From surviving to thriving: how does that happen

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Abstract

Purpose – *The purpose of this paper is to explore what helped seven people in contact with secondary mental health services achieve their vocational goals, such as: employment, education, training and volunteering.*
Design/methodology/approach – *The authors used the practice of co-operative inquiry – staff and peer supporters co-designed an evaluation of vocational and peer support work with service users.*
Findings – *Service users experienced invalidating living conditions that caused serious distress. These life struggles included: isolation, trauma events and stigma. The impact involved distressing emotions such as: despair, fear, pain and confusion. In contrast, when service users experienced supportive validating conditions (trusting relationships, engaging in valued activity and peer support) they reported being able to learn, change and grow – finding their own way forward, to improve well-being and quality of life.*
Research limitations/implications – *Qualitative analysis from in-depth interviews revealed a range of consistent themes that enabled the authors to visually represent these and "begin" developing a model of change – grounded in lived experience. Further research is required to develop this model.*
Originality/value – *The development of a model of change grounded in an invalidation/validation framework offers a different approach – in terms of how people are perceived and treated. This has relevance for Government policy development, clinical commissioning groups and practitioners.*

Keywords *Social inclusion, Mental health services, Vocational services, Peer support, Recovery, Employment support*

Paper type *Case study*

Introduction

Our vocational service forms part of a large NHS mental health trust that operates in a densely populated inner London borough. The population is extremely culturally and ethnically diverse and it is one of the most deprived boroughs in the UK with high levels of social inequality, crime rates and acute admissions.

The drivers that initiated our vocational service developments stemmed from extensive service user consultations – some user-led – audits and service evaluations. Service users were asking for a better deal, a broader range of support and better opportunities to achieve personal goals and make progress. "Replace the fear with real possibilities" (Bertram, 2008, p. 27). We also keep a baseline of how many service users on CPA are employed. Over the last decade this figure has remained between 3.4 and 4.9 per cent. Collectively, this evidence created a compelling argument that a fundamental change was needed, towards prioritising social inclusion.

With the support of our local progressive service director and commissioners we started to grow a range of innovative initiatives in a centre located on the ground floor of a block of council flats, opposite a primary school. These consist of a user run information and support service, a work training project that won a contract with the local council to carpet clean all of its libraries and

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partnerships with the voluntary sector that facilitate an individual placement and support employment service. We also have good relationships with local occupational therapists in community teams and have trained and integrated peer supporters. Service users also run the reception area.

Over the last six years resources for the inclusion agenda were always scarce because of a stretched financial landscape and competing local priorities, but in collaboration with service users, we achieve consistently high rates of social inclusion outcomes. For example: annual data from our user run vocational service shows that 13 service users achieved employment, 22 went into mainstream education, 14 started volunteering and 21 took up training. This amounts to a 62 per cent outcome ratio. We knew it was time to delve deeper and learn why our approach works.

Literature

It is widely recognised that people in contact with mental health services are one of the most excluded groups in society. The causes of this exclusion are complex, multifaceted and not completely understood, but the facts are stark. Employment rates have hit their highest since records began, yet the majority of service users are unemployed (Office National Statistics, Statistical Bulletin, 2015). The response from successive governments and mental health services in the UK boils down to one question: what more can be done to help people become socially included and increase well-being? For example, Government policy intention is that:

> More people will have a good quality of life – greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, improved chances in education, better employment rates and a suitable and stable place to live (Department of Health, 2011, p. 6).

This leads to another key question: how is this going to be achieved? Current critiques of the care programme approach (CPA) and the care planning process state that the work of mental health services through CPA is generally not effective – in terms of helping people achieve their goals and enhancing their life experience. There are calls for a fundamental change to the nature of the relationship between service users and professionals – with an emphasis on partnership and collaboration (Rinaldi and Watkeys, 2014).

It has been argued that the effective use of strength-based models can transform the nature of relationships between staff and service users because of the empowering principles (Rapp, 1998). The helping process focuses on service user's interests and capabilities, rather than on deficits or problems. The role of the staff is collaborative – moving from doing to or trying to fix, to helping people find their own way forward by identifying the things people are able to do and encouraging choice and control within a trusting relationship. This has been described as hope inducing and promotes well-being (Rapp and Goscha, 2010).

