentially 12 hour days for most of the week. However, the hard work was really worth the effort. A few of the workers noted that they felt proud at the end of the day. I in turn feel really proud of their achievements (and Uthink/young carers)...

These two workers, like those on the other sites observed, were in their own ways committed, hard working and genuinely interested in the tasks carried out and in the relationships formed with young people. Modesty rarely permits respondents to make such an honest declaration but the feedback just noted indicates that workers do have a narrative, usually undeclared, about their capacity to work well.

Perspectives of other professionals

Referrers and co-workers strongly endorsed the project and the quality of work by the project workers. It should be noted that those agreeing to speak us were impressed and wanted to champion this type of work more in their locality. What we could not ascertain were any reasons to criticise or resist the project because of self-selected staff who were happy to talk to us.

The respondents spoken to commended the work on three main grounds. First, all of the work was well prepared. Second, the project workers involved was respectful and warm with all of the young people. Third, they managed to generate an ambience of positivity in the work. As one co-facilitator put it, when commenting on the prepared formal activities:

The true essence of the group is not really there on paper. What really matters is the unique nature of the group for these people at that point in time. This is difficult to get across but it is what [the worker] managed to create... new opportunities for the young people to think about themselves at this particular point in their lives.

This raises an important point about the desirability and utility of manualising, operationalising or auditing recorded descriptions of the interventions, rather than attempting to capture the emotional ambience of the group, the personal approach of the workers and the existential opportunities offered and possibly taken by the young people.

The same respondent also provided her perspective on 'clinical supervision' noted in the previous section- 'it helps people reflect on what is going on and not miss anything important'. At the same time she acknowledged that 'they are not doing therapy... I wouldn't call it therapy – more about support and resilience... it's a sort of top up for those already going in the right direction...'. This point about ideologies of intervention in mental health work is picked up again later in final comments. The comment also implies a causal mechanism about mental health gain.

The relationship with the families of the young people of the project was noted. Broadly, working with individuals on their own terms (rather than opting for some form of family intervention) was endorsed as a good thing but it was acknowledged that on some occasions (unspecified) work with relatives might also be important. This ambivalence also links to the point just noted about ideologies of intervention.

Another respondent was very impressed about the pace of the work and its appropriateness for young people:

I liked the way the work is snappy. The young people cannot get bored... it suits their way of life. The rapid turnover of activities was really important to keep them engaged. At the same time [the worker] was able to see patterns and bring the young people back to an understanding of a recurring theme, say about coping or feeling a lack of confidence and when it was possible to overcome it.

Like the previous respondent, she also wanted to emphasise that most of the time it was not what was done but the way it was done; she noted that 'what I see is a lot of empathic listening which is really important for these kids...'. She liked the way in which the activities created an opportunity for feelings, not just thoughts, to be expressed; previously many of the participants had not been given the opportunity in a safe place to express either.

Food was also mentioned. The groups were provided with snacks and drinks and these were endorsed less for their actual nutritional value than what they represented about care and respect for those attending. The impression gained was that this made the young people feel welcome and respected.

The final theme to note about feedback from other professionals was about 'level' or appropriateness of the work done and this may hint at the ambivalence of referrers (including silent resistance to engagement). One respondent expressed some initial ambivalence about using the project: 'I felt that what we do is more at the heavy or serious end of mental health problems in young people'. However, once the project was used a very good impression was gained about the quality of the work. Moreover, at odds with the explicit offer of short term support, he noted that:

I don't think that the NHS could do this sort of work. We keep people out of hospital that might be complex cases and we are under a lot of pressure about rapid throughput. In my view this sort of support from Uthink

decreases the chances of relapse. Uthink are very good at keeping in touch with us when things are not going well in particular cases... This is very valuable work – an extra set of eyes in complex cases for people working in Tier 3 CAMHS. It can also be a useful as a follow up support for early intervention teams and for young people coming out of an acute episode of psychosis... Would like more of it to support young people in recovery.

Two important points are raised here. The first is the utility of the project as a *complement* to statutory services. The second is the idea that the project can offer *follow up*. The latter suggests that the respondent was expressing a desire for this sort of service – the project itself was time-limited and in current piloting character logically pre-empted this follow up function. Nonetheless, the question of long term support and its availability is an important matter, noted again in the final comments. The respondents commented on this question of sustainability, and a fear that worthy and supportive services might fall between the cracks of different service providers and not be supported in a commissioning climate affected by pressures of the economic recession. For example, one provider manager commented:

This sort of work is best kept out of the NHS and it can be complementary to our work. It has shown that co-working has worked in practice. It is has shown that the participants have really benefited and they could all do it- they really could do it. This has been really powerful. Given the current state of the NHS this could all be seen as a luxury, so it really needs to be protected in the voluntary sector.

In the light of the current deliberations of Rethink about the Uthink pilot, this final point along with the previous one about continuity of support and follow-up is important because it highlights the vulnerability of comprehensive forms of local service position under conditions of economic retrenchment (see later discussion).

Perspectives of programme participants

The success of the project from a user perspective is brought alive by the short (12 minute) film made by some going through the 19-25 group. From the perspective of the project workers the provision of supportive and affirming relationships is at the centre of the project. The film content seems to bear out this intended aim. The content (not surprisingly) is very positive about attendance from participants, and it could have an important role in marketing for new groups. Probably of greater importance, though, is that the film was made at all. It is difficult to envisage how such a product would arise from a statutory mental health service dealing with young psychotic patients dealt with on a separate case-by-case basis.

Another example of the unusual outcomes made possible in the Uthink arrangement outside of the statutory sector was the young carers group (14-18 intensive). Feedback was taken from participants after the group and the views expressed included themes about the nature of mental health, enjoyment, new relationships, new skills and coping. Respectively, here are verbatim examples of these themes:

‘I have learned more about mental health’... ‘Everyone has mental health’...

‘Learnt even more about mental health, learnt new words’...

‘I had lots of fun today’... ‘I laughed out loud yet again’... ‘I have had lots of fun and learnt new things’...

‘Got along with new people’... ‘Met new people’... ‘I understand why people with schizophrenia don’t like to talk’... ‘Making friends and being able to be honest’...

‘Enjoyed the photography from the collage’... ‘I learnt more about working as a team’... ‘Know more about looking after our emotional health’...

Specific feedback about the workers is also worth noting. All of it was positive and it included comments such as:

‘They were really nice and kind’... ‘They were really nice and welcoming’...
‘Very friendly and easy to talk to’...

These could be simply noted as blandishments, but they need to be read in relation to our own observations and those of other professionals noted in other sections. They are of particular relevance in relation to a later note on the nature of helpful relationships. Moreover, the self-reported endorsements after the young carers’ intensive were confirmed presently by a written view from this schools outreach worker for young carers:

Thanks again for delivering such an excellent programme to the young carers group... One person said they grew in confidence in a group, would not usually speak at all in front of others and thought no one would be interested in what they had to say but found that speaking out was getting easier... I feel that this course would be valuable to all young carers regardless of whether they care for someone with a mental health difficulty or some other illness/disability...

Returning to directly expressed views from young people, here are some from the 14-18 group that relate to: enjoyment of the activities; forming relationships; and the food:

‘Enjoyed the drumming’... ‘I have had a really bad day but feel brighter, more relaxed and able to hold it together after coming here and especially after doing the drumming’... ‘I liked the happy and sad activity. It’s kinda let my feelings out’...

‘I had a really nice chat during the break’... ‘Talking to someone really cheered me up’...

‘Nice crisps and I have a smoking buddy’... ‘Working as a team and honey and cereal bars’...

This group also provided some feedback about the workers, which chimes with comments made earlier in this section and in others:

'bubbly fun'... 'cheerful'... 'always positive and understanding'... 'kind, always supportive'... 'sympathetic, always smiling'...

Returning to feedback from the older group, the following comments were made in written feedback from the 'up the next level' 19-25 group (May 2009). Although one of the six attendees said that they had learned 'nothing from the day', on a rating scale with 5 being 'really enjoyed', the average score was 4.5. Specific comments referred to positive learning about:

'use of body language'... 'SWOT analysis'... 'leading in interviews – how you can control the interviews'...

Observation of sessions

The work with young people occurred in non-medical settings and the approach of the workers suggest this normalisation emphasis. These settings were intended to make attendance non-threatening for participants, and the relaxed atmosphere and friendly non-clinical feel supported this expectation from observation. Arriving in advance of the participants, it was obvious that there had been extensive planning, which created a mixture of confidence and activity when entering the rooms of both the younger and older groups.

In the younger group those attending seemed to be trust the workers and were able to express themselves, when encouraged, about any task in hand. The drumming exercises are really interesting as they require cooperation about a new shared task and lead quite quickly to a successful joint outcome. All are in the same boat about the challenge and no disclosure of personal material is required. The young people quickly have to connect with one another to create a shared success. (These points emerged in discussion with the drum teacher.)

During the tasks the workers were solution, not problem, focused in the main, but let the young people talk about anything on their minds at the time. The participants had learned already to give due time and consideration to others as a group rule. Overall the feeling was one of positivity in the group, but this was not forced or evangelical. It seemed to emerge from a combination of the strengths focus, a lack of embarrassment about having fun and a confidence in the person-centred and affirming style of the workers. Observations about the latter were in line with the feedback noted earlier from the young people themselves.

On observing the older group a similar impression was gleaned. The worker co-facilitated the group with a statutory worker and at the outset it was obvious that the activities had been well planned. The workers linked in well together and the division of labour worked well. The young people clearly enjoyed the activities, though some functioned much better than others in a social setting. The workers were warm, positive and respectful at all times and were always flexible about digressing, when appropriate, from the planned tasks.

The setting of the group in a college meant that the participants were attending a non-stigmatised place, which was commented on at the time of observation by a young person recently in contact with statutory services. Drink and smoking breaks seems to enable further social contact to be enjoyed by the participants, reminding us that it is the whole exercise that is important, not just those bounded by start and stop times. In a couple of the participants some medication effects could be observed, which seemed to dull their apprehension and appreciation of what was happening.

Final comments

The success of the South East project site seemed to emerge from the following:

- a) confident and committed staff who were hard working and had warm and engaging personalities, which were both endearing to and encouraging for the participants;
- b) good working relationships with local providers;
- c) good working relationships with the participants.

This picture was confirmed in a 'triangulated' fashion from feedback from the participants, other service professionals and direct observations. A number of matters arose from the findings of this site to be noted.

First, the workers overcame early adversity to work together in a sort of 'bootstrap exercise' relatively distant from Rethink management resources. It may be that less committed product champions in a context of piloting might have become demoralised or dysfunctional. Second, the need for strong marketing was an indication that local services may have been ambivalent about cooperating with the project. The accounts from service professionals acknowledged this ambivalence, even though they also endorsed the eventual product in glowing terms. Concern was expressed about the need to continue with a useful project but the current climate casts doubt on this being secured.

Second, it was not clear from the findings whether the tasks in themselves mattered or whether they were simply a vehicle for helping and helpful relationships. We return to this point later in the report.

Third, if this sort of project were to exist in other localities, it may be important to clarify at the outset whether it is simply to complement statutory work or whether it should, or could, offer the degree of ongoing support and continuity of care which the NHS cannot currently guarantee. In the latter the style of engagement tends to be intensive and then the patient is discharged. If this remains the case, can and should the third sector offer ongoing support for young people with emotional problems? This was also an issue in the South West, as we shall see.

8. Findings for the South West

This part of our report is based on:

1. interviews and other conversations with the Recovery Officers;
2. study of local documentation
3. telephone interviews with four professionals
4. attendance at the celebration day of the project (Lifeboat College, Poole)
5. one observation of the 19-25 group, with informal conversation (Weymouth)
6. one observation of the 14-18 groups (Portland)

Activity in the South West

Table 1 shows the programme of work and the numbers of young people taking part in the South West. Note that the variety of the types of work negotiated on this site. This indicates variation on the core activities agreed for all three sites.

Table 1: programme of work in the South West

Bournemouth and Poole Programme	No.
14-18 Community (14/10/08-06/01/09)	6
14-18 Young Mums (28/01/09-03/03/09)	4
14-18 Young Leaders (7&14/05/09)	4
14-18 onto Residential (18/05/09-21/05/09)	2
19-25 Community (24/07/08-29/01/09)	13
19-25 Residential (23/09/08 – 26/09/08, 17/11/08 – 20/11/08)	5
19-25 Young Leaders (7&14/05/09)	4
14-18 Tailored Group Young Carers (08/07/09 – 04/09/09)	9
14-18 Community 2nd Round (03/09/09 – 12/11/09)	
14-18 Tailored Young Parents (Jan 2010 TBC)	
14-18 Tailored LAC Group (Nov 2009 TBC)	

19-25 Community 2nd Round (07/10/09 – 03/02/10) TBC	
West and North Dorset Programme	No.
14-18 Community Group Weymouth (04/03/09 – 29/04/09)	9
14-18 Tailored School Group (Royal Manor, Portland) (11/03/09 – 29/04/09)	6
19-25 Community (30/03/09 – 24/08/09)	9
14-18 Community Group Jan (2010 TBC)	

Perspective of the project workers

In the South West the two project workers were Paul Hanmore (19-25) and Rob Watkins (14-18). The boundary between the two roles was highly blurred, with each taking a lead but with the other participating equally, so the role of each is ambiguous in practice. This seemed to reflect a highly functional relationship. Both workers were very positive in their relationship with one another and the project participants. The office of the two workers was with other local Rethink workers (Discovery Court in Bournemouth). This provided ready access to their manager who was on the same work corridor (and who joined us for part of my visit to the Rethink offices). This arrangement proved to be very supportive for Paul and Rob. They did however consider that more administrative support would have helped on a day-to-day basis in terms of the efficiency of their work. There was a general problem at the outset to stimulate referrer interest, and a particular challenge establishing the 14-18 work because of a wide catchment area. Even though their administrative base is next door to the PCT office in Bournemouth, they found it difficult to engage the interest of NHS commissioners. Eventually though, demand exceeded supply and a diverse set of initiatives was established, whilst adhering to the principles agreed for all three sites.

Because this site was visited in the same time period as the nearby South East site, our observations of the similarities and differences quickly became evident. For example, the workers in the South West had no concern for ‘clinical supervision’

because they did not frame what they were doing as approximating to clinical work. Their identity was more as youth workers than mental health workers. Both were noticeably energetic and enthusiastic and were not fazed by their view of early resistance from referrers. For example one of them noted:

We are going very well- we are very excited. Our 14-18 group is *not* a clinical service but an opportunity for the young people to have some support and have some fun. At first CAMHs were confused about this approach and were not that keen to refer... The beauty is that we do not offer a pathology service...