The recovery model is another evidence-based approach in the UK that attempts to help people achieve life goals and be part of their community. Recovery is seen as a unique and personal journey and the role of mental health professionals is to offer the right support to facilitate that process (Shepherd *et al.*, 2010). Some service users we regularly talk with tell us this does not always happen because professionals are more concerned about medication, monitoring and risk management. We are often told that some service users get talked at, told what to do, or asked what is wrong with them – rather than being supported to find their own way forward in an empowering and trusting relationship.

The term recovery has also become controversial. The Service User Activist Group in our locality has a long tradition of being radical. They reject the term recovery and asset-based approaches through co-production – stating these concepts amount to: imposed individualism because of the capitalist fiscal crisis (Southwark Association for Mental Health, 2015). These service users are calling for the return of day centres as safe spaces where they can meet/network – saying these have been closed because of cuts. This group are also offering T-shirts for sale with "unrecovered" printed on the front and the article in their newsletter is entitled: Recovery in the bin.

Like recovery, there has been a huge growth in the development of peer support initiatives around the world and in the UK reviews of the literature highlight important reasons for this growth.

Peer support can successfully promote hope and growth, increase self-esteem, social inclusion and the self-management of difficulties (Repper and Carter, 2011; Lawton-Smith, 2013). More recently the literature is beginning to explore the differences between user-led peer support and peer support initiatives developed by statutory mental health organisations. The incorporation of peer support into clinical systems can be a risk because it can dilute its original values and compromise its independence (Faulkner and Basset, 2012). We have seen job descriptions where peer supporters are being trained up to undertake duties, such as: "assessing" service users, or "clearly record client casework notes and monitoring information".

In our experience the nature of a partnership or collaboration with professionals, peer supporters and service users is clear: the quality of engagement is simply everything. Service users ask for safe trusting relationships where all of who they are is unconditionally accepted. This can create the necessary conditions (safety and autonomy) for taking steps forward – identifying and achieving vocational goals that lead to greater social and economic inclusion.

However, we found the term social inclusion slippery and too conceptual. When we asked hundreds of local service users – in a number of consultations – what it meant to them, for some it meant nothing or provoked anger and suspicion. These reactions reflect the understandable pessimism associated with many peoples experience of living in a discriminating and oppressive society. For others inclusion was a multi-dimensional process involving the self and an opportunity or a goal, to reach somewhere better. Our conclusion was that inclusion is not a theory or a concept, but can only be explored, lived and experienced by individuals, e.g.:

> Social inclusion is not about disability, symptoms or treatment management. It is about an individual's activity of daily living, and how they relate to the world. It is about bringing the world into a life (Bertram, 2008, p. 26).

Our experience suggests that there needs to be a pragmatic balance of facilitating asset identification and development as encouraged by co-production and strength-based models, with sensitive and insightful support. This is a difficult balance to achieve – as a service our focus has always been about supporting people to achieve their own defined mainstream vocational goals through an asset-based approach. However, it would be trite to suggest people's vocational and social inclusion issues can be taken out of context – in terms of the daily struggles we witness: benefit sanctions, housing problems, trauma, abuse, violence and family breakdowns. As the manager of our user run vocational information project describes:

> When we are assisting users in the Vocation Matters project it feels quite often as if they meet with us and in front of them they are holding up a mirror of their own lives. In this imaginary mirror they are in a very dense wooded area without any light, just themselves looking small and vulnerable. Every tree in this mirror represents a difficulty in their lives. Many of us will have walked though heavily wooded forests and even on the sunniest of days they can be dark, cool unwelcoming places where you could easily get lost. This is more often than not the view of their lives that they bring to the initial meeting. Over a period of time we work together to try and clear the trees a little to get some light shining through. The more problems that are dealt with the happier and more empowered the individual often feels- this is not an exact science and as in everyone's life things do not always run smoothly, but in general individuals do want to do more for themselves (Williams, 2012).

There are continuous calls for new ways of working in mental health services and knowledge from service users to be given its rightful place (Basset, 2008; Beales, 2012; Faulkner and Basset, 2012). What remains less clear in the literature is what service users are actually saying? Specifically, what do service users say are the conditions that help them achieve their goals, increase their well-being and be included?

Method

The purpose of our study was to explore and describe what works for people in contact with mental health services, to help them achieve their vocational goals. This study was more about evaluation than robust research. Anecdotally, we knew the projects were working effectively because service users were consistently achieving a range of vocational outcomes – yearly

project outcome data confirmed this. We wanted to know why our approach worked, how and what does a potential model of change look like.

During our study we were facilitating a co-operative inquiry group (Heron and Reason, 2001). This consisted of peer supporters and staff, integrating peer and vocational support into our centre. We were having regular conversations about what helps people change and hearing that nothing is simple in a genuine helping process – it is crucial to validate people's individual life experiences, emotions, problems with living, trauma and loss stories. We reflected on what questions we could ask service users – how could we get to the heart of their life struggles and distress and what would make a difference in terms of change and growth? To capture their experiences we constructed a range of questions that the group thought were clear and open.

Data collection

We decided to facilitate in-depth interviews with people who were engaged in our peer and vocational projects. We put an advert up on our notice board and asked all of the staff to ask service users if they were interested in participating.

Qualitative data were gathered from the interviews with seven people.

We asked:

1. What areas of life were you struggling with prior to engaging in the peer support or vocational service?
2. What mental health services were you using and how was your mental health and well-being?
3. How were you involved in the project, what worked for you and what life changes have occurred as a result of engaging in peer support or vocational services?

Data analysis

The data were transcribed, content analysed and categorised under the key emerging themes. Validity checks involved giving the participants a copy of their interview with our interpretations. Some minor adjustments were necessary. Overall, the participants agreed that these records were accurate versions of their interview.

We then combined the qualitative data from all the interviews and through further reflection and content analysis we began to see patterns emerging – similarities between the nature and impact of people's struggles and the types of conditions that people were saying helped them in a process of change and growth. These were listed on five pages of A4 and consisted of 50 themes. To try and make the data clearer and more concise, we explored the possibility of creating images to visually represent the themes. We hired a systems designer and she was able to construct initial tree designs. We were then able to embed the themes into roots, trunk, branches and fruits.

We shared these images with staff, peer supporters and service users and the response was enthusiastic and positive. People were saying these images and the themes represented their understanding of the invalidating conditions that cause distress and the validating conditions that facilitate a process of learning, change and growth. Gradually, a model of change – with all its inter-related parts and processes – emerged and this remained faithful to the insights people shared.

Limitations

The sample size was too small to make our findings generalisable and the sampling procedure meant that people self-selected to participate, so they may have had a positive bias towards our service. In terms of subjective outcomes related to well-being no scientifically validated measures were used – we relied on the participant's self-reports.

Findings

Demographic information of participants

This information can be found in Table I.

Life struggles

When we asked people about their struggles and how their mental health was a range of themes emerged. Extreme isolation and its impact featured strongly in all the participants' responses:

> I felt low and hopeless about the future. I couldn't see how I was going to be able to live a normal life again if I couldn't talk to anyone or go anywhere.

> I was completely isolated and depressed. I was living in unsuitable accommodation and did not want to engage with anyone, my windows and curtains were permanently closed.

Many people felt depressed about having nothing to do:

> I was struggling in a cycle of anxiety, depression and isolation. I had nothing to do in the day and my only regular trips were to the chemist or to see my key worker.

Most people's confidence was low and many were experiencing despair because of uncertain futures:

> My self-esteem was very low as I did not have any meaning or focus in my life. I was doing nothing constructive with my time and that was making me more depressed. I had no idea what to do with my life and could not see a way ahead.

> I had no friends, no job, no skills and no hope for the future.

Alongside ongoing struggles with stigma and exclusion a number of people described traumatic life events that had brought them into contact with mental health services:

> Before coming to Beale House I was struggling with everything in my life. I had experienced a lot of trauma, my partner had been killed, my child had been taken into care. I had lost all my family and friends and I was in despair. Due to the trauma I was experiencing my mental health was in a very bad way. I was suicidal and harmed myself as a way to deal with the pain. I was constantly in and out of hospital.

> For the past 2 years I had been an in-patient in a rehab ward, I had been involved in a fire in my house that had left me with significant physical injuries and this had affected my mental health.