Their overall approach seemed to be one of positive life coaching. For example, they made that point that:

We take a positive and prevention approach – how to stay healthy. In the 19-25 group we don't mention medication and we don't open doors without closing them afterwards. In the 14-18 group we accept referrals from anybody about concerns to do with emotional health. Unfortunately the 19-25 group is ring-fenced in terms of referral criteria. Generally the focus is on psychosis but actually we do take the odd person without psychosis. Our concern is not what people have been called but the pragmatic challenge of how they relate to one another in the group. It's all about a common experience in the group itself.

Distinguishing themselves from a pathology-focused statutory service was important in their accounts:

Because we are not a clinical service we think that it is important to have voluntary relationships with all our participants. It's about negotiated confidentiality if we have concerns about risk. This has rarely emerged. For the younger group this is practical and relational youth work – it's mainly about offering them chances for social support. For the older group it's about a social recovery model and we try to turn everything from a negative to a positive. We are not like the early intervention service – they can do some re-

framing but they largely approach their work as treatment – they have a job to do but it's different from ours.

These accounts of a positive non-pathologising ideology are consistent with observations of their group work (see later). They offered views about setting up the project and discussed those supporting and those impeding progress:

We were put in isolation. At the start we were selling programmes that as yet did not exist – it was a struggle to sell something that was ill-formed. The flow of referrals for 14-18 work was easier to stimulate because of wider catchment possibilities. With the older groups we had three separate systems to negotiate with (Dorset, Bournemouth and Poole). The Bournemouth and Poole PCT is in this building, but we cannot get past the reception! Local authorities and schools have been much more receptive. Our sense was of a rift between school nurses and CAMHs – the latter are not sure what to refer. But I think that we could sit in a place between schools and the NHS.

During contact with the workers it was obvious that they would not respond well or be subordinated to the type of bureaucratic processes that would be demanded in the NHS. Not only did they have a non-pathologising approach to their work, they enjoyed the freedom to bend rules about who they accepted in the groups, set up variations on the core activities of the Uthink project and take a laissez-faire and inclusive approach to their practice of positive life coaching and youth work (see later comments on their group work style).

A final note from the project workers' accounts is that some anxiety was expressed even mid-project about its long term sustainability and the implications of this for their own employment status (a repeated concern from the other Southern site.).

Perspectives of other professionals

In the light of the accounts of the workers above, the perspectives from school and NHS professionals will now be considered. In the accounts of the NHS respondents there was a consistent sense that they were the mental health experts (this concern with expertise was not evident from the school staff). For example here a CAMHS manager notes his role in the steering group for the project before it became operational:

I was there in a consultative role – helping them to form their documentation, reviewing action plans etc. I looked at their referral criteria and asked them to come and talk to my team and then think of any young people relevant from within our service. The team was very enthusiastic about the project and the Trust is always looking to innovate, especially about complementary work for our core service. We talked a lot about referral criteria and there was lots of discussion about risk and its management.

Immediately this gives a sense of two worlds, if not in collision (the aspiration for complementary roles recurs on all sides), then certainly with different priorities. Note the gap between the alleged enthusiasm of the teams and the report earlier from the workers that referrals trickled through in a cautious manner. Linked to this point, the same respondent simply stated as fact the following:

We struggle to get a viable number for group work. We tend to go straight for individual therapy, whereas the Uthink group goes straight for self-esteem.

This raises a question about why the NHS should 'struggle' to form groups of young people and opt as a default position for individual therapy, and why the latter is considered a more legitimate option than increasing self-esteem. This point is picked up again below in relation to this respondent's change of view since engaging with the Uthink project. Meanwhile, to reinforce the point about the rhetorical starting point of statutory service expertise, this co-facilitator of one of the 19-25 groups offers this view:

I was approached by my manager to work with the group. My main work is dealing with serious mental illness, so my attendance at the group was useful. I could discuss side-effects of medication on things like sexual functioning. We wouldn't normally work with the voluntary sector to do stuff like this, so it was very interesting for me. The Rethink focus is on the young people themselves, whereas we have to deal with their serious illness. We have less control and option about doing this sort of support work. We would like to do more groups, but service pressures means we don't have time. My work is largely about those at high risk – we have to carefully monitor and manage symptoms, and everyone recognises the need for effective treatments in line with NICE guidelines.

This formal professional account with its rhetorical features of technical superiority and gravitas, and its focus on risk and medication, will be returned to later. Here we simply note the strain inherent between this focus and that of the Uthink project. Is the focus to be people or illness; and should it be about ordinary social support or the technicalities of treatment? The ideological challenge this poses was returned to by the earlier service manager respondent. Having been involved with the Uthink project he began to question himself about his professional assumptions and aims:

We are now recognising that therapy may be replaced by this sort of social support and self-esteem building. We are trying to move more towards mutual selling (sic). There is a lot we can learn from the voluntary sector and vice versa. We need to look at our involvement with those like looked after children and we are sharing some ideas about volunteering. Maybe we should re-configure the workforce so that the voluntary sector could offer more because they are less stigmatising. This is not so much about resources as how they can be used. The NHS is a bit inflexible in this regard. And then there is the enthusiasm factor – Rob and Paul were fantastic – so enthusiastic.

Here the view from a school mental health support worker is given to demonstrate its contrast with the angst of NHS workers about their expertise and its sustainability:

Paul and Rob came with a stall to our college which was very beneficial – they came to us and lots of people were really interested in it. As far as the group work is concerned they are really enthusiastic and I love the holistic nature of their approach. It is less focused on mental health and more on well-being. For young people that is really important and positive – it gets away from a diagnostic model. They are also flexible. A young woman I referred found the group very beneficial – she gave very positive feedback about the group... The other advantage of Uthink is that in education we find difficulty in accessing the medical system – here we have a useful alternative. And if a young person falls between the cracks of the GP and mental health services, this sort of group is a great safety net. Also the medical side is preoccupied by treatment and CBT and stuff whereas here we have a social emphasis which is great. Social integration is at the heart of Uthink, whereas this is not the case with the NHS...

Thus the local view from the outside looks different in education than in health. However, the ambivalence expressed by the NHS service manager points out that the Uthink project is both a complementary option and a challenge to the ethos of mainstream mental health work.

Perspectives of participants

Direct accounts were not taken from participants on this site. However, a view from them was gleaned from attending the celebration event at the Lifeboat College, Poole and chatting to some participants in the breaks at the 19-25 group. Another manifestation of the view of success from a participant perspective was their

enthusiastic involvement in the leadership programme, the production of their own newsletter and their involvement with the community development.

The particular approach by the workers emphasises the right of the young people to develop their own personal solutions, and there is also an emphasis on this site on collective public events. For example, much excitement and enthusiasm was expressed about their visit to Parliament on March 23rd 2009 to meet with representatives of the Conservative Party, including the Shadow Health Secretary.

Their celebration event on June 23rd 2009 was well attended by a range of participants and stakeholders with knowledge of the project, who all reported about it positively. In another example, on July 26th the UThink group from Dorset participated in a Bournemouth event in collaboration with physical disability initiative ('Liveability'). This gives this site a strong community development dimension but the outcomes also manifest a sense of participant endorsement. This practical endorsement is important to note. Along with the enthusiasm for the user-produced newsletter, this sort of collective action suggests that those graduating from the course considered that it had been a highly valuable experience for them. A participant perspective was also manifest in the exercise on what aids recovery in the session of the 19-25 group described below.

Observation of sessions

The first session observed (19-25) was in a pleasant community setting in Weymouth, where the early arrivals met in the kitchen area to chat and Rob reminded us in passing that 'We are here to have fun but also to explore personal issues'. The group formed was of eight people (four male and four female – nine in total had been expected). There was a friendly 'buzz' in the group, which felt welcoming and positive from the outset. In the opening exercise about catching up about what people had done over the weekend, it was noticeable that the workers were as fully disclosing as the participants. The group was expanded that day with

two volunteers attending from Rethink, who it was discovered later had had mental health problems in the past. (This is relevant because the figures noted below in the recovery exercise add up to 10 not 8.)

When the afternoon activity was announced (pitch and putt), Rob emphasised that it was 'for all skill levels, including mine – I'm rubbish'. Some reflections went round about the previous activity (trampolining) and the workers pointedly endorsed each account with some feedback on the individual's participation.

The activities were received well by the participants and led to much discussion from all in the group (with a predictable range of confidence and enthusiasm). In this session there was an emphasis on discussing different expectations about recovery from the young people. It was fortuitous to attend on this day to gain an insight into a participant perspective on what the workers had noted to us was an emphasis on 'social recovery'. This was a lining up exercise (a scaling exercise but done on their feet rather than on paper). At one end of the line was 'does not help recovery' and at the other end 'does help recovery'. The workers then offered statements to the group to which the participants had to respond by standing where they felt right in the scaling line. The results are noted here for their illumination about how participants saw the nature of recovery and how they bunched in sub-groups.

Talking to friends

Does not help-----6-----4-Does help

Talking to your family

Does not help 5 -----5-----Does help

Talking to your care worker

Does not help 5 -----5-----Does help

Talking to your consultant psychiatrist

Does not help 4 -----3-----3 Does help

Getting high

Does not help 4 -----5-----1 Does help

Having a bath

Does not help 4 -----4-----2 Does help

Having a big meal

Does not help 7 -----2-----1 Does help

Going out for a drink with friends

Does not help 1 -----6-----3 Does help

Staying in

Does not help 2 -----7-----1 Does help

Isolating myself

Does not help 4 -----2-----4 Does help

Not only does the above exercise reveal something of the participant constructions on helpful activity, it also reveals the social model of the workers constructing the exercise, especially in term of the emphasis on relationality in the statements posed to the participants. This confirms the discourse of social relating emphasised in the earlier accounts of the workers and other professionals. A final observation was that some of the participants may have been slightly sedated by their medication.

The younger group observed was in Portland and it entailed meeting the children in the reception area of their school. Once assembled they all walked together for five minutes out of the school round the corner to a local community centre. The room was bright and airy and some of the children immediately started to be active while eating and drinking. The session started with a discussion of the shared activity with the group from Weymouth the previous week. We discovered later that culturally Portland is quite separate as it exists on an isthmus and is not easily accessed or left. The relevance of this is that the Portland children with emotional difficulties are isolated within an already isolated community.

The activities in the group were designed so that they could examine their relationship to themselves, to one another and to an extent to the workers. There was an emphasis on coping strategies when problems arose. (This felt akin, not for the first time across the two groups, to solution-focused therapy.) The level of

spontaneous activity varied in the group. At one end was a very disruptive girl who inevitably captured much attention from the workers. At the other end was a girl who was painfully shy and tended to answer monosyllabically and only when spoken to. Working with this younger group raised questions about client mix in this regard – might anxious introverts get lost in the group? Also given the poor attention span of some of the participants, would any of the learning in the group be retained after? Notwithstanding these queries, the group proceeded in an air of fun and positivity. All of this was consistent with the accounts of the ethos of the workers expressed by them and also by colleagues.

Final comments

The success of the South West project site seemed to emerge from the following:

- a) highly energetic and committed staff who were hard working and irrepensible when faced with challenges;
- b) good working relationships with local providers – although some resistance from the latter was noted;
- c) good working relationships with the participants;
- d) flexibility within limits – although the core Uthink programme was adhered to, the workers bent rules about group inclusion and the types of activity to emphasise.

(In regard to the last, much of the activity spread over into social activism.)

The proximity of the workers to Rethink managers and the local PCT did not deter them from expressing a sense of isolation. At the same, there was a sense of them being free agents and moral entrepreneurs who would probably have not welcomed a greater formal attachment to either Rethink or the NHS. These particular two workers were by turns ebullient, charismatic and frenetic in their approach to life and work.

The Parliamentary lobby and disability day raise some interesting questions about the therapeutic value of activism and its potential compared to other more traditional models of group activity, based on personal growth and a smaller social support focus.

As with the other sites, the matter of the complementary role of the work, rather than its challenge to mental health service orthodoxy, came through strongly in the practice of the workers and their views and those of others.

9. Findings for the project as a whole

In this section we report on the results of our research across the Uthink project as a whole, including the two discussions we had with the Recovery Officers as a group, and our engagement with the outcome data for individual users gathered by Rethink as part of the project. We then discuss our findings as a whole, using as a template Donabedian's framework for quality assurance as indicated earlier (see page 8 above).

Meetings with Recovery Officers

A group discussion with the six Recovery Officers⁶ in October 2009 was helpful in clarifying their perspectives on the project as a whole, and in exploring commonalities and differences between the three sites. Key questions we took to this encounter were:

- How important are individual differences such as professional background, personality, approach and style?
- How important is the actual curriculum – the structure and content of the programme?
- Is it primarily seen as education or therapy?
- What is the difference, and the relationship, with statutory services?

In some respects there was a consistent response from the group. Staff expressed the view that breadth in the team was important, in having a range of backgrounds and approaches with which to work, and that the specific blend of mental health and youth work approaches was what produced the 'magic' – something new and

⁶ Rob, Paul, Fiona, Anna, Sarah, Ellie (also James Gorman, and for the first part of the discussion Cathy Street).

distinctive from what services had offered in the past. The language used was seen as important in that 'we don't use technical/diagnostic terms', and all concurred that the approach to group members was one of addressing 'me, not my symptoms' and 'normalising'.

However, differences also emerged in relation to preferred style, with the workers in the South West overtly claiming an approach based on being 'fun, silly' and on reducing boundaries between themselves and group members, while for at least one of their colleagues in the South East boundaries were important, for example in relation to physical contact and self-disclosure, and it was also important to be a role model, for example in relation to smoking. This led to a heated debate which was not entirely resolved by the suggestion that it was important to 'be true to yourself' in adopting a style that was comfortable and authentic. There appeared to be different understandings of the ideology of recovery as 'walking alongside people' as opposed to approaches based on counselling where the distinction between helper and helped may be more marked; a difference between simply being empathic, or actually 'giving a part of oneself'.

In relation to the curriculum, all took the view that the structure and content of the programme was important and helpful, but that the 'magic' was in the relationships made and in 'young people who've had similar experiences feeling safe enough to talk about their experiences in a way that they don't get the opportunity anywhere else'. The process was seen as not simply a social group, or a support group, or psychoeducation, but a combination of all three. As to whether the process could be seen as 'therapy', the group struggled with this, seeing the term as applicable to elements of what happens in the programme, but not wanting to accept some of the baggage that comes with the concept. They preferred to see the work as being about having fun, learning and social contact.

All agreed that for all the young people in the programme, both in the 14-18 and the more severe 19-25 group, there was a fundamental problem of self-confidence and

self-belief which the programme was intended to address, and that a key element in doing this was the experience of not being alone, of being with people who 'get it'.

In relation to the differences between the project and statutory services, three main factors were emphasised:

1. the project works with groups, not with individuals in isolation;
2. the style is more approachable and informal, with no case notes and not focused on diagnosis;
3. the project leaves people in control of their own lives while the NHS tend to take control – 'still governed by risk... that's why they can't fully embrace the recovery model'.