Several participants described their struggles with substance misuse:

> My life was not going well […] I had a large unhealthy expensive drug habit. My family weren't talking to me; I wasn't eating as all my money was going on drugs. I was also drinking as a way to deal with my pain.

People were saying their main struggles with their mental health were related to problems with living and these difficult life experiences had created significant distress over a number of years. Consequently, everyone we spoke with had ended up in secondary mental health services for over five years. One person had been in services for 20 years, including 11 annual admissions to hospital. These were bleak, harrowing and painful situations that people arrived with.

Table I Demographic information of participants

	Age	*Ethnicity*	*Gender*	*Length of secondary mental health service use*	*Length of vocational service use*
P1	42	White British	M	10 years	4 years
P2	57	White British	F	5 years	4 years
P3	27	White British	M	6 years	3 years
P4	48	Black British	F	9 years	4 years
P5	43	White British	M	25 years	7 years
P6	41	Black African	F	5 years	2 years
P7	36	Black British	M	7 years	2 years

Life changes and outcomes

All of the people we interviewed said that as a direct result of being deeply involved in a process of learning, change and growth they experienced a range of significant benefits. In healthcare terms these fell into: health, personal well-being and community inclusion outcomes.

Health

Everyone significantly reduced their use of secondary services and avoided crises. One person was discharged from hospital and six were discharged from their community mental health teams:

> The Doctor on the ward was impressed that I was showing independence by going out and coming to work, and I think that played a part in my discharge from hospital.

Four people stopped and two reduced their use of psychiatric medication. Several reported that they had stopped drug (crack) and alcohol use. Everyone told us that their sense of well-being, mood and physical health had improved – including diet and sleeping patterns. Peer supporters stated that they had helped others avoid hospital admissions:

> My mood has improved, I'm in a better frame of mind. I used to go into hospital all the time as my life felt out of control but not now. I am so happy not to keep going into hospital.

> As far as I am aware none of the people I have supported have gone back into hospital. I feel proud […] this is beneficial to the person and has helped save the NHS money.

Personal well-being

People said their confidence and sense of optimism for the future had improved. They felt a stronger sense of control, more independence and happier. Feeling valued, proud and having a positive state of mind also featured strongly:

> I felt worthless before but now my self-esteem has improved. When I come here I know something positive is going to happen.

> I feel more independent, I feel more in control of my emotions which has lessened my feelings of depression and self-harm.

Community inclusion

Everyone increased their range of mainstream and vocational activity. Three people obtained employment – off welfare benefits. Several had gained new skills through accredited training courses and were experiencing better routines. All participants were pleased about making new friends – widening their social networks through new vocational activities. The majority mentioned that relationships with their families had improved:

> I didn't expect my relationship with my family to improve. What could I chat to them about before? – throwing up after taking drugs, say I sat around all day doing nothing? Now I can ring up my mum and tell her how I earned some money through my cleaning work. They have something to be proud of. I was even able to buy my sister a new top. It's a good feeling.

> I have friends now, and that makes me feel good. I can scroll down my phone and see friends' names and that makes me happy.

> I feel in the last year I am fully active, I have gone from doing nothing to having activity in all parts of my life; from working, to exercise to having friends.

Specific vocational outcomes

This information can be found in Table II.

Table II Specific vocational outcomes

P1	*P2*	*P3*	*P4*	*P5*	*P6*	*P7*
Employment	Volunteering	Employment	Volunteering Education	Volunteering	Education	Employment

What works?

Everyone said that the nature and quality of interpersonal relationships with peer supporters and staff were crucial. For example: feeling accepted as a distinct individual and having respectful trusting relationships that were equality based, holistic and dependable:

> I didn't expect to be able to find somewhere that supported me as a whole person. I come as a package – someone looking for employment but also someone who has been through a lot of bad things. Most services want to put you in a box – and will choose the bit they want to help. But Vocation Matters saw all of me and gave me space to address everything.

> The way the staff treat you here has really helped me. You can talk to them about anything you need to, as they talk to you like an equal, with respect. They don't look down on you or treat you like a child.

It was important that a person's potential was recognised. Although they often doubted themselves initially, a sense of belief and hope from others made a difference:

> They say well done, they help me feel more positive. They affirm their belief in me. They believed in me when I didn't believe in myself. It's easy when you are in distress to get wrapped up in, I should of/ I could of. But they kept me focused and positive.