In terms of the relationship with those services, it appeared that referrers tended to expect to have a lower level of involvement while a client was attending the programme, but were prepared to pick up the work again afterwards:

That was one of our stipulations: there needs to be continuity, we wouldn't accept a referral from just anyone. That's why we didn't go for self referrals, and I suppose that freed us up a bit from being so risk orientated, because we still had somebody statutory who was responsible.

But we do reduce their workload – no, we don't cure people, but for the 19-25s it is six months at that very crucial time of finding yourself, finding how you make relationships, communicate with others, skills, confidence – they know that when they go back to EI without us their need for EI is a lot lower.⁷

The staff from referring agencies who attended the groups were seen to offer something different by adding to the range of responses, and also to be able to answer specific questions – for example about the effects of medication. In addition their attendance was seen as beneficial in 'softening' the way that NHS staff were seen by young people.

⁷ EI = early intervention.

At a second meeting with the Recovery Officers in January 2010⁸ we reported on the research so far and our provisional findings, and gave team members an opportunity to reflect and comment on these. We began by discussing the contrasting management arrangements in the different sites, but the main focus was on what we could learn about contexts, mechanisms and outcomes. This discussion confirmed many of our provisional conclusions, and also added many nuances, which we do not attempt to summarise here but which are fully reflected in our analysis in Section 10 of the Report.

Outcome data

Towards the end of the study period we were able to look at the outcome data generated by the project. It was clear from the data produced that young people generally valued the experience of taking part in the programmes, and there is considerable evidence of a wide range of positive outcomes. The principal tools used were the YP-CORE assessment of general well-being and health for young people (including commonly experienced symptoms of anxiety and depression and associated aspects of life and social functioning) and the Recovery Star which integrates data capture with case work and includes general life and recovery items.

Our specific interest was in patterns that might indicate (a) whether the programmes appeared to be more successful for some young people than others, or (b) whether certain approaches or operational contexts, as represented by the different sites, were more successful than others. Unfortunately the available data do not enable us to draw robust conclusions in either respect. The information on individuals is not sufficient to show patterns of difference in response to the programme. There are some differences in outcome patterns between the three sites, with individual sites having more success on some measures and less on others. The South West generally showed reduced measures of improvement across the board, according to

⁸ Attended by Rob, Anna, Sarah, Ellie and James Gorman.

the Recovery Star self-ratings for both programmes; but low numbers of responses means that little significance can be attached to this, particularly for the 19-25 programme (see Table 2).

Table 2: Recovery Star – % improvement in self-ratings⁹

Site	East Midlands		South East		South West	
	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>
14-18	18.97	30	14.82	6	7.87	21
19-25	17.01	23	17.74	3	9.23	4

The YP-CORE results, on the other hand, do not indicate any such difference, with all three regions showing similar degrees of improvement as shown by the change in scores between the first and last programme sessions (see Table 3).

Table 3: YP-CORE – T¹ and T² ratings (low scores are positive)¹⁰

Site	East Midlands		South East		South West	
	T ¹	T ²	T ¹	T ²	T ¹	T ²
14-18	30.00	17.00	20.50	15.17	21.07	17.00
19-25	15.73	12.55	13.00	8.71	19.75	16.75

Common themes and local variations

When we look at the three sites there are common themes as well as local variations. The former are not surprising, given that they were all adhering to an agreed shared programme. The latter are also not surprising for a different reason. Local factors constrain and enable different aspects of a single concept in practice, as do the competence, attitudes and interests of those charged with its enactment. We noted local factors, especially in relation to the NHS and education sectors, extant on

⁹ Data supplied by John Larsen and Cathy Street.

¹⁰ Data supplied by John Larsen and Cathy Street.

the three sites. Before going on to examine these and other points within our realistic evaluation framework, some general points will be made by using the traditional quality assurance framework offered by Donabedian (1992).

With regard to *accessibility* it was evident that this sort of support for young people with mental health problems was a welcomed product of the Uthink pilot. All of the commentators from the three sites noted that a service such as this, which is based on support not therapy and lies outside of statutory provision, is missing from the landscape of available services at present. This suggests that the type of service being piloted by Rethink represent an important gap in current service provision. Typically there is *no access* to this type of service in most localities.

Turning to *acceptability*, we found no criticisms of the pilot sites from those referring to them or using them. The feedback was overwhelmingly positive and from participants in particular we found a resounding endorsement, whereas they expressed ambivalence about their contact with statutory services. This can be accounted for mainly by the voluntary emphasis in the third sector, whereas statutory services tend to be characterised by high risk concerns. However, other features were evident. The work was done in group settings, whereas the default position of statutory services tends to be individual therapy. The defect and symptom focus of the latter leads to a service ethos of grave concern and seriousness.

By contrast, the Uthink workers had no difficulty in emphasising the need to have fun. This, paradoxically, did not seem to trivialise the experience of the young people. Instead it seemed to raise mood, encourage hope, facilitate common communication and invite a positive framing of experiences. These incommensurable discourses of earnestness and fun shape the experience of the two services, for workers but especially for users. And yet, the harbingers of hope and positivity, who worked as pilot recovery officers on the three sites, in their own ways were all very serious about what they were doing. They could be seen as moral entrepreneurs in relation to person-centred care and recovery, with intimations in

the latter of imagined futures better than today's distress, demoralisation and confusion.

These ideological tensions over service ethos also colour the way we might think of Donabedian's third 'A' – *appropriateness*. This feature of quality is generally controversial because it reflects a tension between expressed need and defined, or 'normative', need (Bradshaw, 1972). A person-centred and voluntary emphasis focuses on young people as people and how they might find their own way on their own terms, with a little help from others, be they lay people or professionals. Such an emphasis is about *expressed needs*. That emphasis can be construed as being highly risky by traditional mental health workers, who are fearful of any deterioration in mental health or risks emerging to self and/or others. This leads to statutory services that emphasise the surveillance of symptoms and personal functioning and, more importantly, the need to ensure treatment compliance. Indeed as one respondent put it, looking expectantly to the Uthink workers, they could become an 'extra pair of eyes'.

This surveillance and treatment emphasis means that professionals determine what is important to consider and how the patient's symptoms should be managed or how they should be protected against 'relapse'. This is about professional action and the patient's experience being determined and guided by *defined need*. Thus what any of us might consider to be an appropriate service for young psychologically troubled people depends on whether we emphasise expressed or defined needs or what balance is being attempted in this regard. This point about tension and balance is applicable to a judgement about any service, including the one under consideration here. It is not our role here to arbitrate on what that balance should be, but we do need to note that it is a balancing act of sorts for all concerned, with different views inevitably being expressed therefore about what 'service appropriateness' means: appropriate for, and according to, whom and under what circumstances? It is certainly not self-evident that what mental health professionals (or any other expert stakeholder) say is appropriate should be accepted uncritically.

Turning now to *equity*, this has already been covered in part in relation to access. Unless this sort of service was to be available in all localities, then there is no meaningful sense in which there can be equity of access. Other considerations inherent to the pilot were also inclusion criteria. It may have been that sometimes the workers 'bent the rules' about referral criteria in relation to age or symptom profiles, in order to subvert the constraint of inequity. We noted that many in the 19-25 groups had not been psychotic, although they had been in severe distress. This matters because it is common now for service allocation to be determined by client characteristics of age, diagnosis, severity of symptoms etc.

With regard to the remaining two 'Es' of effectiveness and efficiency (or cost-effectiveness), this evaluation was not intending, and was not able, to determine firm judgements. It might be worth commenting, however, that the accounts of referrers and participants suggested that the service was benign and helpful to people using it. Some commentators also implied that the community support function of the Uthink project might help to maintain mental health, and so prevent relapse. These are inevitably impressionistic reflections, but they do point to the scope for further research on services of this type with an emphasis on studying effectiveness and cost-effectiveness.

One problem at present is that the effectiveness literature is dominated by studies (especially RCTs) of de-contextualised interventions such as CBT, which rarely study the effectiveness of *service types in context* and judged by service users, not just by professionals. However, this problem has been noted in relation to complex interventions and in relation to the shift of focus to self-management and chronic disease management (e.g. May *et al*, 2009; Lovell *et al*, 2008). This literature is particularly pertinent to people with serious mental health problems, especially if they are in need of long term support or in episodic service contact, live in the community and mainly access the NHS via primary care. Given that the active participation of service users is now guiding this shift to self-management, including self-management of mental health problems, the Uthink initiative, with its emphasis on partnership with users and its blurring of the boundaries between aspects of

psychological treatment (person-centred counselling and solution-focused therapy), social support and even community development, is an important experiment.

Finally, we should note that a range of negative perceptions is undoubtedly missing from the picture presented here, because we were unable to engage either (i) with professionals who were resistant to the appeal of the project or (ii) with potential users who for whatever reason declined to take part. Although we do not think this gap poses a serious problem for our analysis and conclusions, it should nevertheless be borne in mind.

10. Analysis – mechanisms, contexts and outcomes

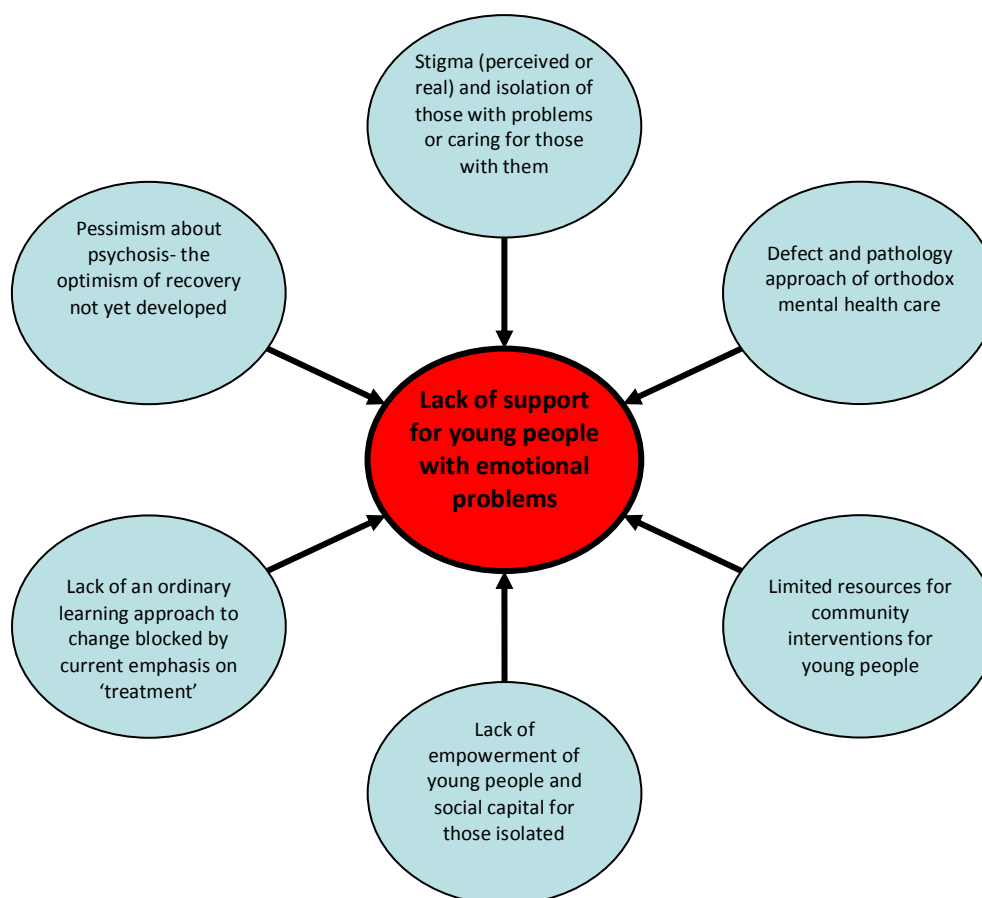
Having considered the findings through the traditional and authoritative quality assurance lens of Donabedian, we now build on that sense-making through the use of Pawson and Tilley's realistic evaluation framework, which guided our methodology. Both in their own way are underpinned by a systemic position about ontology, where the viewpoint of stakeholders in the care system can have a real influence and views are not merely an epiphenomenon or 'anecdotal'. However, the additional advantage of Pawson and Tilley's frame of reference is that it is dynamic and ensures attention to contextual factors such as place, space, resources, particular people and their actions, so it can create a richer picture of understanding.¹¹

A good starting point before we move to examining mechanisms in their context is to describe what the real problem is that the Uthink project was aspiring to address, ameliorate or counter. **Figure 3** (overleaf) captures a view of this based upon the original documentation and confirmed by accounts from the stakeholders subsequently accessed in the evaluation.

Whilst the accounts of people we collected on the three sites confirmed this starting point about the problem being addressed, we did not elicit any clear views about another ontological starting point – what are mental health problems? Whilst we know that this question remains highly contested in academic and professional debates (Rogers and Pilgrim, 2005), none of the respondents made a clear statement about the question. The shared concern was less on arguments about original causes (aetiology) or labelling (diagnosis), and more about the recognition that current arrangements for helping and supporting young people could and should be improved and elaborated – a focus more on consequences than causes.

¹¹ Realistic evaluation allows the interplay of two forms of social scientific understanding: *verstehen* or interpretation and *erklären* or explanation. The latter is attempted more cautiously but is permitted.

Figure 3: View of mechanisms producing lack of support for young people



Mechanisms, contexts and outcomes – initial review

Our initial view of what might be the significant factors was based on our overall data collection (project documentation, interviews and observations) and further refined in discussion with project staff.

The *mechanisms* that seemed to be playing a significant part in the process were:

- i) The specific content of the programme around learning to manage one's own mental health;
- ii) The opportunity for contact with other people in similar position – realising one is 'not the only one';
- iii) The chance to learn new skills and to try new activities;

- iv) The break offered from personal isolation;
- v) The helpful relationships with project workers;
- vi) The positive encouragement given to engage with the project and activities;
- vii) The primary focus on 'the person, not the patient'.

There was inductive evidence that all these mechanisms had a part to play. The project workers considered that the break from personal isolation and the opportunity for contact with other people in a similar position were probably the most significant in promoting recovery.

Key *contextual* factors appeared to be:

- i) The degree of receptivity of local professionals to the project's innovation;
- ii) The culture of a voluntary organisation with its relative openness to innovation and risk-taking;
- iii) The skills and personalities of the workers;
- iv) The actual design of the programme;
- v) The ethos of 'strength' and 'recovery';
- vi) The quality of preparatory work done with group participants;
- vii) The sufficiency of funding for the project and for the associated activities.

Most of the above factors were constants in the project across all sites and programmes. The main exceptions to this were (i) and (iii). The receptivity of local professionals varied considerably between sites and even programmes, as we have seen, and we reflect on this further below. The skills and personalities of the workers, while clearly an important feature in each region, were also very different in some respects, because of variations in professional background, personality and values.