Feeling validated emerged as an important factor within a vocational journey. People valued having their distress understood in the context of their experiences:

> They have helped me feel more comfortable with who I am.

> My life was falling apart, but I have found acceptance, things to do and a focus.

Several remarked on how simple, quick and easy it was to access help, and liked that no referral or assessment forms were used. It was clear many valued having a safe space to explore and work through circumstances that were causing distress:

> They saw me immediately – no long assessment, no complicated referral, no waiting list – they saw me quickly and we started to plan and work together.

> The focus has always been on my future vocation, however they are always giving me essential space to talk and get support for my domestic problems. This has been vital – it's crazy to think I can concentrate just on getting back to work when the situation with my son is so upsetting. They gave me space to talk about this and then move on.

People appreciated the reciprocal relationships and benefits (addressing isolation) that emerged through peer support and how this was facilitated:

> People go into crisis less often as they are less isolated and peer supporters are available to help.

> I think I have developed skills of looking out for quiet, shy people – I can use my life experience and struggles to help others. Some people may have degrees but I think I have the empathy to help others.

> I explain to people that it's ok to feel unsure, or stressed or worthless, it's human. I try to help them understand, by explaining I've been there myself that everyone can feel overwhelmed, but you can get through it.

It was also valuable that the staff – of the user-led service – empathised and emotionally resonated with some of their life struggles:

> He is very insightful and supportive; he understood that it was difficult for me, due to my low self-worth to choose an activity that was just for me. He encouraged and re-assured me that it's ok to do something for myself.

> When you are experiencing extreme feelings of low self-worth and depression it can take a long time to get your confidence back and to see a future. Vocation Matters seem to get this and offer the time and space to help you find your way.

The participants all agreed that having autonomy and control in finding their own way forward was vital. From practical aspects such as choosing courses, to how long they accessed support for the choices remained with them. This was seen as particularly important for the pace of change. People told us – given what they had experienced – change can be difficult, slow and delicate:

> I could not believe it when I met with them and they told me there was no time limit […] with other services they stop after six sessions, like counselling I'll only have eighteen weeks. It can feel- just as

> you are beginning to make progress and trust people, the service ends. They said: you decide when you want to end, this feels very empowering.
>
> They went at a pace that worked for me. I have choices about opportunities, but I needed to go gradually at first. I was given time to absorb the options. If I had been pushed too early I may not have done anything.

Everyone valued having access to a range of meaningful activity. Several described how being supported to match their aspirations to activities had helped them feel less isolated and more purposeful – increasing well-being and a sense of aliveness:

> I have something positive in my life – now I have an answer to the question what did you do today – I'm coming alive again.
>
> My mind is more focused than before. Thinking about work helps me feel better.

There were several comments about the benefits of earning money. People described how economic inclusion helped them:

> The money I earned felt different to my disability benefits, it was clean money and it felt wrong to spend it on drugs.
>
> Because of my changes in finances I am going overseas to see my daughter. I haven't had the opportunity to do this before.

The importance of a good environment where people can have privacy and feel safe featured consistently:

> My first impressions were that it was a place I could feel comfortable in, it felt welcoming and calm.

Validation or invalidation: to be or not to be?

Throughout the interviews people described their life struggles as being detrimental and invalidating to their well-being – bringing them into contact with mental health services. In contrast, they said that with the right validating conditions they were able to learn, change, grow and achieve important vocational goals. The visual representations that depict these two sets of conditions and are grounded in the evidence presented in Table III and can be seen in Figures 1 and 2.

A validation and invalidation framework – as an overarching perspective – can help us understand the lived context. Table III shows examples in important areas of living.