Potential or desired *outcomes* for group members included:

- i) Improved confidence
- ii) Heightened self-esteem
- iii) Richer social life/networks
- iv) New skills and interests

v) Educational aspirations/achievements

vi) Reduced stigma

We saw evidence from project staff, from evaluation tools, and directly from young people that all these outcomes were present to some degree in all programmes. There was a degree of uncertainty in relation to the final point, in that young people did not talk explicitly about stigma. However, there were some signs that the project had enriched their capacity to resist stigmatising processes in various ways. There was not clear evidence of variation in the degree to which different sites and programmes achieved these outcomes.

It is also worth taking account of potential outcomes for professional staff. For project workers these included job satisfaction (with some ambiguity because of the time-limited nature of the employment), and personal and professional development. For collaborating staff (referrers and co-facilitators), the project could provide new possibilities for working, both by being an 'eye opener' and by offering complementary skills. We cannot comment on outcomes for non-collaborating staff because we were unable to make substantial contact with this group.

Realistic analysis

We can now deepen our analysis of *context-mechanism-outcome* configurations in the project. With these initial thoughts in mind about how we understand what the Uthink project was intending to do, according to its stated aims (which found sympathy with local stakeholders), we move to flesh out a realistic analysis of what was going on when the broad initial premises were put into action in the three sites.

Our observations and the accounts we elicited confirm the picture that the Uthink project was endorsed as a success on all three sites, and a desirable local addition to pre-existing service provision (although there appears to have been ambivalence in some quarters regarding the latter point). This general conclusion was drawn in the

previous section within a Donabedian framework of analysis. Here we build on that conclusion by looking at our findings in terms of context and process-outcome links. First these are listed and then they are summarised in a formulaic diagram.

Context

The following conducive conditions were noteworthy:

- The project workers acted as *product champions* or local advocates.
- These product champions were *embedded in an organisational framework*
- The project champions were *manifestly enthusiastic and committed* to their work.
- The project was *materially resourced* (albeit for a fixed period) by the finance supplied at the outset
- Working partnerships were developed with the statutory sector both in the planning and implementation of the programme. These created *necessary alliances* with managers and frontline workers in the NHS. Those managers could act as internal advocates for the project and the therapy staff could act as co-workers, and at times, supervisors.
- Working partnerships were also developed with those working in the education sector. These staff encouraged the project and provided or encouraged *appropriate non stigmatising settings* for the work as well as supplying referrals.

The above need to be considered in relation to the following impeding conditions:

- There were *limited resources* available to test out the programmes. These were relatively small scale projects – only two workers per site compared to the relatively large staffing levels in statutory services.
- *Passive resistance* from statutory services was noted. We could not find anyone who actively criticised the programme, and so this point is one of deduction from two sources of evidence. The first is that despite the surface

acceptance of the principle of the programme, the project workers had to work hard to stimulate the correct number of appropriate referrals. Second, some of the accounts of the statutory mental health workers implied a distrust of the voluntary sector to properly understand the nature and risks of mental health problems in young people. There was a strong implication here of the danger of well-meaning amateurism that might lurk in the third sector. It was not merely that the statutory workers had been invited in for partnership reasons; from their perspective this involvement was necessary in order to compensate for the relative ignorance of the Uthink staff.

- Linked to the last point, many in the older groups were on anti-psychotic medication which has common effects of sedation and akathisia. These *iatrogenic effects* may have limited the capacity of some of the group participants to be fully involved. This leads to the next point.
- In the older group, statutory service contact had been defect- and medication-focused. Whilst the Uthink project offered an alternative space to reflect on their lives and problems, it never aspired explicitly to be an independent service to provide a fully protected alternative to NHS mental health services. Indeed its emphasis on partnerships pre-empted that full guarantee. This *ambiguity about partnerships* was a contextual aspect of the experience of both the workers and the participants.

Process-outcome links

Conducive conditions

- Having highly committed and determined project champions coupled with enthusiasm from (enough) referrers and the participants has been conducive to success. The *project champions in their own ways were extra-ordinary* in their enthusiasm (whether expressed quietly or more noisily). This is important to note in relation to prospects for scalability (see later).

- The funding from Rethink provided the project with vital resources to enable it to grow and develop as did the *ongoing availability of management support* on the three sites.
- The *positive role of the participants* also needs to be noted. Their attendance at the group work or other activities (such as the lobby of Parliament) was voluntary and so in its own way pro-active. This indicates that they were active agents, not passive recipients of a service, which links to the next point.
- The positive benefit of participants taking part in the programme has been conducive to its success and was manifested in the reported and enacted *improvements in self-confidence and self-esteem*.
- This evidence of success was accompanied by evidence of *increased social contact* inherent to the group emphasis of the project
- The *regular but voluntary structure of the programme* also gave service users routine and something to look forward to positively because attendance was invited not demanded.
- The project had *support from key people within both the NHS and education systems*. It was not sufficient for the project to receive 'official' local endorsement at the outset, and during its planning phase, it also had to be supported on an ongoing basis once operational. Key individuals certainly provided that continued support and advocacy.
- The explicit commitment to a *strengths-based and recovery approach* to the work was appreciated by the young people and enjoyed by them.
- The *emotional climate* of the group work observed was one of positivity and fun. This might be a contrasting (alternative or complement) experience to forms of provision which focus on risk management and symptom surveillance.

The following *impeding conditions* can also be noted:

- The project workers suggested that at the outset *they experienced a sense of isolation*. The way this was expressed was not consistently linked to the physical availability of management support.

- The project workers, mindful of the *short-term nature of the project*, were caught between hopes for its continuation and concerns to ensure their own continuity of employment when and if the project came to an end.

In the light of the above lists of conducive and impeding factors about the processes of the project and their context, the following diagram (Table 4) tries to capture them in a summary manner, incorporating some points in addition from the previous section examining the ‘Donabedian’ implications of the Uthink project.

Table 4: Context - Mechanism - Outcome configurations

Context +	Mechanism =	Outcome
<i>Without the Uthink project</i>		
The context has an absence of ordinary supportive services	Statutory services lack time for, and emphasis on, strengths and recovery. Focus on surveillance of symptoms and ensured individual treatment compliance. Service access is determined largely by level of risk.	Services focus on defects and anxious risk management. Lower-risk young people may not enter system or may be kept waiting. Patient needs are defined largely by professionals. Professionals are rule-enforcers governed by ‘normative’ need definition.
<i>With the Uthink project</i>		
The new context has enthusiastic, motivated project champions with an alternative service ideology and provision of group contact in community (not clinical) settings.	Improved relationships with service users come from fun, strengths and recovery focus in voluntary group settings in a non-stigmatising environment. New opportunities for social contact/capital are provided.	Increased engagement of service users and increased generation of service user led projects. Flexible access to service: increased accessibility of projects for service users and reports from them of the service being acceptable and appropriate to their expressed needs. Relationships formed in those previously isolated.

Further reflections on context and mechanisms

Studies of cost-effectiveness or efficiency are often reported in terms of the 'bottom line' of outcomes. If we are to understand how outcomes emerge, in order to build up new and better services for users then it is important to address 'the forgotten pathway from process to outcome' (Brugha and Lindsay, 1996). Conceptually this refers to understanding the context and mechanisms sought out in realistic evaluations. The left hand column in Table 4 indicates how the absence of events creates one set of conditions and then the importation of a new set of condition creates a new presence (in this case the Rethink investment on the three sites). That importation changes the context and thus is the start of new mechanisms (the middle column in Table 4).

Reflection 1

The very presence of the Uthink initiative temporarily changed the context of mental health service provision for young people in the three localities.

Reflection 2

That presence created the conditions of negotiation about service ideology. Much is evident about questions about pathology versus strengths, treatment versus recovery and risk minimisation versus risk taking. In addition the prevalent emotional climate of the two systems was noticeably different.

Reflection 3

Those different service ideologies were then enacted and encountered particular responses from the context of the status quo. Those responses were both resistive and enabling.

Reflection 4

The outcomes achieved or arrived at, within the constraints of time- and staff-level limited innovation, were a product of enthusiastic and talented project workers finding the limits of their freedom to succeed.

Reflection 5

Those limits were set by the extent to which the dominant forces in the statutory services were willing to embrace the innovation (as co-operative referrers and willing co-workers) or resist it (to our knowledge passively, by not embracing those two forms of personal commitment).

Reflection 6

The existence of the tension between the two service ideologies reflects a much deeper dilemma and challenge for mental health provision in all developed countries which contain (the misnomer of) 'mental health law' (Pilgrim and Rogers, 2010). The Uthink project, with its emphasis on strengths and recovery, emphasises mental health gain for the person identified with a problem, under conditions of true voluntarism. By contrast the concern of statutory mental health services is to ensure risks to self and others are minimised under the expert gaze of professionals. This encourages a service orientation, which is problem-focused and concerned with surveillance and the hovering option of coercive control.

The Uthink project's potential for success, however well staffed or financed, will (and did) elicit evidence of constraints arising from this tension, as will moves within statutory services to become more person-centred. The recent policy shifts in relation to 'personalisation' and 'recovery' highlight this point in relation to the latter. Thus, the Uthink project is also bringing out *tensions about core functions of services* that are emerging anyway within statutory services themselves. The Uthink project is not the source of those tensions but its presence illuminates them. That deeper contradiction about the role of mental health services in society was elicited in the particular ways described above by the presence of the Uthink project and created some unintended consequences and offered some lessons about scalability.

11. Conclusions and recommendations

Our overall conclusion is that the Uthink project was a success on all three sites. Good relationships were made with local service providers, the programmes were successfully run as planned, and the outcomes were satisfying to the young people who took part and to those working with them.

The conditions of that success are multiple, as the preceding analysis makes clear, and it is not easy to attribute relative strength to the different contexts and mechanisms, or to point to clear differences in patterns and outcomes between the three pilot sites. However, we can say with some confidence that some combination of the distinctive approach taken by the programmes, the recovery ethos which underpins them, the opportunities they offer for sharing experiences, problems and hopes with peers, and the skills and personalities of a group of committed and enthusiastic workers, have had a strong appeal for young people with mental or emotional health issues, and have been found by them, and those working with them, to meet a real need in ways which other, more traditional, services have not achieved. We can also say with considerable confidence that the receptivity and responsiveness of local providers to this innovative offer makes a critical difference to its success.

Our analysis points to a number of respects in which a project like this adds value to local provision. The evidence is mixed on whether it represents (i) a radically different approach, (ii) a more subtle shift of emphasis or (iii) an extension of existing services with additional resources; although our inclination is to (i). In any case, by addressing needs which are not effectively met through current provision, it has made a real difference to the lives of vulnerable young people.

Within this broad picture two caveats should be noted. First, some events emerged which were not anticipated (an unsurprising point about open systems). For

example, the individual sites 'tweaked' and elaborated the core expectations of the programme according to local circumstances and their own interests. The South West workers in particular deviated from original expectations, in creative and acceptable ways. There was also some learning offered by the ambivalent attitude of the workers towards management support. On the one hand there were reports of a sense of isolation, but on the other hand it was obvious that these pioneers would not necessarily work readily in a traditionally structured bureaucracy. This point about what amount and style of management should be available, in order to support an innovatory project such as this one, is important to consider, because the type of worker who innovates in a pilot is likely to be different from those operating in routine service provision. Initial project champions and those working in a routine manner need to be thought about in different ways if and when the pilot is 'rolled out' elsewhere.

This leads to the second caveat. The prospect of scalability of this successful project seems to be reliant now on the availability of resources, and on strategic priorities for Rethink. In principle the likelihood of success in other localities is high. However, the long term sustainability is only partly a function of the proven merits of the pilot. The latter are necessary but not sufficient conditions for spread to other localities. It is now mainly reliant on further funding. It might of course be used as model service by another provider (once in the public domain there is no reason why it could not be resourced by organisations other than Rethink). This might raise an immediate question to consider about intellectual property for Rethink.

The extra funding now available within Rethink to consider next steps about the Uthink project in the coming year provides an opportunity to consider this matter, along with the implications of this report and the one from John Larsen and Cathy Street. In the first instance a dialogue between us all about 'what next' could create a new context of inquiry. This could place this report alongside theirs and discuss them both in relation to the context of a new Government, the resources available within Rethink, and the wider policy context (in particular personalisation and the emerging consensus on the importance of recovery in all services).

We acknowledge the difficulties which now present in achieving a sustainable future for this project. Conceived in an atmosphere of expansion and optimism about fundamental change in services, it has continued in a very different climate of uncertainty, anxiety and retrenchment. Neither Rethink as an organisation, nor the local commissioners who might want to buy into the future development of the Uthink approach, are shielded from that harsh climate. Nevertheless we consider that it would be extremely regrettable if that meant that the project was not able to continue. It is clear from the evidence we have gathered that it represents a very effective and helpful service for severely disadvantaged groups of young people, whose needs are not responded to by current services.

Finally, the findings and the starting aspirations for this project for the three sites are material that invites a wider theoretical analysis on a number of fronts.

First, the diagram (Figure 3) outlining what maintains conditions of support for young people with emotional difficulties points to the prioritisation of state resources according to *risk*, not person-centredness. This is a wider social policy point about the role of statutory mental health work and its normative social control role. Defined not expressed needs seem to define the scope of mental health work and its ensured and stable funding from the state. This point is at its clearest when we look at the contradiction between the life span prevalence of mental health problems and the coercive management of them. On the first count, mental health problems are at their most prevalent in the very young and the very old (creating a U-shaped curve in which, maybe counter-intuitively, on average our best positive mental health is in late middle age) (Rogers and Pilgrim, 2003). But on the second count, state funding on mental health services generates an emphasis on the management of mental health problems in young and middle adulthood (the period of working age and child rearing) (Knapp, 2000; Mental Health Act Commission, 2009). These trends seemingly contradict one another; but not if we focus on the matter of professionally-defined need.

Second, within that policy trend, will support and voluntarism be constantly cast in a secondary role, as a sort of luxury, unless the nature of mental health work is appraised honestly by all policy developers and professionals involved in mental health work? The discourse of professional mental health workers (evident in the findings) is one of assuming that support is a sort of desirable extra displaced by the opportunity costs entailed in other priorities about treatment, surveillance and risk management. If this remains the case then their services will find it more and more difficult to align themselves with policies about personalisation and recovery – a cue for our next and final point.

The project represents another tilt, conceptually and practically, towards recovery-orientated services, and so also tests out the capacity of the monitor-and-treat tradition of the mental health professions. This project, and any other that takes recovery seriously, will test the capacity of that tradition to be retained undisturbed. We are entering a period in which the capacity of the tradition to justify itself and truly (rather than rhetorically) adopt a recovery orientation, especially in relation to the older group attended to in this project, is becoming challenging for professionals.

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