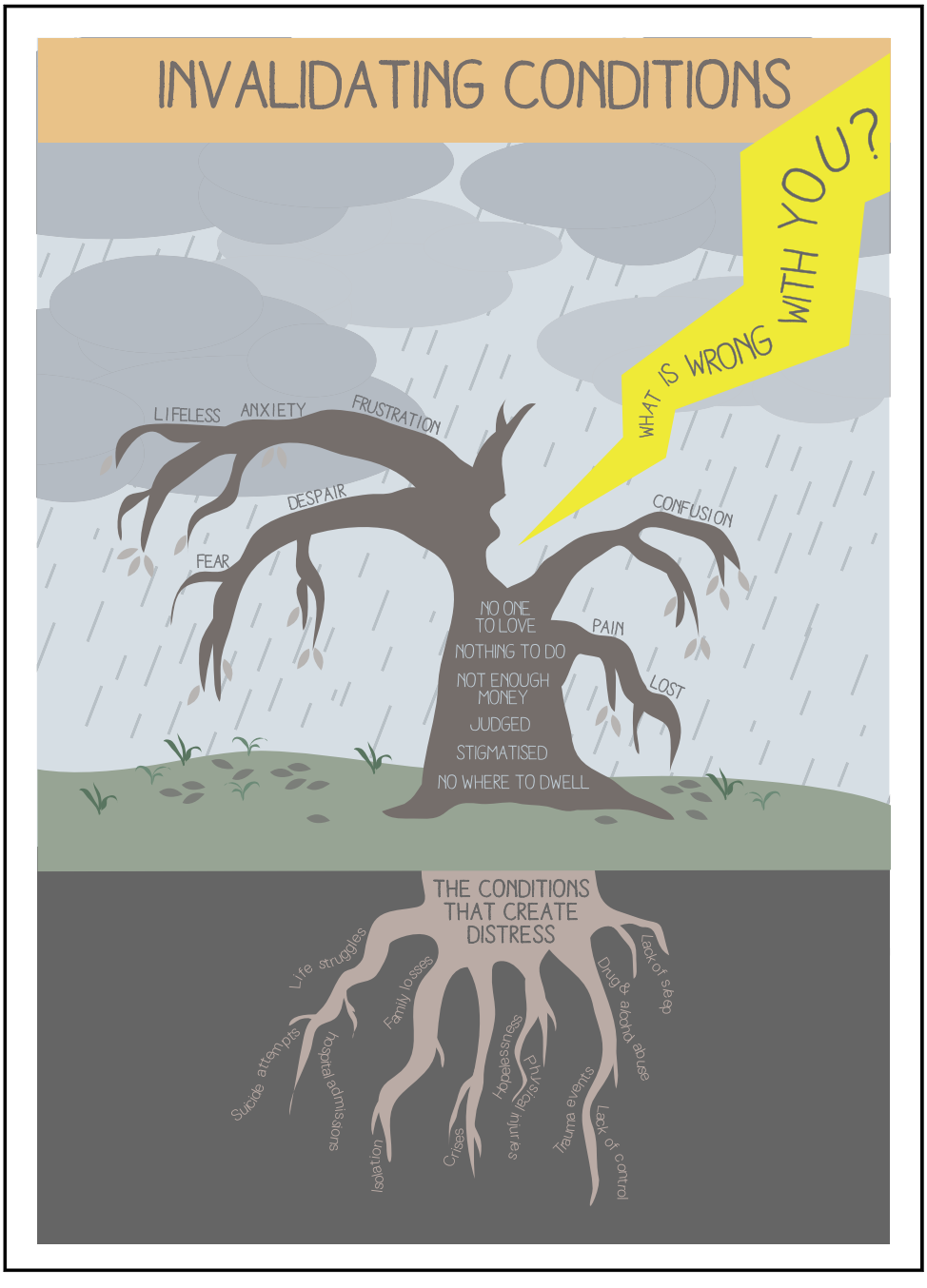
Model of change

For this group of people the types of engagement and conditions that worked to improve mental health, well-being and quality of life have been identified clearly and can be stated. We propose that these conditions are validating – they are the foundation for a model of personal change and what matters most in a helping process. Four key themes emerged.

Table III A validation and invalidation framework

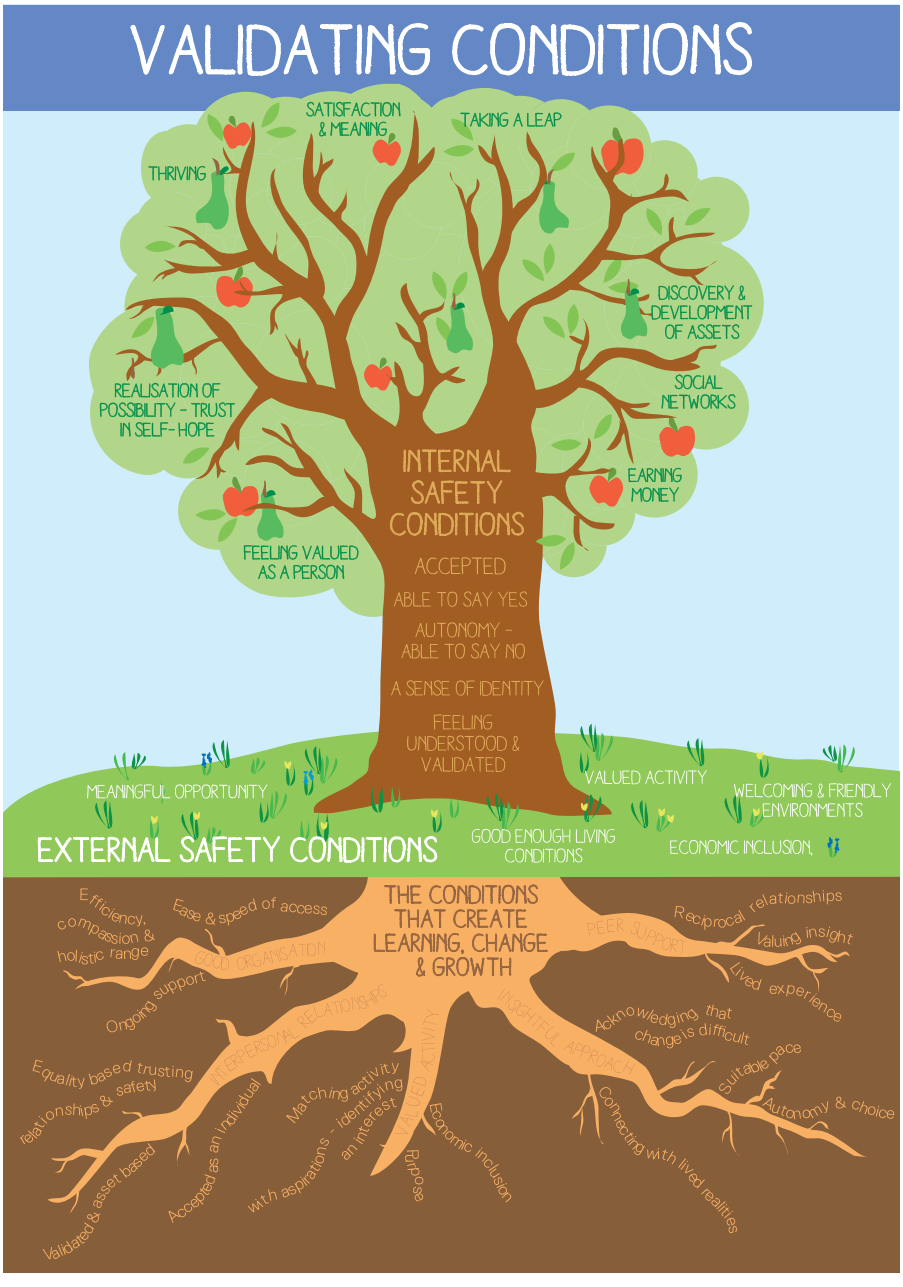
Validating = promoting well-being	*Invalidating = creating distress*
Somewhere to dwell: safe, warm and peaceful	Nowhere to dwell: homeless, incarcerated or noisy and unsafe
Something to do: employment, hobbies, fun things to do and achieving personal goals	Nothing to do: boredom, frustration and no fun easy to slide into apathy and lose confidence and hope
Someone to love: personal and social relationships, friends and networks	No one to love: isolated and alienated
Economic inclusion: enough income to thrive. You can have nice choices	Economic exclusion: not enough income to survive. Hard choices to be made like eat or heat
Accepted: as a citizen in society with rights and responsibilities	Stigmatised: rejection and discrimination
Healthy communication: heard and understood. What happened to you – how are you feeling?	Unhealthy communication: judged, ignored, talked at. Told what to do – what's wrong with you?

Figure 1



1. Interpersonal relationships:
   - listening carefully and accepting all of the person, their entire experience;
   - the development of trusting relationships; and
   - recognising and validating people's potential.
2. Insight-based approach:
   - Staff or peer supporters being able to relate or emotionally resonate with the struggles people experience.

Figure 2



- Helping people find their own way forward, never telling people what to do or asking what is wrong with them.
- Respecting that personal change can be a slow, delicate and difficult process – given what has happened in that person's life. People grow at the pace that suits them.

3. Valued activity:
   - Having a sense of purpose and direction can be beneficial and meaningful. The aim is to help people identify and achieve their vocational goals towards social/economic inclusion.

- Integrate a holistic range of emotional, practical and financial support, to facilitate a compassion-based approach with efficient vocational support.
- Allow people access on a self-referral basis and in order to not feel assessed or judged; no assessment forms or measurement tools are used. Work with people without a time limit.

4. Environment:
    - Warm, friendly, safe, comfortable and good furniture with access to PCs. No glass partitions or CCTV.

Conclusion

This co-produced study explored the life struggles people experienced, what the impact was and what worked – to help people find their own way forward and turn their lives around.

People were very clear and identified a wide range of life struggles that brought them into contact with services such as: income poverty, unemployment, trauma events, serious physical injuries, bullying, isolation, drug and alcohol problems, family losses, stigma, meaninglessness, hopelessness and a lack of sleep. It was the invalidating effects of these struggles that caused serious damage.

We were told the impact involves intensely distressing emotions (anxiety, fear, despair and helplessness). These were attributed to problems with living and trying to survive in extreme situations and/or being exposed to traumatic events that felt, at best difficult, and at worst intolerable. Everyone we interviewed felt invalidated (personally and socially) relative to what had happened to them. Most had given up hope of any kind of healthy future – several were suicidal, or had spent long periods in psychiatric hospitals. It is striking and disturbing, just how bleak, harrowing and precarious people's lives can become in the capital city of a modern society.

However, all of the people we interviewed found their own way through and there are several important threads that bound their stories together. How people were perceived and treated was simply everything. It was the human, can do and co-productive approach within the vocational and peer support projects that shone through. People felt accepted for all of who they were as individuals and they valued the extent of choice and control with no imposed time limit. They felt all of their experiences – struggles and assets – were consistently validated and respected. This foundation underpinned everything that happened.

The level of trust created the internal and external conditions of safety necessary for people to vote with their feet and engage in a self-learning, change and positive growth process. Everyone involved progressed and achieved significant health, personal and social outcomes.

We recognise that not all of these insights about what works with people are new and there are examples of good practice elsewhere – particularly stemming from strength-based models. However, given the poor outcomes and experiences that service users generally report we make the following recommendations.

Recommendations

1. The evidence here reveals that the difficulties that bring people into contact with mental health services are multifaceted, but have common themes – problems with living and being invalidated. The challenge for all mental health services is to recognise and address the economic, psychological and social consequences of these life struggles. If these areas are not addressed then the demand on services will continue to increase because the direct causes of distress are not being resolved.
2. The vocational and peer support projects shared the right validating conditions for co-producing learning, change and growth. Our evidence suggests that whilst people have a huge range of skills, experience and knowledge to be recognised and developed, many people are also still struggling with difficult social problems and distress. To argue that people's assets can be "activated" almost immediately with light touch support, solving problems quickly and saving the NHS millions is to ignore the complexities people are living with. We believe there is still value in long-term holistic support suited to what people say will work for them.

3. The model of change and the invalidation/validation framework that we have described from the insights and wisdom of service users' needs to be developed and implemented. Part of this will be to make the skills, orientation and values of the staff explicit and clear, so that positive health approaches and outcomes can increase substantially across the whole system of primary and secondary care.
4. The wide range of current standardised approaches and pathology-laden practices in the mental health field need to be reviewed in the light of: the extent to which they invalidate or validate service users lived experiences.
5. Significant reductions in the use of expensive secondary services and people gaining employment clearly have cost savings. An economic model needs to be designed to calculate these savings accurately.
6. Vocational and peer support that facilitates social inclusion and learning, change and growth should be the priority for Government policy, commissioning groups and mental health services.

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